

Connecting with Women: The  
Working Lives of Independent  
Midwives and their Perceptions  
of the Mother-Midwife  
Relationship

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## **Abstract**

This study aimed to explore the lived experience of the working lives of midwives in the UK who practice independently of the NHS. It was designed to understand their motivations for working in this way and to explore their beliefs and values about midwifery care with particular emphasis on their perceptions of building and maintaining relationships with childbearing women. Hermeneutic phenomenology informed the methodology for the study and an adapted biographical narrative interpretive method (Wengraf 2001) was used for data collection. In depth qualitative interviews were carried out with twenty Independent midwives in the UK between 2007 & 2009. Data were analysed using Ricoeur's theory of interpretation (Ricoeur 1981).

Keys findings indicate that motivated by a very strong sense of what it means to be "with woman"; these midwives initially chose a career path in the NHS that enabled them to better enact this philosophy. However, constraints on their ability to enact this philosophy in the NHS combined with a desire to form more meaningful relationships with childbearing women and to support their individual needs informed a final move from the NHS into independent practice. Independent midwifery is experienced as very positive career move which results in considerable job satisfaction and an opportunity to use the full range of midwifery skills. Formation of the mother midwife relationship is perceived as a pivotal midwifery tool which facilitates understanding of individual childbearing women and their needs. Ricoeur's theory of interpretation (1981) is utilized to explain how Independent midwives form relationships with their clients in this

context. The concepts of “time”, “autonomy” and “risk” are discussed in the light of study findings, contributing a unique insight into the working lives of Independent midwives, the mother midwife relationship and enactment of the “with woman” philosophy in this context. The study also demonstrates that whilst there are many positive aspects of working as an Independent midwife there are also several constraints and potential vulnerabilities. These include the blurring of work/life boundaries, financial insecurity and the consequences of working with clients who often have very complex needs and particular expectations of the midwife-client relationship. Supporting women’s choices, working flexibly to meet the needs of clients and respecting their right to autonomous decision making can place Independent midwives in a position of potential vulnerability and leave them subject to professional criticism.

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## DEDICATION

This thesis is dedicated to Raymond George Golden and Geraldine Pamela Bacon, my parents and to Betty Bacon, my “Ancient Aunt Bet”, all of whom sadly did not get to see this work completed but who would have been very proud.

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# 1 Introduction and Aims of Study

A general interest in and love of people and communication has greatly influenced the undertaking of this study. Observation over the many years personally spent in the profession of midwifery has led to an understanding of the importance of communication for midwives and their work and indeed its importance in all walks of life. The idea for this study was seeded many years ago at the start of a midwifery career in 1978, when I left a job as a theatre nurse to embark on a career in midwifery. I was confronted by many issues. In my previous role patients had been anaesthetized so communication at best was limited. These patients were patients; they were sick and needed surgery in order to hopefully regain their health. In midwifery there were no 'patients', these were women undertaking a normal life event, who in the main were very healthy and self-sufficient. Communication, I observed, formed much of the work of the midwife. This I observed intensified during labour and birth, and it was here that I witnessed some midwives (but not all), who appeared to be 'connecting' with women and developing a degree of closeness and rapport that left a lasting impression on me. The relationship appeared to be built skillfully and quickly and usually with women that were previously unknown. These exemplary communication skills were contrasted against what could have described as the 'cold' and business like skills of others, who appeared to be heavily influenced by the medical model of care that operated at that time.



Since these times I, the midwifery profession and the Maternity Services (arguably), have moved on and have grown in wisdom and awareness. The psychological well-being of women during pregnancy, labour and the postnatal period has been recognized as being extremely important to women's ongoing health and to that of their babies and children (Department of Health 1993, Lewis and Drife 2003, Sandall 2004, National Collaborating Centre for Women's and Children's Health/NICE 2006). Additionally there is an increasing awareness of the value of public health strategies and the potential of the maternity services and the midwife to transmit information that can positively influence the health of mothers, their babies and families (Department of Health 1998, 1999, 2004a, 2004b, 2007, 2008, 2009, Department of Health/SNMAC 1998, Dept. Education and Skills 2004, Lewis 2004).

Women using the maternity services have increasingly over the years, particularly under the influence of the women's health movement and consumer groups from the late 70s onwards, articulated their discontent with the growing medicalization of childbearing and childbirth (Rich 1977, Breen 1981, Oakley 1980, 1984, Rothman 1982, Davis Floyd 2001, Cahill 2001, Edwards 2006, Kitzinger 2006). They have expressed feelings of being processed through a system that appeared to have little time or interest in individual needs or expectations, or indeed any recognition that women might want to be involved and in control of the decision making process around their care during the childbearing year (Breen 1981, Cartwright 1987, Oakley 1980, Oakley 1984, Edwards 2006). Since the 1970s there has been a series of reviews of the

maternity services, each articulating recommendations for their improvement (Maternity Services Advisory Committee 1982, 1984, 1985, House of Commons Health Committee 1992, Department of Health 1993, 2004, 2007). This has resulted in a considerable change in service philosophy, at least on paper, which has seen a move towards a more individualized and women centered maternity service in which continuity of care and carer are explored and towards one that acknowledges the right of women to exercise choice and control via informed decision making (Department of Health 1993, 2007a, b, c, 2010 a).

Within the midwifery profession there has also been the questioning of the appropriateness of the medical model of care for childbearing women and there has been an exploration of alternatives (Department of Health 1993, Flint et al 1984, McCourt and Page 1997, Campbell & Garcia 1997, Allen et al 1997, Kirkham and Stapleton et al 2002, Kirkham 2003, Walsh and Newburn 2002, Page and McCandlish 2006, Berg et al 2012). Based on the feedback from women using the maternity services (Breen 1981, Department of Health 1993, Garcia et al 1998, National Perinatal Epidemiology Unit 2006) there have been attempts to promote and enact the rhetoric of continuity of care and carer, choice and control in the way that midwifery care is organized and delivered, with midwifery led care and particularly caseload practice, being associated with improved outcomes for both mothers and midwives (McCourt and Page 1997, Walsh 1999, North Staffordshire Changing Childbirth Team 2000, Sandall et al 2001, Stevens 2003, Hatem et al 2008, McLachlan et al 2012) . Promoting better continuity of care has enabled mothers and midwives to interact on a

more individual level with the opportunity for both to get to know one another. In view of this, it has hardly been surprising, that the nature of the mother-midwife relationship has become one of key interest to the midwifery profession (McCourt & Page 1997, Guilliland 1997, Kirkham 2000, Walsh 2002, Henty 2004, Hodnett 2004, Hunter 2005, Pairman 2006, Carolan et al 2007, Barclay 2008, Hunter et al 2008, Huber and Sandall 2010). The individualization of care, and the ideals of choice, continuity and control (the three 'C's') identified in the report 'Changing Childbirth' (Department of Health 1993), and in particular an aspiration that 75% of childbearing women would know the midwife who cared for them in labour, set in motion a number of projects which explored different ways to deploy midwives (Allen et al 1997, McCourt and Page 1997, Benjamin et al 2001). The mantra of choice, continuity, one to one women-centered care, and principles of information giving and informed consent for childbearing women remains a strong tenet of the aspirations of contemporary maternity service (Department of Health 2004, 2007, 2009). How this can be more widely achieved for all childbearing women continues to be the subject of much debate and is set in the complex context of technological advancement and professional, political and economic constraint.

The environment that midwives find themselves working in (community, birth-centers, obstetric led consultant units) and the associated organization of midwifery care have been found to be very influential in relation to the quality of communication and interaction with women (McCourt and Stevens 2010, Walsh and Newburn 2002a, b, Stevens 2003, Sandall 2001, Kirkham 2002, 2003,

2004, 2010, Hunter 2004, 2006, 2008, Walsh 1999, 2005a). Early studies on this subject identified the influence of the medical model on the enactment of midwifery care and philosophy (Methven 1989, Kirkham 1989). These were landmark studies in that highlighted how under the influence of the medical model, notions of being “with woman” could be over-ridden by the technocratic model of care resulting in a “with institution” approach which neither met the needs of childbearing women or midwives. Additionally poorer communication and information giving for both parties was highlighted and this was seen consequently to reduce the ability of women and midwives to make informed and appropriate decisions about care.

This thesis also arises from an interest and curiosity about the nature of building relationships and the creation of rapport and its role in midwifery practice. Rapport is taken to refer to the quality of the mutual experience of practitioner and client. In circumstances where it is believed to be enacted, authors have distinguished three aspects:

First, rapport is an optimal interpersonal experience for both the client and the practitioner that involves concentration, effective communication and enjoyment (Csikszentmihalyi, 1990; Tickle-Dergen, 2006). Secondly, rapport involves behaviour which signals high levels of mutual attentiveness, interpersonal coordination and mutual positivity (Tickle-Dergen and Gavett, 2003). Thirdly, rapport is believed to have positive effects on client outcomes, as well as being associated with them being more likely to listen and take on board health

messages (Di Blasi et al, 2001; Feinberg, 1992; Hall et al 2005, Martin et al, 2000; Porszt-Miron et al, 1988).

Whilst the issue of rapport has been discussed more extensively in other healthcare disciplines such as occupational therapy (Radomsky and Trombly, 2007), and in the research process itself (Dickson-Swift et al. 2007) there has been less discussion in disciplines such as midwifery. This is curious, particularly in the light of the centrality of interpersonal communication to the midwife's craft. Whilst the nature of the midwife mother relationship has been explored and debated in the profession at length (Flint 1986, McCrea & Crute 1991, Page 1993, Hunt and Symonds 1995, Sandall 1995, Pairman 2006, Kirkham 2000, 2010, Garratt 2001, Siddiqui 1999, Hunter et al 2008), few studies have examined the mother midwife relationship when the mother becomes the midwife's paying client or of how those working as Independent midwives build and maintain rapport in this context.

Independent midwives represent a particular group that have chosen to work outside of the NHS. They are self-employed working predominantly in the community and undertaking a high proportion of home births (Milan 2005, Symon et al 2009). As a professional group they represent for many, the "Gold Standard" of midwifery practice as they are able to offer a one to one individualised and tailor made service to their clients, following them through their pregnancy, birth and for a full six weeks following the birth (Hobbs 1997, van de Kooy 2009, 2010, Kirkham 2010). They would also appear to be more

able to enact the major tenets of contemporary midwifery practice philosophy and government aspirations for the maternity services as articulated in the rhetoric of policy documents (Department of Health 1993, 2004, 2007a, b, c, 2009, 2010a, Royal College of Obstetricians et al 2008, 2001, Reed 2010, Hall 2010, Harrington 2010). Independent midwives are not restricted by protocols and procedures common to large NHS institutions, but instead work more autonomously, albeit within the statutory framework of the Midwives Rules and Standards (Nursing and Midwifery Council (NMC) 2012) and are obliged to abide by “The Code. Standards of Conduct, Performance and Ethics for Nurses and Midwives” (NMC 2008).

There have been few studies exploring the working lives of Independent midwives in the UK, their motivations for practising independently and their perceptions of what is important to them as midwives in the relationships they construct and sustain with clients. The current context of the midwifery profession, and the threats to Independent midwifery practice in particular provide a unique dimension to this study.

The present study adds to the literature concerning interpersonal relations between midwives and clients, and to debates about communication in health care more generally. It provides a unique historically distinctive insight into the working lives of Independent midwives at a time of impending change for the profession.

## ***1.1 Aims of Study***

The overall aim of this study was to develop an enhanced understanding of the lived experience of Independent midwives and their working lives and to explore Independent midwives' perceptions of the value of "connecting" and building relationships with childbearing women. To answer this question, the research had three further sub-aims. The first of these being to gain an enhanced understanding of the beliefs and values of Independent midwives regarding their role as midwives and what they hope to achieve for the women in their care. Secondly, to explore the motivations of midwives to practice Independently of the NHS and thirdly, to understand how they build and maintain rapport within the context of a business relationship. These aims are addressed within the approach of hermeneutic phenomenology and an adapted biographical narrative interpretive method (Wengraf 2001).

This thesis presents a qualitative study of Independent midwifery at an important historical juncture. It draws on feminist methodology and the philosophical tenets of hermeneutic phenomenology in order to examine the lived experience of Independent midwives. The participants were qualified midwives who at the time of recruitment worked as Independent midwives and were members of the Independent Midwives UK, formerly the Independent Midwives Association (IMA). Ethical approval for the study was gained from De Montfort University Research Ethics Committee and from Independent Midwives UK. Independent midwives post their contact details on a publicly accessible website (Independent Midwives UK <http://www.independentmidwives.org.uk>), and it was from these details that

midwives were invited to participate. Data was collected by means of a modified biographical narrative technique (Wengraf 2001), to elicit Independent midwives' stories about their lives as midwives. Twenty Independent midwives were interviewed. Data collection involved a two stage interview, the first of which was open ended and which attempted to elicit the informant's accounts of themselves – "tell me the story of your life as a midwife". This was followed by a second interview (after a break of approximately 30 minutes), which was a more focused exploration of participants' motivations for working as an Independent midwife and their perceptions of the data concerning the mother midwife relationship in their working lives and how this was established and maintained.

## ***1.2 Overview of the Structure of the Thesis***

The thesis has the following structure. Chapter 2 examines the literature surrounding this study and provides a background discussion of a number of important contextual issues, a crucial undertaking in the application of the study's underpinning philosophical precepts of hermeneutic phenomenology (Heidegger 1962, Gadamer 1975, Ricoeur 1973). Chapter 3 details this study's methodology, exploring the underpinning philosophy that has informed the overall approach to the study, the use of adapted biographical interpretive method to collect data, and the use of Ricoeur's(1993) theory of interpretation to analyze and interpret data. Three findings chapters are then presented which detail the research findings and an integrated analysis of these. Contextualized quotations are used to illustrate the emergent themes in the data and their subsequent analysis. Chapter 4 is the first of these chapters and it details, "The



journey into independent practice”. Chapter 5 explores perceptions of “the mother midwife relationship” and Chapter 6 presents perceptions of “the working lives as Independent midwives”. Chapter 7 represents a discussion chapter which draws the thesis together highlighting how this study provides a unique contribution to knowledge. “Time”, “Autonomy” and “Risk”, which I identify as key emergent concepts are critically discussed in the light of the study’s findings. Finally this chapter will critically discuss the implications of these findings for clinical midwifery practice and midwifery philosophy more generally, and explores how insights from the study may inform maternity care policy and potential areas for future research.

## 2 Review of the Literature

A search and review of pertinent literature was undertaken using a framework to facilitate a methodical and systematic approach (Hart 2003, Aveyard 2010). The aim of this exercise was to ascertain the extent of the literature and evidence relevant to the research area enabling an understanding of what is already known, the debates and issues surrounding what is already known (Parahoo 2006, Bryman 2008) and importantly for study at this level, to ascertain that the nature of the research held the potential to produce an original contribution to knowledge. The literature searched has been confined to that which is written in English, although no time restrictions were imposed initially. The nature of the research questions have lent themselves to a historical perspective which is helpful in understanding both the social and political context of the research questions and the events that have influenced contemporary midwifery practice and in particular the work of Independent midwives. This perspective also accords with this study's methodology, hermeneutic phenomenology, where the context of phenomena is seen as highly relevant to the understanding and interpretation of findings (Heidegger 1962, Gadamer 1976, Ricoeur 1981). Thus this literature review is informed by two strands of scholarship, one which seeks to explore systematically the available resources in the published literature and another which is attentive to the evolution and genealogy of concepts and how they are deployed and elaborated between different generations of scholars.

A range of search terms were used to find relevant materials related to the following broad subject areas: "Independent midwifery", "the mother midwife relationship", "social support and childbearing", "case-holding practice",

“continuity of care and carer”, “midwifery led care”, “one to one care”, “being with woman”, “the role of the midwife”, “midwifery model of care”, “midwifery philosophy”, “communication skills and midwifery”, “rapport”, “trust and empathy in childbearing”, “organisation of midwifery care”, “the working lives of midwives” (a list of search terms can be found in Appendix 1). Formulating a range of search terms and in different combinations, relevant to the research’s aims, proved to be an extensive task as many closely related areas of midwifery practice have had an impact upon and are relevant to the research questions, and as a consequence a very large volume of literature was highlighted, so a strategy had to be adopted in order to yield a more focused and manageable amount of literature (Aveyard 2010). This was achieved by the employment of a strategy to focus the review more tightly around the research aims and their immediate contextual issues. This included the mother–midwife relationship and the communication skills associated with this and the working lives of Independent/midwives in order to make this task more manageable (see Appendix 1).

The review was accomplished in three phases/stages as suggested by others (Aveyard 2010, Hart 2003, Rees 2003). Initially this involved a review of relevant published books via the DMU library database COPAC as well as booksellers such as Amazon Books and Blackwells.co.uk. Books relevant to the research aims were skim read for further relevance and bibliographies scrutinised for further pertinent references. Any additional relevant references that were cited in these were then obtained for inspection and skim read for

relevance (Hart 2003, Rees 2003, Aveyard 2010). Again references and bibliographies of these materials were inspected for any additional relevant information. Relevant material was again followed up and read. A careful logging of which materials had been read and their relevance was undertaken in order to ensure key material was retrieved. As the search proceeded an updated bibliography was compiled using the reference management software, 'Endnote', enabling cross referencing of citations and grouping of literature into themed headings for later in depth reading and critique.

The second stage involved a search of journal articles for relevant material using a range of databases (including MIDIRS, CINAHL, MEDLINE, ASSIA, Cochrane Database, BNI, Scopus, Academic Elite), and using similar search terms (see Appendix 1). Once searches were completed, article titles were inspected for relevance and where possible, abstracts read to help ascertain relevance to research aims. Articles were obtained and skim read for relevance and again bibliographies/reference lists were scrutinised for further relevant literature, and the research bibliography updated once more (Aveyard 2010). It has been suggested that a strategy that uses databases alone cannot be relied upon to identify all the required studies and literature, and for this reason a variety of approaches to searching is advised (Greenhalgh and Peacock 2005, Aveyard 2010). Thus the "snowballing" strategy of hand searching through reference lists as described above was employed and was found to be an important source of relevant additional data for this study.

The final stage of the literature search involved a trawl of theses and conference papers and proceedings via the databases, “Index to Theses” and “Proquest”. Relevant theses were obtained and skim read for relevance, and any additional relevant references in bibliographies were noted, obtained and skim read for relevance. Finally the research bibliography was updated.

It is recognised that the literature review has to be an on-going activity in order to ensure the continuing currency and relevance of the study, and whilst the initial trawl of the literature represents a finishing point it is also to some extent represents a beginning (Hart 2003, Bryman 2012). To assist in the process of ensuring on-going currency and relevancy as the study proceeded, ‘Zetoc alerts’ awareness service through the British library (<http://zetoc.mimas.ac.uk>) was utilized facilitating a means of continual scrutiny of newly published studies and relevant literature in midwifery and related journals. This is relevant issue to any study at this level (Aveyard 2010, Hart 2003) but the issue of currency has been especially important within this study not only because of the on-going review and debates regarding the current highly pressurised maternity services and their future, but because of the unfolding real life drama that has run alongside this study concerning the plight of Independent midwives as a distinctive group of midwives and their potential demise.

A large amount of literature was found that both informs and contextualises this study but few actual research studies that were directly related to the Independent midwife in the United Kingdom and the specific research questions

were identified. In view of the large quantity of literature available with potential to contextualize this study, a strategy was undertaken to focus the review on research and literature that was more tightly focused around the research aims and their immediate contextual issues. This included the mother–midwife relationship and the communication skills associated with this and the working lives of Independent /midwives in order to make this task more manageable.

Whilst there are a few research studies that examine the work of Independent Midwives specifically in the UK (Winter 2002, 2009, Milan 2004, 2005, Symon et al 2009, 2010), the voice of the Independent midwife is far from absent from broader review of midwifery literature that debates for example, the midwife mother relationship, organisation of the maternity services, what it means to be “with woman” and the nature of what it is to be a midwife (Cronk 2000, Leap 2000, 2004, 2009, Anderson 2000, 2007, Reed 2002, 2009, 2010, Warren 2003, Winter 2002, 2009, van de Kooy 2009, 2010, Independent Midwives-UK 2011). Indeed their voice has been influential in shaping, at least on paper, government policy on maternity services (Department of Health 1993, 2004a, 2007a, 2007b, 2009).

Analysis of the literature that originated within the United Kingdom (UK), demonstrated a dominant orientation toward midwives that work in the NHS setting; this is not surprising as this is where the majority of midwives have undertaken practice since 1948. However, a more global exploration reveals a little more literature around the work of the Independent midwife particularly in

New Zealand and Canada although the cultural context and remuneration of these midwives differs somewhat from that of Independent midwives in the UK, as will be discussed later as part of this review (Pairman et al 2006, Daellenbach 2007, Bourgeault 2000, Mallot & Davis et al 2009).

All of this evidence however, needs to be seen in the broader context of a number of background but highly influential issues that set the stage for this study. These are the historical context of childbearing, the role of the midwife and the evolution of the maternity services, the nature of the mother midwife relationship and what it means to be a midwife. Other important contextual issues include the “with woman” philosophy (the philosophical underpinnings of the original meaning of the word “midwyf” (McCourt and Stevens 2009)), and how this should be enacted in practise, what women want from their childbirth experiences and finally the role of the Independent midwife.

In order to do this, the literature review will present evidence grouped under the following broad headings that reflect these areas:

- The role of the midwife, being “with woman” and the development of the maternity services.
- The midwife mother relationship and communication skills.
- What women want from midwives.
- The Independent midwife.

## ***2.1 The Role of the Midwife in Being “With Woman” and the Development of the Maternity Services***

### ***2.1.1 Looking Back in Order to Understand***

The history of midwifery is particularly pertinent to this study and to the notion of the Independent midwife. The midwifery profession has a strong interest in its own history and scholars as well as practicing midwives often have a strong sense of the antecedents of contemporary practice (Bates 2004, Mander & Fleming 2002, Sargent 2002, Hunt and Symonds 1995, Leap and Hunter 1993, Hunter 2012). There are many historical occurrences that resonate with the current situation the Independent midwives find themselves in. Indeed as Winter (2007) and others have pointed out, Independent midwifery is not a new concept, it has been in evidence for thousands of years (Achterberg 1991, Ehrenreich & English 1973, Donnison 1988, Towler and Brammall 1986, Rhodes 1995). It is important however to revisit this history to fully understand where the midwife has come from and what she hopes to achieve. This history also illuminates how midwives have traditionally practiced within the community setting using knowledge gained from experience, intuition, and full engagement of all the senses, incorporating “ways of knowing” that, within contemporary society, sit outside what has come to be regarded as dominant, authoritative, scientific and medical knowledge in childbearing (Davis-Floyd 1997). This “alternative knowledge” has been aligned to women’s ways of knowing the world and has often been discredited because of this (Belenky 1997, Achterberg 1991, Ehrenreich & English 1973).



Midwifery is deeply rooted in ancient history, and according to Donnison (1988) this probably reaches further back than recorded time. Some authors have speculated that childbirth was regarded as a 'female mystery' and an area where women alone had a special understanding and knowledge (Donnison 1988, Achterberg 1991). This knowledge was passed from mother to daughter, neighbour to neighbour, village to village thus creating a female body of knowledge based on experience, use of the senses and intuition. In addition to this midwives often acted as healers for their communities; in fact both Achterberg (1991) and Ehrenreich & English (1973) who have sought to make visible the role of women in healing, identify that, 'women have always been healers'. These healer roles were many and varied; it certainly was that of midwife but also included other roles such as counsellor, abortionist, herbalist, pharmacist and nurse. With the spread of Christianity throughout Europe in the Middle Ages, the Church focused on a number of moral issues including sexuality. Because of the midwife's close associations with conception, pregnancy and birth, her behaviour, character and conduct was of particular interest to the Church who sought to monitor and control her activity (Donnison 1988). Midwives were required to practice in a way that avoided the use of pagan rituals and instead use approved prayers. If the midwife failed to do this she risked prosecution in the Bishop's Court (Donnison 1988).

From the 14<sup>th</sup> century to the 17<sup>th</sup> century, life for midwives and women healers became even more precarious. These were the times of the witch hunts, referred to by some as the 'witch holocaust' (Ehrenreich & English 1973). The

midwife was thought to be a prime target because of her contact with the 'great female mystery' of reproduction and birth and her access to fetal tissue, umbilical cords, placentas and the 'caul', all of which have been associated with mystical, magical and healing powers and even used in black magic rituals (Donnison 1988, Ehrenreich & English 1973, Achterberg 1991). The witch hunts were very effective in suppressing the activity of women healers and indeed the passing on of knowledge gained from experience. Ehrenreich & English (1973) describe the appalling extent of the executions, usually by live burnings at the stake, with numbers being in excess of hundreds of thousands and possibly millions. It is thought that in the region of 85% of these executions were women (Ehrenreich & English 1973). Failure to report suspicion of sorcery or witchcraft was also a crime, with individuals facing the shame of excommunication and a long list of other punishments (Ehrenreich & English 1973). Thus midwives were extremely vulnerable to accusations of sorcery and witchcraft, particularly if anyone bore them a grudge (Donnison 1988).

Some authors, when discussing the aftermath of the witch holocaust, identify 'an aura of contamination', that continued to surround the midwife and other female healers (Ehrenreich & English 1973). This air of contamination was so great and so effective and the midwife so discredited that during the 17<sup>th</sup> and 18<sup>th</sup> century the medical profession was able to gain a strong foothold into midwifery, an area considered to be the 'last bastion of female healing' (Ehrenreich & English 1973).

The 17<sup>th</sup> century saw the philosophic split of the mind from the body as expounded by Rene Descartes (Hooker 1978), at a time when there was renewed speculation about how these apparently differentiated entities might be connected. The body became increasingly viewed as a machine which was inherently faulty and in need of intervention (provided by the medical profession), to restore smooth function. Cartesian dualism was to divorce aspects of caring, empathy and compassion from the 'curing', the mind and body now being seen as separate entities. What could be viewed as the 'feminine' side of healing was effectively exorcised. Descartes' rationalistic theory of knowing progressively redefined the nature of knowledge that was considered trustworthy leading to the exclusion of knowledge gained by means of experience or by means of the senses and thus women's ways of knowing were discredited and seen as less reliable and valuable than that gained by means of the scientific method (Davis-Floyd & Dumit 1998, Katz Rothman 1982, Shallow 2001). Women in this era were again aligned with Nature, but this time the link was reinterpreted to advance scientific claims that men were intellectually superior to women and that women were closer to the Earth. These beliefs are demonstrated by the writings of Francis Bacon (Farrington 1964), who identified that Nature, (often portrayed as a woman), needed to be controlled, tamed and understood by men's scientific method (Achterberg 1991, Merchant 1980, Keller 1985):

"I am come in very truth leading to you Nature with all her children to bind her to your service and make her your slave," (Francis Bacon 1620 reprinted 2012).

The association of women and Nature in this quotation demonstrates, as has been much debated within feminist circles, the desire to control both (Merchant 1980, Keller 1985, Oakley 1992, Hardstock 1983). Childbearing and childbirth offer a time when there is the potential to do both, and thus this area has and continues to receive feminist attention and be subject for debate (Oakley 1980, 1984, Davis-Floyd 1997, 1998, 2001, Rothman 1982, Kirkham 1986, 2010, Kitzinger 2003, 2006, Stewart 2004, Edwards 2006a, Kaufmann 2004, Downe 2008, Fahy et al 2008, Surtees 2010).

It is interesting to note that women were excluded from the healing arts at this time not for theological reasons as had been the case in the witch hunts, but because of male claims of female inferior mental capacity. However, midwifery continued to be one of the few ways that women were allowed to be healers and up until the end of the 16<sup>th</sup> century midwifery was practiced entirely by women (Achterberg 1991, Wilson 1995). However this changed with increasing medical interest in the birth process heralded the emergence of the man-midwife in Britain (Donnison 1988). There then ensued a steady undermining of the midwife's domain and a period of rivalry which threatened the livelihood of the midwives of the time (Donnison 1988, Towler and Brammall 1986; Rhodes 1995, Wilson 1995, Marland & Rafferty 1997). The man midwives held a more prestigious position in society, having attended university and thus were seen as more qualified to attend women in childbirth. With industrialization the "up and coming" middle classes preferred to pay for the services of a man midwife to attend their wives. The poorer classes had to 'make do' with the 'ignorant'

unqualified midwife (Cahill 2001). Ridgeway (2002) in her historical study of midwifery education states that there is evidence of some sort of education for midwives, in a variety of forms, from 3000-2000 BC, but that it was by no means universal. It was also apparent that doctors were involved with the examining of midwives from the time of the Doctors and Surgeons Act of 1511 and indeed even archbishops of the time were encouraged to examine and educate midwives (Ridgeway 2002). What appeared to be clear however, was that denying midwives access to formal education, furthered the political claims that midwives as women were 'ignorant and incompetent', further discrediting them and bolstering the position and prestige of the medical profession in relation to expertise in childbearing, childbirth and status in society more generally (Ridgeway 2002, Cahill 2001, Tew 1998, Marland & Rafferty 1997).

### ***2.1.2 Medicalization of Childbirth***

The origins of the highly technocratic approach to modern childbearing and childbirth can be traced back to these times, when man midwives started to use surgery and instruments to extract babies from women, sometimes with disastrous and even fatal consequences (King 2012, Wagner 1994, Wilson 1995, Marland & Rafferty 1997). Men-midwives could be doctors but could also be barbers, tailors or butchers who also called themselves barber-surgeons (King 2012, Tew 1998, Wagner 1994, Wilson 1995). The vast majority of women though, were unable to afford the services of the men midwives, and gave birth as previously, in their own homes with the help of an experienced local community midwife, albeit with little formal education. As interest in

pregnancy and childbirth increased so too did the development of scientific knowledge in this respect (King 2012, Cody Forman 2005). It was to be the move of birth from the community into medical institutions that was to have profound effects both on women and how childbearing was viewed and of course upon the role and responsibilities of the midwife (King 2012, Nuttall 2012, Sargent 2002, Murphy-Black 1995, Tew 1998). Wagner (1994) in his provocative and interesting book, traces what he calls the development of the 'birth machine', the reductionist, medicalized view of women's bodies as baby machines, and one that was seen as inherently faulty (Wagner 1994). This view enabled the legitimating of hospital birth, antenatal surveillance of women and the newly formed profession of obstetrics. It also served to further control the work of midwives and to control the care and management of childbearing women (Nuttall 2012, Fleming & Mander 2002). Several authors have now traced the development of the midwifery profession from the independent practice of a largely uneducated midwife to that of professional regulation in 1902 and an education that was heavily influenced by medical thinking (Nuttall 2012, Fleming and Mander 2002).

Hunter (2012) illuminates the working lives of midwives from 1920-2000 whilst unpicking the politics of changing legislation and examining the implications of this on the role and autonomy of the midwife. Whilst there were gains in terms of working conditions and assured income particularly after the 1936 Midwives Act, there was also increasing state control and constraints to the parameters of

practice which were monitored ever more closely by doctors and supervisors of midwives, inevitably affecting the autonomy of midwifery practice (Hunter 2012). Concerns about high infant and maternal mortality rates were also used to legitimize the move of birth from home to hospital, where it was claimed that obstetrical expertise would reduce mortality rates by means of intervention and the use of science and technology (Hunter 2012, Tew 1998, Wagner 1994). The actual evidence for this was tenuous (Wagner 1994, Tew 1998), and in fact there was evidence that women who attended centrally in lying-in hospitals, maternity homes or private nursing homes by doctors were more likely to die than those tended in the community by a midwife (Ministry of Health 1937, Hunt and Symonds 1995). This was associated with puerperal fever which was found to be three times higher in 'well to do' Hampstead than socially deprived Bermondsey (Hunt and Symonds 1995). The maternal mortality rate was 5 per 1000 in 1935 for lying-in hospitals, twice as high as for women attended by midwives. The 1937 report attempted to pinpoint the causes of maternal mortality which remained at high levels at this time. Socio-economic factors such as poverty, housing, unemployment were highlighted, as influential factors, but no single cause was found (Hunt and Symonds 1995).

Despite questionable evidence (Tew 1998, Campbell & Macfarlane 1994) the medical profession's recommendation that birth should take place in hospital was effected incrementally by a series Ministry of Health reports on grounds that this was a safer option for women and their babies (Ministry of Health 1956, 1959, 1970). The hospitalisation and medicalization of birth has served not only

to control childbearing women but also to erode the role and autonomy of the midwife by fragmenting care and opportunities for mothers and midwives to form meaningful relationships (Sargent 2002). The debate regarding the safety of home birth is an enduring one and has featured in reviews of the maternity services since the questioning of the wisdom of unilateral hospital birth on grounds of safety and the promotion of childbearing women's right to make informed decisions about their care in maternity care policy (Department of Health 1993, 2004a, 2007a, b, c, 2010). Evidence regarding the safety of home birth as opposed to birth in other care settings has been subject to debate and study (Sackett et al 1996, Mori et al 2003, Lingren et al 2008, Olsen 2009, De Jonge et al 2009, Janssen et al 2009, Gyte et al 2009, Wax et al 2010, Hodnett et al 2010, NICE 2010) and has been framed in the contemporary context of the healthcare services where the maternity services have been under increasing scrutiny due to the fact that 60% of all litigation payments are for obstetrics and gynaecology cases (Kings Fund 2008). However, the National Perinatal Epidemiology Unit's major "Birthplace" study (NPEU 2011, Birthplace Collaborative Group 2011) has provided the most robust evidence to date (data from 64,538 births) with findings supporting the offering of choice of birth setting to women. The birthplaces reviewed included obstetric units, free-standing birth centres, alongside birth centres (midwife led units on a hospital site with an obstetric unit) and home births. Perinatal and maternal outcomes were measured by planned place of birth for healthy women with low risk pregnancies, these included comparisons of perinatal mortality, stillbirth, and perinatal morbidity outcomes associated with asphyxia and birth trauma as



primary outcomes. Maternal outcomes were also compared, including mode of birth, intervention rates including epidurals/spinal/general anaesthesia, forceps and caesarean section. The obstetrical setting was perhaps unsurprisingly associated with higher rates of intervention, whereas the midwifery non obstetrical environments were associated with less intervention, increased breastfeeding rates and higher rates of “normal birth”. Whilst outcomes related to perinatal outcomes for multiparous women in non-obstetrical settings were comparable with those women birthing in an obstetrical setting, the study has provided some evidence that there is an increased risk of adverse perinatal outcomes in these settings for nulliparous women and this would seem to be most marked in the home birth. Higher transfer rates in labour were also highlighted in nulliparous women in non-obstetrical settings (36-45%) as compared to 9-13% rates for multiparous women (Birthplace Collaboration Group, 2011). Whilst this study has been useful in providing information about physical outcomes and risks associated with planned place of birth it does not further our knowledge in relation to psycho-social and indeed spiritual outcomes that are also seen as important to childbearing women when considering safety (Edwards 2006a, b).

### ***2.1.3 “Industrial Model” Applied to Caring Environments***

The Griffiths report of 1983 (DHSS 1983) introduced another constraint to midwifery practice as business principles were applied to the NHS with the aim of the more effective use of the workforce and resources (Sargent 2002, Baggott 1998). The influence of a hospital environment and the dominance of the medical model and the superimposed effects of the application of a

business model to the NHS continue to have profound implications for both mothers and midwives (Hunter 2012, Hollins Martin & Martin 2010, Dykes 2009, Curtis 2003, 2006a, b, Hunter 2004, Kirkham 1999, Mander & Fleming 2002). The increasing medicalization and incidence of operative births is of concern to both mothers and midwives not only nationally but worldwide (Long et al 2012, Underscheiler et al 2011, RCM 2011, Villar 2006, RCOG 2001). It is interesting to note that decreasing the number of operative deliveries and promoting normal birth has been highlighted as “an area for action” (NHS Institute for Innovation and Improvement 2012). The NHS Institute aims to support innovation and improvement of services but also is concerned with the spiralling costs associated with contemporary healthcare. A recent report from the Royal College of Obstetricians and Gynaecologists (RCOG 2011) calls for a radical review and re-fashioning of Women’s Health Services, including the maternity services because of concerns around sustainability. Within this report there are recommendations for more midwifery-led care in standalone and alongside birth centres, and whilst one might be a little cynical regarding the reasons for these recommendations it does, on the face of it, hold the potential for the midwife to re-establish a degree of autonomy in caring for low risk women and the promotion of normal birth. Crucially though, in spite of the government rhetoric of women-centred individualized care and the promotion of choice, continuity and control, the market forces associated with a business model means that services are increasingly over-stretched and midwives have little time to provide the care they aspire to (Deery & Kirkham 2007, Hunter & Deery 2009). Hunt and Symonds (1995), Kirkham (1987) and Methven (1991) have highlighted,

that all too often, working in a hospital environment requires midwives to focus on getting the immediate job done rather than focusing on developing meaningful relationships - indeed it has been suggested that if midwives only see women on one occasion they may be less willing to expend the time and energy necessary to develop rapport (Methven 1991).

## ***2.2 The Mother Midwife Relationship and the Organisation of Midwifery Care***

The nature of the mother midwife relationship has been the subject of much debate within the midwifery profession. What it actually aims to achieve, the philosophical stance it should adopt and its potential has been subject to varied opinion (Kirkham 2010, Cronk 2010, Leap 2010, Gaudion & Homeyard 2010, Berg 2010, Taylor 2010). These debates have been fuelled by a succession of reviews of the maternity services which have highlighted the psycho-social paucity of the medical model (Maternity Services Advisory Committee 1982, 1984, 1985, House of Commons Health Committee 1992) and culminated in the Department of Health (1993) 'Changing Childbirth' Report. This highly influential report identified a number of key indicators of success to be achieved within five years of its publication, and one key indicator was that 75% of women in labour should "know" the midwife caring for them (Department of Health 1993). The nature of 'knowing' stimulated debate around the nature of the relationship between a mother and her midwife and on how midwives could be deployed so that they could meet a woman on more than one occasion so that they had the opportunity to 'know

one another'. A randomised controlled trial by Flint and Polengeris (1989) had previously highlighted the benefits of team midwifery in the NHS in the guise of the 'Know your Midwife Scheme', and how women had favourably evaluated the formation of a relationship with their named midwife. Unfortunately, due to the way the midwives were deployed, continuity of this carer (on-going care provided by the same midwife), over the intrapartum period was not always achieved. Thus in the later review of the maternity services a target that aimed to address this was highlighted (Department of Health 1993). In order to meet this target a radical departure from the current deployment of midwives and their working lives was required and the concept of 'one to one' care and caseloading practice was born (McCourt and Page 1997). This required midwives to care for a specified caseload of women from early pregnancy, through labour and birth and throughout the postnatal period, working flexibly with other caseloading midwives to provide 24 hour cover for their caseload (Andrews et al 2006). A number of pilot sites implemented case holding where a small group of midwives cared for a defined caseload of women (Benjamin et al 2001, McCourt and Page 1997, Walsh 1999, Campbell et al 1999, Hart et al 1999, Reed 2002, Allen et al 1997). Caseload midwives would have a caseload of 36-40 women per year (Lester 2005, Henty 2004, Hutchings and Henty 2002) Evaluations of these schemes have been very favourable indicating a number of beneficial outcomes for women including that they are associated with reduced requirements for drugs, less conflicting advice, more normal births, less interventions, more breastfeeding, more choices offered, more home births

and higher satisfaction levels for both mothers and midwives (McCourt and Page 1996, Weig 1993, Walsh et al 1999, Sandall 2001, Hatem et al 2008, Hodnett et al 2008, 2010,2011).

Warren (2003) argues that Independent midwifery is caseloading midwifery practice outside of the NHS. She also engages with one of the most contentious areas of debate in relation to the organisation and deployment of midwives: that of continuity of care versus continuity of carer. The former does not require the practitioner to be the same throughout the childbearing experience. Instead care is provided by a small team of midwives that the woman gets to know during the course of her pregnancy. The implication of this for both midwives and hospital managers is that reorganisation of the maternity services is not so radical. However, the relationship is not as close as the midwife does not get to know the woman as well as when continuity of carer occurs; the woman's satisfaction with her care appears to be less in this situation too (Warren 2003, Walsh 1999, Garcia et al 1998, Benjamin et al 2001). Team midwifery is associated with higher levels of stress and burnout for midwives as they battle with fragmented relationships with women, perceived lack of control over their working environment and the stressful nature of on-call team midwifery where midwives do not know the women who call them out (Sandall 1999, Barber 1998, Sandall 1997).

There is considerable evidence which suggests that women like to know their midwife and form a relationship with her and indeed this is associated with better outcomes for her and her baby as previously mentioned (Hodnett et al 2011, Hodnett et al 2008). It also appears that what is good for mothers is also

good for midwives as the opportunity to form meaningful relationships with women is associated with greater job satisfaction and reduced levels of stress and burnout (Lester 2005, Henty 2003, Davies 2003, Stevens 2002, Hunter 2006, Sandall et al 2001).

Whilst there is good evidence of the merits of continuity of carer and case holding practice as it affords the opportunity for midwives and mothers to form meaningful relationships (Hattem et al 2008, Hodnett et al 2011, Hodnett et al 2008), moves to implement this way of practising have been sporadic in the NHS in the UK. Allen et al (1997) detail and evaluate a number of midwifery group practice/caseloading pilot schemes that were set up around the United Kingdom in response to the recommendations of the "Changing Childbirth" report (Department of Health 1993). The continuance and sustainability of some of the pilot schemes were questioned due to concerns about cost and equity of service. Some studies evaluating these schemes have identified them as being "resource intensive" and expensive when compared with traditional maternity care (Allen et al 1997, Hall 1996), whereas Ratcliffe et al (1996) found them to be cheaper. Whilst there has been some acknowledgement that caseloading practice represents a "gold standard" of maternity care (Andrews et al 2006, Warren 2003), it has also been suggested that not all midwives want to work in this way, preferring the security of regular income and regular hours (Warren 2003). Few caseloading practices now continue but those that do continue to provide evidence of beneficial outcomes for women (Fleming and Downe 2007, Hutchings and Henty 2002). A very good example of this was the Albany Midwifery Practice which up until recently was contracted by Kings College

Hospital London, to provide maternity care in a designated socially deprived area in London. The practice comprised of self-employed midwives (equivalent of six full time equivalents), who self-managed a group practice that provided 24 hour caseload midwifery care. An evaluation of the scheme by Sandall et al (2001), detailed very impressive outcomes that compared very favourably with traditional models of care. Examples of these outcomes are demonstrated by the practice's home birth rate of 43% (Sandall et al 2001), national average figures for 2010 were 2.49% for England and Wales, 1.39% for Scotland, 3.47% for Wales and 0.38% for Northern Ireland (Birthchoice UK 2010, Office for National Statistics England and Wales 2010, General Register Office of Scotland 2010 and the General Register Office of Northern Ireland 2010). The scheme had lower induction rates, lower caesarean section rates, higher vaginal delivery rates, less use of analgesia and higher breastfeeding rates (Sandall et al 2001). As the midwives operated a caseload model of care high continuity of carer rates were achieved (89% cared for by the primary midwife and 98% by the primary midwife and one other (Sandall et al 2001). The evidence that outcomes for childbearing women can be improved by being cared for by a midwife with whom there is a meaningful relationship has been well documented (McCourt and Page 1996, Hodnett 2004, Hatem et al 2008, Davis-Floyd et al 2009). In this instance outcomes for women in a socially deprived area were very favourable represented. Unfortunately Kings College NHS Trust chose not to renew the Albany practice's contract and amidst considerable controversy is no longer in operation (Walsh 2009, Jowett 2009,

Boseley & Domokos 2009, National Childbirth Trust 2009, Yiannouzis 2009).

The reasons and context of this will form part of this thesis's later discussion.

### ***2.2.1 The Nature of the Relationship***

In New Zealand the concept of mothers and midwives working in partnership is well established and the caseload model of care dominates (Pairman 2006).

The concept of partnership and its philosophical stance guides midwifery practices there. Pairman (2006) indicates a series of principles she feels must be integrated in the relationship if partnership is to work. These concepts she cites as: individual negotiation, equality, shared responsibility, empowerment, informed choice and consent. Clearly these concepts have substantial implications for the midwife and her motivations for practicing as a midwife, her philosophies and her beliefs around the care of childbearing women as well and for childbearing women they hold the potential for the exercise of autonomy and self-development (Pairman 2006, Guilliland & Pairman 1995, Edwards 2006a).

The concept of partnership however has not been without its critics (Skinner 1999) who voiced concerns about the potential vulnerability of midwives in adopting this approach. Skinner (1999) indicated the potential for women to view partnership in very different terms to that of the midwife with the potential that they might renege on previously agreed decisions leaving the midwife in a vulnerable position particularly when there were less than optimal outcomes.

Cronk (2000, 2010) argues that the nature of the mother midwife relationship could be conceptualised as that of a professional servant. This she argues could address inequalities in the power relationships between the mother and



the midwife, tipping the balance of power and control towards the childbearing woman. She alludes to a longer term view of how this stance can encourage responsible parenting thereby having a beneficial effect on society as a whole.

The notion of friendship within the midwife mother relationship is also debated and explored in the literature and research studies evaluating continuity of care schemes and case holding models of care, report that the formation of trusting relationships, akin to friendship, have been found to have mutually positive and beneficial effects, enhancing experience and indeed encouraging personal development for both the midwife and the mother (Walsh 1999, 2007 McCourt and Stevens 2002, 2009, Stevens 2003, Hunter 2006, Leap 2010, Wilkins 2010). The notion of the 'friendship' is often couched in terms of a 'professional friend', where the midwife is seen to offer professional information from which a woman is encouraged to exercise her autonomy in making decisions about her care (Walsh 1999). The mutual sharing of information in order to better understand one another and in order to form a trusting relationship is a strong theme within the literature (Walsh 1999, Leap 2000, Shallow 2001, Hunter 2006) The concept of reciprocity in the mother midwife relationship has been explored particularly in the work of Stevens (2003), Hunter (2006), Deery and Hunter (2010), it is seen as a particular skill and a practice tool that facilitates the midwife's ability to tune into women's needs by getting to know her better. This will be explored in more depth a little later in this review when considering particular midwifery communication skills.

In one of the few research studies in the UK related to the work of Independent midwives, Winter (2002) sought to find out the means by which Independent midwives assess and monitor women's progress in labour. Her findings, based on in-depth interviews with six Independent midwives, report the crucial nature of the midwife mother relationship in this undertaking. The midwife mother relationship is seen as a crucial part of the 'midwife's tool box'. It was the means by which they assessed the woman in labour, tuned into her needs in order to give her care that was appropriate and to help her get the birth experience that she wanted (Winter 2002). Some of the midwives interviewed went as far as to say that if they had not had the opportunity to develop a trusting relationship built from the antenatal period they would be very reluctant to care for the woman as a major element of information which subsequently informed care would have been missing. The midwives talked about 'tuning into' what was happening and that they used a variety of communication skills involving all of their senses, touch, smell, observation, listening, in order to gain 'clues' as to what was happening (Winter 2002). This study also reports some midwives articulating experiences of spiritual/psychic connection with the woman in their care when the relationship had been particularly strong.

Concerns about the potential closeness of the mother midwife relationship have also been discussed in the literature. Shallow (2001) identifies the potential sense of loss experienced by midwives who have formed relationships and friendships with women when they have needed to hand over care at the end of a care episode. This finding is not confined to midwives; indeed women have

also experienced this sense of loss (Walsh 1999). In order to help address this issue Leap (2000) offers an alternative perspective from which to view the mother midwife relationship. This view draws upon the ancient eastern philosophy of Zen Buddhism, which she feels has much to offer midwives in terms of philosophy as well as offering the opportunity to view their work from a more spiritual standpoint. She argues that midwives need to consider their relationships with women as a possible intrusion and how this might interfere with the exercise of autonomy, potentially compromising the woman's ability to determine her own personal growth. Leap (2000) explores the power relationships within the mother midwife relationship and also recognises the potential for the mother to be left bereaved and bereft when the midwife finishes her episode of care. Her answer to this was to think not only in terms of the three C's quoted by 'Changing Childbirth' (Department of Health 1993) which incorporated notions of continuity, choice and control, but to think about a fourth 'C', that of community. Here Leap (2000) is alluding to the midwife's role in facilitating women and their partners networking and building of relationships with others, (other new parents in the locality), that would continue and be a source of support beyond the time of involvement of the midwife.

Within the literature there are other midwives who have acknowledged the potential therapeutic aspects of the mother midwife relationship (Siddiqui (1999) and Ralston (1998). For Siddiqui (1999) this is encapsulated in the concept of 'caring' and for Ralston (1998) this is more explicitly seen in terms of

communication skills, and that of developing rapport and trust that form the basis of a therapeutic and helping relationship.

### ***2.3 Communication Skills***

Any review of the literature that focuses on midwives' communication skills would not be complete without reference to two studies, that of Kirkham (1987) and Methven (1992). These two early but important studies have been very influential in illuminating the interplay between philosophy and communication skills and use of language. Both studies related to midwives who worked in the National Health Service (NHS) and both were undertaken at a time of growing awareness of the importance of the psycho-social aspects of midwifery and maternity care and the limitations of the medical model had been made apparent by a series of reviews of the maternity services (Maternity Services Committee 1982, 1984, 1985). Both studies highlighted the shortcomings of midwives' communication skills. They demonstrated how a medical approach to care had influenced the quality of midwifery care, illuminating how midwifery's "with woman" philosophy had evolved into a more "with institution" approach. This was seen to be particularly noticeable in consultant led Obstetric units (Kirkham 1987, Methven 1992).

Methven's (1992) study focused on the communication between the mother and the midwife at the antenatal booking interview. This initial contact with the midwife is seen as an important aspect of maternity care which has the potential to highlight and identify any immediate issues that might cause harm to either mother or baby (NICE 2010). This interview is often the first point of contact with

the maternity services. Getting things wrong for the woman at this stage can set the tone for the whole of her pregnancy and childbearing experience. Methven's (1992) findings included the observation of midwives' over reliance on closed questions and how this both controlled and blocked conversation. Time constraints and workload were also seen to influence the type of questions asked. Additionally the format of the obstetrical notes predisposed to the interview becoming an impersonal form filling exercise rather than one of the midwife and the woman getting to know one another, or exploring the woman's individual needs, hopes and fears. Importantly, information that would have helped the midwife to tune into these needs (information about the woman's psycho-social background, diet, exercise and feelings about her pregnancy), were not recorded. Questions instead centred largely on the physical aspects of pregnancy (Methven 1992) demonstrating the influence of the medical approach to care. Methven attempted to contrast the amount of information obtained from a traditional booking interview with that gained from an interview based on a nursing model: Orem's model of self-care (Orem 1980). Nursing models championed a more systematic, holistic and individualised approach to care (Pearson and Vaughan 1986). Nursing models were exactly that, models that were used in nursing, originally developed in the United States of America, which enabled the development of nursing theory, philosophy and a conceptual framework that then could be enacted in practice. They originated from Dewey's (1910) problem solving theory. Although models were embraced in nursing throughout the United Kingdom there was not such enthusiasm in midwifery, mainly because the nursing models assumed some sort of ill health,

a concept that did not align easily to the notion that childbearing women were undertaking an important life event that usually was based in them being healthy. However, these models provided an opportunity to explore values and beliefs and indeed philosophy in relation to caring, and the potential to consider midwifery theory and models for care in the context of the increasing academic profile of the profession (Bryar 1995). Exploration of nursing models at this time signalled the growing dissatisfaction with the medical model and represented steps to search for an alternative approach. In using a nursing model Methven demonstrated that much richer and informative data could be gained from the women, this was very pertinent to their antenatal care and would otherwise have been missed. McCourt (2006) in a later study observes the “booking interview” but this time this is examined in the context of conventional hospital or community midwifery care as compared with, what was new at the time, the midwifery caseload model. The quality of the interaction between mother and midwife was observed and in particular how the midwives responded to women’s questions or needs for information at this time. The study, set in the context of professional rhetoric which aims to offer women informed choice (Department of Health 1993) indicates that working environment, culture and workload pressures influence the quality of midwife interactions and is reflective of the earlier studies previously discussed. The caseload model of care was found to be more likely to promote a partnership approach to communications. This was characterised by a more conversational style to interactions which facilitated the development of relationships. Caseload midwives, because they were not committed to fixed clinic schedules, had more time to interact with

women, to listen to them and to respond to their needs. Conventional hospital or community care, although generally friendly, was found to be associated with rushed interchanges that were limited in this respect, and where limited information and choice were given, and women's questions and needs were not always recognised or acknowledged. It was also noted that women tended to use indirect means to raise their concerns rather than ask a direct question, something that potentially the busy and pressurised practitioner may miss or fail to "hear". These observations led McCourt (2006) to the conclusion that the rhetoric of informed choice was largely non-functional within the constraints of the conventional NHS maternity care system.

Kirkham's (1991) study focused on midwives' communication and information giving skills to women when they were in labour. Kirkham observed the labours of 113 women, some of these were in consultant units, whilst others were in an adjacent G.P unit run by midwives and others at home births. Kirkham observed that midwives would often control information given based on their perception of the woman's social class. She found that midwives responded increasingly to women of higher socio-economic status, both in terms of these women having their questions answered and information that they were prepared to offer. She found that the consultant unit midwives were very influenced by the medical model of care which did not appear to facilitate information giving to women. The needs and wishes of women were often dismissed or ignored by means of what Kirkham refers to as 'verbal asepsis'. The midwives were found to be more concerned with acquiescing to the needs of doctors and colleagues than those

of the women they were caring for, and thus being seen to be more “with institution” than “with woman” (Kirkham 1991)

In the G.P units Kirkham (1991) observed better interaction between mothers and midwives. This was more the midwives’ territory and appeared to result in more information giving and the women given more attention. At home births Kirkham observed the influence of the woman’s domain, here the midwife was a guest, interchanges she observed were more equal and presented an immense contrast to labours that she had observed in other settings.

In addition to the profound influence of clinical environment upon communication Kirkham (1991) also noted that midwives tended to use medicalized language. Unfortunately the consequences of this were seen to result in the alienating and distancing of women from the midwives, the antithesis of the original meaning of what it is to be a midwife and the philosophy of “being with woman” (Kirkham 1991).

Following the publication of ‘Changing Childbirth’ (Department of Health 1993), which highlighted women’s needs for choice, continuity and control, the interpersonal dynamic of both midwifery care and the maternity services was very much thrown into focus. Since that time a ‘back to basics’ approach to communication skills has been apparent, not least in midwifery education (NMC 2012). Strategies have been very much aligned to humanizing midwifery care in, what continues to be the experience for the vast majority of women, large



NHS institutions. The moving of birth back out into the community, although discussed and debated (National Institute of Clinical Excellence 2007), and although there are areas where this happens to greater and lesser degree, (Sandall et al 2001, Birthchoice UK 2012), seems to have happened at a slower rate than its enthusiasts would wish.

The emphasis on getting communication right has never been greater. Government reports continually draw attention to the need to improve communication and highlight the benefits associated with getting it right (Department of Health 1993, 2004, 2007a). There is also considerable evidence that the quality of women's relationships with those that care for them are pivotal to their experience of childbirth (Berg et al 1996, Hallorsdottir & Karlsdottir 1996, Anderson 2000, Kirkham 2000, 2010, Lungren 2004, Edwards 2005, Lungren & Berg 2007, Hunter et al 2008). And although there is evidence of favourable experiences (Healthcare Commission 2007), there is also evidence that these can be much less positive with women reporting unallayed fears, anxieties and lack of support being a key features and subsequently overriding other concerns and outcomes (Green 2003, Hodnett 2002, Nilsson and Lundgren 2008).

Whilst it is widely acknowledged that good communication and interpersonal skills are the cornerstone of midwifery practice few midwifery studies have investigated what these skills are and how they can be developed within a midwifery context (Hunter et al 2008), or indeed from a nursing context (Morse

et al 1997). The skill of developing rapport and a level of trust that enables the midwife and the mother to effectively communicate and trust one another is valued both by women and midwives and key in determining a woman's satisfaction with her care (Walsh 1999, Winter 2001, McCourt and Page 1997, Hodnett 2002). There is some evidence that trust/rapport is built on a notion of 'chatting' and reciprocity which enables a connection between the mother and the midwife to be achieved (Flemming 1998, Fenwick & Barclay et al 2001, Hunter 2005), the ability to and willingness of childbearing women to disclose aspects of personal experience would appear to be central to this (Hunter 2005, 2006, Deery & Hunter 2010).

Hunter (2005) has explored midwives' experience of the mother-midwife relationship, identifying this as a source of potential emotional work for midwives. Hunter (2005) provides a useful frame of reference from which to consider and analyze mother midwife interactions. She identifies balanced exchanges between midwives and women where there is mutual 'give and take' which are emotionally rewarding for both parties and others that require emotional work on the part of the midwife because they are 'out of balance' and consequently experienced as emotionally difficult by midwives. Hunter's work has provided evidence and valuable insight into the ways that individual practitioners perceived interactions with women, and whilst the rhetoric of women-centered care abounds her study provides evidence and explanation of why and how interchanges on a one to one level work well but also when they are less successful and why this might be. Hunter (2005) classifies these

difficult encounters as sources of emotional work for midwives in two ways. First, a “reverse exchange” where the midwife receives support from clients rather than the other way around resulting in “emotional work” for the midwife on account of them feeling this was an inappropriate turn of events and where women were considered to be “over familiar”. Secondly, were the exchanges that were termed “unsustainable” due to women’s unrealistic expectations of the midwife. These interchanges were found to be more prevalent in schemes where continuity of carer was a feature, and where midwives wrestled with the dynamic of becoming “too involved” with their client (Hunter 2005).

There is evidence to support the use of “chatting” to help facilitate the building of positive relationships (Morse 1991, Appleton 1993, Trojan and Yonge 1993, Darbyshire 1994, Williams and Irurita 1998). Fenwick et al (2001) undertook a study in Australia which focused on how neonatal nurses facilitated mothering in a neonatal nursery, and whilst not directly researching midwives, there is much that potentially resonates with contemporary midwife mother relationships. The study found that the skill of “chatting” was perceived to be an important clinical tool by the nurses. Chatting was seen as a means to facilitate care of mothers, and it was seen as a strategy to initiate, maintain and enhance positive interactions with clients. The study that took both the perspective of the nurse and the mother on “chatting” into account highlighted the role of social chat and the sharing of life experiences. Research evidence in the area of reciprocity identifies the importance of mutual sharing of information in the development of ongoing and positive relationships. Hunter (2005) has explored this in a

midwifery context but this has also been identified in other contexts (Kasch et al 1987, Merck 1990, Rundell 1991). This process was felt to facilitate dialogue between the mother and the nurse helping them to get to know one another. Nurses felt that chatting helped them to get to know the woman better and this helped them to tune in more effectively to her needs and appropriate tailoring of her care (Fenwick et al 2001). As a result women reported the development of “trust” and an enhanced sense of “safety” resulting from the ability to express themselves openly and honestly (Fenwick et al 2001). Another key finding was the fact that women would “sandwich” questions regarding serious concerns about their baby amongst the chat. In this way “chatting” appeared to facilitate women voicing concerns and asking questions. Mothers reported seeking out nurses with whom they had had this sort of relationship and how with every exchange their relationship deepened and appeared to enable them to more readily ask these questions (Fenwick et al 2001). Whilst this form of chatting was highlighted as being extremely facilitative it was interesting to note that other types of chatting were identified as being less helpful and in some cases damaging to the establishment of an ongoing relationship and this resonates with Kirkham’s study of midwives on delivery suite (Kirkham 1987). Fenwick et al (2001) noted what they termed “dismissive chat”, where the nurse chatted but did not give the woman time to respond. This strategy was seen to simultaneously block and constrain further interaction and set and control the nature of the interaction. This aligns with the findings of other studies (Faulkner 1979, Macleod Clark 1981, Forrest 1983). The other form of “chatting” that was seen to be problematic was that of chat referred to as “banter”, these were

quick “off the cuff” retorts between mother and nurse often associated with humour, laughing and joking. However, these remarks could be misinterpreted or were not always seen as humorous or funny and at times were seen to cause extreme distress (Fenwick et al 2001). Thus they could constrain the enhancement and development of an ongoing relationship. However, those nurses who were able to use the tool of “chatting” to clients effectively were singled out by clients as having made a difference and had enhanced their experience of care. Additionally this study also observed the skilled practitioners of “chat” also mirrored the style of language used by the client and also some of their behaviours as a further strategy in developing rapport and connection (Fenwick et al 2001).

### ***2.3.1 Cultural Competence***

There is now a wealth of literature that highlights the need for midwives and other healthcare professionals to develop cultural competence (Jomeen & Redshaw 2013, Nursing and Midwifery Council 2012, Maclean 2011, International Confederation of Midwives 2010, Blackman 2011, Adams 2010, Duke et al 2009, Papadopoulos 2006, Richens 2005, Rorie 2004). Indeed, midwifery’s “with woman” philosophy would appear to align with the central tenets of cultural competence, particularly in relation to the provision of women centred individualized care as is seen with caseload practice (Sandall 2001, Walsh (1999). Diversity within and between cultures means that it is now no longer appropriate to adopt a “one size fits all” approach to healthcare. Additionally, inequalities and discrepancies between different cultural groups are shown time and time again to be associated with increased morbidity and

mortality rates in particular vulnerable groups. These include those from ethnic minorities, immigrants, refugees and asylum seekers (World Health Organisation 2012, NICE 2010, CEMACE 2010, Rorie 2004). There would appear to be a strong relationship between ethnicity, social deprivation and poor outcomes in maternity care (Lewis 2007, NICE 2010, WHO 2012, White Ribbon Alliance 2012). These groups share common characteristics including lack of awareness of the maternity services, poor access to or engagement with these services, language or literacy difficulties, poor general health, prejudice and poverty. Deficiencies in the care of those from these diverse cultures have been highlighted (Jomeen & Redshaw 2013, Williams 2010, Briscoe & Lavender 2009, Richens 2005, 2003, O'Hagan 2001, Katbamna 2000). Developing cultural competence/sensitivity is seen as integral to both nursing and midwifery practice (NMC 2008, 2012) and holds the potential to maximise sensitivity and minimize insensitivity when caring for clients from culturally diverse communities (O'Hagan 2001, Rorie 2004). The destructive effects of often misguided or ill-informed beliefs and assumptions about people from different ethnic backgrounds have been reported with the potential of this to detract from the quality of their care and even to "blindness" to their healthcare needs (Cross et al 1989, Katbamna 2000, Rorie 2004, Richens 2005, Jomeen & Redshaw 2013). The teaching of cultural competence and its associated skills is integral to the education of midwives (NMC 2009) with a wealth of literature available to support this process (Leigh 1998, O'Hagan 2001, Rorie 2004, Jefferys 2006, Duke et al 2009).

## ***2.4 What Women Want From the Mother Midwife Relationship***

Pregnancy and childbirth represent a time of uncertainty for women, a time when their identities and physical body changes can make them feel vulnerable (Edwards 2010, Davis-Floyd 1992). Edwards's (2010) work has highlighted that when women have a midwife whom they can trust they feel more confident in the face of this uncertainty. There are a number of studies that have enhanced our understanding of what women want from the mother midwife relationship and the maternity services (Garcia & Redshaw et al 1998, Green & Coupland et al, National Perinatal Epidemiology Unit 2006, Healthcare Commission 2007, Edwards 2006a, 2011, Department of Health 2011). Key to women's evaluation of their childbirth experiences is not only receiving professional and competent care, but also the quality of the relationships they have with those that care for them, their midwives. Women appear to place high value on this interpersonal and supportive aspect of care (Berg et al 1996, Halldorsdottir & Karlsdottir 1996, Kennedy 1995, Walsh 1999, Anderson 2000, Waldenstrom et al 2004, Edwards 2005, 2010, Wilkins 2010). They want their midwife to be with them not only physically but also emotionally "present" with them, understanding their particular personal circumstances and therefore able to tailor care making it appropriate to them as individuals and situated in the correct context of their lives. In this way they feel they can trust their midwife and feel both physically and emotionally safe (Hunter 2006, Edward 2006a, McCourt & Stevens 2009, Pairman 2006). Women want to birth in a pleasant and safe environment and to receive adequate information and explanations about choices for childbirth

(Department of Health 2011, Edwards 2006, National Perinatal Epidemiology Unit 2006, Kirkham 2004, O’Cathain et al 2002, Garcia & Redshaw et al 1998, Green & Coupland et al 1998). Edwards (2010) draws attention to the need to help mothers become mothers and need for midwives to engage with the concept of the social transition into motherhood in order to address women’s unique concerns and needs. The fragmentation of care offered by the team midwifery model does not facilitate the midwife and the woman having this deeper understanding of one another when this might happen (McCourt and Stevens 2009, Pairman 2006). It is also known that when there are trusting relationships between mothers and midwives, disclosure of previous abuse or life trauma may be shared enabling support to be given and appropriate action taken in relation to adult and child safeguarding issues taken (Kennedy & Macdonald 2002). Similarly, it is known from previous research studies that in the absence of trusting relationships women withhold important information (Edwards 2005, 2010, Melender & Lauri 1999), making this a potential risk management issue.

