

**An Interpretative Phenomenological Analysis of  
Midwives' Experiences of Promoting Normal  
Birth in an Alongside Midwife Unit in the United Kingdom**

**Thesis submitted in partial fulfilment of the degree of Doctor of Advanced  
Healthcare Practice**

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## **Summary**

The purpose of this study was to explore the lived experiences of midwives promoting normal birth in an Alongside Midwife Unit (AMU) in the United Kingdom (UK). It aimed to develop a contemporary understanding of those experiences and reveal how the midwives perceived their role in the promotion of normal birth. It also sought to identify any challenges they may have encountered when promoting normal birth. The subjects of normal birth and its promotion have for many years generated much interest and debate both in professional and in public arenas. The publication of the findings of the Morecambe Bay investigation in 2015, however, heralded a new era in this debate. The findings suggested that a group of midwives practising in the Barrow in Furness General Hospital pursued normal birth with a zeal that, at times, may have resulted in inappropriate and unsafe care. Additionally, there is much discussion and debate in the literature about the promotion of normal birth with emphasis being placed on the possible benefits of maximising the potential for physiological birth for most women. The Better Births initiative launched by the Royal College of Midwives (RCM) also has normal birth promotion for the majority of women and the normalisation of birth for all women as its central themes. Increased understanding of the lived experiences of midwives promoting normal birth today will add to the body of evidence which explores the implementation of this agenda.

This thesis employed Interpretative Phenomenological Analysis to explore the experiences of nine midwives promoting normal birth in a UK AMU. Data were collected through face to face interviews conducted over a four-month period. Data were initially analysed idiographically, followed by group level analysis. Further interpretation was developed using the tenets of symbolic interactionism as a theoretical framework and the synthesis of the data with the wider literature.

The findings revealed that the experiences of the midwives promoting normal birth were strongly influenced by reciprocation between the mother and the midwife. The nature of the reciprocation in the mother-midwife dyad manifested itself as 'the bond' that formed between them. This bond appeared to consist of and be strengthened by elements of both physical and emotional reciprocity and connectivity, connectivity that has been identified as the ubiquitous we.

## **Statements and Declarations**

### **STATEMENT 1**

This thesis is being submitted in partial fulfilment of the requirements for the degree of Doctor of Advanced Healthcare Practice.

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This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is it being submitted concurrently for any other degree or award (outside of any formal collaboration agreement between the University and a partner organisation)

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## CONTENTS

<b>SUMMARY</b> .....	<b>II</b>
<b>STATEMENTS AND DECLARATIONS</b> .....	<b>III</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>IV</b>
<b>CONTENTS</b> .....	<b>V</b>
<b>LIST OF TABLES</b> .....	<b>VIII</b>
<b>LIST OF FIGURES</b> .....	<b>IX</b>
<b>LIST OF APPENDICES</b> .....	<b>X</b>
<b>GLOSSARY OF TERMS USED</b> .....	<b>XI</b>
<b>CHAPTER ONE: INTRODUCTION</b> .....	<b>1</b>
<b>1.1 Background</b> .....	<b>1</b>
1.1.1 The impetus for enquiry .....	1
1.1.2 Personal motivation to undertake this study .....	2
1.1.3 Professional motivation to undertake this study .....	3
<b>1.1.4 Historical Context</b> .....	<b>4</b>
1.1.4.1 Midwifery prior to 1902 .....	4
1.1.4.2 Midwifery after 1902 .....	6
<b>1.2 Models of Childbirth</b> .....	<b>9</b>
<b>1.3 Clarification of concepts</b> .....	<b>10</b>
1.3.1 Safety .....	10
1.3.2 Risk .....	12
<b>1.4 The emergence of a research question</b> .....	<b>13</b>
<b>1.5 The study</b> .....	<b>13</b>
1.5.1 Aims and objectives .....	13
1.5.2 Approach .....	13
1.5.3 Structure of the thesis .....	14
<b>CHAPTER TWO: LITERATURE REVIEW</b> .....	<b>15</b>
<b>2.1 Introduction</b> .....	<b>15</b>
<b>2.2 Search strategy</b> .....	<b>15</b>
<b>2.3 Inclusion and exclusion criteria</b> .....	<b>17</b>
2.3.1 Inclusion criteria .....	17
2.3.1.1 Areas of interest .....	17
2.3.1.2 Context .....	17
2.3.1.3 Types of study .....	18
2.3.1.4 Types of participant .....	18
2.3.2 Exclusion criteria .....	18
<b>2.4 Locating and selecting relevant studies</b> .....	<b>18</b>
<b>2.5 Results</b> .....	<b>21</b>
2.5.1 Midwives as protectors of normal birth .....	21
2.5.2 Knowledge, confidence and belief in the promotion of normal birth .....	24

2.5.3 The influence of the birth environment on normal birth promotion.....	27
<b>2.6 Conclusion.....</b>	<b>28</b>
<b>CHAPTER THREE: THEORETICAL CONTEXT.....</b>	<b>30</b>
<b>3.1 Ontological, epistemological and axiological positioning .....</b>	<b>30</b>
<b>3.2 Symbolic Interactionism .....</b>	<b>31</b>
3.2.1 The status of the symbol .....	34
<b>CHAPTER FOUR: STUDY DESIGN.....</b>	<b>36</b>
<b>4.1 Interpretative Phenomenological Analysis.....</b>	<b>36</b>
4.1.2 Phenomenology .....	37
4.1.3 Hermeneutics .....	38
4.1.4 Idiography .....	38
4.1.5 The Limitations of Interpretative Phenomenological Analysis .....	39
<b>4.2 Research Procedure .....</b>	<b>40</b>
4.2.1 Study Location.....	40
4.2.2 Ethical Considerations.....	41
4.2.3 Participant Autonomy.....	42
4.2.4 Sample .....	42
4.2.5 Data Collection .....	43
4.2.6 Harm.....	46
4.2.7 Consent.....	46
4.2.8 Confidentiality.....	46
<b>4.3 My Position as Researcher .....</b>	<b>47</b>
<b>4.4 Data Analysis.....</b>	<b>47</b>
<b>CHAPTER FIVE: FINDINGS .....</b>	<b>52</b>
<b>5.1 Idiographic Data Analyses .....</b>	<b>52</b>
5.1.1 Mary.....	52
5.1.2 Carol.....	59
5.1.3 Karen.....	65
5.1.4 Lilly .....	71
5.1.5 Holly.....	78
5.1.6 Susan.....	85
5.1.7 Anna .....	92
5.1.8 Laura .....	96
5.1.9 Jenny.....	101
<b>5.2 Group Level Analysis .....</b>	<b>107</b>
5.2.1 The Ubiquitous We .....	110
5.2.2 Philosophies of Practice .....	110
5.2.3 Boundaries.....	112
5.2.4 Atmosphere of Birth .....	113
5.2.5 Maternal Expectations of Birth.....	114
<b>5.3 Summary .....</b>	<b>116</b>

<b>CHAPTER SIX: DISCUSSION .....</b>	<b>117</b>
6.1 The Ubiquitous We .....	117
6.2 Philosophies of Practice .....	123
6.3 Boundaries .....	126
6.4 Atmosphere of birth.....	129
6.5 Maternal Expectations of Birth.....	133
<b>CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS .....</b>	<b>137</b>
7.1 Study Summary.....	137
7.2 Study Contributions .....	137
<b>7.3 Strengths and limitations of the study.....</b>	<b>138</b>
7.3.1 Sensitivity to context.....	138
7.3.2 Commitment and rigour.....	139
7.3.3 Transparency and coherence .....	140
7.3.4 Impact and importance .....	140
<b>7.4 Implications for midwifery practice and education .....</b>	<b>140</b>
7.4.1 Implications for midwifery practice .....	140
7.4.2 Implications for midwifery education .....	142
<b>7.5 Suggestions for further research.....</b>	<b>142</b>
<b>CHAPTER EIGHT: REFLEXIVE EPILOGUE .....</b>	<b>145</b>
<b>8.1 From Both Sides, Now by Joni Mitchel (1967) .....</b>	<b>145</b>
8.1.2 Reflexivity as a professional .....	145
8.1.3 Reflexivity as an educationalist .....	147
8.1.4 Reflexivity as a researcher .....	147
<b>8.2 Conclusion.....</b>	<b>149</b>
<b>REFERENCES.....</b>	<b>150</b>
<b>APPENDICES.....</b>	<b>178</b>

## LIST OF TABLES

Table 1: Models of Childbirth (Davis-Floyd 1992 p. 160-1).....	9
Table 2: Six-stage methodological framework for a scoping review, adapted from Arksey & O'Malley (2005) and Levac et al (2010).....	16
Table 3: Philosophical position, theoretical framework, methodology and method.....	35
Table 4: Grade Band Profiles .....	42
Table 5: Participant Profiles .....	43
Table 6: Super-ordinate and sub-ordinate themes that emerged from Mary's transcript with supporting quotations .....	57
Table 7: Super-ordinate and sub-ordinate themes that emerged from Carol's transcript with supporting quotations .....	63
Table 8: Super-ordinate and sub-ordinate themes that emerged from Karen's transcript with supporting quotations .....	69
Table 9: Super-ordinate and sub-ordinate themes that emerged from Lilly's transcript with supporting quotations .....	75
Table 10: Super-ordinate and sub-ordinate themes that emerged from Holly's transcript with supporting quotations .....	82
Table 11: Super-ordinate and sub-ordinate themes that emerged from Susan's transcript with supporting quotations .....	89
Table 12: Super-ordinate and sub-ordinate themes that emerged from Anna's transcript with supporting quotations .....	95
Table 13: Super-ordinate and sub-ordinate themes that emerged from Laura's transcript with supporting quotations .....	100
Table 14: Super-ordinate and sub-ordinate themes that emerged from Jenny's transcript with supporting quotations .....	105
Table 15: Summary of frequency of super-ordinate themes emerging across the group .....	109
Table 16: Quotes elucidating the emergent super-ordinate theme of the Ubiquitous We .....	110
Table 17: Quotes elucidating the emergent super-ordinate theme of Philosophies of Practice .....	111
Table 18: Quotes elucidating the emergent super-ordinate theme of 'Boundaries' ...	112
Table 19: Quotes elucidating the emergent super-ordinate theme of 'Atmosphere of Birth'. .....	113
Table 20: Quotes elucidating the emergent super-ordinate theme of 'Maternal Expectations of Birth' .....	115



## LIST OF FIGURES

Figure 1: Process of locating, identifying and selecting relevant studies .....	20
Figure 2: Data Analysis Process.....	51
Figure 3: Emergent super-ordinate and sub-ordinate themes from Mary’s interview ...	52
Figure 4: Emergent super-ordinate and sub-ordinate themes from Carol’s interview ...	59
Figure 5: Emergent super-ordinate and sub-ordinate themes from Karen’s interview ..	65
Figure 6: Emergent super-ordinate and sub-ordinate themes from Lilly’s interview .....	71
Figure 7: Emergent super-ordinate and sub-ordinate themes from Holly’s interview ...	78
Figure 8: Emergent super-ordinate and sub-ordinate themes from Susan’s interview ..	85
Figure 9: Emergent super-ordinate and sub-ordinate themes from Anna’s interview ...	92
Figure 10: Emergent super-ordinate and sub-ordinate themes from Laura’s interview	96
Figure 11: Emergent super-ordinate and sub-ordinate themes from Jenny’s interview .....	101
Figure 12: Summary of super-ordinate and sub-ordinate themes emerging across the group .....	108
Figure 13: Diagrammatic Representation of The Ubiquitous ‘We’ .....	118
Figure 14: Diagrammatic Representation of Philosophies of Practice .....	124
Figure 15: Diagrammatic Representation of Boundaries .....	127
Figure 16: Diagrammatic Representation of Atmosphere of Birth .....	129
Figure 17: Diagrammatic Representation of Maternal Expectations of Birth.....	133

## **LIST OF APPENDICES**

<b>APPENDIX ONE</b>	Literature Search
<b>APPENDIX TWO</b>	Studies Included in the Literature Review
<b>APPENDIX THREE</b>	Cardiff School of Health Care Sciences Postgraduate Research, Review and Ethics Committee Approval
<b>APPENDIX FOUR</b>	Health Research Authority approval
<b>APPENDIX FIVE</b>	National Health Service Trust Letter of Access for Research
<b>APPENDIX SIX</b>	Participant Information Sheet
<b>APPENDIX SEVEN</b>	Interview Prompt Sheet
<b>APPENDIX EIGHT</b>	Consent Form
<b>APPENDIX NINE</b>	Identification of Emerging Super-ordinate and Sub-ordinate Themes for Each Individual Midwife
<b>APPENDIX TEN</b>	Identification of Emergent Super-ordinate and Sub-ordinate Themes Across the Group

## Glossary of terms used

Term / Abbreviation	Explanation
AMU	Alongside Midwife Unit
Bradycardia	Slowing down of the heart rate to abnormally low levels
FH	Fetal Heart
FMU	Freestanding Maternity Unit – a standalone birthing unit staffed by midwives in the community setting.
Hypoxic Ischaemic Encephalopathy (HIE)	A type of brain damage that occurs when the brain does not receive enough oxygen and blood. Can occur during labour and birth.
Intrapartum	The process of labour and giving birth
Mentor	An NMC registrant who supports learning and supervises and assesses students in a practice setting.
Multiparous	A woman having given birth two or more times
NICE	The National Institute for Health and Care Excellence
Nulliparous	A woman never having given birth
Partogram	A composite graphical record of key maternal and fetal data completed during active labour and entered against time
Primip	A woman giving birth for the first time

## Chapter One: Introduction

### 1.1 Background

The purpose of this chapter is to provide an outline of the thesis. In it I detail how the study question emerged, provide a rationale for the evolution of the research question, outline the study's aims and objectives and introduce the approach used. To contextualise the research question I consider the historical, political and sociological debates pertaining to midwifery and the evolution of the profession; without this contextualisation it will be difficult to appreciate why and how midwifery practice has evolved into that which we know today and why the research question that this study poses has significance. Additionally, to provide further contextualisation, I explore models of childbirth and analyse the complex concept that is risk and its application to maternity services in general and to the promotion of normal birth in particular. I conclude with an overview of the structure of the thesis.

#### 1.1.1 The impetus for enquiry

As a practising midwife and midwifery educationalist I am acutely aware that maternity services in the United Kingdom (UK) are undergoing a time of significant transformation (NHS England 2016). The drivers for this transformation are complex and multifaceted. They include a 1.8% rise in the birth rate and a 21.5% rise in the number of births to women aged 40 years and over during the period 2014-2015. Additionally, from 2005-2006 to 2015-2016 there has been a rise in the caesarean section rate from 24.1% to 27.1% and a fall in the spontaneous vaginal birth rate from 64.8% to 60.0% (Office for National Statistics 2016). Moreover, women are experiencing increasingly complex socio-economic, psychological and physical conditions, with 22% of pregnant women in the UK being classified as obese (Bonar 2016). The promotion of normal birth is central to midwifery practice and as stated in the standards for competence for registered midwives (Nursing and Midwifery Council 2009 p.2) "*Registered midwives will be expected to understand, promote and facilitate normal childbirth and identify complications that may arise in women and babies*". It is amidst this milieu of rising complexity that midwives are endeavouring to continue to fulfil this expectation and promote normal birth. For the purposes of this study a normal birth is defined as one which is:

*"spontaneous in onset, low risk at the start of labour and remaining so through labour and delivery, with the infant being born spontaneously in the vertex position between 37 and 42 weeks gestation. After birth mother and infant are in good condition"* (World Health Organisation 1996 p.4).

However, it is acknowledged that the definition of a normal birth is contentious and lacks consensus agreement across both the midwifery and medical professions (Anderson 2009, Clews 2013). The concept of normal childbirth can be viewed as subjective, contextual, contingent and complex. Gould (2000) argued that a lack of an agreed definition perpetuated the advancement of the medicalisation of childbirth enabling the medical profession to better define abnormality. Wagner (2001) referred to the need to humanize birth as the use of the term normal had connotations of usual. In 2007 the Association for the Improvement of Maternity Services (AIMS), the National Childbirth Trust (NCT), the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) formed the Maternity Care Working Party (Maternity Care Working Party 2007). This group defined normal birth as birth *“without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery”* (Maternity Care Working Party 2007). A more recent definition used by Birth Choice to monitor the normal birth rate in the UK, is *“a birth where labour starts on its own, the woman doesn’t have any anaesthetic such as an epidural, and she gives birth without a caesarean, forceps, ventouse or episiotomy”* (Birth Choice 2018). There has also been significant debate about the use of the word normal; latterly the term normal birth has been replaced with ‘physiological birth’ which is thought to better represent the fundamentally physiological processes that occur during an undisturbed birth (Downe 2008, Powell Kennedy 2010, Powell Kennedy et al 2015). The term physiological birth however may be considered unwieldy and not particularly user friendly. Mander and Murphy-Lawless (2013) recommended replacing ‘normal’ with the term ‘intervention-free’ which was proposed by the Dutch Philosopher Wackerhausen. However, as Mander and Murphy-Lawless (2013) astutely observe, the use of this term raises the important and complex question, what constitutes an intervention?

### **1.1.2 Personal motivation to undertake this study**

Pillow (2003) argues that the process of reflexivity can be used to articulate a researcher’s subjective stance by considering who they were, who they are, how they feel and the influence that these elements may have on the direction of a study, its data collection and its analysis. As these elements constitute the personal drivers for undertaking this study it is important to acknowledge and articulate them. Like many members of my profession, I am committed to the promotion and facilitation of normal childbirth. During my 30-year career as a midwife I have had the pleasure of accompanying many women during their journey through the pregnancy and birth

continuum and gained considerable personal experience of promoting and facilitating normal childbirth.

Following qualification, I practised for ten years as a midwife leading and coordinating intrapartum care on a very busy labour ward situated in a large Consultant unit in an inner London teaching hospital. I gained considerable experience, skill, and job satisfaction in caring for women whose pregnancies were very complicated and whose labours frequently culminated in either instrumental or operative births. I was very comfortable in this high-risk environment. Due to alterations in service demands I was asked to join the community midwifery team; consequently, my practice had to change. The feelings that I experienced during those initial weeks as a community midwife, with only my eyes, ears, hands and a rucksack containing basic equipment to support my practice remain with me as vividly today as they did then. However, it was during the facilitation of my first home birth as a community midwife that I experienced a profound and career changing paradigm shift in the way that I viewed not only birth but also my role as a midwife accompanying women during the final stage in their transition from womanhood to motherhood. I had been a practising midwife for many years and felt myself to have considerable mastery of my professional practice yet this humbling exposure to normal birth in the home environment made me feel that I knew nothing about my craft and that all the skills that I had previously developed were not applicable here. Without wishing to sound clichéd, it was not only a baby that was born that day but also a new midwife. A midwife who had witnessed the physical, psychological, emotional and spiritual power of normal birth and the positive impact that normal birth had upon a woman, her partner and her baby. From that point in my career to this I have been an advocate for the facilitation of normal birth.

### **1.1.3 Professional motivation to undertake this study**

Normal birth and the promotion of normal birth are axiomatic to the midwifery profession and have been the subject of popular professional discourse and debate for many years (Downe 2006, Downe 2008, Stephens 2009, Walsh and Steen 2007, Darra and Murphy 2016, Leap and Hunter 2016). The International Confederation of Midwives (ICM) revised its' definition of a midwife in 2005 to include the promotion of normality, stating that:

*“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” (International Confederation of Midwives 2005 p.1).*

Currently there is much discussion and debate in the literature about the promotion of normal birth with emphasis placed on the possible benefits of maximising the potential for physiological birth for most women (Renfrew et al 2014, Downe and Finlayson 2016). The Better Births initiative launched by the Royal College of Midwives (RCM) has normal birth promotion for the majority of women and the normalisation of birth for all women as one of its central themes (RCM 2015). Increased understanding of the lived experiences of midwives’ promoting normal birth today will add to the body of evidence that supports the success of this agenda and also provides one of the drivers for undertaking this study.

#### **1.1.4 Historical Context**

Shedding light on the historical and political context of a given subject’s past can assist with the illumination and contextualisation of its present (Bosanquet 2009). This premise provides the rationale for undertaking this review of the historical and political literature pertaining to the practice of midwifery, normal birth and the promotion of normal birth by midwives. There is a significant body of literature that documents the rich and intricate history of midwifery practice and the evolution of midwifery as a profession. To ensure clarity this subject is divided into two eras; pre and post 1902. The rationale for using this division is that the Midwives Act of 1902 heralded a new beginning for midwifery practice and the emergence of midwifery as a profession. It is acknowledged that there are potential difficulties when considering historical literature due to scarcity, bias and the possibility of past knowledge being contaminated by the present (Allotey 2011a).

##### **1.1.4.1 Midwifery prior to 1902**

Up until the beginning of the eighteenth-century birth was quintessentially located in the home and the ubiquitous practice that is midwifery was overwhelmingly the dominion of women, with this tradition reaching as far back as Biblical times (Towler and Bramall 1986). Midwives of this period required no formal education or qualification and were ‘trained’ by means of an apprenticeship. However, by the early sixteenth century midwives were required to obtain an ecclesiastical licence from the church to practice. To obtain a license, applicants had to be of good character and have supporting

references from notable members of society and testimonials from six women who would vouch for the midwife's competence (King 2012). It is interesting to note that service user involvement in the selection and validation of good midwifery practice that is used today is not a new concept.

It was during this era that the inter-professional conflict between midwives and their medical counterparts began with the emergence of the man-midwife and the dawn of the medicalisation of childbirth (Allotey 2011b). Celebrated authors Tew (1998) and Donnison (1988) in their seminal works document the rise of the obstetrician and the emerging medical model of maternity care. The dominance of the paradigm of pathology and intervention arguably began to erode the status of midwives and midwifery practice. Men-midwives were a group who evolved from barber-surgeons whose initial involvement in childbirth was as an attendant at emergencies during which they would expedite birth using instrumentation in the form of forceps (Donnison 1988). However, as the eighteenth century advanced so did the man-midwife's encroachment into normal birth and midwifery practice. This was accompanied by an increasing trend of vilification towards midwives, whose reputation for safety and good practice was brought publicly into disrepute (Tew 1998). There was, as a result, significant midwifery antagonism towards men-midwives and their instrumental birth practices, this was notably expressed in 1760 by English midwife Elizabeth Nihell, who published one of a growing number of midwifery books entitled; *A Treatise on the Art of Midwifery Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments*. Nihell railed against the man-midwife suggesting that they were:

*'A band of mercenaries who palm themselves off upon pregnant women under cover of their crochets, knives, scissors, spoons, pinchers, fillets, speculum matrices, all of which and especially their forceps... are totally useless'* (Nihell 1760 p 68)

Cahill (2001) argues that the decline in midwifery and rise of medical control over childbirth was part of the overall pursuit of medical professionalisation. This pursuit was dominated by the argument that medical knowledge was scientific and superior to midwifery knowledge which was deemed to be experiential, intuitive and consequently inferior (Cahill 2001). It was at this time that there also began a movement of birth from the home into the lying-in hospitals which compounded the situation and heralded the beginning of institutionalised birth (Donnison 1988).



It is acknowledged that the rivalry between midwives and the medical establishment has been documented extensively in the literature. Returning to this period in midwifery history provides essential and relevant background not only to present day midwifery practice but also to the context of this study. However, as Cody (1999) astutely observed, even though there has been much written on the subject, exactly how men came to dominate midwives remains elusive. Einion (2017) in her feminist deconstruction of the medicalisation of childbirth offers a solution, asserting that the medical control of childbirth was and is intricately connected with patriarchy. Historically, the medical profession and obstetrics was dominated by men and even though there is a much stronger female presence within these professions today, men remain the dominant presence. Conversely, midwifery is dominated by women providing care for women, as Hunter (2012) suggests midwifery is, therefore, in danger of being relegated to 'women's business' which has the potential to see it marginalised.

The dawn of the industrial era during the latter part of the nineteenth century saw fundamental changes in society and medicine, together with rising concerns about increased rates of maternal mortality (Tew 1998). In 1881, to address this and to improve the status of midwives, midwife Zepherina Veitch founded the Trained Midwives' Registration Society which became the Midwives' Institute in 1886 and then, in 1948, became the Royal College of Midwives. Veitch and others represented a new style of philanthropic, middle class midwife who had previously been trained as Nightingale nurses and gained the London Obstetrical Society diploma (Nuttall 2012). The aim of the Midwives' institute was to improve the status and safety of midwives through education and training, aspirations that paved the way for the Midwives Act of 1902.

#### **1.1.4.2 Midwifery after 1902**

On the 31<sup>st</sup> July 1902 the first Midwives Act attained Royal Assent and was the culmination of the rivalry between those who wanted to see midwives responsible for all births and those who wanted to see them have responsibility for normal births only (Mander and Reid 2002). It was the latter that prevailed and the Act served to establish standardised training programmes for midwives and to regulate their practice. One of the most notable features of the Act was the formation of the Central Midwives Board (CMB) for England and Wales (Towler and Bramall 1986). The CMB was responsible for setting rules and regulations, issuing certificates of training and for maintaining the newly established roll of midwives. By 1911 pupil midwives were expected to undertake 20 normal deliveries and the training lasted three months.

Under the Act midwives were not allowed to manage abnormal cases, however by 1920 the Midwife's role in facilitating normal labour and birth was protected by legislation (Nuttall 2012). Whilst the 1902 Midwives Act did undeniably begin the professionalisation of midwifery and initiate the rise of educated, affluent, middle class midwives, it simultaneously signalled the demise of their poorer, uneducated, working class predecessors known as 'handywomen'. Handywomen were women from local communities who attended the births of women from poor backgrounds who could not afford to pay for their care (Leap and Hunter 1993). Their realm of practice was the home and birth was not considered to be a medical process. There were inevitably variations in the standards of practice between handywomen and some would undoubtedly have been responsible for many poor outcomes, however it is interesting to note that by the 1930's, when handywomen had all but ceased to practice, the maternal mortality rate began to rise (Leap and Hunter 1993).

The inception of the National Health Service in 1948 saw the growth of maternity hospitals into which a growing number of midwives would transfer women experiencing normal pregnancies and normal labours. In so doing midwives were diminishing their power base and reducing their status and role (Mander 2002). This trend of hospitalised birth culminated in the Peel Report of 1970 which recommended that, to ensure safety, all births should occur in the hospital setting (Department of Health 1970). From the mid-twentieth century onwards there continued to be many significant advances in obstetric and reproductive technologies which, whilst improving birth outcomes for women and their babies, also served to perpetuate the dominant cultural norm of birth being firmly located with the hospital arena and its subsequent alignment with pathology and disease (Einion 2017). During this time there was a lack of unity amongst the midwifery profession which was coupled with a continuation of the professional contention between midwives and doctors which centred around two competing views of childbirth, namely, that it is either a normal or risk prone event (Hunter 2012). It was not until 1992 that a House of Commons Select Committee consulted with women about their birth experiences and choices; following this consultation women overwhelmingly requested alternatives to hospitalised birth. The committee also surfaced the existing inter-professional tensions between midwives and their medical colleagues stating that "much of what we have heard appeared to be concerned with which group should have control over maternity services" (House of Commons 1992, paragraph 175). The recommendations of the House of Commons Select Committee report were embedded in the resulting government consultation document Changing Childbirth (Department of Health 1993). This document was both

influential and controversial at the same time, asserting that women in England should be offered choice, continuity of carer and a measure of control over their birth experiences and that midwives should adopt more flexible working patterns to straddle the community/hospital divide and remain the primary providers of care during normal pregnancy and birth (Hunter 2012). The recommendations of this document however, brought into relief divisions within the midwifery profession, with some midwives welcoming the opportunity to practice using their full range of midwifery skills to promote and facilitate normal birth as their sisters had done in the past and others expressing anxiety about the implications of the proposed changes.

This apparent lack of professional unity amongst midwives changed in 2005 with the launch of the Royal College of Midwives initiative, the 'campaign for normal birth' (Day-Stirk 2005). The aim of the campaign was to redress the balance in maternity service provision in the UK by stimulating debate about normality and promoting normal birth practices within a social model of midwifery. The campaign also had other objectives; to improve experiences for women and job satisfaction for midwives, however the primary aim of the campaign was to increase the normal birth rate and decrease unnecessary interventions during childbirth (Day-Stirk 2005). The use of the word 'campaign' to describe this initiative is interesting and worthy of further exploration. The dictionary definition of campaign is a 'planned set of activities that people carry out over a period of time in order to achieve something such as social or political change' (Collins 2016), which is indeed applicable to the initiative. However, the word 'campaign' also has significant military overtones and is also defined as 'a series of military operations intended to achieve a goal, confined to a particular area, or involving a specified type of fighting' (Collins 2016). The premise for the use of this word may have been to galvanise midwives in the pursuit of normal birth but it may also be argued that it provoked further division between midwives and their medical colleagues. This choice of language signalled a shift from the World Health Organization's previous recommendations for 'care in normal birth' in the 1990s (World Health Organisation 1996). Phipps (2014 p.107) suggests that this change in language also signalled a more 'outcome focused agenda' that promoted a particular birth option irrespective of maternal experience or preference. During the latter part of the twenty first century Midwifery 2020 (Department of Health 2010) continued to advocate for the encouragement of normal birth and continued the vision that midwives be the lead professional for all healthy women with uncomplicated pregnancies.

## 1.2 Models of Childbirth

Having considered the historical context of midwifery and the professional tensions that exist between midwives and their medical colleagues, it is appropriate to explore the models of childbirth these different professional groups espouse. Historically, much has been written by medical anthropologists, epidemiologists, social scientists, midwives, and obstetricians about the different models of childbirth that exist around the globe (Davis-Floyd 1987, Davis-Floyd 1992, Walsh and Newburn 2002, Davis-Floyd et al 2009, Kitzinger 2012). Distilled from the literature is the understanding that there are currently two prevailing models of childbirth, the Social model and the Technocratic model (Table 1).

Table 1: Models of Childbirth (Davis-Floyd 1992 p. 160-1)

<b>Technocratic (medical) model of birth</b>	<b>Social (Holistic) model of birth</b>
Male perspective	Female perspective
Woman= object	Woman= subject
Classifying, separate approach	Holistic, integrated approach
Body= machine	Body= organism
Female body= defective machine	Female body= healthy organism
Pregnancy and birth inherently pathological	Pregnancy and birth inherently healthy
Hospital= factory	Home= nurturing environment
Baby= product	Mother/ baby inseparable unit
Fetus is separate from mother	Baby and mother are one
Best interests of mother and baby antagonistic	Good for mother= good for baby
Supremacy of technology	Sufficiency of nature
Institution= significant social unit	Family= essential social unit
Action based on facts, measurements	Action based on body/ intuition
Only technological knowledge is valued	Experiential and emotional knowledge is highly valued
Labour= mechanical process	Labour= a flow of experience
Time is important; adherence to time charts during labour is essential	Time is irrelevant; the flow of a woman's experience is important
Once labour begins, it should progress steadily. If it does not, intervention is necessary	Labour can stop and start, follow its own rhythms of speeding up or slowing
Medical intervention necessary in all births	Facilitation (food, positioning, support) is appropriate
Environmental ambience is not relevant	Labour pain is acceptable, normal
	Mind/ body integration, labour support for pain

<p>Woman in bed hooked up to machines where frequent vaginal examinations by staff is appropriate</p> <p>Labour pain is problematic and unacceptable</p> <p>Analgesia/anaesthesia for pain during labour</p> <p>Birth= a service medicine owns and supplies to society</p> <p>Obstetrician= supervisor/ manager/ skilled technician</p> <p>The doctor/ midwife delivers the baby</p>	<p>Birth= an activity a woman does that brings new life</p> <p>Midwife= skilled guide, responsibility is the mother's.</p> <p>The mother births the baby</p>
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Davis-Floyd the American medical anthropologist has written prolifically on the subject of birth models and first identified the technocratic model after posing the question 'why is a birthing woman like a broken-down car...?' (Davis-Floyd 1987 p.379). The technocratic model of birth, therefore, likens the body to a machine. Mc Court et al (2014) in their ethnographic study concluded that midwifery practice in AMU's adopted the social model of care where midwives practising in this environment aimed to support physiological birth.

### 1.3 Clarification of concepts

To inform the development of the research question and ensure clarity of meaning between myself, my supervisors, study participants, and readers it is necessary to both clarify and validate the key concepts.

#### 1.3.1 Safety

The provision of safe maternity care is considered to be fundamental to achieving optimal outcomes making safety an intensely emotive, politically charged and at times controversial issue. An exploration of the literature reveals several significant events that have brought into question the provision of safe maternity care in general and safe midwifery practice in particular. Between 1997 and 2009 a group of six community midwives established the Albany Practice which provided care for disadvantaged women in South London (Davis and Edwards 2010). There were numerous, well documented benefits to the care provided by this consortium of midwives (Homer et al 2017). However, concerns were raised about safety when a number of babies experienced Hypoxic Ischaemic Encephalopathy during 2006-2008. An internal audit undertaken by the Centre for Maternal and Child Health Enquiries (CMACE) highlighted serious concerns about midwifery care provision which resulted in the

highly contentious closure of the practice in 2009. Following two neonatal deaths that occurred during the period between 2012-2014 at the Princess Alexandra hospital on the island of Guernsey, a Nursing and Midwifery Council (NMC) review concluded that there were serious concerns about the safety of maternity service provision and midwifery practice at the hospital. One of these concerns was a lack of assurance that midwives were working within their scope of practice (NMC 2014). NMC reviewers were concerned about the culture that existed within the maternity unit which was referred to as 'the Guernsey way'. The term was used to describe both general maternity service provision and midwifery practices. This review was closely followed by the publication of the Report of the Morecambe Bay Investigation (Kirkup 2015). The report detailed numerous failings in maternity service provision at Barrow in Furness General Hospital where three women and sixteen babies lost their lives during the period between January 2004 and June 2013. The report identified five problem areas, one of which was that a culture had developed in which:

*"Midwifery care in the unit became strongly influenced by a small number of dominant individuals whose over-zealous pursuit of the natural childbirth approach led at times to inappropriate and unsafe care"* (Kirkup 2015 p.13).

The report further commented that if care had been different then outcomes for one woman and eleven babies could have been more positive (Kirkup 2015). Cathy Warwick, Chief Executive of the Royal College of Midwives at the time posed a very salient question in her response to the report asking, "are the failings we read about reported elsewhere?" (Warwick 2015 p.5). In the wake of the Morecambe Bay Report (Kirkup 2015) the Department of Health commissioned a National Review of UK maternity services, entitled 'Better Births' (NHS England 2016). This review discussed the importance of establishing a positive professional culture and refers to there having been "a culture of midwives promoting normal childbirth 'at any cost' at the Barrow in Furness General hospital" (NHS England 2016 p.31).

The current Government, and those before it, have prioritised safety in maternity services, publishing an abundance of policy documents on the subject (Department of Health 2016a, Department of Health 2016b, Department of Health 2017). Sandall et al (2010) argued that a plethora of policy documents increases the potential for political principles to be the primary drivers for safety debates rather than evidence. 'Spotlight on Maternity' published the government's aspiration to reduce the rate of maternal and neonatal deaths, stillbirths, and intrapartum brain injuries by 50% by 2030 (Department

of Health 2016a). This aspiration was a direct result of the findings of the Morecambe Bay Report (Kirkup 2015), the National Maternity Review (NHS England 2016) and the recent review of maternal and perinatal deaths; Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE – UK) (Knight et al 2016).

However, it should also be acknowledged that there is a considerable body of reputable evidence that supports the fact that midwifery led care is generally safe, resulting in no adverse outcomes and many benefits to mothers and babies (Page 2015). These benefits include a decrease in instrumental birth and episiotomy rates, a reduction in epidural anaesthesia rates and an increase in vaginal birth rates (Hatem et al 2008, Birthplace in England Collaborative Group 2011, Sandall et al 2013, Royal College of Midwives 2015a).

### **1.3.2 Risk**

There has, and continues to be, extensive professional debate amongst midwives, obstetricians, statisticians and anthropologists about the nature of risk in childbirth (Einion 2017). Scamell and Alaszewski (2012) in their ethnographic study argued that the fact that birth continues to be defined as either high or low risk has a significant influence on the way in which care is provided. They further contend that the categorisation of risk is shaped by social context and that the concept of risk is influenced significantly by the language that is used to classify it. It was suggested that midwives were 'creating an ever closing window of normality' where all births were categorised as 'risky' because midwives were imagining futures with adverse outcomes (Scamell and Alaszewski 2012). Scamell (2011) explored the tensions that existed when midwives attempted to facilitate normal birth and reduce the potential for harm to both the woman and her baby. She concluded that midwifery care during labour was not about supporting the normal but about seeking out the abnormal. Coxon and Sandall (2015) argue it is essential that the nature of risk is understood as midwives are, more than ever before, required to promote and support normal birth whilst simultaneously minimising potential risks in an environment where the number of women experiencing complexities during pregnancy is rising, together with increasing intervention rates. Coxon et al (2016) contend that considering the relative and absolute risks associated with pregnancy and birth can be helpful in enabling women to differentiate between actual and perceived risks but conversely can also perpetuate the notion that pregnancy and birth is at best problematic and at worst dangerous.

#### **1.4 The emergence of a research question**

Historical analysis reveals that the professional and political landscape in which midwives have promoted normal birth in the past and continue to promote normal birth in the present is complex. An additional layer of complexity was added by the publication of the findings of the Morecambe Bay Report (Kirkup 2015). These findings were concerning to the wider midwifery community and to women and their families. The finding that caused the main locus of concern was that a small group of midwives known as the '*midwife musketeers*' (Kirkup 2015 p.8) were considered to *be 'promoting normal childbirth at any cost'* (Kirkup 2015 p.13). It is this concern that provides the primary driver for this study and provides the rationale for seeking to capture the lived experiences of a group of midwives' promoting normal childbirth today.

#### **1.5 The study**

##### **1.5.1 Aims and objectives**

The aims of the study are to:

- develop a contemporary understanding of the lived experiences of midwives' promoting normal childbirth in a setting where midwives are the lead birth attendant and where normal birth is actively promoted.
- reveal how these midwives perceive their role in the promotion of normal birth.
- identify any challenges that these midwives' experience in relation to the promotion of normal birth.

The objectives are to:

- critique the current literature pertaining to midwives' experiences of promoting normal childbirth with women experiencing a low risk pregnancy birthing in an Alongside Midwife Unit.
- interview midwives working in an Alongside Midwife Unit about their experiences of promoting normal childbirth with women experiencing a low risk pregnancy.
- Critically analyse the findings that emerge from the interviews.
- Disseminate the knowledge that surfaces as a result of this study to student midwives, midwives and midwifery educationalists.

##### **1.5.2 Approach**

This study utilises Interpretative Phenomenological Analysis (IPA) as both method and methodology. It follows the recommendations of Smith et al (2009) throughout. Cardiff



University School of Healthcare Sciences Research Ethics Committee approval was granted in April 2016. Health Research Authority (HRA) application was submitted in June 2016 and approval given in October 2016. The study consistently adheres to the agreed proposal. Participants were recruited between December 2016 and February 2017. Semi-structured, one to one interviews were conducted with nine midwives between December 2016 and March 2017. All interviews took place in the AMU where the study was conducted and lasted between thirty eight and sixty four minutes; they were audio recorded and transcribed verbatim. Data analysis was conducted following the specifications recommended by Smith et al (2009).

### **1.5.3 Structure of the thesis**

This thesis is organised into eight chapters. This chapter has introduced the reader to the present study, accompanied by an outline of my personal and professional motivations, the background to the study, a historical overview and clarification of concepts. In chapter two, I provide a critical review of the literature pertaining to the experiences of midwives promoting normal birth in the form of a modified scoping review. Chapter three addresses the theoretical and philosophical foundations of the study together with its underpinning theoretical framework. Chapter four discusses the study design and research process, including my rationale for the use of interpretative phenomenological analysis. In chapter five data are presented and the midwives' experiences considered idiographically. Chapter six discusses the midwives' experiences within the wider context of current midwifery practice and maternity service provision. In Chapter seven, I evaluate the study acknowledging its limitations, together with implications and suggestions for midwifery education, practice and research. The thesis concludes with chapter eight, the reflexive epilogue, in which I provide an account of the reflexive journey that I have undertaken during the writing of this thesis. In it I elucidate how my presuppositions were managed and how my thinking has evolved, particularly in relation to the subject of normal birth.

