Integrative power in Swiss home-like childbirths: a qualitative multiple case study

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Conflict of interest

The authors declare that they have no conflicts of interest to declare.

Ethical approval

Cantonal Research Ethics Committees on research involving humans approved the study (CER N° 118 02/12). The main ethical issues were informed consent, autonomy, confidentiality and anonymity.

Funding sources

The Swiss National Science Foundation funded this work (grant 13DPD3 – 136765).

Highlights

- Relaying on integrative power strengthens midwives' decision-making abilities
- Mastering integrative power improves collaborative relationships among health professionals and improves health outcomes
- Exercising integrative power increases women's participation in decision and improves quality of care

1. Introduction and background

Findings from evidence-based frameworks show that midwifery is essential to meeting the specific needs of women who are primarily going through physiological reproductive processes (Renfrew et al., 2014). Over 20 years ago, Page (1995) wrote that midwives should use their power to solve the significant problems faced by families of childbearing age and to enrich the event. At that time, major issues for midwives included continuity of midwifery care and midwife-led care, which required a paradigm shift to become powerful and effective, moving forward as autonomous practitioners with caseloads. Despite such exhortations, midwives still experience problems in playing their full part in maternity services and the communities in which they practise. Power relationships and communication issues are known to affect the way maternity care professionals work together (Pollard, 2007). Pollard later (2011) reported how midwives' discursive practices, reinforcing traditional notions of gender, professionalism and the medicalisation of birth, have contributed to the maintenance of the status quo in English maternity care for decades. Another important, though under-explored, factor connected to interprofessional care are the unequal power relations that exist between the health professions (Baker et al., 2011). In the same vein, a report from the Word Health Organization (2016) showed that midwives are highly committed to providing the best quality of care to women, babies and their families but are constrained by the complex hierarchies of

power that play a critical role in the provision of maternity services. The report says that when other health professionals wield hierarchical power, it can undermine the authority and decision-making ability of midwives. Fahy and Parrat (2006) illustrated how the exertion of power can become pathological with the birth story of a young primipara who became passive, silent and sullenly compliant after a series of acts of midwifery and medical domination. These included a lack of support during labour, the refusal of epidural and poor communication during an assisted birth by vacuum extraction. These authors named the power at work in that story 'disintegrative power', which, when used by professionals, undermines the woman as the decision-maker in her own care, diminishing her sense of self. To bring about a change in midwifery, more understanding on the social structures of power deserves development.

Different typologies of power have been defined, delineated by a mixture of personal processes and structural conditions (Boulding, 1990; French and Raven, 1959). The social structure of integrative power described by Boulding is particularly interesting. For this author, structures of power in groups tend to be hierarchical and generally rest on a complex mix of three types of power: coercive power, exchange power and integrative power. Coercive power means that someone is forced to do something which is against their wishes. This kind of power is typically positional, often used by political institutions to enforce authority and/or enact order in an organisation. However, coercion can lead to dissatisfaction and is often counterproductive or even destructive. Exchange power refers to productive creation or to activity organised through market mechanisms. It comes into play in many everyday actions and may or may not be coercive. Boulding, however, sees the third power, integrative power, as potentially the most dominant and most significant form of power. Indeed, for this author, neither of the first two forms of power can accomplish much in the absence of legitimacy, which is one of the most important aspects of the power of integration. Integrative power may exist in the absence of force or trade, because it is an important binding force to obtain what people need and want in harmony with others. Further, according to Boulding, integrative power will create relationships, bring people together, build organisations, inspire loyalty and develop respect

and legitimacy. Thus, it is worth studying how integrative power may be empirically identified during childbirth, especially when complications occur. Due to a lack of hierarchical structures, childbirth at home or in a birth centre is often more conducive to the application of integrative power, which may afford respect and acknowledgment for midwives' expertise and for women's birthing capabilities.