Creation of an atmosphere of peace, stillness and calm has been highlighted as being beneficial for women and birth (Hubber & Sandall 2009). It is in this “space” that both mothers and midwives have reported they are more effectively able to tune into childbearing and alternative and inner ways of “knowing” (Olafsdottir 2009, Edwards 2005, 2010). This observation and requirement sits in sharp contrast to the environment in which many women birth and midwives try to support them (Olafsdottir 2009).



Nicholls & Webb (2006) investigated the characteristics of a good midwife, and concluded that as well as needing to be competent and proficient, the next most important attribute that women value highly in a midwife was that of having good communication skills. By this they meant being compassionate, showing kindness and being supportive. Indeed there is evidence that the quality of the midwife mother relationship is crucial to how women determine their experiences of childbirth/bearing, and that the impact of these experiences are long lasting (Lundgren & Berg 2007), emphasising the importance of getting this relationship right.

Independent midwifery has the potential to fulfil these requirements purely from the way that care is organised – the caseload model of care and the fact that women choose their midwife and employ them. As far as the compassionate, kind, proficient practitioner is concerned, the client is able assess this, controls any choice and makes their own selection having ‘auditioned’ potentially a number of Independent midwives before deciding which midwife’s services they finally engage.

The National Childbirth Trust (NCT) has demonstrated its support for Independent Midwives (NCT 2007), stating that they feel it is important that Independent midwives are available as one of the range of choices available for maternity care (NCT 2007). They allude to the positive model of maternity care that they provide, and by this they mean the holistic caseload model. The model

of care adopted by Independent midwives is of key importance to this study as it is known to have profoundly positive effects on the mother midwife relationship (Walsh 1999, McCourt & Page 1997, Pairman 2006, Stevens 2003). The NCT value the provision of truly women-centred care including access to home birth, use of water for birth, holistic, women-centred assessment of the progress of labour, physiological third stage of labour, vaginal birth after caesarean (VBAC), physiological breech birth and vaginal birth of twins (NCT 2007). The caseload model of care enables continuity of carer, and the NCT point out (NCT 2007), that the opportunities for this to happen within the NHS can be far and few between (NCT 2007).

### ***2.5 Independent Midwives and Their Working Lives***

In this final section we come at last to the central character of this study, the Independent midwife. It would seem to be appropriate at this point to identify in what ways these midwives differ and are similar to those who work in the NHS. Independent midwives are practising midwives and as with NHS midwives, they are registered with the Nursing and Midwifery Council (NMC) and are subject to the same rules and standards (NMC 2012) and code of practice (NMC 2008) and their practice is subject to statutory supervision in the same way as an NHS midwife (NMC 2012). They will have undergone similar midwifery training either by undertaking a three year “direct entry” programme or undertaking a shortened midwifery education programme (currently 18 months) following qualification as a nurse (NMC 2010). Independent midwives, however, have chosen to work outside of the National Health Service (NHS) and are self-

employed. As evidenced by this study most will have had experience of working in the NHS. Independent midwifery practice is characterised by its community base, high levels of home birth, low intervention and complication rates and high breastfeeding rates (Milan 2004, Sandall 2001). Formation of an on-going mother midwife relationship is seen as crucial in establishing the needs of the woman and her family and also for monitoring the on-going well-being of the woman and her baby (Winter 2002, van de Kooy 2010).

The International Confederation of Midwives (1973, 1990, 2005) produced an internationally accepted definition of a midwife which highlights the full remit and extent of the role of midwife, this was updated in 2005 in order to make explicit the midwife's role in promoting partnerships between midwives and women and their role in promoting normal birth and having responsibility and autonomy in relation to women with low risk pregnancies (Downe 2006). This definition has been accepted by the Nursing and Midwifery Council and underpins the rules and standards of a midwife in relation to her sphere of practice (NMC 2004, 2012). These rules and standards in turn inform the standards of pre-registration midwifery education (NMC 2010) and form the standards against which a student in training is assessed. Importantly all of these standards communicate the philosophy, aims and aspirations of the midwifery profession. Working within the NHS has not always enabled midwives to practice in this way that they can fulfil this philosophy, although this is the ideal that is portrayed to student midwives during their training (NMC 2010). However, failure to be able to enact this in practice has been highlighted by Curtis et al

(2006) and Hunter (2005) as one of the factors associated with midwives leaving the profession. Key issues here are dissatisfaction with the way midwifery is currently practised within the NHS, and the increasing demands and stresses that have accompanied this (Sandall 1999), and crucially an inability to enact the midwifery philosophy of care (Hunter 2005, Curtis et al 2006). Some midwives leaving the NHS move into independent practice, but these midwives constitute very low proportion of the midwifery workforce and there is evidence that these numbers are reducing (IMA 2005, Warren 2011, Griffiths-Haynes 2011). Hunter (2012) identifies the re-emergence of Independent midwifery in the 1970s/80s, albeit on a small scale, as a response to increasing medicalization of childbearing, constraints on midwifery practice and an emerging radical element from within the midwifery profession influenced by a growing feminist consciousness (Hunter 2012).

At the outset of this study there were around 200 Independent midwives working in the UK (Independent Midwives Association 2007), more recently a number closer to 90 has been suggested by the membership secretary of the IM UK (Warren 2011) with a further suggestion from a currently practising Independent midwife that this number may now have reduced further to 80 (Griffiths-Haynes 2011). This reduction in numbers may be reflective of the current context of independent practice and the new legislation that could force its demise (European Parliament and Council of the European Union 2011). Although Independent midwives are self-employed and work outside of the NHS they are very supportive of the aims and ideals of the NHS (Independent

Midwives Association (IMA) 2007). Approximately 80% of Independent midwives are members of Independent Midwives UK (formally Independent Midwives Association) (Symon & Winter et al 2009), and/or the Association of Radical Midwives (ARM). Here they find support and a forum where 'like-minded midwives', can discuss midwifery related issues, share experience and knowledge and also actively campaign to improve the maternity services in line with their underpinning feminist philosophy (Association of Radical Midwives 2009) The IMA was formed in 1985 by a group of Independent midwives for the dissemination of information about, and support for, Independent midwives. They have also championed and lobbied for the retention of the traditional role and skills of the midwife in a number of national forums (IMA 2007).

The Association of Radical Midwives (ARM) is not the exclusive domain of Independent midwives and midwives who work within the NHS setting also seek support, the opportunity to vent frustrations regarding NHS practice, discussion and knowledge (Leap 2004, Association of Radical Midwives 2009). This organisation predates the IMA/IMUK and was formed in 1976 by two feminist student midwives who became very frustrated and disappointed with the level of medicalization and intervention in maternity care and lack of control that women appeared to have over this very important time in their lives (ARM 2007). It has to be remembered that within the second wave of feminist action (1960s onwards), the role of childbearing and medicalization of childbirth formed a considerable focus for feminist attention and analysis of women's exploitation and oppression (Firestone 1979, Rich 1977, Oakley 1980, Martin 1987,

Richardson 1993, Annadale & Clark 1996). In this respect then it was hardly surprising to find, as has been stated by Kaufman (2004), that some feminists, drawn by interests in these areas, wanted to practice midwifery with a view to helping and supporting other women at this important time in their lives.

The ARM, now a registered charity is committed to improving women's experience of the maternity services in the NHS, and believes that all women have the right to a maternity service that is tailored to their individual needs:

“We strongly believe that all women have the right to a service tailored more closely to their needs, and a sympathetic attitude on the part of their professional attendants. We are primarily a support group for people having difficulty in getting or giving good, sympathetic, personalised midwifery care. A few of us are working independently outside the NHS, in order to offer a more woman-centred, one-to-one, style of practice, which at present is not widely available within NHS maternity services. There are contacts and/or local groups all around UK, as well as several overseas members”. (Association of Radical Midwives 2012 available at: [www. http://www.midwifery.org.uk/](http://www.midwifery.org.uk/) accessed 6.11.12)

As can be seen it also aims to provide support for those women who experience problems by giving and receiving, 'good sympathetic, personalised midwifery care' (ARM 2007). The association is 'radical' in relation to its wish to revive the traditional midwifery skills, taking, midwifery back to its 'roots'. 'Radical' of course has other political connotations, forming as the organisation did at the height of women's health movement at a time when feminist and particularly radical feminist ideas were challenging the status quo. This organisation

brought together feminism and midwifery practice in a way that was perceived by some midwives as being uncomfortable, alien and something that 'good midwives' should not be involved in (Garratt 1993). Garratt's study explored the perceptions of NHS midwives being 'with woman'- the literal meaning of the word 'midwife'. Within this study there was a strong rejection of midwifery being regarded as a 'feminist profession', with midwives articulating negative stereotypical notions of 'feminism'. It was interesting to note that when midwives were questioned about 'women-centred care', they articulated ideas that could have been considered 'feminist' in that they seemed to embrace the importance of women's right to have control over their bodies, their childbirth experience and the midwife was seen very much as an advocate for women in this respect (Garratt 1993).

In this way both the IMA (now the IM UK) and the ARM have been regarded by 'mainstream' midwives as organisations for midwives with more 'feminist' and radical ideas, a notion that has perhaps distanced the 'mainstream midwives' of that time from different ways of viewing their work and the valuable feminist literature that held the potential to enhance both their understanding of childbearing women and the wider significance of midwifery practice (Kaufmann 2004).

Since this time, possibly coinciding with the move of both midwifery and nursing education into higher education and universities, exploration of a wider range of literature pertinent to woman's health and position in society has been facilitated

with a resultant enhanced feminist consciousness in midwifery circles more generally (Stewart 2004). However, there is a strong political and feminist consciousness within the Association of Radical Midwives and this organisation has been successful in making a considerable contribution to the shaping government policy regarding the maternity services (Department of Health 1998, 1999, 2004a, 2004b, 2007, 2008, 2009).

In 1997 Hobbs published a useful manual for midwives who aspired to independent practice. This practical and informative book also provides a number of insights that illuminate potential motives for midwives wanting to practice independently. These reasons map closely with the findings of studies that have investigated why midwives leave NHS practice (Curtis et al 2006, Hunter 2005), and importantly against the basic tenets of feminist thought. Hobbs (1997) includes not being able to practice the midwife's role to its full extent, especially within hospital environments where institutional requirements are often suspected to take priority over those of childbearing women. She also cites frustrations fuelled by staff shortages and not being able to provide the level of care they feel women deserve, lack of one to one care and postnatal care that is characterized by conflicting advice, "heat and noise". Hobbs also alludes to the concern and discomfort of midwives "asked" to coerce women to comply with hospital policy including place of birth, lack of support for home birth and disregard of women's rights to make informed choices about their care (Hobbs 1997).



These motivations are articulated in a provocative style, and indeed Hobbs herself identifies that Independent midwives are often perceived as 'mavericks', 'natural rebels against authority' and 'boat rockers' (Hobbs 1997). She does concede that there may be some truth in this, and suggests that without challenge there would be no change and that, 'there would be no pearl without the grit'. Indeed the 'grit' of Independent midwives amongst others, has contributed to a number of reviews of the maternity services and has been instrumental in influencing policy and recommendations (Department of Health 1993, 2004, 2007, 2008, 2009).

Whatever the motivations of Independent midwives, one could argue that they must indeed be strongly felt to leave the relative security of working within a big institution in favour of following what Hobbs (1997) describes as the 'uncertainties of independent practice'. Independent midwives charge between £1800-£4500 per woman for a whole package of care (antenatal care, intrapartum care and postnatal care up to 28 days following the birth) (IMA 2007). Independent midwives are able to control their workload and are able to book as many or as few clients as they wish; that is, assuming there is a steady stream of clients, which may or may not be the case. Generally however, in order to provide the level of service they aspire to it has been suggested that they would probably book no more than two women due to birth per month (Hobbs 1997) and Milan (2004), drawing on evidence from the Independent Midwives Association Database, suggests that midwives on average book around 11 women per year each, some as many as 26 and some as few as 1.

In reality many Independent midwives operate with a partner or within a small group practice of other independent midwives. If this is the case then they might book two each and possibly another one per month (Hobbs 1997). Based on an Independent midwife taking two clients per month on full fees her net income would be around £2500 which she may have to share with other partners (Hobbs 1997). Months with no booked clients would result in no pay.

There is also evidence to suggest that some Independent midwives exercise flexibility over payment of fees, particularly when they feel a woman would really benefit from one to one care but is unable to afford the midwife's fees. Hobbs (1997) cites examples where Independent midwives have accepted payments over a longer period or other forms of "bartering" that result in mutual satisfaction, including a midwife who had her kitchen fitted in lieu of payment, a sentiment echoed by some of the midwives in this study. The reality however, is that for the Independent midwife her fees are her source of income, her livelihood and means of making a living. The financial uncertainties of independent practice may not be for everyone and may indeed partially explain why there are so few practising in the UK.

The future of Independent midwifery practice is currently under considerable threat. In order to comply with new European legislation aimed at protecting consumers, in 2006 the government announced a proposal to make professional indemnity insurance (PII) for all healthcare professionals mandatory and as a condition for on-going registration (IMA 2007, van de Kooy

2010). The impetus for this legislation has arisen because of concerns regarding uninsured members from other professions. The process for the implementation of mandatory PII was scheduled to target one group of health professionals at a time. However, as van der Kooy (2010) indicates, it was not until it was the turn of the nursing and midwifery that the government apparently became aware that Independent midwives were the only group of healthcare professionals that were unable to obtain full PII. The impact of this proposed legislation on Independent midwives therefore will be profound, threatening as it does their very existence, whilst at the same time, the Independent midwifery model of care would appear to deliver a midwifery service that coincides with the rhetoric of government policy and has been associated up until recently (Harrington 2010, Reed 2009, 2002, Sandall 2001, Symon 2009, 2010) with very favourable outcomes when compared with those of NHS maternity care (Sandall 2001, Department of Health 1998, 1999, 2004a, 2004b, 2007, 2008, 2009, van der Kooy 2010, Kirkham 2010).

Up until 1994 professional indemnity insurance had been available to all midwives via the Royal College of Midwives indemnity scheme, regardless of their area of work as part of RCM membership (IM UK 2010). Midwives who work within the NHS are covered by their Trust under the Clinical Negligence Scheme for Trusts (CNST) which is run by the NHS Litigation authority (NHSLA) (IM UK 2010). In 1994 the Royal College of Midwives RCM withdrew their insurance cover for Independent midwives due to concerns regarding the affordability of RCM premiums for the majority of RCM members working in the

NHS. Initially there were a few insurance providers that would insure Independent midwives. However, when the premiums rose to £15000 per midwife per year and more it eventually made them beyond Independent midwives' budgets. In 2002 the last insurance provider withdrew its cover for Independent midwives completely forcing them to practice without any insurance (IMA UK 2010). Latterly, Independent midwives have been able to access indemnity insurance cover for antenatal, postnatal care and parent education, with the exclusion of intrapartum care via the Royal College of Nursing (Royal College of Nursing 2010). Currently women booking with an Independent midwife do so knowing that their midwife has no indemnity cover for care during labour and birth.

The irony of this situation is that Independent midwifery has been regarded by many as a vanguard and beacon to all midwives (Kirkham 2003). The prospect of it no longer existing, particularly when this way of practice exemplifies so many of the aspirations of Department of Health maternity policy (Department of Health 1993, 2004a, 2007a), is a cause for great concern within the profession. Milan's analysis of data (2004) from the Independent Midwives Association Data base project, suggested that caseload practice provided by Independent midwives provides one to one care personal care of a high standard and that this would appear to positively affect outcomes for mothers and babies. She cites the high numbers of normal birth, low caesarean section rate, high numbers of healthy women and babies on discharge and the high breastfeeding rates (Milan 2004). These findings are similar to those from studies of NHS

case-holding schemes (Hutchings & Henty 2002, North Staffordshire Changing Childbirth Research Team 2000, Page et al 2001, Benjamin et al 2001).

The safety of Independent midwifery care as compared with NHS maternity care has been subject to recent consideration (Symon et al 2009, 2010, Kirkham 2010). The Symon et al study (2009, 2010) represents the largest study to date that has examined clinical outcomes over a period of years (2002-2005) for those women who used an Independent midwife in the UK. Outcomes of births booked under Independent midwives were compared with those of a “matched group” birthing in a NHS Maternity Unit, Independent midwifery cases were “matched” 1:5 with NHS cases, a total of 8676 cases were reviewed, 1462 being those of Independent midwives (Symon et al 2009). Outcome measures focused on quantitative medically focused data (spontaneous vaginal birth, live births, perinatal death, onset of labour, gestation, use of analgesia, duration of labour, perineal trauma, Apgar score, admission to neonatal intensive care, infant feeding), thus softer measures of safety/risk as articulated by women in Pilley-Edwards (2006) study were not captured. Results indicated that women booked with an Independent midwife were significantly more likely to achieve a vaginal birth than the NHS group (77.9% v 54%) but significantly more likely to have a stillbirth or neonatal death (1.7% v 0.6%) raising concerns that care management by Independent midwives might be a contributing factor (Symon et al 2010, Hassan 2009, Bury 2009). However, when the data from “high risk” mothers from both groups were removed from the data set these statistics were not statistically different. The women in the Independent midwifery cases had a higher incidence of pre-existing medical conditions (1.5% v 1.0%) and higher

incidence of previous obstetrical complications (21% v 17.8%). This data gives credence to the perceptions of Independent midwives in this study regarding the complexity of the women that can access their services. 66% of Independent midwife cases were home births compared with 0.4% of NHS mothers highlighting the predominant location of the birthing environment for Independent midwives and their clients. The study also highlighted favourable outcomes for the Independent midwife cases across a range of other variables (Symon et al 2009). However, this study is not without its critics particularly in relation to problems of matching the two cohorts or in relation the inferences to the safety of independent practice and the potential for inappropriate defamatory conclusions (Shorten and Shorten 2009, Gyte et al 2009, Hassan 2009, van der Kooy 2009). An urgent review of the cases of perinatal mortality was supported and undertaken (Symon et al 2010) and included interviews with the Independent midwives concerned. These illuminated background and contextual issues made invisible in the quantitative data of the original study (Symon et al 2009) and further reinforce the findings of this study. The review of individual cases plus the midwife interviews revealed a number of factors which may have contributed to outcomes as well as identifying that in some cases perinatal mortality would have happened regardless of who cared for the woman (Symon et al 2010). Potential contributing factors related to women declining to take midwife advice, refusal to have antenatal screening, refusal to be examined and refusal to be transferred into hospital when this is suggested by midwife. Nine mothers in the cohort specifically rejected NHS care, with five of these having experienced this as traumatic. Given the previous discussion

regarding women's right to autonomous decision making and the centrality of this concept to contemporary healthcare policy (DOH 2004), indeed a right that is protected by law (Butler-Sloss 2006) there should be acceptance that some stillbirths or perinatal deaths are to be expected as a consequence to this particularly in the case of women who plan to birth at home with significant risk factors (Symon et al 2010). However, what is significant and relevant to the findings of this study is the spirit in which these results have been received by some members of the medical profession, and whilst the rates of stillbirth and perinatal mortality do appear increased in the group of women cared for by Independent midwives (Symon et al 2009) the response from medical profession is made from a position that perhaps fails to acknowledge the multi-faceted contextual issues of caring for women in this way and unfortunately further reinforces the ideas that Independent midwives are maverick practitioners (Gyte et al 2009, Hassan 2009).

Patient choice has been high on the government agenda for several years (Department of Health 2007c). However, debates around acceptance of the right of appropriately informed and mentally competent adults to make decisions about whether to take a healthcare professional's advice or not continue (Shorten and Shorten 2009, Symons et al 2010). However, it could be argued that the fact that increased perinatal mortality and stillbirth rates have been associated with Independent midwifery practice has provided more ammunition for those who would wish to see its demise (Bury 2009, Hasson 2009).

Currently the IM UK is leading a campaign to save Independent midwifery, and has received considerable support from clients (past and present), politicians, professional organisations, celebrities and members of the public (IM UK 2010). The threatened demise of Independent midwifery has provided a unique and unfolding dimension to this study.

As part of the strategy to save Independent midwifery, the IMA has rebranded itself, now being known as “Independent Midwives UK” (IM UK 2010); a move from being an informal organisation to a legal entity. They have chosen to become an Industrial and Provident Society for the Benefit of the Community, a non-profit making organisation with an “asset lock” which basically means that any ‘surplus’ cannot be given out as dividends to shareholders as in a limited company, but must be used by the society to forward the aims of the community (van der Kooy 2010). This move has enabled IM UK to become a Social Enterprise and as such has enabled them to bid successfully for funds from the Social Enterprise Investment Fund (Van de Kooy 2010).

IM UK is currently investigating the possibility of Independent midwives contracting into Primary Healthcare Trusts (PCTs). In this way they would be able to contract into the NHS and have indemnity insurance through the NHS Litigation Authority which runs the Clinical Negligence Scheme for Trusts (CNST). Initial approaches to PCTs demonstrate that that they are interested in the services that Independent midwives can provide. They are not interested in engaging the services of individuals however (van de Kooy 2010), and it is clear



that groups of Independent midwives would need to come together to provide services to a discrete area.

Up until recently there has been a very good example of this working successfully in the shape of the Albany Practice, a group of Independent midwives who successfully held a contract with King's College Hospital Foundation Trust in Peckham, South London (Sandall 2001). However, in a recent turn of events the Albany Practice has had its contract withdrawn after twelve and a half years of providing a service to around 200 women a year, because of concerns about safety (Reed 2010, Kirkham 2010). This move has been received with great disappointment by the midwifery profession as the Albany Practice had previously been very well evaluated with very favourable outcomes when compared with other models of care (Sandall 2001, Reed 2002, Reed & Walton 2009). Concerns centre around an apparent "cluster" of Hypoxic ischaemic encephalopathy (HIE) cases resulting in a number of babies cared for by the Albany practice being admitted to the special care baby unit. As a consequence the Albany practice has been subjected to an external confidential enquiry by the Centre for Maternal and Child Enquiries known as CMACE (Reed 2010). Controversy surrounds the interpretations of statistics and the legitimacy of the claims of lack of safety within the practice that have led to the decision not to renew the Albany Practice's contract. This has led to the midwifery profession wondering if this move has been more about lack of tolerance of different models of care, power and control of midwifery practice,

the fear of litigation and management of perceived risk (Reed 2010, Kirkham 2010).

Whilst Independent midwifery in the UK is currently under threat, elsewhere it is experiencing more of a renaissance particularly in Canada and New Zealand. Here a review and reconfiguration of the maternity services has enabled an independent caseload style of practice with the facilitation of more choice and control for both childbearing women and midwives. These schemes are free at the point of contact for women, offer a more favourable remuneration scheme for midwives and indemnity insurance is available (Marlott et al 2009, Bourgeault 2000, Pairman et al 2006).

This chapter has reviewed the literature relevant to this study and provided an important contextual background. This has involved an exploration of the role of the midwife and its evolution over time including models of care. It has explored the literature in relation to the mother midwife relationship, communication skills and what women want from the maternity services. Finally it focused on the Independent midwife, the central character in this study and the contextual issues that currently threaten her practice. The following chapter details the methodology of the study and its underpinning philosophy.

## **3 Methodology**

### ***3.1 Introduction***

This chapter presents and discusses the research methodology chosen for this study and demonstrates how philosophical underpinnings have informed the method chosen for data collection and analysis. This chapter also details the research process, and includes reflexive comments of this. The chapter concludes with a discussion of this study's trustworthiness and rigour.

### ***3.2 The Philosophical Underpinnings of the Research Design***

The overall aim of this study was to explore Independent midwives' perceptions of the value of "connecting" and building relationships with childbearing women, and to understand how they build and maintain these. To answer this question, the research had three further sub-aims. The first of these being to gain an enhanced understanding of the beliefs and values of Independent midwives regarding their role as midwives and what they hope to achieve for the women in their care. Secondly, to explore the motivations of midwives to practice independently of the NHS, and thirdly, to develop an enhanced understanding of the lived experience of Independent midwives and their working lives.

Decisions regarding the chosen research paradigm, methodology and method entailed careful consideration of the aims of the research and how they could be best addressed. This involved stage by stage consideration of the philosophical debates regarding epistemology, and the 'field of possibilities' (Dyson & Brown 2006) in relation to methodology and method. A cascade of decision making

resulted from this, each step being informed by the last and eventually producing a research strategy and design what was not only considered to be “the best tool for the job” but also one that was aligned to this researcher’s beliefs and values regarding the conduct and ethics of the research process.

As a result of this, a subjectivist research approach was adopted with the specific orientation of hermeneutic phenomenology, incorporating aspects of feminist theory and feminist principles of research practice. A qualitative approach appeared to best address the exploratory ambitions of this study and was most closely aligned with the desire to explore participants’ own constructions of their career biographies as midwives. The philosophic stance of phenomenology has informed the research approach and method. Further investigation and critical reading of phenomenology, its proponents and accompanying philosophical assumptions resulted in fine tuning of the research design. Phenomenology is not a methodology *per se* (Flood 2010) and does not have a prescriptive set of procedures laid down, nor is it a single philosophy. Thus researchers are required to decide which aspects of the chosen philosophy they will use to guide the methodology of their study (McConnell-Henry et al 2011). Broadly speaking, phenomenological research seeks to understand how individuals make sense of their lived experience (Annells 1999, Standing 2009) and this aligns to the aims of this study. Trying to understand the subjective perspective of an individual’s experience and the effect that this perspective has on their lived experience is the claim of hermeneutic phenomenology (Heidegger 1962, Omery 1983).

Phenomenology has gained considerable popularity over recent years with both nursing and midwifery researchers (Robinson 2006, Mapp 2008, McConnell-Henry et al 2009). This approach, with its focus on enhancing understanding of how phenomena are experienced from the client's perspective, has been seen as crucial to providing appropriate care for clients within a nursing and midwifery context (Robinson 2006, Mapp 2008, McConnell-Henry et al 2009), and is in accord with the central midwifery tenets of women-centred and individualised care.

The cascade of decision making regarding the philosophical underpinnings for this study involved exploration of what are seen as the two major types of phenomenology: transcendental phenomenology and hermeneutic phenomenology (Flood 2010, Robinson 2006). The distinctive associated tenets were appraised, as it was understood that these have a bearing on the choice of data collection methods, analysis, presentation of results and the status of the resultant knowledge claimed (Husserl 1990, Heidegger 1962, Crotty 1996, Robinson 2006, McConnell-Henry 2011).

The German philosopher Edmund Husserl (1859-1938) is most often acknowledged as the "founding father" of the phenomenological movement and credited with developing the study of "lived experience" (Robinson 2006, McConnell-Henry et al 2009, Annells 1996). Although Husserl did not believe that the social and political background and context were relevant to the

description of phenomena (Flood 2010, McConnell-Henry 2009), his philosophy needs to be viewed from this perspective.

Prestigious science has tended to see the mind and body as separate entities as is encapsulated in the concept of Cartesian dualism. Husserl, in seeking to have transcendental phenomenology recognised and afforded the similar prestige as the “rigorous sciences”, also subscribed to this concept (Robinson 2006, Walters 1995). Although he could see that the scientific approach could not provide an understanding of human experience (McConnell-Henry et al 2009), Husserl did share its aspirations that the researcher should try to remain objective whilst trying to describe the “essence” of phenomena as experienced by the research participant. In order to achieve this, researchers were required to suspend their prior knowledge, values and beliefs about these phenomena and set them aside or “bracket” them. It was believed that this would expose them in a “true” and untainted way, thereby adding to the rigour of the research, a tenet aligned with positivist thinking (Flood 2010, McConnell-Henry et al 2009, LeVasseur 2003, Drew 1999). In resonance with positivist thinking Husserl believed that there were universal “truths” or essences which were common to all persons who have lived experience and that there was one correct essence that could be described. In subscribing to Cartesian thought regarding the perceived separation of the mind and body, Husserl did not acknowledge the impact of culture, society, and politics on individuals as important (McConnell-Henry et al 2009, Robinson 2006). In other words the background and context

to phenomena were not seen as relevant and therefore not taken into account when describing the lived experience of individuals.

Heidegger's (1889-1979) philosophy of hermeneutic phenomenology challenged Husserl on a number of levels (McConnell-Henry et al 2009, Robinson 2006) and appeared to more readily support the aims of this current study and the philosophical stance of the researcher and that of feminist research practice (Stanley and Wise 1990, Ramazanoglu & Holland 2004). Heidegger believed that it was impossible for individuals to set aside prior beliefs and values as suggested by Husserl (Heidegger 1962, McConnell-Henry et al 2009), and rather than these beliefs being seen as something that taints the data, they were seen to be integral to the research process (Heidegger 1962). Heidegger talks of the concept of "co-constitutionality", proposing that the meaning that is arrived at in interpretive research is a result of a blending of interpretation on the part of researched and researcher; this has been described as a "fusion of horizons" (Gadamer 1976, Flood 2010). This intimate blend of interpretation and understanding between researched and researcher also concurs with feminist ideology and concepts of reflexivity (Stanley and Wise 1990, Ramazanoglu & Holland 2004, Oakley 1990). It also has resonance with findings in the current study, where midwives spoke about the connection that they had with their clients when their relationship had been particularly close. The nature of the connection was seen in terms of becoming one, a merging to the extent that they expressed this using language such as, "when **we** were in labour" (Ingrid MW5).

Hermeneutic phenomenology moves beyond describing the essence of the lived experience, it aims to interpret this (Heidegger 1962). In sharp contrast to Husserl, central to Heidegger's beliefs is the concept of individuals "being in the world" or "dasein" and that this has a social, cultural, political, temporal and historical context that has relevance to how individuals experience their world and to how the researcher interprets this (Heidegger 1962, Koch 1995, Standing 2009). Heideggerian phenomenology respects the concept of self-knowing and that "truth" is as the person sees it, that there is no single "truth", and therefore multiple "truths" can exist that are context specific (McConnell-Henry et al 2011). The mind and body are seen to have an inseparable connection. Thus, it follows that every time an experience is revisited, the meaning may alter depending on mood, disposition of the researched or the researcher (McConnell-Henry et al 2011). This has implications for the research process particularly in relation to the practice of "member checking" where it has been argued that this activity contradicts the underpinning philosophy of Hermeneutic Phenomenology (McConnell-Henry 2011, Whitehead 2004, Pickles 1985, Heidegger 1962). The practice of "member checking", that of going back to the research participants to verify interpretations of data was introduced as a means of incorporating rigour into qualitative research (Lincoln and Guba 1985, Colaizzi 1978). McConnell-Henry et al (2011), argue that for Heideggerian phenomenology it has the potential to make it less trustworthy for the reasons identified above. As this study aimed to apply the principles of hermeneutic philosophy this activity was rejected, although research participants were sent copies of the verbatim transcripts of their interview, in order for them to verify



that they were happy that their anonymity had not been compromised, rather than to check interpretation or meaning. Issues related to confidentiality and anonymity as they applied to this study will be discussed in more depth later in this chapter.

### ***3.3 The Influence of Feminist Thinking***

Women have supported other women in childbearing for hundreds if not thousands of years (Donnison 1988, Towler 1986, Achterberg 1991), and to this day midwifery remains a female dominated profession. The struggle for control over childbearing is well documented (Towler 1986, Donnison 1988, Tew 1998, Rhodes 1995, Mander & Fleming 2002, Stuart 2004) and the part that gender relations have played and continue to play within this struggle cannot be ignored both in relation to childbearing women and midwives and constraint and surveillance of their practice (Mander & Fleming 2002). To adopt a methodology that was influenced by feminist theory and practice therefore seemed particularly appropriate. This view is also shared by other midwifery researchers (Mander & Fleming 2002, Barnes 1999, Draper 1997, Bortin et al 1994, Kirkham 1986).

In attempting to construct a robust methodology I was mindful of the minefield that awaited me in “the field of possibilities” (Dyson & Brown 2006). To claim a separate and distinctive methodology that is feminist for example, is unacceptable to some (Hammersley 1995, Harding 1989), and indeed that is not what I have aimed to do here. This study is feminist in so far that it is about an under-researched group of women (Independent midwives) who have often

been misunderstood and maligned (Wagner 1995, Hobbs 1997, Kirkham 2010), and that have particular needs and vulnerabilities that have not necessarily been made visible (Creswell 1998). Roberts (1990) suggests that good feminist research is not about rejecting 'academic and scientific rationality', it is about challenging assumptions, principles, justifications and explanations that may have more to do with gender politics and less to do with 'the pursuit of knowledge'. The characteristics of feminist research are subject to debate but there would seem to be consensus in relation to how research is undertaken and written up (Ramazanoglu & Holland 2004). Rather than a distinct or specific method or methodology it is more about providing perspective and principles (Barnes 1999). Stanley and Wise (1990) indicate that feminism should be "present in positive ways" in the research process with particular consideration being given to the researcher-researched relationship, in particular power relationships, emotion as a research experience and the presence of an intellectual autobiography of the researcher. This aligns with the underpinnings of hermeneutic phenomenology, where the concept of "co-constitutionality" suggests that meaning that is arrived at in interpretive research is a result of a blending of interpretation on the part of researched and researcher, this has been previously described as a "fusion of horizons" (Gadamer 1976, Flood 2010).

Oakley (2010) has made reference to the "two stories" that result from this process, that of the researched and that of the interpretation of the researched story by the researcher herself. She also makes reference to the fact that there

has been little written about the challenges of how these two are balanced when writing up life stories research. Within this current study, the strategy taken to try to address this has been one of endeavouring to present transparency of process with reflexive accounts of decision making. As a researcher it was interesting to experience the “fusion of horizons” when undertaking analysis of data, as a connection that appeared to be not dissimilar to the “connection” described by midwives within the study as they listened to the stories of women in order to understand them as individuals, thus informing their perceived ability to provide more appropriate care. The theme of interconnection and partnership between the researcher and the research participants permeates the research process and would appear to concur with feminist philosophy whilst also resonating with central tenets of midwifery care philosophy (Page 1995, Kirkham 2000, Stevens and McCourt 2002a, b, Walsh and Newburn 2002a, Hunter 2005, RCM 2008, Leap 2009). A feminist approach to research for example, acknowledges women as partners in the research process, they are placed at the centre, and research is undertaken for their benefit rather being about the promotion of the interests of others (Barnes 1999). Oakley (2010) also highlights that when working with biographical data the researcher is in some sense an advocate for the research participants. This is seen to operate in three ways, first because the researcher recognises their story is worth telling, secondly, that it has interest value and thirdly because of its external impact. The intention of this study is to acknowledge these aspects, with the aim that this study’s findings could be used to benefit Independent midwives by promoting a better understanding of what it means to Independent midwives to

work in this way. It is also intended to benefit the midwifery profession as a whole by contributing to its body of knowledge and by building on the work of others especially in relation to the mother midwife relationship (Kirkham 2000, 2010, Hunter 2004, 2005a, b, 2008).

Any exploration of the history of midwifery and development of the maternity services and the players involved demonstrates a strong correlation with these issues and what is considered to be authoritative knowledge (Davis-Floyd 1997). As identified by Stewart (2001) resistance to dominant knowledge systems may lead groups or individuals to be labelled as deviant. It is because of this and particularly the questioning of the validity of ways of knowing that sit outside of the positivist paradigm, that feminist theory has been chosen to inform the methodology and indeed the method of this study. There are many shades of feminism and any consensus regarding the nature of knowledge and its production would be hard to find even within feminist circles (Ramazanoglu & Holland 2004). Yet there are some aspects that feminists have highlighted that have served to raise awareness of the possible characteristics of anti-discriminatory and anti-oppressive research strategies (Dyson & Brown 2006). These are two key principles which have been woven into the methodology for this study.

The claimed objectivity of quantitative research has been challenged both by qualitative researchers and feminist researchers (Roberts 1990) and the debate around issues related to bias much discussed (Stanley and Wise 1983, 1990,

Harding 1987). I am acutely aware that as midwife myself, and a lecturer of too many years to mention here, I have developed a certain 'world view' of midwifery and what I believe this to be. It is acknowledged that my personal subjective view of what constitutes midwifery may well have influenced what I have heard/seen in the data and how I have interpreted these. To ignore this and how these ideas may have influenced what I have heard from the participants in the study and how I have interpreted their meaning whilst analysing the data would be foolhardy (Roberts 1990). Recognition of the potential influence of the researcher on the research process is integral to the underpinning philosophy of Heidegger's hermeneutic phenomenology (Heidegger 1962, Flood 2010, McConnell-Henry 2009, 2011). I have selected a research methodology and method that goes some way to address these issues but importantly acknowledges the role of reflexivity in making transparent the researcher's agenda whilst also in acknowledging the role of reflexivity in knowledge production (Harding 1987, Stanley & Wise 1990, Letherby 2002, 2003, Mauthner and Doucet 2003). Thus the methodology chosen acknowledges that data is viewed and made sense of through a particular lens, my 'eyes', in the same way the data generated by the study participants represents their perceptions, their values, beliefs and experiences, all of which constitute valid sources of knowledge, it has been argued, when a feminist stance is taken (Hammersley 1995, Harding 1987, Stanley and Wise 1983). Thus, this study represents the perceptions and experiences of those involved (including myself), at a particular moment in time and in a particular context. Absolute truths are not what this study aimed to identify and indeed it has been

questioned as whether this is actually achievable (Roberts 1990, Stanley and Wise 1983, Bell and Roberts 1984, Harding 1987, Oakley 1990, Graham 1984).

The unfolding background context of this study has been interesting to track as the research has progressed. At the beginning of the study the future of Independent midwifery looked very gloomy indeed in relation to the compulsory public indemnity insurance as a condition for on-going registration (Department of Health 2010). During preliminary discussions with the Nursing and Midwifery Council regarding the necessary changes to legislation the Department of Health was made aware of concerns that the market was unable to offer insurance cover for Independent midwives and that because of this they would lose their registration and livelihood (Department of Health 2010b). The demise of Independent midwifery for this reason presented considerable anxiety for Independent midwives and the midwifery profession as a whole (Harrington 2010, van de Kooy 2009, Walcott 2009, Anderson 2007, Frohlich 2007). This important contextual issue existed throughout the period of data collection and as a consequence may well have influenced the way that Independent midwives were feeling about Independent midwifery and their future at the time of data collection. Events have moved on since that time, with the commissioning of an independent review by the Department of Health of the requirement to have indemnity insurance as a condition for registration as a healthcare professional (Department of Health 2010b). The Finlay Scott Report (Department of Health 2010b) highlighted the plight of Independent midwives. It has recommended that a solution to this be sought, either by all four Health

Departments (England, Scotland, Northern Ireland and Wales) reviewing whether the services of Independent midwives and others in a similar situation, are still required or by the provision of affordable indemnity insurance for this group (Department of Health 2010b, IM UK 2010). IM UK (2013) reported recent and positive meetings with the Department of Health and Royal College of Midwives (2013), who have indicated their support of Independent midwives and willingness to find a workable solution. This being said the issue is by no means resolved.

However, whilst the issue of indemnity insurance continues to be uncertain for Independent midwives, alleged concerns and adverse publicity about safety and poor standards of practice and Independent midwives being reported to the Nursing and Midwifery Council because of alleged misconduct or malpractice, presented other important contextual issues for consideration during analysis (Kirkham 2010, Harrington 2010, Walcott 2009, Frohlich 2007, Anderson 2007, Serena MW15). In such a climate of uncertainty and perceived vulnerability it is important to note that the numbers of midwives practising independently has seen a substantial reduction since the commencement of the study. Hermeneutic phenomenology recognises the importance of the social, cultural, political, temporal and historical context and acknowledges that this has relevance to how individuals experience their world and to how the researcher interprets this (Heidegger 1962, Koch 1995, Standing 2009). This is why within the current study I have endeavoured, from the outset, to present a number of contextual accounts that help frame this research study in such a way so as to

maximise transparency and understanding regarding how this context may have impacted on the research participants and how they may have “seen” their world at this time.

### ***3.4 The Research Method***

The method selected for data collection is a modified biographical narrative interpretive method (Wengraf 2001, 2009). This technique seeks to elicit rich qualitative data in the form of biographical narrative prompted initially by a single question by the researcher, who then actively listens as the research participant tells their life story (Wengraf 2001, 2009). Collecting data by means of a narrative technique was felt to go some way in addressing criticisms made about potential power differentials within a research interview situation, (Stanley and Wise 1983, Oakley 1990, Maynard and Purvis 1994). When viewing the spectrum of possible interviewing techniques, ranging from the heavily structured through to those that are seen as unstructured, biographical narrative interpretive method (BNIM) is seen by Wengraf (2001, 2009) as being as far towards the unstructured end as is possible. This method hands over control of the interview situation to the participant and the ‘interviewer’ becomes more passive although actively listening. This method strongly resists interventions by the interviewer (in the first phase). In this way potential hierarchical relationships in favour of the interviewer are reversed with the intention of empowering the interviewee and minimizing the exploitative aspects of the ‘traditional research’ interview highlighted by others (Wengraf 2001, Oakley 1990, Maynard & Purvis 1994).



Biographical narrative interpretive method (BNIM) (Wengraf 2001, 2009) utilizes a two-stage and sometimes three stage process. The initial stage is concerned with the elaboration of the participant's story; the second is concerned with extracting more narrative around issues raised in the first stage. The third stage, if required, is concerned with any questions arising from preliminary analysis of stage one and two. Stage one and two occur on the same day. Stage three, if it is required, can occur some weeks after the initial interview and can be accomplished via the telephone. Because of concerns highlighted earlier with the potential effects of "member checking" and its potential to alter original meaning and the fact that this contradicts the underpinning philosophy of hermeneutic phenomenology (McConnell-Henry 2011), this part of the method has been resisted.

Stage one uses a single question aimed at inducing narrative. No prompting other than non-verbal signals are used to further encourage narrative (Wengraf 2001, 2009). In this study the single question was:

**'I would like you to tell me the story of your life as a midwife and all the events and experiences which are important to you. Start wherever you like. Please take all the time you need. I'll listen first, I won't interrupt I'll just take some notes for afterwards'.**

Data was collected by means of field notes and audio tape recordings and resulted in the detailed biographical narratives about participants' lives as midwives and the relationships they aim to achieve with the women they care for. In this method when it is clear that the research participant has finished her

story, both interviewee and interviewer are recommended to have at least a 15 minute break before commencing stage two (Wengraf 2001, 2009). In accordance with BNIM, (Wengraf 2001, 2009) as the midwife told her story, issues raised were noted down by the researcher as short headings or topic areas in the order that they were raised in readiness for the second stage of the interview. The fifteen minute break is designed to enable the researcher to consider how they will invite more narrative around the issues raised in the first part of the interview, thus questions asked have to be phased in this way, for example:

**RG: When you were telling me your story before our break you said that you felt the mother midwife relationship was really important to your work as a midwife. Could you tell me more about this?**

Thus, the second stage of the interview is intended to elicit more narrative around topics raised in stage one. During the second stage of the interview, issues were raised with the research participant in the same order as they were raised in the first stage of the interview in order not to disturb the Gestalt (Wengraf 2001, 2009).

On completion of the interview, and after the researcher had left the research participant, a self-debriefing exercise was undertaken which involved the researcher writing a summary of the interview from memory immediately after the interview to aid accuracy of memory recall (Wengraf 2001, 2009). This activity has been strongly recommended by Wengraf (2001, 2009) in order that details and impressions of the interview could be noted down and additionally to

enable the researcher to 'free associate' around the broad topics raised in the participant's story. This also enabled the completion of a reflexive account of the interview process in the form of field notes. In practice this proved to be an invaluable exercise for the current study, as one interview produced a very poor quality audio tape. In fact it was impossible to hear sufficiently well to make an accurate transcription. The completion of the immediate debriefing exercise onto paper meant that some of the data from this interview could be salvaged. Reflexivity has formed an important dimension to this study, it has been suggested that it is a widely agreed principle of feminist research (Ramazanoglu and Holland 2004) and is also seen to be integral to the conduct and analysis of narrative inquiry (Holloway and Freshwater 2007) and as a means of enhancing the quality of qualitative research more generally (Harre 2004).

Trying to pin down a definition of reflexivity is surprisingly difficult (Carolan 2003), as it would appear to mean different things to different people. Ramazanoglu and Holland (2004) emphasize that it concerns the making explicit of power relations between the researcher and the researched. Carolan (2003) details her quest to make sense of reflexivity which ends in a definition offered by Rice and Essy (1999) which is particularly helpful. This definition acknowledges the role and influence of the researcher on the research project. It also states clearly that the researcher should be subject to 'the same critical analysis and scrutiny as the research itself' (Rice and Essy 1999).

Within this study there has been the opportunity to explore reflexivity on a number of levels that in fact mirror some of the research questions. For example, there are clear similarities between the researcher building trust and rapport with the midwives in the study and the trust and rapport that midwives aim to build with the women in their care. The difference being that the researcher, much like the midwives working in the NHS, has a much shorter time than Independent midwives to achieve this relationship. Holloway and Freshwater (2007) identify the researcher-researched relationship as the means by which the researcher creates and maintains an environment in which empathetic dialogue and rapport can blossom. Similarly, as will be seen later in this study's findings chapters, the mother midwife relationship and the building of rapport, is perceived by the research participants as the vehicle that enables them to tune into the needs of the women in their care. The challenge for the researcher in using the particular method chosen was that, after having created an atmosphere and environment and establishing sufficient rapport in order to ask the initial research question, the researcher has to (during the first phase of the interview), communicate empathy by means of non-verbal cues alone and to actively resist entering into conversation (Wengraf 2001, 2009). Critical reflection on this experience has provided insight and understanding of these skills at a very personal level, particularly in relation to the value of listening in order that others can freely express their stories in a way that has meaning for them. Again as will be seen from the findings of this study, there is resonance with this observation and the experience of the research participants as

midwives who identify the value of listening, “really listening”, as one of the most important skills in tuning into the needs of women.

### ***3.5 Gaining Approval for the Study***

Ethical approval was sought and gained from De Montfort University Faculty of Health and Life Sciences Ethics Committee (see Appendix 2). As the midwives in the study were all self-employed there was no requirement to seek ethical approval from the National Health Service Research Ethics Committee. Approval was also gained from the Independent Midwives Association (IMA), now Independent Midwives UK (IM UK). Although there was no formal ethical committee at the IM UK to submit a formal ethical application to, details of the study (research proposal, participant information sheets, invitation letters and consent forms, were sent to the secretary of the IMA for consideration by the IMA Board Members. Approval and permission to approach midwives via the IMA website was subsequently received (See Appendix 3).

### ***3.6 Ethical Considerations***

The following ethical guidance informed the conduct of this study: The Research Governance Framework for Health and Social Care (Department of Health 2005) and Nursing and Midwifery Council Midwives Rules and Standards (NMC 2012) and The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008). These were enacted in the following ways:

### ***3.6.1 Respect for Autonomy: Participation and Informed Consent***

All midwives invited to participate in this study were sent an invitation letter, a participant information sheet and a reply slip (see Appendix 4 & 5). Within this information sheet research midwives were assured that participation in the study was completely voluntary and that there were no adverse consequences related to non-participation. They were assured that they could withdraw from the study at any time, without explanation and without consequence, even if they had previously indicated their willingness to participate in the study by returning the reply slip. They were informed that they could also withdraw their data, having been interviewed, and prior to the write up of the study.

Permission was also sought from the research participants to use an audio-tape to record their interview in order that an accurate verbatim transcript could be produced for later analysis. Non-return of a reply slip was taken to indicate that midwives did not wish to participate in the study, and therefore no further contact was initiated.

This information was reiterated to all participants who agreed to participate in the study prior to the actual interview and the opportunity to withdraw from the study at this point explained. All participants who agreed to be interviewed were asked to sign a consent form indicating their willingness to be interviewed, that they had read and understood the aims of the study and what was expected of them and to indicated their consent to the interview being audio-taped (See consent form Appendix 6).

### ***3.6.2 Non Maleficence***

All research participants were asked to choose a preferred time and location for their interview which was comfortable and convenient to them. During their interview every effort was made to deal with them sensitively and respectfully whilst at the same time monitoring for any signs of stress. Whilst there have been no reports of clinically significant levels of distress in healthcare professionals whilst talking about their working lives, all participants were provided with information regarding potential sources of support should they have wished to discuss any highlighted issues further (see participant information sheet Appendix 5).

As a practising midwife myself I also acknowledged my responsibilities and accountability to the Nursing and Midwifery Council (NMC 2012, 2008) in the eventuality of a research participant disclosing unsafe practice. In order to safeguard the interests of the general public in this eventuality, the midwife's Supervisor of Midwives would be informed in the first instance. This requirement and obligation was highlighted to all participants in the participant information sheet (see Appendix 5).

### ***3.6.3 Anonymity and Confidentiality***

All interviews were carried out by the researcher and the taped conversations and field notes remained confidential, only seen/heard by the researcher. All tapes were labelled by number and a pseudonym in order to protect anonymity. These were stored in a separate location to the transcribed interviews with only the researcher having access to the actual identity of individual tapes. All notes and taped conversations were stored in a locked filing cabinet and accessed by

the researcher alone. Tapes and transcripts will be destroyed after completion of the study.

Fourteen of the twenty taped recorded interviews were transcribed by the researcher and the remaining six completed by the brought in services of an audio-typist in order that the transcriptions could be completed in a timely manner and analysis commenced. The participating midwives were offered the opportunity to review the transcript of their own interviews in order to be assured that anonymity and confidentiality had been maintained. Original data was not changed unless the midwife concerned felt anonymity or confidentiality had been compromised.

Additionally, each research participant was invited to choose themselves a pseudonym which was known thereafter only by the researcher and the midwife concerned. Choosing a pseudonym was a suggestion that came from a research participant, Bethany (MW3), who quite rightly pointed out depersonalising effects of allocating each midwife a number, suggesting that this was what “the system” did to women. This was one of several examples of how the concept of co-constitutionality discussed within hermeneutic phenomenology philosophy operated within this study (Gadamer 1976). Suitably humbled, this served as an excellent reminder that research is a much a journey for the researcher as it is a quest for new knowledge and the seeking of answers to research questions. It also demonstrated how a research study can be enriched by this process of co-creation. Most midwives chose



themselves a pseudonym. A few midwives did not express a preference, and asked me to select a name for them.

There were particular issues and sensitivities around the preservation of anonymity for this particular group of midwives that had to be considered in the writing of this study and will continue to be a consideration in any material published subsequently. These issues were compounded by the fact that Independent midwives represent a relatively small group of midwives as compared with those that work in the NHS. By virtue of this fact members of a smaller group become more “visible”. Additionally, some Independent midwives have a high profile within the midwifery profession as a result of both national and international published works, conference presentations and skills workshops. Consequently their particular values, beliefs and anecdotes may have been publicised and be familiar to a wide audience.

Whilst the strategy of adopting pseudonyms goes some way to address these issues, there was also the need to give consideration to potential “identifiers” within the disclosed text. For this reason the strategy of sending verbatim transcribed interviews to each of the research participants was adopted enabling identification and removal of any potentially sensitive areas which might compromise their anonymity. It is understood that anonymity of research participants is not just an ethical issue but has, with the introduction of the Data Protection Act (1998), legal implications too (Clark 2006, Grinyer 2002). A strategy of checking and re-checking with research participants prior to the

publication of any material resulting from this study will be adopted to ensure that participants are happy for this to be shared with a wider audience. The strategy to remove identifiers, whilst satisfying the requirements of ethical and legal research practice (Clark 2006), also holds the potential to restrict data analysis. It thereby potentially inhibits conclusions drawn and insights gained because of the inability to cross reference data, as has been found in other studies with Independent midwives (Symon et al 2010). The researchers in this study were investigating the findings of an earlier study (Symon et al 2009), which found a significantly higher perinatal mortality rate for births booked under the care of independent midwives than for those in NHS units. Symon et al (2010), who examined Independent midwives' management and decision making in 15 cases of perinatal mortality, also faced dilemmas in relation to confidentiality and anonymity. Because of the sensitivities research participants insisted that all identifiers from individual cases were removed; this requirement was instrumental in leading the researchers towards a voice-centred relational method of data analysis (Mauthner & Doucet 1998) with all identifiers from individual midwife quotations being removed. This strategy, although necessary, also meant that cross linkage between issues identified in individual cases was compromised and was felt by the researchers to have significantly inhibited analysis of data (Symon 2010). Clearly the sensitivities in the current study are not quite the same as for Symon et al (2010). However, concerns about the preservation of anonymity have influenced decisions taken about the conduct of this study, the data included and consequently potentially the insights gained. An example of this is the resistance to providing detailed

demographic data pertaining to individual research participants that may have provided an enhanced understanding and knowledge about the characteristics of independent midwives. However this has been addressed in a slightly different way by means of a “generic” approach using information disclosed during interviews, as will be seen in the next section.

### ***3.7 Sample***

Twenty self-selecting practising Independent midwives were interviewed. 41 midwives were invited to participate in the study via the Independent Midwives (IMA/IMUK) website <http://www.independentmidwives.org.uk> in order that a sample of twenty was achieved. The website enables women searching for an Independent midwife, to type in their postcode and the contact details of Independent midwives located at a distance of 60-100 miles from their home are displayed in list form. As this information was in the public domain I was also able to use this facility to access contact details of midwives and invite them to participate in the study. There were no exclusion criteria. Whilst it has not been the aim of this study to provide a representative sample of independent midwives or to make generalisations applicable across the whole Independent midwifery community, it is interesting to note that at the outset of this study, as previously mentioned, there were approximately 200 Independent midwives in the UK (IMA 2008), making the sample size equivalent to 10% of this community. In view of the fact that the number of Independent midwives at time of writing has fallen to approximately 95 (Warren 2011) this makes the sample size now equivalent to 21% of this group.

Formal demographic information about the midwives interviewed was not recorded due to concerns regarding the potential compromise of anonymity as previously discussed. However, from information disclosed during data collection it has been possible to identify that the research participants ranged in age from approximately 25 years to that of 60+ years. Their overall midwifery experience ranged from approximately 3 to 30+ years, and their experience of independent midwifery practice ranged from 12 months to 20+ years. The number of women in the research participants' caseload varied considerably; however, this was substantially less than the given caseloads of 36-40 women per midwife per annum for midwives working caseload models of care within the NHS (Stevens 2003, Benjamin et al 2001). This is partially due to the fact that there is not a steady source of women who want to engage the services of independent midwives and also because of individual midwife choices about the number of women they want to care for during a given year. From disclosed information the research participants identified a formula of booking a maximum of two women per month if they were working on their own, or if they worked with a partner they might increase this to three if they were able to share on-call cover. This "formula" is much in keeping with that described by Hobbs (1997) in her guide to independent practice. Also midwives indicated that if they wished to take holiday this meant they would perhaps only work 10-11 months a year resulting in a caseload of approximately 20-24 women per annum. Several of the midwives in this sample indicated that their caseload was 10 women or less per annum. All of the midwives in this sample indicated they had a partner/other family member that made a substantial contribution towards the

family income indicating that revenue from independent practice contributed towards rather than provided the mainstay of financial resources for their families.

Additionally other shared characteristics of those interviewed, as disclosed during the telling of their story have been extracted from the data and can be found in Table 1 on page 102. These include experience in NHS hospital settings, experience in NHS community settings and personal experience of childbirth.

Data relating to the prevalence of research participants being bullied whilst in the NHS and being investigated or disciplined has also been extracted. These interesting findings will be discussed more fully in the results chapters of this thesis.

### ***3.8 Research Location***

All interviews took place at a venue selected by the research participants. This was in the majority of cases their own home, although one midwife did choose to be interviewed at a small birth centre. As independent midwives are located all over the UK; this involved travelling up to 200 miles in order to interview the midwives in their preferred location and at their preferred time.

### ***3.9 Data Collection***

Independent midwives were invited by letter to participate in the study (see Appendix 4). They were sent a participant information sheet and a reply slip to indicate willingness to participate in the study along with a stamped addressed envelope for return of the same to the researcher (see Appendices 4 & 5). If midwives did not respond to the invitation this was taken to indicate that they did not wish to participate in the study and no further contact was initiated. Invitations to participate were sent out in batches of 4-6 to enable monitoring of the numbers of midwives willing to participate and pacing of the data collection. Data collection had to fit around the researcher's other work commitments, and as a strategy, pragmatically this worked very well.

Following receipt of a reply slip, contact was made with the midwife to arrange a mutually convenient time and place for the interview. Due to considerations regarding travel and the format of the interview and the time required for this (1.5- 2 hours on average) and in addition the requirement of the researcher to reflect on the interview and write a "de-briefing account" immediately after the interview (Wengraf 2001, 2009), the decision was taken, following a small pilot study of three interviews, to undertake only one interview per day. This process was repeated until 20 midwives had been interviewed. A total of 43 invitations to participate were sent out to achieve the desired sample size of 20. Recruitment to the study took place over a 22 month period commencing September 2007 and was completed by July 2009.

**Table 1 : Additional Disclosed Demographic Information Regarding Characteristics and Shared Experience of Research Participants**

CODE	Midwife (Chosen Pseudonym)	Personal Experience of Childbirth	Direct Entry Midwife	Worked in Hospital in NHS	Worked in Community in NHS	Moved Straight into independent practice on qualification	Investigated or disciplined whilst in NHS	Experienced being bullied while in NHS
MW 1	Erica	✓	✓	✓	✓	X	X	X
MW 2	Grace	✓	X	✓	X	X	✓	✓
MW3	Bethany	✓	✓	✓	✓	X	X	X
MW4	Chloe	✓	X	✓	✓	X	✓	X
MW5	Ingrid	✓	✓	✓	X	X	✓	✓
MW6	Vanessa	✓	X	✓	✓	X	X	X
MW7	Rhianna	X	X	✓	✓	X	X	X
MW8	Emily	✓	✓	✓	✓	X	✓	✓
MW9	Esmie	✓	✓	✓	✓	X	X	X
MW10	Lydia	✓	X	✓	✓	X	✓	✓
MW11	Evelyn	✓	X	✓	✓	X	✓	✓
MW12	Milly	✓	✓	✓	✓	X	✓	✓
MW13	Brigid	✓	X	✓	✓	X	✓	✓
MW14	Phoebe	✓	X	✓	✓	X	X	X
MW15	Serena	✓	✓	X	X	✓	X	✓
MW16	Freya	✓	X	✓	✓	X	✓	✓
MW17	Amy	✓	✓	X	X	✓	✓	X
MW18	Jemima	✓	X	✓	✓	X	✓	X
MW19	Angel	✓	✓	✓	✓	X	X	✓
MW20	Red	X	✓	✓	X	X	X	✓
Key	✓ = YES	X= NO						

### ***3.10 Pilot Study***

A pilot study was undertaken. This enabled the checking of technique and questions, and amendments to be made as appropriate prior to embarking on the main study (Wengraf 2001). Three interviews were conducted and transcribed, each yielding between 6000-7000 words of very rich narrative data. The quality and quantity of the data from the first interview demonstrated the robustness of biographical narrative method (Wengraf 2001) as method of data collection. Experience from the second and third interviews revealed that the initial question, **'Tell me the story of your life as a midwife...'** may not result in midwives talking specifically about how they build rapport and trust with the women in their care, which was one of the key questions of interest to the study. However, motivations regarding why midwives chose to move from NHS practice to practice independently, philosophies, values and beliefs about midwifery care and the role of the midwife were very strongly articulated when this method was employed. In order to address this potential short fall in data collection, during the second phase of the interview, more narrative was invited about the specifics of the participant's relationship with her clients, the processes involved in gaining and maintaining rapport and the participant's view of the role of this process in her practice if this was not raised during the first phase of the interview. In this way it has to be acknowledged that during the second phase of the interview the narratives elicited by the research



participants were directed to some degree by the researcher's interests. Data from the pilot interviews were included in the main study.

### ***3.11 The Main Study- Data Collection***

The main study continued to produce rich and plentiful data, each interview yielding between 4,800-14,000 words. Research participants told their stories freely and enthusiastically. The first part of the interview where midwives were invited to tell the story of their lives as midwives typically took between 40-60 minutes. It took great effort on my part not to speak or express opinion as this took place, using only non-verbal clues to encourage on-going narrative. Once this part of the interview was completed the midwives often appeared tired. This was hardly surprising given that their initial story was told over 40-60 minutes and often delivered with much energy and enthusiasm. The total time for each interview was between 2-2.5 hours.

Wengraf's (2001, 2009) method for noting down key words/events during this phase of the data collection, for picking up afterwards was followed. I was struck by the challenge of actively listening, giving appropriate non-verbal clues so that the participant was encouraged to proceed with their narrative and that I as the researcher was actively listening and interested in what they were saying, whilst, at the same time noting down key words that could be used as trigger areas for inviting additional narrative in the second part of the interview. Wengraf (2001) stresses the importance of inviting additional narrative in the same order (Gestalt) raised by the research participants. In practice I noted that the research participants reacted well to the issues being raised in the order

they had specified and also the use of, “their words and phrases” appeared to reinforced to the research participant the fact that I had been listening actively and appeared to add to the quality of the rapport that was achieved with the midwife. Whilst the questions raised in the second part of the interview were designed to elicit more narrative the midwives were clearly tired by this stage and it felt inappropriate and indeed intrusive on occasion to probe extensively when this was the case. I was mindful of the fact that these midwives were doing this in their own time and for no payment, and doing so with a very generous spirit. I was made to feel very welcome, often given lunch as I had usually travelled a considerable distance to undertake each interview. I needed to exercise sensitivity in reading body language and non-verbal signals as to when it was appropriate to go and not out stay my welcome. These skills again appear to mirror those reported by independent midwives whilst building relationships with the women in their care as will be discussed later in the findings chapters. It is interesting to note that, as has previously been suggested, there are similarities between the skills required to practise related to qualitative research (Robinson 2000, Davies 1995). Certainly my personal experience of being a midwife and conducting research interviews aligns very strongly with this analogy.