## **Chapter Two: Literature Review**

### **2.1 Introduction**

In this chapter, I detail the process that was followed to explore the body of literature that pertains to the research question:

*'What are the lived experiences of midwives' in promoting normal childbirth with women experiencing a low risk pregnancy in an Alongside Midwife Unit?'*

The objectives are to appraise the literature available relating to:

1. Midwives' attitudes to promoting normal childbirth
2. Midwives' experiences of promoting normal childbirth in an Alongside Midwife Unit

The chapter begins by detailing the search strategy that was employed, it will then proceed to provide a comprehensive critique of the relevant literature and an exploration of the emerging themes. The chapter concludes with the identification of gaps in the current literature and an outline of the contribution that this current study makes to the existing body of knowledge.

### **2.2 Search strategy**

A modified scoping review of the literature was adopted for this study since the research question is broad (Arksey and O'Malley 2005). Scoping reviews have also been used successfully in other midwifery studies (Frith et al 2014, Downe et al 2015), although it is acknowledged that there is some debate concerning the aims and definition of a scoping review. The accepted definition for this review is that proposed by Colquhoun et al (2014), who suggest that a scoping review aims to identify gaps in research related to a given field through a systematic search and the synthesis of existing knowledge. This review will also employ a quality assessment of the studies included as recommended by Daudt et al (2013). For this purpose, I have chosen to use the quality assessment tool devised by Walsh and Downe (2006) as it has been utilised before, is compact and reflects the central tenets of qualitative research.

To ensure that this review was rigorous, transparent and comprehensive it was guided by the six-staged framework for scoping reviews identified by Arksey and O'Malley (2005) and the enhancements proposed by Levac et al (2010) (Table 2).

Table 2: Six-stage methodological framework for a scoping review, adapted from Arksey & O'Malley (2005) and Levac et al (2010).

Stage 1	Identifying the research question
Stage 2	Identifying relevant studies
Stage 3	Study selection
Stage 4	Charting the data
Stage 5	Collating summarising and reporting the results
Stage 6	Consultation with stakeholders

The sixth stage, consultation with stakeholders, is considered optional and was therefore, not undertaken as part of this review. Smythe and Spence (2012) argue that the means by which a literature review is conducted should be congruent with the chosen research methodology. I consider that a scoping review aligns very well to IPA as, like IPA, it is an iterative process which encourages the reviewer to conduct each stage with reflexivity, repeating steps if necessary, to ensure comprehensive coverage of the literature (Arksey and O'Malley 2005). In further alignment with the philosophy that informs IPA this literature review also adopted an interpretative hermeneutic approach as advocated by Heidegger (1995) and Gadamer (1982). This review, therefore, aims to not only consider pre-articulated knowledge and understanding relevant to the field of study and reveal any existing gaps, but also to embrace a wider remit and encourage emergent thinking.

I fully acknowledge that as a practising midwife I came to this review of the literature with pre-existing knowledge and understanding of the phenomena of interest, what Heidegger (1995) describes as '*fore-having*'. I also came with what Heidegger (1995) describes as '*fore-sight*', a knowledge of what literature might be advantageous to search and '*fore-conception*' described as preconceptions of what I will encounter in the literature once I locate it (Heidegger 1995). I agree with the view articulated by Smythe and Spence (2012) who argue that it is impossible for a reviewer to completely disregard all that is already known, however it is possible to acknowledge this fact and as Heidegger (1959 p.75) states, to engage in a "restless to and fro" between what is already known and what is yet to be known. My rationale for adopting a combination of interpretative hermeneutics and a systematic approach to this scoping literature review was to ensure that I remained constantly receptive and vigilant for what could be revealed and to ensure that I readily acknowledge my '*fore-having*' whilst maintaining

an enquiring stance, open to the potential to have my '*fore-conceptions*' challenged and changed.

There is some debate in the literature (Aveyard 2014, Philips and Pugh 2015) about the appropriate time to conduct a literature review. In alignment with the one of the key tenets of IPA (Smith et al 2009) this review of the literature adopted an iterative approach which meant that I conducted a comprehensive scoping review of the literature at the beginning of this study and then conducted further reviews of any emergent literature at regular intervals throughout the duration of the study. This was carried out by setting up search alerts in key electronic databases such as EBSCO and Scopus using the search terms used in CINAHL and MEDLINE. The searches ran at regular intervals and I received emails if any new results were identified. Additionally, I set up to receive alerts to receive table of content information from key journals using the journal alerting services Zetoc and JournalTOC this enabled me to easily scan for any new and relevant articles. There were no additional studies from the Zetoc alerts. To complement the search alerts, I also regularly hand searched relevant professional journals and key professional websites.

## **2.3 Inclusion and exclusion criteria**

### **2.3.1 Inclusion criteria**

#### **2.3.1.1 Areas of interest**

The phenomena of interest for this review were:

- Normal childbirth
- The promotion of normal childbirth by midwives
- Midwives experiences of promoting normal childbirth

#### **2.3.1.2 Context**

This review considered studies concerning the promotion of normal childbirth by midwives. These included, but were not limited to, midwives practising in an Alongside Midwife Unit, a labour ward, and the home.

### **2.3.1.3 Types of study**

In line with recommendations of Arksey and O'Malley (2005) this review included both quantitative, qualitative and mixed methods approaches. To avoid the potential for missing any early studies and improve inclusivity no date limit was set.

### **2.3.1.4 Types of participant**

This review included studies that focused on qualified midwives. For this review a qualified midwife was defined as an individual who has successfully completed a programme of midwifery education at a Higher Education Institution and whose name appears on either the UK Nursing and Midwifery Council Register for nurses, midwives and health visitors or the international equivalent.

### **2.3.2 Exclusion criteria**

Studies were excluded if they:

- Involved health professionals other than midwives.
- Were in a language other than English without reliable translation.

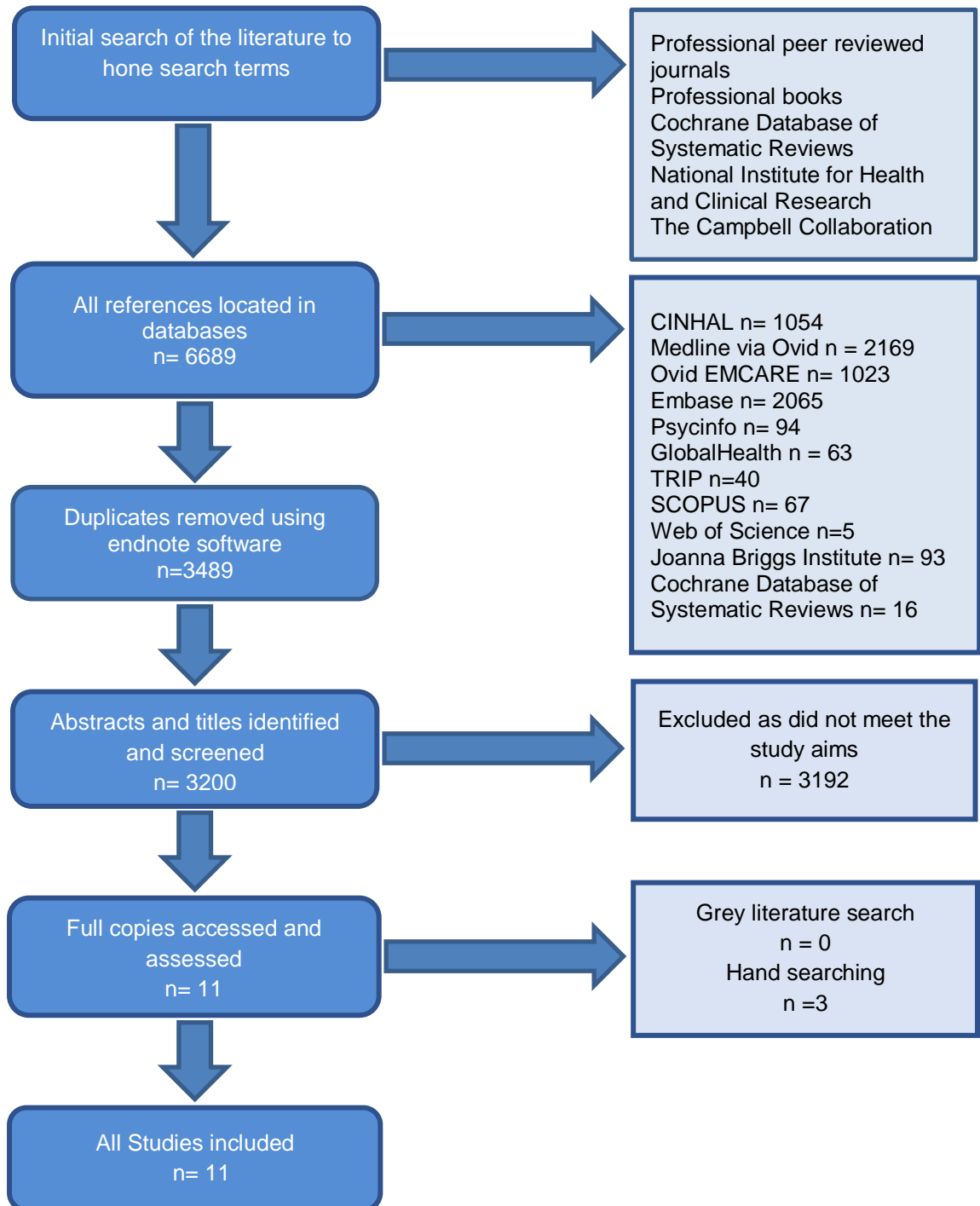
## **2.4 Locating and selecting relevant studies**

An initial scoping review of the literature was conducted to hone and confirm search terms. The following terms were then subsequently used: normal birth, natural birth, normal childbirth, midwives promoting normal childbirth, midwives' attitudes to promoting normal birth, Alongside Midwife Units. Alternative spellings, wild cards, truncations and Boolean connectors were also utilised. Appendix One details the search strategy used to identify relevant studies in electronic databases. My search approach was subsequently checked by a Cardiff University librarian trained in systematic literature searching.

To complement the search of electronic databases and capture any relevant papers that may have been missed, a hand search of hard copy publications and peer reviewed academic journals including 'Birth', 'MIDIRS', 'Midwifery', 'Qualitative Research' was also performed. Additionally, a range of relevant professional text books were also scrutinized. According to Aveyard (2014) a hand search that is well organized and relevant can add depth to a systematic approach. To ensure the hand search was systematic the snowball sampling process advocated by Greenhalgh and Peacock (2005) was adopted; the hand search therefore evolved from the references contained in the papers already obtained. Additionally, when articles of interest were in

a particular journal, further editions of that journal were scrutinised for any other relevant material. To reduce the possibility of publication bias a search of the grey literature was conducted via the databases Open-Grey and [www.greylit.org](http://www.greylit.org) (Dundar and Fleeman 2014). The search of the grey literature included government reports, clinical guidance, conference abstracts and proceedings for unpublished studies. Figure 1 depicts the process used to locate, identify and select relevant studies to include in this review.

Figure 1: Process of locating, identifying and selecting relevant studies



## **2.5 Results**

Studies identified for inclusion were charted, collated and summarized (Appendix Two). Charting the data of the studies included in this review revealed that there is an absence of literature that specifically explored midwives' experiences of promoting normal birth with women experiencing a low risk pregnancy birthing in an Alongside Midwife Unit in the UK. Of the eleven studies selected for inclusion only 4 were conducted in the UK (Price and Johnson 2006, Walsh 2006, Russell 2007 and Guiver 2004) none of which were situated in an Alongside Midwife Unit. Therefore, to fully explore the phenomena of interest, studies were included that examined midwives' experiences of promoting normal birth in additional areas of practice such as free-standing midwifery units, obstetric led units and the home. From the review three themes emerged:

- Midwives as protectors of normal birth.
- Midwifery knowledge, confidence and belief in the promotion of normal birth.
- The impact of the birth environment on the promotion of normal birth.

### **2.5.1 Midwives as protectors of normal birth**

Six of the eleven studies included in this review are included in this theme. Butler (2017) in their interpretative phenomenological study examined the experiences of fourteen midwives promoting normal birth, the challenges they faced and strategies they employed to promote normal birth in British Columbia (BC). In BC there is an increasing demand for midwifery led care and a focus on the promotion of normal pregnancy and birth. Whilst midwifery, as a registered profession in Canada, is in its infancy, being established in 1998, there are several parallels between midwifery practice in BC and the UK; midwives work autonomously within a midwifery model that embraces continuity of midwifery care and maternal choice (Butler 2017). Butler's study had a clear focus and rationale. The method used was consistent with the study aims. The sample consisted of midwives from a range of rural, urban and remote practice areas. A limitation of this study was that the exact locations of the midwives' areas of practice were not revealed therefore it was not possible to identify how many worked in each area or if any worked in an Alongside Midwife Unit. Data were analysed using Thematic Network Analysis, an approach congruent with the method used. Butler (2017) found that seven of the midwives discussed 'guarding' the physical birth space and 'protecting' women from intervention and invasion of their privacy. Butler (2017) also identified that midwives used a 'tool kit' to promote normal birth, the 'tool kit' included a range of interventions that were used 'wisely' to maintain normality.



A strength of Butler's study was that researcher reflexivity was demonstrated. Butler was herself a midwife who acknowledged the potential for this to influence the research process and took appropriate measures to limit this.

Keating and Fleming (2009) explored the experiences of ten midwives promoting normal birth in three obstetric-led units in Southern Ireland using a feminist research approach. The midwives included in this study had more than five years' experience of working on a consultant-led labour ward. The rationale for conducting this study was clear as was the rationale for the approach adopted. A strength of this study is that it contributes to a limited number of studies exploring midwifery practice in Southern Ireland. A possible limitation of this study was that although the importance of reflexivity was articulated it was not made clear how the researchers acknowledged or limited the potential for bias. A further limitation of this study was that the approach to data analysis was not made explicit, it was also not clear whether one or both researchers were involved in the data analysis. One of the findings of this study, however, was that midwives used intuitive knowledge and experience to 'protect the birth event'.

Russell (2007) in her grounded theory study explored the experiences of six midwives supporting normal birth in two UK consultant-led maternity units. A limitation of this study therefore is that the small sample size and specific geographical location means that the findings cannot be representative of all midwives working in the UK. Data in this study were analysed using open and axial coding which was appropriate to the research method used. Russell (2007) concluded that all the midwives in her study considered that the current system of care in obstetric units failed to support normal birth and that suggested strategies to improve this and protect women included 'keeping doctors away from women in normal childbirth'. When considering this suggestion in the context of midwifery practice today and in the wake of the findings of the Morecambe Bay Report (Kirkup 2015) it may be possible to propose that some midwives may have mistakenly taken this suggestion too literally, fuelling a need therefore, to examine the contemporary experiences of midwives promoting normal childbirth today.

Thompson et al (2016) in their exploratory, qualitative study used focus groups to examine the attitudes and motivators towards the promotion of physiological (normal) birth of thirty-seven Dutch hospital and community midwives. The sample consisted of midwives who had self-selected which may be viewed as a limitation of the study as

participants may have had a specific interest in the subject and therefore be less representative of the whole Dutch midwifery population. Focus group discussions were facilitated with three groups of hospital-based midwives (n=14) and four groups of community midwives (n=23). A strength of this study was that the focus group method was entirely appropriate for examining midwives' attitudes and experiences of promoting normal birth. Data analysis processes were made explicit; data were analysed thematically by both authors. A strength of this study was that attention was paid to the auditability of findings, which included that the midwives considered the protection and promotion of normal birth to be a fundamental part of their role. However, paradoxically they also found that some of the midwives in their study were concerned about 'imposing physiological birth on some women'. It is suggested that these concerns arose from the way in which the midwives viewed physiological birth in terms of risk, a view which appeared to be influenced by practice setting and culture.

Carolan-Olah et al (2015) in their Interpretative Phenomenological Analysis (IPA) study aimed to explore the experiences and views of the factors that facilitated or impeded normal birth promotion with a sample of twenty two midwives, one male and twenty one female, in one maternity unit in Melbourne, Australia. A strength of the study can be seen in the choice of method, as IPA facilitates a deeper understanding of barriers or facilitators when promoting normal birth. A further strength of this study can be seen in the sample size and variety as twenty two can be viewed as large in phenomenological terms. Data were analysed in accordance with IPA methodology. Carolan-Olah et al (2015) found that the midwives in their study assumed a protective role, ensuring that women were free to adopt positions of choice and protected from external pressures to intervene to speed labour up. A limitation of this study is that the findings are limited to one hospital and are therefore limited in their generalisability.

Reed et al (2016) in their narrative enquiry aimed to explore midwifery practice during physiological birth from the perspective of both midwives and women. The sample consisted of ten midwives and ten women living in South East Queensland, Australia. The midwives and women had recently experienced a physiological birth. A possible limitation of this study is that it is relying on narrative descriptions of practice rather than observations. Additionally, the study was limited to one location, therefore the findings may not be generalisable to Australian midwifery practice. Data analysis processes were clear, with data being analysed thematically using Fraser's four step process. The findings of this study identified that midwives demonstrated 'rites of protection'. The midwives protected women from interruption and disturbance during

labour, thus promoting physiological birth, whilst simultaneously protecting maternal and fetal wellbeing by performing ritualistic clinical assessments. The clinical assessments had a dual effect of monitoring and protecting maternal and fetal wellbeing but also protecting the requirements of the midwife's professional responsibility and the needs of the institution in which she practised. These protective behaviours were deemed to be working in 'contradictory ways'. It can be seen that the literature presented in this review suggests that midwives are deemed to be protectors of normal birth.

### **2.5.2 Knowledge, confidence and belief in the promotion of normal birth**

Eight studies included in this review identified that midwives' knowledge, confidence and belief were integral to the promotion of normal birth. Guiver (2004) in her qualitative study, interviewed nine midwives practising in a free-standing midwifery unit in a rural market town in the UK, with the aim of understanding how midwifery knowledge was used to support and promote normal birth. Purposive sampling was used to recruit participants which was appropriate to the study aims and the research method used. Aspects of grounded theory and thematic analysis were used to analyse the data until data saturation was reached. A strength of this study was the use of a qualitative methodology that elicited data that were relevant to midwifery practice. It was apparent that the researcher spent time interrogating the data for competing explanations of the phenomena as axial coding was also used to add depth to the analysis. Potential weaknesses of this study were that no reference was made to researcher reflexivity or to any study limitations or weaknesses. Findings included that midwives used multidimensional knowledge to support normal birth, which included experience, woman's behaviour, personal knowledge, knowing the woman, time, judgements, positions and environment. Comparisons were drawn between the environment in which the midwives practised and the knowledge that they used in the promotion of normal birth. It was suggested that there was a 'direct correlation' between the two. It was also suggested that midwives valued the knowledge that they gained from women which was a 'catalyst for creativity in their practice' (Guiver 2004). This 'connected knowing' enabled the midwives to nurture their 'profound belief' that normal birth in the absence of intervention is highly achievable.

Aune et al (2017) in their qualitative study aimed to generate a greater understanding of how nine independent midwives practising in different regions of Norway promoted normal birth in the home environment. Whilst this sample size is appropriate for qualitative methodologies it may be considered a limitation of the study as the findings

may not be generalised, however, that does not diminish their relevance. More than 70% of women in Norway give birth in a hospital birth clinic, however women experiencing a low risk pregnancy are given the option to birth at home (Aune et al 2017). Data were generated through in-depth interviews, which were appropriate to the method used as they enabled the researcher to gain a deeper understanding of how the midwives promoted normal birth in the home environment. Data, when analysed using systematic text condensation, revealed two main themes. Firstly, the midwives had an overwhelming belief in the natural process of birth which they considered was important to communicate to the women, which in turn fostered their belief. The midwives additionally felt that it was crucial to have a 'constant focus' on promoting normality (Aune et al 2017). The second theme to emerge from this study was the midwives' ideology to avoid intervening during normal labour and birth and to be patient, giving women freedom to birth in their own time (Aune et al 2017). The midwives considered a positive knowledge of and attitude towards trusting that the process of normal birth will run its natural course was pivotal to normal birth promotion (Aune et al 2017).

Keating and Fleming (2009) concluded that the midwives' capacity to promote normal birth was constrained by 'hierarchical thinking', where the medical profession was viewed as being at the top of the hierarchy. This resulted in the midwives feeling disempowered by the prevailing medical hegemony in the units in which they worked (Keating and Fleming 2009). The midwives identified that practice in the units was influenced by scientific knowledge which influenced their thinking about normal birth and impeded their ability to promote it. To support the promotion of normal birth and counteract the influence of scientific knowledge, the midwives in this study utilised their midwifery knowledge of the normal labour and birth physiology (Keating and Fleming 2009). Intuitive knowledge employed by experienced midwives was also considered to be very influential when promoting and facilitating normal birth. Experienced and intuitive midwives were seen to be positive 'role models' to other midwives. Additionally, emotional and experiential knowledge was used by midwives to promote normal birth (Keating and Fleming 2009).

Price and Johnson (2006) in their ethnographic study aimed to explore how six experienced midwives provided care for women and their partners during labour in two district general hospitals (DGHs) in the UK. Participants had to have at least five years' experience and were purposefully sampled, it is not explicit how many midwives were observed in each DGH. Data were collected through participant observation and

individual semi-structured interviews which was appropriate to the ethnographic nature of the study. A potential weakness of this study is that contextual detail is not sufficient as the nature of the two DGHs is not made explicit therefore their similarities or differences are not known and consequently, the impact this may have had upon data collection is also not known. A strength of this study, however, was the transparent and explicit discussion about the relationship between the researcher and the participant's during fieldwork observations and the measures that were taken to limit the effects of the researcher's presence during data collection. Data were analysed thematically which was appropriate to the research method, however, all analysis was undertaken by one researcher which may be considered a limitation. The small sample size and location specific context may also be considered a limitation of this study as the findings could not be considered representative of all midwives. Price and Johnson (2006) concluded that there was a need for midwives' tacit knowledge to be made explicit to ensure that their 'artistry and practice' in promoting normal birth was not lost.

Russell (2007) also concluded that the labour ward hierarchy impeded the midwives' ability to 'control normal births'. Russell (2007) further argued that the individual midwife's belief in normal birth influenced her/his ability to support it and that some 'mad' midwives adopted 'tactics' to support normality. Mad midwives were those deemed by other midwives to be confident, experienced and autonomous (Russell 2007). Carolan-Olah et al (2015) in their Interpretative Phenomenological Analysis study concurred with Russell (2007) in that the participants in their study considered that those midwives who promoted normal birth practised 'outside the norm' and that to do this required significant confidence, additional effort and 'pluck'. Carolan Olah et al (2015) further contended that those midwives who believed in normal birth and that were most passionate about it were the ones that were most likely to promote it and to protect women from unnecessary intervention.

Butler (2017) discussed how the midwives' knowledge of normal maternal physiology enabled them to take steps to 'nudge' or normalize a labour and birth. The steps involved interventions such as improving maternal hydration and nutrition. It is suggested that midwives viewed themselves as 'instruments of care', judiciously employing a range of interventions, including their presence, to help to normalise birth (Butler 2017). Thompson et al (2016) also found that there was a direct correlation between midwives' confidence and clinical competence and their ability to promote and facilitate physiological birth.

### **2.5.3 The influence of the birth environment on normal birth promotion.**

Eight studies included in this review considered the birth environment to influence the promotion and facilitation of normal birth. Carolan-Olah et al (2015) in their IPA study found that a supportive cultural and physical environment was integral to the midwives' facilitation of normal birth. Additionally, midwives considered that a supportive professional environment from peers and those in leadership roles facilitated their ability to promote normal birth. Midwifery practice in Australia has commonalities with midwifery practice in the UK as it too uses a caseload model of midwifery. In the caseload model small teams of six to eight midwives provide continuous care to women during the antenatal, intrapartum and postnatal periods. Midwives working in this model had more opportunities to promote and facilitate normal birth (Carolan-Olah et al 2015). Aune et al (2017) similarly found that the midwives in their qualitative study considered a safe, peaceful and stress-free environment to be important to the promotion of normal birth. Thompson et al (2016) also noted that the midwives in their study considered the design of the birthing environment has the potential to affect the behaviour of both midwives and birthing women.

Zinsser et al (2016) in their cross-sectional study of 188 midwives aimed to measure midwives' attitudes to supporting normal labour and birth in two regions of Southern Germany. The advantage of using this research method was that it allowed a large amount of data to be collected at relatively little cost. On-line questionnaires containing a validated general self-efficacy scale were sent out via-email. A strength of this study was that the questionnaire was piloted with 32 midwives living outside the research areas, to ensure clarity and pertinence. A limitation of this study was that data privacy regulations prohibited disclosure of the number of midwives who were invited to participate, therefore no response rate could be calculated. Additionally, more responses were received from midwives practising in out of hospital settings, therefore the generalisability of the findings were limited. Further limitations of the use of a cross-sectional study is that there is no information about each individual participant therefore only group-level information can be used. Additionally, cross-sectional studies do not enable cause-effect relationships to be determined, consequently it was not possible to ascertain if the midwives' positive attitudes towards normal birth was caused by working in out of hospital settings or if their positive attitudes led them to work in this environment. Unsurprisingly, midwives who practised in the community had greater exposure to normal physiologic birth and more positive attitudes towards it (Zinsser et al 2016). Guiver (2004) concluded that midwives created an environment that did not disturb the physiological process of birth and that enabled women to

'disconnect' and focus on normal birth. Butler (2017) also found that midwives emphasised the importance of a supportive environment in which to promote normal birth, an environment that was a 'social space' like the home.

Price and Johnson (2006) in their ethnographic study concluded that the midwives established a birthing atmosphere and environment that fostered maternal strength and valued the woman. The birthing environment was made 'home-like', a style of environment that was felt to enable women to 'be themselves' and to establish trust in the midwives (Price and Johnson 2006). Reed et al (2016) in their narrative inquiry examining the experiences of ten midwives practice during physiological birth in different practice settings in Australia found that the midwives created a private birthing environment that minimised distraction. Limiting disruption during birth was deemed to promote and facilitate normality.

Walsh (2006) in his ethnographic study aimed to explore women's and midwives' experiences of the culture and practice around birth in a free standing UK birth centre. The sample consisted of fifteen purposefully selected midwives who worked in the birth centre, ten of whom were also interviewed. A strength of this study is the researcher's self-awareness and reflexivity, which is made explicit. Data were analysed using thematic analysis which was appropriate to the methodology. Walsh (2006) found that the midwives considered the birthing environment to be pivotal to the women's birthing experience. The midwives are described as 'nurturing' the birthing environment which in turn both responded to and provoked 'nesting' behaviours in women (Walsh 2006). Walsh (2006) further referred to the midwives exhibiting 'matresence' or mothering attitudes and practices which nurtured not only the physical but also the emotional environment of birth. Walsh (2006) recommended that there was a need for further research to examine the impact of matrescent care. As this present study aims to explore the contemporary experiences of midwives promoting normal birth in an Alongside Midwife Unit there is a potential for this study to contribute to this recommendation.

## **2.6 Conclusion**

This review of the literature revealed three themes in relation to midwives' experiences of promoting normal birth in free-standing midwifery units, obstetric led units and the home. These included midwives as protectors of normal birth; midwifery knowledge, confidence and belief in the promotion of normal birth, and the impact of the birth

environment on the promotion of normal birth. The review revealed that there is an apparent absence of literature exploring the promotion of normal birth by midwives practising in an Alongside Midwife Unit. This present study aims to contribute to the body of literature relating to this subject and make a useful contribution that will benefit practitioners, educationalists and students.

This current study also aims to provide a conduit through which the voices of nine midwives will be heard, they are important voices and as the World Health Organisation (WHO) recently stated:

*“globally, midwifery personnel have an in-depth awareness of what is needed to improve quality of care, yet their voices are rarely heard and subsequently key issues are absent from the international, national or local policy dialogue” (WHO 2016 p.3).*



## **Chapter Three: Theoretical Context**

In this chapter I express the philosophical and theoretical foundations of this study. My ontological, epistemological and axiological positions are exposed together with their subsequent alignment to the research question. Blumer's theory of Symbolic Interactionism (Blumer 1969) is deliberated and presented as the theoretical framework upon which this study is constructed.

### **3.1 Ontological, epistemological and axiological positioning**

The identification of one's philosophical orientation is essential as it forms the foundations from which any valid research endeavour can emerge, therefore prior to commencing my research, I identify my ontological, epistemological and axiological positions, referred to by Durant-Law (2005 p.2) as the "philosophical trinity".

Ontology is defined as the philosophical study of existence, being and reality (Jacquette 2002). My personal world view is rooted firmly in the belief that reality is observed through the practical manifestation of ideals and ideas. During my early professional career, I considered myself to be an objective realist. That is, I had a naive and unquestioning acceptance of the practical complexities of life. As my professional career has progressed, I have developed a more subjective, relativist stance and agree with Denzin and Lincoln (2011 p.564) who suggest "We live in an age of relativism... there is no longer a God's eye view that guarantees certainty". I see the world through a more variegated lens and have come to believe that life has much greater subjective meaning. I now consider that truth is not an absolute and that individual perceptions and opinions should always be considered within the context in which they are placed. Therefore, I consider my ontological beliefs align most comfortably with existentialist philosophy. The existential philosophers expound that an individual is free and responsible for determining their own development (Panza and Gale 2008). Cox (2012) suggests that existentialists consider that individuals are not fixed entities but exist in a state of constant change and becoming.

Epistemology is defined as the philosophical study of the nature, scope and theory of knowledge (Greco 1999). It seeks to discover and understand what knowledge is and how we attain it, and to answer the fundamental question "How do we know what we know?" (Greco 1999 p.1). As an individual, a midwife, an educator and a novice researcher I am acutely aware of the fundamental importance of knowledge and place my personal epistemological position, and that of this study, within the social

constructionist paradigm. Social constructionism (SC) takes a critical stance towards our 'taken for granted' ways of understanding the world and ourselves and challenges the view that conventional knowledge is based on unbiased observation of the world (Burr 2015). I further espouse the constructionist view of knowledge proffered by Crotty (1998 p. 52) '... all knowledge and therefore meaningful reality as such, is contingent upon human practises being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social construct'. This study seeks to explore the experiences of midwives promoting normal birth with women experiencing a low risk pregnancy within the social construct of an AMU. Burr (2015) suggests that social constructionism cautions us to be suspicious of our assumptions and how the world appears to be, a caution I am mindful to heed throughout this study.

Having considered my ontological and epistemological positions I will now complete the philosophical trinity and detail my axiological stance. Axiology is the study of values and beliefs and the role that they play when conducting research (Teddlie and Tashakkori 2010). As an individual, a professional and a researcher one of my core values is authenticity. I consider being genuine to be one of the most fundamental qualities that an individual can possess. Flynn (2012) suggests that authenticity is a major aspect of existential philosophy, it is defined as the degree to which one is true to ones' personality and character regardless of external influences, it is "living in tune with the truth of who you are as a human being and the world you live in" (Panza and Gale 2008 p.12). As an individual and a professional I have a strong moral and ethical commitment to duty. As a midwife I am obligated to extend a duty of care to women, babies and their families (Nursing and Midwifery Council (NMC) 2015). In my role as an educationalist and a researcher I consider this duty of care to be no less important.

### **3.2 Symbolic Interactionism**

Symbolic Interactionism (SI) is described as a micro-level theoretical framework which emerged in the mid twentieth century; founded by the American philosopher Herbert Mead (1863-1931) (Charon 1992). Mead's theory has phenomenological roots proposing, like Husserl, that meaning comes from the engagement between subject and object and that this interrelation illustrates how individuals construct multiple social realities (Oliver 2012). Whilst it is suggested that there are some points of convergence between SI and phenomenology, Mead was more strongly influenced by the philosopher John Dewey (Prus 2003). Dewey was a fervent advocate of social telesis. Telesis is defined as 'progress that is intelligently planned and directed; the attainment

of the desired ends by the application of intelligent human effort to the means' (Ferris 2002 p. 231). The intelligently planned and purposefully pursued promotion of normal birth by midwives can be described as a form of social teleosis (Meltzer et al 1975). The term Symbolic Interactionism was first introduced by one of Mead's students, Herbert Blumer (1969), who developed SI to understand how society operates using a 'bottom up' approach, perceiving the individual as autonomous, agentic and integral in the construction of their social world. This perception harmonises well with midwifery practice which is also considered to be individual, autonomous and agentic (NMC 2015).

My rationales for employing SI as the theoretical framework for this study are multiple. Symbolic interactionists are primarily concerned with the interpretation of subjective standpoints and the means by which individuals make sense of their world from their personal perspective (Meltzer et al 1975). It can be argued that this view aligns very comfortably with my research question which seeks to surface the experiences of midwives promoting normal birth and with the idiographic tenets of IPA, where the commitment is to understand a particular phenomenon or phenomena from the perspective of a particular person in a particular context (Smith et al 2009). Carter and Fuller (2016) contend that there are three basic canons of SI. Firstly, that an individual acts based on the meaning objects have for them; secondly, meaning emerges from interaction with others in a shared society and thirdly, meaning is continuously constructed and reconstructed through interpreting processes during social interactions. Burbank and Martins (2009) concur with this view arguing that SI views reality as socially constructed through interaction with others.

This phenomenological study is seeking to explore the lived experiences of midwives promoting normal childbirth with women experiencing a low risk pregnancy who are birthing in an Alongside Midwife Unit. The process of any birth is paradoxically both an intensely private and public social event during which there is constant, dynamic interaction between a woman and a midwife (Kirkham 2010). It can therefore be argued that the reality of those midwives supporting normal birth is quintessentially socially constructed. IPA aligns with the social constructionist view that sociocultural processes are integral to how experience is understood and interpreted (Smith et al 2009). Eatough and Smith (2009 p.184) further argue that IPA sits at the 'lighter end' of social constructionism aligning more comfortably with SI than the poststructuralist stance that is influential in much of discursive psychology. As with SI, IPA contents

that an individual's life world is more than just a linguistic and discursive construct (Eatough and Smith 2009).

The alliance between SI and grounded theory is well documented in qualitative health research literature (Chamberlain-Salaun et al 2013, Aldiabat and Navenec 2011). However, Handberg et al (2015 p.1025) argue that SI can appropriately be utilised as a feasible theoretical framework for other qualitative methodologies; suggesting that SI is particularly suited to exploring human experience on a micro level, enabling the location of "individually constructed meaning within co-constructed social experience". Again, there is a transparent alignment with my research question and IPA's focus on the individual. SI offers a lens through which to view the numerous and thought-provoking meanings that may exist in the patterns that emerge from data analysis. Symbolic interactionism, like IPA, supports the premise that the researcher is integral to the research process. SI further demands that the researcher remains open to the relevant social context in which the individual experiences of participants are shaped (Handberg et al 2015).

A further rationale to support the use of SI as a theoretical framework is that it has been used by midwifery and nursing researchers before to add contextual understanding and to unravel how meaning is constructed by individuals in their social world (Burbank and Martins 2010). The social world for the participants in this study is an Alongside Midwife Unit therefore their experiences will be shaped by this and SI will offer a framework through which the subjective world of the midwives can be surfaced and translated. Atkinson (2015) adroitly observed that much recent qualitative research undertaken in health and nursing studies has embraced interactionist values. Atkinson (2015 p.473) comments that there is a need for qualitative researchers to confirm their enduring interest in interactionism; suggesting that qualitative researchers need to recall their capacity to "take the role of the other" and to consider the influence of the social context on the individual.

With its commitment to the double hermeneutic, IPA data analysis enables this confirmation, encouraging the researcher to immerse themselves in the 'role of the other' when making sense of the participant making sense of their experiences (Smith et al 2009). Charmaz and Olesen (2003 p 643) proposed that symbolic interactionist's studies have added to the body of knowledge that has deepened our awareness of medical institutions as social organisations and have also added to "nascent ideas" that

pose alternatives to those that dominate within an institution. The promotion of normal birth within today's NHS arena can be viewed as just such a 'nascent idea'.

### **3.2.1 The status of the symbol**

Symbolic Interactionism consists of two ideas, symbols and interaction (Hewitt 2003). Symbols are described as any social object; they are the conduit through which people are socialised into sharing the culture of a group and the means by which they understand their role within their cultural group (Charon 1992). Meltzer et al (1975) contend that reality is symbolic and that symbols enable an individual to move outside their own realm and understand the world from another's perspective. Snow (2001) extends Blumer's core premises of symbolic interactionism and offers four wider and more inclusive principles, one of which is the principle of symbolization. This principle questions under what conditions symbolizations or meanings can become taken for granted and routinized to be part of what Bourdieu described as 'habitus' (Bourdieu 1990). Bourdieu defines habitus as "A structuring structure, which organises practices and the perception of practices" (Bourdieu 1984 p 170). According to Bourdieu habitus may influence an individual's actions and the construction of their social world.

Bourdieu argued that what distinguishes one social group from another are the values which that group holds, therefore, when an individual belongs to a certain group they will practice and make choices that reflect that value system (Bourdieu 1990). Habitus is primarily concerned with social action, providing a framework for an individual's practical relationship within the world they inhabit (Nairn et al 2012). As this study aims to explore the experiences of midwives promoting normal childbirth in an Alongside Midwife Unit, the principle of symbolization and the concept of habitus will provide additional lenses through which to garner a greater understanding of the social conditions that have contributed to the current meaning and practice of normal birth for those midwives and to potentially surface some of the factors that have fuelled the current debate contesting the habitus of midwives promoting normal birth.

One of the overarching tenets of SI is that individuals use specific language and symbols in their communication with others in their social realm (Burbank and Martins 2009). Mead discusses the 'significant symbol', arguing that symbols have the capability to signify and generate meaning for both the creator and the receiver (Hewitt 2003). Symbols do not only represent abstract objects, they can also represent

complex patterns of interactions between individuals (Hewitt 2003). Charon (1992 p.46) suggests that “language is a special kind of symbol”. The symbol of interest in this study is the term normal birth. Normal birth has for many years been considered a phenomenon which has been socially constructed, based on the beliefs, experiences and values of individual communities (Rothman 1977, Downe & McCourt 2008). As has been illustrated in chapter one, the term normal birth is a multifaceted and contextual term and subsequently a complex symbol worthy of the further exploration this study aims to provide.

In concluding this chapter, I have demonstrated the constructive alignment and synergy between my philosophical position, theoretical framework, research question and research approach (Table 3).

Table 3: Philosophical position, theoretical framework, methodology and method.

<b>Epistemology</b>	<b>Theoretical Framework</b>	<b>Methodology</b>	<b>Method</b>
Social Constructionism (SC)	Symbolic Interactionism (SI)	Interpretative Phenomenological Analysis (IPA)	Semi-structured interviews

SI has been presented as the lens through which the social connections and influences that exist at both micro and macro levels in midwifery practice today may be revealed. Blumer (1969 p.47) describes SI as a “down to earth approach to the scientific study of human group life and human conduct”, as such it is ideally situated to be the theoretical framework and lens upon which to build and view this study.

## **Chapter Four: Study Design**

In this chapter I will discuss and give a rationale for the use of Interpretative Phenomenological Analysis (IPA) as both methodology and method for this study. Additionally, I will present and justify the approaches adopted for sample selection and size, data collection and data analysis. Ethical concerns pertaining to this study will also be considered.

### **4.1 Interpretative Phenomenological Analysis**

The primary aim of this study is to investigate how midwives make sense of their experiences of promoting normal childbirth within their social reality, that of an Alongside Midwife Unit (AMU).