In Switzerland, approximately 87,000 women give birth/year (Swiss Confederation, Federal Statistical Office, 2018). The vast majority of women opt to give birth in a hospital. Some choose a home-like setting because they believe that physiological childbirth is more respected. Indeed, a lower rate of intervention was shown to have no impact on perinatal outcomes among low-risk women; of concern are the induction of labour, epidural anaesthesia, episiotomy, and instrumented and operative delivery (Birth Place in England Collaborative Group, 2011; Borel et al., 2010; Davis et al., 2011). In 2017, 1,508 babies were born in 23 birth centres and 735 were born at home, corresponding to 2.6% of all births in the country (Grylka et al., 2018). According to Hodnett et al.'s definition (2008), 'home-like settings' in Switzerland practise natural birth under the responsibility of the midwife, have variable staffing (mostly with two midwives at births) and have no routine input by medical practitioners. The home-like setting caters to women who are experiencing uncomplicated pregnancies and expect to have physiological labours culminating in normal births. Women wishing for a home-like birth contact a midwife during pregnancy to arrange their maternity care. A federal law requires that midwives working in home-like settings have at least two years' professional experience and are registered with the canton (administrative area) in which they practise (Swiss Confederation, Federal Office of Public Health, 2018). Costs for non-hospital births are covered by the woman's medical insurance.

2. Aim

The purpose of this paper is to increase understanding of integrative power in decision-making in home-like childbirth from midwives' and women's perspectives.

3. Methods, participants and ethics

To enhance understanding of integrative power, a multiple-case study method was chosen. Gillham (2000) notes that such a method is relevant for investigating a contemporary phenomenon in depth within its real-life context.

In the application of case study research, Yin (2012) argues that the distinctiveness of the case study serves as an empirical inquiry about a contemporary phenomenon, especially when the boundaries between the phenomenon and its context are not clearly evident. Furthermore, multiple case studies sometimes include deliberately contrasting cases, providing greater confidence in findings; each case aims to examine a complementary facet of the main research question. In his book on case study design and analysis, Yin (2009) describes three conditions for which a case study is ideal: when (a) 'how' and 'why' questions are being posed, (b) the investigator has little control over events, and (c) the focus is on a contemporary phenomenon within a real-life context. In the present case study research, these three conditions exist. We addressed the following questions on the distribution of integrative power: (a) How did relationships or alliances between women, midwives and partners proceed when complications arose in childbirth? (b) How were participants brought together during decision-making? (c) How was loyalty created? (d) How was the power legitimate? (e) Why was integrative power potentially significant? The data are based on the thoughts and revelations of the key persons involved in home-like childbirth and a decision had to be made. The real-life context was captured from the actual situations in which women and midwives were involved.

One of the most relevant forms of data collection for case studies are in-depth interviews (Yin, 2009).

Participant recruitment: Twenty midwives were recruited in two areas of Switzerland, one in the French-speaking part and the other in the German-speaking part, using registers of the Swiss Midwives' Federation, which list all self-employed midwives attending to women with

home births or in a birth centre. The inclusion criteria were that the midwives could talk about a birth in which unexpected complications arose that required a decision about whether or not a hospital transfer should occur. Following their interviews, the midwives were asked to contact one of the women described in the interview to ask for permission to pass on contact data to the research team. With permission, the research team contacted the women, obtained their consent and, when appropriate for the women, invited partners to be part of the study.

Data collection: To provide the case studies with insights into integrative power, problem-centred interviews, which consider interviewees as experts in their decisions and actions, were chosen (Witzel, 2000). Cooperation between the interviewer and interviewee stimulated reflection from different perspectives. Interviews began with an initial broad question to the midwife: 'Can you describe a labour in which complications arose and you had to consider a transfer to a hospital?' An equivalent narrative stimulus was given in interviews with women and partners. Next, researchers built on the answers given to maintain the narrative flow. The interviews averaged an hour, were audio-recorded with the consent of the participants and were transcribed verbatim. Quotes from the interviews used for publication were translated from French and German into English.

Data analysis: For this multiple case study, four cases were purposefully selected. The sample size of four cases is derived from Patton's prescriptions (2002) on the purpose of the inquiry: what will be useful, what will have credibility, and what can be done with available time and resources. As with multiple experiments, only the replication of an original finding can ensure high credibility of results. For Yin (2009), an important step in all these replications is the development of a rich, theoretical framework under which a particular phenomenon is likely to be found. An important consideration is that the selected cases will allow the achievement of literal replications with the same or very similar results. Therefore, the four selected cases in the study should show sufficient replications to convince the reader of a general phenomenon.