I had little or no previous knowledge of the majority of the midwives interviewed, and had to work hard to achieve rapport and trust to a sufficient level that the midwife felt comfortable enough to tell me the story of her life as a midwife. The development of rapport with research participants has been highlighted by

Maynard & Purvis (1994) as being imperative to the encouragement of non-hierarchical relationships. On reflection, my experience and skills as a midwife in talking to people certainly supported this process. I was also aware of drawing on life experience of chatting to people, taking cues and clues from their chosen interview environment (invariably their home) to start this process off. The ability to “chat” was also highlighted by the midwives in this study (Amy MW17, Phoebe MW 14), as a key skill in the achievement of rapport and the building of relationships with their clients, as will be discussed within the findings chapters. In hermeneutic phenomenological terms the fact that I was a midwife meant that there was already some common ground, a “shared horizon” established which enabled our lived experience of midwifery to “touch” but only touch at this point, because although I am a midwife I have never practised as an Independent midwife. An enhanced understanding of this perspective of midwifery practice, or to use the terminology of hermeneutic phenomenology: “a fusion of horizons” (Gadamer 1976) did not occur until after completion of data analysis. However, a shared midwifery background provided a starting point for conversation although I found myself discussing and chatting about a range of non-midwifery topics which enabled us both to feel at ease and rapport sufficiently developed to enable the midwives to feel comfortable enough to trust me with their story, or rather the one that they were going to tell me (Holloway and Freshwater 2007). I felt that the achievement of rapport was very important in terms of establishing trust at a particular time when Independent midwives were and continue to be very wary of the motives of midwives outside of their community who might not have their best interests at

heart. This concern was validated when I experienced being “interviewed” by one of the research participants prior to her own interview in order to assess my motivations for undertaking this research (Chloe MW4). Another used the Independent midwife online chat forum to check out my credentials with others prior to agreeing to be interviewed (Phoebe MW14). This wariness served also to remind me of my responsibilities as a researcher and in particular how the research findings are used. This has been an issue that other that feminist researchers (Ramazanoglu & Holland 2004) have stressed, drawing attention to the ethical principle of non-maleficence in accordance with anti-discriminatory and anti-oppressive principles (Beauchamp and Childress 2001). This principle held potential tension for me as a midwife and a Supervisor of Midwives as I have a professional accountability to report any concerns regarding unsafe practice or breaches of the Midwives Rules and Standards (NMC 2012) and the Code (NMC 2008). Independent midwives are bound by the requirements of the NMC, as is any practising midwife (NMC 2012). They are also known to push professional boundaries in order to work flexibly in helping women to secure their hopes and choices for childbirth as they are less constrained by hospital policies which might detract from this (Wagner 1995, Reed 2010, Kirkham 2010). I was concerned with the potential of being placed in a situation where I had to exercise my professional accountability as a midwife, the impact that this might have on the trusting relationships that I had established and the potential impact of any action taken on the future of the study, given the closely knit nature of this community of midwives. Perhaps this perception was partially fuelled by the rhetoric that abounds, (but that does not go unchallenged),

regarding Independent midwives being seen as “different” because they are able to work more flexibly and as such, has resulted in them often being seen as mavericks and risk takers (Hobbs 1997, Wagner 1995, Reid 2010, Kirkham 2010, Jemima MW 18 2009). Fortunately, at no time during this study was I given any grounds to consider my accountability in this respect. Arguably, this was to be expected, as one might consider that no self-aware Independent midwife or indeed NHS midwife would knowingly disclose unsafe practice and expect this to go unchallenged. On the contrary I formed a very favourable impression of a group of very feisty, impassioned women who work very flexibly, creatively and accountably with a group of women who are often very challenging to care for. In order that women are supported in their choices for childbearing and birth elaborate arrangements are often made to mitigate risk whilst acknowledging the woman’s ultimate right to choose what she wants. This can place the Independent midwife in a position of vulnerability (Milly MW12), a position that I, as a Supervisor of Midwives, did not fully appreciate until undertaking this study.

It could be argued that politically, at such a time of uncertainty for Independent midwifery, and for the afore mentioned reasons, those midwives interviewed had a vested interest in presenting themselves in the best possible light, perhaps with an agenda of getting a message “out there” that might help their cause when this study is eventually published (Freya MW16, Jemima MW18, Brigid MW13). There has been considerable debate of the potential for exploitative relationships between the researcher and researched and the need

for researchers to try to address such issues whilst conducting their research (Stanley and Wise 1990, Oakley 1990). The use of the biographical narrative interpretive method facilitates a tilt in the power-base in the research interview context in favour of the researched (Wengraf 2001, 2009) with the possibility of them exploiting the research situation for political reasons and messages of their own. Given the current political context of Independent midwifery this strategy on the part of the research participants was unsurprising. Some interviews illustrated this more strongly than others, with one participant demonstrating a particularly notable example of the exercise of agency within the research situation. This was enacted by her interjecting even before I asked my question inviting her to tell the story of her midwifery career as follows:

*“I just think we have to record, I just feel midwifery is dying, being killed off... we are feeling particularly damaged at the moment, they are expecting midwives to,.... I am going to write an article about it, but they are expecting midwives to be working to the N.I.C.E. guidelines. And they are guidelines, at the front of them they actually say they actually say they are guidelines and should not be used as rules, when you look at the midwives who are struck off, there are a huge number of those who have been referred to the NMC who are eventually removed from the register. And there is a big percentage who have been looking at it. And on lots of those, when you look at the transcripts the accusation is that they did not follow the N.I.C.E. guidelines. Please note I did not say the word “Nice”, I don’t think they are, they are not evidence based and we are all supposed to be working to evidence. And they don’t recognise how*

*women labour, they are just wiping away the evidence about women not being disturbed....” (Freya MW16).*

The sentiments expressed in this quotation are explored in more detail in the following findings chapters and discussion chapter, however, this quotation does illustrate the depth of feeling and frustration associated with a perceived policing and constraint of midwifery and midwifery knowledge and the need to get that message “recorded” as Freya (MW16) expresses this, not as life story but as a political statement.

### ***3.12 Analysis of Data***

#### ***3.12.1 Method, Rationale and Underpinning Philosophy***

The strategy for data analysis intends to demonstrate congruence with the philosophic principles of hermeneutic phenomenology with particular reference to the work of three hermeneutic philosophers (Gadamer 1976, Ricoeur 1981& 1973 and van Manen 1990). As hermeneutic phenomenology does not have a prescribed methodology, method and mode of analysis per se, the researcher is able to exercise considerable flexibility in the interpretation and application of the underpinning philosophical ideas to their research process, picking and mixing congruent principles (Flood 2010) and melding them in order to create a method that meets their particular needs and beliefs around the research process and what they hope to achieve. The thinking of each of these philosophers has contributed in part to the analysis of data and it is recognised that their thinking has built on or extended the original thinking of Heidegger (1962), (Tan et al 2009, Flood 2010). As a consequence it is unsurprising that their ideas overlap and importantly are compatible. In this study Gadamer

(1976) contributes the philosophical concept of the hermeneutic circle, acknowledging the interaction between the lived worlds of the researcher and the research participant as the researcher attempts to move towards a position of enhanced understanding of the lived experience of the researched phenomena, ultimately resulting in a “fusion of horizons”. In this way the resulting understanding is seen as process of co-creation and melding of worldviews (Lavery 2003). Van Manen (1990) offers a thematic approach to analysing hermeneutic phenomenological data in what has been described as his “selective or highlighting approach” and acknowledged as a validated technique for this purpose (Van Manen 1990, Rapport 2003, 2005).

Hermeneutic phenomenology aims to move from describing the lived experience of a phenomenon to that of interpreting and understanding this experience (Flood 2010). Principles of Ricoeur’s (1971) theory of interpretation have been used in conjunction with van Manen’s (1990) approach to data analysis to assist in the move from descriptive themes to interpretation of the underlying meaning and significance of these themes. Ricoeur’s theory (1981) refers to the key concepts of distanciation, appropriation, explanation and interpretation. Ricoeur (1971) articulates three levels of analysis which involve the progressive movement from initial explanation of the text by means of examining transcripts and identifying themes and language used at face value, through to an initial naive understanding facilitated by grouping or clustering themes with closely connected ideas not dissimilar to the van Manen’s (1990) selective/highlighting approach. This is then followed by progression to an in



depth understanding where there is movement back and forth between explanation and understanding as the research participant (in the form of the transcribed interview texts-lived world of the research participant) enters into “conversation” with the researcher (pre-existing lived world of the researcher) in order that the underlying meaning can be interpreted. This back and forth movement is reminiscent of the Gadamer’s (1976) hermeneutic circle although Ricoeur himself sees this as a hermeneutic arc (Ricoeur 1981).

### **3.12.2 *Enactment of Data Analysis in this Study***

Data from two sources were analysed, that of the transcribed individual interviews with 20 independent midwives, and reflexive accounts written by the researcher immediately following each interview.

#### **3.12.2.1 Level 1 Analysis: Explanation**

In this part of the analysis the interview transcripts, the researcher’s reflexive comments were read through and notes made around general themes that appear in the interviews. This stage was about becoming immersed in the data in order to begin to illuminate the ‘internal nature’ of the text (Ricoeur 1981, Tan et al 2009) and in order that a broad overview of the data could be obtained. Immersion and familiarity with the data in the study was enacted by means of the researcher carrying out all the interviews in the study transcribing 14 out of the 20 interviews and reading and re-reading of all transcripts. Personally undertaking transcription proved to be a very effective way of “getting inside the data” and allowed for the initial identification and highlighting of broad themes. Data appeared to fall into three major themed areas, that of “the journey into

Independent midwifery”, the “mother midwife relationship” and “the working life of an Independent midwife”. These broad themes largely align to the original aims of the research and started to form a rough framework in which to start to examine the verbatim transcribed interviews.

Transcripts were re-read and sub-themes identified in order to make visible the “structures of experience” (van Manen 1990) necessary to describe each interview. Within this study a “theme” and a “code” are seen as being synonymous (Bryman 2008). Also within the context of this study a “theme” aligns to van Manen’s (1990) “structures of experience”. Combing of the data to identify themes was facilitated by the use of the computer assisted qualitative data analysis software QSR NVivo7. Specific training to use this package was undertaken with on-going reference to the software manual (QSR NVivo7) to solve any difficulties regarding understanding what the package could do and importantly not do (Bryman 2008, Crabtree and Miller 1999). The package facilitated the effective sorting data under themed and sub-themed headings. Each transcript was entered into QSR NVivo 7 and a line by line review of the transcript undertaken. Quotations from the transcripts were lifted into the themed headings as appropriate. The package enabled labelling of each of the quotations selected and the ability to move from quotations directly back to the actual transcripts so that the context could be easily re-visited and checked. The process of “coding” and the use of computer assisted packages has been criticised by some because of fears that this would decontextualize quotations with the potential to “misconstrue” the data (Hollway and Jefferson 2000,

Bryman 2008). The use of NVivo7 did appear to help mitigate this effect due to the software's ability move constantly from quotes filed under theme coded headings back into the actual transcript in order to ensure that the context of the quotation was appropriately represented, a crucial tenet of hermeneutic phenomenology (Heidegger 1962, Koch 1995, Standing 2009). In this way it was found to be very helpful as a tool in enabling me to stay close to my data and to view its original meaning. It has been suggested that full understanding the intended meaning of the interviewee may well be impossible due to the subjectivity of the researcher's interpretation of what has been said (Hollway and Jefferson 2000) and I would acknowledge this potential. Crabtree and Miller (1999) highlight the wisdom of "seeking creative abundance" by consulting others and looking for and considering other interpretations. To this end my research supervisors provided both verification and challenge to my descriptions, by confirming a similar understanding whilst also encouraging me to consider alternative interpretations.

The process of coding resulted in a reduction in text studied (Newell and Burnard 2006). This involved decisions about what data to include and what to set to one side. It has been acknowledged that this is a necessary step in order to make the vast amount of data collected more manageable (Bryman 2008). Selection of data was driven by the themes identified. The themes selected were those that were most commonly referred to by the research participants in the first instance whilst also noting those that were "unusual" or "noteworthy". This strategy has been recognised by others and also aligns to van Manen's

highlighting and selective approach to data analysis (Bryman 2008, Ryan and Bernard 2003, van Manen 1990). Definition of what is considered both noteworthy and unusual are acknowledged as being highly subjective resulting in the potential elevation of some themes over others (Bryman 2008) and aligning to the “lens” through which the researcher views the data. Bryman (2008) has also pointed out that this might result in a particularly striking comment or statement by a research participant having more significance attached to it than perhaps is warranted in terms of its frequency. Conversely Crabtree and Miller (1999) see “anomalies” in the data as something to celebrate as they hold the potential to provide new insight. Subjectivity in relation to which themes are “seen” in the data and prioritised because of this are acknowledged within hermeneutic phenomenology as the lived experience of both researched and researcher interact creating a new worldview for the researcher which then can be shared with others (Heidegger 1962, Gadamer 1975, Ricoeur 1973). Themes were collected together and any overlaps noted. Similar themes were amalgamated and re-labelled to reflect the regrouped ideas. In this way the themes were reduced to a more manageable number (Bryman 2008).

Appendix 7 details the identified themes and sub-themes under the three broad major themed areas, that of “the journey into Independent midwifery”, the “mother midwife relationship” and “The working life of an Independent midwife”.

### **3.12.2.2 Level 2 Analysis – Naïve Understanding**

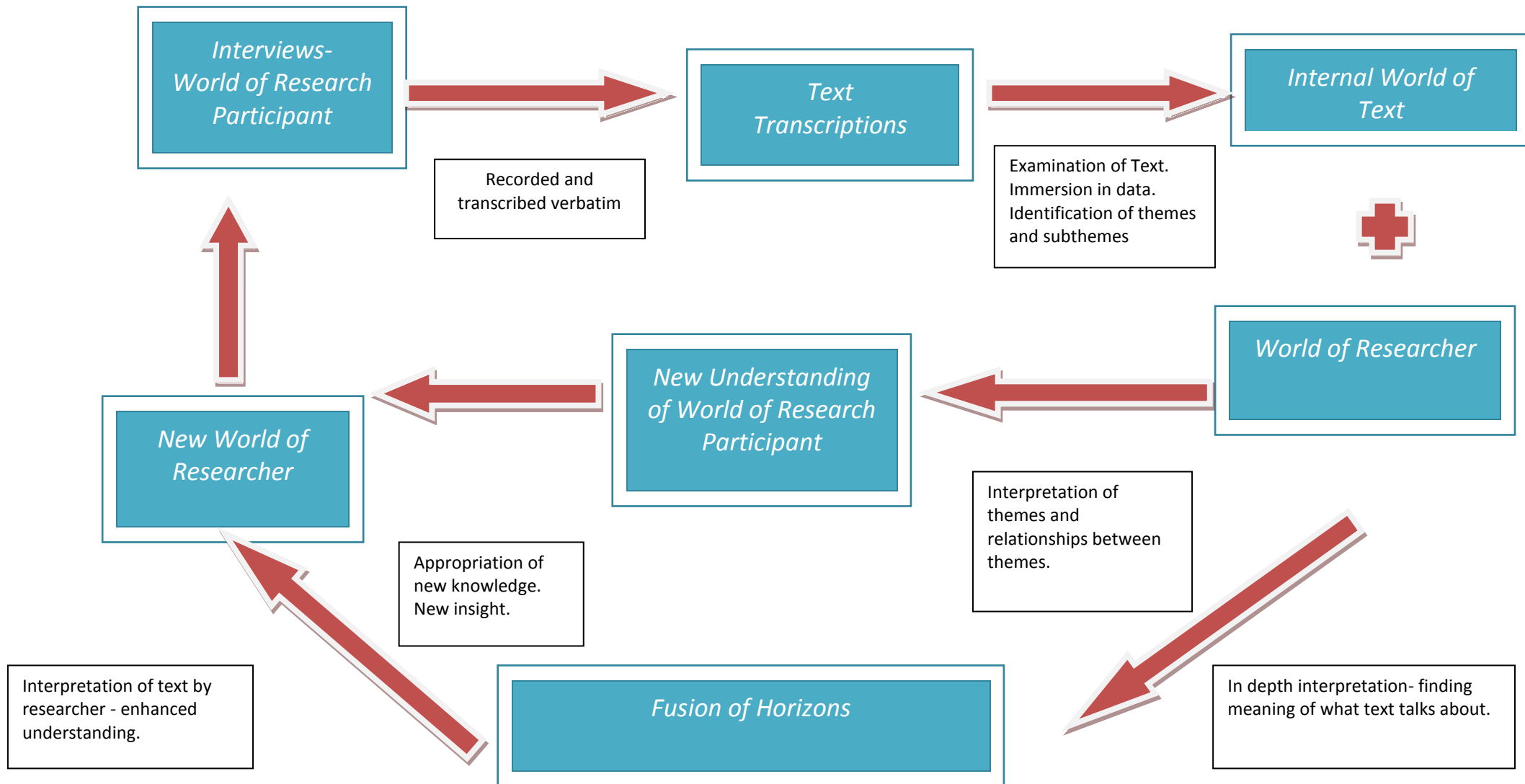
This stage of data analysis, that Ricoeur (1981) calls naïve understanding involved reviewing the material under the themed headings in order to identify

any relationships apparent between the different themes. Using maps or diagrams to facilitate the identification of patterns, linkages, connections and relationships between themes has been seen as a useful tool (Crabtree and Miller 1999). In order to facilitate this process within this study mind maps (Buzan 2010) were utilized and found to be very effective in facilitating the identification of these relationships as they emerged from identified themes. Visualisation of themes and categories followed by reflection on these has been seen as a powerful and creative tool for this purpose (Crabtree and Miller 1999). Examples of mind maps utilised within this study can be found in Appendix 8. As a result of this a naïve understanding of the lived experience of independent midwives could be articulated in the form of description.

### **3.12.2.3 Level 3 Analysis: In-depth understanding**

At this stage and in accordance with hermeneutic phenomenology an attempt was made to move from the description of the lived experience of the research participants to that of an interpretation, as seen through the researcher's eyes. Crabtree and Miller (1999) describe the process of interpretation as being: "a complex and dynamic craft, with as much creative artistry as technical exactitude..." (Crabtree and Miller 1999 p. 128). In accordance with Ricoeur's theory of interpretation (1981) this was achieved critical reflection on the themes and the identification of meaning and concepts underpinning them by moving back and forth between explanation and understanding of the data until a "fusion of horizons" was achieved. The process of data analysis and the application of Ricoeur's theory of interpretation (1981) has been summarised in Figure 1 on the following page.

Figure 1-Summary of how Data was Analysed using the Principles of the Hermeneutic Circle and Ricoeur's Theory of Interpretation( 1981)



### ***3.13 Rigour and Trustworthiness***

Bryman (2012) has reported the considerable debate and controversy which surrounds the evaluation of qualitative research and appropriate criteria to use. Both reliability and validity have been seen as important measures of the quality of quantitative research. However there is considerable debate around the appropriateness of applying these criteria to qualitative research (Bryman 2012, Guba & Lincoln 1994). Some authors have suggested that the terms reliability and validity can be applied to qualitative research and have suggested using similar criteria (Mason 1996). Others have sought to modify the criteria changing the meaning of reliability and validity slightly to make them more appropriate (Le Compte & Goetz 1982, Kirk & Miller 1986).

Alternative criteria for evaluating qualitative research have been suggested in relation to the terms “trustworthiness and authenticity” (Lincoln & Guba 1985, Guba & Lincoln 1994). The importance of using qualitative criteria to judge qualitative research has been seen as imperative (Leininger 1994, Lincoln & Guba 1985), with failure to do this being seen to reflect a lack of understanding of the goals and philosophical assumptions of both quantitative and qualitative research. For the purposes of this study I have applied Yardley’s (2000) alternative criteria which seem to be particularly suited to phenomenology and are reflective of the feminist thinking influencing the conduct of this study as previously stated. Yardley (2000) has proposed four criteria, that of sensitivity to context, commitment and rigour, transparency and coherence and finally impact and importance. These criteria would also appear to have particular

applicability to phenomenological research with a healthcare orientation because of the emphasis of impact and potential relevance and implications for clinical practice (Bryman 2012). Yardley's (2000) criteria form the framework for the consideration of this study's rigour and trustworthiness.

### **3.13.1      *Sensitivity to Context***

I have attempted throughout this study to articulate and be sensitive to the social setting of this research, indeed as previously mentioned the context of the research holds importance/significance to the philosophical underpinnings of hermeneutic phenomenology (Heidegger 1962, Koch 1995, Standing 2009). Important contextual and background information has been included in this thesis in order to highlight factors that have influenced both data collection and its analysis. Contextualized quotations from research participants have been used throughout the findings chapters to facilitate understanding and interpretation of data.

### **3.13.2      *Commitment and Rigour***

This thesis endeavours to represent substantial engagement with the subject matter and the demonstration of the necessary skills and thorough data collection and analysis (Yardley 2000). This has been achieved by clear articulation of the research process and steps taken, with a clear audit trail of this. The major tenets of hermeneutic phenomenology philosophy have guided this process and informed the decisions made with reference to data collection and its analysis.



### **3.13.3      *Transparency and Coherence***

Research methods are clearly specified with rationale given for decisions made that are congruent with this study's methodology and philosophical stance. The thesis has a coherent structure with signposting of themes within chapters and careful linking of chapters in order to form a coherent piece of work. Reflexive comments are integral to the work and important aspects of how the researcher has interacted with the research participants, the data obtained and its analysis are included in accordance with the study's philosophical underpinnings.

### **3.13.4      *Impact and Importance***

Both the potential impact and importance of this study are articulated in the final discussion chapter of this thesis, along with the significance of theory development and the application of this to the future work of Independent midwives and the midwifery profession more generally.

This chapter has discussed the philosophical underpinnings of this research study and has detailed the research process undertaken. The following three chapters detail the research findings and interpretation and analysis of these. The three chapters which follow represent the three major essential themed areas identified in the study, and are reflect the three key aims of this study. These have been entitled, "the journey into Independent midwifery", the "mother midwife relationship" and "the working life of an Independent midwife".

## **4 The Journey into Independent midwifery**

### ***4.1 Introduction***

This is the first of three chapters that detail the findings of this study. Within the study three major areas very quickly became apparent, emerging as they did during early and informal analysis whilst undertaking transcription of the interviews with midwives. Although the data collected was both plentiful and rich it became clear that grouping themes under these three very broad headings would serve as a useful framework to structure an integrated approach to the analysis and discussion of the findings from this study. The three major areas emerged from the data in what could be considered a logical and linear response to a request for the research participants to tell their life stories as midwives. I have adopted a sequence of presentation that reflects the stories as they were told and that retains the temporal ordering provided in the research participants' accounts.

Each chapter will critically discuss and explore key findings under key themed headings. The key themes emerged as a result of consideration and analysis of the data, its sub-themes and the potential relationships between them. Within this chapter, which considers the journey into Independent midwifery, three interlinking key themes will be used to explore the findings in this section. Findings will be presented under the following headings: that of the philosophy of "being with woman" and how this shapes aspirations of clinical practice, the constraint and oppression of midwifery practice as experienced within the NHS

and the effects this has on the philosophy of being “with woman” and finally that of bullying as an expression of constraint and oppression within maternity care and how this is a particular issue for this group of midwives.

#### ***4.2 Being “With Woman”***

For the midwives in this study the philosophy of “being with woman” appears to be the driving force behind their motivation to become and continue to be a midwife. They recognise that certain clinical environments enable them to enact this philosophy more than others and as a consequence they try to make career choices that facilitate this, before they make the ultimate decision to move into Independent midwifery.

What it means to be “with woman” has been previously discussed in Chapter 2. Globally this philosophical stance has come to represent the essence of what it is to be a midwife (International Confederation of Midwives (ICM) 2011, Australian College of Midwifery (ACM 2004). The Australian College of Midwifery’s (ACM 2011) philosophy statement for midwifery draws upon a number of international midwifery philosophical ideas about the nature of midwifery and what it aims to achieve (ACM 2011). It explicitly refers to the fact that being a midwife means being “with woman” and thus this principle shapes midwifery’s philosophy, informs how midwives work and the nature of their relationships they aim to form with women.

Page and McCandlish (2006), in what could be described as a “new wave” midwifery textbook, also articulate the philosophy of the midwife being “with

woman”, developing this a little further in order to indicate that the midwife should be able to work alongside and with the woman, to ensure that care meets her individual needs and those of her family. “With woman” being seen in terms of:

*“...a relationship of knowing each other, of mutual trust, of working in the best interests of the woman and her family and ensuring that their care is uppermost in midwifery work”. (Page & McCandlish 2006: xiii).*

It has also been acknowledged that this philosophy is a strong mantra of the Association of Radical Midwives (ARM) who in turn are very influential in the lives of independent midwives. This has been further reinforced in the current study (Brigid MW13). Importantly the ARM have explicitly identified itself with feminist politics, and as such have been seen by mainstream midwifery managers and midwives as an extremist radical feminist midwife group willing to challenge the status quo (Garratt 1993). As a consequence ARM members have often been seen as a threat and the midwives as deviant (Serena MW15, Brigid MW13, Evelyn MW11, Freya MW16). Within the current study Brigid (MW13) recounts of her experiences of attending early ARM meetings where only the first names of members were recorded on the minutes of meetings because they feared reprisals from NHS managers (Brigid Transcript :MW13). The aura of suspicion around ARM members arguably still continues, and fear of reprisals for publishing strong challenges to the current maternity care system and even the midwives’ professional body, the Nursing and Midwifery

Council are evident with analogies of witch hunts persisting (Jowitt & Kagar 2009, Walcott 2009).

Many of the midwives interviewed in this study were found to be members of the ARM as well as members of “Independent Midwives UK”. This is an important contextual aspect of this study which helps with the understanding of what being “being with woman” means philosophically to these midwives. The objectives of the ARM (ARM 2009) appear to coincide with many of the philosophical beliefs expressed by independent midwives in this study.

### ***4.3 Entry into the Midwifery Profession***

Within this study the midwives indicated that they were committed to a philosophy of being “with woman” even from the time that they commenced midwifery education. These values and beliefs, albeit a germinating seed of the “with woman” midwifery philosophy at this stage, then continue to grow and be influenced by their midwifery education and then their on-going midwifery careers. It is interesting that it is this same philosophy, as will be seen later, that informs their move from NHS practice and into Independent midwifery, or indeed to inform, as it was for two of the midwives in this study, a move straight into independent practice. The “seed” of the “with woman” philosophy was articulated in a number of ways. Here Chloe (MW4) demonstrates her feelings of solidarity towards women for example, being very clear that she did not become a midwife because of the babies:

*“I am not a big lover of babies to be quite honest, they are amazing, but it’s the women, it is really for women that I am a midwife, and you know, helping her*

*and giving her the faith to have a healthy baby. That's why I do it. It is so lovely to know that I am providing them with that security of having their labour at home, it is that uncertainty that remains with home birth". (Chloe MW: 4).*

Ingrid (MW 5) reiterates this focus on the woman and articulates a real love of caring for and helping women during childbearing and childbirth which seems to encompass an understanding that if you look after the woman she then is ultimately able to care for her baby. Being a midwife is also perceived to involve helping a woman to find her own way to motherhood and the nurturing of their children, rather than telling them how to do it. This could be seen as another manifestation of the midwife "being with" rather than "doing to" woman philosophy. What is clear however is the enjoyment and satisfaction that she feels about being a midwife:

*"It is just a wonderful job; I wish I could do it more! It sounds really silly, but just looking after women, and a lot of people just don't understand that, that being a midwife is looking after women. Women look after their own babies, when they are born, they have got that natural instinct and we help them, we help them"*  
*(Ingrid MW: 5).*

For Erica (MW 1) too being a midwife was not about a great love of babies, her definition of "being with" encompasses not just the woman and involves the couple with more focus on supporting parenting. Leap (2009) usefully acknowledges that beliefs by some that "woman-centred care", as a concept, ignores the woman's partner and family, when in reality this concept is seen as including the woman's family and community that she defines as being

important to her. Here Erica (MW1) would appear to be expressing exactly these sentiments:

*"I think that although I like babies, Um, I didn't become a midwife for babies, I really did become a midwife because I saw that it was a time to support the couple, Um, particularly their first experience". (Erica MW: 1).*

For many of the midwives a fascination with the wonders of childbearing and childbirth and then later actual experience of childbearing themselves, be that good or bad, fuelled the move into midwifery. Here Red (MW 20) articulates these ideas, also these have become intertwined with a belief that childbearing was something magical that women alone can do. A sense of a real reverence towards childbearing and women's innate abilities in this respect is evident:

*"It has always been something that has been in the back of my head I think. I remember as a very young child being absolutely fascinated by birth, and very clearly remember watching births on television as a very young child; I must have been about 3 or 4, and being absolutely fascinated by it. I remember it seeming absolutely magical that this is something that women can do. So I think even before I knew what a midwife was, birth has always been something I have been fascinated with" (Red MW: 20)*

Actual experience of childbearing and childbirth in many cases acted as a trigger initially stimulating interest in the process of childbearing and then for several reasons fuelling the desire to become a midwife. Woman gathering to "be with" other women at the time birth is nothing new (Ehrenreich & English 1976, Towler & Brammall 1986, Donnison 1988, Achterberg 1991) Serena (MW 15) explains how she felt:

*“During my first pregnancy I did inform myself and I read a lot and as I read I became completely fascinated and you just couldn’t drag me away from books about pregnancy and birth and babies, the whole process I just found it absolutely amazing and fascinating. It really grabbed me then, although of course I didn’t realise at that time that was midwifery, I just thought as a mother I found it absolutely fascinating. And that fascination never went away”. (Serena MW: 15).*

Personal experience of childbearing coupled with personal experience of having to confront “the system” and in some cases fighting to get what they wanted, led them to consider midwifery as a career. Here the midwives stated that they could see the vulnerability of childbearing women and the support that they required and did not always get. Trying to readdress this balance and being there to support other women in this situation then appeared to be a strong *raison d’être*. Here Amy (MW 17) recounts her experiences:

*“I decided that I wanted to be a midwife after the birth of my child. I’d had a lovely straightforward birth with (names daughter) who is my oldest daughter and had fancied a home birth with her but was talked out of it by midwives and doctors, who said, it’s your first baby you don’t know what your labour is going to be like you are better off in hospital. And it was straightforward and normal and should have been at home. So when I was pregnant with (names son), well before I even got pregnant with (name of son), I was planning a home birth and that’s exactly what I had, a home birth. I had a few run-ins with hospital consultants and midwives unfortunately”. (Amy MW: 17).*

For Amy (MW 17) the self-development and confidence that she personally



achieved as a result of becoming a mother and the positive effects of this was something that she hoped other women could experience:

*“As with most pregnant women I found the whole thing about pregnancy completely fascinating and wonderful and just wanted to carry on feeling like that and helping other women achieve what I had achieved. Because it’s such a huge sense of achievement, empowerment, the birth of your own baby, the way that you want to, and everything is straightforward, it’s just wonderful! And I really felt that more women should at least feel empowered to make that decision rather than being told what to do.” (Amy MW: 17)*

Amy (MW 17) has formulated an understanding of the self-development potential and personal growth aspect of childbearing and birth, demonstrating a worldview more akin to that of a holistic practitioner or even healer and sits in very sharp contrast to the medical model of care as shall be seen later. The notion of helping women to recognise and exercise their power, particularly in relation to choices in childbearing and childbirth, and then having recognised this power, helping them to make decisions was also seen as a key aspect of being “with women”. This will be seen to be enacted to its full potential in the following two chapters where independent midwives talk about their lives as Independent midwives and the mother midwife relationship.

The notion of seeing birth as a vehicle for self-development and achievement was noted by several midwives who incorporated their understanding of the potential of this into their reasons for becoming and continuing to be a midwife. Bethany (MW3) for example had been a teacher prior to coming into midwifery.

Helping others to develop was an important source of job satisfaction:

*“I enjoyed seeing people or kids beginning to realise their potential and finding out what they could do, and enjoying what they were doing too as well, and that really gave me a buzz I suppose. That was the sort of philosophy that I brought with me to midwifery really, was that enabling....you’re not didactic, but you are enabling, a facilitator and you know, you tried as much as you could to do it in a child centred way, you have to accommodate, you have to adapt your way of teaching for individuals and that was the philosophy that I brought with me to midwifery” (Bethany MW 3).*

Bethany (MW 3) identifies that her career choice was based on her perceptions and understandings of the effects of birth and its importance. She wanted a career where she could make a difference whilst also helping people to develop as individuals:

*“I wanted to be involved with something that had a deep impact on the lives of the majority of people rather than just a few, or that maybe have rich parents, but to make a difference to peoples’ lives. I think that even before I was a midwife, I understood it to a small degree the importance of birth, you know, women’s birthing experiences, I think that I just felt I wanted to help or facilitate women to have a birth experience that they would look back on with pleasure, you know, that of becoming parents”. (MW3 Bethany)*

Whilst there is the acknowledgement of birth as an agent for self-development Bethany (MW 3) demonstrates her understanding of the potential of birth to render women vulnerable or even damaged and can see clearly see the

potential for women to need protection, and that care needs to be given tenderly:

*“(Birth), its life in its...without any pretence. It is a reality, isn’t it? Because it is a reality, and because it is so raw, and because women are so vulnerable.*

*Women need such tender care, sort of thing, not damaged”.* (MW 3 Bethany).

The notion of caring is seen as fundamental aspect of midwifery and indeed nursing practice. But how this is defined and what it consists of is subject to ongoing debate (Corbin 2008, Rolfe 2009, Griffiths 2008, Maben 2008, Crigger 1997). But whilst defining the term “caring” would appear to be tricky, the discussion that attempts to do this aligns with philosophical aspects of “being with woman” as previously discussed and it would appear to be closely associated with the relationship between the caregiver and those on the receiving end of this care. Mayeroff (1971) for example, asserts that in order to care there must be an understanding of the other’s needs in order that this is appropriate. Boykin and Schoenhofer (2001) define caring in nursing as being honest, connecting with patients and entering into their worlds whilst also “being in the moment”. In order for this to happen a relationship has to be built. I would argue that there is resonance here with what midwives are attempting to achieve with the women in their care, and as will be seen later has resonance with how I argue midwives create and maintain rapport and relationships with women.

#### ***4.4 Experience of Midwifery Education***

In accordance with a life story approach the midwives' stories tended to move next to their experiences of midwifery training. These accounts provide some interesting insights into the characteristics of the midwives involved and whilst it is not the aim of this research to make generalisations it does appear that the midwives in this study do share a number of experiences and characteristics which may have a bearing on their eventual move into independent practice. Around half of the midwives interviewed entered midwifery via the direct entry route and the other half after nurse training. Many of the midwives in the study talked about the theory practice gap, highlighting the mismatch between professional philosophy and rhetoric and the experience of clinical practice, especially in the hospital environment. The resulting conflict of ideology has been cited by others as one of the key reasons for midwives eventually leaving the profession (Curtis et al 2006, Hunter 2004). As part of the training process student midwives are socialised into the role of the midwife and undertake clinical experience predominantly in the NHS setting. The NMC (2012) Midwives Rules and Standards clearly articulate the International Confederation of Midwives (ICM) and Federation of Gynaecologist and Obstetricians (FIGO) definition of a midwife which has also been adopted by the World Health Organisation. This clearly articulates the full remit of the midwife's role and sphere of practice and provides a useful reference point from which to compare the articulated narratives of the midwives in this study. The definition states that:

*“A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.*

*Scope of Practice*

*The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.”*

(Revised and adopted by ICM Council June 15, 2011).

In addition to this within the Midwives Rules and Standards (NMC 2012b) is cited an extract from the European Union Second Midwifery Directive 80/155/EEC Article 4, (NMC 2012b: 36-7) which details the activities of a midwife as follows:

*“Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:*

- *To provide sound family planning information and advice.*
- *To diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of Normal pregnancies*
- *To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk.*
- *To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition.*
- *To care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means.*
- *To conduct spontaneous deliveries including where required an episiotomy and, in urgent cases, a breech delivery. To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor’s absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus.*

- *To examine and care for the new born infant: to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation.*
- *To care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new born infant.*
- *To carry out treatment prescribed by a doctor.*
- *To maintain all necessary records.* (NMC 2012: 36-7)

Thus both aspiring midwives and midwives themselves are given professional guidance as to their role and remit and are trained in order that they can fulfil these requirements in accordance with the NMC (2009a) Standards for Pre-Registration Midwifery Education. However, working in clinical practice demonstrated a different experience. In observing the theory practice gap during her training Milly (MW12) felt that NHS hospital practice did not require midwives but “obstetric nurses”. She clearly indicates that being an obstetric nurse would not be something that she would entertain. An obstetric nurse in this context being a nurse that is working in a maternity care setting, who has less professional autonomy in this setting than a midwife and who works under the direction of doctors:

*“I think the training developed me into a midwife and then what is needed in the hospital is an obstetric nurse. That was what I found, but I would not change that training because, frankly if they had just trained me to be an obstetric nurse I probably would not have even bothered to practice after I qualified. I really wouldn’t. I would have ducked out before. But they taught me to be a midwife,*

*the holistic side of things and yes, there is a practice theory gap, but that is the fault of the practice, not the theory I think” (Milly MW 12).*

Whilst, the theory practice gap triggered feelings of cognitive dissonance (Hunter 2005), midwives expressed the feeling that if they endured their training and qualified that they might be able to change things:

*“I really enjoyed the academic work ...the bit I found the most difficult was actually the environment of the hospital, because I just could not cope with the hierarchy and the way that people were treated. I just couldn’t believe it because I had just come out of a situation where I had been treated as an adult, I’d been, you know, teaching for fifteen years and treated and trusted as an adult to do her job and all of a sudden I was treated like some sort of insect ...and it was just vile... So that was a big shock for me really, and I suppose you think, well, as a student you have just got to sort of put up with it, and keep going until you become qualified and then you think, well maybe when I am qualified I’ll be able to change things or it won’t be so bad or I’ll be able to stand up for myself.” (Bethany MW3)*

Bethany (MW 3) also comments about the behaviour of other clinical staff towards her. Experience of bullying as students was a common experience in this study and is reflective of the findings from other studies of midwives working within the NHS (Gillen et al 2009, Ball et al 2002, Begley 2001, 2002). One of the characteristics that many of the midwives in this study shared was their willingness to challenge the system, particularly when this was seen as being detrimental to the care of women or being unnecessarily interventionist.



Their willingness to challenge the system tended to make them stand out and therefore a target for bullying as has been found elsewhere (Gillen et al 2009, Ball et al 2002, Begley 2001, 2002).

The pressure to conform that midwives articulated within this study was palpable but even more so was the expressed resistance to this even if this had to be by means of attitude alone whilst in training. Here Jemima (MW 18) demonstrates exactly this in relation to teaching in the classroom she experienced, when she asked challenging questions that tutors were unable or unwilling to answer:

*"...the midwifery tutors who were teaching the midwifery part of the nursing module were expecting their nurses to be docile and unquestioning. And even when you are saying things in the nicest possible way if people don't have answers they get defensive. And I was probably...I was not prepared to be as conciliatory as I probably am now so I would ask that outright, if you don't know just tell me and tell me where else to go to find out the answer, I don't expect you to know everything!" (Jemima MW18)*

Having a reputation for being vocal and speaking up even although this perhaps was not something that they necessarily recognised as one of their traits was a reoccurring experience articulated throughout the study. Emily (MW8) talks about her experience within her cohort of students:

*"I am not by nature a very outspoken person, I have strong opinions, I think, and I am very principled and all that, but I am not the most confident, outspoken person, but I think that I was probably the one that was the most vocal on the course". (Emily MW8)*

Serena (MW15), also a challenger of the status quo, received a tip from one of her tutors in an attempt to protect her whilst in the clinical environment. This left her under no illusions as to the possible ramifications of “speaking up” or challenging:

*“In the clinical areas for the most part I have to say it was rather... it was really hard. Because I think I always remember one of my lecturers saying to me, the more articulate you are the more they will hate you. And I think they perceived, I don’t know why, but they perceived me to be a threat” (Serena MW15)*

However, for some of the student midwives letting things go when they felt they were wrong, on occasion, was more than could be tolerated. However, as indicated by Amy (MW 17), when midwifery training was approaching its conclusion, increased confidence levels plus knowledge that she was not going to be practising in that environment after qualification led her to adopt a much more assertive approach even though she knew this might have repercussions:

*“For the most part, until the third year I kept my head down and tried to keep out of trouble, but I think it was in the third year that I decided that yes, I was really going to go independent. And once I had made that decision I got a bit braver about saying things. I think one example is, I was actually at a home birth with my community mentor, who was lovely. But the lady wanted a physiological third stage and the way the community midwife was handling it was more of a managed third stage but without the oxytocin. I said, get your hands off! And I did actually get told off for speaking out of turn. (Amy MW17).*

Midwifery education appeared to be something that was endured rather than enjoyed with students having to contend with bullying and cognitive dissonance from their strongly held views about the nature of midwifery and maternity care and how this should be enacted. Although most midwives in this study moved into NHS practice on qualification, two moved directly into independent practice. Serena (MW 15) indicates that although she knew that Independent midwifery was what she wanted to do, she did not mention it often when she was in training for fear of even more bullying:

*“So the training was difficult but I kept my head down. I always knew I wanted to practice independently and I mentioned that as little as possible (laughs) because I would have been in even bigger trouble if I had. So I kept my head down and got through the training thinking fine, once I am qualified I can actually practice the way I want to hopefully” (Serena 15)*

Phoebe (MW14) as a student recognised, that because she did not appear to “fit in”, and because she adopted a strategy where she “kept her head down” and kept out of the way, (this involved being in the rooms with the women), she learned what she perceived to be an essential midwifery skill: that of building relationships with women:

*“I did not really feel that I fitted terribly well, so I tried to keep my head down (laughs) and that was huge in actually helping me to learn to just talk, be, listen and just try and build a relationship”. (Phoebe MW14)*

Thus, the narratives of research participants indicate that midwifery education was often endured rather than enjoyed and that this was particularly hard when

in clinical practice. Reasons for this appear to be the perceived mis-match between their professional ideology and the inability to see this enacted in clinical practice. Additionally challenging practice was felt to be fraught with potential repercussions of bullying, so invariably they tried to “keep their heads down” and bide their time in the hope that once they had qualified they might be able to change things. Narratives also indicate some shared characteristics of the research participants namely that they have said that they have been described as being vocal, articulate and/or assertive, willing also to challenge the status quo. There was a common perception that maternity services did not meet the needs of women and did not support midwives in fulfilling their role. The next section details their experiences of working as a qualified midwife in the NHS.

#### ***4.5 Working as a Midwife in the NHS***

The struggle to control women and childbearing over the centuries has been well documented and debated (Ehrenreich & English 1973). Achterberg 1991, Oakley 1976, Oakley & Houd 1990, Towler and Brammell 1986, Tew 1998). The gender dimensions of the control, constraint and oppression of midwives as a predominantly female profession and its interface with patriarchy in the guise of the Church, medicine and then later the general management principles instituted in the NHS from 1979, cannot be ignored. Sargent’s (2002) useful analysis traces the controls on midwifery practice since medieval times and beyond. What is clear is that the autonomy and practice of midwives has been systematically eroded by a number of interrelated factors that have placed both birthing mothers and midwives in highly constraining environments, with

profound implications for both (Sargent 2002, Mander & Reid 2002, Kirkham 2003, and Jowitt 2008). For women the increasing medicalization of birth with the attendant undermining of their confidence in their bodies to undertake this important life event, for midwives the creation of emotional work, stress and burnout as they attempt to resolve issues of cognitive dissonance caused by a mismatch between midwifery philosophy and their ability to enact this in practice (Sandall 1997, 1999, Hunter 2004). In this study the midwifery experience of the participants ranged from less than 12 months to 30 years or more. Midwives who had been midwives for many years often spoke with great sadness about the changes to the maternity services. They characteristically reported a reduction of the quality of services to women, of women subjected to routine interventions, the loss of home birth and for midwives, closer control on their activities and reduction in their professional autonomy by means of the introduction of guidelines and protocols to which they were expected to adhere. Their time to undertake their work as midwives was also reduced. All of these pressures, they perceived, reduced their ability to be “with woman”.

Brigid (MW13), a very experienced midwife of more than 30 years had seen a number of changes in the Maternity services. Some she felt resulted in a reduced quality of service for women. Here she talks about how she was able to function as a District Midwife employed by the Local Authority prior to being employed by the NHS in 1976. She compares the way she worked as a District Midwife at that time and how she functioned as an Independent midwife, birthing women predominantly in their own homes. The only difference being who employed her and crucially, women did not get to choose their midwife:

*“I was employed by the Local Authority. Because district midwives were employed, as you know, by the Local Authority, it was not until 1967/68... it was not until 1976 that we became employees of the National Health Service, anyway I did a couple of years as a district midwife employed by (Names County) County Council, and I was autonomous, I was the district midwife and every woman who was pregnant in (names town) and was having a baby at home, I cared for them” (Brigid MW: 13:)*

*“I was pretty much autonomous there, I looked after women there as I do now as an Independent midwife, the only thing was the women did not choose me, they had to have me as their midwife. They had no choice, and I had very little choice, I could reject cases if I thought they should go into hospital but by and large the women chose to stay at home and I got on with it! I didn’t choose my clients and my clients did not choose me, that’s the only difference with Independent midwifery” (Brigid MW: 13)*

The centralisation of maternity services into large medicalized institutions brought closer controls on midwifery practice and birthing mothers (Jowitt 2008, Mander & Flemming 2002). The control and constrain of the midwifery profession and the implications of this has been subject to much and on-going discussion (Mander & Flemming 2002, Jowitt 2008). The concept of autonomy is seen as pivotal in this study and for this reason will be subject to a fuller critique and exploration in the final discussion chapter. Control and constraint of midwifery practice and professional autonomy as experienced by the midwives in this study is instrumental in their journey into Independent midwifery, their experiences resonating with findings from Freire’s (1993) study of the behaviour

of oppressed groups and Foucault's theory regarding the construction of power relations within institutions (Foucault 1973). For example, the move to centralize both childbearing women and midwives into medicalized institutions has been shown to have a disempowering effect on both. When an individual becomes one of a much larger group they appear more insignificant as an individual and as such their personal (as well as their professional) autonomy is reduced (Freire 1996) and surveillance of these groups is made much easier (Foucault 1973). Jeremy Bentham's "Panopticon" design for prisons in the late eighteenth century is used by Foucault as metaphor for the operation of power and surveillance in contemporary society (Foucault 1991a). It is interesting to note that the participants' experiences of the working in the NHS reflect this analogy and their use language reflects feelings of incarceration. Foucault (1973) also alludes to the use of discipline to exert power and to regulate the behaviour of individuals. He suggests that this is done in variety of ways including how the institutions organise and regulate the use of space (as in buildings and accommodation of services), time (as in duty rotas and off-duty) and people's activity and behaviour (drills, movement and deployment to different areas as required, protocols and guidelines). In addition to this Freire (1993) has indicated that those who are subject to long term oppression of this sort can be seen to take on some characteristics of their oppressors. This is manifest in the NHS by the policing of the policies and guidelines, which are carried out by "senior members" of the oppressed group, with those that fail to comply finding themselves in disciplinary situations (Jowitt 2008). Midwives in this study have articulated their experiences of this, however, their reactions and responses to

the controls and constraints to their professional practice are often characterised and expressed in the form of resistance. Indeed as will be seen many of the research participants explained that they found themselves in disciplinary situations for just these reasons. Brigid (MW13) for example, found the challenge to her autonomy very difficult to cope with. During her long career she had experienced considerable autonomy only to see this taken away from her in more recent years. She found a strategy to challenge and resist this but this was not without personal risk. One of the policies involved the undertaking of routine episiotomies, regardless of whether it was required or not and before there was any evidence to support or refute this practice. Brigid (MW13) highlights at this point the influence of the Association of Radical Midwives and how having attended workshops she had not only received peer support, an important factor in helping midwives to cope with challenges in clinical practice (Hunter 2004, Lavender & Chapple 2004), but also learned assertion skills:

*“I thought, why am I doing this? I am a midwife, I am a professional woman. And I think the assertiveness that I learned through the ARM helped, and I remember to this day confronting the obstetrician and informing him that in the future I would be performing an episiotomy if in my professional opinion it was necessary and if it wasn't, I wouldn't be, and here was the address of the Central Midwives Board to whom he should address his complaints! He went bright...he was a little...pompous man and he went bright red with fury that I had dared do this. I then retreated to the sluice and sobbed my heart out. I didn't make episiotomies and I heard no more! I waited for the skies to fall in on me and they didn't! “ (Brigid MW13)*



Brigid (MW13) gave another account of an occasion where she challenged policy:

*“My next conflict came with my management was when there was a memo issued that all women should have Syntometrine (a drug used in the third stage of labour to hasten the process and curtail bleeding). There was the Syntometrine carry on! And I used Syntometrine; I thought that it was a very big advance on the pill ergot that I used to have. No, I used Syntometrine, but what I resented and what I thought was wrong was that I was being instructed, I was no longer able to use my clinical judgement, that all women were to have Syntometrine. And this was before the Bristol trial... must have been late 1980s, and so I informed my nursing officer, brackets, midwifery, that I would not be giving Syntometrine routinely unless in my clinical opinion I felt it was necessary. And I shook, and again withdrew to the sluice in tears afterwards!”*  
(Brigid MW 13).

Brigid (MW13), like so many who resisted and challenged the system, became a target for disciplinary action and indeed within this study one of the interesting findings was the number of research participants who had been disciplined for some reason or another whilst working in the NHS (see Appendix 10). This has been identified as a potential consequence of challenging the status quo in other literature and studies (Kirkham 2010a, Freire 1996, Jowitt 2008, Wagner 1995).

*“And I was suspended from duty for a while; and this was an issue of my clinical judgement .... what I was standing up for was not Syntometrine, because I used Syntometrine, it was a very good drug, and I still use it with discretion, it was my*

*autonomy as a midwife to practise and to base my practise on research and experience and clinical judgement” (Brigid MW13).*

There is now considerable evidence that the model of midwifery care worked and the working environment has profound impact on the degree to which midwives feel that they can be “with woman” (Kirkham 1987, Methven 1989, Wilkins 2000, Curtis et al 2003, Lavender & Chapple 2004, Hunter 2004) and if, by inference, as discussed earlier being “with woman” is about enacting the full remit of the midwives role, then any situation that prevents this from happening constitutes a constraint and oppression of midwifery practice. Sargent (2002) has highlighted the fragmentation of care that resulted from the application of administration systems in hospitalised care. Kirkham’s (1987) classic research highlighted the effects of the environment upon midwives communication in labour for example. The most clipped and disempowering language and ineffective professional interchanges was seen to take place in consultant delivery units. One of the most important findings was that rather than being “with woman” the midwife tended to exhibit more of a “with obstetrician/institution” philosophy which fundamentally breached the traditional understanding of the midwife’s role. However, in environments where the presence of the medical profession was less evident, for example GP units/birth centres communication skills were seen to be more aligned to the “with woman” philosophy and even more so when in a mother’s home attending a home birth, and on her territory (Kirkham 1987, Walsh 2005b). A succession of reviews of the maternity services (Maternity Services Advisory Committee 1982, 1984,

1985, Department of Health 1993, Department of Health 2007a, 2007b) have helped the profession to refocus its role and priorities and to question both the organisation and model of midwifery care and to explore alternatives that promote continuity of care and carer for mothers (Flint & Poulengeris 1989, McCourt and Page 1997, Benjamin et al 2001, Sandall et al 2001, Allen et al 1997). In spite of this, pressures as identified in this study, particularly associated with working in busy centralised medicalized consultant units, continue to compromise the midwife's ability to be "with woman". In fact the midwives in this study did not want to accept this compromise; it was untenable and triggered cognitive dissonance (Hunter 2005), dissatisfaction and stress because they were unable to function as midwives in the way that they felt they should be working. This mismatch between personal philosophy of care and ability to enact this in clinical practice has been reported elsewhere (Hunter 2004, Curtis et al 2006) as previously mentioned as a trigger for leaving the midwifery profession. Dissatisfaction with fragmented care was epitomised by the inability (due to reduced opportunity) to form meaningful relationships with women as will be demonstrated by the words of midwives in the following quotes. A particular source of frustration was to have to "pick up the pieces" from others when they were asked to take over the care of a woman to enable others to go off-duty. Other areas included "undoable" workloads, staff shortages and bullying by colleagues. In this study, as with previous studies (Kirkham 1999, Ball et al 2002, Curtis et al 2003, 2006, Sandall 1999, Lavender et al 2004) hospital consultant units were identified as being the places where

midwives felt this most acutely with delivery suite being a particular area of dissatisfaction. Here Emily (MW8) articulates her experiences:

*“I did obviously see some normality but a high percentage of women experienced difficulties because I believe the system makes them and it is really frustrating and really difficult if you are on a shift on labour ward and the things that have gone before and have led to a situation that you are then having to manage, and it was fine, and I did the work, yeah, and it was fine, but personally I had huge frustrations working in that system because I disagreed with so much that was done. You know, I really disagreed with it, I really wanted to work in a way that ...even from being a student... that promoted continuity of care.” (Emily MW8)*

The disappointment with not being able to be the midwife that they had trained to be and all the things that they had looked forward to enacting on qualification is expressed by Bethany (MW3):

*“I qualified and worked in a hospital for a couple of years, which I absolutely hated, and I just felt that all the things that we had learned at Uni about being woman centred and birthing normally and supporting women breast feeding and you know, to give birth in the way that they wanted, it was just lip service really.....everything that I had looked forward to, you know, was not there”.*

For Ingrid (MW 5) mismatch of philosophy was also problematic. Here she explains her perception of the delivery suite as a production line and how this is in stark contrast to her own beliefs:

*“But the pressures within the hospital and also the way that we were...not guided but...steered into doing things that we weren't particularly ....I wasn't*

*particularly happy about. I could see all this intervention going on...thinking, 'if they only gave these women time, they won't need this intervention, there is nothing wrong, the only thing that is wrong is that you need the room for somebody else!'" (Ingrid MW 5)*

Having recognized that her personal philosophy did not align to what she was required to do in the NHS; Ingrid (MW5) indicates that she knew she no longer wanted to work in this way:

*"...it is a lot of pressure, and you know, adrenaline and pressure are good for you but not 8 hours a day, five days a week, and also the one thing that I could not get my head round, was after I'd initially admitted these women and sorted them out, they'd be passed on somewhere else, and I'd never see the outcome. I knew that that was not the way I wanted to work ". (Ingrid MW 5)*

Chloe (MW 4) and Rhianna (MW7) also articulate their experience of working on delivery suite and the unrelenting pressures of this. They describe feelings approaching burnout:

*"I think those 12 hour shifts that they do in hospital now, I just think, no; I don't want to see anybody else! Please don't turn up, you've rung up to say that you are in labour, just wait till we have gone, you know". (Chloe MW 4)*

*"On one ward were 30 mothers and babies or antenatal and mixed. I know that is the norm but it was a lot to manage. It was really a lot to manage. I remember somebody coming in, another midwife, and I just burst into tears, and I really was at the end of my tether! I think physically I wasn't coping, I think that I was just exhausted, cos' I was working more hours than I was contracted too. (Rhianna MW7)*

Within the study midwives demonstrated a marked preference to work in the community setting. Just one midwife moved from a hospital delivery suite setting into Independent practice when she was relatively newly qualified (Red MW20). The community was seen as an environment where midwives were more able to be “with woman” and where there was the potential to provide a better service to the women because they had the opportunity to build more meaningful relationships with women and also more opportunity to exercise their skills as a midwife bringing a greater sense of job satisfaction:

*“I had a caseload, I knew my women, that was just lovely. Knowing my women as individuals and their families and everything just seems to be crucial to me really. I would probably be on a bicycle, you know, trundling round through villages given the choice, just knowing my little area and my women. But unfortunately the area is flung rather wider now and a car is necessary. Yes, that knowing people as people” (Milly MW: 12)*

Jemima (MW18) also reiterates the merits of working as a community midwife where she experienced more of control her workload and how she was able to work in a caseload fashion. There is also a sense of midwives working together, supporting on another, something that is not commonly reported within contemporary midwifery practice (Curtis et al 2006, Makin & Sinclair 1998, Gilligan et al ), involving “covering” each other for days off and home births should they occur when other work is also due:

*“I was very lucky when I was a community midwife because we were able to organize our work ourselves. So we worked in a similar way to a one to one scheme. There were two of us working opposite each other in terms of*

*weekends on weekends off and covering each other's clinics, and providing quite a lot of continuity of care. And a fair number of home births or dominos, so that was really nice. We would have between the two of us four or five women a month booked for either home birth or dominos so that was really good"*

*(Jemina MW: 18)*

Caring for women in labour was not commonly experienced as a community midwife except in cases of home birth or Domino Delivery (Domiciliary in and out). In this scheme women were cared for by their community midwife and G.P. The community midwife would follow the woman in to hospital and provide care for her during labour and then transfer back home around 6 hours after birth, the community midwife and G.P, continued to care for the woman in the postnatal period. However, antenatal and postnatal continuity was often good as Jemina reported:

*"I think looking back you had your own clinic and you had your women, or 'ladies' as they were then called. And you did have a sort of ownership because you could provide pretty good continuity of care. So we had very good antenatal and postnatal continuity of care, we didn't have intrapartum continuity except the women who booked for home or dominos. And we were allowed reasonable freedom to arrange things that so that was great". (Jemina MW 18)*

For some midwives the move from hospital midwifery into community midwifery was a profound revelation. It enabled them to see, and more importantly understand the role of the midwife during pregnancy, childbearing and childbirth and in a holistic way, a way that had not been facilitated by the episodes of fragmented care experienced within the hospital environment. In this way it can

be seen that midwifery practice is “re-assembled” having been “deconstructed” by hospitalized administrative organization and for Rhianna (MW 7) midwifery care made sense to her for the first time. The feeling that she might be making a difference to women’s lives also increased her sense of purpose and job satisfaction:

*“It was literally when I got out onto community and booked a woman and did all of her appointments, everything, the whole lot, birth, home birth, went to it, followed her up and then discharged her, that it really made any sense. That is midwifery! Not a little bite of it here and there in a very disjointed way. I don’t like that disjointed...I mean obviously in that position I would do my best, it makes a difference to the woman, that’s what I would hope, that I would make a difference” (Rhianna MW: 7).*

Within this study most midwives appeared to follow a very similar career pattern, that of working in the hospital environment for a while, then following a time during which they recognized that their personal philosophy of midwifery did not match with how they were able to enact this in clinical practice, even although as they had thought they might be able to change things following qualification, their next move was often to actively seek out a community midwifery post.

For Bethany (MW3) the move into community midwifery represented a career move that enabled her to ‘grow’ as a practitioner, she perceived this as a move that allowed her more autonomy and that she developed more confidence in her own clinical skills and in making her own decisions. It is interesting that she uses the word, ‘escape’ to describe her move into community midwifery



perhaps signifying her perceptions of the relative looser scrutiny placed upon her whilst practicing in the hospital environment. In fact several midwives articulated their experiences of the NHS in terms or metaphors related to incarceration and torture as previously mentioned. This theme will be explored more fully in the discussion chapter when the concept of autonomy is examined in relation to this study's findings:

*“After a couple of years I managed to escape into the community which was a lot better, because I had a lot more autonomy and to be paid to drive round lovely countryside and visiting people in their homes and chatting to them was just wonderful. That was a big privilege I think, and I was glad I did that because it gave me confidence to make my own decisions as well, because in the hospital there is always someone else to ask, and you do tend to defer to everybody else in the hospital but in the community you have to decide for yourself.” (Bethany MW: 3)*

After offering initial respite from the constraints of the hospital, community midwifery too became subject to constraint. Midwives reported the looser scrutiny of working practices by general management, which meant that midwives' time was reduced and their ability to interact with women compromised. Additionally they experienced being moved from the community into the hospital in order to cover a shortfall of staff, which further reduced their ability to interact with the women in their area and created stress and burnout and overworked midwives as reported by Sandall (1997). Esmie (MW9) indicates the potential risks associated with spreading maternity services ever more thinly and the inherent dangers of missing, or not passing on a vital piece of information. She highlights

a situation where in the community she and her other colleagues had been able to increase the local home birth rate, changes in management policy meant that this was not able to continue and good midwifery work was undone:

*“...other things were happening within the Trust, other changes were happening, there were a few adverse incidents that happened over a period of 3-6 months, quite serious ones and because of the shortfall in the hospital staffing the community staff were pulled and asked to work one week a month in....which does not sound a lot but then you are a community midwife to help other midwives to covering their clinics, at that point I was having ...I was doing three afternoon clinics, it then meant that I wasn't keeping tabs on the women that I was watching out for. And as good as communication can be, if somebody fails to give you some information or isn't aware of a circumstance within the family or other circumstances...things can get missed and that is where you can have these adverse incidents in the community setting” (Esmie MW: 9).*

With the introduction of general management principles into the NHS following the Griffiths Report (DOH 1983), Evelyn (MW11) highlights the potential challenges she experienced when managers were being brought in from non-midwifery, nursing or health service backgrounds and the frustration of this when the manager had little understanding of what they were managing:

*“Some of these managers are not clinical managers, they have not picked up midwifery and nursing, they have come from a different background, they couldn't understand at a clinical level what was going on. The Edicts! To be suddenly told, “I want this by Friday” when in fact you were having to work two clinical shifts and although I would try to do it by Friday because you were*

*working clinically you couldn't do management and clinical together. People that come from Sainsbury's or Tesco background just didn't understand that. I really struggled with a lot of that!" (Evelyn MW 11)*

Working between the community and hospital settings, not for the purposes of providing continuity of care as had been evidenced as beneficial to both mothers and midwives (Benjamin et al 2001, McCourt & Page 1997, Flint & Poulengeris 1989), but to cover shortfall in hospital settings as a result of sickness or attrition, presented midwives with another trigger for cognitive dissonance and burnout:

*"I found it completely and utterly exhausting. You were working earlies, lates nights in the hospital, day shifts with on-calls, it was just .... And when you did an on-call, because it was under staffed as everywhere is, you know you've done your days' work in the community, you can bet your bottom dollar that then you would be called in at some point in the night and then have to work again the next day. It was just unsustainable! I did not realize actually just how utterly exhausted and losing it I was really until I one day on the way home put petrol unleaded in my diesel engine and I thought I am just not with it am I (laughs)!" (Milly MW12)*

*"While it is happening you just don't realize how absolutely exhausted you are and life becomes a constant....well...when can I sleep? If I am working there, I can sleep for three hours there and I can work then and you....you are constantly trying to manage your life so you have got enough sleep on board so you are fit to do your next shift." (Milly MW12)*

Time as a constraint to midwifery practice and to childbearing women has been an issue that has caused much frustration over the years to mothers and midwives alike (Ball et al 2002, Curtis et al 2006, Lavender et al 2004, McCourt 2009). Time has become a resource, not be wasted and is also something that women have been measured against (Mccourt 2009). Time is measured, metered out and midwives taking too much time over their job are often taken to task (Mccourt 2009, Stevens 2009, 2003). As a survival mechanism the midwives in this study report how they adopt strategies to manage their time in order to cope. Here Serena (MW15) indicates that whilst undertaking her midwifery training her mentor tried to help her in this respect by suggesting several strategies to curtail interactions with women by using body language signals:

*"...I can remember, even as a student saying to one of my lovely community midwife mentors, she was saying to me, "you are spending far too long with her. What you have got to do....." this was in the antenatal clinic... "What you have got to do to get them out, is you have got to start looking at your watch, look at the clock, start picking things up, stand up, you have got to get rid of them, you have got to get on with it." And I said to her, "so what happens when you have got a women who actually has real problems and wants to talk do you make an appointment to go and see them at home or?"... She said, "we don't have time to do that", she said "I would love to be able to do that but we can't, we can't do it". That must be awful and terribly frustrating for them". (Serena MW: 15)*

Angel (MW 19) develops this idea further by suggesting that time can actually be an investment as it facilitates the building of relationships upon which health

education/promotional advice can be offered. Angel (MW 19) sees the limiting of time as limiting the potential of this important area of midwifery practice:

*“We worked out on the community, very busy community shifts, and had lots of women waiting. And had that magic 15 minutes to do everything, no time for any health promotion advice or to develop a relationship, all clinical skills really. And that again was very, very frustrating and I was on the edge of thinking there must be another way, what can I do?” (Angel MW: 19)*

Lydia (MW10) who worked in a very socially deprived area at one stage of her career articulated her disappointment at not being able to provide the care she wanted. She saw the potential for her work to be seen in terms of contributing to the public health agenda, and was frustrated that she had not got the time to do this. This quotation also clearly demonstrates the disappointment experienced when working in the community setting also failed to match philosophical expectations:

*“I was seeking to go and hide in the community because I thought it was a better place, but it was just as bad if not worse! Because I don’t know how you can look after women in such a short time, in this area we have quite a high degree of disadvantaged women....” (Lydia MW10).*

A recurring theme throughout the data and that led midwives to move from the NHS into independent practice was that of having to conform in the NHS when this did not necessarily align to personal philosophy of maternity care. Giving information to women and regard for informed choice were experienced as particularly troublesome areas. Not only did the midwives feel they were expected to conform but they felt they were required to get the women to

conform as well. Bethany (MW 3) recounts an experience she had whilst new to working in the community and a woman who wanted a home birth following a previous caesarean section:

*“The things that I did sometimes as a community midwife I was not proud of, like a woman came who wanted a home birth after caesarean section, I knew that if I said, yes, I’ll support you that I would be on my own because of the rest of the team and the hospital would have jumped on me anyway, so I had to pretend that I did not agree with it, well, I did not have to but that was what I did. I was just betraying my own ideals really, which was awful” (Bethany MW 3)*

This section has presented midwives experiences of working in the NHS and these have highlighted experience of loss of professional autonomy, constraint and fragmentation of their role and the discomfort of midwives trying to work in a system what does not make sense to them or align to their philosophical beliefs about what it is to be a midwife. This mirrors previous studies that have documented findings of midwives’ working lives in the NHS (Curtis et al 2003, Lavender 2004, Hunter 2004, Wilkins 2000). In this study language that reflects incarceration reflects the depth of feeling in this regard, significant however, is the strong expression of resistance to these constraints that appears to characterise the research participants. In trying to “escape” the perceived constraints of NHS hospital practice research participants articulate a deliberate strategy to move into community practice, perceiving this to be an area where they are more able to enact their “with woman” philosophy, and whilst this helped initially, this setting too becomes ideologically problematic especially when they are expect to cover hospital staff shortages in addition to their

community work. There are accounts where midwives feel that they are trying their best to do this but the “undoable workloads” wear them down and leave them feeling exhausted and burnt out and very concerned about the level of care women were receiving as a consequence of staff shortages.