The method adopted for this study is Interpretative Phenomenological Analysis, a method that has been adopted successfully in several health-related disciplines, including nursing and midwifery (Charlick et al 2015, Charlick et al 2016, Sheeran et al 2015). My rationale for selecting IPA as a method for this study is multifaceted. Initially I was attracted to the fact that one of the theoretical principles of IPA is to consider the complexity of the human whole (Smith 1996); that individuals are connected by their thoughts, words and deeds. As a midwife this consideration of the whole resonated very loudly with me. I was also attracted to the flexibility and accessibility of IPA (Larkin et al 2006).

Furthermore, IPA was selected in preference to other qualitative methods such as grounded theory because, unlike grounded theory, IPA engages with existing theories rather than seeking to produce them (Goulding 2005). In addition, grounded theory utilises a purposive but disparate sampling strategy to identify universality (LoBiondo-Wood and Haber 2014), whereas IPA favours a homogenous sampling strategy to enable the identification of similarities and differences (Smith et al 2009). As this study seeks to explore the lived experiences of midwives working in an Alongside Midwife Unit a homogenous sampling approach was deemed the most fitting. This method acknowledges that through the exploration and understanding of individual similarities and differences can come a broader and more collective understanding of the general. Interpretative Phenomenological Analysis has its philosophical underpinnings in phenomenology, hermeneutics and idiography (Smith et al 2009, Shaw 2011).

#### 4.1.2 Phenomenology

Phenomenology is a research tradition that seeks to understand the lived experience of individuals and their engagements within their lived world (Shaw 2010a). Translated literally from the Greek, phenomenology means to 'bring light into it' (Heidegger 1962). Its founding father was the philosopher Edmund Husserl, whose interest lay in the in-depth exploration of how an individual could come to know their own experience of any given phenomenon (Green and Thorogood 2014). Subsequently Martin Heidegger (1949) transformed phenomenological thinking by rejecting Husserl's transcendental and Cartesian ideals and rather than viewing phenomenology as a means of raising 'a consciousness of the world' proffered the view that phenomenology was a means of 'being in the world' (Dowling 2011 p. 65). Heidegger focused on the importance of understanding what it is to be human, he proposed that Dasein, meaning 'there-being' was a fundamental concept by which the person and their lived experiences could be understood within the context of their existence (Miles et al 2013a). Heidegger considered Sorge, meaning caring or concern, to be integral to Dasein, asserting that Sorge enables an individual to engage in their world or that of another. It could be suggested that there is connectivity between caring and concern; if a person does not care then they are not usually concerned (Miles et al 2013b). This notion of Sorge may be interpreted as one of the bedrocks of midwifery practice as being able to build a connected and mutually respectful, caring partnership with a woman enables a midwife to provide optimal care by actively engaging in the life world of that woman. This study, by asking 'what are the lived experiences of midwives promoting normal birth in an Alongside Midwife Unit?', aims to gain valid insights by exploring this potentiality for caring and mutually respectful partnerships.

As this study seeks to reveal the lived experiences of midwives promoting normal childbirth it is apposite to consider the meaning of the 'lived experience' in greater depth. The dictionary definition suggests it means "the process or fact of personally observing, encountering, or undergoing something" or "knowledge or practical wisdom gained from what one has observed, encountered, or undergone." (Collins 2016). Wierzbicka (2010) argues that the term experience is complex with several different meanings and that it provides a lens through which English speakers interpret their world. It is interesting to note that no other European language has an equivalent word for experience (Wierzbicka 2010). Van Manen (1997) comments upon the temporality of the lived experience, suggesting that it can never be seen in its present form but only as a reflection of 'past presence'.



It can be therefore be argued that the notion of the lived experience is a complex amalgam of exclusive, individual and often intangible factors (Miles et al 2015). When attempting to thoughtfully elucidate the tangible from the intangible I considered Merleau-Ponty's four essences of lived experiences; lived human experience or relationality, lived time or temporality, lived body or corporeality and lived space or spatiality (Merleau-Ponty 1962). By applying these life world lenses, I intend to access the "fullness of living" experienced by the midwives (van Manen 2016 p.12). For the purposes of this study the term lived experience is used to include all aspects of the meaningfully lived world of the participants, including all their manifest personal perspectives. In adopting this interpretation of the lived experience, and in line with the aspirations of IPA, it is anticipated that there will be an opportunity to disentangle and interpret what the participants think, say and do (Smith & Eatough 2012)

#### **4.1.3 Hermeneutics**

Heidegger is credited with developing an alternative phenomenological approach, that of hermeneutics. Hermeneutics is defined as the theory of interpretation (Smith and Osborne 2008). It is suggested that IPA is influenced by the tenets of hermeneutics and combines the different stances of empathetic hermeneutics with questioning hermeneutics in what is described as a double hermeneutic (Smith and Osborne 2008, Eatough and Smith 2009). This dynamic and two staged process involves the participants attempting to make sense of their world and the researcher also attempting to make sense of how the participant is trying to make sense of their world (Shinebourne 2011). This double hermeneutic relationship draws attention to the active role of the researcher within the IPA process; the researcher is interacting not only with the participants but also with the data (Smith 2017). IPA also aligns to the principles espoused by social constructionism which advocate the centrality of sociocultural and historical influences upon experience. It is also said to be empathetic as it seeks to comprehend an experience from the perspective of another (Shaw 2010a). Smith et al (2009) suggest that IPA researchers are required to be willing to enter into and respond to the world of the participants with open mindedness and flexibility.

#### **4.1.4 Idiography**

What distinguishes IPA from many of its qualitative counterparts is its allegiance to idiography (Smith et al 1999). Idiography advocates an in-depth focus on the uniqueness of the individual experience at a point in time within a specific social, cultural, economic and political context. It embodies a commitment to the meticulous

micro-analysis of real life for that individual (Eatough and Smith 2006, Eatough and Smith 2009, Shinebourne 2011). It is this aspect of IPA that aligns most comfortably with research exploring midwifery practice because midwives, whilst governed legislatively by the Nursing and Midwifery Council (NMC 2015), practice with very individual idiosyncrasies and nuances which may only be exposed through this idiographic approach. Additionally, it can be argued that IPA aligns to the notion of individuality that is echoed in the contemporary recommendations for individualised, woman centred care in maternity service provision in England (NHS England 2016).

#### **4.1.5 The Limitations of Interpretative Phenomenological Analysis**

Having given a robust rationale for selecting IPA as the method for this study it is pertinent to consider the limitations of this approach and to discuss some of the criticisms and challenges levelled against it in the literature (Giorgi 2010, Giorgi 2011, Paley 2104, Paley 2017). There are two major critics of IPA; the American Psychologist Amedeo Giorgi and the British Nursing Philosopher John Paley. Giorgi (2010) argues that IPA does not reflect the method of continental philosophical phenomenology, suggesting that IPA should be referred to as 'Interpretative Experiential Analysis (IEA) instead. Smith (2010) in his rebuttal refutes this criticism, arguing that IPA is clearly underpinned by hermeneutics and phenomenology. Additionally, Giorgi (2010) raises concerns about the scientific credibility of IPA, suggesting that the non-prescriptive nature of data analysis makes the possibility of replication and subsequent checking of findings by a second researcher impossible.

Giorgi (2010) argues that the absence of a rule which directs the inclusion of all raw data creates a licence for the researcher to be unaccountably selective which has the potential for biased reporting and proposes that IPA fails to meet fundamental scientific criteria. Again Smith (2010) counters this claim arguing that qualitative research processes should not be considered equivalent to the prescribed processes of quantitative research and that it is the skill of the researcher in mastering the research processes that has a major influence on the quality of the research output, not solely the process itself. Smith (2010) further argues that there are mechanisms in place for checking the findings of IPA studies; suggesting that supervisors can check Doctoral students' analytic processes and any reader of an IPA study can check that the methodological steps followed are coherent, transparent and fully evidenced. Furthermore, Smith (2010) contends that when reading a high-quality IPA study, it is possible to check that each theme is sufficiently supported by participants' extracts to demonstrate how that theme emerges. I have endeavoured to follow all these

recommendations in this study to illustrate rigour, reliability and a lack of bias (Yardley 2000). Paley's (2017 p.147) principle criticism of IPA centres around his argument that IPA has 'no method' and that a lack of criteria by which to analyse data creates 'a vacuum into which personal idiosyncrasies can seep'. However, one of the virtues of qualitative methodologies such as IPA are that they offer opportunity for creativity, context, emergence and co-creativity (Tuffour 2017). Conscious effort has been made throughout this thesis to ensure that method is apparent. This has been achieved by adhering to the guidance provided by Smith et al (2009). Additionally, the participant's voices have been clearly articulated and the interpretation of their narratives is thorough and explicit, thus limiting the potential for the 'vacuum' that Paley suggests exists.

## **4.2 Research Procedure**

### **4.2.1 Study Location**

The location for conducting this study was an Alongside Midwife Unit (AMU). An AMU is defined as a birthing unit which provides labour and birth care led by midwives for women categorised as being at low risk. AMUs provide a distinct service but are proximate to obstetric-led maternity units, most often within the same building, both paediatric and obstetric services are freely available (McCourt et al 2014). There were a number of reasons for using this location. An AMU is a birthing environment where labour, birth and initial postpartum care is led by midwives. Additionally, it is an area where care is normally focused on women experiencing a low risk pregnancy. It is therefore reasonable to suggest that the promotion of normal birth is the core business of midwives caring for these women. As this study aims to capture data relating to midwives' experiences of promoting normal birth with women experiencing a low risk pregnancy this location appeared to provide the optimum area to facilitate this. Additionally, current national guidance recommends that health care professionals:

*"Advise low-risk nulliparous and low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit"*

(National Institute for Health and Care Excellence 2014 p.5).

This recommendation increases the likelihood that more women will be birthing in AMUs which adds leverage to the need for research to be conducted in this area.

The primary rationale however, for selecting an AMU in preference to a Free-standing Maternity Unit (FMU) was that in comparison to FMUs, the number of AMU's in the UK has risen significantly from 53 to 97 during the period 2010 to 2016 (Walsh et al 2018) meaning that more women will be given the option to birth in this environment. This study was conducted in an AMU that has been established since 2004. The justification for choosing to conduct this study in a well-established AMU was that there would be greater probability of recruiting midwives with a wide range of experience of promoting normal birth in this environment.

McCourt et al (2014 p.vi) stated that there have been few studies conducted in AMUs and that "there is a need for more research on how to support women effectively in early labour. It is also acknowledged that the UK Midwifery Study System (UKMidSS) is currently conducting research into midwifery led care in AMUs. This current study will contribute to this body of evidence. Downe and Finlayson (2016) suggest that midwives increasingly want to work in birth centre environments such as an AMU and that midwives' wellbeing is improved in settings where physiological birth is more commonly experienced. It is further suggested that learning from areas such as AMUs may offer insights into how to improve the job satisfaction and subsequent retention of midwives. This notion provides a further rationale for selecting an AMU as the site for this study.

#### **4.2.2 Ethical Considerations**

Application for ethical approval from the Cardiff University School of Healthcare Sciences Ethics Review and Screening Committee was first submitted on 16<sup>th</sup> February 2016. The outcome of this application was to "proceed subject to approval of minor amendments by Chair of Committee and one other member". The required amendments were made to the study proposal which was subsequently resubmitted to the School of Healthcare Sciences Ethics Review and Screening Committee on the 8<sup>th</sup> April 2016. This study received favourable ethical approval on 21<sup>st</sup> April 2016 (Appendix Three). As this study was conducted within an NHS Trust in England and involved midwives employed by an NHS Trust an Integrated Research and Applications System (IRAS) form was submitted to the Health Research Authority (HRA) on 20<sup>th</sup> June 2016. HRA approval was given on 7<sup>th</sup> October 2016 (Appendix Four). Following HRA approval a 'letter of access' was received from the NHS Trust confirming the right of access to conduct my research between 29<sup>th</sup> November 2016 and 1<sup>st</sup> December 2018 (Appendix Five).

This study has been guided continuously by the bioethical principles of beneficence and non-maleficence, furthermore, there has been respect for the participants' autonomy and human rights throughout (Beauchamp and Childress 2013).

#### 4.2.3 Participant Autonomy

The autonomy of participants was valued at all times throughout this study. Potential participants were issued with a comprehensive Participant Information Sheet (PIS) detailing the purpose and scope of the study and what involvement in the study would entail (Appendix Six). Participants were given a minimum of seven days between receiving the PIS and signing the consent form to enable them to have the opportunity to consider participation fully and ask any questions. Participation was on a purely voluntary basis with participants having the option to withdraw their data up to one month following their interview. As I was not known to the midwives working in the AMU this conferred on me an outsider-insider status which had the potential to reduce the possibility that participants would feel coerced into volunteering because of a pre-existing relationship with me. Measures were also taken to ensure that participants were not coerced into volunteering by any other key gatekeepers.

#### 4.2.4 Sample

In line with IPA methodology the sample used for this study was small and homogenous, consisting of nine purposefully selected participants (Smith et al 2009). Inclusion criteria were that participants must be a registered midwife, with a variety of experience of promoting normal childbirth, working either full or part-time as a member of staff in the AMU. Homogeneity was achieved through all nine participants being registered midwives and all working in the same AMU. The sample consisted of one band eight midwife, four band seven midwives, three band six midwives and one band five midwife. Table 4 describes the profiles of the different grade bands.

Table 4: Grade Band Profiles

Grade Band	Profile
5	Newly qualified midwives with basic skills
6	Midwives with further knowledge, experience and skills
7	Departmental middle managers, research and specialist midwives
8	Consultant midwives and modern matrons

(NHS Staff Council 2017)

Following appropriate ethical approvals participants were recruited between December 2016 and February 2017. Permission was granted by the AMU midwifery manger to attend midwifery team meetings, where I was given the opportunity to give information about this study, answer any questions and distribute Participant Information Sheets (PIS) (Appendix 2). Two team meetings were attended, but midwives' attendance was irregular, which resulted in me not being able to meet with all the midwives who worked in the AMU. To assist with recruitment the midwifery manager volunteered to email my PIS to all the midwives working on the AMU. The manager and I constructed an email together to ensure that the language used was appropriate to recruitment and to ensure that the midwives did not feel coerced into volunteering. They were given the option to contact me should they wish to discuss the contents of the Participant Information Sheet further, although none of the participants did this. Following these information sessions and the email from the manager nine midwives volunteered to participate, three midwives responded verbally following my information sessions and six responded to my email. Table 5 illustrates the profiles of each participant.

Table 5: Participant Profiles

Participant	Grade Band	Post Qualification Experience (years)	Experience working in the AMU (years)
Mary	8	>20	13
Carol	7	1-5	1
Karen	7	>10	13
Lilly	7	>10	2
Susan	7	>30	13
Holly	6	5-10	1
Laura	6	1-5	2
Jenny	6	10-20	13
Anna	5	< 1	10 weeks

#### 4.2.5 Data Collection

Data were collected during December 2016 and March 2017 using semi-structured, one to one interviews; the method recommended for use in IPA studies. As Smith (2011a) indicates the strength and quality of data is reliant upon the strength and quality of the interview. As a novice interviewer I took measures to ensure that I followed recommendations for interview best practice taken from the literature and from my supervisors (Eatough and Smith 2009, Roulston 2010, King and Horrocks 2010, Edwards and Holland 2013). Biggerstaff and Thompson (2008) suggest the use of a loose interview prompt sheet to form the basis for a conversation, therefore one was

developed (Appendix Seven). As a novice interviewer with a desire to illicit rich data from each interview I originally used the prompt sheet as a metaphorical 'comfort blanket' at the beginning of my interviews. Additionally, as a midwife and healthcare professional used to asking directional questions and at times taking the lead in interviews with women, I was initially a little anxious about and unfamiliar with 'letting go' and letting the interviewee take the lead, as is recommended in IPA. However, as the number of interviews I conducted increased, so did my confidence and I was more able to facilitate the participant led, dynamic and interactive exchanges that are one of the characteristics of a good IPA study, with prompts only being used to guide and not dictate the course of the interview (Smith 2011a). I came to view my participants as story tellers rather than respondents and our interactions as true conversations; the Latin meaning for conversation being 'wandering together with' (Kvale 1996).

All interviews were conducted in a quiet and tranquil room in the AMU normally used by women for relaxation. This was an ideal location as it was close enough to be convenient for the midwives to access but situated away from the main area and therefore quiet enough to avoid interruption during the interviews. As the room was used for quiet relaxation it was decorated in relaxing colours and furnished with comfortable seating and was, therefore, conducive to a fostering an atmosphere where the participants were at ease. This had the potential to enable them to feel more able to go beyond conversing freely and to discuss their experiences in greater depth (King and Horrocks 2010). As many midwives now work a 12 hour shift pattern the majority of interviews were held during the participant's working days. However, one participant requested to be interviewed during her day off as she lived locally and could easily access the AMU and one participant preferred to be interviewed after finishing her early shift. The nine interviews varied in duration from 38 minutes to 64 minutes. Following each interview field notes were made to capture my reflections on the process and to make any additional notes that might need to be added to the transcription such as any non-verbal communication. These notes were stored in a locked filing cabinet.

All interviews were recorded using a digital audio recorder. To ensure the safe handling of data and adhering to Cardiff University data protection guidance, all audio recordings were downloaded from the audio recorder to a password protected computer immediately following each interview. Prior to the commencement of each interview I took time to establish a rapport with each participant, enabling them to feel comfortable and at ease. I shared some of my biographical and professional information so that they knew a little about me before I began to ask questions of them.

It is well documented in the literature that the establishment of a trusting and reciprocal relationship with participants is an essential preamble to any good qualitative interview (Larkin 2013, Hunter 2007). Additionally, I gave a clear outline of what the interview would involve and emphasised that the interview should be considered a relaxed and informal conversation rather than a rigid and formal interrogation. Participants were encouraged to ask any questions about the process and given ample time to consider a response.

Four interviews were conducted during one day, as this was convenient for the participants involved. Initially I was concerned that conducting this many interviews on one day would have a detrimental impact upon the process, in that I would become fatigued and not have enough time in between each interview to reflect on and consider each individual interaction with the diligence it deserved. However, these concerns were unfounded as the interviews were well spaced out during the day giving me ample time between each one to reflect and write my field notes. Additionally, the continuity afforded by conducting the interviews in succession also had the unexpected consequence of enabling me to become more relaxed and confident in my interview technique which in turn enabled the participants to offer richer data. As this study was conducted in an Alongside Midwife Unit (AMU) the data captured can therefore be considered context specific.

In accordance with IPA each interview was transcribed verbatim (Smith et al 2009). Due to time constraints I employed the services of an experienced female data transcriber. Prior to commencing transcription, I ensured that the transcriber was aware of the requirements of an IPA transcript; that each interview was recorded word for word with notes made in brackets of utterances such as hesitations, significant pauses and laughter (Smith et al 2009). I was mindful that Smith et al (2009) suggest that there is no requirement to record the exact length of pauses or periods of silence and that transcription itself can be considered a kind of interpretation. To ensure trustworthiness and rigor I read the first transcription thoroughly, whilst listening to the audio tape, to ensure that the transcription was an accurate representation of the interview prior to the commencement of the second transcription.

An unexpected consequence during the transcription process was the impact that some of the data had on the transcriber. She informed me that the content of two of the interviews had made her cry tears of both joy and sadness, and that whilst listening to and transcribing the data she had been 'transported back in time' and reminded of



her own birth experiences. I had not considered that the data produced during my interviews might have the potential to have an emotional impact upon the transcriber and that the closeness with which she was engaging with the data might have the potential to cause her distress. As a novice researcher I had not fully considered the personhood of my transcriber or considered that she may be vulnerable because of being drawn into the midwives' worlds. Once I was aware of her feelings, I made every effort to discuss them with her and offer any additional support that may have been required. When conducting future research, I will ensure that I consider the needs and vulnerabilities of the transcriber and ensure that support mechanisms are in place should they be required (Gregory et al 1997). Once each interview had been transcribed it was saved to a secure password protected computer.

#### **4.2.6 Harm**

Whilst the potential for physical harm to participants during this study was very low, it is acknowledged that there was a potential for psychological harm due to participants discussing experiences that may have been difficult or traumatic for them. Therefore, participants were advised in the PIS that should they become distressed during or following their interview they should contact their Supervisor of Midwives for support. Additionally, to ensure the safety of women and their babies and to comply with the requirements of the NMC Code (NMC 2015), participants were advised that the Head of Midwifery would be informed about any unsafe practice that may be disclosed during the interviews.

#### **4.2.7 Consent**

To reduce any risks of maleficence and to safeguard the participants, a clear and comprehensive consent form was produced (Appendix Eight). This provided the participants with sufficient information about the study to enable them to make a free choice about whether to participate or not. Additionally, prior to each interview commencing, participants were again asked to verbally reaffirm that they had read and understood the PIS and that they gave their consent to participate.

#### **4.2.8 Confidentiality**

It was acknowledged that due to the small sample size of this study there may be a greater risk of participants being recognised therefore all participants were allocated a pseudonym and any potential identifiers were anonymised to protect their confidentiality. All quotations used were anonymised.

### **4.3 My Position as Researcher**

As a qualified midwife with personal experience of promoting normal childbirth, I was acutely aware of my position in relation to both the participants and the phenomena of interest in this study and also the need for me to be reflexive throughout. Reflexivity is an essential strategy for ensuring quality and is paramount in assuring a study's rigor (Hammersley and Atkinson 2002, Berger 2015). During each interview I was mindful to self-monitor any potential impact that my personal beliefs, values and experiences might have upon the research process. To reduce some of the potential limitations of conducting insider research and to establish my identity as a researcher I chose to conduct this study in an AMU where I was not known either as a midwife or as a midwifery educationalist and was therefore in effect, an outsider. However, I was also mindful that during the interviews I wanted to identify and empathize with the participants to reap some of the potential benefits that an insider's perspective might bring such as the ability to enhance the production of authentic and meaningful data (Lyons and Coyle 2007, Burns et al 2012). As a professional insider I shared a cultural identity with my participants which also had the potential to contribute to the development of respectful and trusting relationships (Larkin 2013). Juxtaposing the binary oppositions of insider-outsider status enabled me to be neither one nor the other but to adopt a position occupying the middle ground between the two. This enabled me to consider both emic and etic perspectives and balance the closeness of subjective familiarity with the distance required for objective analysis.

When conducting the interviews, I was also mindful of the potential for an asymmetrical power relationship to exist between me as the interviewer and the participants as interviewees. By adopting a semi-structured interview approach which privileged the contribution of the participants I aimed to ensure that the power moved to the participants as much as possible and that as the interviews progressed, we engaged in what Hoffman describes as 'the interview dance' (Edwards and Holland 2013).

It is interesting to note that as the frequency of my visits to the AMU increased, and I became more familiar with the community of midwives practising there, they began to refer to me as 'the normal birth woman'.

### **4.4 Data Analysis**

Data were analysed following the six-step process specified by Smith et al 2009, these include; reading and re-reading each transcript, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next

transcript and finally looking for patterns across transcripts. This six-step process was additionally supported by Heidegger's notion of the 'clearing' or *Lichtung* (Heidegger 1971) (Figure 2). In its simplest terms the clearing is a metaphor for a clearing in a forest, a space where the trees thin and clear and through which light can pass.

*"In the midst of beings as a whole an open place occurs. There is a clearing a lighting..." (Heidegger 1971 p.53).*

On a deeper level Heidegger's clearing is an aperture through which the concealed can be revealed.

*"...Only this clearing grants and guarantees to us humans a passage to those beings that we ourselves are not, and access to the being that we ourselves are" (Heidegger 1971 p.53).*

Interpretative Phenomenological Analysis requires dynamic, iterative and multidirectional activity, where the researcher shifts between expansion and reduction a process which requires the researcher to engage in an in-depth immersion with each individual participant's accounts, moving in and out of the data, a process that Wagstaff et al (2014) liken to the movement of an accordion. However, as a novice IPA researcher I should like to offer an alternative analogy and suggest that, for me, the process of IPA data analysis equates more fittingly to being labyrinthine. When one follows the path of the labyrinth, one must move away from the central goal and follow a complex but pre-determined path before turning inwards once again to arrive at the central goal. I believe that the process of IPA data analysis aligns very strongly to this journey, as data analysis begins with close association to the participant's articulated experiences, then moves away from them when considering emerging themes, only to return to reveal sub-ordinate and super-ordinate themes.

It could also be argued that IPA offers the researcher a 'theatre-in-the-round' opportunity, in that the researcher is able to move figuratively in and out of the data from different directions, bringing the researcher into the same space as the participants, facilitating creative connectivity. IPA enables the researcher to look into an individual's sense making processes, how they negotiate and navigate through their experiences. This sense making process aligns to Heidegger's concept of 'thrownness', meaning that people are thrown into the world; that they are constantly trying to make sense of their world; that they are aware of and contained by the features of that world (Heidegger 1982a).

Remaining true to IPA's commitment to idiography each interview transcript was analysed individually. Analysis began with an active engagement with the data. This was achieved by immersing myself in each participant's account by listening to each digital recording several times and then listening to the recording again whilst reading the interview transcript for the first time. This was then followed by further re-reading of the transcript. I actively engaged with the data to enable me to become fully immersed in the participant's world. I wanted to ensure that I captured my first impressions of the transcript but was wary to bracket them off at this initial phase of the analysis.

Analysis occurred line by line looking for similarities, differences, contradictions etc. Therefore, each transcript was converted to one and a half line spacing and wide margins were left on each transcript to enable me to write initial comments on the left side and emergent themes on the right side. Following this preliminary reading I began to examine the language and semantic content of each individual transcript writing exploratory comments in the left-hand margin, developing thorough initial notes. Coloured pens were used to highlight the different levels of analysis at this stage; one to denote the descriptive elements, one for the linguistic and one for conceptual comments. From these initial descriptive notes, more interpretative notes were developed which helped me to understand the participant's explicit meaning (Larkin et al 2006). I was thus engaging in the double hermeneutic recommended in IPA in that I was trying to make sense of the participants making sense of their experiences. I was drawn to the tenets of hermeneutics advocated by Schleiermacher (1998) who suggests the adoption of a holistic approach to iterative and interpretive analysis recommending the use of a range of skills including intuition. Equally, I was aware of the importance of entering into the hermeneutic circle (Dowling 2011), to consider the non-linear nature of analysis by exploring the interrelatedness of the parts to the whole and vice versa. I was equally mindful to adopt rigor and diligence in my analysis to increase the potential for it to reveal what Smith (2011b p.7) describes as the gem(s). These are rare words that can provide "analytic leverage" and add significant value to the research.

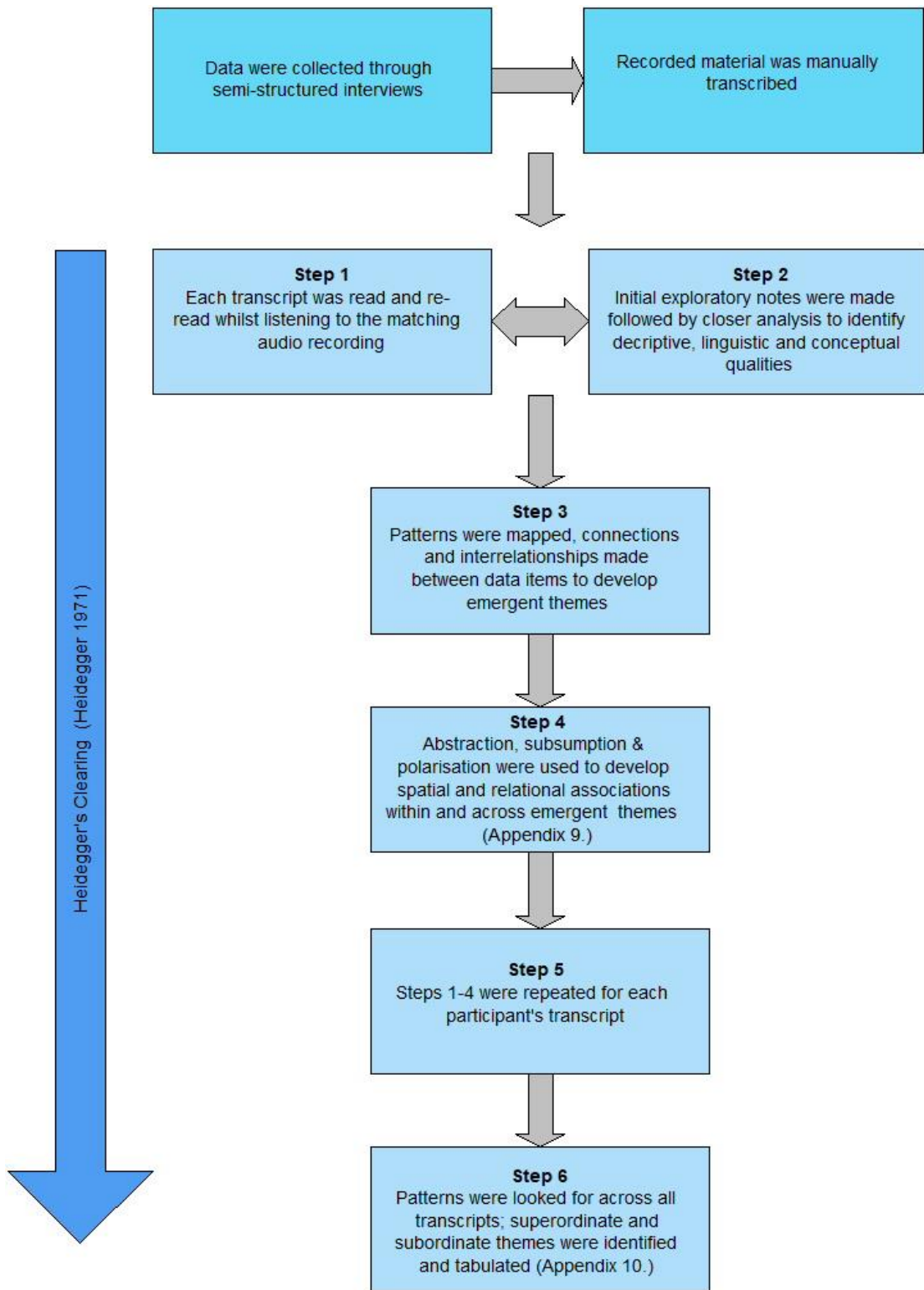
Smith (2011b) considers that there are three types of gem; the suggestive, the shining, and the secret. The suggestive gem is described as the one in the text which is, as its name implies, suggestive, where the phenomenon is partially present. It would require repeated employment of the hermeneutic circle to reveal it. The shining gem is described as one that requires less engagement with the hermeneutic circle to reveal its existence and meaning as it is more obvious (Smith 2011b). The secret gem is

more difficult to find than the others, requiring closer scrutiny to identify and interpret. By definition, a gem is a rare item that may be difficult to find, therefore Smith (2011b) contends that when looking for them one should consider Husserl's recommendation to 'go back to the things themselves'. This I have been mindful to do.

The next phase of the analysis involved the cautious development of the emergent themes. I constructed a table of the major themes in chronological order, being careful to represent each theme truthfully by using verbatim extracts from the transcript. I was mindful to note any connections that revealed themselves across the themes and subordinate themes.

This process detailed above was repeated for each transcript. It was acknowledged that the analysis undertaken for the first transcript had the potential to influence the analysis of subsequent transcripts, however I endeavoured to observe IPA's idiographic commitment and bracketed any emerging ideas and concepts until all transcripts had been analysed. Once each transcript had been interpreted and analysed I then searched for emerging patterns across them all. This table of themes forms the basis for the narrative account which detailed the interpretative process, highlighting the issues that mattered to the participants and what these meant to them.

Figure 2: Data Analysis Process



(Adapted from Smith et al 2009)

## Chapter Five: Findings

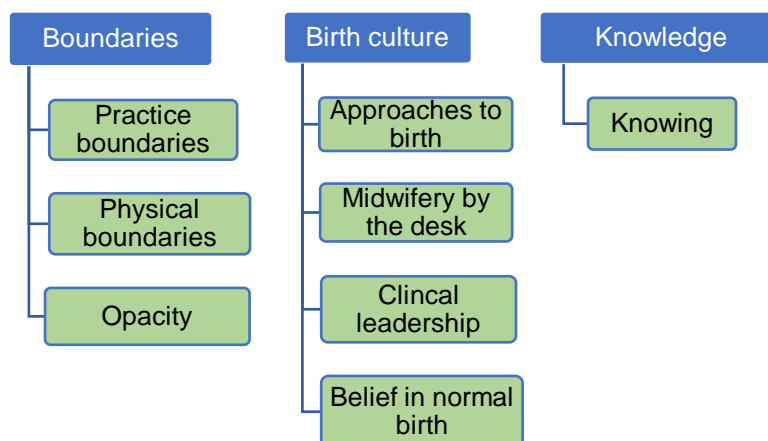
### 5.1 Idiographic Data Analyses

In this chapter I present idiographic analyses of each individual midwife's interview. To maintain confidentiality each midwife is referred to by a pseudonym throughout and all quotations used are anonymised. Where direct quotes are used, they appear in italics, any words used by me appear in plain font. Each analysis is prefaced by a short biographical history of the midwife's professional experience. Emergent themes from each midwife are presented, followed by a description of their experiences using their words. To ensure transparency and trustworthiness, each midwife's account culminates with a table illustrating the quotes used to generate the emerging super-ordinate and sub-ordinate themes. To further ensure trustworthiness during this idiographic phase of analysis, I adopted the 'curious stance' recommended by Rodham et al (2015) being open to the experiences of the midwives. I acknowledged my preconceptions, but as Smith et al (2009) suggest one's true preconceptions only really surface when interpretation of the data has begun.

#### 5.1.1 Mary

Mary led the team who initially established the Alongside Midwife Unit at the Trust in 2002 and has been involved in the AMU ever since. She had extensive experience of all aspects of normal birth and normal midwifery practice. Her current responsibility was promoting normal birth and normal midwifery practice within the Trust in which the AMU was situated. Her interview was my first, it was relaxed and lasted for forty-nine minutes. Figure 3 presents the super-ordinate and sub-ordinate themes that emerged from Mary's interview.

Figure 3: Emergent super-ordinate and sub-ordinate themes from Mary's interview



Mary was a very confident, assertive and articulate individual. Most of her responses were prefaced by “I do believe that...”, the repeated use of this stem has arguably evangelical overtones which I consider helped to communicate her passion, commitment and conviction. She had a clear view about what normality meant:

*... I do believe it's about supporting... it's about supporting a woman in the care that she would like to receive throughout her pregnancy, childbirth and postnatal period.*

The current changes in the physical and socioeconomic profiles of childbearing women in the UK, coupled with Mary's position and role within the Trust, also appear to have influenced her perception of normality, particularly for women experiencing complex pregnancies stating that:

*... in terms of normality it's around influencing normality for women who are complex but also recognising what normal is and having clear boundaries for what that means and a need to recognise deviation from normal because I think sometimes that becomes a bit muddied along the way.*

Mary was concerned about the presence of clear practice boundaries for recognising what normal means but alludes to the possibility that these boundaries are not always clear. I elucidate this by focusing on her use of the term ‘*muddied*’, which implies that boundaries appear to lack clarity and are opaque. This opacity may result in a blurring of the meaning of normal. In her managerial role Mary was also concerned with physical boundaries and the influence of the AMU's geographical location on midwifery practice:

*...I do believe that you need core staff on a birth centre as you need core staff on an obstetric unit to actually carry on the philosophy of what we actually are about and what a midwifery led unit is about and I do believe that that has been eroded because of the sheer capacity of this big unit, we are not a standalone, so we don't stand alone, we are part of the unit...*

When trying to make sense of her observation that there has been some erosion of the AMU's philosophy Mary attributes this to a diminishing number of core staff and the geographical location of the AMU. Her reiteration and rephrasing of ‘*standalone*’ to not ‘*standing alone*’ is significant and powerful as it emphasises that the AMU is not isolated but part of the wider Obstetric unit:

TD: In what way is your philosophy eroded?



*I think it's the loss of ownership of the area...*

Mary's response illustrated the tensions and vulnerabilities that may be felt by those who practice in an AMU, their lack of isolation appears to increase their susceptibility to subsumption. This vulnerability is coupled with the introduction of 'people' who 'dilute' the practice and philosophy of normal birth as Mary continues:

*... I do believe if you have people committed to the area and committed to a philosophy where women are supported and midwives gain skill in normal birth and normal practice, that if you dilute that with people who don't have that belief in normal birth in the first instance and don't have that passion and ability as well to manage care, then it will be eroded and it is across the country.*

It is interesting that in this response Mary is not referring to midwives specifically but to 'people', this exchange of a proper noun for a noun may be the consequence of her subconscious attempt to distance herself from those who do not share her philosophy of normal birth.

When asked to consider any challenges that she may have experienced when promoting normal birth Mary's first response was:

*I think it's the litigation, I think it has an impact on people's confidence.*

Mary again referred to 'people'. When trying to make sense of this response it is reasonable to conclude that in this instance 'people' can be taken to mean everyone; obstetricians, midwives, women and their partners. Mary articulated a further challenge which was caused by the rise in the number of women who are requesting to have an elective caesarean section for 'no clinical indication' and the impact that this is having:

*I think we're almost bowled over, so many women are coming forward so when I do have the conversation with women, I'm finding it more difficult to feel confident about encouraging normal birth because the organisation view point is refer them to me and so that's not the NICE guidance it should be the therapy or psychiatrist I think the link is.*

TD : is this for women with a fear of birth?

*Well not always but some of them will be and so they are referred to me and so I didn't know how far I could push it because there was no agreement in the organisation and I was feeling vulnerable about this. I did 30 years' of working as a midwife, I had my first complaint on this*

*very issue (long pause). So I do believe that's impacting as well on women feeling that they don't want to attempt a normal birth...*

The above responses are both powerful and poignant in that Mary is appearing to convey a diminishing lack of confidence in 'encouraging normal birth' and an uncertainty and vulnerability about how far she can 'push it', 'it' being taken to mean normal birth. This vulnerability appears to be caused by a lack of support and consensus agreement within her organisation and a seeming lack of guidance with which to support her decision making. Mary's statement that 'I did 30 years' of working as a midwife, I had my first complaint on this very issue' is particularly poignant as it was followed by a long pause during which time she appeared to be deep in thought and looked visibly sad. Following this period of silence Mary did not elaborate any further on this event which had obviously affected her considerably and as an interviewer and a professional I felt that it was inappropriate to probe further. Mary concludes her response by appearing to suggest that some women feel that they do not want to attempt a normal birth because they are fearful.

Mary's transcript also revealed tensions that existed for her personal practice and for midwifery practice in general. She suggested: 'So if you are looking after a woman from the desk then you've lost her, so it's about staying with the woman and supporting her...'. In this extract Mary is referring to situations where some midwives may spend more time at the central midwives' desk than they do in the actual room where the woman they are caring for is labouring and 'losing' her as a result. Mary uses 'lost' metaphorically as the woman is clearly not lost in a geographical sense but lost in a physical and emotional sense. It may further be suggested that a midwife who is absent from a woman's birthing room has lost the opportunity to establish the physical and emotional connection upon which to build the therapeutic relationship that is integral to the promotion and facilitation of normal birth; as a result, the woman may indeed be lost. Why a midwife would choose to separate herself from the woman in her care is not clear, but when interpreting the quote below it can be surmised that there is something about the midwife's experience in a birthing room that requires explanation.

*you do need strong clinical leadership to be a voice of normality and understanding and explaining what that is like for a midwife in a room*

Mary implies that strong clinical leadership is required to be a metaphorical voice for normality suggesting that there is an audience that needs to listen.