Trustworthiness measures: After a thorough reading of the transcripts, the research team members realised that integrative power may refer to the use of power by the woman and the

midwife in decision-making that led to seeking an in-depth insight. The team chose the four cases that best reflected the characteristics of the phenomenon under study. Trustworthiness was enhanced by collaborative data analysis of the four cases and by reaching interpretative convergence for the cross case overall synthesis (Patton, 2002). Furthermore, all members selected the quotes that provided the best illustration. Native interviewers who had also conducted the interviews carried out the translation; thus, the meaning of the words was accurately reproduced. The translation into English and the language modifications were compared with the original language, with all authors agreeing that, while no longer a literal translation, the original words' connotations remained accurate. Y.M. wrote the original draft, and all authors contributed to revising the article. V.F., an expert in the domain of partnership and power, supervised the development of this work.

Ethical considerations/data management: The Research Ethics Committee of the Canton of Vaud approved the study. All participants were given detailed information and were invited to ask questions prior to giving written consent. All participants were informed of their right to withdraw from the study without recrimination. Due to the specific nature of case studies, with in-depth interviews in the particular context of home-like childbirth, ethical challenges abound. As a result, confidentiality was respected by removing all identifiable details, and anonymity was guaranteed by replacing the names with coded numbers.

4. Results

The results focus on the four cases, each with a clinical description and quotations on decision-making, followed by an interpretation centred on the mechanisms of integrative power at play. Finally, a cross-case comparison allowed a synthesis of these integrative power mechanisms.

Case 1 (Midwife 9 and Woman 24 and Partner): maternal exhaustion

<u>Clinical situation</u>

A primipara who chose a water birth in a birth centre. On arrival, she was in labour. She spent some time in the bath, but upon coming out, the membranes ruptured and she moved into the active phase. In this phase, the head failed to descend and suddenly the fetal heart decelerated. The fetal heart was then monitored continuously, and oxygen and a tocolytic injection were administered. The two midwives hesitated as to whether to transfer the woman to a hospital. Instead, they phoned a third, senior midwife, who was on background call. This senior midwife (respondent in the interview) advised emptying the bladder if necessary. At the same time, she preferred to personally assess the situation and came to the birth centre. Her intervention was aimed at recognising whether the fetal heart was again reactive and drawing the attention of the midwives to the health and wellbeing of the woman and the fetus. To help strengthen motivation, she refocused the woman on what was important for her, including whether she still had the strength to move. The woman did not want to have to go to the hospital. She found the strength to stand up, to hang on to the wall bars, and to tune into her baby, and it worked. Two hours later, she gave birth to a healthy baby girl.

The senior midwife's view:

> *The midwife took me aside and said to me: 'I'm handing the responsibility over to you... because, I'm just scared. What if there's a bradycardia again and the heart rate doesn't increase? And then I said, 'I understand your concern, so let's monitor it fully now... so that we really consider the whole situation by looking at the other issues as well... but I think at the moment we can accept... the baby's now reactive and the birth should be soon… we'll support both the baby and the mother so that they have optimal conditions // yes // and do we expect she can do it on her own?'... And then we went back into the room… the three of us supported her... the woman was very motivated... and at some stage the head was on the pelvic floor… then I noticed how the midwife breathed better: `It's COMING´, I noticed how, suddenly, a good feeling came back into her, and from then on she really guided the woman again.*

The woman's view:

> *I was totally involved, I was asked if I still had the strength... if I still wanted to do it. Because I thought I still MUST WANT... otherwise it wouldn't have worked... I think if I had said I didn't*

want any more or I can't do it anymore, then they would have decided differently. Mhm I was VERY clearly asked if I still have this strength... and CAN I use it right THERE. Again, I appreciated it so much. I was supported in various ways... through the presence of these three midwives and [my partner]. Then I got acupuncture, and I think something directly into my blood, various different drinks depending on my mood. Yes, I was supported on many levels: the acupuncture, oxygen and even the catheter have all helped, as did different kinds of touching and encouragement. So I found the whole range of possibilities was offered to me.

The partner's view:

When the senior midwife came in, you immediately noticed her experience... and then she came in with a very calm manner… the situation got rid of all the pressure... and then it was VERY interesting to note that there were three parties... each had her own opinion, but it had been DISCUSSED as to what was the best now so that everyone could make her best contribution somehow.

Interpretation

This case shows how this labouring woman was exhausted but preferred to stay in the birth centre, and how the midwives supported her. Having heard her wish, the two midwives decided to take advice from a senior midwife on background call in the middle of the night. In doing so, these midwives created links and established a communication network, extending the available resources. This welcome initiative based on the limitations of available knowledge generated new exchanges and helped to build a different approach to the care.