#### ***4.6 Going the Extra mile***

Going the extra mile for the women in their care because of how they interpreted their role and responsibilities towards them was something that several midwives reported in this study. This made total sense to them as midwives in order to promote a better quality of care, but was an activity that often resulted in them being chastised either by their other work colleagues or their managers because it was “not routine”, and they were often made to feel that they were “different” in even wanting to consider more flexible ways of working. An example of this was cited by Freya (MW16), who as a community midwife, would put herself on-call for her women when she was not scheduled to be on call, and having made provision, with other colleagues, to cover her workload if she was then called out. A new management structure at that time had particular issues with Freya’s (MW 16) intentions to try and be there for the women she had cared for all through their pregnancy:

*“With this new management, she (the new manager) then said that we couldn’t go out on call, we couldn’t go out if we weren’t on call, that was it to begin with, if we didn’t have permission. So after a week of getting phone calls at 2 o’clock in the morning, I said this is rubbish, she is in labour, it’s somebody I cared for all the way through and I have got the workload covered for tomorrow”. (Freya MW :16)*

Going that extra mile and wanting to be there for the women was often experienced by the midwives interviewed as a source of stress and emotional work (Hunter 2005), as the “added value” activities that they felt were important were seen as “add-ons” to the routine care they had been resourced to provide by the NHS. Because colleagues knew that they would take on extra work because they cared, they were often put upon, resulting in heavier workloads when colleagues perhaps did not experience this. Emily (MW 8) explains how tired and stressed she felt as a result of this and consequently received little sympathy from her manager:

*“I was put on by other members of the team, they used to call me when I wasn’t really on call and was sent to a BBA(baby born before the arrival of the midwife-unplanned birth at home) because they thought I could get there quicker. Me being me, I went, but then it meant that I worked a much longer day, so I had done my two days, been on call over night, I mean I did not work a full day but I still did work the second day. And then I would do an early shift and a night in the hospital all in one week! Physically I just all over the shop! I just was really burning out, and I asked my manager, because I was I was betwixt and between, my manager was my hospital manager, I did not really have a community manager, and her focus was running her ward. So she wasn’t particularly sympathetic to my needs” (Emily MW: 8)*

Angel (MW 19) had a similar experience with her colleagues and although she felt that perhaps she was able to change small things for individual women, she appeared to demonstrate frustration at not being able to change bigger issues to any great extent. She uses language that demonstrates her understanding of



the enormity of the shift in culture that would need to happen to make it align to one that she felt she could work in:

*“They (midwifery colleagues) thought I was barking mad really, they just couldn’t always understand why I should put myself out so much. But it was only this drive to give ladies what I felt they deserved to have. And there just needs to be a massive shift in the culture of midwifery. And I just felt I was such a small fish in a massive pond and you can make little changes but you just couldn’t really get to the bottom of that. I just needed to be out of that environment and just be in a position where I have got control and be able to work the way I wanted to. And the only answer was for me to go into independent care” (Angel MW: 19).*

In endeavoring to fulfill the full potential of the role of midwife the midwives in this study appear to have formulated a number of ways to work around the constraints of NHS practice, to go the extra mile for the women in their care in order to provide an enhanced level of service to their clients which often consists of facilitating more time to listen to women and providing continuity of care when that might not happen. There would appear to be a tension between what the midwives in this study perceive to be essential midwifery care and what they feel women deserve as compared with the care NHS resources are able to provide. In going the extra mile midwives stated that they were often taken to task by their managers or by their work colleagues who criticized them and did not understand why they might want to put themselves out at such personal cost.

There are a number of narratives in this section that demonstrate that the research participants experienced being seen as “different” by their colleagues because they undertook activities that went above and beyond what has come to be seen as normal practice within the NHS, even when this normal practice might not represent the full role and responsibilities of the midwife if taken in the purist sense (ICM 2005, NMC 2012). Working in this way is not seen as acceptable to the research participants who feel that women deserve better care and to this end try to provide care over and above expectation to address this perceived shortfall. This was often undertaken with considerable personal cost, particularly in relation to invasion of personal time; however, the strategy enabled them to practice midwifery in a way that made more sense to them ideologically.

#### ***4.7 Bullying Culture in NHS***

Kirkham (1999), in examining the culture of NHS midwifery practice, draws attention to a number of contextual issues that impinge on this, including the recognition of the midwifery profession as an oppressed group. The application of theory from this area and in particular the work of Paulo Freire (1996) helps with the understanding of midwifery behaviour and how and why this is experienced by the midwives in this study. Freire points out that an oppressed group will gradually take on and internalize the characteristics of the dominant group, devaluing their own identity and characteristics in the process resulting in a low self-esteem. This has been as been seen as highly destructive to the profession (Kirkham 1999, Taylor 1996) and the resulting conflict and tension highlighted as contributing but not excusing the manifestation of bullying and

“horizontal violence” (Fanon 1963, Leap 1997). Being seen as “different” to the crowd or deviant in some way has also been identified as a factor that can target individuals for bullying (Ball et al, Wagner 1995, Kirkham 2010a), and this has been seen to be particularly prevalent in the hospital environment (Hunter 2005). Bullying/horizontal violence has been variously defined as behaviour that results in the intimidation, oppressing, coercing, harassing or persecution of another (Waite 1997). In this study experience of being bullied was reported by the research participants during midwifery training and throughout their working lives in the NHS. The widespread nature of bullying/ horizontal violence has also been a finding in a number of other studies of the midwifery workforce and other healthcare settings (Makin& Sinclair 1998, Begley 2001, Ball et al 2002, Curtis et al 2003, 2006, Gillen et al 2009). Within the current study this was experienced as an irritation by some whilst for others it had profoundly affected their working lives, to the extent that they had become very depressed. It is clear that in conjunction with other aspects of their experience within the NHS, particularly that of oppression and constraint of midwifery practice, bullying was a key trigger for movement into independent practice. In line with several studies that have explored bullying and horizontal violence, horizontal violence has been defined as hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group (Duffy 1995). This was experienced as coming from a broad spectrum of staff (Ball et al 2002, Curtis et al 2003, 2006, Gillen et al 2009, Begley 2001).

Lydia (MW10), who reported a particularly unpleasant experience of bullying, was very clear about what she felt was the underlying cause of the bullying and

this appeared to relate to the frustration experienced regarding constraint and oppression of midwifery practice. In order to try and make sense of this experience she had undertaken a leadership course. The language that she uses to describe how she felt is very emotive whilst also reflecting the sentiments of others who allude to the midwifery profession self-destructing (Jowitt 2009, Kirkham 2010a). It also gives resonance to the some ideas of Freire (1996) when talking about the effects of long term oppression on groups:

*“ I think, because of what is going on in the Service or what is happening to us as clinicians or whatever is going on ...we are there beginning to eat ourselves!! It is like a pressure, I mean I sort of did a leadership course; I was part of a cohort that did a leadership course for the NHS. I was mentored and sponsored at work, and a lot of learning around pressure, for, what I do understand after that is that ...the more you squeeze us....they can't squeeze anything else, we are going squeeze ourselves and the women! It is very clear to me! Very clear!”*

*(Lydia MW10)*

The consequence of bullying behaviour is that as a group, midwives do not trust one another, in large institutions midwives are organised in such a way that they do not have the opportunity to form meaningful relationships with women or one another (Jowitt 2009, Kirkham 2010a). The net effect is that of distancing midwives from one another in this environment. This strategy has also been noted by Freire (1996) as a highly effective way of maintaining control over oppressed groups. Here Serena (MW15) paints a less than glamorous picture of her impressions of some midwives. In expressing her ideas she demonstrates exactly the potential distancing effects of reacting in this way:

*“I have to say having lived all over the world and met all sorts of different kinds of people, and mixing with different cultures and loads of different people I have never in my life met such an evil bunch of bitches as midwives. And of course that does not mean all of them because there are some lovely, lovely midwives. But my goodness some of them were quite evil and they actually did go out of to make things difficult for you.” (Serena MW15)*

Evelyn (MW11) alludes to the issue of midwives being distant from one another and not offering one another support, another symptom of the bullying culture that has been noted in previous studies (Ball et al 2002, Curtis et al 2003 & 2006, Gillen et al 2009, Begley 2001, Kirkham 2010).

*“I think from the bullying point of view, I think in some ways I had three fairly consecutive, nasty episodes in my last three posts. I think that was all about midwives just not looking after one another and staff just not caring for one another. I think a lot of people think, well, I’ll just look after myself, I think you see a lot of that.” (Evelyn MW11).*

In Ball’s et al (2002) study certain groups were highlighted as being more vulnerable to bullying than others, this included newly qualified midwives, those that had gone on to acquire higher education qualifications and those that appeared different. “Being different”, not conforming and certainly challenging the *status quo* are all characteristics that midwives in this study exhibited in various ways. These characteristics have also been shown elsewhere to render individuals as targets for bullying behaviour (Wagner 1995, Kirkham 2010). One of the surprise findings of this study was the extent to which the midwives interviewed had experienced bullying and/or disciplinary action. Whilst the

nature of this study is not to make generalisations it is interesting to note that out of the sample of 20, 14 midwives had been bullied and 10 had undergone some sort of disciplinary action. This could be seen to be linked to the characteristics that research participants appeared to share, that of not being afraid to challenge the status quo in order to vocalise concern about the provision of maternity care. This behaviour unfortunately marked them out as trouble makers. Evelyn (MW11) for example, alludes to a “slight slip up” on her part and how she perceived this was taken as an opportunity to discipline her as she was known for challenging the system:

*“This was really what they were waiting for. So they used that to suspend me and then do an investigation and I never at any point say, “I didn’t do it!”, I put my hand up and said, “Yes, I omitted to write in the notes” (Evelyn MW 11)*

The witch hunt appeared to continue and appeared to have been blown out of all proportion leading to her being dismissed for “gross misconduct” after having a long midwifery career and unblemished record. However, to her confusion, she was never referred to her professional body (Nursing and Midwifery Council) or struck off and left feeling very disillusioned and dispirited:

*“I was dismissed for “gross misconduct”! But having said that, um...it never went to the NMC so I can’t have been that wonky! And in 29 years of working full time as a midwife, I started in 1978, that I had never even had a complaint against me, I have got boxes full of cards, letters, acknowledgments from patients that I have looked after, from staff that I have coached, cajoled, looked after, whatever you want to call it, you know. And I was just gobsmacked! I thought, I do not deserve this after 29 years of being an absolute grafter, and I*

*think one of the other sorts of things which probably will remain in my coffin, is that I do say a lot of things.....” (Evelyn MW11)*

Freya (MW16) also experienced being bullied and disciplined for failing to comply with management policy; in fact she had had several experiences of this during her career. The last was the most damaging and resulted in her moving into independent practice. Freya (MW 16) demonstrates how damaged and let down she felt as a result of this experience and how in fact years after the experience she still cried about the perceived injustice of the situation:

*“When I was first suspended I came home here and I spent the weekend curled up in the fetal position under the duvet, it was so damaging. I was so dedicated and really gave my all to that, well half of me because the other half was the family. So after all this went on and then they gave me another final written warning, I have got so many final written warnings in the end it was a joke, I have still got them stuck up in the cupboard..... I had given it absolutely everything (starts to cry). Because being a midwife is part of you, once I discovered that, so that was the final insult from the NHS. But here I am.... years later and still crying about it!” (Freya MW 16)*

Despite their various experiences of disciplinary action or bullying the midwives in this study chose to remain in midwifery and to move into independent practice. Their commitment to midwifery and desire to care for women at this time in their lives is epitomised by Milly (MW12). Following a disciplinary experience in the NHS, and leaving to become an Independent midwife, Milly expresses her reasons for continuing when others in similar circumstances may well have left:

*“I could have actually just stopped practising but I love midwifery! I love it! I love the relationship with the women, the care that you give them and feel that in Independent midwifery you can... you can focus entirely on that woman, you know”. (Milly MW 12)*

This quotation epitomises the responses of other midwives who experienced similar challenges alluding to the characteristics of the midwives in this study, their tenacity, commitment and determination to enact the “being with woman” philosophy. The rigidity of institutionalised NHS midwifery is experienced as a straightjacket. One is reminded of the demonising of women, midwives and nature by the Church and the forefathers of science in an effort to control them (Achterberg 1991, Ehrenreich and English 1973, Donnison 1988, Towler & Brammall 1986). And rather like the thread of feminine consciousness that has continued to connect midwives and women and healers over the centuries as alluded to by Achterberg (1991), there is a sense that it cannot be fully accomplished. Also as alluded to earlier the use of metaphors related to incarceration and escape are reminiscent Foucault’s (1991) theorising of discipline and punishment. Milly (MW 12) articulates exactly these sentiments:

*“I have always thought that the NHS....the NHS felt rather like being in a straightjacket, but bits of Milly squeezing out of the top, you know, where I could not quite be contained by this thing, but yes, that was how I felt really. I felt that I was in a straightjacket, although that might also be a personal characteristic that autonomy has always been absolutely.....all through my school years and through everything. I am just a bolshie old bat really!!” (Milly MW12)*



Bethany (MW 3) also uses the metaphor of constraint/confinement to allude to the influence of science and medicine on the practice of midwifery, identifying this as problematic as midwifery needs to be something that is more fluid, interpretive, intuitive and creative. She uses knowledge and metaphors from her life prior to entering midwifery to express this and importantly expresses her resistance to the dominant influence of science:

*“I write music and stuff, but music is open to interpretation, it’s meant to be interpreted by the player, it is not just something that is rigid...just because it is written down on a page it does not mean to say that you can’t make it your own. And that was the thing I noticed, it is as much about the way midwifery and birth was forced into this framework which was so constrictive and there was no room for interpretation or no room for creativity. It was this hard science, well, that was what they say, hard science, but it was restricted into this box which it should have never have been in. You know, how dare they! I definitely missed that part, when I got into midwifery I realised that I can’t be creative anymore. But as an Independent midwife I could”. (Bethany MW 3)*

Bethany’s (MW3) comments appear to come from a fundamentally different world view to that of the medical model and the requirements of institutionalised midwifery within the NHS. It incorporates the arts, creativity and flexibility, qualities that are arguably diametrically opposed to comparative narrow and reductionist view of the traditional scientific lens (Davis-Floyd 2001). Indeed midwifery has often been referred to as being both an art and science (Silverton 1993). Ingrid (MW 5) concludes that within the NHS midwives cannot be midwives in the purist sense of being “with woman”, and for those midwives

who are highly committed to enacting this philosophy, Independent midwifery offers real opportunity, but as will be seen in subsequent chapters whilst there are many advantages and it is experienced as liberating there are also constraints and vulnerabilities that come from other quarters.

*“I don’t think midwives are allowed to be midwives in hospital settings and I think that is one of the big mistakes the NHS has made”. (Ingrid MW 5)*

#### **4.8 In Conclusion**

For the midwives in this study, the forming of meaningful relationships with clients is paramount. However, the organisational structures of the NHS and the practices of some colleagues within it are experienced as controlling and constraining resulting in the thwarting of professional aspirations, values and beliefs.

Solidarity with women and interest in childbearing and birth are key motivations for entering the midwifery profession in the first place. These reasons are not dissimilar to motivations reported elsewhere (Green & Baird 2009). Midwifery education reinforces the “with woman”, woman centred philosophy and although midwifery programmes are 50:50 theory and practice the theory element reiterates strong philosophical ideals of being a midwife. These ideals permeate the NMC Standards for Pre-registration midwifery education (NMC 2009), the midwives rules and standards (NMC 2012b) and a women centred approach has been highlighted in key government maternity care policy (DOH 1993, 1998, 2004a, 2004b, 2007a, 2007b, 2008, 2009). However, the enactment of these ideals in practice is constrained by the bureaucratic and hierarchical organisation of the NHS, which is in turn influenced by patriarchal power

structures in the shape of the medical profession and the wider context and politics of government funding policy (Kirkham 2010a, Jowitt 2009). This mismatch of philosophies becomes apparent in midwifery training and triggers feelings of cognitive dissonance (Hunter 2005), however, for the midwives within the study there is a feeling that all will be well on qualification when they will be able to be in a position of being able to change things in practice. Unfortunately, this does not materialise on qualification and feelings of cognitive dissonance again emerge (Hunter 2005). Resistance to policies and guidelines practices that are rigidly applied without due consideration to individual women's needs and circumstances or that do not appear to have women's interests at heart emerges in the form of challenging and questioning of practices and attempts to push professional boundaries. This in turn labels this group of midwives as different from those midwives that have been "assimilated" into the NHS (Jowitt 2009) and at the same time makes them a target for horizontal violence and bullying (Ball et al 2002, Curtis et al 2003, 2006, Gillen et al 2009).

One of the interesting threads in this study is that of the professional autonomy of the midwife and midwifery profession and this will form one of the areas of discussion in the final chapter of this thesis, after there has been consideration of findings in relation to the mother midwife relationship and the lived experience of Independent midwifery. Midwives in this study report constraint and control of their practice in the NHS, they do not feel that they are able to be the midwives that they want, to be creative and relate to individual situations and women in a more flexible and informed way which incorporates the full

range of midwifery knowledge, skills and attitudes. They also make the suggestion that what is practiced in the NHS might not any longer constitute midwifery in its “purist” sense and if this is true it has implications for midwifery education. Currently students are educated to become midwives and yet the findings of this study and other studies demonstrate that is not what they are able to enact in clinical practice (Hunter 2004, Curtis et al 2006). This has implications for women and their families, as the rationalisation of services in the name of efficiency and cost savings reduces the scope of the service that can be provided and importantly the time that midwives have to engage with women in order to ascertain, let alone meet their needs. And yet the rhetoric in the form of government and service reports, indicate the aspirations for the health services and maternity services (DOH 1993, 1998, 2004a, 2004b, 2007a, 2007b, 2008, 2009, RCOG 2011) that support the utilization of the full role and remit of the midwife with an important public health role. The aspects of care that appear to be rationalised in terms of efficiency and cost savings are arguably the aspects that address our basic humanity, that of relationships, enactment of caring and communication (Max-Neef 1991, Maslow 1943).

The following chapters continue to examine the stories of midwives moving on to investigate the mother midwife relationship in the context of Independent midwifery and finally the lived experience of working as an Independent midwife.

## **5 The Midwife Mother Relationship**

### ***5.1 Introduction***

This chapter explores the perceptions of Independent midwives regarding midwife mother/family relationships. Ideas are grouped under key themes that emerged from the data. These include what they feel they are trying to achieve in terms of the relationship, what they consider to be the nature of the relationship, how important they deem the formation of a meaningful relationship is to their work, how they believe they are able to build and maintain these relationships and the skills they consider are required to do this. In this way this data both elaborates upon and consolidates what has been discussed in earlier sections and the fact that this data forms a substantial chapter within this thesis is an indication of the perceived centrality of relationships to the working lives of these midwives.

There are certain features of the Independent midwife mother relationship that make it unique, and whilst there has been considerable exploration now of the midwife mother relationship from the perspective of a midwife positioned within the NHS (Kirkham 2000, 2010b, Stevens 2003, Walsh, 2007, 2006, 1999, Stevens & McCourt 2002a,b, Pairman 2000), there has been little discussion of this from the perspective of Independent midwifery practice where hopes and aspirations of maternity care are set also in the context of a business

relationship. This chapter also explores the area of relationship difficulties and how, in this context, the nature of the potential clients seeking the services of an Independent midwife, the increased litigation consciousness in society generally and as a self-employed Independent midwife who operates without full indemnity cover, combine to potentially place the Independent midwife in a position of considerable vulnerability. The source of this potential vulnerability extends not only from the very women and their families that she seeks to serve, but also from the Nursing and Midwifery Council (NMC) who are responsible for the regulation of nursing and midwifery and who purport to protect the public from unsafe practitioners, set standards for practice and behaviour and investigate cases of alleged misconduct (NMC 2008, 2004, 2011). The midwife, regardless of the environment in which she practices, is accountable to the NMC. She is required, as any other practising midwife, to work within the NMC Midwives Rules and Standards (NMC 2012b), The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008) and any other NMC published standards or guidance. Data suggests that a combination of factors can place the Independent midwife in a vulnerable position. These factors include being able to enact the “with woman” philosophy and to work more autonomously than many midwives within the NHS, working in a flexible way and being creative in meeting the needs of individual women (these may be highly complex and are often combined with birth at home, (Symon et al 2009)), whilst also facilitating and supporting women’s right to informed choice. The dynamics of and combination of these factors are not well understood by those who work in the NHS or the NMC making Independent

midwives especially vulnerable when birth outcomes are less than optimal and her practice consequently questioned. This section starts with perceptions of the aim of the mother midwife relationship.

## ***5.2 Aim of the Relationships***

In recounting their thoughts about the aims of the mother-midwife relationship a series of ideas are expressed that resonate with previously discussed and philosophical concepts of “being with woman”. This concept has come to shape all that midwifery is, its values, its beliefs, its philosophy, how midwives work or would like to work and the relationships with women that they would like to form (Page 2003, Stevens 2003, Leap 2009, Australian College of Midwives 2004). Within the recounted stories midwives express a sense of altruism and service whilst also expressing a wish to keep alive a tradition, a legacy of women supporting and being with one another at the time of birth, and whilst not seen as exclusively as women’s business as in ancient times (Achterberg 1991, Ehrenreich & English 1973), there is a strong sense of the mother being nurtured, protected and cared for by her “sister” (the midwife). This ethos is resonant with the concept of “sisterhood and solidarity”, an underpinning mantra of the second wave of the feminist movement (Taylor 1989, Firestone 1971, Morgan 1970, Millett 1970), which perhaps is unsurprising given the philosophical foundations of both the ARM and IM UK and the fact that the research participants are members of one if not both organizations. The articulated intentions and motivations of these midwives appear to go beyond merely supporting women during pregnancy and birth and hold a perceived value that extends to a much broader world view. Erica (MW1) talks about what

she feels Independent midwifery offers and there would appear to be distinct feminist overtones for supporting women but this also appears to be set within a context of how this has the potential to support society more generally. In expressing what she feels is the purpose of her role Erica (MW1) also alludes to a sense of history and tradition whilst also making reference to a role in helping women reclaim birth:

*(Independent midwifery)...."it brings with it so many valuable relationships with the women and their families, and also for every woman that I have worked with who becomes a strong competent mother, she is going to pass some of that on to her aunts and her sisters and everybody else, and I think this is what we do as independents" (Erica MW1).*

*"I think we have given birth back to women, I think we have actually done what our fore-sisters did, women supported women, and probably how they still do in other parts of the world". (Erica MW1)*

Many of the Independent midwives interviewed talked about the power and awe in which they held women. There is a strongly-voiced admiration of women and a celebratory approach to their ability to birth:

*"...Amazing strong, powerful women! They are just incredible! I have some lovely relationships with them." (Esmie MW9)*

Women are often referred to as 'being amazing' and independent midwives talk of their admiration for the sheer capacity of women to cope with a number of competing demands and their ability to give birth in this context. They are often left with a sense of women's tenacity and resilience and strength as epitomised by this quotation from Amy (MW17):



*“It’s just that we are amazing really, every time you watch women going through the whole process we are just such amazing creatures! We cope with pretty much whatever is thrown at us, and it doesn’t matter whether you are juggling work or children or financial problems we find a way to deal with it. And sometimes we need support and help but we do it and at the end of it we give birth to this baby and we carry on and it’s just fantastic watching.” (Amy MW17)*

It would appear that the research participants have a strong identification with the women that they care for and that this is set in the context of a historical tradition that celebrates and protects both women and birth.

### ***5.3 Power Relations in the Relationship***

Helping women to make informed decisions based on a broad range of literature sends clear messages regarding the perceptions and beliefs about what it means to be with “with woman”, it also demonstrates values and beliefs in relation to the politics of the mother midwife relationship and where the power balance should lie. This important principle is not exclusive to Independent midwifery, indeed it has strongly permeated midwifery rhetoric since government reviews of the maternity services and consumer group feedback highlighted women’s dissatisfaction when they lacked control over choices, care and decision making during pregnancy and childbearing (Maternity Services Advisory Committee 1982, 1994, 1985, Department of Health 1993, 1998, 2004, 2007a, b, 2010, NMC 2001, 2004, 2009, NPEU 2006).

Chloe (MW4) indicates that she feels as an Independent midwife she is able to address this imbalance indicating that the nature of the relationship is more of a partnership and on a much more level footing:

*“I think it kind of puts you on a level really ‘em, OK they are paying for my time and my knowledge, I do have a wide range of knowledge that women don’t have, but then on another level I’m exactly the same as them, I’m a woman and I’ve been pregnant and it just feels, I can just feel it, a lot more as an equal as an Independent midwife now.” (Chloe MW4)*

Serena (MW15) reiterates these sentiments:

*“I think it is a partnership, it’s an equal relationship, it’s based on trust, trust of each other and respect for each other and it’s an equal relationship.” (Serena MW15)*

The concept of partnership is not exclusive to Independent midwifery, it is seen as integral to women-centred care and again a wealth of midwifery and government literature supports this as previously cited. Full expression and enactment of the concept of partnership would also appear to be heavily reliant on the care setting and the organisation of midwifery care within that setting with case-holding and social models of care where both women and midwives have the opportunity to get to know one another faring best in this respect (Walsh 1999, Stevens 2003, McCourt & Page 1997, Kirkham 2003). In New Zealand the partnership model of midwifery care (Guilliland & Pairman 1995, Pairman 2006) is underpinned by strong principles of partnerships that permeate the whole of New Zealand Society and which finds its roots in the Treaty of Waitangi of 1840 (Pairman 2006). Partnership is the principle that has influenced the organisation of midwifery care there with “Independent midwife style” case-holding midwifery care being available to all women who choose to access it which is free at the point of access.

Within Independent midwifery in the UK the principle of partnership underpins their working ethos (IM UK 2012). However, unlike in New Zealand, women in the UK employ their midwife and pay fees directly to her. Thus the context and dynamics of a business relationship potentially tips the balance of the partnership in favour of the woman. This was seen as important to Brigid (MW 13) who saw this fact as a means of establishing the correct political footing for the midwife mother relationship, this she appeared to construct in terms of service:

*“I think it is choice when the woman can engage the services of the midwife, and that puts the professional servant relationship right. Who is giving orders to whom?” (Brigid MW13)*

Although this concept was not one that all of the midwives in this study subscribed to, there appeared to be a lot of agreement with the fact that as the woman “auditions”, chooses, and employs her midwife that this automatically puts the relationship onto a very different political footing to the ones experienced in the NHS.

Here Phoebe (MW14) talks about the “auditioning” of Independent midwives by women indicating this is not a rushed process:

*“We have this lovely pre-booking meeting where they talk and often that takes two or three hours where you are just talking through why they are...what has brought them to you. It does depend, I mean some of the primips might not have quite so much to talk about but multips will very much tell you all about the details of their previous births and why they are thinking of going independent. So they are very much choosing you...” (Phoebe MW 14)*

Emily (MW8) adds a further dimension to this “auditioning process” which implies that the midwife also auditions the woman, making reference to the concept of the, “right midwife for the right woman” and there needing to be a matching in this respect:

*“I think that women choose us to be their midwives and I think that they come to us because they need a certain sort of care and it might be that I am not the right midwife for this woman, you know. I do think that they seek out the right midwife for them.” (Emily MW8).*

Part and parcel of enacting the “with woman” philosophy is helping women to maintain control over their pregnancy and birth. Helping women and their families make decisions and helping them to understand that they have choices is seen as a big part of the mother midwife relationship for Amy (MW17). Key to this is the need for accurate and full information. The midwife is seen as one source of this information:

*“I do try very much just to make them aware that the decision is theirs’ and as a health professional I will make sure they will have the information they need, and also give recommendations as I feel are appropriate if they are appropriate. And then support them in whatever decisions they make, even if they are not the ones that I would necessarily choose for myself. As long as you know they have made them based on the available evidence, then it is their decision and you need to support them in taking responsibility for those decisions. So yes, it’s something I do focus on that.” (Amy MW 17)*

*“I think being there to give them the information, and then make them feel that they have it within their power to do something with that information, is very*

*important - and working with the whole family to enable them to enjoy the pregnancy as much as possible.” (Amy MW17)*

Erica (MW1) takes this aspect of the mother midwife relationship a little further again demonstrating her perceptions of the wider world view of how midwifery contributes to society by supporting the woman and her partner to become confident parents that are able to make decisions on behalf of their children:

*“We want them to be decision makers on behalf of their babies and behalf of their children etc, etc. It is not down to the midwife, the doctor, the health visitor, the teacher. It really is quite a big thing to be part of that process that makes them autonomous.” Erica (MW1)*

Jemima (MW 18) reiterates the role of the midwife in helping parents to make informed decisions. For her this is one of the most important aspects of her role and clearly she sees this as influencing the way they parent as well, helping equip them with skills to use beyond the birthing experience:

*“I think things like giving the mum or the parent the responsibility for their experience is such an empowering thing, I don't think that is written about very much, it may be touched on. But I think it effects how they labour as well as how they parent, I think it has an enormous advantages, it's probably the single most useful thing you can do for women, to respect their right to make decisions. You want to make sure they are informed decisions, women aren't opting for something because they don't want something else.” (Jemima MW18)*

It is interesting to note that in amongst the rhetoric of partnership, choice and control they feel that they should be facilitating as midwives there would appear to be a number of ideas expressed that suggest that perhaps they exercise

more power and control, and potential to shape or steer others than they recognize - their language demonstrates this albeit in a subtle way and with the best of intentions.

Brigid (MW 13) found that some women, particularly when she worked within the NHS, did not want to make decisions, they wanted to be told what to do. For her, her role was to help women take up this responsibility and support them in this:

*“Sometimes....it was very challenging for them to make decisions, because they would be asked to make decisions and they wanted to be told what to do.*

*Trying to help them understand that they were the baby’s parent and I did things with their permission. They found this quite challenging.” (Brigid MW13)*

Brigid (MW13) found that she had to be particularly careful in respect of younger mothers where they were not used to taking on responsibility because of their age and the fact that others had previously made decisions for them:

*“You had to be very careful particularly with the young mothers, to help them realise that they were the baby’s mother, that it was their baby and that I came into their home with their permission, and I picked up their baby with their permission.” (Brigid MW13)*

Brigid (MW 13) recognised that during her career she had had to change her approach to women from one that was, “rather authoritarian” to an understanding that it is the parents that have to make the decisions. This shift in power dynamics was felt not to be about absolving midwifery responsibility, but

quite the opposite, professional responsibility now had to include women's preferences:

*"I think I was authoritarian a bit, I learned the hard way to pass over the responsibility, this doesn't mean that you don't have professional responsibility, of course you do have, but part of that professional responsibility is acknowledging the input of the woman." (Brigid MW13)*

For Amy (MW17) too women's control over their pregnancy and birth is seen as being key, in her opinion even if the woman did not end up getting the birth she wanted for whatever reason, perceived that if the woman has been involved in the decision making processes all the way through, and feels that she has been in control, she is usually happy with the outcome:

*"They don't always get the birth that they would like but if they feel they have been able to do everything possible to work towards that and most of them are very happy whatever the outcome, it's just being able to be involved." (Amy MW 17).*

This ethos is supported by a wealth of literature which links women's sense of control of their childbirth experiences with their overall satisfaction with of childbearing and childbirth (Meyer 2012, Hildingsson et al 2010, Owesis 2009, Cheung et al 2007, Christiaens & Bracke 2007) and will be discussed more a little later in this chapter and then again within the discussion chapter where the concept of autonomy is explored.

Within this section perceptions of the power relationship within the midwife mother relationship have been explored. Midwives talk of relationships that are based on an equal footing and in the context of partnership however, there

would appear to be a number of dynamics that impact upon this, that of the context of a business relationship and the power that this potentially affords the woman. Midwives have expressed their desire to promote equal relationships and yet within the language that they articulate these ideas is evidence that they perhaps do not recognise the power that they exercise in relation to perceiving themselves as shaping, informing and “empowering” their clients. As this study considers the mother midwife relationship from the midwife’s perspective only it would be interesting to investigate in future research how the Independent/mother relationship is perceived from the mother’s perspective in order to understand this in the context of a business relationship. Some insight of this is glimpsed as will be seen in later discussion in this chapter where midwives recount their stories of relationship challenges and “difficult clients”.

## ***5.4 The Nature of the Relationship***

### ***5.4.1 “Close but not too close”: Personal Boundaries and Reciprocity***

As previously discussed there has been much debate regarding the nature of the mother midwife relationship within midwifery literature; debate that has encompassed the notions of partnership and friendship (Guilliland & Pairman 1995, Pairman 2000, Wilkins 2000, McCourt and Stevens 2001, 2002, 2003, 2010), through to notions of the professional servant (Cronk 2000). Within these debates the issue of how close these relationships should become and the degree of sharing of personal information or reciprocity has also been explored (Hunter 2005, 2006, McCourt & Stevens 2010). Independent midwifery practice offers an additional perspective on this debate. Within the context of independent practice, smaller caseloads and increased availability of time, plus



the political dynamics of a woman buying the midwives' time and expertise however, have not previously been well explored in relation to these issues. These dynamics potentially add an additional layer of complexity and intensity to relationships. Within this study the midwives interviewed expressed a range of views on how much personal information they are willing to share with their clients which resonates with Hunter's work (Hunter 2006) with NHS midwives. However, there did appear to be some consensus expressed regarding the dangers of having a relationship with a client that was "too close", and how this held the potential to blur professional boundaries and cloud professional judgements as has been identified in other studies (Stevens 2003, Walsh 1999), but as will be seen from the findings present this has particular significance for Independent midwives. So whilst some midwives like Angel (MW19) talk of "friendship", others are much more guarded about the implications of such a label on their relationships. However, for Angel (MW19) Independent midwifery offered the development of a depth of relationship with clients that was in sharp contrast to anything that she had experienced within the NHS:

*"So in comparison to the NHS, the way that we practice is that every time we see our ladies we are with them at least an hour, two hours, every time, we see them in the evening, we see them at the weekends. We get to know all the family and not just that woman, because that is important to have the relationship certainly with the partner and other children in the family. And usually by the end of that 9 months we are not only a midwife we are a lovely special person in that family and have become great friends. There is just nothing like that way of practicing for me." (Angel MW19)*

Whilst Angel (MW19) talks of friendship and hints at an on-going relationship with clients, Milly (MW12) too talks of friendships but puts this in a professional context and does indicate that it does have an end point. She is also wary about a relationship that becomes too close:

*“It is a kind of....it is a finite friendship, it has a point at which it stops, so I suppose it is just a close professional relationship I suppose in an odd kind of way. I think if it actually got to friendship, friendship it would be... I don't know I would always be very wary of looking after somebody that I knew very well.”*

*Milly (MW12 :)*

For Serena (MW15) the relationship is that of a partnership. This partnership also involves the wider family and even pets and is seen as something quite special:

*“The way I see our work is really, it's a terribly clichéd word - partnership but there is no other way of saying it really. I work in partnership not only with the women but their families. I get to know their children, their husbands or partners, their grandparents sometimes, their whole family and that is so special, the dogs, the cats the pets, the hamsters, the rabbits. You become a very special person to that family and actually even after its all over, the baby has been born and everything.”* Serena (MW 15)

*“I think everyone will always remember who was with her when she had her baby, but I think it is very different if she has got a relationship with that midwife. So yes it's working with families, it's the whole family. Sometimes it isn't, sometimes it's just really the women but most of the time the rest of the family is involved.”* Serena MW15)

Phoebe (MW14) is very clear about what she feels are the boundaries of her relationships with her clients and how much she is willing to share her own life with the women:

*“...what is very interesting is that you begin to realise that your clients do begin to think they know you better than they really do. It is a professional relationship. I do occasionally have women come here for an antenatal or something and I am not nearly as comfortable with that, partly because it is an intrusion on my family and partly because I am not terribly house proud, but also I am just very aware that they are getting to know more of me than I am really comfortable with and I have had a few women who have wanted to carry on our relationship way beyond the end of my professional relationship with them. I often get invited to “namings” and christenings and all those sorts of things and I really don’t go.” (Phoebe MW 14)*

Phoebe (MW14) talks about her views on keeping contact with women beyond the professional partnership period. Again reference is made to the amount of information that is shared with the women and how in some ways that is quite limited and largely at a superficial level. It is also interesting note that the sending of Christmas cards takes on business context:

*“It is difficult; I tend to send Christmas cards to the last sort of two year’s births. Part of that is advertising; they will have friends and family and perhaps have more children themselves. But it is also that you have shared something huge and I do feel immensely privileged sharing that with them. But you don’t actually share very much, I mean they know the names of my children and they know the name of my husband, they know where I live, those who have dogs know*

*that I have dogs, so they put together a few little things but they don't really know me. It is an interesting thing, I suppose you do give them this sense that they do, but you don't actually share anything major, although you do have the opportunity in those two hours to talk about wider aspects of parenting, being a mother, being a woman, how you see yourself, if you're confident, the adjusting from your work to being a maybe a full-time mother for a bit, all those sorts of aspects..." (Phoebe MW 14)*

Grace (MW 2) talks about the sharing of information about one another's lives to a certain extent but still she has boundaries, she talks about being 'normal' with people:

*".....it is being 'normal' with people, I mean they know about my life, there is a degree of disclosure, how close you get to someone, but you know these people, you have got to know them over the past 9 months and you see them really regularly and they do ask how your family is and you really get to know them, get close to people. (Grace MW2)*

Jemima (MW 18) talks about sharing a certain level of personal information with clients and that this is necessary if you are going to ask intimate questions of the woman, but the information shared does not have to be the intimate details of the midwife's life because her role is more about listening to the woman:

*"...you don't want to tell all your clients all your life story, but you have got to give them certain amounts of information about you if you are going to be asking such a lot of intimate details about them. And you have got to be aware of how relationships develop, I think a lot of people do it instinctively and I am relatively gregarious. But also we need to listen; you can't overload somebody*

*with all the stuff about your life. But it doesn't do your client any harm to know your husband needs badgering to do the dishwasher or you have to remind a teenage daughter if she want things washing she has to put them in the washing basket. Those sorts of little things you can share.” (Jemima MW18).*

This idea of reciprocity is further developed by Jemima in relation to sharing labour and birth experiences:

*“I do tell people about my daughter's birth when it seems appropriate. But I think that is probably my narrative style is to use proper stories to illustrate without burdening people with... Because you want them to have a range of.. have a little knowledge of a wide range of things. I have just seen somebody this morning and she was asking about long labour, one of her friends had had a very long labour. So we were talking about the average length of a first babies and second babies, and having told her 18 to 24 hours is average for a lot of people I said you know I didn't have any of that with my daughter; she was born in 2 1/2 hours, so it can be like that. So you can use those sorts of things like that. In some ways it's only fair if you are going to want to get to know somebody to let them get to know you.” (Jemima MW18).*

Awareness of professional responsibilities also appears to influence the degree of “closeness” that midwives feel they should achieve with women. Milly (MW12) sees problems with getting too close and how that can affect the midwife's judgement and detract from her responsibilities:

*“I think it starts blurring your judgement you know if you are too close. I have to remember all the time that I am being a midwife and this is my job and I have*

*responsibilities, but yes, I do get on with them tremendously well.” (Milly MW 12)*

Although the midwives in this study do look upon some women as friends they are aware that they cannot truly be so because of the business and professional relationship that exists. Serena (MW15) for example, indicates this:

*“There is a thing about friendship as well, I think, that is really interesting. There are a few clients who I would say, we are very, very good friends, but there is that professional... they are paying you and you are beholden to them in that way. And therefore I feel that you can't really be true friends because of that.. there is always that barrier there, when that professional relationship is in place, but it doesn't stop you knowing that actually you are really good friends. And you end up talking for hours, after all the antenatal business is over you end up talking for hours and hours about all other things. That's very special and you get very close and you have a real bond. So by the time they come to have the baby they are completely at ease, comfortable, trusting, there is that huge bond there. And that just makes such a difference to the experience. And for me, it's lovely for me too.” (Serena MW 15)*

Within this section midwives have recounted their perceptions of degree of closeness that should be aimed for in their relationships with women. There appears to be some consensus regarding the need to share some personal information with their clients but that this is often on an “everyday” level rather than the sharing of intimate personal information, with the recognition that they primarily need to listen to their clients. Although some woman are thought of as friends there seems to be a shared understanding that both professional

responsibilities and the business relationship that they have with their clients are barriers that prevent them from truly being so. The relationship that they are able to achieve with women is something that brings much enjoyment despite these boundaries and in some cases a bond is formed that pushes these parameters.

### ***5.5 Connecting With Women***

The concept of connectedness has been explored in relation to patient provider relationships (Phillips-Salami et al 2011) and has relevance and resonance to this study where midwife accounts align to seven identified attributes of connectedness with clients. These attributes include notions of: intimacy, a sense of belonging, caring, empathy, respect, trust and reciprocity (Phillips-Salami et al 2011) all of which are visible in this study's findings. Several Independent midwives spoke in terms of "when **we** are in labour", illustrating this connection between the woman and the midwife. It was not seen as just the woman that was in labour, but rather a shared experience, with a sense of merging into one. This was also a finding in the doctoral work of James (1997), who explored the mother midwife relationship and the "with woman" philosophy and has suggested that women and midwives experience birth together. Here Erica (MW1) expresses this idea:

*"....when you see her frequently through her pregnancy and it means that when you are in labour you have not an urge to keep checking things." (Erica MW1)*

Emily (MW8) talks about the shared journey with the woman and how knowing the woman and what she is normally like is an additional safety factor:

*"It is just so lovely that you share that whole journey together. It is a short cut because I do not have to be saying, do you know about a physiological third stage, when she is in the middle of her labour, for goodness sake! There is all that shorthand...I know her and I know....it's good for safety as well, because you know what she is normally like." (Emily MW8)*

Esmie (MW9) talks of affinity, connection and solidarity that she feels exists between women particularly at the time of birth. She recounts a story about a woman who was her second independent client and a small gift that she had thoughtfully made for her:

*"...you know I never cease to be amazed by women's generosity, not just because she gave me this book but the whole....I don't know how to put this....this sort of affinity for one another, do you know what I mean? It is sort of a connection thing...very much so, very different from the way that men think. That whole thing about women wanting to be with women, with women, I mean what I have noticed is that quite often women actually prefer women carers there so I think....women...I think that I am probably generalizing now....a lot of the time they would prefer to have their midwife than to have anybody. Not from the safety or safe part of birth thing but just the fact they are female and they can empathise." (Esmie MW9).*

Some of the midwives interviewed described some unusual experiences which accompanied situations where they had become particularly close to women. They reported a physical/psychic connection with clients which manifests in physical symptoms. Ingrid (MW5) for example, who described herself as "peri-menopausal", reported break through bleeding following a birth when there



had been a particularly close 'connection' with a woman. This had even happened after she had experienced several months of amenorrhoea:

*"we do have a strange rapport with women at times....one that I don't mind sharing with you is, I'm going through the menopause at the moment and I haven't really had any periods at all for the last year, and every woman that I have looked after and had a rapport with, about half an hour after they had their baby, I have a period! (laughs loudly), just a small one, and you think, yes, here we go...even my last woman who ended up having an emergency caesarean!"*  
(Ingrid MW5)

Erica (MW1) reported certain physical symptoms that she and other midwives she knew experienced when a client's birth was imminent. This type of knowledge appeared to be used alongside more traditional ways of knowing as another 'clue' to assessing well-being and progress in labour as has been reported also by Winter (2002). This type of knowing appears to be well recognised in independent circles according to Erica (MW1), but why this occurs is not so readily understood:

*"I have had lots of conversations with midwives and not just independents about gut feelings and that you really hope that you are right or that you really hope that you are wrong, you know innately that there is some message coming across. It is the sounds that the woman makes in labour, we all know about these, but it is also the smells."* (Erica MW1)

*"A midwife and I both have the same thing that when... we know when birth is imminent because you have a desire to go to the toilet yourself. In some way your body is so empathetic with what is going on that you're.....there's*

*something happening in your.....and you think right I'm not going to leave the room now or I better go now because I may not have the opportunity later and you can't pin that down- why on earth does that occur?" (Erica MW1)*

*"...there is a smell; a lot of midwives are prone to (smell) a certain acrid smell just before birth" (Erica MW1)*

Freya (MW16) reports this connection with women too and indicates that members of her family notice changes in her behaviour when a client is about to go into labour. Freya (MW16) suggests that this phenomenon is something that has developed and increased over her many years of midwifery practice; she indicates it is useful, but that it has also led to an invasion of her personal time:

*"Because I am so linked with the women now, I have worked with them so closely; I almost get the end of pregnancy feelings. And the children used to say you will be out tonight mum, your end of "pregancyish", you're "labourish", I get all fidgety, it doesn't matter whether they are due or not. In some ways that is a huge privilege but it's also an enormous invasion and I am getting to the point now, where it means I can't go anywhere." (Freya MW 16).*

Red (MW 20) talks about her sensitivities to the emotions of women and how she is able to tap into these. She believes these skills are vital to her work but also recognises that this is a skill that not everyone has. For her it is a very useful tool:

*"I don't mean to say that having that sensitivity where you do pick up on emotions, where you do pick up quite strongly what people feel, makes me a better midwife than someone who doesn't. But I think for myself personally I*

*wouldn't be able to do the job I do if I couldn't do that. So I think we all have different skills in different areas and that's just what I do, and in some ways it's a blessing and a curse. But yes, I think I am quite sensitive to emotion and sometimes I can physically see if women are in distress in that their energy becomes clouded, it's difficult to explain..." (Red MW20)*

Red (MW20) indicated that she was able to see "energy fields" around women sometimes when they were distressed or ecstatic:

*"Sometimes yes, particularly if people are in distress. Or particularly if someone is having an amazing experience as well, I have watched women give birth absolutely ecstatically and just watched their whole energy be just vital and shining, so that is amazing to see." (Red MW20).*

Many Independent midwives mentioned the phenomenon where women who were due to go into labour or birth appeared to postpone this until their midwife was available:

*"...when you have got that link you find mostly, even when we had that link in the NHS, the women would wait until you are ok. I just missed one on Friday and that is the first time in.... I have been independent for about 19 - 20 years, so it's a long time to have not missed a birth! I have gone straight from one to another thinking I am never going to make it, but women hang on. "(Freya MW16)*

Perceptions of energies/forces in the environment at the time of birth have been reported elsewhere (Winter 2002), and also feature in this study. Erica (MW1) articulates some of her experiences, conceptualizing this in accordance with a

holistic view of the world, which includes an awareness of a spiritual and energetic dimension of existence (Davis-Floyd 2001):

*“I do believe in the energies that come to the fore when a woman is having her baby, it is quite amazing to walk into a room where a woman is labouring it hits you forcibly, but maybe, you know, what we do is just tune into it. There is certainly a lot of energy in that room.” (Erica MW 1)*

For some of midwives in this study the relationship that they achieve with women is intellectualized as a connection in both emotional and spiritual terms and on occasion is felt to be associated with both physical and metaphysical phenomena. This connection is seen as both strong and special with midwives perceiving that it helps them tune into the woman to the extent that they may experience this as a sharing and merging with the woman’s experience. There is also a strongly expressed sense of women’s affinity with women during pregnancy and birth which is reminiscent of historical depictions of the role of midwives and women supporting women during pregnancy and childbirth (Ehrenreich and English 1973, Donnison 1988, Achterberg 1991). Within this section there is also evidence that midwives are using a holistic framework to understand human existence which includes spiritual and energetic aspects (Davis-Floyd 2001). Although “holistic care” is something that all midwives are required to understand and be able to practise competently, (NMC 2009), the spiritual and energetic aspects of this have not been well articulated within the midwifery profession within the UK, although there is evidence of interest in this area (Hall 2000). Indeed it might be more accurately described as a humanistic model of care as defined by Davis-Floyd (2001) rather than a truly holistic one

which would require the more general acceptance of metaphysical and esoteric ideas in society more generally. However, it is interesting that in this particular group of midwives, whilst acknowledging that it not accepted by all research participants, there is clear articulation of these ideas. This could be seen to represent the antithesis of the medical model of care which has been so highly problematic to their expressed conceptualisation of being “with woman”.

### ***5.6 “Healing Birth”: Healing Past Negative Experience/Trauma***

Within the study a number of midwives talked about midwifery in the context of facilitating healing, and the means of facilitating this was seen as the skilful use of the mother midwife relationship. The notion of midwives being “healers” is not a new one and we know this dates back to ancient times (Achterberg 1991, Ehrenreich & English 1973, Garratt 2001). However, within the context of contemporary NHS-based midwifery this is not a concept commonly explored (Garratt 2001). The dominance of the medical model in many care settings has constrained exploration of other modalities (Davis-Floyd 2001, NICE 2007). The dissatisfaction of women and midwives with this model of care has also been well documented (Rothman 1982, Oakley 1980, Kirkham 1987, Green et al 1998, Methven 1991, Davis-Floyd 2001, Cahill 2001, Warren 2003, Hyde and Roche-Reid 2004, National Perinatal Epidemiology Unit 2006), with its failure to acknowledge the holistic approach and meaningful relationships required to enact the “with woman” philosophy. Whilst there has been a wealth of literature published regarding midwifery alternatives to the medical model of care, particularly since the publication of “Changing Childbirth” in 1993 (Department

of Health 1993, Flint and Poulengeris 1989, Pairman & Guilliland 1995, McCourt & Page 1997, Stevens 2002, 2003, Walsh and Newburn 2002, Kirkham 2003, Pairman 2006, Walsh 1999), these models have not incorporated the notion of healing *per se* in its broadest sense although without doubt the importance of meaningful relationships that involve midwives and women getting to know one another are central and pivotal to these models, seeing them as having “healing” potential is not well discussed. Interest in “healing” has been more manifest in a resurgence of interest in the use of complementary therapies although this is couched in concerns regarding scientific evidence of their safety and efficacy which, as previously discussed, has been instrumental in constraining and controlling their use (NICE 2010a, Garratt 2001, Tiran 2010, Price & Price 2011, Ernst 2006). An exception to this literature is the work of Milan (2003), an Independent midwife who has discussed the idea of both childbearing as a healing event and the role of the Independent midwives in facilitating this highlighting their attention to the humanistic model of care. She detailed the subjective lived experience of three women clients for whom she cared following emotionally traumatic childbirth experiences in the NHS. These women shared certain similarities in relation to upbringing; she highlights particularly their obedience to authority, low self-esteem and the importance for them of having control over their experiences (Milan 2003). These women each talked of moving on or having resolved previous emotional difficulties and feeling more confident and assertive following successful natural births at home facilitated by the Independent midwifery model of care (Milan 2003). Key to this experience appeared to be the fact that each of these women discovered that

she could undertake something that they had perceived as difficult or frightening.

Within this current study there is evidence that the healing role of the midwife is recognised and enacted in a variety of ways starting crucially with the formation of the mother midwife relationship. Midwives expressed feelings of helping women self-actualise and 'grow' as a result of their childbearing and childbirth experience, facilitating a life phase event and the healing and nurturing that accompanies this, facilitating an important rite of passage, the transition into mother and parenthood and the responsibilities that this brings. Also articulated within the midwives' stories are more obvious accounts of healing in the sense of healing what they term, "damage" from both past life and childbirth experiences all of which concur with the work of Milan (2003).

Esmie (MW9) when talking about the client group that accesses her services alludes to the fact that many of the women coming to her having been "damaged" in some way by previous NHS experiences. She perceives her role as one that sees the woman safely birthed in a positive experience and that this in some way heals the "damage" of the previous experience:

*"The majority of women that I have cared for have had an NHS experience that they have been damaged by in some way, whether it is just the way that somebody spoke to them or an aspect of their care that they had a previous birth experience that was traumatic, so that is probably the main one, so we hope that these women will go on to have their healing birth with us, what we call a healing birth, a healing experience, a positive experience." (Esmie MW9)*

When asked about the term 'healing birth' Esmie (MW9) indicated that this was a term used by many Independent midwives and from her description of her intent, her motives are clearly much more than just helping the woman to birth her baby safely, there is concern for her life and well-being beyond the childbearing event:

*"That is something (healing birth) that is used in independent terms, I think it is a common use of language, I think, I have heard it used before amongst other people. I quite like it, I think it is a positive term and I suppose it's the hope that that somebody will turn the corner on a chapter in their life, rather than keep it as a front page thing and a negative thing. But I would say that most of the women that have birthed before have had an experience that they don't want to have again." (Esmie MW9)*

The theme of healing comes through in Serena's (MW15) story in which she also talks about the nature of the clients that seek Independent midwives and the fact that they might have been traumatised by previous experiences that need healing. The first part of this "healing" she feels involves the midwife listening to the woman's experiences, validating them and saying sorry that they had to experience these things:

*"A lot of our clients come to us because they've had unhappy experiences with their first baby and they come to us and they tell us their stories. I have found that a number of them haven't really talked to anyone else about it because they haven't been encouraged to talk about it. And people, well meaning, their husbands, their families, have said look it's all over now, that's in the past, everything is fine, we just need to get over it. And nobody seems to understand*



*that people need to talk, and they need to weep, and they need to re-live what happened to them, and talk it and talk it and talk it, and then they feel better. So a lot of women will spend a long time talking about what's happened to them, how they felt, weeping. And I just sit there and listen and let them talk and just accept what they are saying because no one has done that before, no one has accepted or validated what they have said." Serena (MW 15)*

Seeing a previously traumatized woman come through a healing birth experience for Serena (MW15) brings great job satisfaction. Talking about the experience and listening to the woman is seen as crucial in helping this to happen. Serena also indicates that recognition of and the value of this work is not a well appreciated or understood aspect of independent practice:

*".....being able to talk about it brings them through it, and then they have a lovely birth and that heals them and then they move on in their life. And that is just enormously rewarding actually to see someone come through that - a very damaged person have a healing birth, having been able to just talk. I sit and listen for 3 hours - that's fine, they need to do that, and then they become this healed person, that's just so rewarding. Some of them just don't get it, they just don't understand what we do at all, "Oh, you are a midwife, oh, you deliver babies occasionally". What else do we do?" (Serena MW15)*

The invisibility of the value of the mother midwife relationship is discussed by Hunter et al (2008) who use the metaphor of a tapestry to discuss midwifery care, suggesting that human relationships are the hidden warp threads that are integral to holding care together, but are unseen and subsequently undervalued and the visible weft threads, which in this analogy, relates to physical outcomes

associated with care, have become seen as the most important focus in care (Hunter et al 2008). However, the midwives in this study have indicated that they work from an understanding that midwifery care is based in relationships and that they believe that for certain women, in conjunction with a very tailored and individualized model of care, it can result in a healing experience. This may be from previous traumatic experiences or as part of helping them adapt to the major life event of birth and the change of role and responsibilities that accompany this rite of passage (Gaskin 2011). Also midwives are indicating that women who access their services may do so because of previous life or birth trauma. The mother midwife relationship is used to listen to and then validate these experiences for the women and then to help them move onward to a healing birth experience. Research participants' stories indicate that this can be very time consuming but is very rewarding however, this aspect of the Independent midwife's role is not well understood, and rather like the analogy used by Hunter et al (2008) as a "warp thread" remains invisible to those who do not appreciate the potential clientele group who access the services of independent midwives. The next section details the lived experience of independent midwives working with these "damaged women".

### ***5.7 Who Accesses Independent Midwifery?***

Recent evidence has begun to illuminate the potential women who might access the services of an Independent midwife. Symons et al (2009) in a study that attempted to compare the birth outcomes for women cared for by Independent midwives with those birthing in NHS maternity units found that although outcomes for Independent midwife booked women were significantly

better across a range of variables for women deemed low risk, the perinatal mortality for women deemed high risk was significantly higher. They observed that women deemed “high risk” made up a significant proportion of the Independent midwife’s caseload and of these a high proportion of these women, having made informed choices, were booked for home birth (Symons et al 2009, 2010). Symons et al (2010) discuss the boundaries of and respect for autonomous decision making by clients, and this theme will be revisited when the concept of autonomy is discussed in the final chapter of this thesis. Within this current study it is therefore unsurprising that the research participants make reference to this particularly challenging client group.

For Emily (MW 8), the nature of the clients who are attracted to an Independent midwife, are often perceived as emotionally difficult. Although she relished and enjoyed coping with and working with these women she also acknowledged the additional work and energy that helping these women required:

*“Lots of our clients are emotionally challenging. I love the emotionally challenging women, even when I was working in the NHS I would often be assigned the ‘difficult clients’ and I really get a kick out of working with people who are a bit challenging. It is not always easy. I don’t really know how I do it”.*  
(Emily MW8)

Jemima (MW18) indicated that around a third of her clients are “damaged” in some way and not necessarily because they have had a difficult birth. She indicates that the birth may have been normal, but the way that they were spoken to or treated had traumatized them, often as a result of feeling bullied or out of control:

*“I think probably at least a third of our clients come to us because of their previous damaging experience. And for some of them if you look at the notes it’s not clear from the notes that it’s been difficult or damaging. They may have had a normal spontaneous vaginal birth and somebody else would look at them and say I don’t know what you are going on about everything was fine. But they have not felt listened to or they have felt over ridden or they have felt bullied into doing things.” (Jemima MW18)*

Angel (MW19) feels that building trust is especially important with these particular clients as they have often indicated that they have been in situations where their trust had been abused on a number of levels:

*“I think fundamentally it’s about trust, because certainly ladies who have come that have had a previous traumatic experience- they have always felt very much out of control of the experience. They felt their trust had been abused in a lot of circumstances. So to develop that relationship with them where they absolutely trust you, that having the confidence yourself to always be open and honest, because there are never any guarantees. What we can guarantee is that we will be there with them whatever happens.” (Angel MW 19).*

Hunter (2005) has explored the mother midwife relationship in relation to the concept of “emotional labour” and “emotional work” as mooted by Hochschild (1983) and in relation to the notion of reciprocity. For Hunter (2005) reciprocity is taken to mean ‘exchanging things with others for mutual benefit’ (Oxford Dictionary 2003). It has been evidenced by this current study and that of others that midwives derive a lot of pleasure and job satisfaction from mutually meaningful relationships with women (Walsh 2007, Olafsdottir 2006, Hunter

2004, 2005). Hunter (2006) in her exploration of reciprocity and the mother midwife relationship makes a distinction between balanced and unbalanced reciprocity, where balance reciprocity represents a situation where there is mutual give and take between mothers and midwives which includes affirmation and appreciation of the midwife's role, a finding supported by others (McCrea & Crute 1991, McCrea 1993, Stevens 2003). Importantly this affirmation is associated with healthcare worker's perceived enactment of "doing a proper job" (Prottas 1979, Lipsky 1980). This has particular significance for independent midwives who, as evidenced from this study, have a strong sense of what it is to be "with woman" having made career choices that have incrementally enabled them to move into a perceived working environment that facilitates their doing this. Unbalanced reciprocity is where the woman does not show that she appreciates the work of the midwife, or for example does not appear to subscribe to the notion of partnership (Hunter 2006). In the context of Independent midwifery there is the potential for a woman to exercise her rights as a paying client and to see the midwife as an employee or to choose not to take the midwife's advice. In these situations it would appear that the Independent midwife's sense of "being with woman" can be disrupted creating "emotional work" for the midwife. There would appear to be certain clients that create "emotional work" for the research participants and whom they describe as being difficult, much in keeping with the findings of Hunter (2006).

Emily (MW 8) talks about "difficult clients" and how midwife and mother need to be suitable for one another, a sentiment expressed previously by other midwives in this study. Emily explains how she took on a client but knew from

day one that she was going to be a challenge. She indicates that other Independent midwives might not have taken her on, Emily did but it was a very challenging experience:

*“You know from day one when you meet some women that they are going to be a “challenge”, and some of the “challenges” go ahead and give birth.....and sometimes you don’t know until the labour how it is going to go and I have had women who...one lovely client actually, who pushed me to my limits and I was nearly in tears at our consultations. And I just thought, I don’t know that I can care for you, I didn’t tell her that! But I really felt... gosh, I can’t deal with this woman! She did not trust me all the way through the pregnancy and then she trusted me completely, it took her to have the baby for her to trust me and then I was her best buddy, but she was a real challenge!” (Emily MW8)*

Emily (MW 8) also makes reference to clients that are “damaged” in some way. She believes that this in turn creates challenges for the Independent midwife as supporting these women in their choices can also make the midwife vulnerable, particularly as there is no indemnity insurance currently available. For these reasons and because of the intensive emotional work that these cases may involve, Emily acknowledges that she would perhaps restrict the number of these types of client that she would take in a year:

*“There are lots of damaged people going through the NHS too, but they obviously are a self-selecting group and there are lots of different types of people, but a lot have difficulties with the NHS and so it makes them a very high risk group to work with for all sorts of reasons. I really enjoy working with them*

*and yes, it is challenging, and I suppose we joke about it and say that we can only deal with one a year that is really challenging.” (Emily MW8).*

The research participants make reference to the client group that seeks out their services. They indicate a high proportion of women that are highly complex to care for, bringing with them a number of issues from previous life or childbirth trauma. In these situations there can be a lot of challenging and time consuming interpersonal work for the midwife and this can be experienced as difficult. Midwives also indicate that this aspect of their role is not well understood by others. These women can challenge the midwife’s “with woman” philosophy and also place her in a position of vulnerability. Midwives have to carefully consider and weigh their professional aspirations to help women achieve the birth they want, assessing whether they feel they personally can help the woman, against the potential risks to their registration. Unlike their NHS colleagues independent midwives do have a choice as to whether they take on a client, and this decision can have important ramifications particularly when they get this decision wrong and there is the potential to for this not to result in a trusting relationship.

Some midwives expressed feelings of dismay when the women exercised their rights as paying customers. This appeared to be at odds with the midwives perceptions of the nature of the midwife mother relationship, the notion of working as equal partners. When women tipped the relationship into the “professional servant” domain this elicited feelings of alienation and disappointment in some midwives who were clearly trying to come to terms with an approach which was at variance to their own perhaps romanticised views of what midwifery care was about, creating emotional work for the midwife (Hunter

2006). Within this study this was something that was expressed particularly by midwives who were relatively new to Independent midwifery. Cronk (2000, 2010) indicates that thinking of the midwife mother relationship in terms of being a professional servant enables the woman to take the political lead in her childbearing and birth experience and puts the whole experience onto the correct “political footing” as previously discussed. However in practice, being seen as a “private midwifery service” by clients was experienced as challenging by some of the Independents interviewed. Getting used to the context of a business relationship was something that required reflection and adaptation on the midwife’s part. Bethany (MW 3) gives an example of a situation that illustrates this whilst also highlighting her personal journey in terms of adjusting to Independent midwifery practice and the clients who might access this and understanding why they might ask for things in a certain way:

*“I think that one particular woman I am thinking about, she was right at the end of her pregnancy and she was getting quite a lot of discharge, and I was saying it is just discharge, it’s not ..you know, you have not broken your waters, it’s just normal discharge, she wanted to me to get hold of one of those Amnio-stix... what do you call them?...Nitrazine swabs! She’d heard about them and she wanted one! And she said that I am paying for you and you should get me one! And stuff like this. She was having a go at me like that and then she was really awkward about a speculum, I was really mad with her, not to her face, I tried to be really patient with her, but behind her back I was really cross, she was a real madam, being so manipulative. Then all of a sudden it twigged, no, there is something there, there is some reason that she is like this, and it sort of took all*



*of the steam out of the situation somehow, so I think realising that there was a reason why she was like she was and although she never disclosed it to me, there was a good reason for it. So, she probably thought that she was being perfectly reasonable. And there just are some people that are unreasonable sometimes. She seemed unreasonable by my reckoning but people come different angles don't they? And what I think is reasonable, they might not, so I think it is learning to accept a different reality.” (Bethany MW3)*

*“Mostly as an Independent midwife you find that women...you sort of work in a partnership really, but some women, particularly that one I was thinking of, say well, I am employing you to do this for me, and there was not very much of working together. She wanted me to do things for her, and she was paying so that I would, you know, and it was a completely different ethos for me.*

*“(Bethany MW3)*

Moving into independent practice is an exciting time which potentially offers midwives the opportunity to fully enact the “with woman” philosophy. Midwives in this study demonstrate that they have a strong sense of what this might be. This includes the belief that they will be working in partnerships with women, and helping them to achieve the birth experience they want. However, these beliefs have to take into account the business relationship that exists between midwife and her client and this requires a period of learning for the midwife as she adjusts her perceptions of “partnership” within the context of independent practice. When women exercise their autonomy and rights as employers of the midwives’ services, this can trigger feelings of cognitive dissonance in the midwife, destabilizing her professional sense of purpose and worth. These

clients are experienced as “difficult” and the midwife perceives her vulnerability as she comes to understand the locus of control in this situation. The rhetoric of partnership permeates much of contemporary midwifery philosophy as previously discussed and it is seen as crucial to effective midwifery care (Guilliland & Pairman 1995, Kennedy et al 2004, Page 2003) however it has also been challenged with the questioning of whether this can be achieved in every case and indeed if women want this (Fleming 1998, Sharpe 2004, Carolan & Hodnett 2007). There is emerging evidence that perhaps women do not always place as much significance of the mother midwife relationship as their midwives (Fleming 1998, Sharpe 2004, Carolan & Hodnett 2007, Carolan 2005, Harrison et al 2003), and perhaps other agenda’s that are currently not well understood. This potential mis-match of agendas particularly in the context of Independent midwifery can place the midwife in a vulnerable position, an awareness of which is detailed in the following section.