When asked about the qualities that a midwife might need to possess when promoting normal birth Mary commented:

*she'd need the passion as well, I believe there's the passion and the belief in normality and normal birth because I do believe there are people and they would probably come forward and say that themselves that they don't really believe in the process of normal birth or the philosophy of normal birth or the physiology of normality or physiology of normal birth and I do believe that you've got to have – I think that's innate actually.*

Mary's language here is interesting in that she refers to nebulous 'people' rather than specifically naming the individuals she is referring to. 'People' could be taken to mean midwives, doctors, women or their partners. The use of the idiom to 'come forward' is also interesting as it implies the need for bravery and the need to stand out and be known. She also considers that skill and knowing are important qualities:

*...skill and knowing when something is not right and not sitting on an issue that is not safe to carry on with and the partnership that you have with obstetricians is so key as well so when you have a deviation that you have got to be respecting their skill and vice versa.*

Here, in Mary's concluding comments, she is alluding to the need for midwives to be skilful in the recognition of unsafe situations and not 'sit on them'. To 'sit on' something is a metaphor that is frequently used in midwifery practice to describe a period of waiting or inactivity. Mary is advocating that if safety is an issue, midwives should act in a timely manner. She is also recognising the important partnership between midwives and obstetricians where mutual respect and recognition are paramount.

Mary's transcript contained an in-depth and, at times, emotional combination of reflection on the past and contemplative consideration of the present. It also revealed both personal and professional tensions in relation to the promotion of normal birth with women birthing in an AMU. Table 6 presents the super-ordinate and sub-ordinate themes that emerged from Mary's transcript.

Table 6: Super-ordinate and sub-ordinate themes that emerged from Mary's transcript with supporting quotations

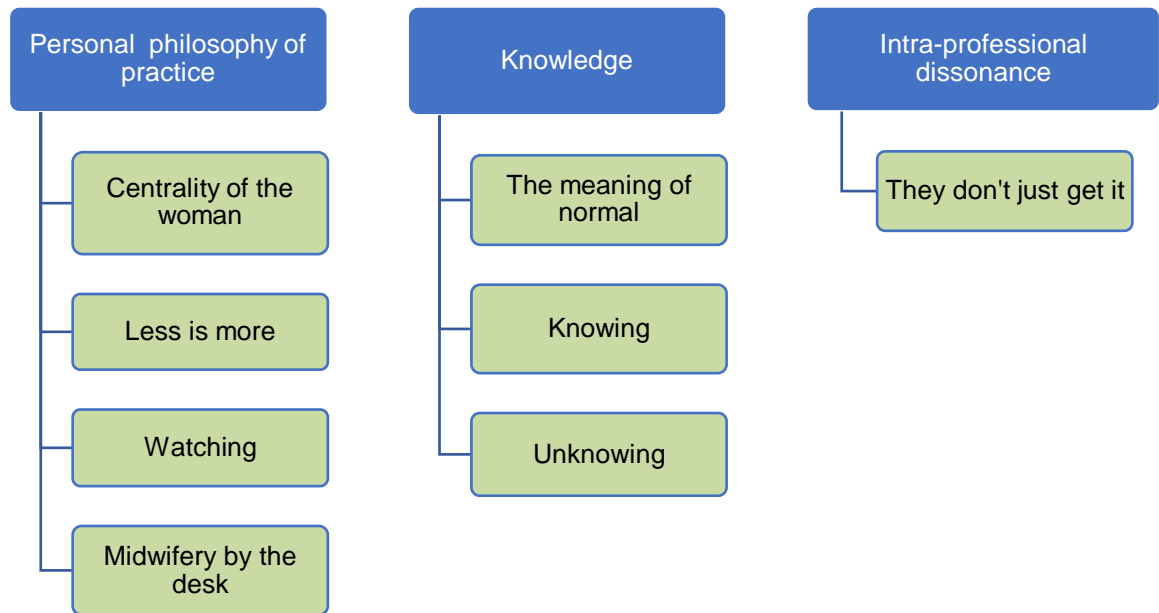
Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Boundaries	Practice boundaries	<p><i>...and having clear boundaries for what that means and a need to recognise deviation from normal because I think sometimes that becomes a bit muddied along the way.</i></p> <p><i>I think it's the litigation, I think that has an impact on people's confidence'.</i></p> <p><i>so, I didn't know how far I could push it because there was no agreement in the organisation and I was feeling vulnerable about this. I did 30 years' of working as a midwife, I had my first complaint on this very issue (long pause). So, I do believe that's impacting as well on women feeling that they don't want to attempt a normal birth.</i></p>	<p>5.91-93</p> <p>10.215</p> <p>16.345-350</p>
	Physical boundaries	<p><i>I do believe that you need core staff on a birth centre as you need core staff on an obstetric unit to actually carry on the philosophy of what we actually are about and what a midwifery led unit is about and I do believe that that has been eroded because of the sheer capacity of this big unit, we are not a standalone so we don't stand alone, we are part of the unit</i></p>	5.101-105
Birth Culture	Approaches to birth	<p><i>...there are differences with the way you might manage a woman in inverted comas on an obstetric unit to how you might support a woman in a birth centre...</i></p>	7. 155-156
		<p><i>So if you are looking after a woman from the desk then you've lost her, so it's about staying with the woman and supporting her, enabling her partner to be supportive.</i></p>	23. 503-505
		<p><i>you develop the skills and that's through your peers and through living and doing it and breathing it and somebody who actually wants to be with the woman as well because I do believe there are some people who come to work and do the job and go home again, in some ways there's no problem with that as long as they give it their all when they're here...</i></p>	22.495-500
		<p><i>...and the partnership that you have with obstetricians is so key as well so when you have a deviation that you have got to be respecting their skill and vice versa...</i></p>	23. 5

	Midwifery by the desk	<i>And being with the woman. So if you are looking after a woman from the desk then you've lost her, so it's about staying with the woman and supporting her, enabling her partner to be supportive.</i>	23. 502-505
	Clinical Leadership	<i>I think it's having strong clinical leadership is really important and having a birth centre sister particularly with a large unit like this is so important so managerially she can keep an eye on the calibre of midwives coming through that were not getting too diluted with the obstetric unit.</i>  <i>you do need strong clinical leadership to be a voice of normality and understanding and explaining what that is like for a midwife in a room and also sharing when things haven't gone so well with midwives about how they not necessarily recognise deviation from normal.</i>	21.459-463  21.466-469
	Belief in normal birth	<i>... I believe there's the passion and the belief in normality and normal birth because I do believe there are people and they would probably come forward and say that themselves that they don't really believe in the process of normal birth or the philosophy of normal birth or the physiology of normality or physiology of normal birth and I do believe that you've got to have – I think that's innate actually.</i>	22.489-494
Knowledge	Knowing	<i>...skill and knowing when something is not right and not sitting on an issue that is not safe to carry on with...</i>  <i>I think it's confidence as well, it's knowledge, it's your peers.</i>  <i>I think there is the need to be confident and I think but also careful and mindful and sharing knowledge between people as a group.</i>	23.512  7. 144  9.199-200

### 5.1.2 Carol

Carol had between one and five years' post qualification experience and a passion for all aspects of normal birth; her interview was relaxed and lasted fifty-one minutes. Figure 4 presents the super-ordinate and sub-ordinate themes that emerged from Carol's interview.

Figure 4: Emergent super-ordinate and sub-ordinate themes from Carol's interview



Carol's interview began with the following intense and emphatic response to my initial question about what the term normality meant to her; '*Do you know I hate the word normality*'. The use of the emotionally laden word '*hate*' conveyed Carol's unequivocal dislike of this term. When trying to make sense of her response Carol proceeded to pose the question '*what does normal mean?*'. Employing the double hermeneutic the root of Carol's hatred for the term normality appears to stem from a perceived lack of clarity about what the term actually means. Like many members of the midwifery profession today, she is questioning the meaning of normal; she continues to offer some suggestions about what it might mean going on to say '*to me here, it's about believing in women and being physiological and understanding how their body works*'. In the light of this professional uncertainty Carol clearly needs to qualify and emphasise her own understanding referring '*to me, here*' implying her personal perspective in this AMU which may be different to midwives practising elsewhere.

Following a conversational thread about midwives promoting normality in general Carol mentioned student midwives:

*yes, I think the students here are really good but a lot don't believe in normal, I think that's the same anywhere because I think it's what they've. I always say I was completely ruined by my 2 first year mentors because they believed in normal.*

TD: and when you say you were complete ruined.... you weren't ruined were you?

*No, but I was seeing things differently to my student colleagues...*

Carol's unfinished initial sentence may signify that she was uncertain about what is it that student midwives have or have not done that has resulted in generating this lack of belief in normal, or it may also signify that she needed more thinking time to give greater consideration to her response. It is however possible to suggest that this statement may be alluding to issues relating to the education of student midwives about normal birth or their exposure to normal birth in clinical practice. In relation to Carol's reference to being *ruined* it is possible to deduce that her use of the term '*ruined*' is ironic and that she is not using this word in its literal sense to convey that she was falling and damaged but in its colloquial sense meaning she was actually developed and improved. This interpretation is supported by Carol's admission that she was not ruined but that she was seeing things differently.

Carol communicated a consistent premise throughout her interview that to promote and facilitate normal birth both midwives and women need to know about normal birth and its related physiology and be able to apply that knowledge:

*... I think it's knowing what happens and why things happen so early labour, if you know what's happening... so I think it's really important to engage that knowledge...*

When asked about the qualities required of a midwife working with and promoting normal birth Carol placed emphasis on the woman being positioned firmly at the centre of her care:

*... the woman and the family to be the centre, it's about her journey, ... I really believe that it should be about that woman and her journey so yes I think you should always be in the room with the women especially if they are in labour, I'm a big one in I don't believe in midwifery by the desk ... I know that women do far better even if you're just sat watching, I'm a really lazy midwife I'm quite happy just sitting and watching.*

Carol is prioritising the woman and her family and is therefore relinquishing any personal or professional ownership or control over birth, additionally she repeatedly

uses the metaphor of a *'journey'* to describe the progressive process that is birth. She continues to state that she feels that midwives should always be with labouring women and not physically apart from them. When justifying this lack of belief in *'midwifery by the desk'* Carol remarked that women *'do far better even if you are just sat watching'*, and concluded with implying that she is a *lazy midwife*. Carol's use of the self-deprecating term *'lazy'* appears to have ironic overtones because when it was spoken it was accompanied by a smile; using the double hermeneutic it is possible to suggest that she does not actually consider that being a lazy midwife should be associated with indolence, more that it is a positive behaviour trait. It is possible to surmise that she considers inactivity to be beneficial as it enables her to focus on listening and observing rather than continually participating. Paradoxically, therefore Carol is both present and absent at the same time and may be learning more by doing less.

When asked if she had experienced any challenges when promoting normal birth, Carol responded, *'I think sometimes it's where we have the rotation, so midwives come from delivery suite and they don't just get it, that's a massive challenge*. In this response she does not elaborate on what *'it'* is, however, when re-reading the transcript, it can reasonably be assumed that *'it'* means promoting and facilitating normal birth. Carol proceeds to give an account of an experience supporting a junior midwife in the promotion of normal birth:

*So why I'm trying to work on my transfer out stats is to see for instance epidural transfers or deceleration transfers because I've gone... to support a 6 and she's said 'her FH is at 100' and you are like 'okay, now just breathe, so is it after her contraction?' 'I don't know' 'was it for the full minute?' 'possibly not' 'okay, so we'll listen after the next one then and we'll see what's going on'... – and it's – and she said 'I'm really sorry, I just panicked and if I was next door I'd have just grabbed a monitor and put her on the monitor' I said 'okay' so I think it's about building her confidence as well...*

The above extract suggests undercurrents of intra-professional dissonance and tension when promoting normal birth for both Carol as a senior midwife and for the band 6 midwife. Carol initially refers to her *'trying to work on her transfer out stats'*, the term *'working on'* is interpreted to mean reduce; since an AMU's performance is, in part, measured by the number of women who are transferred *'out'* during their labour to a labour ward for continued intrapartum care. It is therefore possible to surmise that she is under pressure to ensure her *'transfer out stats'* are reduced or reducing which may have an influence on her practical decision making. Carol's intention to provide support to her junior colleague in the management of a fetal heart rate that was below



the expected normal range '*FH is at 100*' and the promotion and facilitation of normal birth practice may have been subconsciously influenced by this imperative. This may have subsequently resulted in her support being misinterpreted as intimidation because the band 6 midwife felt the need to apologise to Carol and justify her clinical decision making. Whilst this apology was intended for Carol, it may be suggested that the band 6 midwife may also have been apologising to herself illustrating her own inner dilemmas, uncertainty and insecurity about the promotion of normal birth in this scenario.

As the interview concluded Carol observed that '*Sometimes – I don't know – you see if they've been to delivery suite first and then they come to us we have to unpick everything*'. In this excerpt Carol used '*they*' twice to refer to her fellow midwives suggesting that they were in some way different and separate. The fact that these midwives needed to be metaphorically unpicked may imply, on a superficial level, a need to separate and expose their clinical skills. Utilising a deeper level of interpretation, it can be suggested that to *unpick* is to unlearn or unknow. She may be suggesting that these midwives need to unknow the skills they have utilised when supporting women birthing on the delivery suite to enable them to embrace and employ the skills required to promote normal birth when supporting women birthing in the AMU. It would appear that there are therefore different ways of knowing and that she feels the need to enable the midwives to unknow before they can then know.

Carol's transcript was a thought-provoking amalgam of both personal normal birth practice experiences and wider managerial experiences, and both revealed very different interpretations. This dichotomy of experiences was accompanied by her use of figurative language and the employment of metaphor, irony and humour which appeared to enable her to reconcile practice tensions and inner uncertainties. Table 7 presents the super-ordinate and sub-ordinate themes that emerged from Carol's transcript

Table 7: Super-ordinate and sub-ordinate themes that emerged from Carol's transcript with supporting quotations

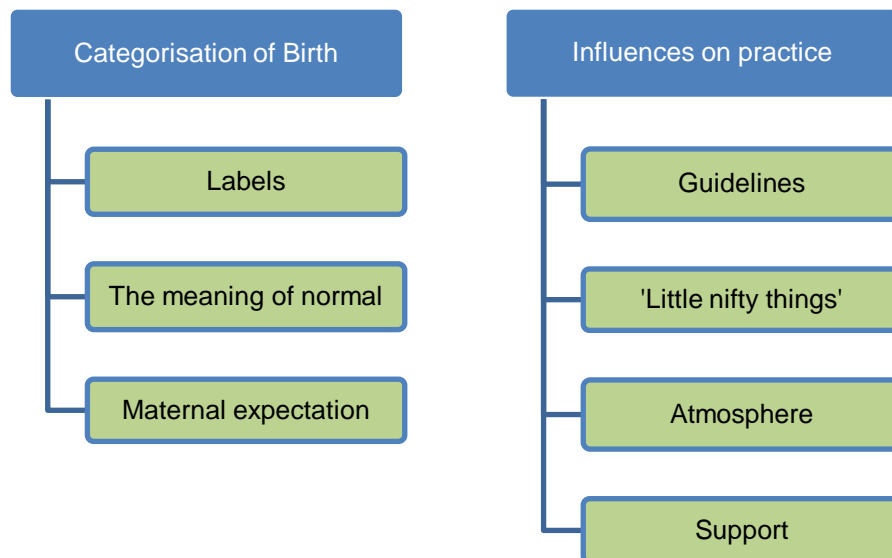
Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Personal Philosophy of Practice	Centrality of the woman	<i>The woman and the family to be the centre, it's about her journey, it's not about actually I haven't seen who I'm working with for the last 3 weeks so we'll just have a catch up. I really believe that it should be about that woman and her journey.</i>	4.66-68
	Less is more	<i>I'm a really lazy midwife I'm quite happy just sitting and watching</i>	4.73
	Watching	<i>so yes I think you should always be in the room with the women especially if they are in labour, I'm a big one in I don't believe in midwifery by the desk where you just run in to make sure you get your auscultation in at the 15 minute mark and then come back out because I know that women do far better even if you're just sat watching,</i>	4.68-72
		<i>...and you could kind of by just touching and watching her see that things were really progressing really quite...</i>  <i>...being able to sit in a room with a woman and just watching labour which is a bit crazy because if you don't know the physiology – because if you know the physiology you can sit in a room and watch a woman labouring on delivery suite you don't necessarily have to be doing.</i>	6.124-125  23.505-507
	Midwifery by the desk	<i>...yes I think you should always be in the room with the women especially if they are in labour, I'm a big one in I don't believe in midwifery by the desk where you just run in to make sure you get your auscultation in at the 15 minute mark and then come back out...</i>	4. 68-72

Knowledge	The meaning of normal	<p><i>Do you know I hate the word normality because its – what does normal mean? ...to me, being here, it's about believing in women and being physiological and understanding how their body works and looking at how you can support them, so it doesn't matter where it is but here very specifically because they are trusting in you a little bit more, their bodies...</i></p> <p><i>yes, I think the students here are really good but a lot don't believe in normal, I think that's the same anywhere because I think it's what they've – I always say I was completely ruined by my 2 first year mentors because they believed in normal</i></p>	<p>3.45-50</p> <p>24. 525-527</p>
	Knowing	<p><i>I think it's knowing what happens and why things happen so early labour, if you know what's happening to that woman why she might be in and out over 36 / 48hours actually having that discussion 'this is what's happening to your body and this is what it's doing' so I think it's really important to engage that knowledge about her body so that actually she can go 'oh I can imagine that happening, the cervix is all the way at the back and this is coming forward and it's getting shorter'...</i></p> <p><i>... knowing that women don't fit that text box...</i></p> <p><i>... they need knowledge, they need to be surrounded by it happening</i></p>	<p>3. 55-60</p> <p>4.75</p> <p>5.98</p>
	Unknowing	<p><i>Sometimes – I don't know – you see if they've been to delivery suite first and then they come to us we have to unpick everything</i></p>	<p>23.508-509</p>
Intra-professional dissonance	'they don't just get it'	<p><i>...some midwives, I think the younger ones, the newly qualified ones it's more 'I'm not sure' and they are looking to you to 'what do I do?'</i></p>	<p>9.197-198</p>
		<p><i>I think sometimes it's where we have the rotation, so midwives come from delivery suite and they don't just get it, that's a massive challenge.</i></p>	<p>13.291-292</p>
		<p><i>– and it's – and she said 'I'm really sorry I just panicked and if I was next door I'd have just grabbed a monitor and put her on the monitor' I said 'okay' so I think it's about building her confidence as well...</i></p>	<p>14.297-300</p>

### 5.1.3 Karen

Karen was a band 7 midwife with extensive experience in the promotion and facilitation of normal birth. She had worked in the AMU since it opened, a total of thirteen years. Karen's interview was my third; Karen appeared nervous at the beginning of her interview and, despite my best efforts to enable her to feel at ease, she continued to appear nervous for the duration of her interview. This may have been influential in there being long monologues, which at times strayed off topic. Due to my inexperience as an interviewer, I felt unable to interrupt her which may have had an impact upon the data. Karen's interview lasted 48 minutes. Figure 5 presents the super-ordinate and sub-ordinate themes that emerged from Carol's interview.

Figure 5: Emergent super-ordinate and sub-ordinate themes from Karen's interview



When asked what normality meant to her, Karen responded:

*I mean it's a term we use isn't it and we apply it to women but actually it probably doesn't sound like a great label to be applied to a woman, a normal woman or whatever because I'm sure all women think they're normal don't they and I think when we talk about – sometimes you hear people talk about high risk women and low risk women – it's the pregnancy that's high risk or low risk not the woman so I'm always aware of labels than labelling a woman or hearing labels used like that.*

Karen's nervous disposition and possible uncertainty is elucidated in this response where she sought validation from me twice asking 'isn't it and don't they'. She proceeded to describe the terms normal and high and low risk as 'labels' which appear to be wrongly applied to women and should instead, be applied to their pregnancy.

Karen articulated a very relevant debate in current midwifery practice where the use of the term normal is being questioned. On a deeper level her use of the term 'label' is interesting as it may be that she is either consciously or subconsciously considering labelling theory which hypothesizes that if a label is applied to an individual it can subsequently influence behaviour and outcomes. The sub-ordinate theme of labels continued:

*...there's something with regards to promoting normality, there's labels that they've issued now that get stuck on to the woman's hand-held notes with the most suitable place of birth and it could be home, midwifery led unit or home birth centre or delivery suite*

Here Karen is referring to physical labels rather than figurative ones which are used to help promote normality and a woman's designated birth place preference. These physical labels appeared to be viewed as beneficial, in contrast to their figurative counterparts.

A further sub-ordinate theme that appeared to emerge from Karen's transcript was her continuing uncertainty about the meaning of the term normal:

*so it's quite a broad term isn't it as people interpret it and then people might also think about being on here as keeping it normal in other words trying to keep things natural whatever that means as well, trying to facilitate women who want to have perhaps a less mechanised type of experience a less high tech type of experience, like a low tech type of experience. But it's a hard word to define in that sense, it's quite a broad term isn't it*

When trying to make meaning of the term normal Karen introduces another term, 'natural' which she then also questions the meaning of. This adds emphasis to the dilemma that she and other midwives experience in midwifery practice when discussing and defining physiological birth.

When asked about her experiences of promoting normal birth Karen expressed some concern about the influence that maternal expectation may have on birth outcomes, 'we pin a lot of importance in this society on what happens during that labour and birth, don't we?' Here, Karen is employing the plural 'we' choosing not to elaborate on who the 'we in this society are', she also appears to seek affirmation again following her statement or is perhaps seeking to add emphasis.

A second super-ordinate theme to emerge from Karen's transcript was 'influences on practice'. It became apparent that Karen's practice when promoting normal birth was influenced by a number of factors. She was very aware of her professional responsibility;

*I know we have guidelines and so on and I don't go against the guidelines*

Here she also appeared to be inferring that practice guidelines are some form of possible barrier that she is mindful not to cross.

Karen also considered that she and other midwives employed '*little nifty things*' which enabled them and her to work with and promote normality. Nifty is defined as meaning skilful. In Karen's case, her '*nifty thing*' was not to commence a partogram too early. She was also aware of the atmosphere that existed between midwives working on the AMU and how that influenced her practice, stating:

*...so if you come out of a room and say 'I've tried this and this and this, my lady's doing this, she's got a posterior position or whatever what else can I try?' and someone will say 'oh have you tried such and such' and that's quite good so I think the atmosphere is such that you feel you can say without thinking 'oh I'm showing myself up here, someone is going to criticise me or whatever'.*

When interpreting the possible meaning of this statement it can be suggested that Karen harbours feelings of uncertainty about her facilitation of normality and some vulnerability to undergoing criticism, but that she can speak freely to colleagues on the AMU.

The final sub-ordinate theme to emerge from Karen's transcript was that of support in the promotion and facilitation of normal birth; midwife to midwife support and mother to midwife support. Karen alluded to the support she gained from her colleagues in the AMU:

*... some confidence, good support as well if you've got support from your colleagues as well...well generally we are, generally quite supportive here definitely we were when we first set up, definitely and I think we still are largely supportive to each other here...*

However, when interpreting the above extract Karen expressed some uncertainty about the levels of support she currently received, this is elucidated by her interchanging use

of the words '*generally and largely*' to describe current support processes and '*definitely*' to describe past processes. Karen further discussed the influence that new staff to the AMU had upon the number of women who are transferred out of the AMU, implying that there is a direct correlation between the two:

*when you get a new influx of staff your transfers out change and that's understandable it takes time to work through these things and you need support and so on don't you?*

She further suggested that new staff to the AMU might require additional support;

Karen also spoke of her experiences of supporting women:

*... you try and facilitate something that the woman wants and you help her and you support her and you assist her but it's her experience, you're just trying to facilitate that for her,*

Here, Karen expressed the facilitative role that midwifery support has during the intrapartum mother-midwife relationship. She used supportive adjectives '*help*', '*support*' and '*assist*' suggesting that the power in the relationship lies with the mother and the facilitation of her '*wants*' and that she is trying to ensure that they are met. Table 8 presents the super-ordinate and sub-ordinate themes that emerged from Karen's transcript.

Table 8: Super-ordinate and sub-ordinate themes that emerged from Karen's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Categorisation of birth	Labels	<i>...I mean it's a term we use isn't it and we apply it to women but actually it probably doesn't sound like a great label to be applied to a woman, a normal woman or whatever because I'm sure all women think they're normal don't they and I think when we talk about – sometimes you hear people talk about high risk women and low risk women – it's the pregnancy that's high risk or low risk not the woman so I'm always aware of labels than labelling a woman or hearing labels used like that.</i>	3. 42-47
		<i>I suppose we think in terms of obstetrics and the high risk end of care we tend to look on that as not quite normal and yet for many women they might have that kind of care and they still feel they've had a normal birth so I think we have to be careful with labels and applying things don't we.</i>	3. 60-63
		<i>As I say, I think we have to be careful about labels we have to be careful about labels and labelling women really because things may not go according to plan but a woman can still achieve a satisfying experience.</i>	4. 76-79
		<i>...there's something with regards to promoting normality, there's labels that they've issued now that get stuck on to the woman's hand held notes with the most suitable place of birth and it could be home, midwifery led unit or home birth centre or delivery suite</i>	24. 539-542
	The meaning of normal	<i>so it's quite a broad term isn't it as people interpret it and then people might also think about being on here as keeping it normal in other words trying to keep things natural whatever that means as well, trying to facilitate women who want to have perhaps a less mechanised type of experience a less high-tech type of experience, like a low tech type of experience. But it's a hard word to define in that sense, it's quite a broad term isn't it?</i>	3. 54-60
	Maternal expectation	<i>we pin a lot of importance in this society on what happens during that labour and birth don't we and for some women it's good and for some it's less good and perhaps their expectations if they are not fulfilled that can be quite devastating for some women</i>	4. 72-75

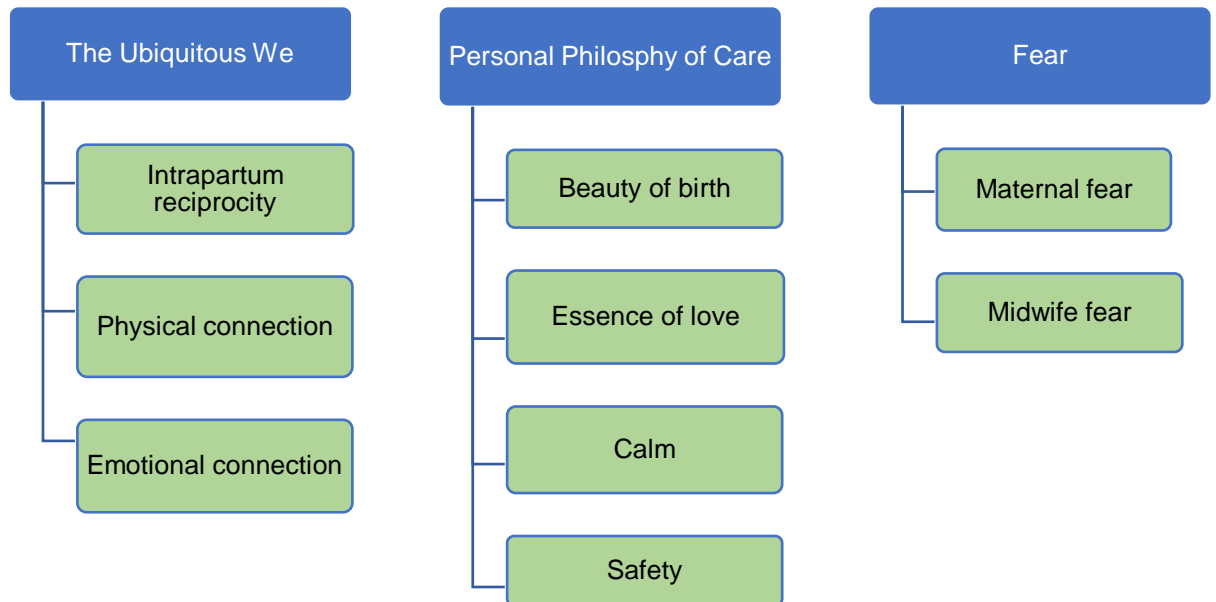


Influences on practice	Guidelines	<i>I know we have guidelines and so on and I don't go against the guidelines...</i>	8. 164
	'Little nifty things'	<i>...the midwives have these little things – not tricks but what's the word – little nifty things they do sort of thing and for me one of the things is not to start a partogram too early.</i>	8. 172-174
	Atmosphere	<i>... so I think the atmosphere is such that you feel you can say without thinking 'oh I'm showing myself up here, someone is going to criticise me or whatever' ... usually someone can think of something that you've forgotten in the moment so that's a good thing.</i>	10.223-229
	Support	<i>... some confidence, good support as well if you've got support from your colleagues as well ... well generally we are, generally quite supportive here definitely we were when we first set up, definitely and I think we still are largely supportive to each other here...</i>	10.216 -219
		<i>And also we try and support our younger colleagues and who are new in a band 5 to having worked here so we do try and support them we try if they want us in the room, be in the room or make suggestions or bring some aromatherapy paper to the room or something we do try and support each other that way</i>	11. 230-233
<i>when you get a new influx of staff your transfers out change and that's understandable it takes time to work through these things and you need support and so on don't you?</i>		20. 453-455	
	<i>... that kind of practice of midwifery where you try and facilitate something that the woman wants and you help her and you support her and you assist her but it's her experience, you're just trying to facilitate that for her,</i>	27. 606-610	
	<i>Sometimes we – people in the NHS, we're up and down aren't we, you can be down about something but actually when you reflect on the environment we work in and the – what's the word – the opportunities we have to support people and help them that is a very good thing really, I think that's a very positive thing...</i>	29. 640-644	

### 5.1.4 Lilly

Lilly was a band 7 midwife who had more than ten years' post qualification experience and a passion for all aspects of normal birth. She was a very articulate, relaxed and reflective individual who spoke slowly, she frequently punctuated her responses with long pauses. The interview felt very comfortable and calm, it lasted fifty-five minutes. Figure 6 presents the themes that emerged from this interview.

Figure 6: Emergent super-ordinate and sub-ordinate themes from Lilly's interview



Lilly's interview began with her giving a descriptive and emotive account of what she considered normal birth to be:

*...a complete miracle... to see a woman become completely overwhelmed with what she's just achieved still means a lot to me, I still find it quite overwhelming and beautiful.*

TD: How would you describe beautiful?

*... I just think 'oh' isn't that beautiful, that kind of essence of love that you have in this real intimate setting...this relief that floods over you with this pure love and happiness and relief and achievement and I think that's beautiful.*

Lilly clearly felt that normal birth has beauty. When articulating her understanding of 'beautiful' Lilly emphasised the association between beauty and love. She continued this emphasis by referring to a love that is pure. This is interesting to note as the hormone, oxytocin, which is responsible for many of the physiological processes associated with normal birth, is also known as the love hormone. When continuing to

assign meaning to beautiful birth she described *'the relief that floods over you'* when interpreting this it is reasonable to surmise that if there is relief there must have been tension, anxiety or distress which there often is during birth but her use of the term *'you'* may be taken to mean either *you* meaning herself, or the woman or in the plural meaning anyone present at the birth.

When articulating her experiences of promoting normal birth Lilly provided a powerful example:

*... women will grab your hand and say 'don't leave me I need you' or I had a lady not long ago say 'I just really need to hug you, I just need to hug you' so we had a really long, really long lovely hug... but it was a kind of feeling that she needed me and I was there for her and I was happy to be there for her and it was just lovely.*

In this extract there is an intimate moment where Lilly connected with a woman both physically and emotionally. This account illustrated the mutually beneficial and reciprocal nature of the mother-midwife connection that can occur during labour and birth. This mother-midwife connectivity continued as a prevailing theme throughout this transcript with the repeated use of the term *'we'*. When further discussing her experiences of promoting normal birth Lilly stated:

*... 'why don't we just try and have a bath, why don't we have a walk around, why don't we try some aromatherapy oils, let's get a TENS machine on'.*

*... and I said 'right, we can't have an epidural right now so let's think of what else we can do'*

When considering the meaning of these accounts, it is possible to interpret Lilly's use of *'we'* in different ways. Firstly, it can be suggested that *'we'* emphasises her partnership with the woman and that their decision making is a mutual and reciprocal process resulting from the bond and alliance that exists between them. Conversely, it may also be suggested that there is an element of paternalism in Lilly's use of the term *'we'*. The use of *'we'* may suggest patronizing undertones and that she is assuming that the woman is adopting the passive role of a child incapable of reaching her own independent conclusions. This also may have implications when considering the ownership of birth and the power balance that may exist between Lilly and the woman she is with.

Another prevalent theme that was revealed throughout Lilly's transcript was her reference to achieving a state of calm and its association with the achievement of normal birth:

*...in the end she really calmed down... that initial being able to calm someone down and then you get to encourage them with normality then because you get that control back and that focus and be able to help them know that they are safe that what's happening is okay...*

Lilly appeared to associate the need to induce maternal calm with the encouragement of normality and that a state of calm enables 'you to get that control back'. It is well evidenced that maternal calm is conducive to normal birth physiology. Again, however, in this account she used the term 'you' which could be taken to mean the woman gaining control over herself but equally it could be interpreted to mean Lilly gaining control over the woman which may also be suggestive of a power imbalance. In both possible interpretations it is reasonable to suggest that there is a perceived need for reciprocal calm.

Lilly's transcript revealed a rich tapestry of emotional ranges that might be expressed by a woman and a midwife when promoting and experiencing normal birth. In particular, the contrasting emotions of calm and fear which are notable as they are both inextricably linked; if an individual is fearful they are unlikely to be calm and vice versa:

*... but I think yes, fear is a big, big thing and if you can keep someone calm that's the biggest (unfinished sentence)*

She referred to the fear felt by women either before or during birth, but in the quotes below she discussed the fear felt by herself and some of her midwifery colleagues:

*I just stood there thinking 'Ahhh!' she was like a ferocious animal, I felt frightened of her...*

*But I think it's also their fear because they haven't done it and they don't know how to do it, they are worried about it and that puts a stop to normality and I think because I work on the birth centre and delivery suite I try and encourage as much normality as we can*

Above, Lilly revealed the tensions that existed for some midwives when promoting normal birth, suggesting that they are fearful because 'they don't

*know how to do it*, 'they' meaning midwives and 'it' meaning to promote and facilitate normal birth, which in turn *'puts a stop to normality'*.

A further theme that appeared to emerge from Lilly's transcript was safety for both mothers and midwives. In the excerpt below she asserted that she tells 'people' they are safe:

*... I've been telling people they're safe because I think that's what people feel frightened of that their vaginas are going to explode, that they're going to be the first people that their pelvis shatters, their baby will get stuck, that's what went through my head when I had my baby...*

Lilly used graphic imagery to describe what she perceived maternal fears to be, then when making sense of this she alluded to these fears as being her own fears when she gave birth. Lilly may mistakenly transfer her own fears onto the women she is caring for when perhaps they do not actually exist. When asked if safety matters to midwives Lilly responded:

*Yes, I think you need to – yes I do just in the general running of your room and what's happening, you're not going to trip over, you're following the guidelines that you're keeping people safe in that respect that people aren't in danger from anything that you're doing or not doing...*

Here Lilly spoke metaphorically about avoiding 'tripping over' by following guidelines and keeping 'people safe'. Lilly again favours the use of the word 'people' rather than women to describe those in her care. This is interesting as it can be suggested that this distanced Lilly from the women she clearly felt very close to. Table 9 presents the super-ordinate and sub-ordinate themes that emerged from Lilly's transcript.

Table 9: Super-ordinate and sub-ordinate themes that emerged from Lilly's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
The ubiquitous 'we'	Intrapartum Reciprocity	<i>...why don't we just try and have a bath, why don't we have a walk around, why don't we try some aromatherapy oils, let's get a tens machine on'</i> <i>... and I said 'right, we can't have an epidural right now so let's think of what else we can do'</i> <i>I think they need to – we need to be educated in how to do it, we need to be confident in what we can offer.</i>	6.121-123 8.159-160 5.333-334
	Physical connection	<i>... women will grab your hand and say 'don't leave me I need you' or I had a lady not long ago say 'I just really need to hug you, I just need to hug you' so we had a really long, really long lovely hug... but it was a kind of feeling that she needed me and I was there for her and I was happy to be there for her and it was just lovely and that was a really intimate moment too that I felt between a woman and midwife that was her saying 'I need you and I'm happy that you're here' and me saying 'I am here and don't be frightened' and I wasn't going to push that hug away when she needed it.</i>	5.93-103
	Emotional connection	<i>...you've got time to just sit and think 'what shall I do next' or just to really be part of the experience because you're just sitting there being with the woman ...'</i>	19.416-417
Personal Philosophy of Care	Beauty of birth	<i>... just this kind of love that lots of people have for their babies straight away it might be the language they use, people that say 'oh my gosh, my baby, my baby I love you' straightaway and I just think 'oh, isn't that beautiful that kind of essence of love that you have in this real intimate setting where you've gone through so much excruciating pain and fear and then suddenly this relief that floods over with this pure love and happiness and relief and achievement and I think that's beautiful.</i>	4.74-81
	Essence of love	<i>where I'm just a midwife again and I look after everybody and I have my own women and I love it and I think it keeps my skills, it keeps me thinking about normality...</i> <i>... but properly for probably for the past 2 years' I've been really focussed on working here and I love it.</i>	3.42-44 3.51-52
		<i>...the look between them when the woman will say 'I can't do this' and he'll say 'you can, I love you, you can' and those moments that are usually very private moments that they would probably share in their home without people listening, you are then a witness to those moments and I think that's really special.</i> <i>I've had women say to me 'oh I love hearing you talk it's really comforting, I can just doze and come in and out and you're talking'</i>	5.90-93 19.432-433

	Calm	<p><i>oh it really calms me too, it makes me feel really calm and relaxed...I think then with that environment I feel calmer and then you can put on that calm voice because you feel calmer and more relaxed and so you might think about things a bit more or make better decisions</i></p> <p><i>...in the end I really calmed her down...</i></p> <p><i>.she swore at me a couple of times and I said 'okay, let's calm things down' I helped her with her breathing and she calmed down a bit...</i></p> <p><i>so then just to kind of really bring it down we start to use a really calm, quiet voice and get her to breathe again</i></p> <p><i>when people are in pain you can't always reason with them straight away it takes a while to just try and calm things down</i></p> <p><i>just stay calm don't lose control of it because you're in control of your body and you can do this' I think saying things like that helps</i></p> <p><i>I didn't know how to calm her she was flinging and kicking and punching and it was kind of like you didn't know how to calm that...</i></p> <p><i>...in the end she really calmed down and we managed to get her some pain relief and she was okay but I think that initial being able to calm someone down and then you get to encourage them with normality then because you get that control back and that focus and be able to help them know that they are safe that what's happening is okay</i></p> <p><i>it was a really lovely environment, we had the warm water and she was in the pool and she was floaty and it was just really, really calm...</i></p>	<p>19.422-424</p> <p>7.145</p> <p>8.157-159</p> <p>8. 165-166</p> <p>9.183-185</p> <p>9.199-200</p> <p>10.206-207</p> <p>10.218 -223</p> <p>17.369-370</p>
	Safety	<p><i>I think over the years' I've said different things but recently I've been telling people they're safe because I think that's what people feel frightened of that their vaginas are going to explode, that they're going to be the first people that their pelvis shatters, their baby will get stuck, that's what went through my head when I had my baby</i></p> <p><i>so to tell somebody they're safe and that nothing is wrong I think is a big thing if they trust you because to be told this is okay and you are safe I think feels comforting and nice, makes you feel warm, looked after, protected</i></p> <p><i>yes, I think you need to – yes I do just in the general running of your room and what's happening, you're not going to trip over, you're following the guidelines that you're keeping people safe in that respect that people aren't in danger from anything that you're doing or not doing...</i></p>	<p>9.192- 196</p> <p>11.239- 242</p> <p>11.244-247</p>

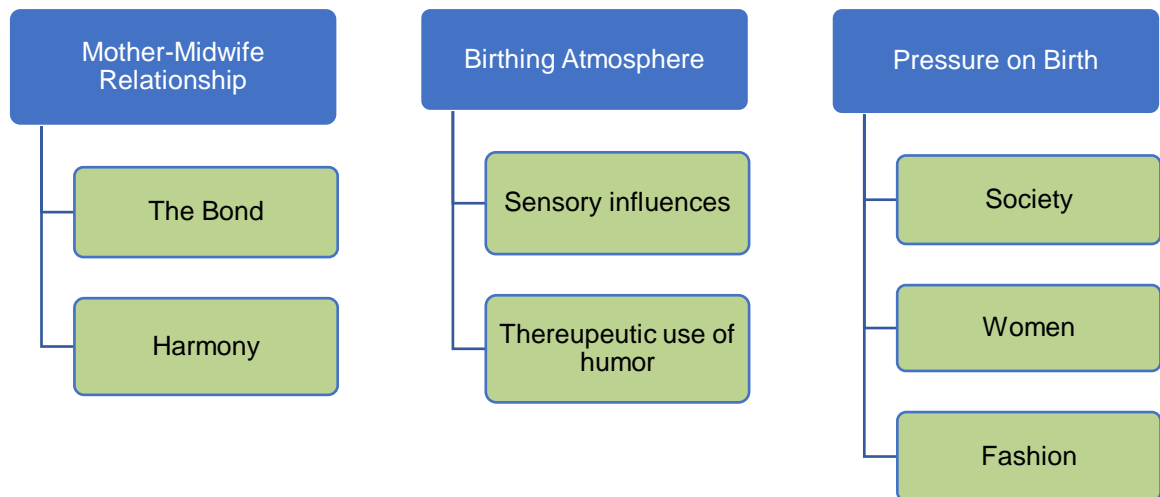
Fear	Maternal fear	<i>...but for them it's very private and a fearful thing so it's an intimate part of the whole process too I think...</i>	.107-108
		<i>But I think sometimes you have to think before you speak and just think right, what's really going on here, is she cross with me, does she hate me or is she just frightened and a lot of it is just fear isn't it? And it's just being able to try and dissolve some of that fear.</i>	9.185-188
		<i>... but I think yes, fear is a big, big thing and if you can keep someone calm that's the biggest (unfinished sentence)</i>	11.226-227
	<i>I think when women are in transition, when they are going to start pushing or even just that going from latent to active phase there's that fear because it's painful and they fear that something is wrong</i>	11.229-231	
Midwife fear	<i>I think the challenges are people that are not educated in what's available, so they feel a fear of those things</i>	20.442-443	
	<i>But I think it's also their fear because they haven't done it and they don't know how to do it, they are worried about it and that puts a stop to normality and I think because I work on the birth centre and delivery suite I try and encourage as much normality as we can</i>	21.469-472	
		<i>I just stood there thinking 'Ahhh!' she was like a ferocious animal, I felt frightened of her</i>	9.202-205



### 5.1.5 Holly

Holly was a Band 6 Midwife, with between five and ten years' post qualification experience and a considerable passion for all aspects of normal birth. Whilst I connected with all the midwives in this study, I felt a particularly strong personal and professional connection with Holly, consequently our conversation was very much an inter-view with data production being authentic and co-constructed. Her interview lasted thirty-eight minutes. Figure 7 presents the themes that emerged from Holly's interview.