On her arrival, the senior midwife analysed and discussed the situation with all parties. She probed the woman's desire for birth and gave her some keys to find new energy despite her great fatigue. She also dealt with the responsible midwife's concern for fetal wellbeing and reassured her about the safety of the strategy: The baby's condition had improved, and after a while, progress in the head's descent was clear. At some point in the situation, destructive

power was not far away. Under pressure, the senior midwife could have undermined her loyalty by unilaterally taking the woman's or the junior midwife's side. In reality, she was able to integrate the needs of both. On one side, the powerlessness of the woman made her weak and inactive. However, she was able to assert her wish and reinforce her active participation. The senior midwife demonstrated her personal integrative power by showing great respect for the physical and mental abilities of the woman and the baby to give birth naturally. She also demonstrated individual skills of great use for the woman to overcome fatigue. Conversely, the senior midwife had to face the concerns of the first midwife over the possible consequences of fetal asphyxia if birth was pursued in the birth centre. She heard her colleagues' fear without minimising risks, and she showed ways to ensure good surveillance. By so doing, she commanded respect that contributed to the legitimacy of her intervention. The women's partner observed that each of the three midwives had their own opinions but were able to discuss them together, which allowed everyone to contribute their best.

Case 2 (Midwife 16 and Woman 35): high blood pressure

Clinical situation

A multipara whose previous births had been supervised by the same midwife. During this pregnancy, the midwife discovered pregnancy-induced hypertension and referred the woman twice for medical consultations. The investigations did not detect anything abnormal. However, the doctor advised against giving birth at home, arguing that even if it was not a gestosis, there were risks nonetheless. The midwife then took advice from another obstetrician, who gave a contrary opinion. It was then the woman's informed choice to give birth at home with antihypertensive medication. The labour began spontaneously with good progress, but because the woman's blood pressure was high during labour despite the treatment, a joint decision was made to transfer her to the hospital by private car. The transfer was not easy because of vomiting, but the woman described it as 'funny'. On arrival at the hospital, the health personnel were very busy, and the self-employed midwife was allowed to stay with the

agreement of the team. The labour progressed very quickly, and the child, a baby boy, was born shortly later. Everyone was fine, and the woman's blood pressure steadily decreased. The immediate postpartum was perfectly in harmony with the woman's expectations, and she decided to stay overnight at the hospital.

The midwife's view:

> *I said to myself... 'I don't want to have a woman whose blood pressure suddenly increases, because if it does I don't know what I will do. I don't feel comfortable with such a situation. Resuscitating a baby, we know the ropes... but I never resuscitated an adult. And really, I did not feel at all comfortable, it did not seem to me to be part of my skills; and that's it, this baby was born at hospital for midwife anxiety (laughs)*

The woman's view:

> *I realised afterwards that I wasn't scared at all... but that [the midwife] didn't know what to do or how to do it. It was not that at all. But I, I thought to myself, well we still have more children, I really have to be sure that if something happens... because I had never known that before high blood pressure did things like that; but I got the impression that when my blood pressure went up, it was... I had an anxiety that was linked… clearly, when it was high, I was more... I was less calm internally. And even worse, while being in labour, I said to myself, well what am I doing; I have more children... I think it's more sensible if I go to the hospital. I think the decision was really driven by fear. Not fear of birth... well, I knew how a homebirth goes, I don't think it was at that level; it really was I think... what if something happens to me, I did not want to die. It was something like that. Therefore, it seemed to me that I would feel safer in hospital.*

<u>Interpretation</u>

This case shows that plans for a home-like birth can change even after previous births without problems in the same context. The choice of another home birth was maintained after hypertension was investigated and after a second medical opinion. However, during labour, a new wave of hypertension caused the plans to be changed. The midwife who attended to that labouring woman was influenced by the way she felt 'most uncomfortable' imagining the scenario of eclampsia requiring resuscitation. The woman was also influenced by the way she

felt ‘less quiet internally’ when her blood pressure was high, even fearing she could die. The two treated each other with loyalty – that is to say, faithfulness to commitments or obligations. The midwife was aware of her duty of care to the mother and baby, but although the woman did not have any doubts about the skills of the midwife, she was also preoccupied with her safety and responsibility as a mother. This safety issue brought the midwife and the woman together to make the decision to transfer to the hospital. The power of decision was not hierarchical, but rather well and truly integrated.