### ***5.8 Potential Vulnerability of the Independent Midwife***

Potential tensions between enacting the “with woman” philosophy and all that this means, particularly in relation to respecting a woman’s right to make choices and decisions and supporting her in meeting her needs can sometimes take midwives into the potentially vulnerable territory of being at odds with professional requirements (NMC 2012b, 2008). The requirements for a high standard of record keeping is not of course confined to Independent midwives and extends to all practising midwives (NMC 2012b, 2008, 2010), but Independent midwives are acutely aware of their professional vulnerability because they operate in a more autonomous way, push professional

boundaries whilst at the same time being required to work within them, and with no professional indemnity insurance. They are seen as working in a different way, often challenging NHS practice and feel that they are a target for “witch-hunts” (Wagner 1995, Jowitt 2009, Kirkham 2010a). But as well as professional vulnerability, the midwives are potentially at risk from the women themselves. Chloe (MW 4) demonstrates her awareness of this and the need to document advice and events as they occurred. As an example of this she talks of a woman who chooses to say “no”.

*“I knew she was not going to allow me...she would not let me check her Hb (Haemoglobin levels), and we had a good discussion and I made sure that I wrote it properly, that is one of the things I have learned is that your documentation has to be...you have to be careful about that. I am not saying that I just do it for fear of reprisals but, I do know that there are quite a few independent midwives who have been pulled up professionally because of their paperwork.” (Chloe MW4)*

This client was an on-going challenge for Chloe (MW4) to care for. She tried to give her advice regarding her perineum which had torn at the time of her baby’s birth but she had refused to have this examined or sutured. Chloe (MW4) researched possible alternative modes of care which included rest and a good diet, paying particular attention to iron and vitamins which helped with healing and shared this with her client. Despite this advice the woman exercised her autonomy and chose to ignore this which Chloe (MW4) found challenging to deal with. Working flexibly and offering alternatives to clients is a key characteristic of Independent midwifery practice as recounted in research

participant narratives, and the potential exists as recounted above for them to reject these too.

Emily (MW8) also acknowledged that pushing the boundaries is what women want them to do, to offer something that offers more flexibility than the NHS, however on the other hand the Independents are acutely aware that in doing so they leave themselves wide open to professional criticism and/or litigation:

*“It is very scary as well because, gosh, we are working without insurance; we are pushing the boundaries of what are the accepted norms. We are laying ourselves very much open to a lot of trouble. But equally, the women are wanting that of us generally, we do push the boundaries, because we do, but equally as much as it is us, the women are wanting it.” (Emily MW 8)*

Milly (MW 12) raises again the importance of getting the right midwife with the right woman and talks about a woman who approached her with what seemed like a completely unreasonable request that involved her feeling as if she was policing her colleagues and that placed her in a very precarious situation. This story also indicates that there are limits to which the midwife feels she can comfortably go in supporting a woman’s choices for birth:

*“There was actually one woman who contacted me and she giving birth in a Unit to the west of here, what she basically wanted was a qualified midwife to be with her in labour, in the hospital, although I could not give her care in that hospital, I could just be with her as a supporter, but to be with her, to make sure that she was getting the right care from the midwives in the hospital. So basically she was asking me to be a midwife police person! I thought, no, absolutely no way! I am not policing my colleagues in another Unit. And I*

*thought if I felt she is not getting the care she should, and I say so, and then she sues, and then I'm off in Court being a witness, I thought I'm not playing this game, I'm not going there.” (Milly MW 12)*

Serena (MW15) draws attention to the fears that increasing litigation in society brings and how this might influence the role of the Independent midwife and her practice:

*“.....it's getting more and more dangerous to practice because of the litigious society we live in at the moment. And the amount of defensive practice you see, and people know that they are practicing defensively and you end up thinking of doing it yourself. You are starting to practice defensively because you are forced into doing it to protect your registration. And that's terribly sad.” (Serena MW15)*

Amy (MW17) had been involved in an investigation by the Local Supervising Authority and although no problems had been identified with her practice she had learned lessons about the potential for professional criticism when supporting a woman's choice when this was clearly controversial. In acknowledging that woman's right of choice she would also be expected professionally to make a recommendation to her client:

*“I am also very aware now how supporting somebody can also get us into trouble, so it's having to look at documentation and how we word recommendations. That was one of the things that I picked up from the investigation, before I was very much in favour of give the women a choice and the information and let them make their choices. But having been through that system now I think there probably are times when I should be making a*

*recommendation, or I may advise, or I may recommend, or I may strongly recommend depending what the situation is. And that is just me being a little bit defensive in the future.” (Amy MW 17)*

This sentiment is also expressed by Freya (MW16):

*“I think that is the other thing, when you are in a caring profession people are in a vulnerable state and so you as the professional, you have an enormous power, and we always have to be aware that we have got that power because it’s too easy to misuse it. And I think sometimes it can backfire on us, all this, well, yes, these are your choices what would you like to do....I have just been through absolute hell for the last month because I had a women who’s baby had a bradycardia and she said, “the baby is absolutely fine”. Oh good grief! I have rung the hospital, I have been to see my Supervisor, well, what if... blah, blah, blah.... And actually we did end up with a section but the baby still got a bradycardia, its still, “absolutely fine”. But when you find a FH (fetal heart) with base rates between 90 and 110 it’s a bit scary. They (women) will not always....you know, I wasn’t going to bully her and that’s where the NMC falls down” (Freya MW16)*

Serena (MW15) is acutely aware of the Independent midwife’s vulnerability in an increasing litigation conscious society, she talks about her needing to be honest and “upfront” with her clients about professional requirements for record keeping as this constitutes an important record of care she provides and the information given and received from the woman. There is also a clear sense of needing to trust the woman as well:

*“I do nowadays sadly, I do actually tell my clients, look if you think I am being a bit nit picking with my notes there is a reason for that and that is I have to protect myself, I have to protect my registration. I am actually putting it on the line every time I do a birth. So I just have to be really careful and I always tell them I have got your best interests at heart and I would hope that you would have mine at heart as well. And I think they really appreciate that and understand that things are quite tricky for us these days” (Serena MW15)*

Awareness of vulnerability is clearly evident from research participants’ stories. They see this vulnerability as coming from two sources, the women who employ them who want them to be more flexible and supportive of their choices for birth. This is a key principle in the mantra of the “with woman” philosophy, however, these women can have complicated pregnancies with very complex care needs and are often wanting to birth their babies at home, which could result in delays if transfer in labour is recommended. Exercising their right to decline the advice of the midwife, may result in a less than a positive outcome with the potential for litigation. Midwives perceive that the Nursing and Midwifery Council may be critical of their practice because, in trying to meet the needs of their clients they work flexibility and push professional boundaries in a way that sits outside the frame of reference for NHS midwifery practice. Midwives have also intimated that the NMC do not understand the nature of their potential clientele and their vulnerability as midwives if their client decides not to take professional advice. In order to mitigate this risk they understand the need for exemplary record keeping and the need to be explicit in this respect with clients. There is also a sense that they try to take on clients that they feel

they can work with, articulating this in terms of matching the “right mother to the right midwife” and seeing this as being achieved through the mother midwife relationship and the establishment of a trust on both sides of this relationship.

The next section focuses on midwives perceptions of their business relationship with women.

### ***5.9 The Business Relationship - Talking Money***

Overlaying all the professional rhetoric of the midwife mother relationship for independent midwives is the business relationship that also exists between themselves and the woman. It was an issue that many midwives in their early days of independent practice found difficult to deal with, particularly when it came to talking about money with women. It appeared to be an alien concept and did not always sit easily with their notions of contemporary midwifery rhetoric. However, the realities of having to pay bills and making a living often focused attention on developing these skills and the lesson of sorting out money issues early on had to be quickly learned. Chloe (MW 4) talked about the difficulties she and her partner midwife had initially in relation to talking to women about money. This was an unfamiliar and alien thing for them to do which clearly had associated skills that had to be learned. She found that some women would also try to negotiate a reduction in fees in certain circumstances. This tested the Independent midwife’s skills in holding firm to their price, valuing themselves and also enabling them to make some sort of living:

*“We found it quite difficult, the business side of things, the tax and all that kind of thing was a bit bewildering, let alone the paperwork, and sort of tip- toeing your way around the bureaucracy, you know, silly things like getting blood*



*results, how to talk to women about money, and their partners about money and it is still difficult but have got a little more confident about that.” (MW4 Chloe)*

*“You get people asking, ‘Can I have a reduction as I am 30 weeks or 35 weeks or 36 weeks, and having to be really firm about that and say we are qualified professionals who are offering professional care, you know, it is very intense.”*

*(Chloe MW4)*

Jemima (MW 18) also made reference to how women who book late often ask for a reduction in fees. She indicates her personal stance is not to reduce her price, saying that there is more work to do in a shorter time to get to know the woman that justifies this decision. It is interesting to note that it is the building of the relationship that is highlighted as the work, indicating the centrality of this to midwifery practice:

*“.....But I don’t drop my fees, some independent midwives drop their fees when they book late, but I don’t drop my fees because you have to work harder to make that relationship.” (Jemima MW 18)*

Esmie (MW9) talks about how strange it felt initially asking women for money as an Independent midwife but how she got used to this. For her focus at an initial meeting with a prospective client was also about whether she liked the woman and felt that she could work with her:

*“....what I found really interesting was the process of having to ask women for money and the initial consultation fee which I gathered was £50.00 and that was really bizarre! But I got used to it quite quickly and like my business head said you are working for this money but the whole thing about meeting women for the first time and gauging whether you like her or not. There are not many*

*women that I have met in my life time that I have never really got on with....”*

*(Esmie MW9).*

Again Esmie (MW9) talks about the business side of Independent midwifery and how to some extent how alien this feels:

*“ I think one of the things, as an Independent midwife, what I have found really difficult is as I said is asking for money and also that whole business side of things, because I never thought that I would be sitting here saying that I am running a business! (laughs). I suppose in the grand scheme of things it doesn't feel like a business, but it is!” (Esmie MW 9)*

Esmie (MW9) talks about the issue of marketing her business but also highlights the fact that she is technically in competition with other Independents for clients and yet they are also there for one another in terms of support. The level of service that Independent midwives aim to provide for their clients means that they cannot take on too many clients if they are to guarantee being there for them, this is seen as a crucial underpinning principle of independent practice which in turn limits their earning potential, but this does not appear to be the most important concern:

*“...that whole side of marketing yourself and although you know (name of Independent midwife nearby), we are actually in competition with one another but we also look out for one another so, we tend not to take more than two women to birth each month, and that is because...in fact it is really quite crucial because the whole point offering the type of care that we do as an Independent midwife is that we can guarantee that we are going to be at the birth.” (Esmie MW9)*

Esmie (MW9) acknowledges that her clients are paying customers and that she is providing a service. She felt that she had this same philosophy when she worked within the NHS, so had not found this aspect of Independent midwifery difficult. Within Esmie's story there is again a recurrence of the theme of matching the right midwife to the right woman, however she adds to this stating how if this is not in place it could be detrimental to the woman's experience, and indicating that if she did not feel that she could not "tune into" a woman she would not take on her care:

*"at the end of the day they are paying for that care, but the other choice for them, if they did not like me would be to opt out of it, so I think a lot has to be said about that initial consultation and booking. It is having that feeling that this is right. I think that there is only one woman that I have ever met that my colleague booked and when I met her at an event that I knew that she was going to be at, because I was going to be her back up midwife, I said I actually wouldn't book that lady, because I didn't feel, there wasn't a good vibe. I haven't had to do that yet and I imagine that the day I do it will be quite difficult because I like to think that I get on with everybody that I meet but I know that life isn't always as straight forward as that and there could be someone that I don't tune into. And that probably means that I am probably not the best person for them."*

*(Esmie MW 9)*

For Amy (MW17) talking about money had been incredibly difficult at first and because of personal beliefs that the level of service provided by Independent midwives should be available to all women:

*“(I found it)...Incredibly difficult. Because in my heart of hearts I believe that they actually should be able to access this care on the NHS. I think it’s something that every woman is entitled to, so I do find it difficult having to charge. And a couple of clients have said initially when they speak to you they say the fees sound very high, but by the end of it they say you don’t charge enough for what you actually do. Which is nice, but it’s still getting over that barrier of having to talk in thousands of pounds when somebody comes to you.”*  
(Amy MW17)

Amy (MW17) talks about the running of an independent practice as a business and for her it is much more than a business especially when friendship develops, she feels that she sometimes loses sight of that business relationship. Commercially, independent practice does not appear to be an activity associated with getting rich:

*“Me and my husband don’t talk about the financial side at all, he runs his own business and he just can’t see how it’s commercially viable to be an Independent midwife at all. I have recently redone my fees and even though I have costed it all out properly if your second midwife ends up taking the birth care of it, you really haven’t made any money at all! And you do become friends with them as well so you get to the point where you say oh pay me when ever, just pop in, and it’s all very relaxed and easy and you do tend to forget that it is a commercial arrangement.”* (Amy MW 17)

On a very practical level the dealing with fees and monies early on pregnancy when there is the potential for a woman to miscarry is something that this midwife articulated and for this reason she delayed payment of fees until after

12 weeks in order to avoid having to talk about monies with women and their families at a time when this felt very inappropriate:

*“I prefer not to book women until after 12 weeks, I don’t really want to put myself in a situation where they end up miscarrying and having to deal with the money at that point. Which I think would be awful for them and just as awful for me as well having to talk about it. So I try to avoid early bookings, or if somebody wanted to book that early then I would delay payment until a little bit later. But then you would be doing yourself out of the money that you have already spent on things, so there isn’t an easy way.” (Amy MW17)*

Being able to be flexible in relation to payment of fees in order to enable more women to access their services is viewed in a variety of ways. For Amy (MW17) this is not something she finds she is able to do for very practical reasons, which are making financial ends meet:

*“I know some midwives will accept payment over a few years, I am not really in the position to do that at the moment. I am happy as long as my costs are being covered and I’m not having to pay for fuel and travel then that’s ok. But to do it so that I am bearing the costs, I am not really able to do that with my expensive children. (laughs) Which again makes me feel guilty because I would like to be able to offer an extended payment to make it open to more people, but then I think my husband would probably divorce me!” (Amy MW17)*

From this section it can be seen that the business side of independent practice is not the main reason for midwives choosing to practice in this way. There is a sense that this is secondary to being able to practice in way that enables them to fulfil the philosophy of “being with woman”. Independent midwifery is not

something that is undertaken to become rich as strong principles associated with the level of service they aim to provide controls this. The business side of practice and talking about money is something that is dealt with in order that the more important work associated with building a relationship with and getting to know their client can be undertaken.

### ***5.10 Importance of the Relationship to Midwives***

The value of the midwife mother relationship and the continuity of care which facilitates the building of the relationship is seen as being crucially important to the work of midwives (McCourt & Stevens 2010, Hunter 2006, 2005, Hunter et al 2008, Kirkham 2010b, Lungren & Berg 2007, Fahy et al 2008, Hunt & Symonds 1995). In this study the relationship appears to take on a particular significance. It becomes a very important tool to the midwife, one way of ascertaining the well-being of both mother and fetus and also how they feel they are able to tune into the needs of the women in order that appropriate individualised care can be given. Erica (MW1) believes that knowing the woman well enables the midwife to detect when something is not right and the time available to Independent midwives enables exploration of these issues in a way that is not always possible within the NHS. This carries through in terms of benefits into labour, as things that the midwife would have to be doing in labour in order to support her when she is not known to the midwife or not known very well, as in NHS practice, are already known and in place, and the woman can “just be”:

*“When you know a pregnant woman and you go into her home you can sense that something is not quite right, she is out of sorts today and sure enough you*

*find out over a period of time whether it is physical or emotional, but during that session you can find out what it is when you walked in which you do not get in a 15 minute doctor's appointment. They could be frustrated about because they have got to go and pick their child up from school . . . the opportunity for really understanding a woman and what makes them tick, when you see her frequently through her pregnancy and it means that when you are in labour you have not an urge to keep checking things.” (Erica MW1)*

This sentiment is echoed by Chloe (MW4) who feels she is able to detect when things are not right, and therefore feels that she is able to take action earlier because she knows the woman so well. In this case this possibly resulted in saving the baby's life:

*“I had a very ...experience with a couple who had been in early labour at home for a while and she had been sick and I had phone contact with them and I ended up going late afternoon and I could just tell straight away, because I knew her so well that she was not well, she looked really pale and grey and I just thought what is this vomiting, cos' she had been really, really poorly all day....” (Chloe MW4)*

Freya (MW 16), an experienced Independent midwife, was very clear about the value of the relationship and how in particular the building of trust helps the midwife as well as the woman. She recognises the potential of this as a tool for detecting when things are not quite right. She uses an example of how her colleagues, when she worked in the community when in the NHS, did not like it when women achieved a good relationship with her and asked for her when they went into labour. This she said, made her colleagues feel that they were

not good enough, and that this was not the case. The fact was that there had been a considerable investment of energy on both sides between midwife and mother that had resulted in the crucial trust being formed:

*"...But what they hadn't recognized was that actually it wasn't that they weren't good enough it was because I had worked with that women through all her antenatal pregnancy and we had got a huge way down the line of really trusting each other. And that is such a huge issue, that if a women can trust the person she is with for a start it works better for you as a midwife, she will birth better if she trusts you. But as a midwife if you know that something is not quite right, or you are a bit worried about something, and you have worked with somebody right through their pregnancy she is going to trust you. And so you are less likely to get into a sticky situation even if it's only an instinct." (Freya MW 16)*

Jemima (MW18) echoes Freya's (MW16) sentiments, that the relationship is a tool for safer midwifery practice. The formation of this relationship antenatally means that understanding what the woman wants and how to support her in labour is much easier:

*"...if you know the women well and you know what they want and you know what they like antenatally it's so much easier to look after them when they are in labour. And it's so much easier to pick up when things aren't right and things are going wrong. So for me initially it was the fact that looking after someone in labour that you knew was so much easier because you knew them. And I think often midwives do an amazing job to make that initial bond with women that they have never met before in labour, and make that women feel good about her birth experience. But it takes an awful lot more effort." (Jemima MW 18)*



Milly (MW12) indicates how important the formation of the mother midwife relationship is from early in pregnancy. She indicates that she is reluctant to take on the care of a woman late in her pregnancy because she feels there is insufficient time to get to know her well enough to care for her appropriately and that she would be uncomfortable in taking on the care of a woman in these circumstances:

*“They would have to do an awful lot of persuading! Because I just do not know them! Initially people can appear to be something other than what they are and you do need that sort of on-going thing to get to know them properly I think.”*

*(Milly MW 12)*

Several independent midwives talked of NICE guidelines in rather scathing terms. Freya (MW16) draws attention to the N.I.C.E. antenatal guidelines (NICE 2010a) and talks about the fact that they refer to reduced antenatal appointments which coincide with scan appointments. Following this model, for her is about obstetric care not midwifery care and reduces the opportunity for social support and interaction with the midwife, and if followed literally reduces the opportunity for the development of the mother midwife relationship. This for Freya (MW16) was something to be challenged:

*....“I was going to go back to “holding the space”, as a midwife because the women, and you hopefully, have put all that work in, and this is where there is a huge hole in these NICE guidelines, they are saying you cut it down to 3 antenatals, for scan appointments or is it five? They are not talking about midwifery care that is obstetrics and we must fight back against that!” (Freya MW16)*

It is clear from the midwives accounts that the mother midwife relationship in the context of Independent midwifery takes on crucial importance. It appears to be viewed as an essential tool for the midwife's tool-kit, and is something that takes time to build effectively. It appears to be seen as a risk management tool in some respects, allowing midwives to tune into women's needs whilst also being able to be alerted to deviations from normal. Thus, in stark contrast to what often occurs in the NHS, situations where the mother and the midwife have little time to form this relationship are avoided with the intimation is that it is "risky" to do otherwise.

The following section continues to detail the study's findings in relation to the mother midwife relationship and looks specifically at the communication skills associated with the building and development of rapport with clients.

### ***5.11 How the Relationship is Built***

When telling the story of how they built relationships with the women in their care, the participants tended to be rather dismissive of the complex interpersonal skills they appeared to have developed. Much of the credit for these enhanced relationships was placed on the model of care and the increased time that Independent midwives have available for this. However, amongst the stories there was evidence of awareness and attention to skills associated with good communication which accords with the considerable body of literature that details the skills of good communication and counselling (England & Morgan 2012, McCorry & Mason 2011, Sully & Dallas 2010, Arnold & Underman Boggs 2010, Belzer 2009, Donnelly & Neville 2008, Freshwater

2005). Several midwives in this study indicated that they had sought additional training in relation to improving their skills or having to re-focus their skills in order to enact the principles of the “with woman” philosophy as an independent particularly in relation to giving non-biased information to women and their families. They recognised both the importance and the potential of having enhanced skills and the implications of these for midwifery care and the service they could provide for women and their families. Also, there was the recognition that good communication skills served as a protection for themselves as midwives to help avoid “misunderstandings” with clients that could result in dissatisfaction with care and possible litigation.

#### **5.11.1 Skills Needed: Listening and Non-verbal Clues**

When asked what skills she felt she had learned as an Independent midwife, listening was a key feature for Lydia (MW10) who listened in order to hear what the woman wanted whilst also noting body language for additional clues. She also listened for her own benefit, to make sure that she did not miss anything that could render her vulnerable, and she, like so many others was acutely aware of her vulnerability as an Independent midwife:

*“I have learned to listen to the women, to listen to the things that they are saying and the things that they are not saying. To look at how they behave and perhaps even though sometimes people have been damaged by their experience that there are reasons behind why they behave the way they do. But also to listen to safeguard myself because working as an Independent midwife*

*you are kind of standing well on the margins, listening for my own satisfaction as well.” (Lydia MW10)*

Milly (MW 12) also thought that listening was one of the most important skills that she had learned as an Independent and as a midwife, she talked about a particular ploy that she employed when she was meeting women for the first time that helped her to listen and to tune into the needs of the woman:

*“I think I always found it reasonably easy to form relationships with women, but I think it is about listening actually. It is about ...when I go and see a woman for the first time I just sit there and I say, I would just like you to tell me your story and about what you are looking for and I am just going to listen, and I reflect bits back at them, did I understand that rightly?” (Milly MW 12)*

Milly (MW12) found that undertaking a short counselling course had helped her in her work as a midwife. She recognised that this was not something that she had been taught during her midwifery training but that she had learned subsequently, this has been echoed by other midwives:

*“I did do a little sort of counselling skills course for about a couple of terms, it was an evening class sort of thing. What I learned there has been really very useful. About reflecting back and the art of listening and I think that if women feel that they are being listened to you are 80% there really. That is the crucial thing that was not part of my midwifery training at all but something that I have done previously.” (Milly MW12)*

Jemima (MW18) talked about how she learned to build relationships with women and reiterated Milly’s (MW12) sentiments about midwifery training.

Jemima (MW18) went further however, and indicated that from recent

experience of working with newly qualified midwives who want to become independent practitioners there are skills that have to be learned and those that have to be unlearned:

*"...it certainly wasn't anything you learnt in our training; I don't think they learn it now. Because I am aware particularly when we had these two midwives come out straight from training, they have quite a lot of unlearning to do before they, they are very competent midwives but they have a lot of unlearning to do before they can feel comfortable as independent midwives." (Jemima MW 18)*

Esmie (MW9) felt that to some extent being good at communication was something that you either could or couldn't do, but acknowledged that some aspects can be learned. She talked about the influence of midwifery role models who exhibited qualities that she had admired as she had progressed through her midwifery career and how she tried to incorporate the bits that she liked into her own practise; similarly if she came across negative traits she made a conscious decision not to adopt these:

*"There was a lovely midwife she was very softly spoken, very quiet, would listen really nicely to a woman and that was what I took from her...to sit and listen and to be quietly spoken sometimes. It is just really interesting the different people that you meet, and if there was someone that I didn't particularly like, I thought well, I'm not going to be like that, I must remember not to be like that, and so taking certain things away with me. I think that is how as a newly qualified midwife you grab all the special things that you take from the wonderful people, the wonderful midwives out there, and that forms how you will practice and how*

*you are with people. I think... the communication side, it is something that you can learn but it is something that you generally have in you.” (Esmie MW9).*

This section provides insight into the importance placed on the skill of listening by this group of midwives, listening in order to meet needs but also as means of protection. The business and professional side of their relationship building with clients, which is about providing a service for which their clients pay, puts listening into a particular context. They need to be able to clearly understand what a woman wants. Midwives also imply that the skills for this were not really learned during their midwifery training and that although a lead was taken from clinical role models, their role as an Independent midwife had required them to re-orientate and unlearn some of the approaches to interpersonal skills. The art of listening to women, really listening to women featured highly on many of the Independent midwives lists and being able to listen effectively was seen to be facilitated by time. Closely allied to listening was the ability to notice and interpret non-verbal clues and body language. Esmie (MW 9) talked about her thoughts on this matter particularly in relation to working with a midwifery colleague when they were aware that something was “not quite right” and they did not want to worry the client at that point:

*“All the jobs that I’ve ever had I’ve had to communicate with people so, I’m not saying that I did it very well, and I still think that I have a lot to learn but I think that now I do listen a lot more. And that is interesting as well to talk about non-verbal clues, because quite often when I think about times at home births with a colleague of mine.... quite often when we were at a birth together, it is all these non-verbal cues that you give each other...I’m looking, that doesn’t look quite*

*right, you know, we do these odd little facial expressions and we would be able to read each other that way, so it was really quite interesting, the non-verbal stuff that goes on. But then you have to be very wary that other people can pick up...members of the public can pick up on that and so it's having a lot of tact, you have to be careful that you are not ....if you are worried about something not to make it too obvious.” (Esmie MW9).*

In addition to being able to read body language midwives also talked about how they started to build rapport with clients and that this started from their very first meeting. For Phoebe (MW 14) first impressions and getting this right for individual clients appeared to be an important consideration. This involved a bit of preparation in which she tried to gauge “where the woman was coming from”, in order not to offend or alienate her and make her feel at ease and also perhaps to stand a better chance of getting the case! This assessment of the woman would start from thinking about the area where she lived, her address, how she made contact, so that “clues” could be assembled. Phoebe (MW14) indicated that women often used email as an initial contact with her and how this did not enable her to pick on “clues” from say a telephone conversation. As a result Phoebe (MW14) would try to call the woman on the phone, prior to their first meeting in order try to tune into the woman by means of verbal communication, prior to actually meeting her. Phoebe (MW14) also tried to gauge from all of this information what sort of clothes might be appropriate for her to wear to their first meeting in order to make the woman feel most at ease: “....when I go for that pre-booking meeting, to try and gauge where the woman is coming from. Whether to dress appropriately whether you'd put them off if

*you wore an A line skirt and heels when they really want you in your boots and cords, or whether they want you to be smart formal and professional. So I try and gauge that from where they live but also the conversation we have had. But that is getting more and more difficult when the first point of contact is becoming more and more by email. So I try and telephone and arrange that pre-booking meeting as far as possible, so at least we have talked down the phone a little bit. On email it is quite difficult to gauge where they are coming from.” (Phoebe MW 14).*

Phoebe's (MW 14) approach to and preparation for the first meeting with a client bears some comparison with that of a job application, which of course to some extent this meeting is. Knowing which sort of approach will facilitate the building of rapport and a trusting relationship requires the midwife to assemble a number of clues, in the form of information. This information is quite sketchy at first until the first meeting. From their narratives midwives indicate another important interpersonal skill midwives used to develop relationships was that of being able to chat. Here Amy (MW17) talks about visiting women for an antenatal examination and how the actual physical examination took a relatively short time but the chatting part took much longer. Chatting served the function of adding to the midwife's knowledge of the woman and this in turn helped her to give the woman the appropriate care enabling the midwife to work with her strengths and to be aware of her fears:

*“...a lot of the time during the pregnancy and the run up to the birth it's just spent talking. Obviously we do the ante natal checks and everything else but for 5 or 10 minutes and probably about an hour is spent just chatting. And it could*



*be about the weather, it could be about a shopping trip they went on last week, but just getting to know them as a person. And finding out what makes them tick and what makes them anxious or what makes them feel strong. And within that we do discuss what their hopes are for the birth.” (Amy MW 17)*

Chatting has been identified elsewhere as an important clinical tool that facilitates care (Fenwick et al 2001) and helps to build understanding and relationships (Morse 1991, Appleton 1993, Tojan & Yonge 1993, Darbyshire 1994, Williams & Irurita 1998), and as such has been seen as a powerful clinical tool (Fenwick et al 2001). In an Australian study (Fenwick et al 2001) that sought to explore how chatting was used by neonatal nurses when attempting to facilitate mothering, found that nurses who chatted with parents were perceived very positively by them, and that this opening up of dialogue that was focused more on life outside of the nursery, enabled the building of rapport and trust, and a way of getting to know the woman better, which in turn facilitated a better understanding of needs and therefore the giving of more appropriate tailor made care. As both parties chat there is the opportunity for self-disclosure and the potential for this to increase over time. Work in the area of reciprocity identifies how important the sharing of information is in the development of positive relationships (Kasch et al 1987, Hunter 2006). These findings have much resonance with the findings of this current study. An interesting other finding was that women interspersed serious concerns or questions about their babies in amongst this chat, enabling them to voice concerns and anxieties that perhaps would not have been possible in its absence (Fenwick et al 2001). This

issue will be discussed further a little later in this section under the heading of “time”.

Forming the relationship with women and their families appears to be a source of great satisfaction to midwives and this combined with an understanding that women want someone to be interested in them and their pregnancy is something that Amy (MW17) expresses:

*“...biggest thing I like is being able to build that relationship up, not just with the women but with their families as well. It’s such an important time to women, and whether they are planning a hospital or a home birth, most of them are just wanting to feel that somebody is actually interested in their pregnancy.” (Amy MW17).*

In order to facilitate trust between midwife and client many Independent midwives talked about the need for honesty in communications. Esmie (MW9) describes how she does this:

*“it is really important to be truthful to people and I’ve always said that if the baby has gone to the resuscitaire and it is not breathing, I’ve said to the woman, “Your baby has gone to the resuscitaire and it’s not breathing, and they will try and get your baby to breathe”, rather than say it is going to be alright, because I know that there are times when it is not alright. I think that is one of the important things, is being honest with them and not saying it is going to be alright, my darling, my love and all that..... I keep using that word affinity, but it is, it is having the common sense to be truthful.” (Esmie MW9)*

For Amy (MW17) the issue of being honest and up front with a woman about her expectations of the birth and things that might concern her as a practitioner

and in particular make her sufficiently concerned to want to transfer the woman into hospital are discussed antenatally. She felt that if this situation arose in labour and trust has been established, the woman then understands if a move into hospital is required there is a good reason for this:

*“...we also talk about what our hopes are for the birth, and situations perhaps that would make me feel uncomfortable and where I might need to say to them, ok something is not quite right, I don't know what it is, but something is not right here and we might need to start thinking about transferring in. And to be able to do that without always giving a good reason for it you need to have that element of trust there.” (Amy MW17).*

Working towards a mutually trusting relationship appears to be what Amy (MW17) is implying here. The woman needs to feel she can trust the midwife and the midwife to feel she can trust the woman. For midwives this is linked to really understanding the expectations of the woman and her partner, their hopes and fears and what they want from their midwife. The midwife has to negotiate this to ensure that she can trust the woman to understand her professional responsibilities. Women's needs that have not been met can leave the midwife vulnerable with the potential for her client to ignore her professional advice or to report her to a Supervisor of Midwives:

*“I have been lucky in that all the clients I've had that relationship has been there, and I think it must be very difficult if you are trying to work with a client where that trust isn't available. And I know it does happen and I think sometimes that's a lot of the time when it goes to supervisors because the women's expectations are different to ours. And I do think we do enter the*

*relationship with some expectations as well, it's not just the women.” (Amy MW17)*

This section details the interpersonal skills that Independent midwives feel are important and why they feel they are important. They are very much aimed at understanding the needs of the individual woman in order to try to meet these. It is also about the establishment of mutual trust. The importance of the establishment of a trusting relationship with childbearing women has been well documented (Meyer 2012, Phillips-Salimi et al 2011, Hunter et al 2008, Lungren & Berg 2007, Coyle et al 2001). It has also been acknowledge that both time and continuity of carer facilitate this process (Hodnett et al 2008). It is therefore unsurprising that in a situation where midwifery care is organised on a tailored one to one basis and there is a luxurious amount of time available that the issue of time is mentioned by the midwives in this study as being extremely important.

### **5.11.2 Time**

Esmie (MW9) like so many Independents, talks about the issue of time and how this facilitates the mother midwife relationship. Their experience of having more time to undertake their work is seen in sharp contrast to what they have experienced in the NHS. Having more time to support women's needs for information is seen as particularly beneficial for women:

*“I am finding that because you have more time as an Independent midwife, women will talk to you for as long as you will talk to them. So where in the NHS as a community midwife you might have...well, I used to have 15 minute appointments, an hour for booking. My bookings are two hours!! Women get all the information that they need, I have a good selection of books that, because I*

*am not having lots of clients I can actually refer them to...A lot of the AIMS books are really well written and very informative and I think women are really....they are like sponges, they want to learn as much as they can about their pregnancy and want to have a gathering of information.” (Esmie MW9)*

Erica (MW1) sees the time available to the Independent midwife during an antenatal appointment as an opportunity to further develop a trusting relationship. This may well involve the exploration of other aspects of the woman’s life and because the appointments take place in the context of women’s lives it becomes another opportunity to tune into the woman’s needs, and a way of understanding and knowing how best to meet them:

*“...I’m not watching the time at every appointment, and if during the course of it you are down the garden talking about vegetables it really does not matter, because it is all part of developing a trusting relationship. I am my time keeper, I am my manager and it just means ....the whole point is.... it is all geared around the woman and what the woman’s needs are.” (Erica MW 1)*

When asked about the skills associated with forming relationships with women Grace (MW 2) felt that it was more about having time to spend with the woman and her family:

*“It is different for each person; I think that you have got to find out what each person wants from you, and where they are coming from. It is just a time thing, I am sure; it’s just a time thing...” (Grace MW2)*

Bethany (MW3) was also clear about the benefits of having more time as an Independent midwife to build relationships with women:

*“It was definitely that I could spend as much time as I wanted with an antenatal, you know, I could go for a couple of hours, we’d have a cup of tea and a piece of cake and nobody was telling me that I have got to be back to do aqua-natal or 16 visits to do this afternoon. So that really made a big difference...”*

*(Bethany MW3)*

Red (MW20) also identifies that the building relationships and trust with women takes time, and it also helps to know how to best support her:

*“I think that is so important, creating a relationship with women is having time as a midwife to find out what you need to know in order to support her. And time for the relationship so that you can build that sense of trust together.”* (Red

*MW20)*

Time and exposure builds relationships plus the ability to be empathetic and to have good listening skills and the ability to chat appropriately (Fenwick et al 2001). It is seen to be about enabling, empowering, the need to achieve rapport, empathy and trust. Phoebe (MW14) talks about the rewards of listening to women and how time to do this is one of the many advantages of working as an Independent midwife. However, there is also an acknowledgement that midwives have to be sensitive to not overstaying their welcome, to be mindful of the woman’s body language, and sensitive to the fact that they as midwives are working in the context of a woman’s lives:

*“...really listening to what they have to say and giving them the time, and having the time to do that is huge, but also being sensitive to whether they have the time because some of the women want to be very matter of fact and want to fit you in amongst everything else that they do in their lives or whatever. They very*

*much begin to look at their watch after a while and all that body language you have to be very, very aware of. I just feel so fortunate to be able to work like this because I allow two hours for each antenatal, so you can't help but build a relationship.....It is a very different kind of relationship (being an Independent midwife). Within those two hours, obviously you have plenty of time to use listening skills and to reinforce that you are really there for them and that you are really wanting to hear what they have to say and understand where they are coming from, and to explore hope and fears and to find out how they would cope if it is plan B rather than Plan A for the birth. It is very interesting how one to one care, giving that sort of relationship influences the sort of birth that these women have. Just look at our outcomes!" (Phoebe MW: 14)*

A number of the midwives in this study raise at several points the contrasting experience of working as an Independent midwife as opposed to working in the NHS. They voice their concerns about the current NHS maternity provision and the influence of NICE guidelines. An example of this is raised by Jemima (MW18) in relation to time and the reduced schedule of antenatal appointments (NICE 2010a) where she sees this as a reduced opportunity for women to explore issues of concern with carers:

*"..they don't have time to ask questions. You remember when all women were coming to the hospital clinic and they were waiting 2 or 3 hours to be seen for 2 or 3 minutes, when offered the choice of less antenatal visits they jumped at it. But there was supposed to be things like a help line and a drop in thing put in place and that didn't happen. So we have cut back on the antenatal*

*opportunities for women to interact with their carers without putting anything else in place.” (Jemima MW18).*

Time allocated for appointments within the NHS is also seen as very limiting by Milly (MW12) and even within Independent midwifery she has found that when a woman has asked her to pay her a visit it is often not until she indicates that she is about to go that the woman might actually disclose what it is that is troubling her. Milly is very scornful of the limitations of what might or rather might not be disclosed in the NHS during very time restricted slots and the false economy perhaps of this approach:

*“...and all this... you should be seeing x-number of women in x- amount of time, fifteen minute slots for antenatal. I think for God sake what can you do in that time! It is ridiculous! When I go and see my women, nothing is shorter than an hour! Nothing! You sit, you chat and you listen. It is often a time where you start to go, you think that you have done it all, and you start to pack up your stuff and then that’s the moment that they actually say the thing that they really want to say. You know, your hand is on the door and they say, oh.....so you sit down again and then it comes out, the real reason for the visit and stuff. And that you just cannot do in this time slotted antenatal or postnatal thing! I don’t rush myself you know! (laughs). You can see that they want their value for money out of their staff and all the rest of it, but it depends on how you define value for money, doesn’t? It is all very depressing really!” (Milly MW12)*

This chapter has considered the midwife mother relationship from a number of perspectives as perceived by the Independent midwives in this study. There are



many areas of overlap with previously published research findings relating to the mother midwife relationship however, areas not previously discussed because of the particular dynamics of independent practice have been made visible. Midwifery in any care setting is very challenging, the ever growing expectations of those that use the service make for challenging clients who are aware of their rights and are equipped to question. Independent practice has the potential to attract those women who are seeking a more tailored personalised service who may have been affected by previous traumatic life and/or childbearing experiences, which may be associated with lack of control. In this study Independent midwives appear to be strongly motivated to enact the “with woman” philosophy encapsulated within the rhetoric of contemporary midwifery literature and government policy. The opportunity to form meaningful relationships is facilitated by the case-holding model of care and the time independent midwives are available to devote to this activity. The formation of relationships is much more than a pleasant social activity born out of an interest in childbearing and childbirth and women. It is portrayed by the midwives in this study as a pivotal midwifery skill which provides the vehicle for supporting the transition to motherhood and parenting, personal development for both mother and midwife. The perception of the potential of the mother midwife relationship in this context to facilitate healing, and also to act as a risk management tool is particularly noteworthy. The time and continuity of care that is available to Independent midwives facilitates this process.

The strong motivation to enact the “with woman” philosophy can also place midwives in a vulnerable position. The trust that midwives strive to develop with

women also needs to be reciprocated by the women themselves. A midwife trusts a woman with her registration, trusts that she will listen to her and take her professional advice when for example she wants to transfer a woman into hospital if progress deviates from the normal. There is also evidence that when women do not place the same significance on the mother midwife relationship this is experienced as emotionally difficult for this particular group of midwives who have invested so much of their personal careers in being able to enact their strong sense of “with woman” relationship.

The following chapter represents the final findings chapter of this thesis. In this chapter Independent midwives recount their lived experiences of working in independent practice.

## **6 The Working Lives of Independent Midwives**

### ***6.1 Introduction***

This chapter details the research participants' perceptions of their working lives as Independent midwives in the United Kingdom, and as there has been little research in this area, these findings constitute part of this study's original contribution to knowledge. Aspects of their experience have been echoed in other studies that have examined the experience of midwives that have been able to provide continuity of care and/or work a case-holding model of care (Allen et al 1997, Hart 1999, Benjamin et al 2001, Stevens & McCourt 2002a, b, Stevens 2003, Fleming & Downe 2007, Davis et al 2010), however, this study extends our knowledge of working in this way because of the smaller caseloads and the very tailored individualized care that can be provided. This chapter also highlights a number of unique dimensions that are particular to Independent midwifery practise in this country (UK) and to this moment in time. One of these is the self-employed status of the midwives and the fact that women select and engage their services and pay an agreed fee directly to them. Thus, midwifery and the "with woman" philosophy is also enacted within the context of a business relationship where the woman is very overtly the consumer of a service provided by an individual midwife who is personally and professionally accountable for this and, whom she has chosen and employed to best support her needs. This perspective illuminates a number of interesting dynamics, not

least the potential tensions that exist within this for both the mother and the midwife as will be seen as this chapter unfolds.

There have been a number of important contextual issues that have perhaps influenced how Independent midwives have perceived their working lives during this study and particularly during data collection. The most important of these is that of the impending demise of Independent midwifery in its current format due to the enactment, (on 25.10.13), of European legislation requirements for compulsory professional indemnity insurance (PII) for all healthcare providers. It has been suggested that the best way to ensure there is compliance with this requirement is to make this a condition of on-going registration (European Parliament and Council of the European Union 2011, NMC 2013a). Independent midwives are unable to access adequate PII and therefore are unable to fulfil this requirement (Department of Health 2010) and despite investigation into a possible solution to this (RCM & NMC 2011a) the future for Independent midwifery is at best uncertain and at worst in danger of imminent demise. It is hardly surprising, given the major implications of this issue, that this subject has featured in their narratives.

This chapter has been organised largely in an order presented by the research participants themselves, and details under key themed headings their lived experiences as Independent midwives. These initially relate to their initial impressions of being an Independent midwife, and the transition associated with this. This is articulated in terms of perceived “liberation” from the “incarceration” experienced whilst working in the NHS. This relates not only to professional and personal autonomy and their associated skills but also to enhanced learning

and understanding of childbearing women. Reference is also made to their highly supportive peer networks and organisations which are experienced in a way that sharply contrasts their experiences of peer support in the NHS.

Whilst there are many glowing accounts of what it is to be an Independent midwife, there is also evidence of new constraints and vulnerabilities that influence their practice, with the suggestion that work/life boundaries are not as easy to define as when working within the NHS. Finally midwives share their perceptions of the future of Independent midwifery. The following section details experience of the transition from NHS midwifery practice to that of being an Independent midwife.

## ***6.2 Transition to Independent Practice***

Moving from the NHS and into Independent midwifery practice for the midwives in this study, even although this was a well-considered decision, presented them with challenges. From a philosophical “with woman” and feminist perspective midwives reported great angst at leaving the NHS and for many this move involved wrestling with their conscience. The “with woman” philosophy that had been instrumental in their initial move into midwifery in the NHS also influenced careful consideration of the morality of leaving it. For in moving into an environment where this philosophy could more easily be enacted the midwives were also leaving behind the majority of childbearing women who could not afford to engage the services of an Independent midwife. The ethical and political issues associated with this for those with a strong feminist consciousness was experienced as guilt, guilt in terms of the perception of not having tried to do something more to help all women. Here Red (MW 20)

articulates exactly these sentiments claiming that this had delayed her move into independent practise:

*“One of the things which held me back from going independent was that sense that every women deserves good maternity care, and in an independent practice you can only offer that to women who can afford to pay for it, which predominantly means white middle class women. And I really struggled with that because I wondered how ethical it was to be taking myself out of where it felt I was needed most”. (Red MW 20)*

Brigid (MW 13) as a very experienced midwife also felt this guilt keenly and for her this is something that had never really gone away:

*“I was aware of the Independent Midwives Association and various friends had said, why don’t you go Independent? But I felt badly that I should stay within the National Health Service and fight. I still have a conscience, should I have stayed within the NHS and fought it, and to only look after women that can afford to pay me is something I still find difficult. But then if I don’t value myself how can I be expected to be valued by others?” (Brigid MW 13)*

Some of the midwives attempted to rationalize this guilt by indicating that the pressures and stress of working in the NHS were such that they were becoming burnt-out and rather than leave midwifery completely they decided that Independent midwifery offered an opportunity to provide good quality maternity to a few women, admittedly those women that could pay, and still practise midwifery which they felt was very important to them and to the midwifery profession in terms of retaining rather than losing midwifery skills and expertise. Both Red (MW20) and Jemima (MW 18) articulate these ideas:

*“I felt like I was deserting a sinking ship, I felt like the NHS is just... I feel awful saying this because I feel so strongly that the NHS is a wonderful thing. And that health care should be free to all, good health care. But it’s not good health care, it’s over stretched, under paid, grumpy, stressed out people doing the best they can with the minimal of resources. And I felt like how can I leave and leave all these other midwives to cope with it? So I did feel an enormous sense of guilt at leaving it but the guilt was actually more towards the women I was leaving and the midwives”. (Red MW 20)*

*“A lot of people say you should try and fight the system, you should stay within the system and fight the system, and I think you should for a bit but I think there is only so much you can do down those lines and then you get out for self-preservation. Because you see midwives getting burnt out within the NHS. And we are losing good midwifery expertise”. (Jemima MW 18)*

Some midwives were very candid about leaving the NHS because they could not practice in the way that they wanted, and what they perceived to be happening within the NHS and how this was unacceptable to them. They could not be the sort of midwife they wanted to be. These findings coincide with those of other studies that have identified these emotions as a trigger for midwives leaving the profession (Curtis & Ball 2006, Hunter 2004). Here both Chloe (MW 4) and Lydia (MW 10) express their feelings in this respect:

*“I have great respect for the NHS and I really, really wish that I could do this without having to leave the NHS but unfortunately it just does not work like that”.(Chloe MW 4)*

*“I would love to work as a midwife within the NHS; I can’t do it because it makes no sense to me what is going on at all. In fact what is going on is not what should be going on and that I really could not be doing with!” (Lydia MW 10)*

Once an Independent midwife the midwives referred to a transitional phase which appeared to vary in length from midwife to midwife, during which they acclimatised to the more autonomous ways of working, and an understanding that they were now able to more fully enact the “with woman” philosophy and were free of the constraints imposed by the NHS. This period was experienced in a number of ways, from the unlearning of NHS ways of doing things to the “re-learning” of others and often from a different and more women-centred perspective. Gaining an enhanced knowledge of childbearing women and birth, communication skills and taking responsibility, in partnership with women, for clinical decision making were highlighted as key areas of learning. The period of time required to acclimatise to a model of practice that is philosophically different to the traditional medical model of care, as in case-holding practice, has been identified by other studies (Allen et al 1997, Stevens 2003, Page 2003, Davis et al 2010). Transition into independent practice demonstrates some shared experiences as Erica (MW1) indicates. It is interesting to note that she also feels that the length of time she has been an Independent is longer than it has actually been. This perhaps is indicative of the perception that time has slowed down in Independent midwifery practice in comparison with the speed of working in the NHS and as evidenced by the midwives stories in the previous chapter. The issue of time and the concept of ‘fast’ and ‘slow’



midwifery will be explored more fully in the discussion chapter as the concept of time has been identified as a key underpinning concept within this study.

*“I have been Independent for a year and a half. It seems like much longer, finally the NHS is fading from my memory which is good, because I think you have unlearn a lot of it.” (Erica MW 1)*

For Bethany (MW 3) the new found autonomy and freedom from hospital policies and risk management strategies and the pressure that she had experienced whilst in the hospital setting to comply with these, was gone as an independent. However, it took a while for her to stop “hearing” the nagging and to realise that she was now personally accountable for making the decisions based on her knowledge and clinical judgement of individual situations. She found that this experience was accompanied by self-development. Although not sharing the same degree of autonomy experienced by Independent midwives, self-development has also been reported in studies of midwives making the transition to case-holding practice (Stevens 2003, Stevens & McCourt 2002a, b, Page 2003, Fleming and Downe 2007).

*“I suppose.....coming from a hospital.... being a hospital midwife you still have got all those voices, Yak! Yak! Yak! Policies! Risks! Don't do that! But, I think that you develop that much more as an Independent or as a community midwife as well, because you are that much freer”. (Bethany MW 3)*

For Amy (MW 17) one of the biggest areas of learning was the different approach to information giving as an Independent midwife. This was no longer about telling women what the NHS was offering but what was really on offer, the full range of choices. She noted how differently Independent midwives gave this

information. It was not about making the women comply but attempting to give them full information and then trying to support their choices. This would appear to coincide with a philosophical movement from being “with institution”, a stance characterised by highly medically orientated environments and which have been highlighted and criticised in midwifery literature (Kirkham 1987, 1991) to being one of being more “with woman”:

*“Because I was trained by the NHS, so you are used to feeding information in a certain way, and it’s just being able to listen to how the Independent midwives give that information without making it sound as if they (the women) have to. So, that was a big learning curve. I think one of the first times I realised that I had to be careful about what I was saying, I thought I was quite good actually, So just a very different involvement and whole approach. I don’t think I could commit to working there (NHS) full-time, because the options they offer and the informed choice aren’t really informed choices. Information about what the NHS is offering or willing to do but not what is really available”. (Amy MW 17)*

For Grace (MW 3) moving into Independent midwifery was not so much about unlearning but rather a change of perspective and as for Erica (MW 1), this process had taken about a year to complete. The perspective that she had to learn was again around the political stance of and facilitating of “real” choice for prospective parents rather than getting them to comply with NHS services:

*“I don’t think there was anything in particular that I had to unlearn . . . it is more a different perspective, and it’s taken me the past year to change my perspective from like, NHS this is the care you get, and this is what you have to have, to . . . this is the NHS and this is what they are offering you and if you want it take it,*

*but you are entitled to take it or leave anything that they are offering you”.*

*(Grace MW 2)*

Thus, it can be seen that becoming an Independent midwife requires changes in behaviour to fully enact the “with woman” philosophy. This strong mantra of independent practice requires the NHS orientated midwife to change the socialised behaviours of the NHS and become “assimilated” into a “with woman” culture with different sets of behaviours. In perhaps rather simplistic terms Maslow’s hierarchy of needs (Maslow 1970) offers an explanation of this in that individuals need to “fit in” to a culture as one of the requirements towards self-actualisation. The cultural environment that midwives enter into in this case however is one that they have chosen because it more closely aligns with their personal philosophy of midwifery. The rhetoric of this “ideal” form of midwifery is indeed seductive, with its potential for professional liberation and enhanced autonomy. But living the “dream” does appear to come with constraints from other quarters, as will be seen as our discussion progresses.

Both Serena (MW15) and Amy (MW17) moved into Independent midwifery directly on qualification, unlike others in the study who worked for varying periods of time in the NHS and in various care settings (delivery suite, postnatal ward, community) before going independent. Even though this was the case Serena (MW15) indicated that she experienced a “steep learning curve” on moving into Independent midwifery. Students on qualification do experience a “steep learning curve” even within NHS practice as they take on the responsibilities of a midwife and for this reason preceptorship, is recommended for a period of one year (NMC 2006). This process in independent practice is

intensified as the level of decision making is very different and the clients include both low risk and a significant proportion of high risk and highly complex women (Symon et al 2009, 2010). Serena (MW 15) indicates that she was also required to think of alternative approaches to care that involved a considerable amount of reading and learning in order to meet these women's needs. Many of the texts that she needed to access were new to her and not previously recommended during midwifery education:

*"I did have to very much learn another way; it was a very steep learning curve. Not only in terms of experience but in terms of reading, so I probably spent the first couple of years after qualifying reading all the right books which were not of course on the curriculum at the university, none of them". (Serena MW 15)*

For those midwives who practiced within the NHS there appears to be a variety of experience of early encounters with Independent midwifery. Jemima (MW18) had considerable experience as a community midwife. She had been able to enact a reasonable level of continuity of care and had experience of home births. For her the "socialisation" was more gradual:

*"I think because of the way we have been able to organise our community the unlearning that's happened for me has been gradual stuff. And its things like physiological third stage, I had physiological third stage but I could only see one or two as an NHS midwife. We rarely have an actively managed third stage in our practice, we give people information, and I don't think we've had one for 3 or 4 years. We use Syntometrine when we need it or if you think you might have a retained placenta before transferring in you might use your oxytocics. But that is a gradual sort of learning thing, and learning to do less." (Jemima MW 18)*

Jemima (MW18), whose independent group practice has supported both student midwives on elective placements and also midwives moving directly into independent practise following qualification, indicated that a key area for midwife learning and orientation was that of language. Medicalized language needed to be challenged in order to reflect the philosophy of Independent midwifery:

*“When we are talking, they are always having to think about their language because they have been using medicalized language for such a long time. And while you are talking about language you are also talking about ethos and ideology as well aren’t you?” (Jemima MW 18)*

But even for experienced midwives the early experiences of Independent midwifery involved a steep learning curve. Here Rhianna (MW7), a very experienced hospital based midwife articulates exactly this:

*“So I went Independent and it has been a steep learning curve as they say, but never a truer phrase.” (Rhianna MW 7)*

Moving into Independent midwifery was seen by many as “taking a chance” however, none of the midwives interviewed indicated that they had regretted this decision and articulated the move in a very positive light:

*“And then I took the chance on setting up my own practice, so that is back in 2004, quite some time ago. I just made the break and it was the best thing I ever did, it was a lovely, lovely way to work”. (Angel MW 19)*

This section has explored the experiences of the midwives in this study as they made the transition from NHS midwifery practice to that of independent practice. This appears to be associated with acclimatisation to the knowledge,

skills and responsibilities associated with a professional philosophy which has been aspired to for some time but has not been able to be fully enacted. In order for this to happen they had to actively disengage from socialised behaviours learned whilst practicing midwifery in the NHS and that had constrained their autonomy, scope of practice and their ability to respond to the individual needs of childbearing women. From analysed transcripts this process appeared to take between 1-2 years and was associated with a “steep learning curve”. This transition period also involved thinking about meeting women’s needs in more flexible and alternative ways, offering the full range of choices and then supporting women in their choices. The next section details findings of the lived experience of Independent midwifery and its potential to “liberate” both midwives and the midwifery profession.

### ***6.3 Independent Midwifery: Liberation of Midwives and Midwifery?***

There are many positive aspects of independent practice which the midwives in this study recount. This stems from autonomy, control over work load, continuity of care and the ability to form relationships with women. These findings further reinforce the findings of previous midwifery studies about case-holding and continuity of care schemes which indicate that they are associated with greater job satisfaction and reduced stress levels (Sandall 1997, 1999, Allen et al 1997, McCourt & Page 1997, Stevens & McCourt 2002, Walsh 2007). Additionally, and in stark contrast to their experiences in the NHS, the midwives in this study talk about the advantages of having more time to undertake their practice. The

notion of time in relation to both childbearing and childbirth and also midwifery care time have recently become an area for professional discussion (McCourt 2009, Browne & Chandra 2009), mainly because of concerns that time to provide midwifery care within the NHS is increasingly being reduced in the name of “efficiency savings”. Because less midwives are expected to do more there have been concerns about the reduced quality of care that can be achieved (RCM 2011b, RCM 2010), and the increasing number of “near misses” in the maternity services more generally as a result of this (Ashcroft 2003, Kings Fund 2008, Nelson-Piercy et al 2011, Bewley & Helleur 2012).

A recent and fascinating theme to emerge as a midwifery discourse has been the notion of time and in particular the notion of ‘slow midwifery’ (Browne & Chandra 2009). Within this study the midwives report the ability to be able to practice ‘slow midwifery’ with the view that this brings with it a number of advantages and an awareness of the behaviours of childbearing and birthing woman that they had not previously understood or noticed whilst practicing ‘fast midwifery’ in the NHS. Working at a slower pace also enabled them to access knowledge and understanding of childbearing and childbearing women that was not as successfully accessed “at speed” in the NHS. When midwifery time was slowed down this knowledge became “visible”. This finding was also a feature of an Icelandic study by Olafsdottir (2006) where midwives reported much learning about childbearing from “sitting with and over” labouring women.