Figure 7: Emergent super-ordinate and sub-ordinate themes from Holly's interview



When asked at the commencement of her interview how she felt about normal birth Holly responded, '*I think the day I get tired of it is the day that I ought to leave midwifery*', this statement emphasised her passion for normal birth and it could be surmised from this that normal birth is Holly's professional *raison d'être*. She continued to comment that:

*... it is a privilege and I know it's a cliché ... and that's what midwives are constantly saying that it's a privilege to be there at the moment, but it is, it's such a privilege and to be there for a normal birth and to witness that oxytocic rush that people get when they first meet their baby*

Holly's repeated use of the noun '*privilege*' demonstrates the strength of feeling she has about being present at a normal birth. She appears concerned that her use of the word may be considered clichéd but continues to repeat it nonetheless.

A predominant theme that appeared to run through Holly's transcript was the importance of the relationship she forged with women during a normal birth, what Holly refers to as *'the bond'*.

*...it's just the bond that you create, the relationship you build up as a midwife... it's just brilliant and witnessing them meet their baby for the first time but that's relevant for normal birth, that's midwifery.*

*to have grown to know a woman, to have got to know a woman ... I think sometimes you just click with women... sometimes you just click with them and sometimes you form that bond and sometimes it's harder because we're all individuals' um but I think if you've got that relationship with that woman that's what makes midwifery and especially with midwifery with normal births so special because you can – it's that relationship that you've got with her...*

Holly elaborated on her relationship with women in a normal birth context and spoke metaphorically, stating *'you just click with women'*, she repeated this statement to add emphasis. When making meaning of her relationship with women Holly's use of this idiom implies that this special, positive and effortless connection is an integral part of forming the bond, the bond *'that makes midwifery and especially midwifery with normal births so special'*. Holly also comments that the *'click'* only happens *'sometimes'*, repeating *'sometimes'* four times. When interpreting this it can be surmised that the all-important *click* does not happen all the time. Holly referred to achieving continuity as being an important precursor to developing the relationship with a woman, suggesting that:

*and the continuity that we got prior to that, the relationship that we'd built up it was like the archetypal kind of perfect, sort of, you know, and I'm sure that in that process, the process facilitated that normal birth*

She described the relationship she experienced with this woman as the *'archetypal kind of perfect'* and that this *'perfect'* relationship helped to facilitate that normal birth. It is possible to conclude therefore that, for Holly, the mother-midwife bond played an integral role in the promotion and facilitation of normal birth.

Another recurring theme that appeared to emerge from Holly's transcript was the importance she placed on the influence of atmosphere on normal birth. This theme links very closely with the preceding theme focusing on the mother-midwife bond as Holly commented:

*...but when you've developed a relationship with a woman even if it's only brief, even if she's only been admitted for a short period of time – you've still got, I don't know, the atmosphere – (long pause) it's really hard to describe*

When interpreting Holly's meaning making it can be inferred that she is referring to the emotional and psychological atmosphere that evolves when a midwife and mother establish a relationship with one another. Holly also referred to the importance and influence of the physical atmosphere during a normal birth:

*I think creating the right atmosphere in terms of the lighting and in terms of the music and in terms of sound and in terms of smell – all those senses, all that sensory stuff is hugely important in achieving normal birth because of helping that oxytocic adrenaline balance ...*

An additional theme that seemed to emerge from Holly's transcript was the importance of humour and its influence on the mother-midwife relationship:

*but we were laughing, we were laughing...she was laughing... to be able to laugh in between and have a giggle with your midwife I think it makes for a big difference...*

Holly clearly felt that there is a therapeutic use for humour during birth, for both the mother and the midwife.

When asked to consider any possible challenges she had experienced when promoting normal birth Holly commented:

*...so there's a lot of pressure put on births, there's an awful lot of pressure put on births especially in modern society and I think there's a lot of pressure certainly in certain bits of society there's a lot of pressure put on women to achieve a normal birth...*

TD: And these pressures on women, where do you think they are coming from? Do you think that it's a recent thing?

*I think we think it's recent but I don't think it is recent at all. I think people have put pressure on women about how they give birth for centuries it just depends on the fashion at the time as regards to how they put pressure on them but I think women have always had pressure on them about how they are supposed to give birth and in what particular way...But certainly within the sort of middle class range of women there's a lot of emphasis placed on having the perfect birth... but at the*

*same time when women put too much pressure on themselves to have this perfect birth that they come in and they are so tense...*

Holly described the pressures she felt are put on '*births*' both in the past and today and pressures to achieve a normal or perfect birth; it is possible to interpret that Holly considers a normal birth to be a perfect birth. The pressures appear to be exerted from a number of sources, '*people*' who can be interpreted to mean health professionals and wider society, 'women' collectively and women individually. It would appear that Holly felt that this pressure is exerted particularly on women from the '*sort of middle class*' and that these multiple pressures do not have a positive impact upon birthing women. Table 10 presents the super-ordinate and sub-ordinate themes that emerged from Holly's transcript.

Table 10: Super-ordinate and sub-ordinate themes that emerged from Holly's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Mother-Midwife Relationship	The Bond	<i>...it's just the bond that you create, the relationship you build up as a midwife with the family that you are looking after if you can give them that reassurance that everything is going to be okay and that this will all work out and then when it does it's just brilliant and witnessing them meet their baby for the first time but that's relevant for normal birth, that's midwifery.</i>	5.97-101
		<i>the continuity that we got prior to that, the relationship that we'd built up it was like the archetypal kind of perfect, sort of, you know, and I'm sure that in that process, the process facilitated that normal birth</i>	7. 148-150
<i>to have grown to know a woman, to have got to know a woman – and I think in any capacity I think sometimes you just click with women, sometimes regardless of whether you've known them for 2 months or whether you've known them for 2 hours sometimes you just click with them and sometimes you form that bond and sometimes it's harder because we're all individuals' um but I think if you've got that relationship with that woman that's what makes midwifery and especially with midwifery with normal births so special because you can – it's that relationship that you've got with her...</i>		8. 177-184	
		<i>I had this one lady on here not too long ago who'd picked this fabulous playlist and I think it really helped us bond and the relationship that we got...</i>	9. 202-204
	Harmony	<i>I think women pick up on that very, very quickly and I think they know, they look at you and they've got that knowing look of 'you're on to something' 'yes I am' but yes, women – they know and we know it's that harmony isn't it.</i>	18. 398-401

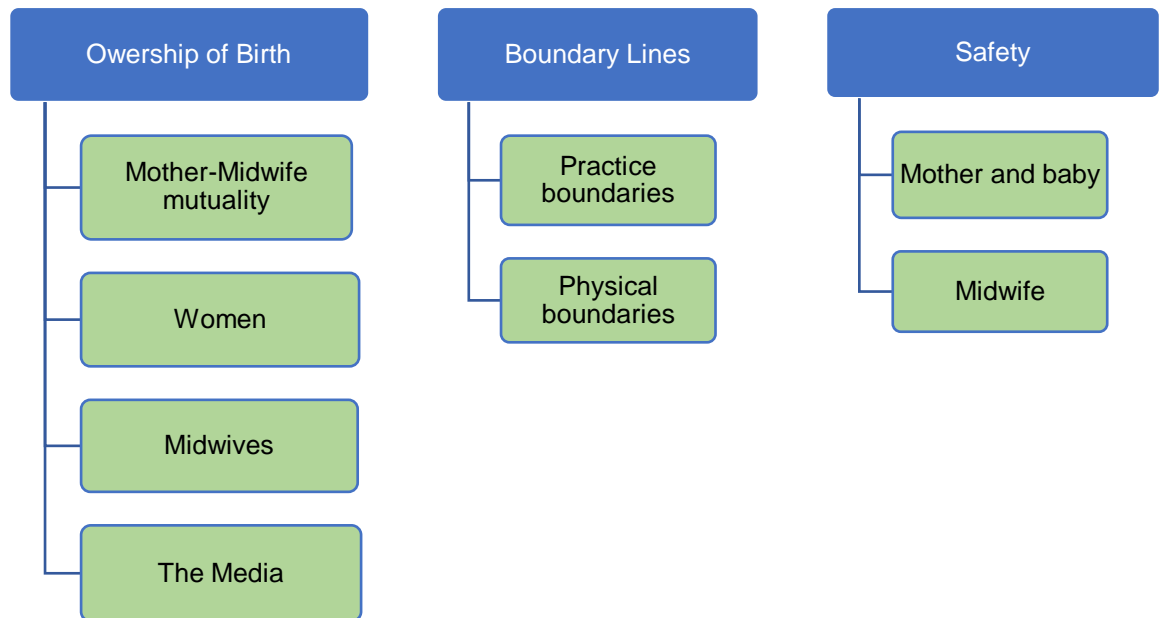
Birthing Atmosphere	Sensory influences	<p><i>...but when you've developed a relationship with a woman even if it's only brief, even if she's only been admitted for a short period of time – you've still got, I don't know, the atmosphere – (long pause) it's really hard to describe.</i></p> <p><i>The atmosphere in the room needs to be an actually yes, talking about (laughter) – that oxytocin it will just up it will increase that oxytocin so much and that's where it works but yes I think creating the right atmosphere in terms of the lighting and in terms of the music and in terms of sound and in terms of smell – all those senses, all that sensory stuff is hugely important in achieving normal birth because of helping that oxytocic adrenaline balance and I think in our sort of rush, rush, rushed unit here on delivery suite certainly when you have the lights on full, you've got people coming in and out, you've got buzzers, we've got the worst buzzer system in the world here it sounds like a cat that's been strangled it's a horrible noise, a vile sound it slices into the room.</i></p>	<p>5. 92-95</p> <p>17.376-386</p>
	Therapeutic use of humour	<p><i>...but we were laughing, we were laughing during her birth...and I think that really helps because you build up that relationship and she was laughing in the pool...to be able to laugh in between and have a giggle with your midwife I think it makes for a big difference, I think if they can look back on their birth and think 'well that was funny'...if you can laugh during the process – I always try and appropriately be relatively humorous during the process because I think laughter helps a lot um in achieving um – not necessarily in achieving normal birth but in just making this feel like it's not as intense as it is in just trying to lighten the mood a little bit... if you can make them laugh at some point during the process it just lifts it a little bit, it just breaks that tension that's in the room sometimes so I always try and crack a joke if I can – (laughs) appropriately.</i></p>	10.207 -223

Pressure on birth	Society	<i>...so there's a lot of pressure put on births, there's an awful lot of pressure put on births especially in modern society and I think there's a lot of pressure certainly in certain bits of society there's a lot of pressure put on women to achieve a normal birth and obviously ultimately that's the best thing for mum and for baby in terms of health outcome but I think putting too much pressure on oneself isn't necessarily all that helpful and I think if you can be relaxed and maybe even have a laugh occasionally during the process it does help an awful lot.</i>	11.237-244
	Women	<i>But certainly within the sort of middle class range of women there's a lot of emphasis placed on having the perfect birth and I think that obviously that's fantastic and obviously education is hugely important but at the same time when women put too much pressure on themselves to have this perfect birth that they come in and they are so tense and they are so 'I want this, I want that and I want the other' that it's – you've got to chill out then,</i>	12. 254-259
	Fashion	<i>I think we think it's recent (pressure on birth) but I don't think it is recent at all. I think people have put pressure on women about how they give birth for centuries it just depends on the fashion at the time as regards to how they put pressure on them but I think women have always had pressure on them about how they are supposed to give birth and in what particular way...</i>	11. 247-251

### 5.1.6 Susan

Susan was a Band 7 Midwife, with more than thirty years' of midwifery practice. She had extensive experience of all aspects of normal birth and was one of the original team of midwives who established the AMU. She was approaching the end of her midwifery career. Her interview was very relaxed and lasted forty-seven minutes. Figure 8 presents the themes that emerged from Susan's interview.

Figure 8: Emergent super-ordinate and sub-ordinate themes from Susan's interview



Susan's extensive experience as a midwife promoting normal birth in the AMU was captured during the initial stages of her interview when she said '*I've been doing it for so long it's like a second skin to me now*', this implies that she was very comfortable in her role. When asked about her feelings about normal birth she responded:

*... but for me personally I think it's a normal event in somebody's life and give that woman that opportunity to let her body do what needs to be done we are here just to facilitate the birth.*

It can be surmised that Susan believed in enabling the normal physiological processes of birth and that she perceived her role as facilitative rather than controlling. This theme of mother-midwife mutuality recurred throughout her transcript:

*For me I find it a privilege now to be alongside a woman, yes I'm the professional but it's her experience and I'm just walking alongside with her with my professional hat and I intervene but at the end of the day*



*with normal, with normality they come in you create that rapport with them...*

*...but I see that as my role as well I'm not a bystander, I'm in it with you, you're going to have the baby but I'm here with you so that's my encouragement*

Susan again referred to her alliance with women, '*walking alongside them*' and '*not being a bystander*' yet, she retains her professional persona through wearing her '*professional hat*'.

Susan's transcript also revealed an imbalance within the mother-midwife relationship, where she appeared to separate herself from women:

*I want to look after them, I want them to have a good time, and I'll be honest not all of the women are easy to care for but that's neither here nor there I'm here to do a job, I want the woman to have a good experience, I want her to trust me, I want her to know she's in safe hands.*

*...it's up to me to create that relationship it isn't up to them they have come as a client or lady, whatever word you want to use – it's me, it's my place to make them feel comfortable it's my place to make them feel as if they can trust me and that they are in safe hands.*

Susan is clear that whilst she wanted to facilitate a '*good time*' for women during birth she is also separating herself from them. Employing the double hermeneutic, it can be construed that Susan experiences professional and personal tensions as it appears that it is not always easy for her to build a mutually constructive relationship and that not all women '*are easy to care for*'. She proceeds to say, '*but that's neither here nor there I'm here to do a job*', I consider that this statement could be classified as a '*suggestive gem*' (Smith 2011b), because Susan appeared to be suggesting that the fact that some women are more difficult to establish a relationship with than others is not relevant as she is '*here to do a job*'. This may be interpreted to mean that she wears her professional persona not just as a hat but also as a shield to protect her from women who are '*difficult to care for*'.

Susan also appeared to take her personal responsibility for establishing a relationship with women during birth very seriously repeating '*it's up to me*' positioning herself in her '*place*'. The place where Susan resides can be considered different to that in which the woman resides which may make the establishment of a mutually beneficial relationship more difficult.

Susan also referred to '*her safe hands*'. The theme of safety also appeared to be prevalent throughout her transcript, it is often discussed at the same time as material choice suggesting that she experienced a tension between the two:

*...so I'm open to anything, within reason, and when I say within reason it's got to be safe, safe for mum and safe for baby and safe for me because as a professional you've got to keep yourself safe...*

It can be surmised here that Susan wished to facilitate maternal choice '*within reason*', meaning that '*it's got to be safe*', safe for both the woman and for Susan. She had a very clear understanding of her professional responsibility stating:

*...whatever she wants can I give that to her within the bounds of safety where her baby is concerned and herself is concerned and also herself – I'll always say a midwife must – it isn't just about mum and baby it's about you, this is your profession and you have to be safe. If you're an unsafe midwife, then that's no good you've got to work within the remits of your profession*

Susan referred to the '*remits*' of her profession which can be interpreted to mean her professional boundaries, which led onto another strong theme that appeared to emerge, which was boundary lines. She was very aware of her professional boundaries and the consequences of crossing them:

*...we've got remits that we have to work within and if we step out of those remits and things happen then we've left ourselves wide open to criticism or even litigation so I'm very aware of that...*

However, conversely, she also felt that because of the location of the AMU she could push those boundaries:

*but for me I wouldn't advocate it for anybody else but for me I think 'yes she will do, she will do it' so I might sort of just push the boundary lines a bit further because of my experience whereas if I was on a standalone unit and I had to transfer the woman I probably wouldn't ...*

*but if that lady is in second stage and I know she's going to deliver and it's only thin meconium again I may push the boundary lines again I'm not expecting it of anybody else, I'm only expecting it of myself because I've only to answer to myself*

When making sense of these accounts Susan appeared to be experiencing tensions between facilitating normal birth and the boundaries she felt she was contained by.

The influence of the media on maternal choice and maternal expectation about birth also appeared to be a strong theme:

*... I sometimes joke and say 'listen, this isn't soap land' on the soaps they have one contraction and the waters break and the baby's here and sometimes it's getting them back to perspective this now is reality and what we see in the media isn't always what happens in life...*

*... I think as I said I mentioned about soap land they see all these programmes, they'll say to you 'oh this is going on a long time is this normal?' and I'll say 'yes' and sometimes they'll mention they've been watching 'One Born every Minute'... they've edited it that's not the reality of it'*

The reference to not being 'Soap land' implied that the fictional portrayal of birth by the media is influential upon maternal expectations of birth. It may also be suggested that these expectations may also have an influence on women's birth choices, the birth choices that Susan appeared to hope were 'within reason'.

Susan's transcript suggested that she cares very deeply about promoting normal birth and enabling women to be supported to receive the care and normal birth experience that they choose; she would even privilege their needs above her own personal needs 'so now they can do whatever they want to do I'm quite happy with whatever they want to do, if they want to be on the floor even though it might be a bit hard for me to get up off the floor with them'. However, it appeared that she experienced significant tensions between managing maternal expectation, facilitating maternal choice, pushing the boundary lines whilst simultaneously working within her 'remit' and maintaining safety for herself and the women and babies in her care. Table 11 presents the super-ordinate and sub-ordinate themes that emerged from Susan's transcript.

Table 11: Super-ordinate and sub-ordinate themes that emerged from Susan’s transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Ownership of Birth	Mother-Midwife mutuality	<i>they need you but they are going to do it and I like to think that we work together sort of thing, we’re working together your body’s doing it I want you to do what you want to do</i>	3. 55-57
		<i>...but I see that as my role as well I’m not a bystander, I’m in it with you, you’re going to have the baby but I’m here with you so that’s my encouragement</i>	6.112-114
	Women	<i>For me I find it a privilege now to be alongside a woman, yes I’m the professional but it’s her experience and I’m just walking alongside with her with my professional hat and I intervene but at the end of the day with normal, with normality they come in you create that rapport with them...</i>	3.49-52
		<i>I think things have changed because women change, the media changes, they are more informed, they know what their rights are, they read a lot more...</i>	14.311-312
Midwives		<i>In the years’ of doing midwifery I look back now and yes in the early 80’s, 90’s women just came in and had their babies they didn’t have any idea of what they wanted, how they wanted it, it was more or less we directed them and told them now we don’t tell them, in some cases they tell us what they want which is a good thing within reason because it is their experience...</i>	14.313-317
		<i>so now they can do whatever they want to do I’m quite happy with whatever they want to do, if they want to be on the floor even though it might be a bit hard for me to get up off the floor with them...</i>	15.328-331
Midwives		<i>I want to look after them, I want them to have a good time, and I’ll be honest not all of the women are easy to care for but that’s neither here nor there I’m here to do a job, I want the woman to have a good experience, I want her to trust me...</i>	4.73-76
		<i>... sometimes it’s hard, sometimes we have a bit of tears, sometimes they say ‘I can’t do it, I can’t do it’ but that’s why I’m there to say ‘yes you can’ I’m her advocate, I’m the one that encourages her that says ‘come on we’re going to do this together’ because for me it’s almost sometimes I think ‘gosh I feel as if I’ve just had that baby!’ because it’s that working together and that’s an achievement for me when I see her with the baby in her arms, she’s done the work but it’s also an achievement for me as well.</i>	4. 78-85
		<i>...it’s up to me to create that relationship it isn’t up to them they have come as a client or lady, whatever word you want to use – it’s me, it’s my place to make them feel comfortable...</i>	9.190-192

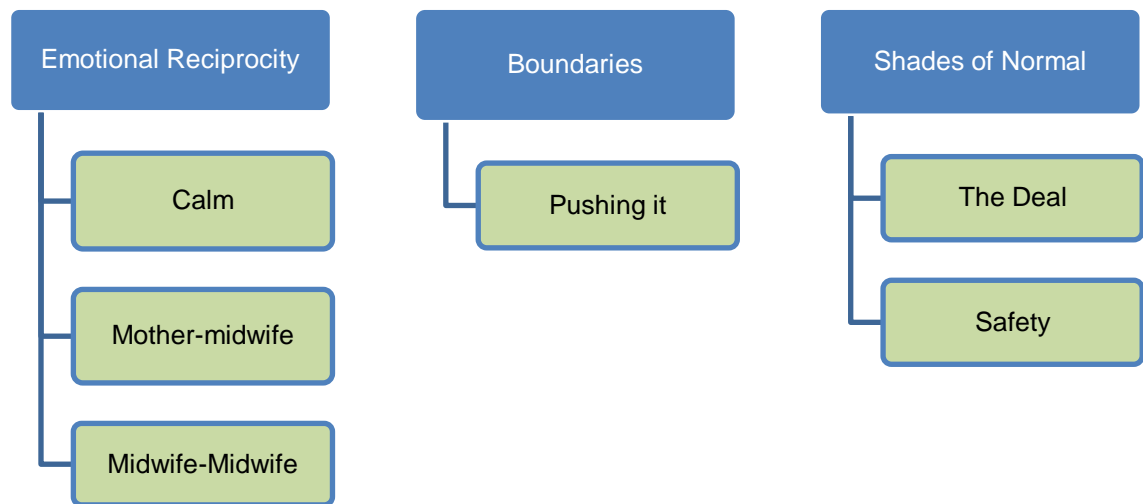
	The Media	<p><i>However, if things are not as they should be then we need to take action because it's no good having this fairy tale illusion that everything is going to run smoothly – I don't know,</i></p> <p><i>... I sometimes joke and say 'listen, this isn't soap land' on the soaps they have one contraction and the waters break and the baby's here and sometimes it's getting them back to perspective this now is reality and what we see in the media isn't always what happens in life...</i></p> <p><i>... I think as I said I mentioned about soap land they see all these programmes, they'll say to you 'oh this is going on a long time is this normal?' and I'll say 'yes' and sometimes they'll mention they've been watching 'One Born every Minute' and I'll say 'but you just think about that now, that's an hour's programme, you see the beginning the woman comes in, she's all laughs and smiles and you see the end and she's got the baby but they've edited it that's not the reality of it'.</i></p>	<p>6.122-124</p> <p>9.180-184</p> <p>12. 268-274</p>
Boundary lines	Practice Boundaries	<p><i>...we've got remits that we have to work within and if we step out of those remits and things happen then we've left ourselves wide open to criticism or even litigation so I'm very aware of that...</i></p> <p><i>but for me I wouldn't advocate it for anybody else but for me I think 'yes she will do, she will do it' so I might sort of just push the boundary lines a bit further because of my experience whereas if I was on a standalone unit and I had to transfer the woman I probably wouldn't ...</i></p> <p><i>but if that lady is in second stage and I know she's going to deliver and it's only thin meconium again I may push the boundary lines again I'm not expecting it of anybody else, I'm only expecting it of myself because I've only to answer to myself</i></p>	<p>16.342-344</p> <p>17.369-372</p> <p>17. 375-378</p>
		Physical Boundaries	<p><i>I feel as if we've been swallowed up a bit by the delivery suite because we've had new management and different people come in and maybe they haven't got the passion for birth centres, maybe they believe that women should have some additional help...</i></p>

Safety	Mother and Baby	<i>...so I'm open to anything, within reason, and when I say within reason it's got to be safe, safe for mum and safe for baby and safe for me because as a professional you've got to keep yourself safe... but if it's safe for the mum, safe for the baby as long as I can listen in to that baby and know that that baby is happy you can do whatever you want, if you want to stand on your head that's fine</i>	16. 340-347
	Midwife	<i>...I want her to know she's in safe hands...  ...it's my place to make them feel as if they can trust me and that they are in safe hands...  ...whatever she wants can I give that to her within the bounds of safety where her baby is concerned and herself is concerned and also herself – I'll always say a midwife must – it isn't just about mum and baby it's about you, this is your profession and you have to be safe. If you're an unsafe midwife then that's no good you've got to work within the remits of your profession, so those things are very important and if there is something that isn't quite what you would like I think you have to discuss it with the lady ask her 'why do you want to do this?' and see what her reasons are, you can't be dogmatic and say 'well you've got to have it' in this day and age that's not happening at all so I think discussion is important, communication is very, very important.</i>	4. 77 9.193 18. 403-413

### 5.1.7 Anna

In contrast to Susan, Anna was a newly qualified Band 5 Midwife, with less than twelve months post qualification experience of promoting normal birth, consequently her interview was shorter in duration than the others and lasted twenty-two minutes. Figure 9 presents the themes that emerged from Anna's interview.

Figure 9: Emergent super-ordinate and sub-ordinate themes from Anna's interview



When asked about her thoughts about promoting normal birth Anna responded:

*'I think that one of the most important jobs as a midwife is to promote normality... I'm very pro – even with a woman with an epidural on the delivery suite can have normality in there, it's just a different kind of normal as long as it's a normal that makes her feel safe'*

TD: When you say 'feel safe' what do you mean by safe?

*I think that it's a very different atmosphere from a birth centre to a delivery suite. On the birth centre – I wouldn't say that we're relaxed because you're not relaxed but you're in a very calm, safe environment where we're relaxed because we're not expecting anything to be wrong*

In the above exchange Anna was clearly motivated to promote normal birth and alluded to there being different kinds of normal. Interestingly she suggested that '*normal*' needs to make the woman feel safe. There appears to be an implication here that normal may not make all women feel safe in some circumstances. When asked to describe what she meant by '*safe*' Anna appeared to find this difficult as she contradicted herself, stating that the atmosphere on the AMU is relaxed but also not relaxed. Anna appeared to equate relaxation and calm with safety.

During her interview Anna continued the notion of being relaxed and brought a new dimension to the concept of emotional reciprocity because Anna alluded to the affects that the other midwives in the AMU team had upon her own practice, this in turn affected her relationship with the woman she was with:

*...I find that I was instantly more relaxed because I knew I had a supportive team around me so because I was instantly more relaxed with the women and making the atmosphere more relaxed because I was relaxed myself that impacted on the women...*

It can be further surmised that the quality of emotional reciprocity between midwives had the potential to influence the quality of emotional reciprocity between midwives and mothers. Anna appeared to regard the reciprocal exchange of the emotional state of calm as particularly important:

*... I'd say calm more than anything if you're calm... and sometimes you just need to give them a smile...and look really calm and then if she's calm then we can be calm, that kind of confidence to look calm or even look calm when you don't feel particularly calm...*

Anna repeated the word calm seven times which would suggest that she wished to add emphasis to her meaning. When discussing an earlier experience of prompting normal birth Anna again mentioned calm in her description of a woman '*she was really relaxed, calm, chatty, lovely ... we really clicked*'. When interpreting Anna's meaning here it can be implied that she felt positively about the state of maternal calm and that it may have contributed to her ability to '*click*' with the woman in this scenario.

When asked if she felt comfortable promoting normal birth in the AMU Anna responded, '*Yes, I love it, I love our centre. I like women coming in and getting what they expected out of the deal*'. Anna was passionate about normal birth promotion and alluded to women getting what they expected from '*the deal*'. Anna's use of the noun '*the deal*' was interesting and could be considered a hidden gem (Smith 2011b). The deal could be interpreted as the often unspoken mutually beneficial relationship or contract that is established between a midwife and a woman where maternal expectation is supported and realised, where possible, by the midwife or the wider maternity service.

Another superordinate theme that appeared to emerge from this transcript was 'boundaries'. This was revealed when Anna was asked to consider any concerns she



had about promoting normal birth in the AMU, she commented; *'I suppose after reading things like Morecombe Bay there's always a bit like okay you have to be careful how far you push it...'* It would seem that Anna's practice had been affected by the findings of the Morecombe Bay enquiry and that she was *'careful how far to 'push it'*. It can be surmised that *'it'* is referring to normal birth. Anna further commented:

*...I don't think you can push it too far either way at the end of the day it's what's safe for the mother and the baby you can't do it for your own need, just because I like normality I can't keep a woman normal...*

When interpreting Anna's meaning making in the above excerpt it can be suggested that she considered maternal and neonatal safety to be paramount and that the promotion of normal birth should always be conducted with this premise in mind and not to fulfil her own needs or desires for normality. Table 12 presents the super-ordinate and sub-ordinate themes that emerged from Anna's transcript.

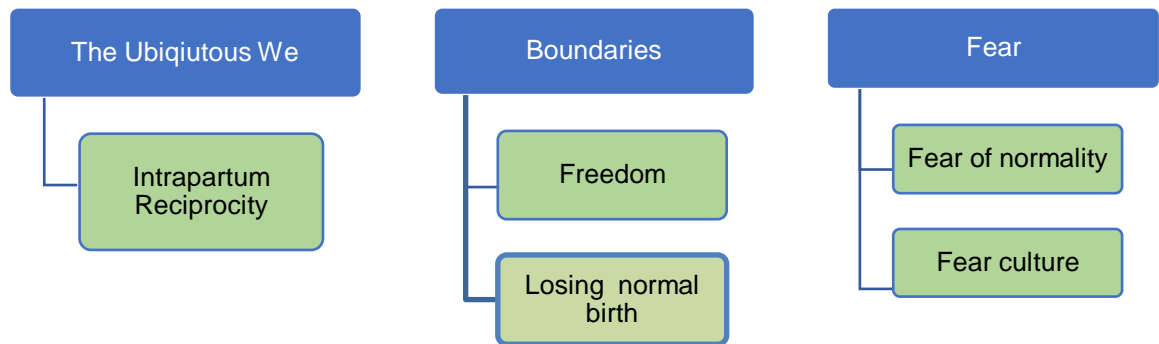
Table 12: Super-ordinate and sub-ordinate themes that emerged from Anna's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Emotional Reciprocity	Calm	<i>... I'd say calm more than anything if you're calm... and sometimes you just need to give them a smile...and look really calm and then if she's calm then we can be calm, that kind of confidence to look calm or even look calm when you don't feel particularly calm</i>	12.240-248
	Mother-Midwife	<i>and she was really relaxed, calm, chatty, lovely ... we really clicked..</i>	6.122
	Midwife-Midwife	<i>especially as a newly qualified midwife I find that I was instantly more relaxed because I knew I had a supportive team around me so because I was instantly more relaxed with the women and making the atmosphere more relaxed because I was relaxed myself that impacted on the women</i>	4. 69-72
Boundaries	Pushing it	<i>... I suppose after reading things like Morecombe Bay there's always a bit like okay you have to be careful how far you push it...</i>	9.185-186
		<i>I think at the (Trust name withheld) anyway I've had a really nice balance of normal and not normal and how to keep women as normal as possible without pushing it...</i>	13.259-260
		<i>...I don't think you can push it too far either way at the end of the day it's what's safe for the mother and the baby you can't do it for your own need, just because I like normality I can't keep a woman normal...</i>	13.266-268
Shades of normal	The Deal	<i>...that's probably how I'd see normal but everyone's normal is different. Some women who've had 3 previous caesarean sections come in for their 4<sup>th</sup>, that's normal birth so.</i> <i>I like women coming in and getting what they expected out of the deal, I like them coming in and walking away and being really satisfied with themselves that they did it</i>	6.103-105 9.176-178
	Safety	<i>because I'm very pro – even with a woman with an epidural on the delivery suite can have normality in there it's just a different kind of normal as long as it's a normal that makes her feel safe.</i>	3.41-43

### 5.1.8 Laura

Laura was a band 6 midwife, who had worked intermittently on the AMU for the past five years but continuously for the last two years. Her interview was not as relaxed as some of the others as Laura appeared a little tense and melancholy. Her interview lasted 44 minutes. Figure 10 presents the themes that emerged from Laura's interview.

Figure 10: Emergent super-ordinate and sub-ordinate themes from Laura's interview



When asked about her feelings about promoting normal birth Laura responded:

*'I am pro being an advocate for women, I'm pro on what she chooses and supporting her to have a normal birth and I feel personally sometimes as a profession you can try and – not steal normal birth off a woman is a bad turn of phrase but intervene too much and so I feel that sometimes quite sad that we do lose normal birth quite a lot.'*

When interpreting Laura's meaning in the above extract, she appears to be having difficulty finding the words to describe how she perceives the promotion of normal birth to be, using the metaphor to steal normal birth but then contradicting herself replacing 'steal' with 'intervene'. She also expresses feelings of sadness that 'we lose normal birth a lot'. Laura does not expand on what she means by 'lose normal birth', it is however possible to surmise that she means that some women do not always achieve a normal birth due to too much intervention.

As Laura's interview progressed, she described what it was like for her working in the AMU, she commented:

*'But that is what I love about the birth centre is no one intervenes unless you absolutely have to and the women are just free to move as they want to...'*

TD: when you were talking about women being free – can you tell me a bit more what free looks like?

*free – just – to me – I keep going back to intervention and things but a free woman is one who is trusting her body and is not scared of the process and is free to move around, is free to adopt whatever position she wants, is free to do whatever she wants to do in her birth environment, have the people there that she wants there, is free with – has not got any inhibitions – is that the right word?*

In the above exchange Laura began by stating ‘*free just to be me*’, this may mean that she herself was free as well as the woman being free. She then proceeded to describe the different aspects of maternal freedom repeating the word ‘*free*’, six times. Laura’s use of the juxtaposing custodial metaphors ‘*free to birth*’ and ‘*robbed of a normal birth*’ may be a creative medium through which she is trying to make sense of her experiences and illuminate her world. The use of the opposing metaphors suggests that she experiences a dichotomy and tensions in her practice. Laura uses another term to continue her description of maternal freedom stating:

*...you can just see the positivity here because we are not intervening with her all the time so she has the facility to just – it’s all about hormones isn’t it, about being relaxed...*

Laura described the woman as having ‘*the facility to just...*’ facility implies a broader meaning to freedom, but Laura did not finish her sentence which may indicate she found her thoughts difficult to articulate.

When further describing her experiences of promoting normal birth Laura emphasised the effects of mutual mother-midwife calm and stress:

*If a woman’s relaxed... you automatically feel more relaxed if a woman is stressed even if you as a midwife clinically are not stressed about the situation you get stressed because you’re spending time trying to calm the woman down and trying to make her more relaxed so if she is relaxed – it’s like a cycle, then the midwife is more likely to be relaxed and so you’re more likely to have a more positive birth experience for both of us, I mean we’re there to share the woman’s birth experience*

Above Laura alluded to the emotional reciprocal exchange that can occur between a woman and a midwife during birth and how she experienced this as ‘*a cycle*’. She further alluded to the beneficial impact that this ‘positive feedback’ exchange could have on the mutual birth experience. When Laura

concluded '*I mean we're there to share the woman's birth experience*' it is possible to suggest that this sharing is at both a physical and emotional level.

When asked if she considered there to be any advantages to promoting normal birth in an AMU Laura responded:

*...I think, sometimes we stretch our guidelines quite a lot... I think in a way you can push the boundaries a bit because you know the delivery suite is just next door... you know you can get help quickly... so it's always nice having that little safety blanket next door...*

Laura's practice appears to be less restricted by guidelines and boundaries because she was supported by the metaphorical '*safety blanket next door*'. *Next door* being taken to mean the Consultant Unit labour ward. It can further be surmised that Laura may have considered guidelines and boundaries to be constraining as she felt the need to *stretch* and *push* them.

When asked about any possible disadvantages or potential challenges that she may have experienced when promoting normal birth Laura said:

*...with a primip I think sometimes you get a bit frightened that the unknown even though every birth is different and there's no reason – I don't know it's probably a psychological thing.*

Laura alluded here to being frightened by the unpredictable nature of birth, particularly with a *primip* (a woman having her first baby). When trying to make sense of her fear she suggested '*it's probably a psychological thing*', she does not go into any greater depth about her fear almost implying that because it is psychological it is perhaps not important. As the interview progressed Laura continued this theme of fear:

*for myself – again probably back to the defensive practice in a way I get twitched about some things and I get anxious about some things I think of all the bad scenarios in my head of this of me pushing for this woman to push for longer and she ends up having a postpartum haemorrhage and I just feel like I give myself to the system rather than to the woman because I feel like I'm so worried that if something bad happened that it would come back on me and it would be 'you didn't follow the guidelines' do you know what I mean?*

Here, she is trying, once again, to make sense of her fear. There appeared to be a clear contrast in her relationship with the boundaries she was pushing earlier; in this account Laura seems to be fearful of pushing them and gives herself to '*the system*

*rather than to the woman*'. When interpreting Laura's meaning making it can be suggested that there appears to be a very strong undercurrent of tension that she experiences between meeting the individual needs of the woman, following the guidelines and honouring the needs of the system. All these factors may have contributed to Laura's sad and melancholy demeanour. Table 13 presents the super-ordinate and sub-ordinate themes that emerged from Laura's transcript.