Case 3 (Midwife 2 and Woman 23): prolonged labour

Clinical situation

A primipara who wished to give birth in a birth centre. She arrived at the birth centre with strong contractions at night. She was in labour, but the head had not begun to enter the pelvis. Six hours later, after a bath, and a lot of moving, she felt exhausted, with sudden, heavy symphysis pain. The midwife discussed things quietly with her. Although the labour had progressed well, the head was still high but not yet worrisome, and the fetal heart rate was normal. Two alternatives were discussed: whether to continue the labour on the spot, trying to help the birth process with position changes, or using an epidural. The woman decided to go to the hospital for an epidural because she was at the limit of her strength. The transfer was made by private car. At the hospital, the epidural was inserted without delay, and the labour progressed, but slowly. The woman gave birth to a healthy baby girl, after a Kristeller manoeuvre and an episiotomy.

The midwife’s view:

> *She [the woman] herself started saying, ‘there [at the symphysis] it is such weird pressure and how about an epidural’ etc. And then we examined one and a half hours later... the head was*

ALWAYS the same, and also at the cervix nothing had changed. There was no progression at all. Then I also raised the subject of epidural... maybe so there can be some relaxation [helping to move forward]. THEN she wanted that too... she had ALSO noticed it was NO progress anymore... and then we really decided at peace with each other (…). We could continue to try, as for me there was no danger…. but then I looked at her and saw that she was exhausted and I didn't want to risk a critical situation (…) so I asked her if we should go together to the hospital.

The woman's view:

[The midwife] then noticed that the baby... the head pressed on the pubic bone and didn't really slip down into the pelvis… we then continued to move about… and at some point she said... 'how about an epidural? how's the pain?' … she herself might try to wait for an hour but... she realised I couldn't take any more, and at that moment I thought 'yes SURE… I know it's not moving forward... somehow I also noticed with the strength [of the contractions] I could not manage anymore and I just said, 'YES let's go to the hospital' … I just did not care.

Interviewer: Why?

Because these pains had been SO strong and I was SO exhausted ... and I just wanted the baby to be there and that I and especially the baby were WELL... and I just had such SUCH strong faith in the midwives that they KNEW... if it was really necessary and... afterwards also VERY surprised that there was no caesarean section, and that they waited so long.

<u>Interpretation</u>

This case shows how the midwife involved the woman in the decision, outlining two possibilities when the labour progressed slowly and the woman was exhausted. The relationship between the woman and the midwife was mutually respectful. Each party was able to follow what they believed to be the best course of action. With the choice of continuing for an hour using active positions or having an epidural at the hospital, the midwife advocated a safe approach to labour

and birth, and the woman could express her preference. The woman quickly accepted the second alternative because it met her own perceptions, feeling exhausted and aware that the labour was progressing poorly. She could express her faith in all the midwives who took care of her, as well as in the birth centre and the hospital, because thanks to them and despite a prolonged labour, she avoided a caesarean section.

Case 4 (Midwife 13 and Woman 34): retained placenta

Clinical situation

A multipara who wished for another homebirth. In this pregnancy, the woman had several antenatal visits by the midwife. Her haemoglobin was at the limit at which her midwife was comfortable, and the woman was advised about sources of iron. At term, she spontaneously gave birth to a healthy baby at home. Immediately after the baby was born, she experienced heavy bleeding. The midwife checked the fundus and the perineum and diagnosed a retained placenta. She promptly said to the woman that she would help the placenta to deliver, and she carefully, manually removed the placenta. The woman experienced no signs of excessive pain. Expelling of the placenta was followed by the administration of an intravenous medication of oxytocin to stop the bleeding. Removing the placenta from the uterus was easy, and checking the placenta showed it was complete. Bleeding stopped soon after delivery of the placenta.

The midwife's view:

> *She gave birth while sitting on the small chair; very good… And then suddenly, she began to bleed massively. In such cases, I am not going to sugar-coat things (smile). So I just told her that I was going to help her a bit, that she had to hold the baby, her partner was behind her, was supporting her with her baby, and then I told her I was going to help expel the placenta. Then I carefully, manually removed the placenta. Unlike what we are taught, women don't faint and have little pain. She barely felt… that I was feeling inside her womb. And then the placenta came and I finished with… an intravenous injection of oxytocin.*

The woman's view:

I was sitting on the little birthing chair, and when the baby came out, [the midwife] saw the blood flowing ... not as if it was arterial, but still I saw that she was worried. She just pulled out the baby, put it on my lap, and then started taking care of the placenta, doing a manual extraction...