In many ways moving from NHS midwifery practice, which, as reported by the midwives in this study was experienced as an oppression of midwifery practice,

could be viewed as a form of liberation. As previously mentioned in first findings chapter, the metaphors of imprisonment, being placed in “a straightjacket”, “being confined”, used by the midwives in this study and are reflective of the experienced control and constraint of institutionalised NHS midwifery practice. Indeed Hatem et al’s (2008) systematic review of midwifery led care identified the limiting potential of hospital policies and guidelines on midwives ability to provide midwifery led care in certain settings. Moving into independent practice could therefore be considered a liberation of practice and indeed the midwives’ narratives in this study are reflective of this perception. Here Evelyn (MW 11) uses the metaphor of an opening door to reflect the opportunity that she felt Independent midwifery now offered her:

*“Wow!! Thoughts of why didn’t I do it earlier and you know, it was just like a door opened and suddenly life was anything I wanted. I had that space, you know”. (Evelyn MW 11)*

Liberation is experienced at two ways, that of freedom to fully enact the role of midwife, and also a relative liberation experienced individually by the midwives, where increased levels of confidence and development of skills in decision making were reported. Increased confidence, self-development and the learning of new midwifery skills has also been reported by Stevens (2003) in her doctoral study of case-holding midwifery. Midwives in this study reported the need to adjust to an increase of autonomy, responsibility and the need to develop critical clinical judgement and decision making skills in order that they could refer women appropriately in cases that deviated from the normal. This involved the weighing of risk of harm to the mother and baby against facilitating a



woman's journey through a normal process and "holding the space" for her to birth as she chooses. The woman is the midwife's client and she is employing the midwife to support her birth choices and negotiating these potential tensions are perceived as advanced midwifery skills with high stakes if the decision is wrong or misjudged. Bethany (MW3) indicates that having dealt with several incidents of this sort successfully helped her to increase her confidence, self-esteem and development:

*"I think it felt safer, I felt more confident, funnily enough, being an Independent midwife, I felt more confident, I think that is because...not because.....I think I was better as a midwife, because I knew the woman better and you were more likely to detect, you can't just ignore it. But you have not got people breathing down your neck and trying to sort of say well, she should be doing this, or you should be doing that. I felt well, I can decide. That can give you confidence".*

*(Bethany MW 3)*

Lydia expresses feelings of liberation not only for herself but also for the profession of midwifery and what it means to be a midwife:

*"I am now an Independent midwife having stepped out properly from the NHS and now I beginning to feel that I am really beginning to practice again as a proper midwife, in terms of I can't hide behind anything or anyone, I have to learn about lots and lots of things – but that pleases me because I like to learn. It means that I can speak to somebody on a level with plenty of time, you don't have to rush anything." (Lydia MW 10)*

Some midwives expressed other forms of self-development where, for example, when they had worked predominantly in one area in the NHS, and then on

becoming an Independent midwife had to undertake the full range of midwifery skills spanning antenatal care, intrapartum care and postnatal care as they supported clients throughout their childbearing and childbirth experience. The current predicament amongst independent midwives in terms of their uncertain future, has also encouraged the exploration of alternative ways of working and project work have offered other means of self-development that might not have been experienced when working in the NHS:

*“I have been working independently for 7 months now, I can’t believe it, and it’s fantastic! The scope of my practice now has just broadened incredibly. I have got my finger in so many different pies whereas before it was just that delivery suite focus. And you realise how small the world is on delivery suite, nothing exists outside those delivery rooms and that policy. And now I am taking clients, independent clients, for home births. And I am also working on a couple of projects, one with a children’s centre in (name of town), offering parent craft antenatal classes”. (Red MW 20)*

For Jemima (MW18) and Evelyn (MW11) Independent midwifery is what “midwifery is all about”. Evelyn (MW11), like so many of her colleagues, talks about the enhanced standard of midwifery care that can be achieved for women:

*“Doing Independent midwifery I see as being at the forefront of midwifery”.  
(Jemima MW 18)*

*“I am working in a way that I wanted, yeah, I am working differently, but it is about frustration with policies. You know, it has been good..... and things like postnatals, I see women postnatally up to 28 days, and what a difference that*

*is! You would expect out of the eight that I have had just birthed, you expect at least one of them to have some sort of postnatal depression. Not one of them has. Not one of them. It has been very, very rewarding". (Evelyn MW 11)*

Much of the learning about childbearing and childbirth and women that the midwives disclosed in their stories comes from the opportunity to watch women in their natural state, when left to do what they want to do, when they want to do it, a finding aligning to Olafsdottir's study of Icelandic midwives (2006). This opportunity is facilitated by the model of midwifery care which gives midwives the time to practice "slow midwifery" and the opportunity to be quiet, listen, observe, and to realise that women are very well equipped, in most cases, to birth their own babies. Knowledge gained empirically by midwives in this study, for example, challenges guidelines on the progress of labour and what is deemed to be a satisfactory rate or progress (NICE 2010b, O'Driscoll 2003, 1973, Friedman 1954, Cesario 2004). From observation of labouring women research participants suggested that women can control their labours to a certain extent and can "hold them back" until such time that they feel safe and ready to birth, even when, in one instance, an account is given of a woman nearing the second stage of labour. The midwives in this study appear to have an understanding of this and endeavour to "hold the space" for women to birth in their own time. In a medicalized environment the slowing of labour may result in unnecessary interventions (Hatem et al 2008, Hodnett et al 2010). Study participants demonstrated an inherent understanding of the mind body connection, and to utilize a holistic approach to supporting women which acknowledges this (Winter & Duff 2010, Winter 2002). Phoebe (MW 14) for

example, expressed an understanding that women will hold off their labours if they need to:

*“I saw it a lot in (names a county in south west), where army wives waited until their husbands came back from a posting or even on an exercise on (names an area for military exercises) where they were not contactable, but also as a community midwife having a long weekend off every other weekend, I would see someone planning a home birth on the Thursday and think that they are just so ready or that they are 41 weeks and that they will have this baby when I’m not working or weekend off and they’d go into labour on Monday when I got back. And time and time again you saw that happening” (Phoebe MW 14)*

Independent midwives, as previously mentioned, are very aware of the need to maintain quality of care and this in turn influences the number of women that they can take on at any one time. However, there is the potential for, if two women are booked per month, them to go into labour at the same time, if one or other labour either early or late. Women have also been known to hold off their labour until their midwife is available. Esmie (MW9) recounts her experience of this:

*“And although I do actually say to clients that I look after that there is always that potential for someone to be early, someone to be late and that two woman may birth on the same day, it’s very, very unlikely to happen because we usually choose women that are a couple of weeks apart you see. But we have some close shaves, I have two clients who birthed within 23 hours which isn’t too bad, it’s just the next day, but I know my colleagues have had births literally within hours. But I think that because of knowing the woman...the second one*

*that is labouring, if you say to them I am with another client they will actually shut down the labour to slow to enable the midwife to care for the first one that she is with and it is amazing...and then when she knows that the woman has birthed and that her midwife is on her way she will then get on and birth”.*

*(Esmie MW 9)*

This phenomenon has also been seen to operate when a woman is in active labour. Both Ingrid (MW5) and Esmie(MW9) have observed the behaviour of labouring women and indicate that women need to feel safe and in right environment before they will birth:

*“Women can slow their labours down, I have seen it so many times, if they are frightened or ... and really it is a primitive reaction, isn't it? I don't want to have my baby here; I'll slow things down until I can find a place of safety. I have seen it more as an independent.” (Ingrid MW 5)*

*“I knew she wasn't going to birth this baby until the mother was out the way with the children. She hung on and hung on and she was making sounds like she was in second stage and making some pushing sounds and just by her demeanour, pacing the floor and she was getting quite agitated. So I said to her mother, “We feel that you need to go now, because she will not birth this baby with the boys in the house”. Literally they had gone 10 minutes and she had given birth! She was just waiting, waiting for them to go, and I'm sure that she would have had that baby half an hour or so before had they not been hanging around. She just did not want to do it in front of the children; she did not want them to see her distressed”. (Esmie MW 9)*

The midwife is also seen as having the potential to interfere with the process of

labour. For one particular midwife labour moves from being a process to being that of a dance and with the notion of a dance comes the idea of rhythm, harmony and balance, again echoing tenets of a holistic model of care (Davis-Floyd 2001). But crucially this dance involves the woman, her baby and the creative forces of birth. Freya has come to understand midwives also need to understand that they too can interfere and disrupt this complex interaction:

*“If you watch a women you will know whether she is in labour, that is another article I have been asked to write but haven’t got round to! And we must remember that what we do interferes with what is happening between that women, her baby and the ....I almost said process there because in some ways it is but it’s the dance they are doing isn’t it that is done so very, very different.”*  
(Freya MW 16)

Amy (MW17) has learned this as well and as a consequence has modified her behaviour, particularly in relation to refraining from chatting to a woman when she is in labour. This resulted in her literally being “with woman” and watching, listening and in having the time and space to do this she was able to notice subtle clues and even smells which she has come to relate to a woman’s progress in labour:

*“I try not to talk to women too much unless they want to, it depends on the stage of the labour, some want to chat and be distracted and others just very much want to be left alone in their own space. And in those cases I will just listen in as unobtrusively as possible and leave them to do whatever feels right and normal. And I think it’s a real privilege being able to watch women birth that way. And I think that is where you pick up the small signs and sounds and smells, that in a*

*hospital you would probably never even notice because you are talking to the partner about what football match was on last night, while the woman is in the middle trying to have a baby. I sit quietly in the corner and you are there if you are needed and if you are not, that's fantastic, and support them the way that they need". (Amy MW 17)*

There are several reasons why Independent midwives are able to access this knowledge about childbearing women, this includes the fact that women who are cared for by Independent midwives tend to have more home births (Symonds et al 2009, 2010), so are in their own environment, additionally they often do not access pharmacological methods of pain relief, so behaviour in labour is very natural and not masked by the effects of drugs (Winter 2002). Additionally the midwives know the women so well that they do not need to chat to get to know the woman and her partner in labour as would be more often the case than not in the NHS (Winter 2002). These observations are perceived to have influenced their confidence as midwives in women's abilities to birth their babies (Winter 2002):

*"Because the vast majority of clients who birth at home don't use anything at all and so you are watching a labour naturally, so you get used to watching them being uncomfortable and sometimes in pain, whereas in hospital they are drugged. And one of the things, even if you have gone into hospital, one of the first things I say, very early on is I won't offer you pain relief. You are an intelligent woman I am sure you will tell me if you feel that you need any extra support to help you deal with the contractions, and that's it I don't mention it again. Because I just think we are undermining their confidence in their own*

*body if we are repeatedly saying do you want anything, do you want something? So it's nice, I have been able to watch women birth as naturally as possible. And I can use that to try and facilitate a more normal labour". (Amy MW 17)*

There are resonances with gaining knowledge in this way and how midwives from ancient times came to know about childbearing and childbirth (Ehrenreich & English 1973, Achterberg 1991, Donnison 1988, Towler & Brammell 1986). This type of knowing engages all the senses. There have been two contemporary studies that have also alluded to midwives accessing these "alternative" ways of knowing, (by alternative here I refer to knowledge that is not regarded as authoritative or that that has come to be regarded as mainstream or dominant (Davis-Floyd 1997)), one is a qualitative study of independent midwives in the UK and how they assess progress in labour (Winter 2002) and the other is an study of Icelandic midwives who, much like the midwives in this current study have learned about childbearing women by "standing over" them (Olafsdottir 2006). Unlike the midwives in ancient times, independent midwives have the advantage of being able to access a much improved education system which encompasses and recognises a range of dominant forms of knowledge, their holistic model of care also embraces "alternative" methods of knowing about the world enabling a range of knowledges to be utilized when caring for women (Winter 2002). Arguably, the subtleties of knowledge gained in this way constitute a rediscovery of a much older midwifery knowledge about childbearing and childbirthing women perhaps very familiar to midwives and women healers of much earlier times when the pace of life was slower and



technology and medicalization did not crowd and displace the sensory and spiritual experiences of society (Ehrenreich & English 1973, Achterberg 1991, Garratt 2001). The following quotation from Amy (MW17) also indicates how awareness of olfactory and non-visual clues have been added to her experiential bank of knowledge and utilized in order to understand what is happening during childbirth:

*“And I can’t even describe what it is but there is a smell. And that is not anything that has ever been taught to me. And that is something that you begin to realise because you smell it and then you smell it again and you think hmm ok, and then it just clicks and you just think oh that’s what it is. And things just like putting their arms over their head and small movements or shifting positions that nobody ever says oh that might be a sign that this women is coming up to fully. That is just experience and being in position and watching women who haven’t had pain relief”. (Amy MW 17)*

Because Independent midwives see so much “normal midwifery”, they argue that when something is not right and deviates from the normal (the point at which the midwife is required to refer her client to an appropriately qualified practitioner (NMC 2012b), they are very quick to spot this. Esmie (MW 9) articulates exactly this sentiment:

*“It is really interesting when you watch behaviours of women, as a midwife seeing so much “normal”; the abnormal things seem to smack you in the face. I was always taught that as a student, do as much normal as you can because the abnormal things will be really obvious to you, so it is quite interesting”.*  
*(Esmie MW 9)*

This section has detailed narratives of the freedom to practice as a midwife experienced as an Independent midwife. This liberation is experienced as increased professional autonomy and also individually as increased opportunity for personal self-development. Both are viewed very positively. Midwives also suggest that the increased availability of time facilitates access to alternative sources of knowledge and understanding of childbearing and childbirth—midwives report having the time to notice subtleties of behaviour and even olfactory clues that help them to assess how a woman is progressing with her labour for example. They have also reported an understanding and tolerance of the fact that women’s psychological state can influence the progress of their labour, demonstrating an orientation to a more holistic model of care and world view, which can be seen to be in sharp contrast to the technocratic model of care which prevails in the NHS. The mismatch of these two philosophies holds the potential to be problematic especially if the Independent midwife needs to refer her client to NHS services as will be seen later in this chapter.

#### ***6.4 Supportive Networks, Supportive Colleagues***

Independent midwives’ support of one another is seen by the research participants as being in sharp contrast to what they had experienced as midwives working in the NHS, where a culture of bullying was commonly reported and also acknowledged by other studies as explored in the previous chapter exploring “the journey into midwifery” (Curtis & Ball 2006, Begley 2001, Gillen & Sinclair 2004, Haddy 2009, Hollins Martin & Martin 2010). Rather than undermining one another and there being a fierce competitive culture, as one might be forgiven for expecting, given that independent midwives are technically

in competition with one another for paying clients, the Independent midwifery culture was reported to be one of caring, sharing and support, indeed this tenet is integral to the aims of both the IM UK (2010) and ARM (2009). Both of these organisations are also founded upon feminist principles the notion of being “with woman” clearly not only applies to childbearing women and their families but also appears to embody solidarity of midwives towards one another. The midwives in this study recount in glowing terms the support that they have received from their Independent midwife colleagues and indeed as Kirkham (2010) has suggested, and I would agree, that there is much to be learned from the strength of this support and its positive effect on midwifery morale and enthusiasm, and the facilitation and sharing of midwifery knowledge, skills and attitudes. Both Angel (MW14) and Chloe (MW4) express their positive experiences of this:

*“Words cannot express that difference really!! I just felt like I had come home and I had found my family, and I just couldn’t believe there was such like-minded people. Because you do start to think is it me, am I being unrealistic, am I seeing this very differently that how it is. And to be involved with like-minded people was just wonderful.” (Angel MW 19)*

*“I’ve really found so much inspiration from other independent midwives who are so full of enthusiasm and lust for life, not that midwives that I have worked with in the NHS haven’t individually but I have never, never come across such a community that was so passionate about what they do”. (Chloe MW 4)*

The notion of colleagues being seen as “family” was also discovered by Walsh (2009) in his ethnographic study of a freestanding birth center in the UK, where

staff experienced a supportive working environment with a strong sense of community and as he observes at the heart of community lies a strong sense of belonging and commitment to one another (Walsh 2009). An increased sense of camaraderie between midwives, social support, and willingness to help colleagues has also been reported in other continuity of care schemes (Collins et al 2010, Fleming & Downe 2007, Stevens & McCourt 2002). The fact that Independent midwives are technically in competition business wise, and may live a considerable distance away makes this supportive attitude all the more impressive and would appear to override any business competition concerns:

*“We are hugely supportive network. You can call any...I mean there will be the odd one, I am sure, who says, no I’m not coming, but if you were at a birth and in trouble you could call anybody and if they could come they would come and bring you some more Entonox... or whatever ...we are very supportive of each other, and when things go wrong we are very good at supporting each other and debriefing”. (Emily MW 8)*

*“There is that sense that we are very much there for one another, and that is very true...I had a hairy time last (names month) when my middle of (names previous month) birth went to 44 weeks, my beginning of (names month after) went to 42 weeks and my middle of same month birth was also due. So I had three of them and it did come to that point when I was waiting for three women and they didn’t live that geographically close! And you know the ‘Girls’ were amazing, the (names city nearish by) midwives and (name of Independent midwife), they all rallied round and would have come if they possibly could”.(Phoebe MW 14)*

Running a business is one of the skills that Independent midwives have to acquire, and from the evidence of this study, this would appear to be one of the more challenging aspects of this role, particularly in relation to talking to women about money and negotiating appropriate remuneration. This may reflect in part their lack of training and orientation in this respect as it is not included as part of pre-registration midwifery education (NMC 2009). However, a philosophy of wanting to be “with woman” and the altruistic principles that support this create tensions for Independent midwives, particularly when it comes to making sufficient money to earn a living. Within this study when recounting their stories of how they dealt with these dilemmas I was struck by the similarity of responses. There appeared to be a group rhetoric on this subject, a party-line to be duplicated, a common strategy developed based on the experience of those Independent midwives who had learned from prior experience and had shared their experience with others.

For the newly qualified and newly Independent midwife the support of other more experienced midwives was seen as particularly beneficial and perceived to be better than would be received if working the NHS:

*“I probably received more support as a newly qualified midwife being Independent than I would have done in a busy hospital. And felt if I had issues I could go and talk to somebody without being judged. I also felt, in my own head, I am continuously running through emergency drills so if and when it happens I knew that I would be competent do deal with it, although nobody wants it to happen, it’s just one of those things. And I was happy that I was able to deal with it. ”. (Amy MW 17).*

*“Being a newly qualified midwife and going independent straight away I really felt I needed that support and mentorship while I went through the very steep learning curve of the first years in an independent practice”. (Serena MW 15)*

Ingrid(MW 5) had not experienced a home birth when she became an Independent midwife and although an experienced midwife in other respects the sensitivity of her colleagues in supporting her in this situation was articulated and much appreciated. Support in this instance was characterised by physically being alongside, actually being “with midwife” and involved a considerable “gifting” of the other midwife’s time:

*“I had never done a home birth since I qualified and I was really, really quite twitched because I was so used to having the Obstetric unit there and my colleague, although she was second on call, she came with me for the whole 14 hours even though she did not need to. She came straight away” (Ingrid MW 5)*

Other support mechanisms that the midwives referred to involved meeting up in groups be these in a discreet local/regional groups or national meetings. Additionally, information technology is utilized in the form of internet chat rooms or blogs to help midwives keep in touch with one another, to ask advice and to pose questions (IM-UK 2012, ARM 2012). Midwives indicated that they valued these gatherings and respected one another for their knowledge and experience. Individual experienced Independent midwives were seen as a resource and the meetings a venue to test out ideas, share experiences and decisions made in client cases, in the knowledge that this would be received in a non-judgemental and supportive way:

*“The other independents are very supportive, especially round here, we all*

*know one another and we meet up for lunch now and then and it's very good. There is a lot of on-line chat that goes on our own private group, so that we can discuss particular....obviously anonymity is protected, but we discuss particular problems, so we are all each other's resource in a way for things". (Milly MW 12)*

*"We do have this Yahoo group and we can put anything on there, from a little query about something small and people will email you back. If you are needing some bit of equipment and you haven't got it, and you ask for it, you get sent six in the post the next day. Someone might post on there that they have been very low and they have been very fed up and someone somewhere will pick it up and do something for that person. We do have fairly regular meetings, we are meeting up on Monday, we just outpour everything in a very safe environment. We swap equipment, we lend each other bits of equipment. It is just like meeting a group of friends and it is so different. It was just so welcoming. (Evelyn MW 11)*

The supportive meetings are not always exclusively for Independent midwives as Jemima (MW18) indicated in her story. The aims of the meetings are to provide support to midwives and the opportunity for discussion of clinical decisions and dilemmas and reflection on and development of practice. The opportunity to "rant and rave" as Jemima (MW18) describes it, is not a support mechanism that is readily visible within the NHS system, although the statutory supervision of midwives in its contemporary form offers the potential for this (NMC 2012, 2009, 2010), it is not always experienced as such and this is especially the case in relation to Independent midwives (Kirkham et al 2012):

*“We are not an inclusive of Independent midwives so we do get other midwives coming to our meetings sometimes. But we have a very accepting feel, so people can say, I think I slipped up yesterday doing so and so, and so you can explore what somebody could have done, what effect that might have had in a very safe environment. And we can rant and rave which helps us let off steam about things as well. And you can say what you did, “you did what? Without it being at all a problem. It’s really good having that safe group, like that. And so we are always learning little things that we can put into practice.” (Jemima MW 18)*

The informal support mechanisms detailed above appeared to be highly valued by the research participants and experienced in sharp contrast to their perception of support in the NHS. Accounts of bullying and intimidation in the NHS are further reinforced now by numerous studies (Curtis & Ball 2006, Begley 2001, Gillen & Sinclair 2004, Haddy 2009, Hollins Martin & Martin 2010). In contrast in Independent midwifery the feminist principles associated with the “with woman” philosophy also influence midwives support of one another, as “with woman” can be seen to apply to midwives as well.

Support from Supervisors of midwives, the provision of which is a statutory requirement (NMC 2012) was not something that the midwives in this study really talked about *per se* during data collection. This was possibly because other informal networks provided for their needs in this respect, as was found by Kirkham and Stapleton (2000). Potentially they may have also felt wary about disclosing their thoughts on the subject to me, when they did not really know me, other than the fact that I was a midwife and not an Independent midwife.



That of course may have been the crux of the issue as it has been suggested that midwives who are trying to provide sensitive women-centred care based on individual needs rather than standardised packages of care, have been subject to particular scrutiny, investigation and disciplinary action (Wagner 1995, Edwards et al 2011, Kirkham 2011), and despite my attempts to create rapport and trust with the research participants, they may have been guarded in sharing their thoughts. However, it is surprising that this area of support was not really raised to any great extent in the midwives narratives in view of increasing numbers of midwives being referred to statutory supervision and to the NMC and that this is a particular issue for Independent midwives (Edwards et al 2011, Kirkham 2010a, Wagner 1995). The original ethos of supervision was to protect the public from unsafe practitioners and police the midwives' rules (Heagarty 1996). The remit of Supervision remains the protection of the public from unsafe practitioners but has also broadened aiming to achieve this by supporting and helping to develop a high standard of clinical practice through a more supportive approach rather than the punitive one (NMC 2012, 2009, 2010) experienced after its initial introduction in 1902 with the first Midwives Act. Supervision's remit also encompasses the promotion of childbirth as a normal physiological event, aims to work in partnership with women and create opportunities for them to engage with the maternity services. It has a role in supporting women to make choices and to provide support to women experiencing difficulties in care choices (NMC 2009). Certainly this rhetoric implies a "with woman" philosophy as far as childbearing women are concerned, but there is evidence to suggest that supervision is still being experienced as punitive with an alarming trend

reported of increasing criticism, investigation and disciplinary action being taken against midwives who attempt to meet the individual needs of women and work flexibly in order to support their choices (Kirkham et al 2012, Kirkham 2011, Edwards et al 2011). It is felt that this is because these actions do not coincide with an increasing trend within the NHS towards the provision of standardised packages of care that are based on guidelines and protocols driven by risk adverse strategies (Kirkham et al 2012, Kirkham 2011, Edwards et al 2011). Whilst midwives attempting to work flexibly in the NHS are also subject to this scrutiny, Independent midwives have been seen to be particularly vulnerable to this, as has been evidenced by a disproportionate amount of referrals to the NMC (Kirkham 2011). It has also been highlighted that although midwives are expected to work to the NMC rules and standards, which clearly support the importance of focus on the needs of the client, that they should work in partnership with women and, that they should enable women to make decisions about their care (NMC 2012). They are increasingly being judged against NICE guidelines and Trust Protocols which are driven by medicalized risk management strategies (Edwards et al 2011, Kirkham 2011, Kirkham et al 2012). Whilst the midwives in this study did not really talk about statutory supervision as a support network, there was a clearly demonstrated understanding of their vulnerability because they perceived that those who potentially were going to judge them do not really understand what Independent midwives are trying to achieve for their clients, and the subtleties involved with independent practice. These “mis-understandings” were felt to render Independent midwives vulnerable to criticisms about their professional practice,

not because they are necessarily bad practitioners but because they did things a little differently, working flexibly to meet the often very complex needs of clients whilst also supporting their autonomy and control over decision making. Those that judge them are perceived to be not always able to see the difference as Jemima (MW18) suggests:

*“But that is probably our biggest hassle with having senior NHS midwives, or any NHS people within the supervisory system, thinking we are doing things wrong because we are doing them differently. Because we have a great knowledge of different ways of doing things, and they have a very in-depth knowledge of one way of doing something. So whilst we are aware of their way and our range of others, they are only aware of probably one of our biggest challenges” (Jemima MW18)*

The debate about what constitutes valid childbirth/childbearing knowledge and whose knowledge “counts” is an enduring one (Davis- Floyd & Sargeant 1997, Page 1997, Stewart 2001, Fahy 2008). Within these debates social, political and gender dynamics are seen to be influential (Birke 1986, Stanley 1993, Walsh 1996, Stewart 2001, Wickham 2004a, Fahy et al 2008). The androcentric bias and super valuation of knowledge gained by the scientific method, the construction of hierarchies of evidence (NICE 2005, Sackett et al 1996) with the consequent side-lining of knowledge obtained more subjectively via experience, reflection on experience and intuition for example being highlighted (Wickham 2004, Jordan 1997, Davis-Floyd 2001). Knowledge gained by these subjective means has been traditionally employed and valued by midwives since ancient times, (Achterberg 1991, Davis-Floyd & Davies 1997, Page 1997, Stewart 2001,

Wickham 2004, Barnfather 2013), with knowledge being passed on by means of an oral tradition and often in the form of stories (Wickham 2004, McHugh 1999). The construction of authoritative knowledge and the associated power structures in this context have particular impact both for childbearing women and midwives especially in relation to the exercise of autonomy (Fahy 2008, Wickham 2004, Edwards 2006a, b, Reid 2007, Kirkham et al 2012). Foucault (1980) in his analysis of power structures within society, has argued that society affords power to those seen as valid knowledge makers, and within this context medicine and its links with science is seen to hold power and control of what has come to be sanctioned as best evidence for practice (Fahy 2008, Reid 2007, Stewart 2001). It has also been suggested that the power of authoritative knowledge is not that it is correct/accurate but that it counts (Jordan 1997). These arguments have particular resonance for childbearing women and also midwives and the exercise of their autonomy as will be discussed in the final chapter with the issues of control and oppression being at its heart.

Within this study the informal meeting groups, the yahoo internet group, blogs and networking arrangements that characterise Independent midwifery and additionally the role of and activities of both the ARM and IMUK are seen to facilitate the sharing of midwifery knowledge. This knowledge is not always the kind that is readily found in textbooks as previously discussed and involves the sharing of skills and experiences, of decision making and would appear to be highly valued by the midwives in this study in contrast to other existing hierarchies of knowledge and what is deemed to be best evidence (NICE 2005, Sackett 1997):

*"I am always amazed at the midwives that know loads about natural childbirth and things and I feel so behind the times. I am also so intrigued by the non-written things, the skills that you learn from each other that are not necessarily research based and that are built in tradition". (Esmie MW 8)*

The organisation IM UK puts on study days to facilitate the exchange of this knowledge and provide clinical updates in relation to different areas of practice, but it is the way that it is done that appears to be valued and well received. The learning is perceived to be much less formal and more akin to how women enjoy learning (Belenky 1997, Merriam & Heuaer 1996, Hooks 1994, McHugh 1999, Pinoka 1992):

*"In the IMA we also run updates, I went to one a few months ago. It is quite a difference between the formal way that perhaps the NHS learning opportunities and how we do it as independents, much more geared towards our learning style". (Erica MW 1).*

Independent midwives in this study allude to the fact that they utilize knowledge from a spectrum of ways of knowing about the world, this reflects again the influence of postmodernist thinking and the previously discussed tenets of a holistic frame of reference (Davis-Floyd 2001). Recognition and understanding of this when it is deemed necessary to transfer a client from home to NHS hospital care, is not always apparent with Independent midwives reporting delay in dealing with serious issues concerning the health and well-being of mother and/or baby on transfer. This interface between Independent midwifery and NHS care and the discounting of knowledge and intelligence about the woman's care to that point is experienced. Here the exercise of both authoritative

knowledge and power are seen in operation with the potential to delay appropriate action. This is seen by Freya (MW 16) as dangerous practice:

*“We have to get...this is dangerous practice, and it’s been going on for as long as I have been a midwife. You have got a woman labouring at home, something is not quite right, you transfer in, and they discount everything that has gone on at home! And it’s particularly bad as an Independent midwife because you are a witch and you don’t know anything about midwifery.” (Freya MW 16)*

Within this study Independent midwives also recount other experiences of having to transfer a client to NHS care during labour. Unless the Independent midwife has been able to negotiate an honorary contract with the NHS Trust they are unable to practice as a midwife and are present in the capacity of birth companion or doula. Sometimes the difference in approach to care and its underpinning philosophy creates challenges for them. They are left to ponder their position as the woman’s advocate whilst also wanting to forge positive relationships with the staff of NHS trusts being mindful of how Independent midwives might be perceived. The following quotation illustrates some of the difficulties encountered:

*“And then other times it has been the midwife going, “right some big pushes now”, and I am thinking, do you say anything and risk upsetting everybody or do you just say quiet? It’s quite difficult. The way I try to approach it is I don’t go in with an attitude of I am an Independent midwife and we are going to do it our way, I do try and work very much with the hospital staff. At the end of the day we are all there to try and help this women and partner have the birth that they want. So the more friendly and open I am to the midwives it makes life a lot*

*easier. I haven't had any difficult ones, I have been quite lucky"! (Amy MW 17).*

Chloe (MW4) also found that adopting a similar strategy was helpful to her in order to achieve her end goal of providing appropriate care for her client, however, she is aware that alternative strategies might make this more difficult, so she understands that she has to tread carefully:

*"I can ring up and have a kind of conversation with a stuffy antenatal midwife on the antenatal clinic, who I know is teetering on being very difficult, and could make life very difficult for me. , like arranging a scan for example, and I can kind of cope with that. I know that I must not lose my cool, that I must be polite, I must be respectful to get what I want". (Chloe MW 4).*

Angel (MW19) also experienced tensions when interfacing with the NHS, particularly as times of transfer in, she perceives this to be resistance:

*"...whenever we needed clients to be transferred to hospital care the relationship wasn't always as good as it could be with other health care professionals, and I faced quite a lot of resistance." (Angel MW 19).*

Jemima (MW18) recounts the potential complexity of an Independent midwives caseload, indicating that this might be seen risky by midwives working in the NHS, giving rise to the label that Independent midwives are risk takers and mavericks. She counters this argument with reference to the mother midwife relationship and knowing the women so well. She alludes to what she see as the shortcomings of NHS care when there is lack of continuity of care and how this could be viewed as risky as there is the potential to miss vital information:

*"And breeches at home too, or twins at home, for us they can be more normal, they aren't necessarily abnormal, breech or twins. So I can understand why*

*there are some NHS midwives who think we are risk takers but I think we take a lot less risks than the NHS. And it's easier for us to take those risks because we know the women. I think one of the reasons the women get better care and are safer relates directly back to the relationship. If you think of someone newly delivered on the labour ward, there are midwives dotted around and gone off to catch another baby, someone else comes in and somebody else comes in, and nobody knows the total extent of her postpartum loss. Whereas if there is one midwife there all the time, knows". (Jemima MW 18)*

Within this section midwives' narratives detail a very positive evaluation of the informal support mechanisms that they have experienced as Independent midwives and that this is seen in sharp contrast to their experiences of peer support whilst working in the NHS. The support is given in a variety of ways and uses a variety of mediums. Support can span assistance at births, sharing of equipment, sharing of knowledge, skills and experience. It is indicated that communication happens in a non-judgemental environment without fear of reprisals or ridicule. This communication may occur on a one to one basis, in small local/regional groups, national meetings and also with the aid of information technology. Although Independent midwives may be geographically distanced apart, this network of support enables them to stay connected to one another. The knowledge share sessions are perceived to be informal and accessible and much valued, particularly in relation to the sharing of knowledge that cannot always be found written in textbooks. There is resonance here with ancient times and how women's knowledge was passed on by oral tradition (Achterberg 1991, Ehrenreich & English 1973), with the suggestion that



midwives are aware that this knowledge also sits outside of the dominant and authoritative knowledge hierarchy of what constitutes a valid and reliable evidence base. Nevertheless, this alternative knowledge appears to be highly valued by the research participants. There is also evidence within this section that when there is occasion to refer clients to NHS care there can be tensions between the model and philosophy of care worked as an Independent and that of NHS practice. There is also a perception expressed by research participants that both midwives and medical staff working in the NHS do not always understand what it is to work as an Independent midwife. They can construe their caring for women at home with complex needs as risky practice and when the independent transfers a woman to NHS care they often discount their assessments and care sometimes delaying urgently needed care in order to make their own assessments. This is perceived to potentially jeopardise the wellbeing of mother and/or baby.

In the following section midwives' narratives focus on Independent midwifery as a business.

### ***6.5 Independent Midwifery as a Business***

There are many tensions that exist when thinking about midwifery as a business. Some of these have already been explored in relation to the business relationship in the second of my findings chapters. Within this section however the focus will be on the actual running of the Independent midwifery business. Independent midwives acquire clients from several potential sources. First, from the Independent Midwives UK (IMUK) website (<http://www.independentmidwives.org.uk>), where all independent midwives who

are members of the IM UK are listed along with contact details and with a link to their own personal business website. Prospective clients can type in their own postcode and a list of Independent midwives from a 60-100 mile radius are displayed (IM UK 2010). They are then able to decide from the information posted on individual websites which midwife they wish to contact and audition their services. Secondly, clients are found through informal social networks via word of mouth from previous satisfied clients. Another potential source of clients is via other Independent midwives and finally, although more rarely, via other health professionals within the NHS who have knowledge of Independent midwifery and who recognise that sometimes particular clients would benefit from the services they can provide. Serena (MW 15) talks about the source of her client base illustrating exactly this:

*“I would say most of, if not all, of my business comes from the IMUK web site. I have got my own web site as well, (names midwife colleague) and I have together, so that too, because there are links obviously from the IMUK website. But yes, if someone is looking for an Independent midwife they are probably going to end up on the IMA or IMUK website, and from there they can click onto individual midwives website. Occasionally word of mouth, occasionally GP, very, very occasionally, once I think! and community midwives actually. One particular community midwife has referred quite a number of women to me. I think she feels that I can't give you the time so perhaps you would benefit from an Independent midwife, or I can't guarantee I can be there for you when you have your baby at home, or you are a VBAC (Vaginal birth after Caesarean Section). I am sorry I can't. So she has actually referred women”.* (Serena MW

15)

In Phoebe's (MW14) case she indicated that a lot of her business came via word of mouth:

*"I think there is more word of mouth because so much of our work is word of mouth, you ask how they found out about Independent midwifery and you go through the history, it is very often a friend or a friend of a friend". (Phoebe MW 14)*

And for Emily (MW 8), other Independent midwives helped her find her first clients:

*"I probably got some bookings from some independent midwives, I can't remember... but anyway it took off, and it was the best decision, you know I don't regret it for one moment". (Emily MW 8)*

Often initially the business, like any business, appeared to take a while to get going and for the midwife to establish herself in this new context. This was often reported as being a 'lean time'. Serena (MW 15) and Jemima (MW18) recount their experiences. Jemima (MW18) indicated that moving from "down south" to further north where perhaps women were not so familiar with the concept of Independent midwifery, had made a difference to the number of clients that approached her:

*"It was quite hard the first two years because you have to build up your network and get yourself known and get yourself a supervisor and all that stuff. So the first few years were quite lean really in terms of work. But over the last couple of years I have just got busier and busier which is lovely". (Serena MW 15)*

*"The practice was built very slowly, I only had one independent birth the first*

*year I was here, compared with the 8 or 9 I'd had in the 6 months in (names city in south of England). There was a lot more midwifery going on there, a lot more people aware of independents. And the practice has grown". (Jemima MW 18)*

Independent midwifery offers the opportunity to practice midwifery to its fullest extent using the full range of midwifery skills as previously discussed and as such offers the potential of professional liberation in comparison with NHS Midwifery practice. But whilst this advantage exists there are constraints from a number of other quarters that might, for many, make Independent midwifery an unrealistic alternative. Not least amongst these constraints is that of financial insecurity. For the midwives in this study this was something that had been taken into consideration with particular adjustments to their lifestyles, or social circumstances made in order to accommodate this. These adjustments involved the support of family and partners if these were a consideration. Certainly it was apparent that Independent midwifery was not associated with becoming rich. Part of this is related to the fact that an Independent midwife provides a service for which clients are paying. This service involves tailored one to one care and being there 24/7 for clients throughout pregnancy, labour, birth and the postnatal period. In order to fulfil this considerable commitment midwives have to be mindful of how many clients they can take on at any one time. This is particularly the case when midwives are working alone. In order to then build in some respite time the midwife has to reduce or stop bookings over a particular period, and no clients means no income. Booking too many women to birth at a similar time can compromise the quality of their service and also make life very stressful. For some midwives who need a certain level of income to survive

however, this might be a temptation as Rhianna (MW7) indicates:

*“From a business point of view, you start to realise the things that before you are an Independent midwife, you really just do not realise, and one of those is you can’t get rich doing Independent midwifery, which is very important, you can’t get rich doing it, there is a real tight limit on how many women you can take on, because you are actually seeing women.....so basically to be sure of being there, if you are on your own, you can only take one a month and be absolutely sure that you won’t run into trouble. Then if you want to have any holidays at all you have to have big blocks without booking women at all, so probably realistically only about 9 months of the year can you really book a woman. Now I know there are other midwives that book willy nilly, and are often in a position of panic, but I am not like that, so, I like to have things covered”.*

*(Rhianna MW 7)*

Both Chloe(MW 4) and Esmie (MW9) indicate the financial sacrifices that they and their families had made in order that they could become Independent midwives and although hard this was something that they had not regretted doing as the benefits outweighed these restrictions:

*“I’m really lucky because I am not the breadwinner and I know a hell of a lot of, seems to be a lot of independent midwives that are single mothers or are the breadwinners, or their income is a big, big mainstay in the family. I am lucky that I am not. But that is probably because we are quite frugal and we are quite self-contained really without any big out lays” (Chloe MW 4).*

*“But then I decided to become an Independent midwife, I had gone along to the introductory day that the independent midwives do and I was just so excited! I*

*knew it was going to be really hard work, and I was grateful for my husband, he has been really, really supportive, because in my first year I had probably three clients that paid me, and then you go from earning around £30,000 a year to zilch!! Negative equity (laughs loudly), you know it is hard and you know that um...so from the family point of view we had to think about finances and things, but oh, my goodness what a difference, it was just absolutely wonderful”!*

*(Esmie MW 9)*

Milly (MW12) had been considering Independent midwifery for quite a while but financial commitments in the past had prevented her from exploring this further and even when this restriction was lifted she was only able to start with the support of her partner:

*“I had been looking at Independent midwifery for a long time but not been able to do it because, I had had one daughter by this time, and one going through University and you know, all this stuff, mortgage to pay and everything. And then I met my partner (names him) and he said, “If this is something you really want to do, you really, really want to do, I will support you until it is up and running”. (Milly MW 12)*

Even when the business is up and running financial insecurity remains a challenge as Amy indicates:

*“There are times when I think it would be nice to have a regular income which you don’t have. Even when you are busy you might have a group of friends at the same time and then nobody for a few months, so you never know that you are always going to get someone on your books”. (Amy MW 17)*

Within the study midwife attitudes on the payment of fees remained fairly consistent with regard to the amount charged and the fact that they would resist attempts by women to negotiate a reduction in fees if they booked later on in their pregnancy. On occasion this tested the “with woman philosophy”:

*“The other thing to say about it is that some people say that you only get the posh and rich and famous, you actually don’t but it is not open to all women. I wrestle with my conscience on that because.....I am actually not prepared to .....I had a set fee and that is what it is. If I go doing deals with people I would have to cut corners and sell myself short and how can you give a person a less than good care by saying that I will cut down on the antenatal visits. I think it devalues the work we are doing. So I personally feel that I cannot do that. I know that some will, but I can’t accept that, I just think it is a business and there are people out there that have finance, loans and put on hold a holiday, because this is more important to her”. (Evelyn MW 11)*

Freya (MW 16) on the other hand adopts a different approach which appears to be grounded in being “with woman” and helping women to access the midwifery care of their choice rather than being too concerned about financial constraints and burden on herself, in fact she intimates that having to charge women in the first place for what she provides is “hard” and that this is something that other independents feel as well. Importantly her personal philosophy recognises the value of this system of care and the relationships that facilitate health education advice that she perceives has potential to extend beyond the actual pregnancy and childbirth event:

*“We had big discussions, because I said, the women pay us, I hate that for a*

*start, we all hate that (independent midwives), but in some ways they really respect themselves because they pay. I have got one person who is paying me £100 and something a month because that is all she can do, but she really values herself. And it makes a huge difference, she really listens and is working hard, there is a huge amount you can do antenatally around diet and all that sort of thing". (Freya MW 16)*

Angel (MW19) was the only midwife in the study that clearly indicated that she offered her services for free on occasion, I have a suspicion that she is not the only one, however, given the level of passion expressed by the midwives interviewed regarding their role and what they wanted to achieve for women and given the nature of the relationship achieved with the women on occasion as previously discussed in my chapter entitled the "mother midwife relationship". There are considerable tensions demonstrated between the caring nature of midwifery and the concept of seeing it as a business proposition. Within the NHS we are currently reaping the "benefits" of economic sanctions on caring services as previously discussed, where important aspects of the caring role (the time and opportunity to form relationships, undertake care and communicate with clients), are constantly under threat due to reduced practitioner time, staff and resource shortages with consequent implications of this for safety (RCM 2010, 2011b, Ashcroft 2003, Kings Fund 2008, Nelson-Piercy et al 2011, Bewley & Helleur 2012).

*"I have supported lots of women free of charge and go out to deliver education to women. So we do everything that we can to help them but we would like to be able to offer them everything so that they can come here and have this*



*wonderful service". (Angel MW 19)*

Amy (MW 17) indicated that she felt that it was because of the situation in the NHS that she was getting more enquiries:

*"I think generally we have far too few women who are aware of what their options are. And the clients who have booked tend to come from the Southern areas really. But yes, there are definitely more people at least finding out about it, whether the cost is an issue for them I don't know, but more enquiries on the whole. I think that just reflects what is happening in the NHS at the moment in time". (Amy MW 17)*

However, set within the current context of national and global financial pressures it appears that independent midwives too are feeling the consequences of this:

*"I think a lot of midwives are finding that clients just aren't coming, people are struggling financially". (Red MW 20)*

For Angel (MW19) these financial concerns were particularly acute, she had spotted a niche in the market to provide tailor made services within a small Independent midwifery birth centre and had invested money in buying a property for this purpose. The overheads in just being able to open the doors of the birth centre appeared to constitute a much higher financial burden for her personally as compared with the standard Independent midwife set up:

*"...Because as Independent midwives primarily you are working from home, with very little to pay out in terms of resources. And sometimes you might have clients that are not booked in one month but you can keep going. Whereas working in this way, having all of the overhead costs to keep this building going,*

*and to pay everything that comes with it, but that is the struggle financially. So to be able to get some secure funding to be able to carry on working that's the hardest part of the way we are working. In terms of working as a midwife its 100% satisfying, it's more the financial situation that is stressful at the moment, certainly given the climate". (Angel MW 19)*

It can be seen that there are perceived tensions between earning a living and enacting the "with woman" philosophy. The financial uncertainty associated with independent practice and particularly in the current financial climate means that Independent midwifery is not something you undertake to become rich. Those midwives interviewed explained that they could not have contemplated becoming an Independent midwife without the support of their family and in particular a partner/husband who was able to financially support the reduced family income. This in some cases required families to make adjustments to their life style in order to manage this. Clearly this is not a position that all midwives are able to entertain. All of the midwives interviewed however, indicated that they had not regretted moving into Independent midwifery and suggested that the financial sacrifices were worthwhile in order to practice midwifery in a way that had meaning.

## **6.6 New Constraints**

Earlier in this chapter there was discussion of Independent midwifery being seen as liberation not only of individual midwives' practice but also in terms of liberation of the midwifery profession. As previously discussed, Independent midwifery is portrayed by those interviewed in very glowing terms and aligned to enhanced levels of job satisfaction, autonomy, utilisation of the full range of the

midwife's role, enhanced skills and knowledge of childbearing which has resonance with other studies of one to one care and caseholding practice (Stevens 2003, Fleming and Downe 2007, Stevens & McCourt 2002a, b). One could argue, given the currently predicament that Independent midwives find themselves in that they had a vested interest in portraying independent practice in this way. However, as the midwives stories unfolded a number of different constraints, vulnerabilities and even disadvantages that had a control on their lives and their midwifery practice begun to emerge. These new constraints appeared to operate on two levels, that of professional practice and that of impact on the midwife's lifestyle. The current situation regarding lack of professional indemnity insurance cover for the intrapartum episode of care for example, is perceived by Milly (MW 12) to effect the way she practices, she talks of having to be very careful with decision making and with documentation as she understands that she is personally liable for any mistakes:

*"You are really careful about your practice, because you know we have got this insurance business? We are really careful about our practice...taking away that safety net of the hospital and the policies and all the rest of it, makes you think very carefully all the time about what it is you are doing, what it is you are documenting and all the rest of it". (Milly MW 12)*

Although acknowledging the great personal risk that this can present, the midwives interviewed seemed to be fairly philosophical about this risk. Rhianna (MW 7) when recounting her story, talked about the time when she wanted to move into independent practice and was fearful about the lack of insurance. Despite realising that she had the potential to lose her house if she was sued by

an unhappy client she had backing from her husband and realised that this was a risk that she was willing to take:

*“You need a lot of backing from your partner. You do practice Independent midwifery at great personal risk, so ... the situation with insurance....that seemed to be a stumbling block....but my husband was great he said, ‘Just do it, what is the worst that can happen?’ And I said, ‘Well, we could lose the house!’ ‘Yeah?’ And I thought, okay, that frees me up then (laughs), suddenly you think, OK right, OK,.....fine!” (Rhianna MW 7)*

Red (MW20) expressed her feelings towards the lack of indemnity insurance and how carefully this has to be explained to clients. But she too was very philosophical about what this lack of cover meant to her personally. Her personal beliefs and lifestyle meant that she felt there was nothing that she had to lose:

*“We discuss it at consultation with all our potential clients and talk to them about the issues around PII and what it means not to have indemnity insurance. Really you start to realise that the only thing that it, having insurance doesn’t protect you from anything at all. The only reason that insurance is necessary is, the only time when it would be called into play is if you were found to be negligent and I would hope that wouldn’t happen. Insurance doesn’t protect from anything. If I was negligent I could be sued but I don’t have anything. So.....” (Red MW 20)*

One of the most striking constraints of Independent midwifery practice that was expressed by those interviewed was the blurring of work/life boundaries and the consequent effect on the midwife’s life style. The potential blurring of work/life

boundaries has also been acknowledged in other studies of caseholding practice/continuity of care schemes (Allen et al 1997, Sandall 1997, Sandall 2001, Stevens & McCourt 2002b, Stevens 2003, Fereday 2010). However, these have been associated with group practices, rather than individual midwives perhaps working with a backup or partner, and with paying clients. This dynamic creates a different perspective, and creates particular constraints as will be seen from the narrative accounts. I was also made aware, during data collection that Independent midwives' clients do not necessarily live locally and midwives may travel distances of 50-100 miles to attend them. Travel time therefore becomes an important further constraint for midwives to factor in. Unsurprisingly therefore, within this study it was acknowledged that when a client is approaching labour, the Independent midwife has to be mindful of the activities that she undertakes in her private life in order that she deliver the service that she has said that she will provide should the woman commence labour. The examples cited involved the drinking of wine, going away for weekends or even just going out. Both Lydia (MW 10) and Chloe (MW 4) express their personal experiences of this whilst acknowledging the requirement for professionalism when undertaking direct client care. However, although these constraints could be construed as oppressive, midwives again stressed that it was worth it to practice as an Independent midwife:

*"It is also hard working as an Independent midwife, for me, because I do love a glass of red wine! I do! And I like it when I am cooking, cos' I like to cook and love to garden. I absolutely adore music. So I am really cooking something I have dreamt up I like sip a little wine. When I book a woman, when she comes*

*to a point that I have to there to look after her and I am in charge of her, I just cannot until I have discharged her. If you are looking after women in this intensive care situation, you know, psychological, my commitment to women is, not that I want to look after them 24/7 because I do have a life! But I do need to be .....if I say to a woman, if I take her on to fully look after her then I have to be available for her to talk to me about things she wants ....she will have problems she will have". (Lydia MW 10)*

*"I do like the odd glass of wine and having to say no to camping trips away at this time of year, you know, it is a big responsibility and that is just the simple stuff of being on-call, having to respond to situations which sometimes really need you to respond quickly or just having that judgement and knowing whether it is a situation you need to respond to quickly. So...it has been....I don't regret it". (Chloe MW 4)*

Rhianna (MW7) also explains how she and her partner had modified their lifestyle to work around some of these perceived constraints:

*"I can't tell you how it is all mingled in (work/life), because even stuff like the garden, okay, we dug up half of the garden to grow veg, why have we done that? Well, basically because I can't go anywhere, we used to go to our boat in (name of town) at the weekend, but that has gone, I can't do that now, so what can I do as an interest and a hobby that actually allows me to be on call at the same time and not be going anywhere? I thought, well, I'll do some gardening! (Laughs). So that is very....as much of part of it as anything else. You don't quite realize even when you try and think it through, you don't quite realize how restrictive it is, and your partner does not quite realize. He might say, the*

*forecast is good for the weekend shall we go down to the coast, shall we go walking, shall we go camping, and of course you are constantly saying, "I am on call darling!" It suddenly dawns on them that this is a massive life change. Yes, you have a job to go for a walk really, a long walk. We like walking and sometimes go on a two or three hour walk on a Sunday afternoon or something, but if you are two hours away from the car, and then you have got to go back to the car and then you have got to drive back and then you have got to pick up your kit and if you have got a multip, it's not really very good. It is a huge change."* (Rhianna MW 7).

This section has highlighted areas of constraint as perceived by the research participants, in the main these seem to centre round the blurring of work/ life boundaries, particularly when clients are approaching their due date. These constraints have been acknowledged in studies of NHS caseholding practice too (Allen et al 1997, Sandall 1997, Sandall 2001, Stevens & McCourt 2002b, Stevens 2003), where adjustments have been made to share on-calls and workload amongst colleagues in order to avoid burnout (Sandall 1997, Fereday 2010). However, in independent practice where midwives have smaller caseloads, paying clients and may have to travel a considerable distance to attend clients these constraints can be seen to be quite oppressive.

Data was collected for this study between 2007 and 2009, a time when negotiation and exploration of alternative solutions to the professional indemnity insurance issues was still very much a matter for debate and the Flaxman Report, which set out specifically to investigate the potential feasibility and insurability of Independent midwives in the UK, had not been published (RCM

2011a). Comments regarding both this insurance and the future of Independent midwifery need to be framed in this context as do the narratives in the following section which detail midwives perceptions about the future of Independent midwifery which are reflective of the time of data collection.

### ***6.7 The Future of Independent Midwifery***

Data was collected by inviting midwives to recall the story of their life as midwives and although not specifically asked about almost all of the midwives interviewed, unsurprisingly, given the current situation of Independent midwifery practice, wanted to express an opinion regarding the future of independent practice. A range of ideas were expressed regarding this and from a number of viewpoints. The compulsory requirement for all healthcare professionals to have professional indemnity cover by 25.10.13 heralds the imminent demise of Independent midwifery in its current format (European Parliament and Council of the European Union 2011), despite an investigation into the impact of such legislation on the livelihood of Independent midwives, and after much petitioning of government (van de Kooy 2010, IM UK 2010, Royal College of Midwives & Nursing and Midwifery Council 2011a). The demise of Independent midwifery was seen by the research participants to signal the end of “true” or “proper” midwifery. “True” or “proper” midwifery being aligned to being able to enact fully the “being with woman” philosophy and having professional autonomy by practising the full range of midwifery skills and having clinical decision making responsibility in partnership with women:

*“I think we are very privileged and honoured to be able to work the way we do, it’s very under threat sadly. But if we lose Independent midwifery in this country*



*I think that is the beginning of the end of midwifery. I think autonomous midwifery practice, midwives as a separate autonomous profession I think it will just be swallowed up and become obstetric nurses for the most part". (Serena MW 15)*

Freya (MW 16), a very experienced Independent midwife expressed the opinion that the insurance requirement was a deliberate move to "kill off" or exert control over midwifery, or at least what she and many of her colleagues consider to be midwifery:

*"I just feel midwifery is dying, being killed off. I have said for many years, and I don't want to be a doom monger, but I have said that we would have to lose midwifery before we say, well, we are at that point. (Freya MW 16)*

Faced with the prospect of the demise of Independent midwifery, research participants indicated that they had thought of a number of alternative strategies to cope with this at both a personal and professional level. Serena (MW 15) for example, the prospect of working back in the NHS was not something she relished, unless she was able to work in a holistic case-loading fashion. She alludes again, as many of her colleagues have, to her support of the underlying principles and concepts of the National Health Service however:

*"I just couldn't imagine working as a midwife in any other way. Well I can imagine it actually, but I wouldn't want to unless it was a case loading practice, I would certainly do that within the NHS. If it was available I would be happy to work for the NHS, I agree with it, I think we are very lucky to have the NHS and I would be more than happy to work there if, if, I could practice in the way that I want to".(Serena MW 15)*

Another strategy articulated by research participants was that of exploring the potential of groups of Independent midwives contracting into Primary Healthcare Trusts (PCTs). In this scenario indemnity cover would then be provided by the PCT and midwives would therefore be able to practice legally. At the time of data collection a number of Independent midwives were in negotiation with the government regarding this potential (van der Kooy 2010) including some of the midwives participating in this study. However, this model was thought to represent a potential compromise to truly enacting a “with woman” philosophy. It was envisaged that as part of any contract, midwives might have to sign up to PCT policies and guidelines, part of the mechanisms that they perceived had constrained their previous practice in the NHS and had been instrumental in triggering their departure as both Angel MW19 and Serena MW15 indicate:

*“So I am working really hard at trying to agree commissioning contracts to make our service accessible for everyone. The biggest problem for me is that I don’t think women should ever have to pay for good quality midwifery care. So I am in the process of trying to negotiate ways of working with and alongside the NHS to make our service available to everyone”. (Angel MW 19)*

*“I am involved in one of the working groups and I think we are all doing it because we know we need to take ownership of our own clinical governance, we need to develop guidelines. We all are aware that it is the start of a very long slippery slope and the thin end of a huge wedge (laughs). We are going to end up like the NHS, in order to contract into PCTs we need to have guidelines. They won’t look at us otherwise. And that is the beginning of the end for*

*autonomous midwifery practice.” (Serena MW 15)*

Milly (MW 12) demonstrates some resistance to contracting into the PCTs for these very reasons, perceiving this to be a way of controlling the practice of Independent midwives:

*“Unless we can sort something out, I mean they are working really hard on things, but the way they are approaching it is sort of sub-contracting through the PCTs and that to me....well you might just as well go back into the hospital, because you will then come under all the same restrictions. I do think that independent midwives are slightly regarded as loose cannons, to be honest you know, but ....and I think that perhaps some are. But most of us are providing safe, careful care. That is what I aim to do anyway. I don't know, I don't want to....I don't want to be particularly be sub-contracted into the PCTs because you will then have to follow all the local Unit's policies I am quite sure that that is what they will insist on. It is just not the way I want to do it”. (Milly MW 12)*

This sentiment is also shared by Red (MW20) who sees this move as a potential threat to midwifery autonomy:

*“I have a lot of hope and faith I suppose that things will work out. I think there is a lot of amazing work being done by a lot of amazing midwives in Independent midwifery because they feel so passionate about it. I hope that rather than going down the route of having to contract in, although I am doing a bit of that work at the moment, it's not something I would want to do 100% of. My sense is that with the best intentions in the world it would constrain the autonomy of the Independent midwife.” (Red MW 20)*

Phoebe (MW14) also expresses very mixed feelings about contracting into the NHS, however, the fact that this move may enable more women to access a more tailor made service did appear to hold attractions. This sentiment is expressed by many of the midwives in this study and indeed, as discussed in the previous findings chapter, the move into independent practice was often tinged with the guilt of not staying in the NHS to campaign for better maternity services for all women. Phoebe (MW 14) can see the advantages of contracting in order to promote more access to services. She also indicated that she tried to help less wealthy women access her services in order to facilitate this, albeit in a very limited fashion, with apparent financial consequences to her. However, on the other hand she perceived that contracting in might bring greater financial security but with another potential trade-offs for this being the expectation of taking on a higher caseload of women:

*“We are trying very hard; there is all this sort of contracting in. I have very mixed feelings about the contracting in, very mixed feelings, it would help.... I mean I probably have, I don’t know, probably a third of the women who book me each year really can’t afford to pay me. I get quite a few women each year who will pay me their Sure Start £500 and then maybe they will pay me £20 per month for two years or something like that. So it would be nice to be paid in a better way although I am not sure how much that will be per actual case, and how many cases would you then having to increase your caseload to actually.....”*

*(Phoebe MW 14)*

Contracting into the PCTs was not something with which all Independent midwives appeared to agree, with the perception that this could divide what had

previously been articulated to be a very cohesive and supportive group of midwives:

*“There are certainly some independent midwives, who I know are very, very wary about going down this route, which I totally understand, but I would not want to ostracise those midwives who would be worried about being in the system. It is a very tricky situation”. (Phoebe MW 14)*

Within this sample of midwives those midwives who rejected the idea of “contracting in”, expressed their views very passionately, in fact, some of the midwives indicated that they wanted to continue to practice as an Independent regardless of the new legislation and wondered what in reality would be consequences of this decision. Both Freya (MW 16) and Brigid (MW 13) for example, articulate considerable resistance to the new legislation and the requirement to comply with this to continue to practice as a midwife:

*“We have possibly got a way of being contracted in but that’s not going to come in before the law for the insurance is implemented. So I don’t know, we have told them, we have told Chris Beasley (Chief Nurse) in 2006, she told us oh, you will just have to go back in to the NHS and we said, well we won’t, what are you going to do about it? Put us all in prison?” (Freya MW 16)*

*“I hope that we will be contracted in and that we have something similar to New Zealand .....I think the mandatory indemnity insurance.....I think we should have confronted them...my colleagues wanted to go down the road of trying to co-operate, but I think we should have challenged it. We should have said, I’m practicing, I am a professional practitioner, I can’t have indemnity insurance, if you sue me you are not going to get very much, you can have me struck off and*

*quite rightly too, but you cannot sue me because I haven't got any money. If it is illegal to practice, well, I don't think that they would have me in Holloway, and I don't think that they would have 30 midwives in Holloway! I think we should have challenged, challenged it but we didn't."* (Brigid MW 13).

Brigid (MW13) makes reference to the revolutionary system of maternity care in New Zealand, which has enabled midwifery to re-establish itself as an autonomous feminist profession based on a model of partnership with women and where midwives are able to access payment and indemnity insurance from the state (Guilliland & Pairman 1995, Surtees 2010). She also demonstrates that she feels more should have been done earlier to challenge this legislation, indicating the perceived potential for division amongst Independent midwives was already beginning to manifest.

Whilst her colleagues expressed ideas about "contracting in" to the NHS or resisting this and the potential death of "true" midwifery, Jemima (MW18) perceived that the status quo would prevail, and at the time of data collection her view was that this was not going to happen. This of course is not the case and new European legislation will come into force 25.10.13 (European Parliament and Council of the European Union 2011), however, the Royal College of Midwives has indicated that is striving to protect Independent midwifery and its practice by looking to an alternative solution to the requirement for indemnity insurance (Warwick 2013). This on-going contextual issue will run up until this deadline and probably beyond.

Jemima (MW 18) saw the working environment in the NHS as a trigger for more and more midwives, over a period of time, to move into independent practice.

She did however see potential for both NHS and Independent midwifery to come together in the future if midwifery led units (within the NHS) are allowed to function properly as such. However, her perception was that the medical establishment and its influence would not allow this happen fully:

*“I don’t think anything will happen, in stark contrast to quite a lot of my colleagues. I think we will continue to limp on in many ways providing pockets of good .... I think there will slowly be more independent midwives but that is probably because the NHS is getting a horribler and horribler employer. Working conditions, I think, within the NHS is not improving. I don’t see us contracting in. I think the gulf between Independent midwifery and the NHS midwifery is widening despite the midwifery led units; they’re our only possible bridge. If they really take off, if they were properly supported by the establishment, rather than sabotaged by government, by the establishment, then we could merge at some point. But I don’t think that will happen, I think the medical establishment is too strong”. (Jemima MW 18)*

The power of the medical establishment is seen as being insurmountable in Jemima’s (MW18) view this is because insufficient women and midwives are willing to challenge what she sees as the growing medicalized view of childbearing. Contracting into the NHS she sees as the ideal solution to Independent midwifery’s current dilemma, but also acknowledges the potential for policies and protocols to constrain autonomous practice, however, her view is that Independent midwifery will continue:

*“I don’t think there are enough stroppy women either as midwives or as women to really take off and overturn the medicalization of child birth. I like the idea of*

*contracting in, a lot of my colleagues are anxious thinking it just means we become NHS midwives governed by all their policies and protocols. I think it doesn't necessarily mean that but we would have to work hard to prevent that happening. I don't think we will become illegal, I think because of European law of not preventing people from following their profession they won't be able to make insurance compulsory. But I probably veer towards the more optimistic line on that". (Jemima MW 18)*

So the future of Independent midwifery is seen by the midwives from several different viewpoints. A number of ideas abound. As Evelyn (MW11) put it, it is a case of watch this space:

*"So I think we are looking at the future, it is watch this space; we just don't know how it is going to unfurl". (Evelyn MW 11)*

## **6.8 Conclusion**

Independent midwifery can be seen as a liberating move for both individuals and for the midwifery profession. Research participants indicate that as an independent there is scope to enact the full remit of the midwife's role (as defined by the NMC rules and standards, EEC Activities of a midwife (NMC 2012) and the International Confederation of Midwifery (ICM 2005)) with the ability to exercise far more professional autonomy than is possible within the NHS setting. Informal support mechanisms are very positively evaluated and are perceived to sustain and support individual midwives in a way that had not been experienced in the NHS. Informal mechanisms and group networking at both a local and national level have also been highlighted as an effective means



of passing on midwifery knowledge, skills and experience and align to recognised ways that women prefer to learn and communicate and often using the medium of storytelling (Belenky 1997, Merriam & Heuaer 1996, Hooks 1994, McHugh 1999, Pinoka 1992). Whilst offering professional liberation on one hand Independent midwifery also is associated with some constraints. These include financial constraints due to uncertain and reduced financial income which has meant that some Independent midwives have had to make considerable adjustments to their lifestyle to accommodate this. Finances are uncertain because these are directly dependent upon the number of clients booked and where midwives have to consider the amount of clients they can realistically care for in order to be able to provide the level of service they aspire to. Midwives have also reported the major impact that Independent midwifery has had on their lives, this is recounted to be a positive and fulfilling but has also resulted in a considerable blurring of life/work boundaries which again have been reported to require adjustment to lifestyle and activity.

Within this study there is an emerging picture of the potential vulnerability of the Independent midwife which is juxtaposed with the ability to enact what is considered by many to be ultimate expression of midwifery practice (Kirkham 2003). At the outset of this study the concept of vulnerability and Independent midwives was not something that I would have immediately put alongside one another and from the experience of undertaking interviews with the research participants, I was left with an impression of a spirited and enthusiastic group of women, passionate about what they do and who are prepared to be very flexible in order to support the informed choices of their clients and pushing

boundaries of existing practice as has also been acknowledged by Nightingale (2010). It was only after analysing transcripts that this theme emerged, and the dynamics of the vulnerability became clearer. This was not something that I had anticipated finding. They are also potentially vulnerable because they often work with women who require highly complex care because of past traumatic NHS childbearing experiences, and who may be considered “high risk” and who are seeking a home birth, a finding also illuminated by Symon et al (2009). Amongst the midwives’ narratives there is an articulated understanding of their professional vulnerability in relation to the difference in philosophy and model of care and the philosophical stance of an increasingly risk adverse NHS, and NMC (Kirkham et al 2012) and how they both tolerate and respond to midwives who work outside of this frame of reference (Kirkham 2011, 2010, Edwards et al 2011, Kirkham et al 2012). Government maternity policy rhetoric, particularly in relation to choice and control largely coincides with what Independent midwives appear to be trying to achieve for their clients (Department of Health 2010, 2009, 2007a, b, 2004). However, the experience of both women using the service and midwives working in the NHS suggest that this is far from reality (RCM 2011b, Kirkham 2011, Edwards et al 2011, Beech 2009, Edwards 2006a, Curtis et al 2006, Hunter 2004).

Supporting what Nightingale (2010) has described as “truly informed choices”, is seen as a corner stone of Independent midwifery practice as is respect for women’s autonomy and control over these choices and decisions (Nightingale 2010). Indeed women’s right to have control over their childbearing and birthing experience has been a focus of recent discussion both within and outside of the

midwifery profession nationally and internationally with recognition in law that this is a human rights issue (Ternovszky v Hungary 2010, Prochaska 2012) and this theme will be discussed further in the following final chapter. The other vulnerability for independent midwives is that of their inability to secure professional indemnity insurance and with the enactment of new European legislation on 25.10.13 they will not be able to practice legally without this. Midwives in this study have identified their thoughts regarding the future of Independent midwifery and it is evident from these that feelings within Independent midwifery are divided in terms of where this might be. The following and final chapter seeks to pull the threads of this thesis together, choosing to focus on and to critically discuss three main conceptual and underpinning themes represented in this study. These are time, autonomy and risk.

## **7 Discussion**

### ***7.1 Introduction***

This thesis has produced an abundance of rich data about the lives of Independent midwives and their relationships with their clients. Data has illuminated their reasons for entering the profession, what they hope to achieve, their experiences of working within the NHS, their journey into independent practice and finally their lived experience of working as Independent midwives. Their *raison d'être*, I will argue, is a strong motivation to enact the “with woman” philosophy, the traditional meaning of the word “midwife”, and the essence of what it means to be a midwife (Stevens 2003, 2009, Walsh 2009, Page 2000, 2008, Leap & Pairman 2006). The findings from this study suggest that this desire has guided their career path and the environment in which they have actively sought to practice. Central and indeed pivotal to the “with woman” philosophy is the establishment of a “connection” with the women in their care by means of the mother midwife relationship. In recounting the stories of their lives as midwives the emergence of themes and issues that have already been well discussed within midwifery literature, particularly around case-holding practice and continuity of care (Stevens 2003, 2007, 2009, Walsh 1999, McCourt & Page 1997, McCourt 2006, 2008, 2010, Hodnett 1995, 2004, Sandall 1997, 2001, Hatem & Sandall 2009) are apparent and no less valuable because of this as they further reinforce the credibility and trustworthiness of past evidence in this respect (Holland & Rees 2010). However this final chapter aims to focus on and discuss the findings that represent a new contribution to midwifery knowledge. It will be argued that whilst Independent midwifery

presents gains for both women and Independent midwives as compared with their NHS counterparts, new risks and vulnerabilities are also inherent in independent practice at this time that do not appear to be well understood. This relates particularly to situations where an Independent midwife feels it necessary to transfer a client to NHS care in emergency situations. Delays have been reported because the midwife's assessment of the situation and her knowledge of the woman have been disregarded or the midwife's practice before transfer is criticised because it does not align to NHS policies and guidelines.

The study has also illuminated several new and interesting aspects of Independent midwifery practice in relation to the mother midwife relationship when this is set in the context of a business relationship. Additionally the study provides insights regarding the working lives of Independent midwives, the characteristics of Independent midwives and why they feel so passionately about practicing as independents when often this can place them in a position of personal and professional risk and vulnerability. Within the context of aspiring to create and maintain a strong "connection" with the women they care for there are particular issues associated with the business and contractual relationship that they need to consider. Several factors act in combination to potentially place the midwife in a position of vulnerability. These factors include the midwife's strong desire to enact the "with woman" philosophy, and in particular the recognition of women's right to make informed decisions and acknowledgement women's autonomy in this respect. Many aspects of these

findings have been discussed in earlier chapters of this thesis when detailed data were presented. Within this chapter three key overarching concepts are highlighted and explored in more depth. I have chosen to discuss “time”, “autonomy” and “risk” in midwifery which I perceive to be key emergent concepts within this thesis. Importantly, these concepts do not stand in isolation; they are seen as inter-related and interwoven in complex ways. Each of these concepts is considered from several different perspectives: that of the Independent midwife, the women that access their services and that of NHS midwives and doctors.

In the first section the abundance of time available to be a midwife in Independent midwifery as compared to that available in NHS midwifery is discussed. This explores a number of frames of reference from which time can be considered and includes an exploration of the notion of “slow midwifery” and working in women’s time and “institutional time”. Time as an essential requirement for the formation of rapport and a meaningful mother midwife relationship is theorised using an adaptation of Ricoeur’s theory of interpretation (1981). This adapted theory sees the childbearing woman as a phenomenon to be interpreted and understood by the midwife in order that she can give appropriate and individualised care.

The second section discusses the midwife’s ability to exercise autonomy from the perspective of both NHS and Independent midwifery practice. New found autonomy in independent practice on a number of levels is juxtaposed against

new constraints on the midwife's personal autonomy. Autonomy to practice midwifery in a way that is meaningful which includes respect for childbearing women's autonomy, is also discussed from the perspective of its potential to place the Independent midwife in a position of vulnerability.