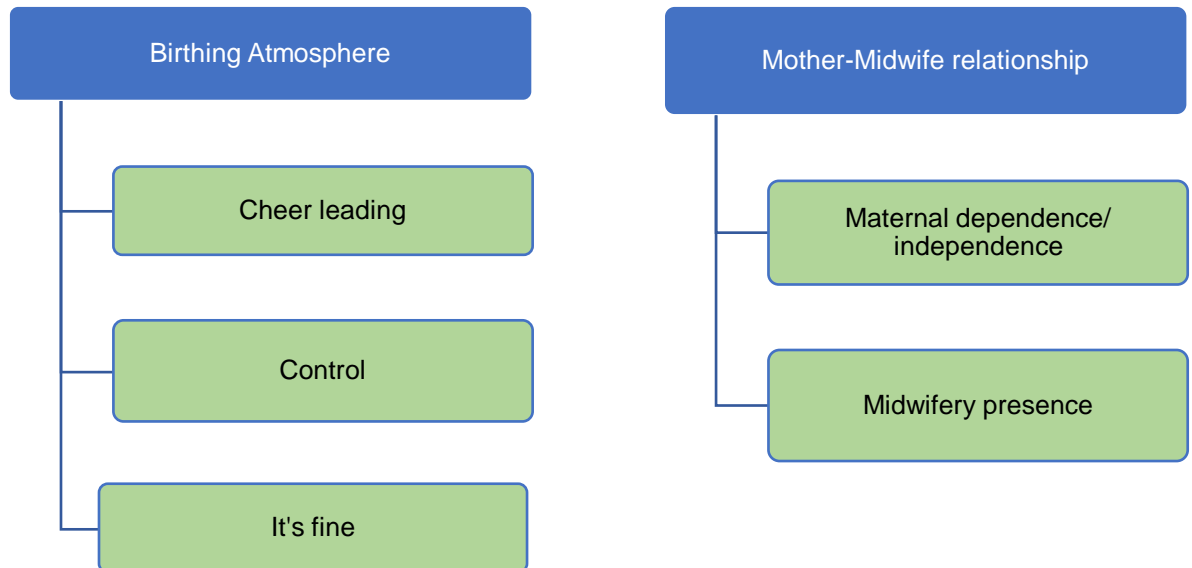
Table 13: Super-ordinate and sub-ordinate themes that emerged from Laura's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
The Ubiquitous We	Intrapartum Reciprocity	<i>If a woman's relaxed in whatever situation you automatically feel more relaxed if a woman is stressed even if you as a midwife clinically are not stressed about the situation you get stressed because you're spending time trying to calm the woman down and trying to make her more relaxed so if she is relaxed – it's like a cycle, then the midwife is more likely to be relaxed and so you're more likely to have a more positive birth experience for both of us, I mean we're there to share the woman's birth experience really</i>	10. 221-227
Boundaries	Freedom	<i>the women are just free to move as they want to and that was nice too</i>	5.108
		<i>...the woman's free to birth rather than ... but it's a bit freer, the boundaries are a little bit more relaxed</i>	6.121-126
		<i>free – just – to me – ...a free woman is one who is trusting her body and is not scared of the process and is free to move around, is free to adopt whatever position she wants, is free to do whatever she wants to do in her birth environment, have the people there that she wants there, is free with... she's free to be however she wants to be, however she naturally wants to be rather than trying to act in a certain way</i>	11. 236-245
		<i>...because I think in a way you can push the boundaries a bit because you know the delivery suite is just next door...</i>	16.359-360
	losing normal birth	<i>... I feel personally sometimes as a profession you can try and – not steal normal birth off a woman is a bad term of phrase but intervene too much and so I feel that sometimes quite sad that we do lose normal birth quite a lot.</i>	3. 48-50
Fear	Fear of normality	<i>some midwives who've been on delivery suite for years' and years' and years' are frightened of normality and frightened of intermittent auscultation</i>	6.133
		<i>with a primip I think sometimes you get a bit frightened that the unknown even though every birth is different and there's no reason – I don't know it's probably a psychological thing</i>	13.286-288
		<i>a lot of midwives are frightened almost of low risk next door</i>	17.384
	Fear culture	<i>...a lot of it's the fear culture</i>	7.139

### 5.1.9 Jenny

Jenny was a Band 6 midwife with between five and ten years' midwifery experience, who was deeply passionate about the promotion of normal birth. She was a very contemplative and reflective individual, consequently, her interview was very relaxed and punctuated by long pauses; Jenny's interview was my longest, it lasted sixty-four minutes. Figure 11 presents the themes that emerged from Jenny's interview.

Figure 11: Emergent super-ordinate and sub-ordinate themes from Jenny's interview



When asked about her feelings about prompting normal birth Jenny responded:

*It's where I feel most comfortable and it's where I feel most competent and most confident. I feel I just automatically assume normal and healthy unless proven otherwise...*

Jenny appears not to experience any uncertainty about promoting normal birth.

A predominant theme that emerged during Jenny's interview was the influence and importance of the birthing atmosphere. She appeared particularly concerned about the influence of other midwives entering the birthing atmosphere that she created:

*depending on who the midwife is the atmosphere can completely change in that some midwives are very vocal and very cheer leaderey and I'm sure it's difficult for the woman to focus on who she's supposed to be listening to because it's difficult when it's just me and a relative sometimes because you've got the mother saying one thing and the*



*woman not knowing whether to listen her or me so I do find it difficult if it changes the atmosphere...*

*...it was a shame that the atmosphere changed, it changed from being 'yes she's having this baby it's fine and it's lovely' to somebody shouting at her to have this baby or cheering her on when she didn't actually need it she was doing it...*

Jenny likens the support and encouragement that some midwives give to being overly enthusiastic, as a cheer leader might be, which she perceived negatively. She appeared to feel that the 'shouting' cheer leading is not required and that women do not need this level of encouragement as women are capable of giving birth without it. On a deeper level it can be surmised that Jenny sees the power and control over birth as the woman's and not the midwife's. She continued:

*I can remember lots of incidences I'd say where the second one comes in and you think 'you didn't need to be quite so loud in that room' and I think if I was a fly on the wall I wouldn't know who's in charge of this, who's actually the one that's taking charge and I think if you can't tell then the woman doesn't know who to listen to.*

Jenny questioned the power balance in the birthing room assuming that those midwives who are loud are perceived as being 'in charge' or 'taking charge' instead of either herself or the woman. This theme of cheer leading and its influence on control continued:

*I've found it hard sometimes like I say with relatives because of course they are definitely cheer leading a lot of the time but there might be 3 of them there and you think 'she's listening to 4 voices, who is she supposed to listen to' and I'm quite confident in saying the woman's name and 'come on listen to me'.*

Here Jenny is considering control within the birthing room and demonstrating her ability to gain control by directly asking the woman to listen to her voice.

Further in the transcript Jenny recounted an experience she had supporting a woman during a normal birth from which the super-ordinate theme of the mother-midwife relationship emerged:

*she just followed her body and she needed me to – when she was clearly second stage and she was a bit panicky she needed me to just say 'it's fine, you're fine the baby's fine' and then she wasn't so panicky but she didn't need me to tell her to do anything that to me is normal if she does need me for anything she knows how to ask but she didn't need, she just followed what her body was doing anyway – that's normal*

Here Jenny appeared to be making sense of her relationship with a woman as an interplay of maternal independence and dependence, where Jenny was required to say 'it's fine' as a form of reassurance but not required to physically do anything. Jenny alluded to a hidden understanding between herself and the woman whereby if the woman needed her 'for anything she knows how to ask'. It would appear that this hidden understanding between a mother and a midwife enabled the woman to adopt instinctive behaviours, behaviours that Jenny considered to be 'normal'.

Later, Jenny described a further experience of promoting normal birth with a woman whose spoken English was limited. The woman was accompanied by relatives who did speak English:

*...I was in and out, I wasn't there all the time and she was fine with that because she'd got really good support ... and then I came into the room, ...and the mother in law was a little bit aggressive in that she said 'can you stay in here' and she said it via the aunt, she obviously didn't like that the last time I'd left she hadn't liked it,.. but as soon as I was there she relaxed, she was fine and there was just a lot of love and gratitude in the room afterwards and it was lovely, so it was a nice normal birth as it's supposed to be*

TD: when you say a lovely, what does a lovely birth look like?

*That she followed her body, I didn't examine her to diagnose second stage, I didn't examine her to diagnose established labour she clearly needed me there...*

In the above excerpt Jenny described the impact that her absence and presence in the birthing room had upon the woman in her care and upon the relatives. From this it can be assumed that Jenny's presence had a positive impact and her absence had the reverse. Jenny describes the woman as being 'fine' when she was there.

The subordinate theme of 'it's fine' emerged from the numerous occasions on which Jenny used this adjective throughout her transcript when discussing her experiences of promoting normal birth in the AMU. When describing her experience of supporting a woman who was having a long latent phase of labour Jenny commented:

*...but now it's a much calmer atmosphere and hopefully that is at least in part because my atmosphere is 'it's fine, yes it might be frustrating but it's fine, this will end it just isn't time yet'*

*she's fine there's no reason to do anything else this is taking longer than she wants it to but there's no reason to do anything else it will come to*

*fruition at some point and I think it also puts it across to the relatives if my way of being with them is 'it's fine, yes it's frustrating but it's fine...*

Here Jenny described both her *atmosphere* and her *way of being* as *it's fine*. When interpreting this it may be suggested that Jenny intends to engineer a state of calm, and reassurance, because she reinforces the message that everything is *fine* to both women and their relatives. Fine is a much-used adjective which implies that all is well, however, it is also commonly used as a nonspecific response which has a closed and finite quality, indeed the word fine is said to originate from the Latin *finis* which means a border, limit or end. It may therefore be suggested that Jenny's prolific use of *fine* may be a subconscious act to limit questions from women and relatives and consequently it may not be as reassuring as it is intended to be. Table 14 presents the super-ordinate and sub-ordinate themes that emerged from Jenny's transcript.

Table 14: Super-ordinate and sub-ordinate themes that emerged from Jenny's transcript with supporting quotations

Super-ordinate Themes	Sub-ordinate Themes	Quotes	Page and line number
Birthing Atmosphere	Cheer Leading	<p><i>...so you've got a second midwife in and depending on who the midwife is the atmosphere can completely change in that some midwives are very vocal and very cheer leaderey and I'm sure it's difficult for the woman to focus on who she's supposed to be listening to...</i></p> <p><i>it bothered me a bit, it was a shame that the atmosphere changed, it changed from being 'yes she's having this baby it's fine and it's lovely' to somebody shouting at her to have this baby or cheering her on when she didn't actually need it, she was doing it.</i></p> <p><i>but some midwives are sort of like it even if you don't need it, they wouldn't think 'do I need to be cheer leading her it's coming anyway'</i></p> <p><i>Yes, I've found it hard sometimes like I say with relatives because of course they are definitely cheer leading a lot of the time but there might be 3 of them there and you think 'she's listening to 4 voices, who is she supposed to listen to'...</i></p>	<p>7. 148-151</p> <p>8. 170-173</p> <p>8.179-181</p> <p>9.199-201</p>
	Control	<p><i>...and I think if I was a fly on the wall I wouldn't know who's in charge of this, who's actually the one that's taking charge and I think if you can't tell then the woman doesn't know who to listen to...</i></p>	9. 195-197
	It's fine	<p><i>she needed me to just say 'it's fine, you're fine the baby's fine'...</i></p> <p><i>patience, trust and confidence that it will be fine</i></p> <p><i>the atmosphere now is fine, the atmosphere now is early labour, she's clearly in early labour so I think what's helped her is I've had long discussions with her about 'this is frustrating, this stage can be frustrating, but it will be okay, you're fine, the baby's fine. I know you're tired but you're obs are fine, the baby's heart rate's fine'.</i></p> <p><i>...but now it's a much calmer atmosphere and hopefully that is at least in part because my atmosphere is 'it's fine, yes it might be frustrating but it's fine, this will end it just isn't time yet'</i></p> <p><i>she's fine there's no reason to do anything else this is taking longer than she wants it to but there's no reason to do anything else it will come to fruition at some point and I think it also puts it across to the relatives if my way of being with them is 'it's fine, yes it's frustrating but it's fine...</i></p> <p><i>...that sort of midwife may not get across the normality of this is fine, this is normal early labour, you're fine the baby's fine the best place for you is at home, there'll be a point when you won't want to be at home and then you come back and if that's in half an hour then that's fine but there are midwives who don't really understand that because it's just not where they've trained or where they've come from.</i></p>	<p>12. 256</p> <p>12. 262</p> <p>13. 277-281</p> <p>13. 286-288</p> <p>13. 291- 294</p> <p>18.396-401</p>

Mother-Midwife Relationship	Maternal dependence/ independence	<i>...in the short term she just followed her body and she needed me to – when she was clearly second stage and she was a bit panicky she needed me ... but she didn't need me to tell her to do anything that to me is normal if she does need me for anything she knows how to ask but she didn't need, she just followed what her body was doing anyway – that's normal.</i>	12. 254-259
	Midwifery presence	<i>but as soon as I was there she relaxed, she was fine and there was just a lot of love and gratitude in the room afterwards and it was lovely, so it was a nice normal birth as it's supposed to be.</i>	11. 238-240

## 5.2 Group Level Analysis

Having conducted in-depth idiographic analyses and identified super-ordinate and sub-ordinate themes for each individual midwife, patterns were then looked for across all the midwives' transcripts. To facilitate this process each midwife's super-ordinate and sub-ordinate themes were colour coded, they were then cut up so that each individual super and subordinate theme could be moved around. These individual themes were laid out on a large table for ease of movement and pattern recognition (Appendix Ten). The process was further assisted by using contextualisation, abstraction, polarization, numeration, subsumption and function (Smith et al 2009).

In common with many other IPA researchers I found this process challenging, but achievable because as the idiographic data was scrutinized it revealed common constellations of sub-ordinate and subsequent super-ordinate themes across the group that were representative of most of the midwives' lived experiences thus limiting any potential tensions between the individual and the group, an area of dualism that may sometimes be experienced at this point in IPA analysis (Wagstaff et al 2014).

All midwives, without exception, expressed belief, enthusiasm and positivity for the promotion of normal birth with women experiencing a low risk pregnancy birthing in the AMU; as Laura commented working in the AMU is '*like a breath of fresh air*'.

Five super-ordinate themes emerged from the data across the group: The ubiquitous we; Philosophies of practice; Boundaries; Atmosphere of birth and Maternal expectations of birth. Figure 12 illustrates the super-ordinate and sub-ordinate themes that emerged across the group. Table 15 represents the frequency of the super-ordinate themes.

Figure 12: Summary of super-ordinate and sub-ordinate themes emerging across the group

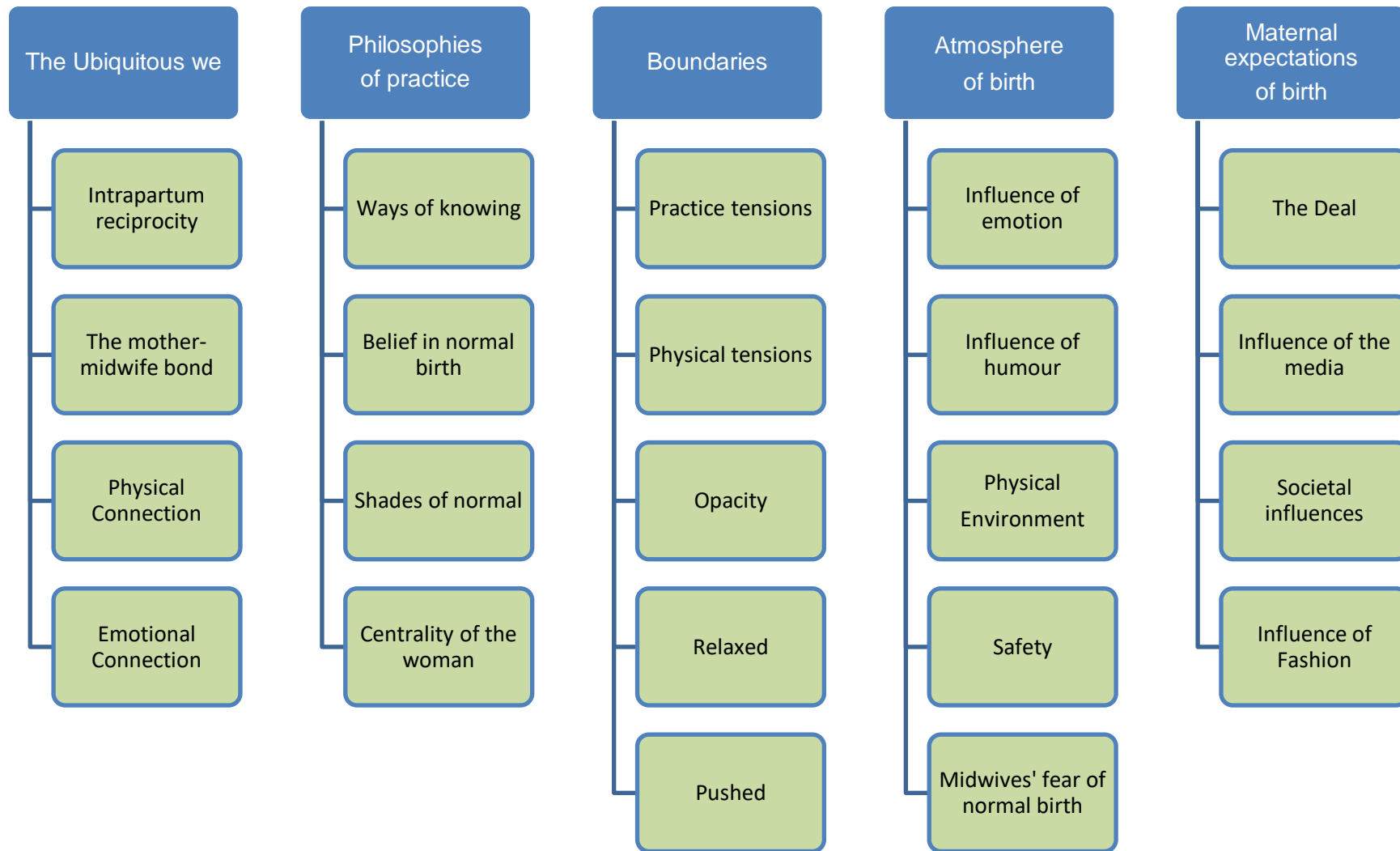


Table 15: Summary of frequency of super-ordinate themes emerging across the group

Superordinate Themes	Mary	Carol	Karen	Lilly	Holly	Susan	Anna	Laura	Jenny	Total Yes
The Ubiquitous We	NO	NO	NO	YES	YES	YES	YES	YES	YES	6
Philosophies of practice	YES	YES	YES	YES	YES	YES	YES	YES	YES	9
Boundaries	YES	YES	YES	YES	NO	YES	YES	YES	NO	7
Atmosphere of birth	YES	YES	YES	YES	YES	YES	YES	YES	YES	9
Maternal expectations of birth	YES	NO	YES	YES	YES	YES	YES	NO	NO	6



### 5.2.1 The Ubiquitous We

Lilly, Holly, Susan, Anna, Laura and Jenny considered that the reciprocal relationship that they established with women during labour was deemed pivotal in enhancing the normal birth experience for both the woman and themselves. Therefore, the ubiquitous we emerged as a super-ordinate theme. The sub-ordinate themes that subsequently emerged to support this super-ordinate theme were: Intrapartum reciprocity; the bond; physical connection; emotional connection. Two of the midwives discussed their ability to form a bond with women during birth which appeared to be central to the promotion and facilitation of normal birth. Holly suggested *'it's just the bond that you create, the relationship you build up as a midwife with the family that you are looking after'* and Anna stated *'... some women when you've built that bond with them because you're just relaxed around each other they look to you more than they look to their family and their partner because they've put their trust in you'*. It was interesting that both Anna and Holly elaborated on the bond referring to it as the 'click', Holly suggests *'...to have grown to know a woman, to have got to know a woman – and I think in any capacity I think sometimes you just click with women...'* and Anna states *'...we really clicked and when things were progressing'*. Table 16 presents the data that led to the emergence of the super-ordinate theme of the ubiquitous we.

Table 16: Quotes elucidating the emergent super-ordinate theme of the Ubiquitous We

	<b>The Ubiquitous We</b>	<b>Line</b>
Lilly	<i>...why don't we just try and have a bath, why don't we have a walk around, why don't we try some aromatherapy oils, let's get a tens machine on'</i>	6
	<i>... and I said 'right, we can't have an epidural right now so let's think of what else we can do'</i>	8
	<i>She needed me, and I was there for her</i>	98
Susan	<i>I'm in it with you, you're going to have the baby but I'm here with you</i>	112-113
Anna	<i>...we really clicked...</i>	122
	<i>...If she's calm, we can be calm...</i>	246
Holly	<i>Sometimes you just click with women–</i>	178
	<i>...they know and we know it's that harmony isn't it</i>	401
Laura	<i>... it's like a cycle, then the midwife is more likely to be relaxed and so you're more likely to have a more positive birth experience for both of us, I mean we're there to share the woman's birth experience really</i>	225-226
Jenny	<i>she needed me to just say 'it's fine, you're fine the baby's fine'</i>	256

### 5.2.2 Philosophies of Practice

All the midwives' experiences of promoting and facilitating normal birth were influenced by their individual philosophies of practice, which resulted in the identification of this as a super-ordinate theme. There were however commonly shared elements of their

individual philosophies which emerged as the sub-ordinate themes, these were; ways of knowing, belief in normal birth, shades of normal and the centrality of the woman. Table 17 presents the data that led to the emergence of the super-ordinate theme of Philosophies of Practice.

Table 17: Quotes elucidating the emergent super-ordinate theme of Philosophies of Practice

	<b>Philosophies of Practice</b>	<b>Line</b>
Lilly	<i>where I'm just a midwife again and I look after everybody and I have my own women and I love it and I think it keeps my skills, it keeps me thinking about normality...</i>	42-44
	<i>...but then people say 'would you have a breech birth' 'oh no' because I saw one that went horribly wrong and that frightens you to think what if that happens to me but I think as midwives you know too much.</i>	510-512
Susan	<i>'I've been doing it for so long it's like a second skin to me now'</i>	339
	<i>now we don't tell them, in some cases they tell us what they want which is a good thing within reason because it is their experience...</i>	316-317
	<i>I think yes, normality is what every woman should have obviously there are some women who can't come through our doors for one reason or another but for them that can let us give them every opportunity to let their body's do what their body's need to do</i>	393-396
Anna	<i>that's probably how I'd see normal but everyone's normal is different. Some women who've had 3 previous caesarean sections come in for their 4<sup>th</sup>, that's normal birth so.</i>	103-105
Holly	<i>I think the day I get tired of it (normal birth) is the day that I ought to leave midwifery, I think there's nothing like that feeling of being present at a birth when it goes right and it's what we all aim for especially on the birth centre</i>	67-69
	<i>... it is a privilege and I know it's a cliché ... and that's what midwives are constantly saying that it's a privilege to be there at the moment</i>	75-76
	<i>I think if you're going to be a midwife on the birth centre then you really need to be enthusiastic about normal child birth and about promoting normality so I think enthusiasm and knowledge about what actually works and physiology... , those things combined are hugely important in promoting normality.</i>	354-356
	<i>I think women pick up on that very, very quickly and I think they know, they look at you and they've got that knowing look of 'you're on to something' 'yes I am' but yes, women – they know and we know it's that harmony isn't it.</i>	398-341
Laura	<i>'I am pro being an advocate for women, I'm pro on what she chooses and supporting her to have a normal birth</i>	46
Jenny		

	<i>I feel I just automatically assume normal and healthy unless proven otherwise</i>	80
	<i>...so it's that confidence in knowing that she's fine there's no reason to do anything else this is taking longer than she wants it to but there's no reason to do anything else...</i>	290-292
Carol	<i>Do you know I hate that word normality because its... what does normal mean?</i>	45
	<i>I think it's knowing what happens and why things happen so early labour, if you know what's happening to that woman why she might be in and out over 36 / 48hours actually having that discussion 'this is what's happening to your body and this is what it's doing' so I think it's really important to engage that knowledge</i>	55-58
	<i>The woman and the family to be the centre, it's about her journey</i>	66
Karen	<i>so it's quite a broad term isn't it (normal birth) as people interpret it and then people might also think about being on here as keeping it normal in other words trying to keep things natural whatever that means as well...</i>	54-56
Mary	<i>committed to a philosophy where women are supported and midwives gain skill in normal birth and normal practice</i>	124

### 5.2.3 Boundaries

All the midwives, except for Holly and Jenny, appeared to experience practice tensions caused by boundaries; this resulted in 'Boundaries' being identified as a further super-ordinate theme. The boundaries took different forms which were reflected in the emergent sub-ordinate themes; practice tensions, physical tensions, opacity, pushed and relaxed. Table 18 presents the data that led to the emergence of the super-ordinate theme of Boundaries.

Table 18: Quotes elucidating the emergent super-ordinate theme of 'Boundaries'

	<b>Boundaries</b>	<b>Line</b>
Mary	<i>Recognising what normal is and having clear boundaries for what that means and a need to recognise deviation from normal because I think sometimes that becomes a bit muddied along the way.</i>	91
	<i>I do believe that you need core staff on a birth centre as you need core staff on an obstetric unit to actually carry on the philosophy of what we actually are about and what a midwifery led unit is about and I do believe that that has been eroded because of the sheer capacity of this big unit, we are not a standalone so we don't stand alone, we are part of the unit</i>	101-105
Carol	<i>... so people just come through all the time sometimes the door is propped open with a fire extinguisher, sometimes the midwives will come in and pinch our equipment because they haven't got it in room</i>	322-326

	<i>11 so you are forever battling to kind of keep your unit as your unit because it's – it's really frustrating...</i>	
Susan	<i>... I feel as if we've been swallowed up a bit by the delivery suite because we've had new management and different people come in and maybe they haven't got the passion for birth centres, maybe they believe that women should have some additional help...</i>	43-46
	<i>we've got remits that we have to work within and if we step out of those remits...</i>	342-343
	<i>but if that lady is in second stage and I know she's going to deliver and it's only thin meconium again I may push the boundary lines again I'm not expecting it of anybody else, I'm only expecting it of myself because I've only to answer to myself</i>	375-378
Anna	<i>...like okay you have to be careful how far you push it</i>	186
Lilly	<i>you're not going to trip over, you're following the guidelines</i>	245
Laura	<i>...the boundaries are a little bit more relaxed...</i>	125
	<i>...because I think in a way you can push the boundaries a bit because you know the delivery suite is just next door...</i>	359-360
Karen	<i>I know we have guidelines and so on and I don't go against the guidelines</i>	164

#### 5.2.4 Atmosphere of Birth

All the midwives without exception commented on the importance and influence of the birthing atmosphere, and the impact that it had on their experiences of promoting normal birth. This subject was, therefore, identified as a super-ordinate theme across the group. The birthing atmosphere appeared to be influenced by emotions, humour, physical environment, safety and midwives' fear of normal birth, these subsequently were identified as the sub-ordinate themes. The birthing atmosphere appeared to have a significantly positive influence on the development of the reciprocal mother-midwife relationship which in turn had a positive influence on the birthing experience for both the mother and the midwife. Table 19 presents the data that led to the emergence of the super-ordinate theme of Atmosphere of Birth.

Table 19: Quotes elucidating the emergent super-ordinate theme of 'Atmosphere of Birth'.

	<b>Atmosphere of Birth</b>	<b>Line</b>
Lilly	<i>I think that's something nice to have that atmosphere...</i>	367
	<i>I think it's also their fear because they (midwives that have been qualified 20-30year) haven't done it and they don't know how to do it, they are worried about it and that puts a stop to normality.</i>	470-471
	<i>that you're keeping people safe in that respect that people aren't in danger from anything that you're doing or not doing</i>	246-247
Holly	<i>I think atmosphere in the room is hugely important...</i>	363

	<i>but we were laughing, we were laughing during her birth...and I think that really helps because you build up that relationship...to be able to laugh in between and have a giggle with your midwife I think it makes for a big difference, I think if they can look back on their birth and think 'well that was funny'...if you can laugh during the process – I always try and appropriately be relatively humorous during the process because I think laughter helps a lot...if you can make them laugh at some point during the process it just lifts it a little bit, it just breaks that tension that's in the room sometimes so I always try and crack a joke if I can – (laughs) appropriately.</i>	207-233
Anna	<i>I think that it's a very different atmosphere from a birth centre to a delivery suite,</i>  <i>I don't think you can push it too far either way at the end of the day it's what's safe</i>	45  266
Jenny	<i>at least in part because my atmosphere is 'it's fine,..</i>	287
Susan	<i>because it's your environment and your environment has a lot to do with how you behave.</i>  <i>it's got to be safe, safe for mum and safe for baby and safe for me</i>	164  341
Laura	<i>some midwives who've been on delivery suite for years' and years' and years' are frightened of normality.</i>  <i>...because I know there's that safety blanket next door...</i>	133-134  395
Mary	<i>skill and knowing when something is not right and not sitting on an issue that is not safe to carry on with.</i>	512-513
Carol	<i>well we went from bright lights of a triage, crossing the waiting room to come to the birth centre and then actually going into quite a dim, very peaceful, music on – a kind of – I don't know, you walk on to a midwifery led unit and you tend to want to talk in a hushed voice, nobody tends to want to make too much noise</i>	154-157
Karen	<i>...so I think the atmosphere is such that you feel you can say without thinking 'oh I'm showing myself up here, someone is going to criticise me or whatever...</i>	223-225

### 5.2.5 Maternal Expectations of Birth

Lilly, Holly, Anna, Susan, Laura and Mary appeared to experience tensions which they experienced when endeavouring to meet birth expectations for some women, whilst simultaneously ensuring safe and positive birth experiences and outcomes for both the woman and her baby. Therefore, the super-ordinate theme of Maternal Expectations of Birth emerged across the group. Women's expectations of birth appeared to be influenced by the media, society and fashion and by what Anna described as '*the deaf*'. These subjects were subsequently identified as the sub-ordinate themes. Table 20 presents the data that led to the emergence of the super-ordinate theme of Maternal Expectations of Birth.

Table 20: Quotes elucidating the emergent super-ordinate theme of 'Maternal Expectations of Birth'

	<b>Expectations of Birth</b>	<b>Line</b>
Lilly	<i>I think a lot of the Asian women that come want to just get on their backs on the bed, cover up with blankets and it's like they're ill, they're in hospital 'I'm going to lie on the bed and be nursed and then push my baby out' whereas trying to encourage them 'no, get in the pool, it's okay to be naked, you're safe and this is private this is just for you and I'm the only person that's going to be here' to encourage something different than they expected and for them to feel it's okay to carry on with that is really nice.</i>	129-136
	<i>... I think women think they know and they don't they think they know what it's going to be like because they've watched these programmes and they've spoke to their mums and their sisters but actually a lot of them don't know what their cervix is...</i>	326-329
	<i>I think more birth programmes are showing water births but instead of showing people strapped to a bed on a monitor and the dramatic music and the doctors come and save the day, they need to show a midwife sat on a birthing ball giving somebody a massage and using a tens machine instead of all this high risk stuff because this is what women watch and this is what women expect so then the normality of birth isn't what's expected so then it becomes a battle and so many women come in with their laminated birth plans that kind of tell you off 'I'm not sitting on a bed, and I'm not going on a monitor, and you will not examine me' and I think 'whoa, where is this'...</i>	575-584
Holly	<i>I think people have put pressure on women about how they give birth for centuries it just depends on the fashion at the time</i>	248
	<i>so there's a lot of pressure put on births, there's an awful lot of pressure put on births especially in modern society and I think there's a lot of pressure certainly in certain bits of society there's a lot of pressure put on women to achieve a normal birth</i>	237-239
Anna	<i>I like women coming in and getting what they expected out of the deal</i>	176
Susan	<i>... I sometimes joke and say 'listen, this isn't soap land'</i>	180
	<i>I think things have changed because women change, the media changes, they are more informed, they know what their rights are, they read a lot more</i>	311
Laura	<i>delivery on the birth centre is a really easy place to facilitate normal birth and my favourite client to care for is quite often women, particularly women who've had babies before because they've been through the first time so they know a bit what to expect</i>	67-70
	<i>sometimes I think women's perceptions of how birth should go, everyone should have a normal birth but sometimes women aren't suitable for a normal birth and maybe sometimes that can leave them feeling disappointed and leave them feeling like they've been robbed in some way...</i>	479-483
Mary	<i>...the package that women want...</i>	138

### **5.3 Summary**

In this chapter I have offered both idiographic and group level data analyses. The following chapter will critically discuss the emergent super-ordinate themes in the wider context of contemporary midwifery practice and contemporary maternity service provision.

## **Chapter Six: Discussion**

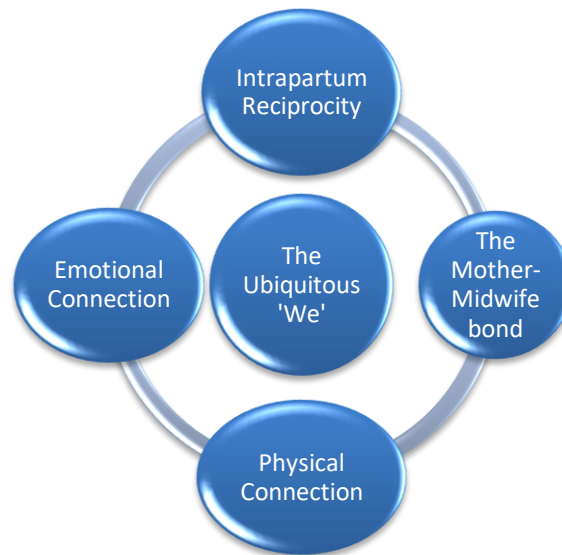
The aims of this study, as described in Chapter One, were threefold: firstly, to develop a contemporary understanding of the lived experiences of midwives promoting normal childbirth with women experiencing a low risk pregnancy in a setting where midwives are the lead birth attendant and where normal birth is actively promoted; secondly, to reveal how those midwives perceived their role in relation to the promotion of normal birth and thirdly, to identify any challenges that they may have experienced in relation to the promotion of normal childbirth in this setting. Consequently, the core subjects of interest were normal birth and the experiences of midwives in promoting normal birth. In this chapter I present and discuss the findings of this study using the five group-level super-ordinate themes that emerged in Chapter Five as a framework. Furthermore, I will consider how these findings either complement, contrast with or contribute to the current body of knowledge.

### **6.1 The Ubiquitous We**

The term ubiquitous we was derived from the prevalence and centrality of the reciprocal mother-midwife connection articulated by five of the midwives in this study. Carol, Lilly, Holly, Susan, Anna, Laura and Jenny all considered that the reciprocal relationship that they developed with women during labour and birth played a significant role in their ability to promote and facilitate normal birth. The nature of reciprocation between the mother midwife dyad during the intrapartum period manifested itself as 'the bond' that formed between them. This bond appeared to consist of and be strengthened by elements of both physical and emotional reciprocity and connectivity, connectivity integral to the establishment of the ubiquitous we. The data also revealed that the nature of the ubiquitous we during the promotion and facilitation of normal birth was diverse and multifaceted; consisting of intrapartum reciprocity, the mother-midwife bond, physical connection and emotional connection.



Figure 13: Diagrammatic Representation of The Ubiquitous We



On several occasions Carol, Lilly, Holly, Laura and Susan used 'we' instead of 'you' or 'I' when discussing their experiences of promoting normal birth. Carol suggested *'we'll listen after the next one then and we'll see what's going on'*, whereas Lilly commented *'... and I said 'right, we can't have an epidural right now so let's think of what else we can do'*; Holly when discussing her relationship with a woman stated *'they know and we know it's that harmony isn't it?'*; Laura summarised her experiences by commenting *'I mean we're there to share the woman's birth experience'*. Susan summed up her experience with, *'I'm the one that encourages her, that says 'come on we're going to do this together'*. Here Susan was using 'we' to emphasise the alliance and partnership between herself and the woman. This interpretation of the use of the term we, contrasts to that of Darra (2016), whose qualitative, reflexive study exploring the normal birth experiences of sixteen hospital based and community-based midwives also identified the use of 'we' by midwives when discussing accounts of their individual practice. However, Darra (2016) suggested that the use of 'we' in the context of her study referred to 'we' as a community of midwifery practitioners, with a shared accountability for practice rather than 'we' meaning the mother-midwife dyad.

Employing the hermeneutic circle, I considered the midwives' use of 'we' to be what Smith (2011b p. 6) describes as a suggestive gem in that this short plural pronoun had a 'significance completely disproportionate to its size'. It was intriguing and offered significant insights into the experiences of both individual midwives and midwives across the group as a whole.

Within the context of the AMU the midwives appeared able to create strong reciprocal ubiquitous we relationships with women during normal labour and birth.

The concept of reciprocity is multifaceted; it stems from the Latin *reciprocus* meaning to move back and forth (Goulder 1960). It is loosely defined as a relationship of mutual interaction, action or exchange (Collins 2016). It is described in the literature as a social norm, with some evolutionary biologists suggesting that reciprocity is the foundation for cooperation in society (Molm 2010). It has further been argued that reciprocity is structured and that this structure can have a significant impact upon the exchange of power and the development of solidarity and trust within relationships (Molm 2010). Pembroke and Pembroke (2008) maintained that there is the potential for an asymmetrical power relationship to exist between a woman who is experiencing the physical and emotional vulnerabilities of labour and her midwife, and that the midwife has a responsibility to reduce this potential imbalance through exercising reciprocity and the sharing of power.

This current study also found that there was a reciprocal physical connection between some of the midwives and women which appeared to contribute to intrapartum reciprocity and to strengthen the mother-midwife bond. Lilly referred to the mutual exchange of a hug, *'I had a lady not long ago say 'I just really need to hug you, I just need to hug you' so we had a really long, really long lovely hug'*, Carol also alluded to the importance of touch stating *'and you could kind of by just touching and watching her see that things were really progressing'*; whereas Susan took this potential for reciprocal physical connection a step further, suggesting *'because for me it's almost, sometimes, I think 'gosh I feel as if I've just had that baby!' because it's that working together.'* It can be argued that this physical reciprocity between these midwives and women is a manifestation of an alternative stress response; instead of initiating the adrenaline provoked 'fight-or-flight' response these midwives and women are utilising the alternative oxytocin releasing 'tend-and-befriend' response (Taylor et al 2000). Taylor et al (2000) contend that females have evolved this 'tend-and-befriend' response to maximise the positive benefits of nurturing affiliative relationships with other females to manage stressful encounters. Birth can be suggested as one such stressful encounter.

A further interesting finding of this study was the influence of emotional reciprocity between the midwives and women. In particular, the influence that the reciprocal exchange of the emotional state of calm appeared to have on both the mother-midwife

bond between four of the midwives and the effect this had on the midwives' facility to promote normal birth. Lilly, Anna, Laura and Jenny all alluded to the importance of achieving maternal calm during labour and the impact that this then had on generating a positive maternal experience and a positive midwifery experience when promoting normal birth. As Lilly said:

*that initial being able to calm someone down and then you get to encourage them with normality then because you get that control back and that focus ...*

Anna made specific reference to the reciprocal nature of calm during birth stating, '*...and then if she's calm then we can be calm*'. It can be suggested that this mutual state of mother-midwife calm is important to both the woman and the midwife. This reciprocal exchange of calm can be interpreted further through the application of Heidegger's lifeworld lens, mood (Heidegger 1995). Mood, Heidegger suggests, is complex, interactive and perceptual. Our mood is an integral component of emotional attunement to both the self and others. Lilly, Anna, Laura and Jenny all appeared to be emotionally attuned to women during birth. This finding aligns with the findings of Thelin et al (2014) whose descriptive phenomenological exploration of the lived experience of ten Swedish midwives caring during childbirth on two separate delivery suites in one hospital, concluded that midwives in this study also felt it was important to establish an atmosphere of 'calm serenity'.