I remained relaxed ... I didn't add fuel to the fire, but on the contrary, I tried to stay calm because I trusted her. So I told myself, `she will manage´, and if she assesses the situation as urgent, we take the car and... we go to the hospital… But as I told you, I had the impression that she knew what to administer, what to do; so, for me, there was no reason to stress ... I let her do what was needed; in fact... it was more up to her to make the decision; I stayed on my side and I remained confident.

Interpretation

This case shows how the midwife in the third stage of labour promptly saw the abnormal bleeding and very quickly decided to remove the placenta manually. The measure is unusual for a midwife in Switzerland, even though she is legally allowed to provide such care in emergencies. This midwife acted well and in compliance with the midwifery regulatory framework. These elements speak to her legitimacy and experiential knowledge.

The power was hierarchical because of the special emergency care that was required. However, even though time was lacking for shared decision-making, the woman was able to understand what was going on and, above all, she was compliant and confident. Respect for the midwife's skills was enormous and allowed the woman to remain calm despite being aware of the critical situation.

For the woman and the midwife, it was an integrative power experience, since both acknowledged the benefit of the decision.

Cross-case comparison

In all four case studies, mechanisms for building integrative power were actively exercised by midwives, women and partners when complications occurred in labour. These mechanisms, such as the creation of relationships, cooperation, loyalty, respect and legitimacy, are reconsidered below across the concrete cases.

The creation of relationships was central in developing mutual understanding. Obviously, each team's discussion around criteria for ensuring safety allowed the contribution of all parties in supporting mother and child and optimising the birth condition (case 1). Further, exchanges around mobilising or pain relief helped to comprehend the woman’s perceptions in the situation of prolonged labour (case 3) and to choose the best solution.

The cooperation and the act of working together on joint goals supported mutual decision-making. Notably, calling a senior midwife for advice allowed the development of a strategy consisting of re-questioning the wishes of the woman for childbirth and doing so focusing on her capabilities for active participation (case 1). In another case, hypertension and the mother’s safety issue brought the midwife and the woman together to make the decision to go to the hospital (case 2).

Loyalty was inspired by trust in the midwives’ judgement, which increased the feeling of competent decision-making. Apparently, the woman's confidence in her safety-minded midwife when faced with labile hypertension mobilised values of loyalty with a seamless decision to transfer to the hospital. Loyalty appeared also in the collaborative relationships between the midwives considering health outcomes (case 2). In a same vein, the woman who had faith in all the midwives who cared for her during a prolonged labour helped her to cope with the transfer and birth in the hospital (case 3).

The legitimacy conferred by midwifery regulation and by shared professional knowledge helped decision-making. In particular, this was evident from the appropriate way the midwife practised within the prescribed scope of practice in an emergency (case 4). Indubitably, being

persuaded by a senior midwife against her own feelings of fear extended the boundaries of decision-making (case 1).

Respect was manifest through the recognition of reciprocity in relationships and of midwives' expertise. Visibly believing in the woman's capacity to give birth by herself and her empowerment in turn enabled the woman's gratitude for the support she received (case 1). Otherwise, respect for the midwife's skills in solving the problem of postpartum haemorrhage was not gratuitous but rather built throughout the woman's relationship and experiences during her previous births and during the present pregnancy with the midwife (case 4). Here, respect and legitimacy are very close in the sense that the woman has full confidence in midwives' skills, which are already legitimate by social rules.

Our results confirm the replicability purpose. The four selected cases allowed the achievement of literal replication, which means that there is compelling support for integrative power in decision-making on the side of women and midwives. Nevertheless, each case did not require the same weighting among the mechanisms for building integrative power. In case 3, the creation of relationships and loyalty prevailed; whereas in case 1, the most significant mechanism was the creation of relationships, cooperation, legitimacy and respect. One explanation could be that the complexity of each situation requires flexible prioritisation of different aspects of integrative power.