The final section considers "risk" and how both independent midwives and childbearing women construct notions of "risk". Crucially, how this is felt to influence Independent midwives' practice is discussed. The quality of the mother midwife relationship where women's needs are understood is contrasted with situations where lack of time to form rapport and a strong and trusting relationship is aligned to risks for both the mother and the midwife

## ***7.2 Time***

This section considers the concept of time and how this has been represented within the study. It explores notions and frameworks of time as demonstrated by the midwives in this study and their experiences of how they have seen these operate in their lives as midwives. Having and giving time is seen as crucial in the expression of "being with woman", the essence of what it means to be a midwife (Brodie & Leap 2008, Walsh 2009, Browne & Chandra 2009) and to the building of the mother midwife relationship. Anthropological Studies have highlighted a variety of notions and frames of reference from which to consider the complex phenomenon of time (Thompson 1967, Elchardus 1988, Gronmo 1989, Postill 2002). Notions of "time" can also be seen to exist both between and within different societies (McCourt 2009, Griffiths 1999, Frankenberg 1992,

Bloch 1989). If there is a lack of understanding or appreciation of these different connotations, meanings and uses of time between and within societies and cultures there is a potential to cause tension to all concerned (McCourt 2009). Notions of time have also changed over time. In pre-industrial societies natural phenomena were used to measure time, for example, the notion of night and day, light and dark and how activity was associated with one and sleep, perhaps with the other. Time has been seen to be further demarked by sunrise (time to get up and start work/activity) and sun set (time to stop work or go to sleep). The lunar cycle provided another frame of reference for time as did the changing of the seasons, the former being closely associated with women and their menstrual cycle and therefore very relevant to their reproductive lives (Stevens 2003, 2009). Pre-industrial societies worked with the natural rhythms of the earth, and even now some aboriginal societies, much to the frustration of others that work and live in post-industrial societies, continue to measure and understand time in this way (Becker 2009). These frustrations result from the valuing of “fast” over “slow” that permeates present Western society. Life has become faster and faster with increasing expectations that progress and efficiency is associated with speed (Parkins 2004, Browne & Chandra 2009). This legacy from the industrial revolution and advent of mechanization has profoundly affected the rhythms of life (McCourt 2009, Stevens 2009, 2003). Maternity care could be seen to reflect the values and beliefs of society in this respect. Additionally the influence of the medical model of care has facilitated the view that childbearing and childbirth are inherently faulty processes requiring technology and intervention, often to speed it up when physiological



time is deemed to be too slow (Browne & Chandra 2009, Kitzinger 2003, Davis-Floyd 2001, Murphy-Lawless 2000, O'Driscoll 1973, 2003, Cahill 2001). Women's control over their childbearing and childbirth time has also been further eroded by the move of childbirth from the community into large centralized hospitals on grounds of alleged safety (Tew 1998, Oakley 1980, 1984, 1987), and where they are obliged to adhere to institutional notions of time (Frankenberg 1992). But it is not only "women's time" that has been subject to control and restraint by this move; the time of midwives has also been controlled by an amalgam of power, gender, professional autonomy and socio-economic factors that have collectively influenced the ability of midwives to enact the full expression of their role (Fahy et al 2008, Mander & Fleming 2002, Reid 2007, Cahill 2001, Sargent 2002). The issue of the autonomy of midwifery and in particular how this operated in this study will be discussed below. However, the speed at which midwifery is now practiced within highly pressured centralized maternity units (Sandall 1997, 1999, Hunter 2004, Curtis et al 2006, Royal College of Midwives 2011b, Stafford 2001) contrasts sharply with the experience of Independent midwifery as reported in this study.

### ***7.2.1 "Slow Midwifery"***

"Slow midwifery" as a concept is something that has been discussed relatively recently within midwifery literature amidst increasing dissatisfaction of practitioners in practising "fast midwifery" within the NHS setting (Walsh 2005a, Browne & Chandra 2009). Walsh (2005a) has drawn attention to the underpinning philosophy of the "Slow Food Movement" (Schlosser 2001, Jones et al 2003, Parkins 2004), which emerged in the 1980s as an antidote to "Fast

food” restaurants like MacDonald’s. Walsh’s analogy comparing consultant led, hospital based midwifery with the fast food industry and consumption makes links with more pervasive critiques of modernity whilst also presenting an alternative way to consider Independent midwifery, what it aims to achieve and how its practitioners see themselves. “Fast food” has been criticized for a number of reasons including failing to champion local produce and local cuisine, food preparation and traditional cooking methods and not facilitating time for consumers to savour food through maximum use of all the senses (Walsh 2005b, Parkins 2004). Based on his own research related to free-standing birth centres, Walsh (2005b) points out that the “Slow Food Movement’s” overarching principles have high resonance with his study’s findings (Walsh 2005a). Free-standing birthing centres are seen to work at a “slower” pace than that of an NHS Consultant Unit. He claims that this slower pace has served the “slow food movement” on several levels; it is a local service for local families; it focuses on preparing the birth environment; there is a focus on traditional skills, rather than on technology in supporting women and there is an orientation to experiencing the physicality of labour, usually not masked by external drugs. Finally and importantly, there is an overarching relaxation of clock time.

Independent midwifery as evidenced by and articulated by the midwives in this study, does all of this and more, while the birth centre is able to offer “slow midwifery” (Walsh 2005a), working as an Independent midwife means that a more focused and entirely individual service can be provided which can be almost exclusively predicated on “individual childbirth time”. Within this concept

of childbirth time there is also the recognition that each woman has to find her own way on this journey and to be able to reach a space within herself where she feels “safe enough to let go” (Anderson 2000). The midwife supports her by being “with” in the sense of being alongside her. This timeframe has been recognized by Pizzini (1992) as “women’s time”, and it is seen as individual and unique to each woman. As we see in chapter five working with women in their time is something that the model of Independent midwifery can offer, because midwives have had time to observe, get to know and understand women in labour in an “undisturbed natural time”. This is very different to the “institutional time” characteristic of midwifery practice in large NHS consultant units, where women’s physiology is plotted against time in the execution of the dominant medical model of care that is perpetuated there (McCourt 2009, Simonds 2002, Murphy-Lawless 2000, O’Driscoll 1973). It is also very different to the industrial model of time, where time is money, and speed and efficiency are synonymous with production line industries. The application of business and industrial principles of cost effectiveness and efficiency to the health services by means of the introduction of business managers following the Griffiths Report in 1983, has meant that time, both women’s and midwife time have been under constant scrutiny and controlled by sanctions. Independent midwives although self-employed and technically running a midwifery business resist this approach. Their concerns being that they would not be able to provide the high level of tailored one to one service that they aspire to if too many women were taken on at any one time. The philosophy of care and the enactment of this is prioritized over financial considerations, a complete antithesis to the situation within the

NHS. Independent midwifery, as articulated within this study, is something that is practiced at considerable personal cost to midwives, both in financial terms and in terms of personal time. As we have seen in chapter five and six rather than focusing on monetary rewards, midwives perceive gains in rather more altruistic ways, articulating the need to help women achieve their personal goals for birth, perhaps healing previous trauma caused by life or previous NHS birth experiences, working with women on an holistic and individual basis which they as midwives find meaningful and from which they derive much job satisfaction.

Increased job satisfaction has been aligned with holistic and caseload models of care have been highlighted by other midwifery studies (Sandall 1997, Walsh 1999, Hunter 2004, 2006, Kirkham et al 2006, Olafsdottir 2006, Walsh 2007). But in order to achieve this satisfaction, Independent midwives in the UK, make the decision to move from a situation of relative financial security to one where this is uncertain and income relates directly to the number of women they take on. In order to deliver the quality of service to their clients and enact the “with woman” philosophy, numbers have to be limited. It is very clear that Independent midwifery is not something you do to get rich, and the opportunity to run a business is not one of the chief drivers for moving into this type of practice; it is rather a means to an end. It is also something that felt very alien initially to the midwives in this study although seen as a necessity in order to practice in this way, as an alternative has not existed within the NHS. Significantly the midwives interviewed unanimously stated that they felt that this type of care, which is rooted in individual childbearing women’s time, should be

available to all women and not just those who could afford it. As reported earlier, they often went through a period of angst as they worked through their feelings about leaving the NHS, leaving the majority of childbearing women for the minority of women who could access Independent midwifery care.

### ***7.2.2 Time as an Investment***

Independent midwives have told me they invest time in women. This ethos reflects a model of care which is more akin to the humanistic or even the holistic model of care as defined by Davis Floyd (2001). In her critical exploration of models of care, Davis Floyd's (2001) definition of holistic care is very different to the rhetoric around holistic care that can be seen to abound in professional midwifery which perhaps more accurately reflects the social model of care (Walsh & Newburn 2002a,b). The holistic model of care, according to Davis Floyd (2001) engages the mind, body, emotions and additionally spirit of individuals and principles of connection and integration are seen to underpin therapeutic relationships. This model has considerable resonance with the model of care practiced by Independent midwives on certain levels, for example the view that their clients are seen as whole people and viewed within a whole life context. In this holistic approach there has to be an essential unity and interconnection between the client and the midwife and in line with holistic healers, the client is encouraged to take responsibility for making fully informed choices and decisions about their care (Davis Floyd 2001, Oschman 2000, Worwood 1997, 1999, Quest 2010, Sayre-Adams & Wright 2011).

Independent midwives have rejected the medical model of care (Milan 2003) and undertake care in the home of their clients where time has different meanings and connotations to that which operates in institutionalized care settings. Frankenberg's (1992) analysis of how time frameworks operate within medical institutions, theorizes how patients are disempowered by being placed and treated in timeframe which is alien to them and is based on the power structures and status hierarchies of a medicalized institution. The recognition of individual time is overridden by the needs of the institution to care for the masses. Independent midwifery presents a completely opposing approach to this as care is focused on the individual woman, her family and her social context and commonly happens in her home. It is interesting to consider the positioning of the midwife in time in this situation, using Frankenberg's (1992) analysis in order to consider how the power structures differ in these two contexts. The woman and her family operate in their time frames, the Independent midwife is placed in this "alien" timeframe when she attends the woman to care for her at home and is required to adapt to this by spending time there. The midwife is not disempowered in quite the same way as Frankenberg (1992) suggests patients are in institutional settings, however, she endeavours to respect and adhere to the woman's frame of reference with regard to time, being mindful that this is necessary as the woman is her client. Nevertheless, this is not the only reason as evidenced by Freya's (MW16) narrative in Chapter Six. By spending time with the woman in her "time" helps the midwife to understand the ebb and flow of woman's individual rhythms enabling her to interpret and understand these and in order to work appropriately with the

woman. Indeed the midwife would argue that the woman's home is the best place to care for her as it enables her to be given appropriate care in context. Nevertheless the power relations that could be considered to favour the woman, need to be considered because of the potential implications of this for the midwife, particularly in situations when care and outcomes do not go to plan. This will be explored further when the concept of risk is considered.

Having invested time in building the mother midwife relationship Independent midwives articulated a number of benefits associated with having more time available to observe, listen and care for women in an unrushed manner. As articulated in their stories in Chapters Five and Six, midwives provide accounts of how they "hear" the hopes fears and expectations of their client, how they get to know them, and understand what makes them strong and what makes them vulnerable. They observe body language, behaviour of women in labour, gestures, facial expression; they have the time to notice these things. Importantly they see these things as sources of information which help them to understand the woman herself. In the same way that perhaps busy people who, when they have some holiday and slow down hear the birds sing. This is not to say that the birds were not singing before this time, merely that they had not the time to notice or hear them. From this study, as we see in Chapter Five the midwives talk about Independent midwifery as being in a state of slowed time, they recount the extra time that they have and the benefits this brings. The birds that they hear "sing" are the women they care for, they are able to observe them in their own time and particularly when they are in labour. This for many

midwives brought with it new knowledge about childbearing (Esmie MW9, Erica MW 1), a finding which has been echoed in Winter's study (2002) about Independent midwives in the UK and how they make assessments of women's progress in labour. As is evidenced in Chapter Five, spending more time with childbearing women during their pregnancy enables the midwife to get to know them better. Consequently, when labour ensues the Independent midwife is able to quietly be "with woman" rather than constantly chatting to her potentially disrupting the rhythms of her body and importantly, the psychological and spiritual transitions and adaptations that labour brings (Winter 2002). Within this study as we saw in Chapter Six midwives report their observations that woman can slow their labours down if their "environment for birth" is not how they want it to be (Ingrid MW5, Esmie MW9). Here birth environment not only refers to the physical setting but also to the social and psychological and even spiritual factors that surround it, that influence a woman's ability to labour. They recount tales of women who want other young children to be taken to school or picked up by grandparents before they will let their bodies go on to birth their new baby. This resonates with Pizzini's (1992) notion of women's internal time, and from what has been expressed by the midwives in this study, this understanding means that they respond differently to any lull in proceedings (Freya MW16, Ingrid MW5). In this eventuality there is an exploration of any psycho-social concerns with the woman in order to work with her to try to resolve these, rather than quickly identifying this as a deviation from the normal and referring the woman to an obstetrician within an NHS institution (NMC 2012c).



This evidence does not sit easily with a medicalized view of progress in labour that focuses on physical indicators and in particular insists that a woman's cervix must dilate at a standard rate, and guidelines that suggest that if this standard is not reached the woman's body has "failed to progress" (Downe & Dykes 2009, Adams 1992, 2007, O'Driscoll 1973). Time restrictions are not rigidly enforced because there is an understanding that provided all observations of maternal and fetal wellbeing are satisfactory, women will birth in their own time. As evidenced in Chapter Six the challenge comes for independent midwives when they have to transfer a woman to NHS care because of concerns about well-being. In this scenario I have been told about the interface with the NHS which in this context could be aligned to a clash of philosophies and where "slow" meets "fast" midwifery (Freya MW16). The interface with NHS colleagues is often experienced negatively by independent midwives. The care that they provide is criticized because a fundamentally different model of care has been worked, one that acknowledges evidence based care and use of clinical guidelines but that exercises professional judgments and decision making which is then applied to individual circumstances rather than following protocols and guidelines to the letter. Independent midwives try to work with the woman in order to try to meet her needs, requiring them to practice in flexible and in creative ways that may differ from standard NHS care. Different, however, does not necessarily mean wrong. However, those that review the practice of independent midwives under the statutory framework and requirements of supervision of midwifery (NMC 2012c) are predominantly based within the NHS, and this fact highlights one of the

potential areas of vulnerability for independent midwives unless that supervisor understands the ethos and dynamics of independent practice. This lack of understanding, as evidenced in this study in Chapter Six and also in other literature, has been experienced as punitive rather than the supportive ethos which contemporary supervision of midwives purports to have at its heart (Kirkham et al 2012, Kirkham 2011, Edwards et al 2011, NMC 2010b).

### ***7.2.3 Time and the Mother Midwife Relationship***

Within this study time was highlighted by the midwives again and again as key to how they achieved connection and rapport with the women in their care. Whilst they also mentioned the importance of interpersonal skills and in particular, “listening, really listening” (Serena MW15), time to chat with women about more general issues as well as hopes and fears around their pregnancy was by far the most important factor. “Chatting” enabled the midwives to gain information about the individual women, and in the words of one of the research participants:

*“..finding out what makes them tick and what makes them anxious or what makes them feel strong. And within that we do discuss what their hopes are for the birth.” (Amy MW 17)*

In Chapter Five it can be seen that the midwives try to get to know the women as individuals in order to understand their world view. This in turn helps the midwife to understand how she can work with the woman to achieve her wishes and crucially to achieve a trusting relationship.

In analysing this data, I used Ricoeur's theory of interpretation (Ricoeur 1981). This theory, based on hermeneutic phenomenology (Heidegger 1962), and in particular notion of the hermeneutic circle (Gadamer 1976) provides an understanding of the way in which independent midwives articulate how they achieve connection with the women in their care. The hermeneutic circle (Gadamer 1976) and Ricoeur's theory of interpretation (Ricoeur 1981) have been previously described in Chapter Three when this study's methodology was discussed and is visually depicted in Figure 1 on page 118. Hermeneutic phenomenology seeks to understand and interpret the lived experience of phenomena (Heidegger 1962, Gadamer 1976, Ricoeur 1981). This understanding is achieved incrementally by means of the researcher interacting with the data, and moving from an initial description of the lived experience, then one of understanding the experience and finally to being able interpret the underlying meaning and significance of this. This process is seen as cyclical as the researcher constantly examines and re-examines data in order to come to an increasing level of understanding and insight that then allows them to interpret meaning and significance (Heidegger 1962, Gadamer 1976, Ricoeur 1981). Crucially, the worldview/lived experience of research participants as represented in the written data, interacts with the worldview/lived experience of the researcher until understanding of and interpretation of meaning is achieved resulting in what has been termed as a "fusion of horizons" (Gadamer 1976, Ricoeur 1981). An analogous process is apparent in the practice of Independent midwives, where the midwife effectively "researches" the childbearing woman with the aim of understanding her lived experience and

importantly interprets the significance and meaning of this lived experience in order that appropriately tailored midwifery care can be given to meet her needs. The vehicle for achieving this is the mother midwife relationship. Immersion in the worlds of their clients is facilitated by continuity of care and carer and the enhanced time that independent midwives have to interact with the women.

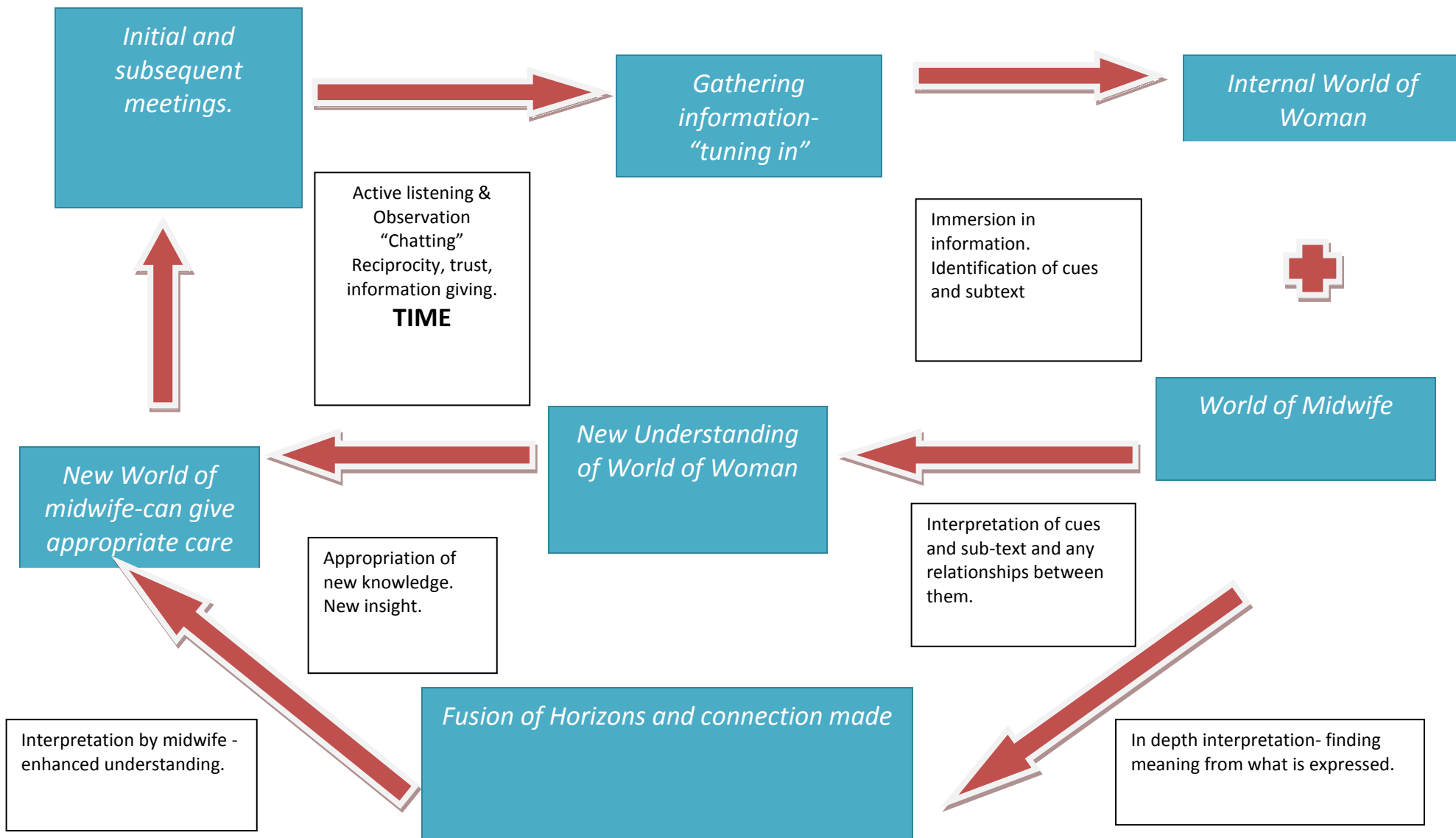
From their initial and subsequent meetings with women in their care midwives, like a researcher, gather data. In this context, this information about the woman is gathered from a number of sources on numerous occasions over the course of the woman's pregnancy: those verbally expressed (requiring active listening skills), body language (observation skills) and exposure to the social context of her world (home environment, family and significant others). This information enables the midwife to "tune in" to the woman in her care, but repeated exposure and identification of further cues and subtext expressed by the woman and immersion in more "data" from repeated interactions appears to allow the midwife to glimpse the "internal world" of the woman and begin to understand her as an individual. This understanding requires that the world of the woman and the world of the midwife interact, the midwife "moving" between her own world and that of the woman until a point is reached where there is enhanced understanding of the world of the woman, a "fusion of horizons" where both understand each other and there is connection and trust. The midwife having an enhanced understanding of the woman perceives that she is better placed to give appropriate care and the woman understanding she can trust the midwife. The degree of reciprocity on the part of the midwife is seen in this study to vary

with clear understanding of the need to keep sight of professional responsibilities. Figure 2 presents a diagrammatic depiction of this theory (see page 327).

The enhanced understanding or “fusion of horizons” (Gadamer 1976) that results from this process then enables midwives to not only know how to best support that individual woman but also importantly to know when there were deviations from that woman’s “normal”. Thus the context of the mother midwife relationship takes on huge significance to the work of the Independent midwife as it is seen as a crucial midwifery tool. The role of time is critical here. The “fusion of horizons”, that of the internal world of the woman and that of midwife understanding this internal world takes time and repeated exposure. This at least partly explains why independent midwives are reluctant to take on a woman late in pregnancy when they have not had the opportunity to reach an understanding of the woman’s world, indeed this is perceived by midwives as being risky as is evidenced in Chapter Five. There are particular reasons why risk in this context has significance to Independent midwives as will be discussed in the next section, however, as has happened so many times during this study, one is left pondering NHS maternity provision as articulated in this study and in this instance the lack of time available to form relationships with women in order that their worlds can be understood and how this could also be considered an area of risk. This lack of time has been raised as an area of concern within the midwifery literature (Hunter et al 2008). “Slowing down” of midwifery time holds the potential to facilitate the building of relationships with women but this unfortunately within the NHS has not been valued over other

priorities (Browne and Chandra 2009). Several authors have raised the question of why it is that within a healthcare system that values efficiency and has in place policies to avoid risk that investment in time to build relationships with women is not valued (Murphy-Lawless 2000, Browne and Chandra 2009), nor is this “efficiency saving” acknowledged as a potential risk area in itself when it reduces the opportunities for the formation of meaningful relationships and this warrants further investigation. There is now considerable evidence that supports the beneficial effects of the presence of a labour companion particularly one with whom the woman has had a continuing relationship (Hodnett et al 2004). Additionally, Hatem et al (2008) point to the value of midwifery led care models where the building of meaningful relationships and working in partnership with women are central tenets, indeed this concept can be seen to be embedded in government policy for the Maternity Services (Department of Health 1993, 1998, 2004a, 2007a, b, c, 2009, 2010a). However, the valuing of economic drivers over a caring agenda limits the time practitioners have to form relationships in order to assess the needs of women. This could be viewed as false economy when one considers that this strategy may lead to vital information being missed, resulting in inappropriate care and potentially increased mortality, morbidity and litigation claims (Nelson-Piercy et al 2011, King’s Fund 2008, RCM 2011b). Indeed the women who feel they have been poorly served by the NHS maternity services have been shown to be those that may well access the services of an Independent midwife (Symon et al 2009, 2010). Although not directly related to maternity care very recent

Figure 2 –How Independent Midwives in this study connect with women using the Principles of the Hermeneutic Circle and Ricoeur’s Theory of Interpretation (1981)



evidence in the form of the “Francis Report” (The Mid Staffordshire NHS Trust Public Inquiry 2013) provides further disturbing evidence of the consequences of prioritising cost cutting and “efficiency measures” over the quality of client care.

This study has focused on the narratives of Independent midwives and thus presents one side of a complex story of Independent midwifery practice. The value placed on Independent midwifery by clients was reported by the midwives in the study and these accounts resonate with other studies which have explored women’s experiences more directly. A very small phenomenological study by Milan (2003) recounts three women’s experiences of Independent midwifery comparing care with previous instrumental births in the NHS. The women recounted very positive experiences which they felt were life changing and the effects of which went beyond the pregnancy and birth itself, one of them using the term “healing” to describe her experiences. The study pointed to a number of key factors in their experience of Independent midwifery that made this special. Women reported that this included being listened to, being the centre of attention, having available as much time as was necessary and being given information and strategies for coping (Milan 2003). Midwives in this study have articulated at several points the complexity of the women who access their services and this has been further confirmed by Symon et al (2009, 2010). As can be seen in Chapter Five they have talked of women who have been traumatized by their life or NHS experiences. They also perceive that one to



one care and access to 24/7 midwifery care by an Independent midwife, that incorporates listening, support and facilitation of women's control over their childbearing and childbirth experiences can be seen as a "healing" experience. The outcome of which is a positive birth experience over which the woman feels in control. Time and the mother midwife relationship are perceived by these midwives as the healing agent. But in line with models and philosophies of holistic care and healing the "healing" is something that the woman undergoes herself (Davis-Floyd 2001, Brennan 1990, Angelo 2009, Le Quesne & Beckman 2005) with the midwife, "holding the space" for her (Browne & Chandra 2009, Pizzini 1992, Fahy, Foureur et al 2008). Davis-Floyd's (2001) definition of holism resonates with the major tenets of many other healing traditions, some of which are now considered as "alternative therapies" and that acknowledge a spiritual and energetic dimension of existence as previously mentioned (Brennan 1990, Angelo 2009, Le Quesne & Beckman 2005). This resonance takes us full circle to the concept of the midwife as a healer, as she was often seen in her local community in ancient times (Achterberg 1991, Ehrenreich & English 1979, Garratt 2001). However, within this study whilst there was articulation of the spiritual aspects and understandings of childbearing expressed by some Independent midwives (Ingrid MW5, Angel MW19, Red MW20) this was also resisted by others (Erica MW1, Chloe MW4), who preferred to see their role in terms helping others to self-actualize (Maslow 1970). However, regardless of the terms in which the midwives chose to articulate this, time was seen as being crucial in order to develop an understanding of the individual childbearing women in their care.

### **7.3 Autonomy**

Within this section the concept of autonomy and how this emerged as a key theme within this study will be critically discussed. The concept of autonomy is central to the definition of the midwife (World Health Organisation 1992) and this autonomy has been considered to be central to women's freedom to control their healthcare (Wagner 1997). The concept of autonomy however has been subject to considerable debate and as a consequence has been subject to diverse definitions and ideas (Kant 1959, Rousseau 1968, Curtin 1979, Sargent 2002, Fleming 2002, 1998, Symon 2010, 2006). Dworkin (1988) attempts to summarize this diversity of thinking by stating that autonomy is equated with:

*“dignity, integrity, individuality, independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation; with knowledge of one's own interests...It is related to actions, to beliefs, to thoughts, and to principles. About the only features held constant from one author to another are that autonomy is a feature of persons and that it is a desirable quality to have” (Dworkin 1988: 6)*

Despite varied definitions there would seem to be some agreement that it does at least have to do with the exercise of choice and power to make decisions and to act upon those decisions (Henry and Fryer 1995, Pollard 2003). This is of interest to midwives because in the UK the legal responsibility for their practice is based on the assumption that they are “autonomous practitioners” (Dimond 2006, Pollard 2003). However, as has been asserted by Fleming (1998) an autonomous profession is one that is self-regulating and self-governing and by this definition within the UK the midwifery profession cannot be defined as such because of the control that has been exerted, and continues to be exerted by nursing and medical organizations and their attendant policies, frameworks and guidelines (NMC 2012, 2008, 2009, Pollard 2003, Fleming 1998, Jowitt 2000). Whilst acknowledging no-one can be considered to be without some kind of formal or informal regulatory practice or sanction, or indeed to operate as an agent outside of any constraints, Independent midwives can be seen to exhibit enhanced characteristics of autonomous professional practice (Pollard 2003), as compared with midwives working in the NHS. This comes at a cost however as discussed in Chapter Six, as boundaries between professional and private lives are seen to blur exerting different constraints to those experienced in the NHS as reported in Chapter Four. These are, as will be discussed chiefly experienced in relation to their personal autonomy.

The management of childbearing in the UK in the 20<sup>th</sup> century has been subject to huge changes with massive implications for the autonomy of both childbearing women and midwives (Mander & Fleming 2002). A critical factor

influencing this has been the move of birth from home and the community to a medicalized hospital setting resulting in a reduction of autonomy for both as has been previously discussed (Page 2008, Robinson 1989). Growing dissatisfaction with the maternity services as a result of this increasing medicalization of childbearing, particularly from the 1970s onwards, triggered a number of service reviews which have had profound influence on the aspirations of the midwifery profession in the UK and what it hopes to achieve for childbearing women (Maternity Services Committee 1982, 1984, 1985, Department of Health 1993, 1998, 1999, 2004a, 2007a, b, 2010). As a result, a number of schemes to re-organize midwifery care, re-deploy midwives and reconfigure their working practices have attempted to provide a more women-centred, humanistic and individualized service. These also facilitated feelings of increased autonomy, job satisfaction and control over working lives for the midwives working in these schemes. (Association of Radical Midwives 1986, Flint & Poulengeris 1989, McCourt & Page 1997, Allen et al 1997, Walsh 1999, Benjamin 2001, Stevens 2003, Pairman 2006, Page 2006). These new arrangements involved either the concepts of team or case-holding practice and were aimed at providing less fragmented and better continuity of care and carer. The erosion of the midwife's role has been well documented over the years (Bates 2004, Stewart 2004, Rhodes 1995, Achterberg 1991, Oakley & Houd 1990, Donnison 1988), Towler & Brammall 1986, Oakley 1976, Ehrenreich & English 1973) although there would appear to be some discussion and debate as to when this started (Mander & Flemming 2002). Some cite the invention of the obstetric forceps by the Chamberlain family (Donnison 1988, Towler &

Brammall 1986), whilst others highlight the passing of the 1902 Midwives Act as a means for doctors to control the midwifery profession (Sargent 2002). However, the move of birth from home into centralized consultant units is seen as having a profound effect on the ability of midwives to enact their role, particularly from 1970 onwards after the publication of the Peel Report which recommended 100% hospital birth on grounds of safety (DHSS 1970). Page (2008) and others (Sargent 2002, Fleming 2002) have illuminated the mechanisms by which midwives were regulated, professionalized and controlled by the medical profession in less than a century. This control was achieved by fragmenting care resulting in the “distancing” women and midwives, undermining the very essence of midwifery practice, the “with woman” philosophy. Chapter Four details and discusses the varying experiences of midwives in this study when they worked in the NHS, and because of the age range and experience range of the research participants there is a sense of how these constraints and controls have changed over time. The manifestation of bullying and “horizontal violence” has been identified by Freire (1996) as characteristic of oppressed groups and this has been evidenced within the midwifery profession by a number of studies (Kirkham 1999, Curtis et al 2006, Gillen 2009, Hollins 2010). Indeed this has been further reinforced within this study when midwives recounted their experiences of practice within the NHS in Chapter Four.

As reported in this study midwives recount a very different experience of working alongside Independent midwife colleagues. None of the participants

intimated that bullying was a feature of Independent midwifery, in fact quite the contrary with reference made to experiences of social support, sharing of equipment, information and professional advice, teaching of skills, mentoring, email forums, regional meetings and study days and accompanying colleagues to be present as a second midwife at births. The “with woman” philosophy appeared to extend to encompass and connect colleagues, a strong sense of purpose, shared values and aspirations as midwives connecting them to one another in a way that appears, as reported in Chapter Four, less likely to happen in the NHS. Whilst there is the need to acknowledge the good practice that occurs within the NHS there is potentially much that can be learned from Independent midwives in this respect as bullying continues to be a worrying feature of NHS practice (Hollins Martin et al 2010, Gillen et al 2009, Reid et al 2007).

More recently the midwifery profession has undergone something of a renaissance, at least on paper, as challenge to the medical model of care and enactment of more women-centered and midwifery led models of care have been shown to be beneficial to both mothers and midwives (Stevens 2003, Walsh 2007, McCourt & Page 1997, Hatem et al 2008). The “new midwifery” (Page 2006, 2008) has emerged particularly following publication of the landmark “Changing Childbirth Report” (Department of Health 1993) and for Page (2008) is founded on the “with woman” relationship. Schemes that championed choice, continuity and control for women also resulted in the potential of midwives and mothers forming meaningful relationships (Flint &

Poulengeris 1989, Stevens 2003, Walsh 2007, McCourt & Page 1997, Allen et al 1987, Benjamin et al 2001). Pairman (2006) has gone as far as to say that midwifery is the relationship. Case-holding schemes have been associated with increased autonomy, decision making, job satisfaction and crucially enhanced relationships with the women they care for (Steven 2003, Walsh 2007, McCourt & Page 1997), as compared with more traditional maternity care that often fragmented care and distanced midwives from childbearing women. This rhetoric is integral to the standards and rules for midwifery practice and standards of midwifery education (NMC 2008, 2009, 2012b), and yet case-loading schemes that have been shown to be beneficial have largely fallen by the wayside and there has been a return to more traditional models of care leaving midwives frustrated, disillusioned because they are unable to be the midwives they want to be (Hunter 2004, Curtis et al 2006) and as a consequence have left NHS practice. A few have moved into independent practice where they have experienced increased autonomy. Pollard's (2003) concept analysis of autonomy identifies the characteristics of personal autonomy. This includes determining and controlling one's sphere of activity, having the right and the capacity to make and act on choices and decisions in this sphere, having this right acknowledged by others affected or involved in these decisions and finally to take responsibility for these decisions. These are useful parameters to consider how autonomy could work for midwives and for the women in their care. By these characteristics the aspirations of the midwives in this study and what they hope to achieve for the women in their care are clearly recognizable in Chapters Four, Five and Six. Pollard (2003)

usefully alludes to the consequences of exercising autonomy as being that responsibility is taken for decisions made, the right to have made a decision is accepted as valid by others involved in the situation (even if disagreeing with the decision itself) and finally that personal esteem and confidence increase.

The midwives in this study have made decisions related to their career path that have incrementally resulted in an increase in their ability to practice the full range of skills that encompass the midwife's role and a move towards more autonomous practice (Bethany MW3, Ingrid MW5, Milly MW12, Freya MW16, Angel MW19). This study has illuminated the experience of both constrained and liberated autonomy and several shades in between as midwives make career choices that take them towards their ultimate goal-full enactment of the midwife's role, and in being with woman. They move typically (but not exclusively) from NHS hospital midwifery care, to NHS Community midwifery care and then the eventual move into independent practice (Bethany MW3, Ingrid MW5, Milly MW12, Freya MW16, Angel MW19). Whilst in the NHS their experience of their practice being controlled, constrained, fragmented, and subject to bullying resonates with other studies that have looked at midwifery practice and culture in the NHS (Kirkham & Stapleton 2001, 2004, Sandall 1997, Curtis et al 2006).

As reported in Chapter Six the enhanced professional autonomy that independent practice affords is experienced as liberating as compared to working in the NHS; however this is not without cost in terms of personal autonomy. The reasons for this are intimately tied to enactment of the "with



woman” philosophy, the investment of time in the mother midwife relationship and the depth of that relationship. This is also set within the context of a business relationship where women have engaged the services of the midwife in order to help support their choices and aspirations for birth, as well as a contractual commitment to provide 24/7 for their clients including being present for their birth. Midwives have also expressed their perceptions of potential risk in this context too. According to my participants, women that access the services of an Independent midwife are often highly complex both obstetrically and psycho-socially. This has also been confirmed by Symon et al (2009, 2010). Midwives are aware that the risk of missing vital clues and information may have implications for the health of the mother and her baby for which she has professional responsibility. She is required to refer promptly to other appropriate professionals when care deviates from normal in order to promote optimal outcomes (NMC 2004, 2008, 2012). She also has a contractual responsibility to deliver the quality of care that the woman has paid for. As indicated in Chapter Six the heavy on-call commitment for individual women means (from around 36 weeks gestation until birth - 24/7), that midwives have to consider how far they can venture out, particularly as labour approaches. Women in their care often live up to two hours away, so travel time also has to be considered. Whilst caring for one woman in this situation may not present too many problems, two that are due to birth at similar times might, particularly if they live two hours away in opposite directions. Consequently, in order to deliver the level of care they aspire to they have to consider how many women they can take on. This has direct impact on their earnings and on their own

personal time as work and life boundaries become blurred with the potential for personal autonomy to be constrained as demonstrated by the accounts given by both Rhianna (MW7) and Freya (MW16) in Chapter Six.

Additionally since the 1990s, UK maternity services policy, at least on paper, has promoted the right of childbearing women to exercise their autonomy in relation to making informed choices and decisions about their care (DOH 1993, 2004, 2007). Facilitating this has been at the forefront of midwifery philosophy and rhetoric (IM UK 2012, NMC 2010, 2004, ARM 2009, Page 2006, Pairman 2006) and is seen as one of the cornerstones of independent practice (Nightingale 2010). Evidence from this study suggests that some clients understand their right to exercise their autonomy and chose not to take the advice of their midwife. Freya (MW16) recounts a situation where she was very concerned about the wellbeing of a baby in the last month of gestation. The baby's heart rate was lower than expected and in her professional capacity informed the woman of her concerns, and suggested referral of the woman for consultant review. The woman refused this advice, and continued to refuse this advice, and the midwife remained in a very anxious state. However, she recognised and respected the woman's autonomy in making this decision. The woman finally agreed to go to hospital and had a Caesarean section and a live baby. As Independent midwives recognize a woman's right to make autonomous decisions this can clearly place the midwife in a vulnerable position particularly when they perceive either the mother's or the baby's health is at risk and the woman chooses not to take the professional advice of her midwife

particularly in relation to time to transfer to hospital care if this is deemed appropriate. The midwives in the study know that they practice often from a position of risk and vulnerability and yet their sense of agency and purpose is such that they still wish to practice in this way. When recounting their life stories as midwives they actively seek experiences/roles that enable them to better pursue and enact their very strong sense of “being with woman” which includes being able to exercise more professional autonomy and importantly being able to support childbearing women’s birth choices. It is known that midwives leave the profession because they are not able to be the midwife they want to be (Hunter 2004, Curtis et al 2006). But not all midwives that leave the NHS go on to become independent midwives and indeed it is thought that there are only around 90 Independent midwives in the UK (IM UK 2010). It would be inappropriate to conclude that independent midwives are more passionate about what they do than some of the midwives that leave the profession or indeed those that stay within the NHS. What is apparent from this study however is that the midwives interviewed were able to contemplate a move into Independent midwifery, and experience more autonomy in this respect because of financial and emotional support from their partners. A move into independent practice however, is not without cost as there is evidence that personal autonomy is more constrained. In some cases this meant a radical review of family lifestyle (Chloe MW4, Esmie MW9). As we saw in Chapter Six one of the midwives in this study talked about her and her partner living a very much more frugal existence than before Independent midwifery (Chloe MW4). She reported that this had brought much more satisfaction, purpose and sense of

achievement to their lives and that they were happier with this way of life. All of the midwives in this study recounted the financial uncertainty associated with Independent midwifery and how they felt more midwives would be willing to pursue Independent midwifery if it was not for the financial insecurity associated with it at the present time. There are few families who are able to withstand the financial insecurity that can accompany Independent midwifery without the safety net of a partner with a secure income. Independent midwives' incomes are dependent on women soliciting the midwives' services and being able to pay their fees. All had needed to adjust their finances and life-styles (some more than others) to accommodate a considerable reduction in financial income from that experienced when they worked in the NHS. All of the midwives interviewed however, regardless of their financial set up, stated they would not want to work in any other way and had no regrets about moving into Independent midwifery.

Independent midwifery and the autonomy that this encompasses has resonance with popularized notions of midwifery practice in ancient times (Achterberg 1991, Donnison 1988, Ehrenreich & English 1973), but arguably with all the insights, knowledge and understanding that have resulted from vastly improved midwifery education and opportunity for further research and doctoral studies (NMC 2012, 2009). It is seen by many as the gold standard of midwifery practice and yet it is currently under threat. Not only does it appear to address the aspirations of government maternity care rhetoric (DOH 1993, 1998, 2004a, 2007a, b, c, 2009, 2010) but also represents one of the last bastions where full

enactment of the midwife's role and sphere of practice and in particular the ability to be "with woman" rather than "with institution" (Kirkham 1999, Page 2008) can be exercised. Its future has been placed under threat by new legislation in the form of the new European Directive on patients' rights in cross border healthcare; this requires all healthcare practitioners to have professional indemnity insurance by the 25<sup>th</sup> October 2013 with a proposal that this be made a condition of on-going registration (European Parliament and Council of the European Union 2011, NMC 2013a). The dilemma that Independent midwives find themselves in has been acknowledged by Department of Health (2010b), the RCM and NMC who were subsequently tasked with investigating a potential solution to the problem (RCM & NMC 2011). As a result a report, (RCM & NMC 2011) highlights potential insurability if a group of independent midwives become a formally constituted legal entity, such as a social enterprise company, or a limited company (RCM & NMC 2011, Hewson 2011). At the time of writing there are currently two initiatives that are exploring this (One to One (North West) Ltd 2012, Neighbourhood Midwives 2012). Importantly, both initiatives offer tailored individualized caseload midwifery care which is free to mothers, enabling women from all social groups to access and benefit from the service. One has already successfully secured a three year commission with NHS Wirral (One to One (North West) Ltd 2012). The Neighbourhood Midwives Scheme (2012), championed by members of IM-UK, have actively sought a solution to the requirement for Professional Indemnity Insurance (PII). Both enterprises have aspirations of creating national networks which if successful could affect considerable change to the options and choices for maternity care for women

(One to One (North West) Ltd 2012, Neighbourhood Midwives 2012). There is also potential for more midwives (those currently in the NHS) to work in a way that might be considered more meaningful to them and which may enable them to enact the “with woman” philosophy without the financial uncertainty that has accompanied Independent midwifery. Also, based on the research findings of Curtis et al (2006), and Hunter (2004) one could speculate that if more midwives achieved job satisfaction in this way they may be more inclined to remain within the profession particularly if these schemes are successfully rolled out nationally. However, whilst these new developments offer hope for the future they also need to be considered in the light of autonomy for midwifery and for childbearing women. As have seen in Chapter Six some independents see these developments as a compromise to the autonomy of the midwife and her ability to enact the full extent of her role whilst others see these as a means of survival and an opportunity to work with more autonomy than can currently be achieved within the NHS. It could be argued though that political astuteness has been exercised by Independent midwives in the formulation of these schemes, although reaction to these is currently unfolding. As we outlined in Chapter Six midwives within this study have expressed their feelings about the future of Independent midwifery and what this might look like, and from their comments on this subject it is clear that not everyone will be in agreement with the compromises that have been made, particularly when this means losing midwifery skills in relation to caring for and supporting women with, for example, a breech birth, or twin pregnancy and birth. It could be argued however that political astuteness has been demonstrated by the acknowledgement of the

RCOG (2011) report's proposals for change to the maternity services where responsibility for low risk women is clearly demarcated as the sphere of practice of the midwife and that she should have more autonomy in this respect. In line with RCOG's recommendations and recent evidence on the safety of home birth (Birthplace in England Collaborative Group 2011), the Neighbourhood Midwives Scheme in particular has chosen to care only for low risk women and those for whom home birth has been shown to be as safe as hospital birth (women with second or subsequent pregnancies) (Birthplace in England Collaborative Group 2011, Neighbourhood midwives 2012).

The RCOG (2011) have highlighted that maternity services are currently highly pressurised. In response to this the Neighbourhood Midwives (2012) have emphasized to commissioners of healthcare the advantages of their proposed scheme and how this will relieve the currently overstretched services. It is proposed that the majority of women cared for by Neighbourhood Midwives will need only midwifery input in a local community or home setting thus freeing up hospital time and space for those women with more complex pregnancies. Additionally they envisage their model will address health inequalities by improving midwifery services for socially disadvantaged women as demonstrated by, for example, the Albany Practice which operated in socially disadvantaged Peckham (Sandall et al 2001). These are all attractive selling points for commissioners, whilst there is also the potential for midwives to earn real recognition and acknowledgement for their expertise, an antecedent for

recognition of professional autonomy (Pollard 2003), potentially leading to future advances in the status and standing of the midwifery profession.

For some Independent Midwives, the Neighbourhood Midwives Scheme represents a loss of autonomy with particular concern expressed for women who are deemed “high risk” and the degree to which these women will be able to access choices for care particularly if access to Independent Midwives as they practice currently, no longer exists. It is known that a high proportion of “high risk” women currently access the services of Independent Midwives because of dissatisfaction with the NHS. These women often exercise their autonomy in choice of place of birth by seeking birth at home, a service which is not always readily accessible to them via the NHS (Symon 2009, 2010). Negotiating a home birth has been experienced as difficult by women with “low risk” pregnancies and is even more problematic for women with medically defined risk factors (Edwards 2006, Nolan 2011). How the needs of this group of women will be served in the future has yet to be addressed, with the possibility of them failing to engage with healthcare practitioners at all and “free birthing” (Kaplan Shanley 2012 a, b, Bulmer 2007, NMC 2012) with the attendant potential consequences for their wellbeing and that of their babies. “Free birthing” or unassisted birth is where a woman chooses to give birth without professional or medical support (NMC 2013b).

#### **7.4 Risk**

This section aims to focus on the concept of “risk” and how this is perceived by the research participants. Their accounts indicate that they understand that



there can be a tension between their intentions to support women in their birth choices and the need to stay within professional parameters. Whilst independent midwives indicate that they work in very flexible and creative ways to meet the needs of their clients while also practising within professional parameters, they are aware of potential vulnerabilities which might put their registration at risk. Ironically, one of these risks comes from their clients as will be discussed, and is related to the type of client that accesses their services and their often highly complex needs. Another relates to a lack of understanding of/lack of tolerance of how Independent midwives practice because this is different to NHS practice. This particularly relates to situations when client outcomes are less than optimal and there is cause to review or investigate their practice. As reported in Chapters Five and Six Independent midwives, unlike their NHS counterparts have the opportunity to choose the clients that they care for, in the same way that clients choose which Independent midwife's services they would like to engage. For the potential client and the midwife an initial meeting provides a means of assessing both safety and risk for both parties. The decision for both parties is seen as crucial and getting this decision wrong is understood by the research participants to have major implications. Time invested by the midwife to develop rapport and a trusting relationship with clients is seen as a means of understanding the needs of clients, giving appropriate care and importantly identifying any potential risks either to the client or her baby or to themselves as midwives. This section will start by placing the concept of risk in childbearing in context by discussing the events which have been seen to contribute to our increasing risk adverse

society and how this has impacted on how risk in childbirth and childbearing has been perceived in society and the debates surrounding these viewpoints. It will then focus on and discuss more directly perceptions of risk as represented in this study and how this relates to the work of the Independent midwife, considering first the concept of risk from the perspective of their clients and then from the perspective of the Independent Midwife.

#### ***7.4.1 Risk Childbearing and Childbirth***

Western Society has become increasingly risk adverse (Beck 1992, Giddens 1998, Rose 1999), particularly in relation to childbearing, and yet it has been argued that Western childbirth has never been safer in terms of mortality and morbidity (Edwards 2006, Symon 2006, Walsh et al 2004, Hewson 2004, CMACE 2011, Mackenzie Bryers et al 2010). Risk in these terms is linked to the medical model of care where fear of uncertainty and a focus on physical dimensions of wellbeing and pathology are characteristic (Walsh and Newburn 2002, Mackenzie Bryers et al 2010). The underpinning theories related to risk see their inception with Modernity, the Age of Enlightenment and the industrial revolution (Beck 1992, Mackenzie Bryers et al 2010, Ekberg 2007) and would appear to draw from the philosophies of Descartes, Marx and Weber (Morrison 1995). Notions of order and control as a result of Enlightenment and advance of knowledge by means of the scientific method has been highlighted by Beck (1992). Additionally, advances in the collecting of information about populations and individuals as a result of improved information systems and technology has facilitated their over monitoring. The impact of these complex events on society has been subject to much debate although there would appear to be agreement

with increasing awareness of “risk”, the fear, insecurity and uncertainty that this has created and the potential of this to control and order both populations and individuals (Beck 1992, Giddens 1998, Rose 1999, Ekberg 2007). Foucault (1991b) has highlighted these as mechanisms of governance and surveillance suggesting that risk theory rests on the premise that populations, communities and individuals need to be measured, managed and protected in order to maximise their productivity.

It is both interesting and relevant to this discussion to note that pre-modernity, attitudes to risk and uncertainty were very different. Traditional concepts of risk have moved from a relatively neutral position of being concerned with defining the possibility of something happening or not happening, to what is now understood as something potentially harmful and therefore to be avoided at all costs (McLaughlin 2001, MacKenzie Bryers et al 2010). Prior to Modernity there was a certain acceptance of “fate” and of risk being attributed to metaphysical/supernatural forces or divine intervention (Eckberg 2007). Beck (1992) has suggested that current focus on risk avoidance in society obscures a possibility of there being an “acceptable” level of risk that can be tolerated or even seen as desirable. The negative connotation of risk in modern society would appear to have moved towards meaning danger, disaster, injury harm and fatality (Eckberg 2007).

Clinical governance was introduced into the NHS in 1997 and integral to this was the concept of risk management and management of staff (Braine 2006). The purported rationale for this was the then Labour government’s focus on reforming the NHS, minimising risks and improving the quality of healthcare

(Department of Health 1997). Healthcare providers are required to contain risk and the potential and increasing risk of litigation that may occur as a result of any adverse outcomes (Mackenzie Bryers et al 2010, Kirkham et al 2012). The development of evidence based guidelines and protocols has led to the centralizing and standardising of care, (Flynn 2002, Mackenzie Bryers et al, Kirkham et al 2012) rather than a move to individualised women-centred care as suggested by the rhetoric in government maternity care policy (Department of Health 1993, 2004, 2007). In Chapter Four several of the very experienced midwives articulated their experiences of living through these changes (Freya MW 16, Brigid (MW13), Jemima (MW18) and their increasing difficulty of having to comply with them as they felt these changes detracted from their ability to give appropriate care. Additionally concern has been expressed over the increasingly rigid implementation of guidelines and protocols and the bullying and disciplining of midwives who fail to conform or who wish to support women whose choices do not align to these (Stapleton et al 2002, Hollis Martin & Bull 2008, Jowitt 2008, Kirkham 2011, Kirkham et al 2012, Edwards 2011 ). Chapter Four has detailed midwife accounts of bullying for these reasons and as can be seen from appendix 10, eleven of the twenty midwives interviewed had this experience. Kirkham et al (2012) observed that the needs of the institution would appear to have ascendancy over midwives' prime imperative to be "with woman". This has the potential to cause contravention of the midwives rules and standards as laid by statute (NMC 2012). The risks and tensions in this way for midwives practising in the NHS requires a constant juggling of priorities in order to remain "safe" but their vulnerability remains palpable (Mackenzie

Bryers et al 2010, Scammell 2011, Stapleton et al 2002a). As evidenced in Chapter Five and Six Independent Midwives are also engaged in staying safe as will be seen a little later in this section.

The formation of the National Institute of Clinical Excellence in 1999 and their production of evidence based guidelines were designed to help address inequalities in healthcare provision, access to healthcare and the promotion of optimal outcomes (Office of Public Sector Information 1999). Whilst the aims of such guidelines are extremely laudable, there are for both women and midwives, and particularly Independent Midwives, potential risks associated with how risk is perceived in the first place and the nature of the evidence that underpins and is seen as valid on the other (Walsh et al 2004). Although the very positive effects of this have been presented, it has been argued that there also appears to be a focus on avoiding worse case scenarios, scrutinizing near misses, training for emergencies and handling complaints (Walsh et al 2004, Hewson 2004, Furedi 2002, Mackenzie Bryers 2010, Kirkham et al 2012). In both cases there is the potential for labelling, women being seen as irresponsible (Edwards 2006) and midwives as negligent when they exercise personal or professional autonomy in decision making about care (Kirkham 2010, Davies 2009). This appears to be particularly problematic when these decisions sit outside of the normal paradigm of risk interpretation (Kirkham et al 2012, Kirkham 2011, Edwards et al 2012, Edwards 2006, Walsh 2006).

### ***7.4.2 Childbearing Women and Perceptions of Safety and Risk***

We know that childbearing women perceive risk in different ways to healthcare professions and that feeling safe is important to them (Halldorsdottir & Karlsdottir 1996, Edwards 2006). It has also been acknowledged that safety is not an absolute concept and that it encompasses all aspects of health and well-being (Department of Health 1993). A large proportion of the childbearing women that access the services of the Independent Midwife have been described in Chapter Five and Six as, “damaged” or traumatised by either previous childbirth experiences in the NHS or previous life experiences. Often these women are also obstetrically highly complex (Symon 2009, 2010). Lack of control over situations, abuse of trust and being bullied into doing things have been a reported feature of these women’s experiences (Emily MW8, Jemima MW18, Angel MW19). Understanding the need for childbearing women to feel safe and in control is clearly articulated in this study (Jemima MW18), indeed facilitating this seen by the research participants as integral to the “with woman” philosophy. As reported in Chapter Five the mother midwife relationship is seen as a pivotal midwifery skill which enables the midwife to connect with the woman, establish her hopes, fears and expectations. It provides an open channel for communication, for trust and rapport to develop and importantly to listen to the woman (Smythe 2010). It is also the means by which both the mother and the midwife establish whether they are right for one another and that they can work together. The mother wants to establish that she can trust the midwife to respect her choices and facilitate her decision making, and help her to remain in control of her journey into motherhood. The midwife wants to

establish a connection with the woman that enables her to understand the needs, hopes and fears of the woman in order that she can work with her to help her achieve her goals. The midwife also wants to establish that she can trust the woman with her registration, and that she will listen to the advice that she gives, whilst at the same time acknowledging the woman's right not to take this advice. In Chapters Five and Six of this study there is clear articulation of the idea of a "right" midwife for the "right client" (Milly MW 12, Emily MW8, Chloe MW4). In this way it can be seen, as reported in both Chapters Five and Six, that both the woman and the midwife are engaged in negotiating and balancing notions of safety and risk from their own perspectives and in the context of their own lives. For the midwife this includes the context of professional practice as previously alluded to.

Edwards (2006) has presented an analysis of how childbearing women are obliged to negotiate between obstetric definitions of risk and their own potential scepticism of these. By exercising their autonomy by rejecting medical definitions of risks, women may be labelled as irresponsible, and being seen to be risking their or their baby's health (Kirkham et al 2002b, Fredrikensen 2005). Edwards (2006) provides evidence that women conceptualize risk using a much broader framework than medical definitions which tend to focus on mortality and morbidity statistics. Women also consider their and their family's wellbeing in relation to physical, social, psychological and spiritual factors. Women also appear to view medical and obstetrical practices as a potential risk to their achievement of a "safe birth". Safety for them also includes the consideration of

the birth environment, their ability to maintain control due to obstetrical impatience with the process of birth, the potential for coercion and potentially unnecessary medical interventions (Edwards 2006). This evidence gives some insight into why women might want to access the services of an Independent midwife and to birth at home even although they might have numerous high risk factors as defined by obstetricians. Data presented in this study in Chapters Five and Six confirm these reasons (Emily MW 8, Milly MW12). In viewing risk and safety from this perspective, rather than being seen as irresponsible, women can be seen to have both their and their baby's wellbeing at the heart of their decision making (Edwards 2006), and that they have exercised their autonomy in relation to this by seeking out a service that more closely meets their needs. In Chapter Five research participants accounts report women who have been traumatised by their experiences in the NHS and who are keen not to repeat these experiences. In helping and supporting women in their choices, particularly when this occurs following a traumatic experience in the NHS, is seen by the research participants as a means of helping women to feel safe. Helping women to feel safe in these circumstances has been experienced as particularly emotionally challenging for midwives as Emily (MW8) reports in Chapter Five, often requiring a considerable investment of midwife time as previously discussed and sometimes with the client's assumption that because the midwife's services are being paid for this will guarantee that expectations will be met (Chapter 5 Milly MW 12, Bethany MW3). As will be seen in the next section supporting women's choices can also potentially place the Independent midwife at risk.



### ***7.4.3 Risks for the Independent Midwife***

Murphy-Lawless and Edwards (2006) have, from their work with childbearing women, found that the obstetric focus on risk can be experienced by women as both omnipresent and disempowering resulting in the undermining of women's confidence in their ability to birth and the instillation of fear. On the other hand they found an approach that is based on "watchful waiting" and optimism rather than the pessimism and surveillance of the medical model, inspires confidence and allays fear. This philosophy resonates loudly with the midwifery model of care and the values and beliefs of Independent midwives as articulated in this study in Chapters Five and Six. The social construction of risk means that "risk management" or perception is never objective (Nolan 2011, Walsh 2003) within the healthcare setting, it has been argued that this is heavily influenced by those who are most powerful (Walsh 2003). The care setting also appears to be influential in terms of how risk is perceived and also potentially to a distorted perception of who or what is to blame should problems arise (Walsh 2009). Beech (2009) intimates that when a baby dies in a hospital setting, for example, it is assumed that all that could be done was done and that the tragedy was inevitable. If a death happens in the community it is immediately assumed that negligence on the part of the mother/midwife must be a significant factor (Beech 2009). When investigation and disciplinary panels are set up to assess quality of care following such events the level of technological intervention is scrutinized with the assumption that the right professional choice should have been to use technology, despite the acknowledgement there are still no tools that can effectively predict the outcomes of labour (RCM & RCOG 2007). This

stance places obvious limitations on and perceptions of women's choices and midwives' professional autonomy (Stapleton et al 2002, Walsh et al 2004), with the potential to recast both the childbearing woman and the midwife as "passive creatures", who are dependent on professional advice (Hewson 2004a).

Additionally our increasingly litigation conscious society has meant that there is less tolerance by consumers when things going wrong (Beck 1992). An example of this in childbearing litigation has been the magnitude of damages awarded as a result of cerebral palsy cases. It has been argued by Bassett et al (2000) that there is a subtle relationship between medical and legal professions which has resulted in defensive practice and less tolerance in taking risks. As a consequence both professions would appear to benefit from affirmation of their status and value in society. In this context guidelines and protocols take on another connotation, that of seeking out errors and to punish non-compliance, with the potential that guidelines are used rigidly instead of taking individual clinical circumstances into account (Kirkham 2012, Edwards 2012).

The potential to use guidelines in a rigid way has particular relevance for Independent midwives in this study, as we see from Chapters Five and Six Freya (MW 16) and Jemima (MW 18) have articulated their concerns about these issues particularly in relation to circumstances where outcomes are less favourable. They indicate that they are acutely aware of being judged by those who were more influenced by medically defined evidence and risk management strategies and who perhaps do not understand of the subtleties' of independent practice. For these reasons there is the potential to set aside or dismiss a

women's right to make autonomous decisions that perhaps do not coincide with NICE guidelines and other forms of knowledge used by the midwife that sit outside the NICE hierarchy of evidence (Winter 2002, NICE 2008, 2010, Guyatt & Sackett et al 1995). Indeed childbearing women, as is their right, may refuse to take the professional advice that is offered leaving the midwife aware of her professional vulnerability as is reported by Chloe MW4, Freya MW16, Amy MW17). As a result it may be that an Independent midwife finds herself potentially being blamed or even referred to the NMC because of perceived malpractice when this might not necessarily be the case (Amy MW17). This study reports several experiences when midwives had wanted to refer a client to the NHS for emergency or specialist review and the client refused to go (Chloe MW4, Freya MW18). However, the midwives in this study perceived that the consequence of this is that they may be viewed as "mavericks" (Jemima MW18, Freya MW16, Hobbs 1997, Wagner 1997). Independent midwives feel that because they do things differently, trying to think around problems whilst also trying to meet the needs of often highly complex women while also working within the midwives rules and standards (NMC 2012), they are a potential target for professional criticism (Jemima MW18). In trying to work with women they have told me that they often have to be quite creative in constructing alternative strategies in order to minimize risks however, as evidenced in Chapters Five and Six there is the real perception of a potential risk to the midwife's registration and/or to be subject to litigation for which the individual midwife, working without insurance is personally liable (Emily MW8, Serena MW15, Amy MW17, Freya MW18, Red MW20).

There is another dimension to the vulnerability of the Independent midwife that potentially put them at risk that also needs to be considered here. As previously reported women who access the services of Independent midwives often have highly complex histories and may have rejected the NHS for numerous reasons including previous traumatic experiences (Symon 2009, 2010). As was seen in chapter five, midwives in this study use the term “damaged” women to describe a significant proportion (1/3), of the women on their caseload (Esmie MW9, Jemima MW18). They explained that as a result of this, the women may have very strong views about what they want and what they don’t want to happen during their current pregnancy. Engaging an Independent Midwife’s services and paying may be seen as a way to facilitate these wishes as previously discussed. Women that are less than satisfied with the care they have received have the right to make a complaint, and within the NHS this is made directly to the midwife’s employer, although it is perfectly feasible for a member of the public to make a complaint directly to the NMC if they wish (NMC 2012). As Independent midwives are self-employed, women have to report the midwife directly to the professional regulatory body, the Nursing and Midwifery Council and as a result an NMC investigation is triggered. As was presented in Chapters Five and Six, research participants indicate they are very aware of this potential and as a consequence the need to build a strong “connection” and trusting relationship with their clients is also associated with their need to be able trust the woman with their registration. As reported in the findings of this study there is an intimate relationship between the investment of time, the

mother midwife relationship and the concept of risk for both mother and midwife. Indeed there is evidence that having insufficient time to form a meaningful relationship is seen as potentially risky (Chapter Five Milly MW 5). Skinner (1999) has previously voiced her concerns regarding the vulnerability/risk to the midwife when considering the mother midwife relationship and the midwifery concept of partnership working in New Zealand. It is worthy of consideration here due to its resonance with the current discussion because it provides further illumination of how the “with woman” philosophy, beloved of midwives, and their reason d’être, may ironically place the midwife in a position of potential vulnerability even where there is felt to be an established relationship and partnership with the client and her family. Skinner (1999) argues that the notion of partnership is based on unwritten rules and perceptions of partnership between midwives and their clients, with the potential that women, in situations where outcomes of birth are less favourable, may switch alliances to that of the dominant medical care paradigm with the potential for the midwife to be “hung out to dry” (Skinner 1999). The danger to the midwife she feels, is in assuming they have a partnership with their client, because they have come jointly to a decision about care which may or may not be accepted by medical thinking. All is well if the outcome is favourable but if this is not the case she suggests that the woman may return to the dominant medical patriarchal way of analysing the situation, switching alliances as it were and rejects the validity or any previous partnership agreement. As the midwife is unable to do this the whole notion of partnership as the founding principle for relations between mother and midwife, is called into question philosophically

and indeed can be seen to position the midwife is a place of vulnerability (Skinner 1999). Whilst Skinner's arguments are very much framed within the New Zealand partnership model for midwifery care and this is tied in with the wider social and cultural context pertaining to New Zealand more generally (Guilliland & Pairman 1995, Boston 1991) there are also resonances with the experiences of Independent midwives' in this study. There are perhaps sobering lessons to be considered around the enactment of midwifery ideology and the relationship that midwives strive to have with women and whether this ideology is indeed shared by the women they care for particularly when things do not go to plan, and this constitutes an important area for further research in the context of midwifery practice. Although this situation was not experienced directly by the midwives I interviewed, I was made aware, following data collection, of two instances where Independent Midwives were exposed to this criticism (Davies 2009, IM-UK 2012, Plymouth Herald 2012).