When an individual achieves a state of calm it reduces the psychological and physiological effects of the stress response (Tucker Blackburn 2013). The stress response is a chain of complex physical and physiological reactions that involves neurohormonal and behaviour adaptations (Dixon et al 2013). The impact of neurohormonal influences on a woman's physiological progress, behaviour and emotions during labour and birth are well documented in the literature (Dixon et al 2013). Studies have also explored the impact of emotional sharing between midwives and women during traumatic births and the potential for there to be a negative impact on the emotional well-being of the midwife (Leinweber and Rowe 2010). However, the impact of neurohormonal influences on midwives and their practice during the promotion and facilitation of normal birth is not so well recognised.

The importance of establishing a strong midwife-mother relationship throughout the pregnancy, labour and birth continuum is well evidenced as a fundamental cornerstone of good midwifery practice (Kirkham 2010, Hunter 2008, Deery and Hunter 2010, Leap

et al 2011, Sandall et al 2016). The importance of understanding and valuing of connection is similarly considered to be central to the midwifery model of practice (Kitzinger 2005). The value that reciprocity adds to this relationship is also not a new concept and is one that has been discussed in previous studies (Hunter 2006, Hunter 2010, McCourt and Stevens 2009, Berg et al 2012, Lewis et al 2017). Following an ethnographic study exploring relationships between community midwives and women. Hunter (2006) developed a model of midwife-woman relationships founded on the notion of reciprocity, suggesting however, that more investigation is required to increase opportunities for reciprocal relationships between midwives and mothers in the wider maternity service. The findings of this current study have identified that opportunities for reciprocal relationships between women and midwives appear to be abundant in the AMU setting.

Lundgren and Berg (2007) in their secondary analysis of eight Swedish phenomenological studies aimed to identify central concepts in the midwife-mother relationship during normal and high-risk circumstances. Their findings also concluded that an essential component of mutuality experienced in a constructive midwife-woman relationship was reciprocal giving. Berg et al (2012) in their hermeneutic study aimed to design an evidence-based, woman centred, midwifery model of intrapartum care for women in Iceland and Sweden. The findings of Berg et al (2012) support the findings presented in this current study; they identified that establishing a reciprocal relationship between a midwife and a woman during labour was important and subsequently developed a model identifying 'a reciprocal relationship' as one of the model's three central themes. A retrospective Q-methodology Norwegian study by Dahlberg and Aune (2013) examined 23 women's experiences of relational continuity during pregnancy and childbirth also found that when women experienced mutuality in their relationship with their midwife they had a more positive birth experience.

It can be suggested that for midwives to nurture a reciprocal relationship with women experiencing normal birth they need to be attuned to them both physically and psychologically. Heidegger's (1995) philosophy offers a different perspective on the notion of existential attunement in which he considers attunement to be a way of being-in-the-world; what he calls *Anganglichkeit* or *Anganglich* meaning capable of letting something come closer or nearer (King 2001). When midwives are with women during a normal birth in an AMU the findings of this current study suggest that they do indeed let the women they are with come closer both emotionally and physically and are therefore also fostering attunement and a state of authentic Being-with in accordance

with Heidegger's philosophy. This finding contrasts to those of Thomson (2011), whose interpretative phenomenological study explored the lived experiences of 14 women who had experienced a self-defined traumatic birth. The women in Thomson's study described their caregivers, as 'cold, harsh, uncaring and clinical' suggesting that the quality of the mother-midwife relationship experienced by these women lacked physical and psychological attunement and consequently demonstrated the characteristics of what Heidegger (1982b) terms inauthentic Being-with.

The emotional and physical closeness demonstrated by the midwives in this current study is suggestive of an interconnected human intimacy, which when viewed through a Heideggerian lifeworld lens reflects spatiality, intersubjectivity and embodiment (Todres et al 2007). Heidegger (1995) argues that the existential spatiality of Dasein is characterised by *de-severance* or a bringing close, this can be interpreted to mean not only a physical closeness but also a closeness in terms of significance and meaning. For Carol, Lilly, Holly, Susan, Anna, Laura and Jenny the being close to the women they were with during normal birth was meaningful and significant both physically and emotionally. The midwives' connectivity to women is also illustrative of intersubjectivity and embodiment, where the midwives are, through their meaningful location in their lived world and the language of their bodies, relating and interacting intuitively with the women with whom they are sharing the normal birth experience.

An unexpected finding of the study presented in this thesis was the notion of '*midwifery by the desk*' which was alluded to by Mary and Carol. It is implied, by them, that some midwives choose to spend time at the midwives' desk rather than being present in the birthing room where a woman is labouring. There is a significant body of evidence to support the positive influences of a constant midwifery presence during labour on both maternal birth experiences and normal birth outcomes (Hodnett et al 2013, Aune et al 2014). Therefore, it can be posited that a midwife's absence from the labouring room has the potential to have a negative impact upon the latter and on the opportunity to build and develop a reciprocal and attuned mother-midwife relationship. Why midwives should choose to spend time at the desk rather than in the birthing room is not clear. It is possible to contend that the midwives are seeking to look after the self rather than the woman and that they require time to pause from the emotion in the birthing room. Alternatively, the findings of Sosa et al's (2018) ethnographic study exploring one-to-one midwifery support during labour in midwifery led environments may be relevant in that they concluded that midwives gauged the need for their presence in the birthing

room on the individual needs of the woman. Some women favoured their midwife to be near and present, some favoured privacy and absence.

The findings of this current study suggest that the intrapartum reciprocal mother-midwife relationship during the promotion and facilitation of normal birth is complex and dynamic. The meaning of the word *midwife* is derived from Middle English and literally means *with woman* (Hunter 2002). Bradfield et al (2018) in their exploration of the concept of being with women concluded that it too is a 'dynamic and developing construct' and that there is a paucity of evidence considering practising midwives' contemporary understanding of being with women. Interestingly, Heidegger's philosophy considers '*Mitsein*' or 'being with' to be a fundamental feature of being human (Rentmeester 2018). The findings of this present study suggest that revealing the reciprocal relationship that develops between mothers experiencing normal birth and their midwives may further our understanding of an element of the contemporary nature of the phenomenon of midwives being with women today.

There is a prevailing discourse in contemporary midwifery literature that alludes to the potential influences of stress on burnout amongst midwives and the need for midwives to nurture personal resilience to enable them to mitigate against this potential (Hunter and Warren 2014, Sheen et al 2015, Creedy et al 2017). McCourt and Stevens' (2009) study of caseload midwifery practice argued that midwives who held a caseload found the reciprocal relationship that they were able to develop with women acted as a form of defence against the potential for professional burnout. These findings were echoed by McAra-Couper et al (2014) who identified that New Zealand midwives acting as the Lead Maternity Care provider for women experiencing a low risk pregnancy similarly found that the reciprocal partnership relationship they developed with woman not only sustained them but also gave them joy. The findings of this current study suggest that further research is needed to investigate the impact of the reciprocal mother-midwife relationship on midwives promoting and facilitating normal birth in an AMU setting and on their experiences of stress in this setting.

## **6.2 Philosophies of Practice**

When discussing their experiences of promoting normal birth it emerged that all the midwives in this current study had their own individual philosophies of midwifery practice. However, there were some commonalities between these philosophies which consisted of ways of knowing, a belief in normal birth, a consideration of different shades of normal and the centrality of the woman.

Figure 14: Diagrammatic Representation of Philosophies of Practice



Much has been written about the ways in which midwives acquire and utilise ways of knowing to inform their practice when caring for women during all stages of the childbirth continuum (Davis-Floyd and Sargent 1997, Hunter 2008, Barnfather 2013). Carper's seminal work on patterns of knowing utilised by the nursing profession included 'aesthetic knowing' which considers the art of nursing (Carper 1978). Midwifery practice is likewise described as an art (Power 2015). Kitzinger (2005) defines the art of midwifery as midwives being able to assist women to 'work in harmony with their bodies...'. It can be argued that this expression of artistry is seen when midwives are promoting and facilitating normal birth. This was elucidated by Holly when she commented '...women – *they know and we know it's that harmony isn't it.*' and Susan who remarked '*...and give that woman that opportunity to let her body do what needs to be done we are here just to facilitate the birth*'.

All the midwives in this current study expressed a belief in the process and promotion of normal birth, a finding that has been identified in previous midwifery studies (Powell Kennedy and Shannon 2004). However, some midwives expressed uncertainty and frustration about what the term normal birth actually meant, this frustration was voiced most strongly by Carol when she commented '*Do you know I hate that word normality because its... what does normal mean?*'. This uncertainty led to the emergence of the sub-ordinate theme of 'shades of normal'. The meaning and use of the concept normal in relation to childbirth has been passionately debated in both historical and

contemporary midwifery literature (Davis 2000, Downe 2006, Werkmeister et al 2008, Young 2009, Powell-Kennedy 2010). Darra (2009 p.297) concurred with this assertion in her postmodern exploration of the idea of normal, suggesting that the idea of normal birth is 'being debated and promoted as never before'. At the heart of the debate is the meaning of the word 'normal', a potentially value-laden and emotive term that is seemingly difficult to define.

The dictionary definition of normal is 'conforming to a standard; usual, typical, or expected' (Collins 2016). It is a complex and composite term that also has numerous synonyms: 'ordinary, routine, average, commonplace, regular, customary' (Collins 2016). When asked to describe their experience of giving birth women do not commonly use these terms, as for women, their individual birth experience is anything but ordinary, routine or commonplace (Darra and Murphy 2016). Wickham (2011) argued that the terms normal and normality have scientific and mathematical connotations originating from the time of the Enlightenment. Some suggest replacing the use of the word normal with the more appropriate and less value laden term 'physiologic' or 'undisturbed' (Downe, 2006, Powell-Kennedy 2010).

Clews (2013) urged the UK midwifery profession to reclaim what she referred to as 'the fragile construct' of normal birth and return to its physiological and sociological roots. Carolan and Hodnett (2007 p.143) also expressed a belief in normal birth and advocated for its reclamation and promotion in Australia. However, they posed some salient and thought-provoking questions:

- 'Is it possible to focus on normal and yet still be acutely sensitive to early indications of complications?
- Does an emphasis on normal birth as a primary goal detract from the experience of women who do not have normal births or lend itself to a different form of authoritarianism where women are 'persuaded' to birth in a certain way?'

These questions resonate very strongly with the discourse concerning the promotion of normal birth today; particularly the debates that have followed in the wake of the end of the Royal College of Midwives Campaign for Normal Birth. In response to a fall in the UK normal birth rate (Downe et al 2001) the Royal College of Midwives Campaign for Normal Birth began in 2005 to support and encourage midwives to promote normal birth. The campaign concluded in 2014 being replaced with the Better Births Initiative (NHS England 2016). All references to the Campaign have been removed from the



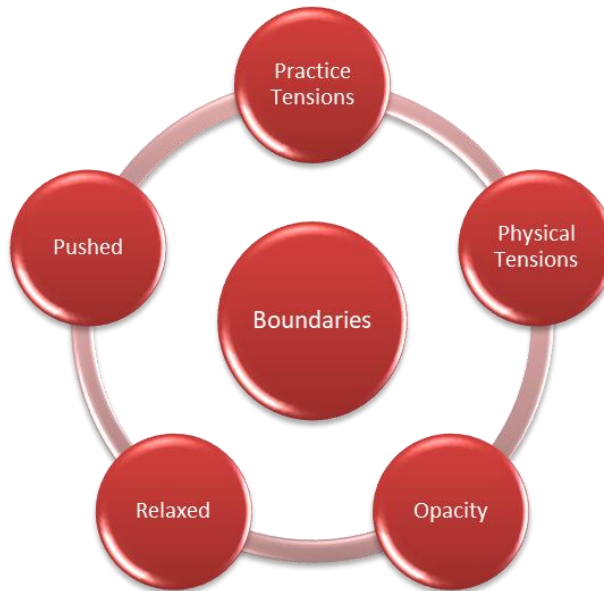
Royal College of Midwives webpages. It was suggested in the media that the Campaign was criticised following the investigations into the maternal and neonatal deaths that occurred in the maternity and neonatal departments of the University Hospitals of Morecambe Bay NHS Foundation Trust between 2004 and 2013 and the subsequent publication of the Kirkup Report (Kirkup 2015). Hundley and van Teijlingen (2017) however, countered this suggestion, arguing that the end of the Normal Birth Campaign was not in response to a particular event but a move to reinvigorate the philosophy behind the campaign in response to changes in the needs of society.

The midwives in this current study expressed the opinion that the woman was central when considering their personal experiences of promoting normal birth, as Carol astutely commented, '*The woman and the family to be the centre, it's about her journey*' and Susan stated '*now we don't tell them, in some cases they tell us what they want which is a good thing within reason because it is their experience...*'. This central positioning of the woman is not a new concept. Wagner (1994) discussed the importance of the centrality of the woman, recommending that a woman's care cannot be separated from her own goals. This finding of the present study also echoes and supports current UK maternity policy guidance which advocates and supports the provision of 'personalised care, centred on the women, her baby and her family' (NHS England 2016 p.8).

### **6.3 Boundaries**

When discussing their experiences of promoting normal birth Mary, Susan, Anna, Lilly, Laura and Karen identified that their experiences were influenced by the presence of boundaries which gave rise to the emergence of this subject as a super-ordinate theme. The nature of these boundaries varied and were identified in the sub-ordinate themes of practice tensions, physical tensions, having opacity, being relaxed and being pushed.

Figure 15: Diagrammatic Representation of Boundaries



The findings of this current study resonate with those of several other studies that have identified and explored the influence of boundaries on the promotion and facilitation of normal birth practice (Hunter 2005, Page and Mander 2014, Hunter and Segrott 2014). In the current study Mary articulated a need for clearer boundaries to help guide normal birth practice. *'Recognising what normal is and having clear boundaries for what that means and a need to recognise deviation from normal because I think sometimes that becomes a bit muddled along the way'*. This finding supported those of Hunter (2005) who identified that a lack of intra-professional boundary clarity within midwifery resulted in intra-professional dissonance and uncertainty. This element of uncertainty in relation to experiences of promoting normal birth was also echoed by Page and Mander (2014) who identified that midwives developed a 'normality boundary' that informed their practice and helped them to overcome uncertainty when experiencing normal intrapartum care. Hunter and Segrott (2014) whose exploration of the impact of the Wales 'normal birth pathway' revealed that midwives found the presence of a clear pathway, which provided boundaries of practice, gave them 'permission' and confidence to promote normal birth practices.

This current study revealed that some midwives felt the need to extend or push their practice boundaries. Susan articulated that *'...I may push the boundary lines again I'm not expecting it of anybody else, I'm only expecting it of myself because I've only to answer to myself'* and by Laura who commented, *'because I think in a way you can*

*push the boundaries a bit because you know the delivery suite is just next door...'. A boundary is defined as 'a dividing line that indicates the farthest limit' (Collins 2016). This perceived need to push boundary lines suggests that Susan and Laura may have considered that the lines that have been demarcated have fallen short of the farthest limit and constrained rather than supported their practice. Anna further commented that ... 'I suppose after reading things like Morecombe Bay there's always a bit like okay you have to be careful how far you push it...'. Anna was the only midwife in the current study to mention the influence that the findings of the Morecambe Bay Report (Kirkup 2015) may have had upon her practice and experiences of promoting normal birth. She clearly acknowledged that care should be taken when considering pushing 'it', 'it' being interpreted as normal birth. The contestation of boundaries is not new, McIntyre et al (2012) in their critical discourse analysis considered that boundaries of midwifery practice in relation to normal birth promotion were being contested.*

A further finding of this current study was that some of the midwives found the physical boundary that existed between the AMU and the labour ward 'next door' influenced their experiences of promoting normal birth. Mary elucidated this when she commented, *'I do believe that that (the MLU philosophy of practice) has been eroded because of the sheer capacity of this big unit, we are not a standalone, so we don't stand alone, we are part of the unit...'*

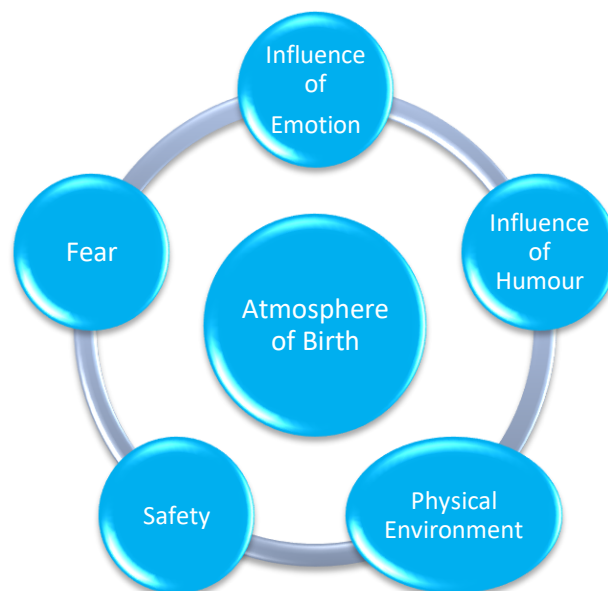
Susan also stated *'... I feel as if we've been swallowed up a bit by the delivery suite because we've had new management and different people come in and maybe they haven't got the passion for birth centres, maybe they believe that women should have some additional help'*. Carol further commented *'sometimes the door is propped open with a fire extinguisher, sometimes the midwives will come in and pinch our equipment because they haven't got it in room 11 so you are forever battling to kind of keep your unit as your unit'*. Similarly, Miah and Adamson (2015) also identified the potential for the distinct philosophy of care found in an AMU to be eroded by a blurring of boundaries between AMUs and Obstetric Units (OUs). Walsh and Devane (2012) recognised a 'clash of models and culture' between AMUs and the maternity Units in which they were situated and Mc Court et al (2014) whose ethnographic organisational study of four UK AMUs identified that there was a potential for tensions to exist between models of care in AMUs and OUs. Mc Court et al (2014) recommended that the creation of different care settings and choices required careful boundary management. Mc Court et al (2014) further contended that boundaries between AMU's and OUs need to be clear and stable to ensure safety but 'permeable enough' to facilitate the appropriate transfer of women from one area to the other. Effective

working across boundaries to ensure safe care provision was also a recommendation of the National Maternity Review (NHS England 2016).

#### 6.4 Atmosphere of birth

This current study revealed that the atmosphere of birth was fundamental to the experiences of all the midwives when they were promoting and facilitating normal birth. I suggest that the midwives were as attuned to the birth atmosphere as they were attuned to the physical and emotional needs of the mothers when engaging in the reciprocal mother-midwife relationship. For the purposes of this discussion an atmosphere is defined as the mood or feeling of a place that affects the people within it (Collins 2016). The birthing atmosphere, as experienced by the midwives in this study, appeared to be influenced by several factors which were identified as the sub-ordinate themes of the influence of emotion, the influence of humour, the physical environment, the midwives' fear and safety. This finding of this present study complements the findings of several other studies that have recognised the relationship between the birthing atmosphere, mood and the experiences and practice of midwives (Fahy and Parratt 2006, Hammond et al 2013, Hammond et al 2014, Crowther et al 2104, McCourt et al 2014, Davis and Homer 2016).

Figure 16: Diagrammatic Representation of Atmosphere of Birth



Walsh (2009) in his ethnographic study conducted in a freestanding birth centre identified that the birthing environment influenced midwifery practice, and that midwives in turn nurtured the birthing environment, practicing 'vicarious nesting', by preparing an environment that was conducive to enhancing maternal physiology. As Carol observed '*...actually going into quite a dim, very peaceful, music on – a kind of – I don't know, you walk on to a midwifery led unit and you tend to want to talk in a hushed voice, nobody tends to want to make too much noise...*'. Similarly, McCourt et al (2014 p.53) concluded that the midwives in their study also considered the birthing environment of an AMU should have a 'low intervention look' that supported the physiology of normal birth and supported a 'certain kind of birth philosophy'.

Hammond et al (2013) in their discussion paper concluded that a birth environment that is conducive to the release of the neuropeptide oxytocin, may have a proportional influence on the ability of midwives to provide care that was emotionally responsive. Hammond et al (2013) also postulated that an environment that enhances the release of oxytocin also has the potential to improve the quality of midwifery care provision. This finding is mirrored by this current study; Susan stated '*... it's your environment and your environment has a lot to do with how you behave*'. Susan's experience can be further interpreted using Heidegger's lifeworld lens of 'attunement to mood' revealing that the environment is influential on mood and the mood on the environment. This complements the findings of Crowther et al (2014) in their phenomenological study who concluded that there is a shared and sacred mood present at birth that should be attuned to in order to be protected. Lilly also interestingly commented when discussing the influence of an environment that was calm during labour, '*you feel calmer and more relaxed and so you might think about things a bit more or make better decisions*.' Davis and Homer (2016) in their qualitative descriptive study explored the impact of birthplace on the practice of twelve midwives; four from the United Kingdom practising in hospital or at home and eight from Australia practising in a Consultant delivery suite or in a birth centre. This current study complements that of Davis and Homer (2016) as it is exploring midwifery practice in a UK AMU, a birthing environment that was not included in the Davis and Homer study. The finding of the beneficial influence of the birthing atmosphere also aligns with those of Davis and Homer (2016). Davis and Homer (2016) further concluded that an environment that is most conducive to normal, physiological birth is also advantageous to promoting safe midwifery practice.

The findings of this current study revealed that for Mary, Susan, Lilly, Anna and Laura safe midwifery practice was identified as being an important contributor to the birth atmosphere. The concept of safety during childbirth is intensely complex and for the purposes of this study is defined as 'the management of risk and the reduction of harm' (Magee and Askham 2008 p.7). The following quotes elucidate the sub-ordinate theme of safety further: Mary, when discussing the skills required of a midwife promoting normal birth in an AMU, considered they would require '*...skill and knowing when something is not right and not sitting on an issue that is not safe to carry on with and the partnership that you have with obstetricians is so key*'. Lilly stated '*... that you're keeping people safe in that respect that people aren't in danger from anything that you're doing or not doing*'. It was interesting to note that Susan, whose post qualification experience exceeded thirty years, was very concerned about safety for mothers, babies and midwives '*...so I'm open to anything, within reason, and when I say within reason it's got to be safe, safe for mum and safe for baby and safe for me because as a professional you've got to keep yourself safe...*'. Anna provided a different lens through which to view the issue of safety, stating '*it's just a different kind of normal as long as it's a normal that makes her feel safe*'. Anna also commented '*I wouldn't say that we're relaxed because you're not relaxed but you're in a very calm, safe environment*'. Laura viewed the co-location of the AMU and its proximity to the Labour ward as influential to her experiences of safety when promoting normal birth stating '*...so it's always nice having that little safety blanket next door...*'.

The data in this study indicated that for five of the nine midwives the safety of women, babies and themselves was a central consideration of their practice. From this it can reasonably be surmised that safety took precedence over their desire to promote and facilitate normal birth. This finding is in accordance with that of Berg et al (2012) who identified that midwives needed to promote an atmosphere of safety to enable women to feel safe. Furthermore, this sub-ordinate theme of safety echoes the philosophy of UK national policy guidance which recommends that safety be the 'golden thread' that runs through the current Maternity Transformation Programme (MTP) (Department of Health 2017). The MTP was established by NHS England following the National Maternity Review (NHS England 2016) to ensure high quality, safe maternity care provision across the UK.

A further sub-ordinate theme to emerge when considering the atmosphere of birth was the influence of humour. Holly stated '*I always try and appropriately be relatively humorous during the process because I think laughter helps a lot...if you can make*

*them (women) laugh at some point during the process it just lifts it a little bit, it just breaks that tension that's in the room sometimes so I always try and crack a joke if I can'*. There appears to be a scarcity of research examining the appropriate use of humour by midwives during labour and birth, which is interesting as the Royal College of Midwives (2012) specifically mentions the use of humour in their evidence-based guideline for midwifery led care during labour. Shirley (2015) argued that certain types of positive humour help to lessen the impact of potential stress upon pregnant women. Martin et al (2003) identified four different styles of humour; affiliative and self-enhancing, which have positive influences and aggressive and self-defeating, which have negative influences. It can be suggested that Holly was employing affiliative humour to enhance her therapeutic relationship with women. Mallett (1995) discussed the potential for laughter to be used as a therapy in nursing, referring the science of laughter, known as gelotology, taken from the Greek *gelos* meaning laughter. This too is interesting as Holly when describing one of her experiences of promoting normal birth stated; *'...but we were laughing, we were laughing during her birth...and I think that really helps because you build up that relationship...to be able to laugh in between and have a giggle with your midwife I think it makes for a big difference'*. Holly used humour and laughter as a means of nurturing her reciprocal mother-midwife relationship. This finding concurs with that of Mallett (1995) who contended that nurses use humour with their patients, particularly when discussing difficult subjects, as a way of fostering 'friendly reciprocity'. Allen (2014) also observed that laughter enhanced the bond between nurses and their patients.

The findings of this current study indicate that laughter increases the bond between midwives and women. Launer (2016) further suggests that humour is used in many health-care settings, predominantly those in the acute sector. McCreddie and Payne (2012) in their grounded theory study explored the use of humour from the patient's perspective concluding that patients wanted staff to both 'initiate and reciprocate humour' and that even though the use of humour may be considered, by some, to be 'risky', McCreddie and Payne (2012) considered it is 'a risk worth taking'.

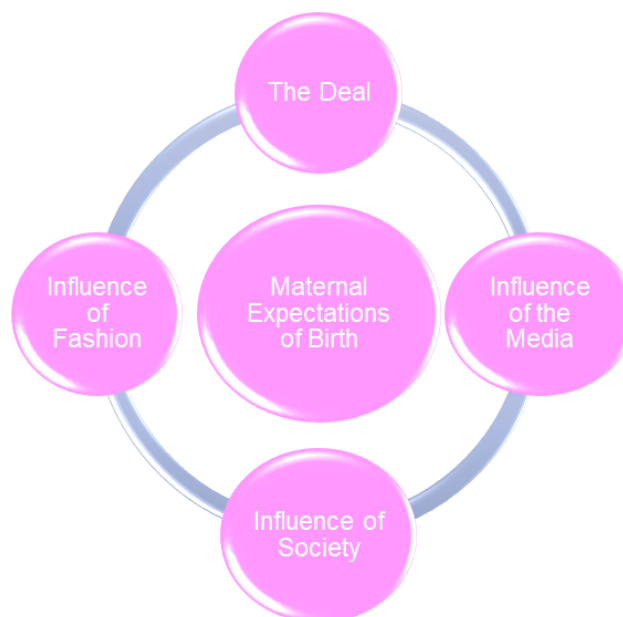
Midwives' fear of normal birth was the final sub-ordinate theme to emerge when discussing the atmosphere of birth. This emerged following the data collected from Lilly and Laura's transcripts. Lilly when considering some of the challenges when promoting normal birth reflected on her more senior colleagues, *'...I think it's also their fear because they (midwives that have been qualified 20-30year) haven't done it and they don't know how to do it, they are worried about it and that puts a stop to normality'*. Laura continued this theme, suggesting *'...some midwives who've been on delivery*

*suite for years' and years' and years' are frightened of normality'*. This finding is congruent with those of other midwifery studies that have examined fear amongst midwives (Dahlen and Caplice 2014, the Birth Project Group 2015). Dahlen and Caplice (2014) identified the predominant fears of Australian and New Zealand midwives when caring for women during childbirth, one of which was fear of 'losing their passion for and confidence around normal birth'. Dahlen and Caplice (2014) suggest that one reason for this fear may be rising levels of litigation. Whilst it is acknowledged that maternity service provision in Australia and New Zealand is different to that of the UK, parallels can however, be drawn between midwifery practice in all three countries.

### **6.5 Maternal Expectations of Birth**

Lilly, Holly, Anna, Susan, Laura and Mary alluded to the fact that their experiences of promoting normal birth were influenced by maternal expectations of birth. This led to the emergence of this as the final super-ordinate theme. Maternal expectations appeared to be influenced by the media, fashion and society and what Anna termed 'the deal' which were consequently identified as the sub-ordinate themes.

Figure 17: Diagrammatic Representation of Maternal Expectations of Birth





The influence of the media on maternal expectations of birth emerged as a subordinate theme. For the purposes of this study the media is defined as a means of mass communication, in particular, television and newspapers (Collins 2016). The finding of this present study complements the findings of others that have examined the portrayal of birth by the media and its effects (VandeVusse and VandeVusse 2008, Young 2009, Tyler and Baraitser 2013, Luce et al 2017). Lilly stated ... *I think women think they know, and they don't, they think they know what it's going to be like because they've watched these programmes*. Lilly further commented *'I think more birth programmes are showing water births but instead of showing people strapped to a bed on a monitor and the dramatic music and the doctors come and save the day, they need to show a midwife sat on a birthing ball giving somebody a massage and using a tens machine instead of all this high risk stuff because this is what women watch and this is what women expect so then the normality of birth isn't what's expected so then it becomes a battle...'* Walsh (2007) also made this observation noting that childbirth in the media is often represented by medicalised stereotypes that do not reflect the midwifery model of birth. Page (2013) similarly observed that the interpretation of birth through the camera lens of contemporary reality television programmes is often the result of the director's cut, which has metaphorically trimmed away the holistic nature of birth, leaving fragmented interpretations. Page (2013) further commented on the vicarious experiences of birth that women and men are exposed to via the media; suggesting that the factual or fictitious depiction of birth via television programmes can often reflect accepted cultural norms and accentuate emotions, particularly fear.

The findings of this present study revealed the impact that the media portrayal of birth has upon midwives' experiences of promoting and facilitating normal birth, contributing to the growing debate about the effect of the portrayal of birth by the media and its potential to influence maternal expectations of birth (Luce et al 2017). Luce et al (2016) in a scoping review commented that whilst there has been some discussion in the literature about the negative consequences of reality television increasing maternal expectations of adverse outcomes, there has been little exploration about the effects of the media portrayal of birth on normal birth. It can also be argued that there has been little exploration of the effects this portrayal has had on midwifery practice. Luce et al (2016) concluded that the media depiction of childbirth may favour the medicalisation of birth and exclude the portrayal of normal birth. Like Walsh (2007), Luce et al (2016) recommend the increased engagement of midwives with television producers to ensure a more balanced representation of birth and midwifery practice. De Benedictis et al (2018) in their content analysis of two seasons of the UK reality television programme

One Born Every Minute (OBEM) suggest that it is dominated by the medical model of birth with women represented as passive recipients of care. Conversely, Bull (2016) in her comparison of UK, US and Scandinavian television programmes depicting childbirth concluded that OBEM does represent normal birth and that some Scandinavian programmes go further than those of the UK to idealise the notion of normal birth.

Holly commented about the pressure that some women feel about achieving a normal birth '*...there's a lot of pressure put on births, there's an awful lot of pressure put on births especially in modern society and I think there's a lot of pressure certainly in certain bits of society there's a lot of pressure put on women to achieve a normal birth...I think people have put pressure on women about how they give birth for centuries it just depends on the fashion at the time.*

The increased depiction of childbirth by the media can contribute to this pressure and influences women's expectations of birth (Luce et al 2017). As Susan observed '*... I sometimes joke and say 'listen, this isn't soap land'... this now is reality and what we see in the media isn't always what happens in life...*

Anna summarised maternal expectation when she commented '*I like women coming in and getting what they expected out of the deal*'. The issue of importance here is that terms of '*the deal*' that women expect are arranged to ensure that all those entering it are mutually advantaged and not disadvantaged.

In 2017, the subject of normal birth and its promotion received significant attention from both UK and international media sources who appeared to launch an 'against' normal birth campaign. Media interest began with an article published in the UK Sunday Times on January 8<sup>th</sup> entitled 'Why the Natural Birth Bullies Should Back Off'. In this emotive and deeply scathing opinion piece the author levels significant criticism against midwives implying that they are inappropriately promoting normal childbirth to "big themselves up to run the childbirth industry" (Sarler 2017). On the 12<sup>th</sup> August the Times newspaper led with a provocative frontpage article entitled 'Midwives back down on natural birth' (Smyth 2017); the Guardian similarly led with a further article entitled 'Midwives to end campaign to promote 'normal birth"' (Sandeman 2017), The New Scientist headlined with an editorial entitled 'Time to stop pushing natural over safe' (Wilson 2017). In an interview for the Independent Newspaper Professor Cathy Warwick the then Chief Executive of the Royal College of Midwives stated '*what we*

*don't want to do is in anyway is contribute to any sense that a woman has failed because she hasn't had a normal birth. Unfortunately, that seems to be how some women feel'* (Vaughn 2017).

What provoked the plethora of antagonistic journalism in 2017 is not entirely clear; Dahlen (2017) suggests that the attack on normal birth from normal birth 'arsonists' may have been provoked by the fact that the promotion of normal birth sits on a strong scientific evidence base which may be viewed by some as a threat 'to those in power with misogynistic agendas'. Dahlen (2017) continued to argue that it is not normal birth that is the problem per se but the lack of 'evidence-based... relationship-based care'. The findings of this current study revealed the importance of the intrapartum reciprocal mother-midwife relationship which has the potential to contribute to the expansion of this evidence base.

## **Chapter Seven: Conclusion and Recommendations**

This chapter summarises the research and details the contributions that it makes to the field of study. The strengths and limitations of the study are discussed. The chapter concludes with exploring the implications for midwifery practice and education and by offering suggestions for further research.

### **7.1 Study Summary**

This Interpretative Phenomenological Analysis study explored the experiences of nine midwives promoting normal birth in Alongside Midwife Unit (AMU) in the UK. The midwives had varying degrees of post qualification experience ranging from less than one year to more than thirty years, they also had differing lengths of experience practising in the AMU, extending from ten weeks to thirteen years. Individual face to face interviews were conducted over a four-month period between December 2016 and March 2017, in a quiet and tranquil room in the AMU normally used by women and their companions for relaxation. The interviews were transcribed, and data subsequently analysed in accordance with IPA methodology, firstly idiographically and then at the group level.

Interpretative Phenomenological Analysis enabled the detailed exploration of the midwives' lived experiences of promoting normal birth. Interpretation of the data revealed that the midwives were unfailingly passionate and positive about the promotion and facilitation of normal birth. Their experiences were influenced by intrapartum reciprocity, their individual philosophies of practice and the atmosphere of the birthing environment. Their practice experiences were challenged by physical and practical boundaries and maternal expectations of birth. The nature of the intrapartum reciprocation between the mother-midwife dyad manifested itself as 'the bond' that formed between them. This bond appeared to consist of and be strengthened by elements of both physical and emotional reciprocity and connectivity, connectivity identified as the 'ubiquitous we'.

### **7.2 Study Contributions**

This study offers both methodological and subject contributions. The use of IPA as a research method and methodology has added to the small body of existing midwifery IPA studies which may serve to encourage future midwife researchers to consider the merits of IPA (Charlick et al 2015, Charlick et al 2016, Sheeran et al 2015, Atkinson and McNamara 2017).

This study's contribution to original knowledge is that midwives appear to form a bond with women experiencing normal birth in an AMU, a bond based on elements of physical and emotional reciprocity. This bond was identified as the 'ubiquitous we'. The development of a bonded intrapartum reciprocal relationship between mothers and midwives in an AMU birthing environment appears to enable midwives to optimise normal physiological processes and to work in partnership with women. This study has also therefore, added to the contemporary understanding of some of the factors that contribute to the complex yet fundamental mother-midwife relationship during birth.

This study has also offered insights into midwifery practice in an AMU and helped to tease out some of the influences on midwives' experiences of promoting normal birth there. National guidance (NICE 2014) is recommending that nulliparous and multiparous women experiencing a low risk pregnancy be offered the choice to birth in an AMU as it is 'particularly suitable for them'; therefore the number of UK AMU's may increase as may the number of women choosing to birth in them, the insights provided by this present study may also therefore be increasingly useful. This is particularly relevant as between 2008-2015 14 Freestanding Midwifery Units in England were closed. Closure justified because of low use and financial constraints (Rayment et al 2019). The closure of FMUs will inevitably diminish women's choice of birthplace making the AMU as a choice of place of birth even more important.

Having detailed the contributions this study proposes, it is recognised that the interpretations made within it are those of one person at one moment in time, should the study be repeated, different interpretations may be revealed.

### **7.3 Strengths and limitations of the study**

Whilst every effort has been made to ensure the quality of this study it is fully acknowledged that it is not without its limitations. Smith et al (2009) recommend the use of Yardley's (2000) four broad principles for assessing the quality of an IPA study, therefore these have been utilised below.

#### **7.3.1 Sensitivity to context**

This study has shown sensitivity to context throughout. In Chapter Two sensitivity to context was demonstrated through an awareness of existing literature on the topic of investigation. As discussed in Chapter Four, all interviews were conducted with sensitivity and an awareness of the participants needs. I was acutely aware of my insider-outsider status as a researcher and the potential this may have to influence the

relationship that I had with the participants. Once data were collected, I continued to observe sensitivity to context during my analysis, ensuring that I was immersed in each individual transcript enabled me to offer cautious interpretation of the participants making sense of their experiences. This analysis was supported by a significant quantity of verbatim extracts, which not only gave the participants voice but also enabled the reader to check the interpretations I had offered.

### **7.3.2 Commitment and rigour**

I have demonstrated consistent commitment to this study. This can be evidenced through my prolonged engagement with the subject of normal birth not just as a novice researcher but also in my capacity as a practising midwife. I remained fully immersed in this study from its inception until its conclusion. Additionally, I approached this study very seriously, acknowledging the need to make every effort to gain and hone those skills required to become an effective qualitative researcher undertaking IPA. This is evidenced through my attendance at IPA workshops on data collection and analysis and through my diligent attention to the advice and recommendations of my supervision team.

Attention to rigour has been a priority for me throughout this study, consequently I have adhered to the guidance of Smith et al (2009) during each stage. The sample size of this study was appropriate to the question posed and to the methodology used, however the homogeneity and relatively small numbers may be considered a limitation as the findings may not be generalisable. Rigour was further demonstrated during the conduct of the interviews, I endeavoured to ensure that there was a balance between being close to and separate from the participants.

A limitation of this study may be my status as a novice researcher in that my inexperience may have, at times, limited my ability to recognise significant cues and probe sufficiently or follow up some responses with further questioning. Independent auditing of an audio recording of one of my interviews by my supervisors provided valuable feedback on my interview technique which enabled me to develop and improve. Rigour has been demonstrated through my interpretation of the data through my commitment to each individual participant as well as to the group. I have judiciously endeavoured to ensure that each super-ordinate and sub-ordinate theme has been evenly distributed to represent not only the individual but also the group as a whole.

### **7.3.3 Transparency and coherence**

There has been a commitment to transparency and coherence throughout. Transparency is evidenced by the disclosure of all aspects of the research process including the presentation of my data analysis and the audit trails that led to the development of the super-ordinate and sub-ordinate themes. Coherence is demonstrated through the alignment of the research question, the study aims and objectives, the lens of Symbolic Interactionism and the adherence to the principles of IPA. Coherence is further demonstrated through the commitment to phenomenological and hermeneutic ideologies during the writing up of this study.

### **7.3.4 Impact and importance**

Having satisfied the above principles for ensuring the quality of this study it is anticipated that it will be deemed important and have an impact upon the midwifery community for whom it was intended.

## **7.4 Implications for midwifery practice and education**

The findings of this study have the potential to influence both midwifery practice and midwifery education.

### **7.4.1 Implications for midwifery practice**

Renfrew et al (2014) in their seminal *Lancet* Series examining the contribution that midwifery can make to the quality of global maternity care defined their vision of midwifery practice as:

“skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life. Core characteristics include optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women’s individual circumstances and views; and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families”

The findings of this present study have identified that the development of an intrapartum reciprocal relationship between mothers and midwives appears to enable midwives to ‘optimise normal biological processes’ and to ‘work in partnership’ with women, thus realising the vision proposed by the *Lancet* series. Strengthening opportunities for this reciprocal relationship to develop will contribute to the quality of care received by women. Powell Kennedy et al (2016) conducted an analysis of gaps in the evidence presented in the *Lancet* Series on midwifery (Renfrew et al 2014),

identifying thirty possible research topics. The analysis team consisted of contributors from World Health Organisation, United National Population Fund, the International Confederation of Midwives, and a representative for service users. The fourth area for research recognised was, 'Identify and describe aspects of care that optimise, and those that disturb, the biological/physiological processes for healthy childbearing women and fetus/newborn infants and those who experience complications' (Powell Kennedy et al 2016 p.778). The findings of this study have the potential to contribute to the evidence base that might inform the former component of this research thread as they have identified factors, from the midwife's perspective, that may contribute to the promotion and facilitation of normal physiological birth.