5. Discussion

The mechanisms of integrative power described by Boulding (1990) were all found at the time of labour in which a complication developed that led to a decision. It is interesting to note that integrative power mechanisms were well demonstrated in midwifery decision-making activities, although they were hidden until probed by the analysis done by the research team. Thanks to these multiple case studies, the implementation of these mechanisms has been made visible and highlighted. In the introduction, however, several authors were cited as showing that midwives are not using their power well to solve the problems encountered in their practice.

How should this gap be explained? When the literature addresses issues of power, the negative effects of authoritarian power are most often seen. In addition to the authors already mentioned in the introduction, Clews (2013) describes the rise of authoritarian knowledge and power by the increasing medicalisation of the twentieth century, which has transformed the vision of normal childbirth: 'Midwives can be submissive to the dominant medical discourse and may themselves unintentionally contribute to the marginalisation of women', p. 4. In home-like childbirth settings, shared decision-making prevails even though authoritarian power may occasionally be exercised for safety reasons, especially in emergencies (Hodnett et al., 2008). Generally, however, the positive aspects of integrative power in midwifery are poorly described in the literature.

Leap (1994) describes strategies to maximise the potential to maintain and develop power around childbirth, with three proposed strategies: alliances with women, alliances with midwives and alliances with other practitioners. Working in partnership has become a recurrent theme for midwifery (Wilkes, 2015). In the cases presented here, partnership between midwives and women worked as an alliance system, one which created, consolidated, offered and reinforced a balance of power and allowed a type of power sharing that improved relations.

Fleming (1994) took up the concept of partnership and associated it with the power of independent midwives in New Zealand. Her findings showed that midwives were aware of the issues of power in their practice but failed to address them.

More recently, in the Lancet 'Series on Midwifery', the power of midwifery based on a particular set of values, including respect, communication, community knowledge and understanding, and care tailored to a woman's circumstances and needs, was briefly described (Horton and Astudillo, 2014). Among these values, there are two cardinal values which are part of the mechanisms of integrative power deployed in all the cases we presented: the creation of relationships through communication, understanding and respect.

Helberget et al (2016) described yet another facet of power, which is that of a shared philosophy among midwives in an alternative delivery clinic in Norway, providing the women in birth with the resources to make good decisions and respect them as equal to midwives. This shared philosophy resonates with the respect for benevolent practice in the birth centre, as well as at hospital after the transfer (Case 1 and case 3).

Another recent study among 11 Dutch community midwives investigated conflicting values encountered in similar home-like settings (Fontein-Kuipers et al., 2018). In that qualitative study, one of the three conflicting values that emerged was the dilemma of loyalty. The underlying factors were when midwives find it difficult to conform to a woman's wishes, to guidelines and to collaborative relationships with other professionals. In contrast, it can be inferred that when midwives can move smoothly in these different registers of loyalty, their power assert itself. Our findings showed that midwives addressed these factors of power.

The strategies and values mentioned above have been developed and are part of core competencies of the International Confederation of Midwives (ICM), which sets out the midwife's mandates (ICM, 2014). Furthermore, ICM has defined midwifery regulation core documents which establish processes ensuring legitimacy, especially support for autonomous practice and accountability for clinical decision-making (ICM, 2011). The fundamental principle of legitimacy was one of the mechanisms of integrative power found in the studied cases.

However, at no time do these core documents mention the exercise of power. Yet, this research shows that it would be justified to name the power, especially the positive forms of power, because it is an unavoidable aspect of influence tactics and leadership practices (Boulding, 1990; French and Raven, 1959).

6. Conclusion, limitation and recommendations

This multiple-case study report highlights the essential role of integrative power in decision-making. When midwives are in tune with the mechanisms of integrative power, it may help bring professionals and women together, create collaborative relationships, endorse loyalty

and respect in work, and encourage woman's participation, which is paramount for intended home births and midwifery in general. Study limitations arise from the fact that integrative power was examined in terms of its applicability solely to unexpected complications requiring decisions during labour. Furthermore, the cases were not conflictual, whereas perinatal events in home-like birth settings are not immune to traumatic events (Sheen et al., 2016). Further research exploring power use and misuse in clinical situations where professional conflict exists is warranted. Indeed, Boulding's theory also applies to the recreation of integration mechanisms when these mechanisms have been damaged (Boulding, 1990).

Integrative power could be a promising approach to reinforce decision-making strategies. Therefore, clinical and policy measures explicitly addressing the positive aspects of power should be developed and evaluated.

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