The other potential effect of women referring independent midwives directly to the NMC is that it may appear that there are more independent midwives being referred to the NMC. This has the potential to reinforce ideas of Independent midwives as "mavericks". When a complaint is received the standard against which the midwife should be judged is the NMC Rules and Standards (NMC 2012) and The Code (NMC 2008), however, increasingly in practice midwives are being judged in relation to local protocols and guidelines and NICE guidelines (Mackenzie Bryers et al 2010). Kirkham et al (2012) has alluded to the move of Trusts to standardised care packages in an effort to protect the

institution by controlling the practice of its employees and thereby being able to control risks of litigation. For Independent midwives as indicated in Chapters Five and Six this represents the antithesis of what they hope to provide for their clients, namely individualised and tailored care. An increasing trend where failure to comply with guidelines and protocols in NHS settings has resulted in midwives being bullied and coerced and even disciplined has been noted (Kirkham et al 2012, Edwards et al 2011). If a case is referred to the NMC disciplinary panel they are necessarily judged by their peers (Davies 2009) and whilst this is problematic enough for midwives working in the NHS this has particular implications for Independent Midwives because the subtleties of independent practice are not well understood. An NMC panel may consist of one NHS senior midwife who will have a particular perspective of midwifery practice (Davies 2009). The rest of the panel may consist of others who have little or no knowledge of midwifery, and even less of Independent midwifery (Davies 2009, Kirkham et al 2012). The midwife's only recourse is then to appeal to the High Court and at her own expense (Davies 2009, Edwards et al 2011). It is interesting to note that several striking off orders involving Independent Midwives have been recently challenged in the High Court and have been overturned (Davies 2009, Plymouth Herald 2012, IM-UK 2012b) and midwives concerned able to return to practice (Edwards et al 2011, Kirkham et al 2012). Although none of the Independent Midwives interviewed were directly involved in this situation, awareness of their vulnerability and the risks associated with Independent midwifery practice are clearly articulated in Chapter Six.

Good record keeping is integral to midwifery practice (NMC 2012, NMC 2010a, b, NMC 2012), within the context of independent practice and the issues that have been previously discussed this takes on a particular significance as it should provide a comprehensive record of all care undertaken, discussion of client's preferences and choices, detail all assessments and reviews, any risks or problems identified and any action taken. The client is also encouraged to be involved in the process of record keeping process (NMC 2010a). Awareness of and understanding of the need for exemplary documentation and record keeping of all discussions and care decisions made with the woman is evident within this study (NMC 2012). Represented in midwives' narratives is an understanding that this also presents a certain tension with their strongly held beliefs about being "with woman". However, it is seen as a means of offering some form of professional protection, that of documented evidence of what they did and said whilst caring for clients.

This study adds to our understanding of the multi-faceted factors that can potentially ensnare and put at risk the midwife's registration because of referral and investigation by the NMC, and a possible subsequent striking off order. Ironically, this might be as a result of enacting "with woman" philosophy by supporting a woman's choices and preferences when these do not align to what is considered "safe" by professional guidelines, but does represent respect for a woman's autonomy, a right protected by law (Butler-Sloss 2006). The client may exercise her autonomy and reject the information or advice of the midwife,



potentially resulting in delays, morbidity and on occasion mortality of her baby (Symon et al 2010). The woman, as identified by Skinner (1999) may potentially swap allegiances from the midwife and a previously agreed plan of care to that of medical management of her case and claim negligence particularly when the outcome of her pregnancy is less than optimal. The midwife is also potentially at risk because of potential criticisms of her care if this is based upon the midwifery/social model of care rather than a more medicalized institutionally risk management model of care against which it has been suggested midwives are increasingly being measured (Kirkham 2012, Edwards et al 2012). This is particularly significant if those that may have cause to judge her (Supervisors of midwives and those on NMC Fitness for Practice panels), are unfamiliar with the complex subtleties of independent practice and the potential nature of the client group she may have (Davies 2009).

### ***7.5 Limitations of Study***

This study has sought to understand the stories of Independent Midwives lives as midwives at a particular and crucial juncture in the history of Independent midwifery. One could argue that they have a vested interest in presenting themselves and the way that they practice in the best possible light. Much has been written about the reliability of narrative as a research method in terms of what this represents in terms of accuracy of account, and how near this is to the actual lived experience (Bauer 1996, Hollway & Jefferson 2000). Both argue as I would, that it is the story that matters and how this is expressed that is

important. It has been suggested that story-telling may stay closer to the actual life-events than methods that elicit explanations (Hollway & Jefferson 2000). At the very least I have represented here the perceptions of the Independent midwives interviewed albeit through the lens of my eyes. In an attempt to demonstrate the trustworthiness and rigour of this study Yardley's (2000) framework for the evaluation of qualitative research has been utilized as previously discussed in Chapter Three. I have tried to stay close to the data by using contextualized quotations from research participants. The rationale for this being that this transparency will enable the readers of this research to verify what is being claimed but also to consider alternative ways of viewing what has been said. Additionally, I have shared transcripts and thoughts on the analysis of the data with my supervisors and have been able to receive feedback and alternative views throughout the completion of this study. This has facilitated the critique of ideas presented here and has provided a mechanism for testing the trustworthiness and rigour and coherence of this study. I have also presented a peer reviewed paper of initial findings of an aspect of this study at a conference which was well received (see Appendix 9). I was also very heartened by positive feedback received from Independent midwives who had also attended. This thesis represents data from a snapshot in time and context which is in accordance with the philosophical underpinnings of a hermeneutic phenomenological study (Heidegger 1962, Gadamer 1975, 1976, 1987, Ricoeur 1973), it bears a considerable imprint of my own values and beliefs (my lived experience) as these have interacted with the data (the lived experience of the participating midwives). The thesis represents the fusion of these two horizons

and has resulted in a much enhanced understanding of Independent midwifery and respect for this group of women who have done so much to offer alternative choices for childbearing women. As previously discussed in my methodology chapter, it is acknowledged that my personal subjective view of what constitutes midwifery may well have influenced what I have heard/seen in the data and how I have interpreted these. Recognition of the potential influence of the researcher on the research process is integral to the underpinning philosophy of Heidegger's hermeneutic phenomenology as previously stated (Heidegger 1962, Flood 2010, McConnell-Henry 2009, 2011). I have endeavoured to make this process transparent in order that the reader is drawn into the research process by the sharing of rationales for decisions made. The role of reflexivity in knowledge production is both acknowledged and celebrated with the potential that there is always another way interpreting and understanding phenomenon (Harding 1987, Stanley & Wise 1990, Letherby 2002, 2003, Mauthner and Doucet 2003).

Biographical narrative interpretive method (Wengraf 2001) has been used as a data collection method and has been followed very closely in line with the original tenets of this method for this purpose (Wengraf 2001). Whilst this method of data collection was found to yield a vast quantity of rich narrative, was found to be highly effective in addressing criticisms of the power differentials within a research interview situation in favour of the research participant, and in enhancing the researcher's active listening skills, it was also found to be associated with a "lack of sharpness" in relation to certain research

aims. This was found to be directly related to the method particularly in relation to the first phase of the interview where interventions by the researcher in the form of questioning and probing are strongly resisted, and the researcher is required to actively listen (Wengraf 2001, 2009). All study participants talked at length about the mother midwife relationship and its importance. They appeared to be less likely to talk about the specific skills they used to build and maintain this without a degree of prompting to invite narrative around this area. Thus the research aim that appeared particularly vulnerable to this “lack of sharpness” was the one related to specific communication skills. The second phase of the interview method did however enable the researcher to invite more narrative around the issues raised in the first phase of the interview. If this involved communication skills the opportunity to invite more focused narrative around these specific skills could be taken, and the research aim addressed. In circumstances where the research participants did not specifically talk about communication skills in this context then a more focused question inviting narrative around this area could be asked to elicit this data. However, the method did not allow for in depth probing of specific issues which represents a potential limitation to the study’s findings in this respect.

This study has also presented challenges in preserving the anonymity of the midwives concerned. This is partly because of the relatively small and diminishing community of Independent midwives but also because some are well known to the midwifery profession as a whole, having published or spoken at conferences. Whilst I have sought to remove all identifying factors and have

sent transcripts to each midwife in the study for them to confirm that they were happy with the information they contained and in some cases they assisted with editing to ensure this was achieved to their satisfaction, some of the anecdotes may have been familiar to those who have attended conferences where particular midwives have spoken. In order to address this issue I have endeavoured, to the best of my ability, to remove these anecdotes. It is also envisaged that any material for potential publication will be sent to each research participant prior to submission for publication to ensure that anonymity is maintained to their satisfaction and that any sensitive “identifiers” are removed.

Data was collected between September 2007 and July 2009 and therefore could now be considered to present a historical perspective, particularly in the light of the changing context of independent practice and the enactment of legislation that could see its demise. However, in accordance with the tenets of hermeneutic phenomenology data is seen to present a snapshot in time with the acknowledgement that thoughts and opinions may change over time as the lived experiences of individuals change (Heidegger 1962), for Independent midwives this change has been on-going throughout data collection and throughout the writing up period of this thesis and this needs to be acknowledged here.

### ***7.5.1 Future Research***

This study has illuminated the perceptions and views of Independent midwives; it represents their perceptions and opinions alone highlighting the lived

experience of this little researched group of midwives. There are certain aspects raised within these narratives that would be interesting to research from another perspective. For example, to view the accounts of Independent midwives being subject to disciplinary action from the perspective of those taking the disciplinary action in order to better understand their perceptions of these events and to understand how statutory supervision might be able to better support the needs of Independent midwives. Additionally, I have been told by Independent midwives that women really benefit from their care, indeed Milan (2004, 2005) has presented statistics from the IM-UK that provide confirmation of these accounts. There have also been less favourable evaluations of their outcomes as previously outlined (Symon et al 2009). Whilst acknowledging the limitations and flaws in Symon et al's (2009) study there are a number of additional potential future research questions that both this study (Symon et al 2009), and the current thesis have highlighted that would serve to unpick some of the complex issues involved.

It would be interesting to explore, for example, the experiences of women who have accessed the services of an Independent midwife, their motivations for doing this and in particular to ascertain whether the mother midwife relationship holds as much importance for them as it does for midwives. There is also potential to explore the experiences, from both the women's and Independent midwife's point of view, of transfer to NHS care when this is deemed necessary. The interface between independent midwifery care and NHS care has been highlighted by this study and that of Symon et al (2010), as a potential time of vulnerability for both the mother and midwife.

## ***7.6 Conclusions and Implications for Clinical Practice***

The overall aim of this study was to develop an enhanced understanding of the lived experience of Independent midwives and their working lives and to explore Independent midwives' perceptions of the value of "connecting" and building relationships with childbearing women. This thesis had three further sub-aims, the first was to gain an enhanced understanding of the beliefs and values of Independent midwives regarding their role as midwives and what they hope to achieve for the women in their care. Secondly, to explore the motivations of midwives to practice independently of the NHS and thirdly, to understand how they build and maintain rapport within the context of a business relationship. I feel that these research aims have been achieved and that the use of a modified biographical narrative method for data collection has meant that Independent midwives have told the story of their lives as midwives and this has enabled the capture of their perceived motivations for entering the profession, their experience of midwifery education, both in theory and practice, has traced their working lives in the NHS and their reasons for moving into independent practice as self-employed individuals. This study has provided possibly one of the last opportunities to study this particular group of UK midwives, They work without professional indemnity insurance and at considerable personal and professional risk to themselves whilst also offering the opportunity to fully enact the full range of midwifery skills, have more professional autonomy and responsibility and achieve considerable job satisfaction. This study has provided greater understanding and insight into how the mother midwife relationship is developed and why it is seen as being a crucial midwifery tool. The midwives in

this study identify that getting to know their clients well and building and maintaining rapport with them is a strategy that helps to keep both women and midwives safe. The application of the philosophical underpinnings of hermeneutic phenomenology, the hermeneutic circle and Ricoeur's (1981) theory of interpretation has provided a means of enhancing our understanding of how rapport and connection is achieved within the mother midwife relationship in the context of Independent midwifery. It provides a theoretical and philosophical rationale to explain how continuity of care can work in the context of this relationship. Rapport is achieved by repeated interaction between the mother and the midwife, the sharing of information and the continual reassessment of the worldviews of both parties as they form a relationship based on trust, understanding and reciprocity. In examining how this relationship can work and by using Ricoeur's theory to structure this, the consequences of inadequate relationships or lack of time to form relationships can be highlighted. Failures in relation to communication formed part of the recent "Francis inquiry" (The Mid Staffordshire NHS Foundation Trust Inquiry 2010, 2013) which concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe and compassionate care. Lack of time, failure to listen and engage with clients, misdiagnosis were all reported findings, and have resonance with accounts given in this study about working in the NHS. Although not labelled as a risk management issue per se there is clear articulation by midwives that lack of time to establish a "proper" relationship with their clients is "risky" and makes it harder to provide



appropriate care. Following the publication of the “Francis Report” (The Mid Staffordshire NHS Foundation Trust Inquiry 2010, 2013) a new strategy and vision for nursing and midwifery details an agenda for greater emphasis on caring and compassion in practice (Department of Health 2012). It is interesting to note that many of the features of independent practice align to the aspirational 6C’s detailed (see Appendix 10), suggesting that there are potential lessons to be learned from independent practice in this respect. Independent midwives invest time in their clients and getting to know them. This is perceived to be an important risk management strategy, and in the light of the “Francis Report” (The Mid Staffordshire NHS Foundation Trust Inquiry 2010, 2013) this strategy is worthy of urgent consideration by maternity care policy makers and healthcare providers more generally.

Application of Ricoeur’s (1981) theory of interpretation to the mother midwife relationship offers an alternative way to consider this relationship whilst also providing a new framework that can be utilized in the education of present and future midwives. It holds the potential to contribute important theoretical underpinnings to this pivotal midwifery skill.

The importance of interpersonal skills and communication is already highlighted as an essential skill for midwives (NMC 2009), however, there is potential to strengthen this further particularly in pre-registration midwifery education to encompass practical counselling skills sessions and in particular the skill of active listening.

Midwives in this study perceive that there is a lack of understanding of Independent midwifery on the part of NHS Colleagues, the NMC and Statutory Supervision of Midwives. They perceive that some supervisors of midwives do not understand the complexities of independent practice and in particular the nature of the client group that they serve. The potential to misunderstand the model of care that Independent midwives work due to different perceptions of risk and how these interface with respect for and support of women's autonomy, decisions and choices is evident. Independent midwives understand their professional vulnerability in relation to the difference in philosophy and model of care they work and the philosophical stance of an increasingly risk adverse NHS, and NMC (Kirkham et al 2012) and how they both tolerate and respond to midwives who work outside of this frame of reference (Kirkham 2011, 2010, Edwards et al 2011, Kirkham 2012). Government maternity policy rhetoric, particularly in relation to choice and control largely coincides with what Independent Midwives are trying to achieve for their clients (Department of Health 2010, 2009, 2007a, b, 2004). However, the experience of both women using the service and midwives working in the NHS suggest that this is far from reality (RCM 2011b, Kirkham 2011, Edwards et al 2011, Beech 2009, Edwards 2006a, Curtis et al 2006, Hunter 2004). Independent midwives aspire to enact this reality and support women's control over their autonomy, choices and decision making with the recognition that this is a human rights issue (Ternovszky v Hungary 2010, Prochaska 2012, Nightingale 2010). These "misunderstandings" and perceptions of Independent midwives need to be

articulated and I would hope that this study would play some part in addressing this by increasing awareness of the highly complex issues involved.

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## 9 Appendices

### 9.1 Appendix 1 : Search terms, Databases Used and Numbers of Hits

Search Terms	Database							
	OPAC	COPAC	MIDIRS	AMED Psyc Info Academic Search Elite	MEDLINE CINHL BNI	ASSIA	Cochrane Database	Index to Theses
Independent midwife	2	12	176	1	72	5	0	0
Midwife- mother relationship	1	6	0	0	12	2	1	0
Midwife and communication	0	32	250	0	250	33	5	1
Midwives and rapport	0	0	9	0	140	1	0	0
Building relationships	26	3380	3	6	721	112	38	2
Trust	1134	95481	250	298	96509	10187	1	350
Trust and midwife	0	53	100	4	1191	10	0	10
Communication skills and midwife	0	2	12	182	157	1	2	1
Therapeutic alliance	0	69	2	25	0	307	110	9
Communication	2861	145730	250	398101	227451	34008	102	2642
Interpersonal skills	114	1007	31	1998	4858	391	5	13

Search Terms	Databases							
	OPAC	COPAC	MIDIRS	AMED Psyc Info Academic Search Elite	MEDLINE CINHL BNI	ASSIA	Cochrane Database	Index to Theses
Communication and rapport	2	336	4	0	3068	282	9	0
Women centred care	1	15	5	17	92	6	9	0
Communication and empathy	3	61	16	1564	5628	533	3	4
Mutuality and midwifery	0	0	3	1	37	2	0	0
Counselling	631	6742	250	14024	31480	6624	86	386
Midwifery models of care	0	93	9	7	29	1	3	0
Continuity of care	15	9	250	3	1185	0	4	7
Organisation of midwifery care	2	107	7	0	8	0	0	0
Social support	175	6	250	105	837	6910	85	162
Communication in healthcare	1	933	1	1850	22826	0	8	1
Interpersonal skills and the midwife	0	2	2	66	0	1	0	0
Communication, empathy and the midwife	0	250	0	1	0	0	0	0
Counselling and the midwife	0	69	28	822	1	7	0	0



**Examples of Key Literature: Working Lives of Independent Midwives in the United Kingdom**

Author(s)	Publication year	Study details	Key findings
Milan M.	2003	Childbirth as Healing: three women's experiences of Independent midwifery care. <b>Complementary Therapies in Nursing and Midwifery</b> 9,140-46.	Qualitative reflective study of three women's experiences of Independent midwifery (author's clients), previous traumatic hospital births. Demonstrated that, for some women, childbirth maybe experienced as healing and life-changing. Interviews with three ex-clients were analysed, and the common themes identified and grouped. The three women had negative memories of the birth of their first child, but all birthed their second babies at home. The quality of care received was described as empowering, reassuring and emotionally supportive. Practical inputs such as listening presence, information, referrals, touch, were all identified as facilitative. The women framed their perception of the changes which had occurred in terms of self-development and achievement from the birth experience. Healing of previous trauma and lack of control. Limited study-small numbers but interesting. Backs up accounts given by midwives in current study.
Milan M.	2004	Independent Midwives Association Database Project <b>Midirs Midwifery Digest</b> 14,4 pp.548-554	Data collected from 750 episodes of client care collected by members of the IMA from 2001-2003. Outcomes presented are very positive, with low intervention, induction, analgesia and caesarean section rates. Midwives have smaller caseloads of Max. of 26 and as few as 1. Average 11. High proportion of home births, breastfeeding, normal

			births. Perinatal mortality rate higher than for England and Wales: 9.5 per 1000births as compared with 6.2 per 1000 births. Reasons for this given. Biggest proportion stillbirths. Tailored one to one care by IMA associated with many positive outcomes. Stillbirths in need of unpicking.
Milan M.	2005	Independent midwifery Compared with other caseloading practice. <b>Midirs Midwifery Digest 15,4 pp.439-449</b>	Sister article to above looks at risk in relation to IMA Database, data collected by IM's. Records of 717 women and 743 babies. Includes 26 sets of twins and 43 breech births. Data compared with other figures from caseloading midwifery schemes, One to one, N. Staffs, BUMPS and Albany. IMA women have older profile, over 30+, mostly Caucasian, higher social status and professional backgrounds. 2/3 were classified as higher risk. Outcomes point to similar outcomes to other schemes but context to higher risk profile needs to be considered. Study points to the potential value of home based individualized care for high risk women.
Sandall J, Davies J. Warwick C.	2001	Evaluation of the Albany Midwifery Practice: Final Report	An independent review of the operation and outcomes of the Albany Practice. 6WTE independent midwives contracted Kings College Health Trust to provide tailored midwifery care to women in an area of high social deprivation (Peckham South London). This independent review sought to review outcomes and how the scheme was run. The Albany Practice had a lower induction rate, higher vaginal delivery rate, a lower elective caesarean section rate, higher intact perineum rate, lower episiotomy rates, more use

			of the birthing pool, less use of pethidine and epidural higher breastfeeding rates at birth. The outcomes for neonates are unavailable for Albany. Very good continuity of carer achieved. Study points to the potential of tailored midwifery one to one care being associated with better outcomes for socially deprived women.
Symon A. Winter C. Inkster M. Donnan PT.	2009	Outcomes for births booked under an Independent midwife and births in the NHS maternity units: matched comparison study. <b>British Medical Journal</b> 338, B2020.	Study compared clinical outcomes between women employing an Independent midwife and comparable pregnant women using NHS services. Design anonymized matched cohort analysis. Cases from the database of the Independent Midwives' Association (IMA) matched up to 1:5 with Scottish National Health Service (NHS) records for age, parity, year of birth, and socioeconomic status. Multivariable logistic regression models used to explore the relation between explanatory variables and outcomes; analyses controlled for potential confounding factors and adjusted for stratification. Setting UK databases 2002-5. Finding indicated very positive and favourably comparable results for low risk women as reported in other studies. Highly complex nature of client group highlighted. Significant proportion of IM clients high risk and very complex. Outcomes for this group included a significantly higher perinatal mortality rates for high risk cases in this group. An urgent review of these cases suggested. The significantly higher prematurity and admission rates to intensive care in the NHS cohort also highlighted. Follow up study below.

<p>Symon A. Winter C. Inkster M. Donnan PT. Kirkham M.</p>	<p>2010</p>	<p>Examining Autonomy's boundaries: A follow-up review of perinatal mortality cases in UK Independent midwifery <b>Birth</b> 37, 280-287.</p>	<p>This study follows the study above which found a significantly higher rate of stillbirths associated with Independent midwifery. This study examines the midwives decision making in the 15 cases of perinatal death identified in the previous study. Home birth was attempted in 13 of the 15 cases. IM client group associated with multiple risk factors. Consensus of opinion was that in 7 cases death of the infant was unavoidable. The study highlighted the complex caseload of IM's and how these clients may not agree with professional advice given. Study debates the autonomy of the woman when she is fully informed in these situations and the position of the midwife in caring for her in these situations when supports the woman's right to make these decisions. The potential for professional criticism is discussed.</p>
<p>Winter C.</p>	<p>2002</p>	<p><b>Assessing the progress of labour: orderly chaos.</b> Unpublished MSc South Bank university</p>	<p>Small qualitative study of independent midwives in UK and how they assess progress in labour. Purposeful sample of 6 midwives interviewed using unstructured technique and guided by principles of grounded theory. Findings indicate that independent midwives turn their back on medical protocols and use midwifery skills to assess progress of labour. They utilize knowledge from a variety of sources to make their assessments. The mother midwife relationship is crucial part of this process. Midwifery skills include listening and observing women and knowing them holistically.</p>

## Initial Literature Review: more focused inclusion criteria

Research studies

1990's onwards

Written in English

Studies based in UK

Mother midwife relationship

Independent midwifery practice

Working lives of midwives

Caseloading practice in UK.

## 9.2 Appendix 2 : DMU Ethical Approval



Wednesday 6<sup>th</sup> June 2007

Rosemary Garratt  
School of Nursing and Midwifery

Dear Rosemary,

**Re: Ethics application – Connecting with Women: Independent Midwives Perceptions of How They Build and Maintain Rapport Within the Mother-midwife Relationship (ref: 174)**

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on Wednesday 20<sup>th</sup> June 2007.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee. Also, The Faculty Research Ethics Committee should be notified by e-mail to [HLSFRO@dmu.ac.uk](mailto:HLSFRO@dmu.ac.uk) when your research project has been completed.

Yours sincerely,

A handwritten signature in black ink that reads "Paul Whiting".

Professor Paul Whiting  
Chair  
Faculty of Health and Life Sciences  
Research Ethics Committee

### 9.3 Appendix 3: Ethical Approval/Permissions IMA/IM-UK

Inaugural Research Midwifery Conference, Dundee, 1st November 2007 nm-midwiferyconference@dundee.ac.uk

>>> "Rosemary Garratt" <RGarratt@dmu.ac.uk> 03/07/2007 10:52 >>>

Hi Clare,  
Thank you so much for this, yes, I have been able to open it. It would be useful to know what your research question was in order that I can interpret the findings. It looks great stuff! Kind regards, Rosie

-----Original Message-----  
From: Clare Winter [mailto:C.F.Winter@dundee.ac.uk]  
Sent: 03 July 2007 10:18  
To: Rosemary Garratt  
Subject: RE: Ethical Approval

Hi there Rosemary  
These holidays don't last long - I'm back! I've attached a copy of the findings, hope you can open it

Kind regards

Clare

Inaugural Research Midwifery Conference, Dundee, 1st November 2007 nm-midwiferyconference@dundee.ac.uk

>>> "Rosemary Garratt" <RGarratt@dmu.ac.uk> 03/07/2007 10:17 >>>

Hi Clare,  
Many thanks. Have a good holiday - I hope the rains stops for you! Kind regards  
Rosemary

-----Original Message-----  
From: Clare Winter [mailto:C.F.Winter@dundee.ac.uk]  
Sent: 29 June 2007 18:42  
To: Rosemary Garratt  
Subject: RE: Ethical Approval

Glad things are moving along for you it all takes time doesn't it. I'll send you another copy when I get back from holiday, if I forget do nag me and I'll send it - brain is going!

Kind regards Clare

>>> "Rosemary Garratt" <RGarratt@dmu.ac.uk> 06/28/07 4:26 PM >>>

Hello Clare,  
You very kindly forwarded onto me a copy of the work that you had completed about independent midwives. I have been able to open the attachment but now for some reason it won't open. I wonder whether you would mind resending it? I would very grateful as I feel this is important work to include.

I have now gained ethical approval for my research and hope start collecting data soon.

My very best wishes meantime  
Rosemary

-----Original Message-----  
From: Clare Winter [mailto:C.F.Winter@dundee.ac.uk]  
Sent: 30 January 2007 13:16  
To: Rosemary Garratt  
Subject: RE: Ethical Approval

Dear Rosemary

If you get your ethics approval you would be welcome to contact directly any of the independent midwives on the website. You can get their address and contact details from the site or you can contact the secretary to get a hard copy of the IMA register

sent to you, her contact details are on the website but I have pasted them below

Andrya Prescott  
Independent Midwives Association  
89 Green Lane  
Farncombe  
Surrey  
GU7 3TB

Tel: 0870 850 7539 (local rate)

We are in the midst of changing our secretary, I think the new person will be Liz Nightingale in Oxford but Andrya at the address above will still help you out if the transfer is not complete yet

Kind regards Clare

>>> "Rosemary Garratt" <RGarratt@dmu.ac.uk> 23/01/2007 14:41:55 >>>  
Hi Clare,  
Is there any news regarding the way forward with ethical approval? I have not heard back from the IMA as yet. I confirm that I have submitted my proposal to De Montfort's Ethics committee and I am awaiting approval. I will only be wanting to speak to midwives or rather listening to their stories about their lives as midwives! Kind regards Rosemary

-----Original Message-----  
From: Clare Winter [mailto:C.F.Winter@dundee.ac.uk]  
Sent: 08 January 2007 09:19  
To: Rosemary Garratt  
Subject: Re: Ethical Approval

Dear Rosemary  
I will pass your email on to the group, we have an IMA meeting on the 16th of Jan and they can look at it there. Though I am sure you would also have to go through the usual ethics committee and then ask permission of the midwives and women cared for by independent midwives.

Please let me know if anyone in the IMA get back to you.

Regards Clare

>>> "Rosemary Garratt" <RGarratt@dmu.ac.uk> 05/01/2007 16:05:58 >>>  
Dear independent midwives,

I am a midwife who is currently undertaking a PhD at De Montfort University. I am very interested in the work of the Independent Midwives Association, its values and beliefs and what it strives to achieve for women. I am specifically interested in the midwife mother relationship and the skills related to the formation of rapport. I would very much appreciate your guidance as to how I obtain ethical approval from the IMA, who do I need to write to or contact etc?

Kind regards,

Rosemary Garratt



#### ***9.4 Appendix 4 Invitation to participate in research study+ reply slip***

Dear \_\_\_\_\_ ,

Re: Connecting with women: Independent Midwives' perceptions of how they build and maintain rapport within the mother-midwife relationship study

I would like to take this opportunity to invite you to participate in the above research study which I am undertaking as part of a PhD at De Montfort University, Leicester. The study aims to investigate the nature of the mother-midwife relationship and how independent midwives form this relationship. As you will be aware the nature of the midwife-mother relationship has been an area of recent focus for the midwifery profession. As you are aware communication has always been and is increasingly a very important part of the midwife's work. This study aims to discover how independent midwives achieve and maintain rapport with the women they care for and the skills they associate with this.

I enclose an information sheet which gives you more information regarding what participation in the study would involve. If, following reading this information, you would be interested in participating in the study, I would be most grateful if you would complete the enclosed form and return it to me in the stamped addressed envelope and I will make contact with you so that we can make arrangements to meet.

Thank you for taking the time to read this information. My very best wishes meantime.

Yours sincerely,

Rosemary A. Garratt

**Reply Slip:**

I would be interested in participating in the research study:

**‘Connecting with women: Independent Midwives’ perceptions of how they build and maintain rapport within the mother-midwife relationship ‘.**

Please contact me to make arrangements for us to meet:

Signature:

Date:

Name:

Address:

Telephone:

email address:

## ***9.5 Appendix 5: Participant Information Sheet***

### **Participant Information Sheet**

#### **Study title:**

**‘Connecting with Women: Independent Midwives perceptions of how they build and maintain rapport within the mother-midwife relationship’.**

#### **PART 1**

##### **Invitation**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others if you wish.

##### **What is the purpose of the study?**

This research is being undertaken as part of a PhD at De Montfort University. The study aims to investigate the nature of the mother-midwife relationship and how midwives form this relationship. As you will be aware the nature of the midwife-mother relationship has been an area of recent focus for the midwifery profession. Communication has always been and is increasingly a very important part of the midwife’s work. This study aims to discover how midwives achieve and maintain rapport with the women they care for and the skills associated with this.

##### **Why have I been chosen?**

Previous studies in relation to midwives and their communication skills have largely focused upon midwives that work within the NHS. This study aims to explore the views and perceptions of midwives who work independent of the NHS, in relation to the nature of the midwife-mother relationship and how rapport is built and maintained. The study aims to recruit between 15-20 midwives who are members of the Independent Midwives Association (IMA).

##### **Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not have any consequences.

##### **What will happen if I agree to take part?**

Participation in the study would involve an interview that would take approximately 2 hours and would be scheduled at a time and place that is convenient to you. The interview consists of two parts (these take place on the same day), what this means is that in the first part of the interview you will be asked to tell the story of your midwifery career to date and about the relationships you build with the women you care for. You will not be interrupted as you do this and the researcher will listen whilst you tell your story and take some notes as you speak. After a short break (approximately 30 minutes), you will be asked more focused questions in order to clarify any aspects of your story and your meaning. The interview will be taped, with your permission, in order that it can be transcribed and analysed at a later date. Your anonymity is

guaranteed and all information and taped transcripts will be labelled with a number and will be stored in a locked filing cabinet to which the researcher alone will have access, confidentiality will be maintained throughout. Following completion of the study all tapes and transcripts will be destroyed.

**What are the possible disadvantages of taking part?**

This interview study is unlikely to result in major disadvantages to you; the main disadvantage is that this interview will take up between one and a half hours and two hours of your time. As a midwife myself I am responsible to and accountable to the Nursing and Midwifery Council. I am obliged to report any unsafe practice that is described (NMC 2004). This would be reported to a Supervisor of Midwives in the first instance.

**What are the benefits of taking part in the study?**

It is envisaged that you will contribute to a body of midwifery knowledge which will include a more precise understanding of the skills utilized by midwives to achieve rapport and a good on-going relationship with the women in their care. It is hoped that a systematic understanding of these skills will lead to a greater understanding of the specific interpersonal skills that midwives need to develop, with a view to informing curriculum development and the enhancement of midwifery students' communication skills. It is hoped that the study will also provide a greater understanding of the working lives of independent midwives.

It is anticipated that the research may also provide insight and greater understanding of the circumstances that both enhance and detract from the formation of rapport.

The study should also provide greater understanding of the philosophical underpinnings that motivate the practice of independent midwives.

**What if there is a problem?**

Any complaint about the way this study has been undertaken will be addressed.

If you have any concerns please contact:

Dr Brian Brown  
De Montfort University  
Faculty of Health and Life Sciences  
The Gateway, Leicester LE1 9BH

If the interview raises any particular issues you may also want to contact the Independent Midwives Association/ Association of Radical Midwives or your Supervisor of Midwives.

**Will my taking part in the study be kept confidential?**

Yes, all the information about your participation in this study will be kept confidential. The details are included in part 2.

**Contact Details:**

Should you have any questions or queries or wish further information about this study please contact:

Rosemary Garratt  
Principal Lecturer Midwifery  
De Montfort University  
Faculty of Health and Life Sciences

Hawthorn Building  
The Gateway  
Leicester LE1 9BH  
Telephone: 0116 2078707  
Email: rgarratt@dmu.ac.uk

**This completes part 1 of the information sheet.  
If the information in part 1 has interested you and you are considering participation, please continue to read additional information in Part 2 before making any decision.**

## **PART 2**

### **What happens if I don't want to carry on with the study?**

You can withdraw from the study at any time. Any materials/tapes/notes relating to your participation in the study will be destroyed immediately.

### **Complaints**

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions on 0116 2078707. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedures via:

Dr Brian Brown  
De Montfort University  
Faculty of Health and Life Sciences  
The Gateway  
Leicester LE1 9BH Telephone: 0116 2078755  
Email: [brown@dmu.ac.uk](mailto:brown@dmu.ac.uk)

### **Harm**

It is not envisaged that this study will result in any harm to you. There are no reports of harm in the literature of people participating in interviews regarding their working lives. However, if you feel you need to speak to someone contact the researcher in the first instance:

Rosemary Garratt  
Principal Lecturer Midwifery  
De Montfort University  
Faculty of Health and Life Sciences  
Hawthorn Building  
The Gateway  
Leicester LE1 9BH  
Telephone: 0116 2078707  
Email: [rgarratt@dmu.ac.uk](mailto:rgarratt@dmu.ac.uk)

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service mechanisms may be available to you.

**Will my taking part in this study be confidential?**

All taped recordings of interviews will be labelled only by number in order to preserve anonymity and confidentiality. Once the study is completed all tape recordings and transcripts will be destroyed. Tapes will be stored in a locked filing cabinet which will be accessed by the researcher alone. Your name will not be used in any published documents and any identifying factors will be changed in any research reports/thesis or other printed material.

All interviews will be transcribed by the researcher alone and you will have the opportunity to review your own interviews and make amendments you wish.

**What will happen to the results of the research study?**

The results of the study will be written into the PhD thesis with the potential to also to present findings in the form of conference papers and journal articles. The results will also be made available to all the research participants. Individual participants will not be identified in conference or journal articles and confidentiality and anonymity will be maintained throughout.

**Who is organising the funding of the study?**

The researcher themselves is currently responsible for the funding of the research.

**Who has reviewed this study?**

De Montfort University Research Ethics committee has reviewed this study. The research has been given favourable ethical opinion for conduct in the private sector by the De Montfort University's Research Ethics Committee. Approval has also been sought and approved by the Independent Midwives Association (IMA).

**The researcher would like to thank you for taking the time to read this information sheet and considering participating in this study.**

18.5.07 Final Version 4

RG

## 9.6 Appendix 6: Consent Form

Midwife Identification for this trial:

### CONSENT FORM

**Title of Project:** 'Connecting with Women: Independent Midwives perceptions of how they build and maintain rapport within the mother-midwife relationship.'  
**Name of Researcher:** Rosemary A. Garratt

Please complete and initial boxes below to indicate your consent:

1. I confirm that I have read and understand the information sheet dated 18.5.07(version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my legal rights being affected.
3. I agree to my interview being tape recorded by the researcher for later analysis.
4. I understand that I have the opportunity to review the written transcript of my interview and make any amendments I feel are appropriate.
5. I agree to take part in the above study.

Name of Midwife

Date

Signature

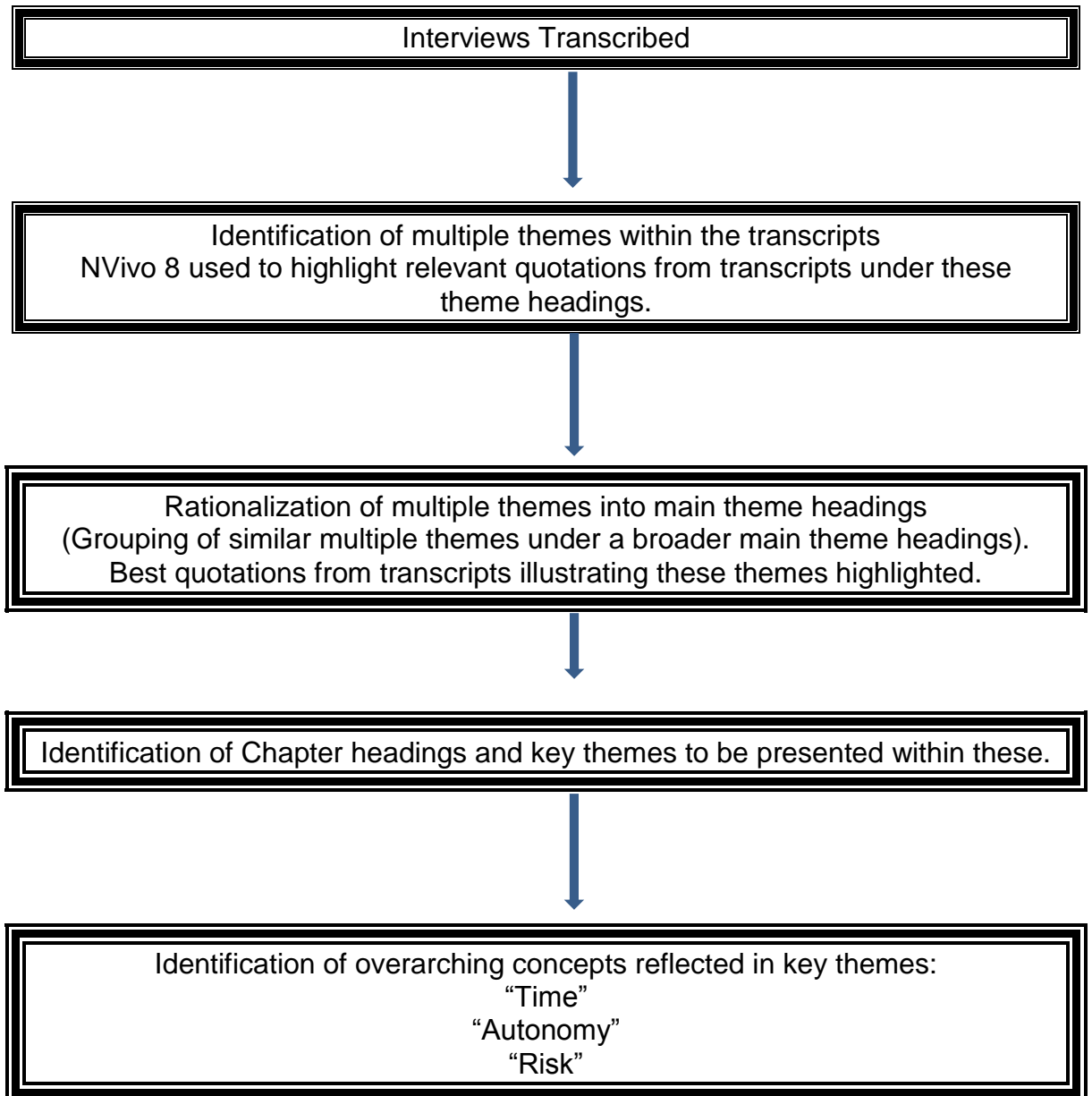
Name of Person taking consent

Date

Signature

## 9.7 Appendix 7: Identification of Themes and Sub-themes

### Data Analysis Process





## **Multiple Themes Identified in Data**

- **Reasons for becoming a midwife**
  1. Own experience of childbearing very positive
  2. Interest in birth
  3. Drifted into it
  
- **Philosophical thoughts on role of the midwife**
  1. "With woman"
  2. Returning to midwifery roots
  3. Choice, continuity and control, giving information in an empowering way.
  
- **Experience of midwifery training**
  1. Tutors and theoretical component
  2. Clinical practice
  3. Theory practice gap
  
- **Working in the NHS**
  - Experience of the NHS
    1. Doing good by stealth
    2. Going the extra mile
    3. Lack of time
    4. Poor continuity in hospital
    5. Fragmented care
    6. Medicalization- power of Obstetrician
    7. Forced to comply
    8. Midwives with Obstetrician not women
    9. Limited choices and information for women
    10. Constraint!
    11. Often very stressful
  
  - Why they left the NHS
    1. Own philosophy about midwifery and level of service to women did not match that of experience in NHS.
    2. Experience of being disciplined or dismissed
    3. Experience of being bullied, ostracised, seen as different, stropky, challenging status quo.
    4. NHS did not offer flexibility of working needed with young family.
  
  - Traumatic experiences/ witnessed cruelty to women.
  - Lack of support
  - Impossible workloads

- **The working lives of independent midwives**
  - Advantages
  - Disadvantages
  - Guilt about leaving the NHS
  - Gaining skills and confidence
  - Work/life boundaries
  - Vulnerability
    1. Physical
    2. Emotional
    3. Litigation
  - Caseloads
  - Uncertain future
  - “Witch hunts”
  - Midwifery as a business
    1. Advertising
    2. Fees
    3. Websites
    4. Services
  - Support
    1. Colleagues (other independents)
    2. The IMA/ IMUK
      - Assertiveness training
      - Study days/ Setting up an independent and skills sharing
      - Preceptorship
      - “Sisterhood”
      -
    3. Supervisors of midwives.
  
- **The mother midwife relationship/ family relationships**
  - How midwives build relationships
    1. Time, continuity
    2. Reciprocity
    3. Listening
  - Successful relationships- characteristics of
  - It’s a family affair
  - Difficult relationships with women
  - The business relationship
  - When things go wrong
  - Encouraging women and partners to take responsibility for their care and make informed choices.
  - Thoughts on nature of the relationship- boundaries and friendship

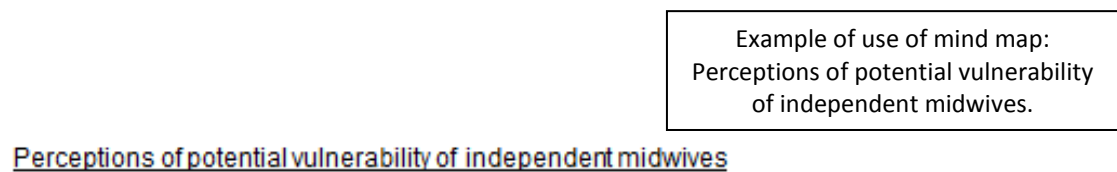
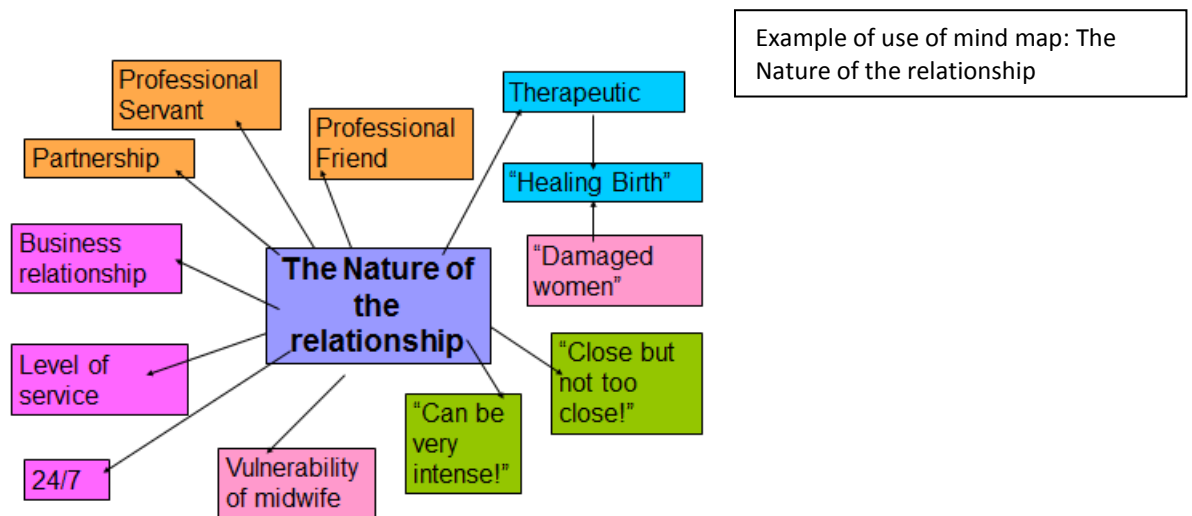
- Healing birth, healing agent
- **Knowledge gained about childbearing and childbirth since becoming an independent.**
  - Knowing the woman facilitates giving appropriate care, helps to pick up deviations from normal.
  - Connecting with women at a spiritual/energetic level
  - Deeper understanding of women and childbearing and family relationships.
  - Women can stop and start labour
  - To drink tea intelligently!
  - Trusting women's bodies
- **Links with feminist organisations or thoughts**
  1. ARM and IMA
  2. "Sisterhood"
  3. The midwife means "with woman"
  4. Alternative sources of knowledge more likely to be explored and valued alongside more traditional ways of knowing.
  5. Celebration and sanctity of birth
  6. Woman as goddess

## Rationalising of Key themes

Chapter heading	Multiple themes from initial coding with NVivo 8	Rationalised main theme headings
Journey in midwifery	<p><b>Reasons for becoming a midwife</b> Own experience of childbearing very positive Interest in birth Drifted into it</p> <p><b>Philosophical thoughts on role of the midwife</b> "With woman" Returning to midwifery roots Choice, continuity and control, giving information in an empowering way.</p> <p><b>Experience of midwifery training</b> Tutors and theoretical component Clinical practice Theory practice gap</p> <p><b>Working in the NHS</b> Experience of the NHS Doing good by stealth Going the extra mile Lack of time Poor continuity in hospital Fragmented care Medicalization- power of Obstetrician Forced to comply Midwives with Obstetrician not women Limited choices and information for women Constraint! Often very stressful</p> <p><b>Why they left the NHS</b> Own philosophy about midwifery and level of service to women did not match that of experience in NHS. Experience of being disciplined or dismissed Experience of being bullied, ostracised, seen as different, stropky, challenging status quo. NHS did not offer flexibility of working needed with young family. Traumatic experiences/ witnessed cruelty to women. Lack of support Impossible workloads</p>	<ul style="list-style-type: none"> <li>• Being "with woman"</li>   <li>• Entry into midwifery</li>   <li>• Experience of midwifery education</li>   <li>• Working as a midwife in the NHS</li>   <li>• Going the extra mile</li>   <li>• Bullying culture</li> </ul>
The Mother Midwife Relationship	<ul style="list-style-type: none"> <li>• Aim of the relationship</li> <li>• Making a difference</li> <li>• Facilitating positive birth experiences</li> <li>• "Holding the Space"- guardian of birth</li> <li>• Influence of own childbirth experience</li> <li>• Facilitating informed decisions and choices</li> <li>• "Healing births"</li> <li>• Birth as women's business/contributing to wider society/altruism</li>   <li>• The Nature of the Relationship</li> <li>• "Close but not too close", friendship, partnership</li> <li>• The influence of professional</li> </ul>	<ul style="list-style-type: none"> <li>• Aim of the relationship.</li>   <li>• Power relations within the relationship</li>   <li>• The Nature of the relationship</li> <li>• Close but not too close.</li> </ul>

	<ul style="list-style-type: none"> <li>responsibilities</li> <li>• Power relations</li> <li>• Personal boundaries</li> <li>• Spiritual/psychic/energetic connections with women</li> <li>• Changes to the relationship in labour</li> <li>• The business relationship <ul style="list-style-type: none"> <li>○ Fees and talking money</li> <li>○ Meeting the standard that has been set out/practicalities</li> </ul> </li> <li>• “Difficult relationships” <ul style="list-style-type: none"> <li>○ Demanding clients</li> <li>○ Vulnerability of the midwife</li> <li>○ “Damaged women”</li> </ul> </li> <li>• Importance of the relationship to midwives</li> <li>• Continuity of Care, benefits for women</li> <li>• Benefits of the relationship to midwives</li> <li>• How the relationship is built</li> <li>• Skills needed <ul style="list-style-type: none"> <li>○ Listening</li> <li>○ Observation/non-verbal cues</li> <li>○ Ability to chat</li> <li>○ Showing empathy and interest</li> <li>○ Giving information</li> <li>○ First impressions</li> </ul> </li> <li>• Perceptions of the influence of different organisation and environment of care</li> <li>• Hospital setting</li> <li>• Community midwifery</li> <li>• Being an Independent midwife</li> <li>• Time</li> <li>• Technology and communication with women</li> </ul>	<ul style="list-style-type: none"> <li>• Connecting with women.</li> <li>• Healing birth.</li> <li>• Who Accesses Independent midwifery?</li> <li>• Potential vulnerability.</li> <li>• The Business relationship.</li> <li>• The importance of the relationship</li> <li>• How the relationship is built. <ul style="list-style-type: none"> <li>○ Skills needed</li> <li>○ TIME</li> </ul> </li> </ul>
<p>Working lives of Independent Midwives</p>	<p>Advantages Disadvantages Guilt about leaving the NHS Gaining skills and confidence Work/life boundaries Vulnerability</p> <ul style="list-style-type: none"> <li>• Physical</li> <li>• Emotional</li> <li>• Litigation</li> </ul> <p>Caseloads “Witch hunts” Midwifery as a business</p> <ul style="list-style-type: none"> <li>• Advertising</li> <li>• Fees</li> <li>• Websites</li> <li>• Services</li> <li>• Uncertain future</li> </ul> <p>Support</p> <ul style="list-style-type: none"> <li>• Colleagues (other independents)</li> <li>• The IMA/ IMUK</li> <li>• Assertiveness training</li> <li>• Study days/ Setting up an independent and skills sharing</li> <li>• Preceptorship</li> <li>• “Sisterhood”</li> <li>• Supervisors of midwives.</li> </ul>	<ul style="list-style-type: none"> <li>• Transition to Independent midwifery.</li> <li>• Independent midwifery liberation of midwives and midwifery?</li> <li>• Independent midwifery as a business</li> <li>• New constraints.</li> <li>• The future of Independent midwifery</li> <li>• Supportive networks.</li> </ul>

## 9.8 Appendix 8 : Examples of Mind Map Techniques used in data analysis



Examples of Mind maps used in data analysis.

## 9.9 *Appendix 9: Conference presentation*

Page 1 of 1

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**Rosemary Garratt**

**From:** Joanne Gibbs [j.gibbs@worc.ac.uk]  
**Sent:** 23 July 2009 13:31  
**To:** Rosemary Garratt  
**Subject:** Women and Birth: Politics, Power and Practice Conference

*Sent on behalf of Professor Mary Nolan*

Dear Rosemary

On behalf of the University of Worcester Annual Birth Conference Organising Group, I would like to thank you very much for your contribution to our conference last week. Feedback strongly suggests that the parallel sessions were very much appreciated, with delegates finding them lively, relevant and thought-provoking. Delegates also recognised that these sessions had been carefully prepared and were grateful for the effort put into them.

I do hope that you had a straightforward journey home and enjoyed your time in Worcester.

Very best wishes for your future work.

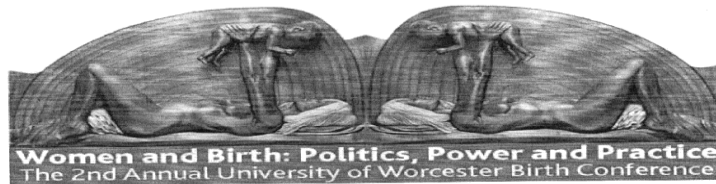
Mary Nolan  
Professor of Perinatal Education  
On behalf of Kim Russell, Sarah Snow and Jenny Edwins

Joanne Gibbs  
Departmental Administrator: Allied Health Sciences  
University of Worcester  
Institute of Health and Society  
Henwick Grove  
Worcester  
WR2 6AJ

Tel: 01905 855147  
Fax: 01905 855589

E-mail: j.gibbs@worc.ac.uk

06/08/2009



**'Women and Birth: Politics Power and Practice'**

**Parallel Workshops – Day Two (15 July 2009)**

**AM**

- 'Mutual Newness' – why student midwives are good for women
- Sarah Snow
- ❖ Promoting Normal Birth
- ❖ Alison Talbot and Claire Allen
- Exploring autonomy from an "alternative" perspective
- Catriona Graham-Jones

**PM**

- Gender, Power Relations, Domestic Abuse and Pregnancy
- Ruth Jones
- ❖ Connecting with Women: Independent midwives perceptions of how they build and maintain rapport within the mother midwife relationship
- ❖ Rosemary Garratt
- Increasing water birth rates in a Consultant led unit
- Lyndsay Durkin



Kim.Russell@worcs.ac.uk  
UK



**Programme: Day Two (15 July 2009)**

09.00	Registration and coffee	
09.30	Welcome from the Chair	Professor Mary Nolan Professor of Perinatal Education, University of Worcester
09.40	The broad view: can we make a fundamental change to breastfeeding practices?	Gabrielle Palmer
10.30	What is choice and who decides?	Debbie Garrod Consultant Midwife in Public Health Stockport NHS Foundation Trust
11.15	Coffee	
11.45	Parallel Workshops	
12.30	Lunch	
13.30	Time to get out of the water? The impact of labour ward culture on midwives practice behaviours.	Kim Russell Senior Lecturer University of Worcester
14.10	Parallel Workshops	
14.50	Afternoon Tea	
15.20	The Promotion of Despair and Anxiety – the Modern Approach to Maternity Care	Caroline Flint Director of the British Birth Centre
16.15	Evaluation and Close	Professor Mary Nolan Professor of Perinatal Education, University of Worcester



Health & Life Sciences

## Connecting with Women:

Independent midwives perceptions of how they build and maintain rapport within the mother midwife relationship

Rosemary A. Garratt  
Principal Lecturer Midwifery

Health & Life Sciences

### Aims

- To share information and initial findings of the Connecting with Women Study.
- To explain the research process taken.
- To focus on the key findings related to the independent midwives perceptions of mother midwife relationship.

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### Background and Context of Study

- The nature of the mother midwife relationship subject to much debate (Kirkham 2000, Edwards 2005, Hunter et al 2008).
- No studies have examined the mother midwife relationship when the mother becomes the midwife's paying client or of how independent midwives build and maintain rapport in this context.

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### Background and Context

- There have been few studies exploring the working lives of independent midwives in the UK.
- Their motivations for practicing independently.
- Their perceptions of what is important to them as midwives in the relationships they construct and sustain with clients.

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### The Independent Midwife

- Practices outside of the NHS
- Is self employed
- Women engage their services and pay a set fee for a package of care.
- Classically antenatal care, home birth and postnatal care.
- Tailored one to one caseload practice.
- Offer additional services eg. waterbirth, complementary therapies, hypno-birth.

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### The Independent midwife

- Continuity of care.
- High and low risk women.
- Do interface with NHS as required.
- The quality and nature of mother midwife relationship seen as crucial.
- Work within the Midwives Rules and Code (NMC 2004,2008).
- Supervisor of midwives.
- No indemnity insurance for intrapartum care.
- Current threat to livelihood.

### Aims of Study

- To develop an understanding of how independent midwives achieve and maintain rapport in the midwife mother relationship.
- To explore midwives' accounts of the skills required to achieve rapport in the mother midwife relationship and how these are learned and developed.

### Aims of Study

- To explore independent midwives' perceptions of the value of achieving rapport with childbearing women.
- To gain insight into the beliefs, values and working lives of independent midwives and what they hope to achieve for the women in their care.
- To gain an enhanced understanding of the motivations of midwives to practice independently of the NHS.

### Methodology and method

- Qualitative study
- Feminist methodology
- Adapted biographical narrative interpretive method (Chamberlayne & Wengraf 2000, Wengraf 2001).
- Midwives invited to tell their life stories as midwives.

### Method and Methodology

- Three stage interview:
  1. Invited story of life as midwife.
  2. Pick up main events and invite more narrative.
  3. Clarification of issues after interview. (Wengraf 2001)

### Sample

- 20 independent midwives- members of the Independent Midwives UK.
- Midwives from all over the UK
- Invited to participate by letter- reply slip.
- Travelled to midwives.
- All interviews audio-taped
- Transcribed- reviewed by midwives.

### Progress

- Data collection complete.
- Interviews 1-3 hours.
- Yielded very rich narrative text.
- 6000-13,000 words each interview.
- Analysis in progress
- Write up and publications to come!

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### Analysis

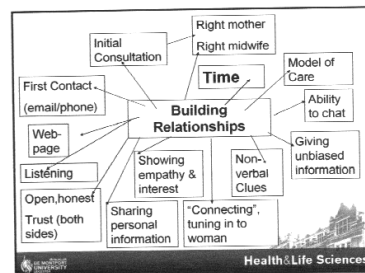
- Thematic analysis
- Broad themes identified → Sub-themes
- Major theme- mother midwife relationship.
- Visibility of many of the issues that had been highlighted in the literature already (Hunter et al 2008, Walsh 2007, Kirkham 2000, McCourt & Page 1997).
- However, some interesting issues and insights have become visible in relation to independent practice.

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### Results

- Vast amount of data
- Concentrate on:
- Building the relationship- skills
- The nature of the relationship

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### Building the relationship

- First impressions
- "...when I go for that pre-booking meeting, to try and gauge where the woman is coming from. Whether to dress appropriately whether you'd put them off if you wore an A-line skirt and heels when they really want you in your boots and cords, or whether they want you to be smart formal and professional. So I try and gauge that from where they live but also the conversation we have had. But that is getting more and more difficult when the first point of contact is becoming more and more by email. So I try and telephone and arrange that pre-booking meeting as far as possible, so at least we have talked down the phone a little bit. On email it is quite difficult to gauge where they are coming from." (Phoebe: 21)

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### Building the relationship

- Listening
- "...you have to learn how to listen and see what is on their agenda." (Bethany: 11)
- "I think I always found it reasonably easy to form relationships with women, but I think it is about listening actually. It is about...when I go and see a woman for the first time I just sit there and I say, I would just like you to tell me your story and about what you are looking for and I am just going to listen and I reflect bits back at them, did I understand that rightly?" (Milly: 14)

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### Building the relationship

- Listening, no-verbal clues, vulnerability
- "I have learned to listen to the women, to listen to the things that they are saying and the things that they are not saying. To look at how they behave and perhaps even though sometimes people have been damaged by their experience that there are reasons behind why they behave the way they do. But also to listen to safeguard myself because working as an independent midwife you are kind of standing well on the margins, listening for my own satisfaction as well." (Lydia:21-22)

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### Building the relationship

- Chatting:
- "... a lot of the time during the pregnancy and the run up to the birth it's just spent talking. Obviously we do the ante natal checks and everything else, but for 5 or 10 minutes, and probably about an hour is spent just chatting. And it could be about the weather, it could be about a shopping trip they went on last week, but just getting to know them as a person. And finding out what makes them tick and what makes them anxious or what makes them feel strong. And within that we do discuss what their hopes are for the birth." (Amy:14)

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### Building relationships

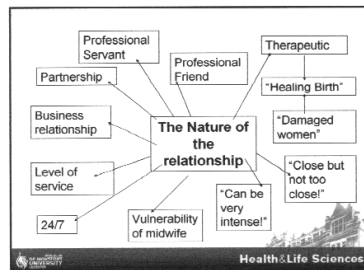
- "I think that building relationships with my independent clients it is...there are so many factors that come into play that make it very easy, I think it is a completely different ball game to in the NHS, for one thing they are booking me rather me booking them." (Phoebe:20)

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### Building relationships

- Time:
- "... really listening to what they have to say and giving them the time, and having the time to do that is huge, but also being sensitive to whether they have the time because some of the women want to be very matter of fact, and want to fit you in amongst everything else that they do in their lives or whatever. They very much begin to look at their watch after a while and all that body language you have to be very, very aware of. I just feel so fortunate to be able to work like this because I allow two hours for each antenatal, so you can't help but build a relationship." (MW Phoebe : 21)

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### Nature of relationship

- Professional responsibilities:
- "I think it starts blurring your judgement you know if you are too close. I have to remember all the time that I am being a midwife and this is my job and I have responsibilities, but yes, I do get on with them tremendously well." (: Milly: 15)

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### Nature of the relationship

- "There is a thing about friendship as well, I think, that is really interesting. There are a few clients who I would say, we are very, very good friends, but there is that professional... they are paying you and you are beholden to them in that way. And therefore I feel that you can't really be true friends because of that." (Serena :9)

### Nature of the relationship

- Politics & right mother for right midwife:
- " I think that women choose us to be their midwives and I think that they come to us because they need a certain sort of care and it might be that, I am not the right midwife for this woman, you know. I do think that they seek out the right midwife for them." (Emily: 27)

### Nature of the relationship

- Politics:
- "I think it is choice when the woman can engage the services of the midwife, and that puts the professional servant relationship right. Who is giving orders to whom?" (Brigid: 17)

### Healing birth

- A Healing birth:  
"That is something that is used in independent terms, I think it is a common use of language, I think, I have heard it used before amongst other people. I quite like it, I think it is a positive term and I suppose it's the hope that that somebody will turn the corner on a chapter in their life, rather than keep it as a front page thing and a negative thing. But I would say that most of the women that have birthed before have had an experience that they don't want to have again."  
(Esmie: 34)

### Healing Birth

- Therapeutic relationship:  
"A lot of our clients come to us because they've had unhappy experiences with their first baby and they come to us and they tell us their stories. I have found that a number of them haven't really talked to anyone else about it because they haven't been encouraged to talk about it. And people, well meaning, their husbands, their families, have said look its all over now, that's in the past, everything is fine, we just need to get over it. And nobody seems to understand that people need to talk, and they need to weep, and they need to re-live what happened to them, and talk it and talk it and talk it, and then they feel better."  
(Serena :15)

### Healing birth

- The value of this work:  
" (You see)... how being able to talk about it brings them through it, and then they have a lovely birth and that heals them and then they move on in their life. And that is just enormously rewarding actually to see someone come through that, a very damaged person have a healing birth, having been able to just talk. I sit and listen for 3 hours, that's fine, they need to do that, and then they become this healed person, that's just so rewarding. Some of them, (other people) just don't get it, they just don't understand what we do at all. Oh, you are a midwife, oh, you deliver babies occasionally. What else would we do?" (Serena: 15)

### Nature of the relationship

- Vulnerability of midwife:
- "It is very scary as well because, gosh, we are working without insurance; we are pushing the boundaries of what are the accepted norms. We are laying ourselves very much open to a lot of trouble. But equally, the women are wanting that of us generally; we do push the boundaries, because we do, but equally as much as it is us, the women are wanting it." (Emily: 29)



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### In Conclusion

- Model of care facilitates the mother midwife relationship.
- Time- slowing things down- notice, feel and hear more- access different types of knowledge.
- The quality of the relationship hugely important to midwives- need to connect- safety issue.
- Important midwifery tool and skill.
- Mother chooses midwife- right political footing.



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### In Conclusion

- 'Healing' aspects of midwifery made visible-interesting area.
- Some clients pose particular challenges for midwives making midwives vulnerable.
- Supportive Supervisors very helpful.
- Highly enthusiastic and dedicated group of midwives who are passionate about facilitating best possible birth outcomes for women.



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### Last word....

- (Independent midwifery)...."it brings with it so many valuable relationships with the women and their families, and also for every woman that I have worked with who becomes a strong competent mother, she is going to pass some of that on to her aunts and her sisters and everybody else, and I think this is what we do as independents" (Erica: 4)



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## **9.10 Appendix 10 The 6Cs**

### **1. Care**

Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

### **2. Compassion**

Compassion is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.

### **3. Competence**

Competence means all those in caring roles must have the ability to understand an individual's health and social needs. It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

### **4. Communication**

Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.

### **5. Courage**

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.

### **6. Commitment**

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients. We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

(Department of Health 2012 Compassion in Practice)