Maternity service provision in the UK is undergoing a time of considerable change. The report of the National Maternity Review, Better Births (NHS England 2016) contained a vision for a safer maternity service that was kinder, more personalised and more woman centred. The UK Maternity Transformation Programme sets out to realise the vision of Better Births through the organisation of nine workstreams, one of which is transforming the workforce (Department of Health 2017). Transforming the workforce workstream aims to ensure that the workforce, including midwives, have the right skills to implement the Better Births vision, these include new models of working and continuity of carer. The findings of this study could be utilised to inform the skill development of midwives to enable them to deliver the care envisioned by Better Births (NHS England 2016). In particular, this study revealed that the midwives formed a bond with women experiencing a normal birth based on physical and emotional reciprocity. I argue that enhancing continuity of midwifery carer has the potential to strengthen the bond and therefore enhance the intrapartum experience for mother and midwife. To enable midwives to engage in reciprocal relationships with women during labour they need to nurture their individual physical and psychological capacity to do so, therefore maternity units should consider developing and sustaining supportive and nurturing cultures that encourage this process.

This current study revealed the midwives were prodigiously positive about the promotion of normal birth. This is significant as it is recognised internationally and, in the UK, that the promotion of normal birth is important as it protects the health of women and babies (International Confederation of Midwives 2014). There is a growing body of international research exploring the possible association between non-physiological interventions during the intrapartum period and an interruption of the eustress associated with normal birth (Dahlen et al 2014). It is hypothesised that this



eustress is required to support the neonatal immune system (Dahlen et al 2013). It is also postulated that intervention during childbirth could have the potential to trigger epigenetic consequences that may affect the human epigenome. These hypotheses have yet to be proven but a greater understanding of the factors that influence a midwife's ability to appropriately promote and facilitate normal birth will strengthen their ability to do so, which may ultimately bring about a decline in intrapartum interventions.

As specialists in normal birth midwives need to continue to promote this physiological process as concern continues to be voiced both nationally and internationally about the steep rise in obstetric interventions and caesarean section rates (Dahlen et al 2014, Dahlen et al 2016). Brownlee et al (2017 p.159) also identified that the overuse of medical services is a global problem asserting that 'overuse of unneeded services can harm patients physically and psychologically'.

The phenomenon of interest in this study was normal birth and midwives' experiences of promoting it. Normal birth is paradoxical in nature; it is both an uncomplicated and yet seemingly a complicated socially constructed event, influenced by the epistemological understanding of individuals and communities. However, continued support for normal birth is an important aspect of safe and effective maternity care, now and in years to come.

#### **7.4.2 Implications for midwifery education**

The findings of this study strengthen the need for midwifery educators to ensure that the subject of normal birth continues to be explored fully throughout undergraduate midwifery curricula as both a concept and a philosophy. It is incumbent upon midwifery educationalists to support normality and ensure that student midwives, at the point of registration, are fully equipped with the knowledge and skills to enable them to effectively and appropriately promote and facilitate normal birth. Continuing postgraduate professional development for midwives, should also include a focus on relationship building with women during normal birth. Allowing midwives space and time to consider their personal philosophies of practice and how they might foster a mutually beneficial reciprocal relationship with women during a normal birth may enhance not only their experiences but also those of the women in their care.

#### **7.5 Suggestions for further research**

From the data extrapolated in this current study suggestions for further research are cautiously offered. An unexpected finding of this present study was the phenomenon

of 'midwifery by the desk' which may be worthy of further exploration. If the intrapartum reciprocal relationship between mother and midwife is to be encouraged, it may be beneficial to gain further insight into why midwives may choose to spend time away from the birthing environment. A further finding of this current study was the positive influence that the birthing environment had upon the midwives' experiences of promoting normal birth; research examining this phenomenon may also be beneficial.

The therapeutic use of humour during intrapartum care was touched upon in the current study and may also merit further exploration, to ascertain the potential influence humour may have on the birth experiences of midwives and woman.

The reciprocal relationship that exists between midwives was also very briefly discussed in this study. Examining this relationship in greater detail may provide insights into how midwives relate to one another and how this interaction may influence or enhance their practice. Sandhu et al (2015) identified that reciprocity between professionals may influence their job satisfaction and have a positive effect on levels of burnout. Hunter et al (2018) in their recent survey of the emotional wellbeing and work environment of just under 2000 midwives practising in the UK revealed several disturbing findings that indicated that the midwifery workforce is experiencing a time of considerable emotional distress. Research exploring midwife to midwife relationships in the intrapartum environment may provide insights that contribute to strategies that may assist midwives during this emotionally challenging time.

This current study revealed that fear of normal birth existed for some midwives. This finding adds to a growing body of evidence examining this phenomenon (Dahlen and Caplice 2014, Dahlen and Gutteridge 2015, Pezaro et al 2016). Fear has been shown to impede the release of the hormone oxytocin which has a fundamental influence on the physiological process of normal birth (Uvnäs-Moberg 2003), it is also suggested that experiencing fear may have a detrimental impact upon the quality of care that a midwife is able to provide (Mander and the British Pregnancy Group 2018). Further research exploring midwives' fear associated with the promotion and facilitation of normal birth may illicit useful data to increase awareness and understanding of this potentially detrimental and distressing phenomenon.

van Manen (2014 p.224) offers an appraisal of Heidegger's notion of wonder, where one can see the 'extraordinary in the ordinary and the unusual in the usual'. The

phenomenon of interest in this study has been normal birth. Normal, by definition, has been described as usual or ordinary, however the experiences of the midwives promoting normal birth are anything but usual or ordinary and it is hoped that data extrapolated during this study has indeed revealed the extraordinary. Heidegger (1994) further suggests that there are two significant challenges for any phenomenological researcher. Firstly, to remain open to a 'profound sense of wonder' and secondly to ensure that when writing about the phenomenon under investigation the reader would be captured by that same sense of 'wondering attentiveness'. I can confirm that during the process of writing this study I have been most certainly been struck by a sense of wonder and hope that I have managed to rise to Heidegger's second challenge too.

This study concludes with an excerpt taken from Laura's transcript where she shared a poignant and powerful memory of being present at a normal birth, during which she listened to the well-known song performed by Billy Joel entitled 'always a woman to me'. Laura stated, '*when I came out of the room that song was playing and so now whenever I hear that song I always think of that experience*'. The findings of this study would suggest that for Laura and indeed for all the midwives who participated in this study, the mothers with whom they shared their experiences of promoting normal birth were most certainly always a woman to them.

## Chapter Eight: Reflexive Epilogue

### 8.1 From Both Sides, Now by Joni Mitchel (1967)

But now old friends they're acting strange  
They shake their heads, they say I've changed  
Well something's lost, but something's gained  
In living every day.

I've looked at life from both sides now  
From win and lose and still somehow  
It's life's illusions I recall  
I really don't know life at all

I've looked at life from both sides now  
From up and down and still somehow  
It's life's illusions I recall  
I really don't know life at all

In this final chapter I detail the reflexive journey that I have undertaken during the writing of this thesis. In it I elucidate how my presuppositions were managed and how my thinking has evolved, particularly in relation to the subject of normal birth. I will also consider how I reconciled tensions that may have existed when balancing my roles as a professional, an educationalist and a researcher. When considering how to effectively articulate my reflexive journey, I am drawn to the words of Joni Mitchel, whose evocative lyrics, detailed above, capture the fact that I have undoubtedly 'changed' as a person, a professional and a researcher. I have looked at life from 'both sides now' from my own perspective and from that of the participants in this study. During my research journey I have learned two significant lessons; firstly, that the management of personal and professional presuppositions is fundamental to the research process. I have unquestionably 'lost' some previously held beliefs and 'gained' others. Secondly, I have reaffirmed the belief, that as an existentialist and social constructionist, 'I really don't know life at all'.

#### 8.1.2 Reflexivity as a professional

As discussed in Chapter Four, during the period of my data collection I became known by the staff at the AMU as the 'normal birth woman'. At the time, this felt very natural and welcoming, it did not occur to me that they were not referring to me as the 'normal birth midwife'. It is only now, when contemplating this through a reflexive lens, that I am able to acknowledge that, in this instance, I felt more comfortable being referred to as a woman rather than a midwife, which might explain why I did not notice it. This

may be due to the fact that the term woman reconciled some of the tensions I felt as a midwife, interviewing midwives. My womanhood in part, separated me from my professional midwifery self, helping to balance my insider outsider status.

In Chapter One I discussed my positionality in relation to the subject of normal birth and adopted the definition of normal birth offered by the World Health Organisation (1996), which suggests that a normal birth is one which is:

*“spontaneous in onset, low risk at the start of labour and remaining so through labour and delivery, with the infant being born spontaneously in the vertex position between 37 and 42 weeks gestation. After birth mother and infant are in good condition”* (World Health Organisation 1996 p.4).

However, as this study progressed, I have come to consider the definition of normal to be much more than just a physiological process. Davis Floyd (2011 no page number) suggests normal birth be viewed through a critical lens advocating that, ‘we combine the best of what technological innovations we have to offer, whilst embracing the wild beauty and instinctive power of the big bad wolf in the birthplace’. The big bad wolf being used as a metaphor for nature. My own personal definition of normal birth has come to reflect this call to embrace the nature of normal birth; supporting Buckley’s definition of an undisturbed birth as one which facilitates optimal hormonal orchestration resulting in a smooth physiological, psychological and emotional transition from womanhood to motherhood. I now consider that normal birth should, wherever possible, be a safe and undisturbed event which is supported and nurtured by a beneficially reciprocal mother-midwife relationship.

When considering the meaning of normal birth, it is important to consider women’s perspectives and explore how their perceptions may correspond or contrast with those of midwives. Darra and Murphy (2016) concluded that both women and midwives appeared to value non-intervention in association with normal birth. Downe et al (2018 p.1) in their recent systematic review exploring what matters to women during childbirth concluded that most women wanted a birth experience that ‘...enables them to use their inherent physical and psychosocial capacities to labor and give birth to a healthy baby in a clinically, culturally, and psychologically safe environment...’

From the above it can be concluded that women too value the opportunity to experience a physiological birth. The global debate surrounding the understanding and meaning attributed to normal birth is on-going. The World Health Organisation (WHO) (2018 p.1) recently acknowledged this fact stating, ‘In spite of the considerable debates

and research that have been ongoing for several years, the concept of “normality” in labour and childbirth is not universal or standardized’. The WHO contend that what is important is that all women have a ‘positive childbirth experience’ irrespective of mode of birth. A positive childbirth experience being defined by the WHO (2108 p1) as:

‘one that fulfils or exceeds a woman’s prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff.’

In the future, references to ‘normal’ birth should perhaps, as suggested by the WHO (2018) be replaced with the term ‘positive’ birth.

### **8.1.3 Reflexivity as an educationalist**

I have experienced very few tensions when reconciling my role as a researcher and a professional with my role as an educationalist. I am in, what I consider to be, a privileged position. When in my role as a teacher I am able to interweave my experiences as an experienced professional and as a novice researcher. I am however, mindful to ensure any potential for subjectivity is counterbalanced with objectivity to ensure unbiased, evidence informed practice.

### **8.1.4 Reflexivity as a researcher**

Elaborating on my position as a researcher discussed in Chapter Four, I have learned the fundamental value of reflexivity, and the importance of the self-evaluation. Shaw (2010b p.234) states reflexivity involves looking again and ‘turning your gaze to the self’ to recognise one’s ‘positionality’, that is questioning one’s values, attitudes, beliefs, and experience and their relation to the research question and to others. Throughout the study I have engaged in regular reflexive discussions with my supervisory team during which I have honestly discussed my thoughts and feelings in relation to all aspects of the study but particularly in relation to the participants. This process has assisted in the limitation of subjectivity and enhanced rigor and reliability. (McNair et al 2008). I have also constantly conducted what symbolic interactionists describe as ‘minding’ (Charon 1992); the inner conversation which can be used to consider alternatives before acting. The processes of reflexivity and minding have guided my progress and served to continually remind me of the humble yet influential position of the qualitative researcher.

To further enhance my reflexivity as a researcher, I used a reflexive diary whilst collecting my data. Following each interview, I recorded my impressions and

interactions with the participants. The use of a reflexive diary during data collection is recommended as a vehicle for recording initial thoughts (Smith et al 2009). This in turn enables the researcher to stand back and consider deep and potentially difficult questions (Clancy 2013). Whilst the reflexive diary was useful at the time of initial note taking, it is not until now that I truly comprehend its value. Looking back, my notes captured essences of my interviews and illuminated my thoughts and feelings. Below is an excerpt taken from notes recorded after Lilly's interview:

*'This felt like a very difficult interview initially as Lilly was very reflective and thoughtful. There were long pauses between and during her responses. Surprisingly, I tolerated the silence and resisted the urge to fill the spaces left by the silence or encourage Lilly to speak – actually, I didn't have the urge! Felt a sense of expectant excitement and wanted to wait to hear what she had to say.'*

This extract is very powerful, particularly to me, because I have always had a very low tolerance of silence. As a novice interviewer I had concerns that this intolerance would detrimentally impact upon my interview interactions, and that I would speak more than I would listen, particularly when encountering periods of silence. However, as the extract above illustrates, during my data collection, I developed my ability to tolerate silence. The nature of my interactions with my participants was such that I did not want to either punctuate, or fill the spaces created by their pauses. The concept of silence is complex and intriguing; it is much more than merely the absence of sound (Kenny 2011). Picard (1952) describes it as an autonomous phenomenon suggesting that silence is an empowering component of language. Heidegger (1962) considered that silence reveals possibilities in communication and referred to the concept of 'thinking silence' or 'Sygetics', from *sigan*, the Greek, to be silent. Heidegger (1962 p.225) further contends that 'who is silent during a conversation can suggest, that is, help understanding more genuinely than the one who scatters his words'. This contention aligns very clearly with the double hermeneutic employed during IPA, the more one silently listens the more one is likely to hear and understand the meaning of the words spoken by the participant. During the course of my data collection I came to view silence as a special place to dwell in which to think, listen and learn.

At the beginning of my data collection I felt quite anxious about all aspects of the interview process. As the number of interviews I conducted increased, I learned to relax, and became very aware of the potential influence that my demeanour and body

language may have on my participants. The following extract is taken from my reflexive notes written after Holly's interview:

*'Felt very relaxed during this interview, it seemed to flow very easily. I had a particularly close affinity with Holly both as a woman and as a midwife myself, mutual understanding, parallel perspectives, reciprocal experiences. I was able to be more responsive, felt much less anxious about referring to my prompt sheet, felt like real co-production and a capture of essences. Learned the importance of human sense of agency.'*

This excerpt demonstrates how I relaxed during my interviews and learned the importance of mutual exchange and the co-production of data. I also learned the importance of responding to participants and gained an emerging understanding about the importance of maintaining the participants sense of agency. I became increasingly aware of the importance of prioritising the needs of the participants and ensuring that at all times they felt in control.

## **8.2 Conclusion**

In concluding this thesis, I return to the labyrinth analogy. My Professional Doctorate journey has indeed followed the path of the labyrinth, a path with numerous twists and turns that has ultimately reached a central goal. I began my Professional Doctorate studies with a passion for reading and for expanding my knowledge and understanding of research and the research process. As my study journey has progressed my passion has been fuelled further. I have gained in confidence, and whilst I remain a novice qualitative researcher, it is my intention to conduct further qualitative research to continue to build my confidence and experience. I am grateful for the insights that Heidegger has given to me personally and to the writing of this thesis. Whilst I would not consider myself to be a Heideggerian scholar I have come to value his philosophical perspectives and their application when seeking to understand the lived experience.

In the final words of this thesis I would like to pay tribute to my late father, who instilled in me a lifelong desire to question and learn. His maxim "there's no use standing on the touch-line" encouraged me to always engage in the challenges of life; it resonates as loudly with me today as it did when I was a child.



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## **APPENDICES**

### **APPENDIX ONE (Literature Search)**

## Initial Key Words

Normal childbirth	Alongside midwifery led unit	Promotion	Midwives
Delivery obstetric (subject heading)	Alternative birth centres (tag)	Health promotion (subject heading)	Midwives attitudes (subject heading)
Low risk childbirth	Midwifery service (tag)	Promot*	Midwives (subject heading)
Low risk labour		Advoca*	
Low risk birth*			
Low risk pregnanc*		Encourage*	
		Support*	
Normal labour	midwi* led	Facilitat*	
normal birth*	midwi* N2 unit	Enabl*	
normal childbirth*		Experience*	
Normal deliver*	Birth cent*		
vaginal birth*	AMU		
vaginal childbirth*	AMUs		
Vaginal deliver*	Alongside midwi*		
Natural birth*			
natural childbirth*			
Natural deliver*			
Natural labour	Alongside maternity		
	Alongside maternity		
Physiologic* birth*			
Physiologic* childbirth			

## Final Search Terms

Normal childbirth	Promotion	Midwives
Delivery obstetric (subject heading)	Health promotion (subject heading)	Midwives attitudes (subject heading)
Low risk childbirth	Motivation (subject heading)	Midwives (subject heading)
Low risk labour	Promot*	Midwi*
Low risk birth*	Advoca*	
Low risk pregnanc*	Encourage*	
Normal labour	Support	
normal birth*	Facilitat*	
normal childbirth*	Enabl*	
Normal deliver*	Experience*	
vaginal birth*		
vaginal childbirth*		
Vaginal deliver*		
Natural* birth*		
Natural* childbirth*		
Natural* deliver*		
Natural* labour		
Physiologic* birth*		
Physiologic* childbirth		

**APPENDIX TWO**  
**(Studies included in the literature review)**



Author	Setting/Location	Title	Method	Participants	Conclusion (s)	Comments/Limitations
Aune et al (2017)	Norway Home birth locations	Nature works best when allowed to run its course. The experience of midwives promoting normal births in a home birth setting.	Qualitative in-depth interviews	9 independent midwives with 5-26 years' experience	Midwives attitudes had a significant impact on promoting normal birth. The midwives had faith in normal birth and considered it important to transfer this belief to women.	Being in a safe environment with a known midwife provides a secure base for a normal birth. Study limitations: small sample size, did not offer a comparison between the attitudes and experiences of midwives working in 'birth clinics'.
Butler (2017)	British Columbia Hospital and community locations	Exploring the strategies that midwives in British Columbia use to promote normal birth	Interpretative phenomenology	14 midwives with 5 -20 years' experience 1 collaborative 4 solo practice 9 midwifery group practice	'Midwives consider themselves as instruments of care and use a range to interventions and skills to 'nudge' pregnancy, labour and birth towards normal.'	Continuity of midwifery care was deemed essential to the promotion of normal birth. Study limitations: small sample sizes used to represent each area of practice which reduced the applicability of the findings.
Carolan-Olah et al (2015)	Australia A public hospital birthing suite	Midwives' experiences of the factors that facilitate normal birth among low risk woman in a public hospital in Australia	Interpretative Phenomenological Analysis	22 midwives with 5 or more years' experience	Factors that facilitated normal birth included a supportive environment, midwifery attitudes and a desire to promote normal birth. The promotion of normal birth required 'pluck'.	Facilitating normal birth was tough and required effort beyond usual care. Study limitations: the findings were restricted to one hospital reducing generalisability. Only midwives who supported normal birth were included in the study.
Guiver (2004)	UK A free-standing Midwifery Led Unit	The epistemological foundation of midwife-led care that facilitates normal birth	Qualitative critique of semi-structured interviews	9 midwives with 1->10 years' experience	The skills and knowledge that support normal birth are decreasing because of the predominance of the medical paradigm.	The midwives demonstrated knowledge that protected and supported normal birth which could be used by midwives in other birth settings. Study limitations: small sample size

Author	Setting/Location	Title	Method	Participants	Conclusion (s)	Comments/Limitations
Keating and Fleming (2009)	Ireland obstetric led labour wards in 3 urban maternity units	Midwives' experiences of facilitating normal birth in an obstetric-led unit: a feminist perspective	Qualitative feminist research approach	10 midwives with 6-30 years' experience 5 from unit 1 3 from unit 2 1 from unit 1	The midwives' capacity to facilitate normal birth was impeded by the medical culture of birth.	The ability to implement evidence-based normal birth care was promoted in the units in which the midwives worked. Study limitations: findings confined within the context of Irish maternity service provision.
Price and Johnson (2006)	UK 2 obstetric unit labour wards	An ethnography of experienced midwives caring for women in labour.	Ethnography	6 midwives, 3 from each unit with > 5 years' experience	The tacit nature of midwifery knowledge needs to be made explicit or midwives may risk losing the artistry in their practice which involves midwives and women working together to promote normal birth.	The creation of a supportive and welcoming birth environment helped the midwives to establish a rapport with the women. Midwives acknowledged the importance of peer support in enabling them to support women. Study limitations: Small sample size
Reed et al (2016)	Australia 1 private hospital 1 public hospital Home birth setting	Midwifery practice during birth: Ritual companionship	Narrative inquiry	10 midwives with 2-27 years' experience	Midwives adopt the role of a 'ritual companion' during labour.	Two types of midwifery practice were illustrated 'rites of protection' and 'rites of passage'. The narratives concentrated in what had occurred rather than observational data.
Russell (2007)	UK 2 obstetric unit labour wards	Mad, bad or different? Midwives and normal birth in obstetric led units	Grounded theory	6 midwives (3 from each unit) With 2->15 years' experience	The midwives' individual empowerment and faith in normal appeared to influence their ability to support normal birth	Some midwives used tactics to maintain control over normal labour and birth. Study limitations: small sample size and confined geographical location

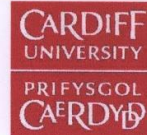
Author	Setting/Location	Title	Method	Participants	Conclusion (s)	Comments/Limitations
Thompson et al (2016)	The Netherlands 1 obstetric led unit and community settings	Exploring Dutch Midwives' attitudes to promoting physiological childbirth: A qualitative study	Exploratory, qualitative design using focus groups.	14 Hospital - based midwives, 23 Community - based midwives with 4-38 years' experience	Midwives, regardless of setting, need to develop strategies to 'facilitate rather than manipulate physiological birth'	To become confident and competent physiological birth practitioners' midwives need to know what helps and what hinders this mode of birth. Study limitations: participants were self-selecting who were pro physiological birth and therefore may not be representative of the wider midwifery community.
Walsh (2006)	UK Free-standing birth centre	'Nesting' and 'Matrescence' as distinctive features of a free-standing birth centre in the UK	Ethnography	10 midwives with a range of experience	Midwives established an environment for birth that encouraged maternal 'nesting'. Midwifery behaviour was deemed 'matrescence' (becoming mother).	Matrescence is described as an attitude to birth, one which fosters mothering behaviours. These behaviours were deemed pivotal in helping women to make the transition to early motherhood. Study limitations: small numbers and singular location limit the generalisability of the findings.
Zinsser et al (2016)	2 regions of South Germany Obstetric and midwifery led units	Midwives' attitudes towards supporting normal labour and birth – A cross-sectional study in South Germany	Cross-sectional study.	188 midwives with an average of 14 years' experience 80 labour ward midwives 80 midwives providing only antenatal and postnatal care 24 midwives working in either MLU of home birth settings 4 midwife teachers.	German midwives need to do more to support & promote normal birth. Midwives with less experience had more confidence in the promotion of normal birth than more experienced midwives.	The midwives' attitudes towards supporting and promoting normal birth was most greatly influenced by their work environment. Study limitations: inability to calculate a response rate. The study design did not allow for a cause and effect relationships to be determined.

**APPENDIX THREE**

**(Cardiff School of Health Care Sciences Postgraduate Research,  
Review and Ethics Committee approval)**

School of Healthcare Sciences  
Head of School and Dean Professor Heather  
Waterman

*Ysgol Gwyddorau Gofal Iechyd  
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt*



21 April 2016

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Tina Dennis



Dear Tina

**What are the lived experiences of midwives promoting normal childbirth with women experiencing a low risk pregnancy in an Alongside Midwifery Unit (AMU)? A phenomenological study.**

At its meeting of 19 April 2016 the School's PGT Research Review and Ethics Committee considered your research proposal. The decision of the Committee is that your work should:

**Pass –and that you proceed with your Research.**

The Committee has asked that the lead reviewers' comments be passed onto you, please see below.

**The PIS says Chris Shaw can be contacted to raise a complaint, but the Consent Form advises contacting Liba Sheeran with any concerns, in fact it should be the Director of Research Governance.**

Please note that if there are any subsequent major amendments to the project made following this approval you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months' time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Mrs Liz Harmer – Griebel

**APPENDIX FOUR**  
**(Health Research Authority approval)**

Mrs Tina Dennis  
[Redacted]

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

07 October 2016

Dear Mrs Dennis

**Letter of HRA Approval**

**Study title:** 'What are the lived experiences of midwives promoting normal childbirth with women experiencing a low risk pregnancy in an Alongside Midwifery Unit (AMU)?  
A phenomenological study.

**IRAS project ID:** 207046

**REC reference:** 16/HRA/2145

**Sponsor** Cardiff University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

**Participation of NHS Organisations in England**

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from [www.hra.nhs.uk/hra-approval](http://www.hra.nhs.uk/hra-approval).

### Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

### After HRA Approval

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk), and emailed to [hra.amendments@nhs.net](mailto:hra.amendments@nhs.net).
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk).

### Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application



procedure. If you wish to make your views known please email the HRA at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

#### HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **207046**. Please quote this on all correspondence.

Yours sincerely

Beverley Mashegede  
Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

Copy to: Ms Helen Falconer (Cardiff University), Sponsor Contact

[REDACTED] Hospital Foundation Trust Research  
& Development Office), Lead NHS R&D Contact

Dr Judith Carrier (Cardiff University), Supervisor

## Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Contract/Study Agreement [Statement of Activities]		07 October 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]	1	16 June 2016
IRAS Application Form [IRAS_Form_20062016]		20 June 2016
IRAS Application Form XML file [IRAS_Form_20062016]		20 June 2016
IRAS Checklist XML [Checklist_20062016]		20 June 2016
Letter from sponsor [Sponsorship letter]	1	06 June 2016
Other [Schedule of Events]		07 October 2016
Participant consent form [Consent form]	4	07 October 2016
Participant information sheet (PIS) [Participant Information Sheet]	4	07 October 2016
Research protocol or project proposal [Research Proposal]	1	18 June 2016
Summary CV for Chief Investigator (CI)	1	17 June 2016
Summary CV for student [Student CV]	1	16 June 2016
Summary CV for supervisor (student research)	1	17 June 2016

## Appendix B - Summary of HRA Assessment

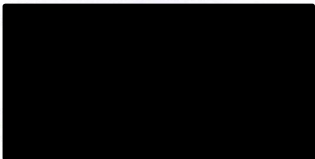
This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.***

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Ms Helen Falconer, 02920879277, [falconerhe@cardiff.ac.uk](mailto:falconerhe@cardiff.ac.uk)

### HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	<p>The student researcher's details were left out in error on section A2-1;</p> <p>Name: Mrs Tina Dennis</p>  <p>Name and level of course/degree: Doctorate in Advanced Healthcare Practice (DAHP) (level 8)</p> <p>Name of educational establishment: Cardiff University</p>
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments

Section	HRA Assessment Criteria	Compliant with Standards	Comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor intends that the statement of activities acts as the agreement between the site and the sponsor.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study.
4.3	Financial arrangements assessed	Yes	No application for external funding was made. No funds will be provided to the participating organisation to support this study.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	This is a non-REC study.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

This is a student (Doctorate in Advanced Healthcare Practice) study and there is one site type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). The HRA will work with these organisations to achieve a consistent approach to information provision.

### Confirmation of Capacity and Capability

*This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.*

The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research.**

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- Following issue of the Letter of HRA Approval the sponsor may commence the study at these organisations when it is ready to do so.
- The document "[Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected](#)" provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expected, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix.

### Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

No Principal Investigator or Local Collaborator is expected at the participating organisation.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

### HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

No Letter of Access is expected as this is a staff only study being undertaken in non-clinical areas.

### Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

**APPENDIX FIVE**  
**(National Health Service Trust Letter of Access for Research)**

[REDACTED]

[REDACTED]

[REDACTED]

Tina Dennis

[REDACTED]

29 November 2016

Dear Tina,

**Letter of access for research**

This letter should be presented to each participating NHS organisation before commencing your research at [REDACTED] NHS Foundation Trust.

In accepting this letter, [REDACTED] NHS Foundation Trust confirms your right of access to conduct research for the 'What are the lived experiences of Midwives promoting normal childbirth with women experiencing a low risk pregnancy in an alongside midwifery unit (AMU)?' Study through our NHS organisation for the purpose and on the terms and conditions set out below. This right of access commences on 29<sup>th</sup> November 2016 and ends on 1<sup>st</sup> December 2018 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating NHS organisation. The NHS organisation is satisfied that the research activities that you will undertake in the NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the NHS organisation. Evidence of checks should be available on request to [REDACTED] NHS Foundation Trust.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the NHS organisation permission to conduct the project.

NHS to NHS Agreement Letter Version 2.3



You are considered to be a legal visitor to [REDACTED] NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by [REDACTED] NHS Foundation Trust to employees and this letter does not give rise to any other relationship between you and [REDACTED] NHS Foundation Trust, in particular that of an employee.

While undertaking research through [REDACTED] NHS Foundation Trust, you will remain accountable to your employer Birmingham City University but you are required to follow the reasonable instructions of your nominated manager [REDACTED] Consultant Midwife, [REDACTED] NHS Foundation Trust or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [REDACTED] NHS Foundation Trust or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [REDACTED] NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [REDACTED] NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [REDACTED] NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating [REDACTED] NHS Foundation Trust prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The NHS organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the NHS organisation accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the NHS organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform the nominated manager [REDACTED] Consultant Midwife, at [REDACTED] NHS Foundation Trust.

Yours sincerely

[REDACTED]

**Research & Development Manager**

**cc: R&D office at [REDACTED] NHS organisation  
HR department of the substantive employer – Birmingham City  
University**

**APPENDIX SIX**  
**(Participant Information Sheet)**



## **Participant Information Sheet**

Dear Midwife

This letter is an invitation to consider participating in a research study that I am conducting as part of my Professional Doctorate in Advanced Healthcare Practice (DAHP) at Cardiff University under the supervision of Professor Billie Hunter, Dr. Judith Carrier and Dr. Lucie Warren. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part. I am hoping to recruit between 6-8 midwives, across all grade bandings.

**IRAS ID:** 207046

### **Study Title**

What are the lived experiences of midwives promoting normal childbirth with women experiencing a low risk pregnancy in an Alongside Midwifery Unit (AMU)?: A phenomenological study.

### **The Purpose of This Study**

The purpose of this study is to explore the lived experiences of midwives promoting normality with women experiencing a low risk pregnancy who opt to birth in an Alongside Midwifery Led Unit.

### **What's involved?**

If you are willing to participate you will be invited to a one to one, semi-structured interview with me at a location within the clinical area at a time that is convenient for you. The interviews will be held between December 2016 and May 2017. The interview will last approximately 60-90 minutes and consist of approximately 6-10 open ended questions e.g Can you tell me what normality in midwifery practice means to you?

You may decline to answer any of the interview questions if you so wish. With your permission, the interview will be audio recorded to facilitate the accurate collection of information, which will be transcribed at a later date for analysis.

### **Voluntary Participation**

Participation in this study is entirely voluntary.

### **Anonymity**

Your name will not appear in any thesis, publications or reports resulting from this study, however, with your permission quotations may be used. If quotations are used they will be anonymised and so will not be attributable to you.

### **Right to Withdraw**

It is important that you are aware that you have the right to withdraw from this study at any time up to one month after your interview has taken place. In addition, I will send you a copy of the interview transcript to give you an opportunity to confirm the accuracy of our conversation and to clarify or withdraw any particular comments that you do not want to appear in the public domain.

### **Storage of Data**

All personal identifiable data e.g. your name and contact details collected for this study will be stored separately from the data generated by the interview transcripts. All data will be retained in a locked filing cabinet in a locked office. Personal identifiable data will be destroyed on completion of the study and data generated will be stored for a maximum of 5 years; when it will be destroyed appropriately in accordance with university policy. Researchers associated with this project, transcriber(s) the study sponsor and supervisors will have access to the study data. All word processed documents will be saved and password protected.

### **Risks**

This is a low risk study. However, should you become distressed during or following your interview you are encouraged to contact your Supervisor of Midwives for support. Additionally to ensure the safety of women and their baby's and to comply with the requirements of the NMC Code (NMC 2015) the Head of Midwifery will be informed about any unsafe practice that may be disclosed during your interview.

### **Raising Concerns**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to me. I will do my best to answer your questions, and my contact details are given at the end of this document. If you remain unhappy and wish to complain formally, you can do this by contacting Dr Kate Button, Director of Research Governance, School of Healthcare Science, at Cardiff University, room 2.20 Cardigan House, Heath Park, Cardiff CF14 4XN or contact her by either telephone on 029 206 87734 or via email at [Buttonk@cardiff.ac.uk](mailto:Buttonk@cardiff.ac.uk)

### **Feedback on Study Results**

Upon completion of the study I will inform you of the study results by email.

### **Further information**

Information sessions about this study will be held at the AMU on the following dates:

TBC

If you would like any further information, please do not hesitate to contact me:

Researcher: Tina Dennis

Email: [REDACTED]

Telephone: [REDACTED]

**APPENDIX SEVEN**  
**(Interview Prompt Sheet)**

## **Interview Prompt Sheet**

### **Introduction**

- Thank you for agreeing to be interviewed today. Please feel free to speak freely and think of this more in terms of a conversation than a one sided interview. Please contribute as much or as little as you want.
- This is not a test and there are wrong or right answers.
- Can you confirm that, having given your consent to participate, you still happy to do so?
- This interview will be audio recorded.

### **Prompts**

1. Please can you tell me how long have you been practising as a midwife?
2. Please can you tell me a little about your midwifery career so far?
3. How long have you been working on the AMU?
4. Please can you tell me about your views and feelings about normal childbirth?
5. I would be very interested to hear about some of your own experiences of promoting normal birth, please can you tell me some of your stories?
6. Have you experienced any challenges when promoting normal birth?
7. Do you have any concerns about promoting normal birth?
8. Is there anything else that you fell would be useful to include that we have not discussed?

### **Closing discussion**

Thank you for your time today.

Would you mind if I contacted you again to clarify any points?

**APPENDIX EIGHT**  
**(Consent Form)**





**Consent Form**

I have read the information presented in the participant information sheet about the study being conducted by Tina Dennis DAHP student at Cardiff University.  
IRAS ID: 207046.

I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that my interview will be audio recorded to ensure an accurate recording of my responses.

I am aware that verbatim extracts from the interview may be included in the final published thesis and any other publications to come from this research, with the understanding that any quotations used will be anonymous.

I am also aware that to ensure the safety of women and their baby's and to comply with the requirements of the NMC Code (NMC 2015) the Head of Midwifery will be informed about any unsafe midwifery practice that may be disclosed during my interview.

I was informed that I may withdraw my consent at any time up to one month after my interview has taken place without penalty by advising the researcher.

This project had been reviewed by Cardiff University, School of Healthcare Sciences, School Research Ethics Committee (SREC) and received favourable ethical opinion, I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact [redacted] Director of Research Governance, School of Healthcare Science, at Cardiff University, [redacted] either telephone or [redacted]

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

YES       NO

I agree to have my interview audio recorded.

YES       NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

YES       NO

Participant's Name (please print) \_\_\_\_\_

Participant's Signature \_\_\_\_\_

Date:

Researcher's Name (please print) \_\_\_\_\_

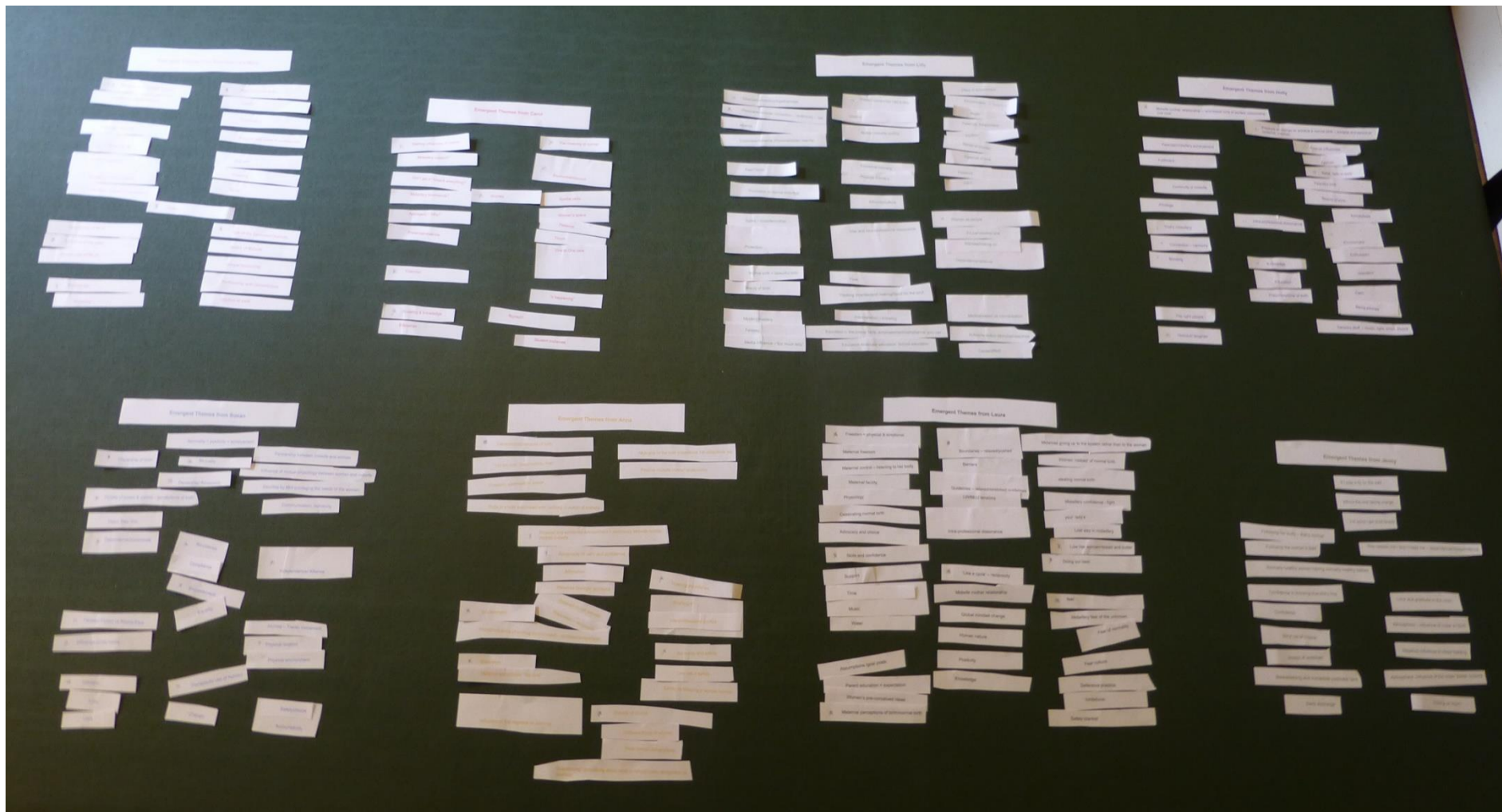
Researcher's Signature \_\_\_\_\_

Date:

## **APPENDIX NINE**

**(Identification of emerging super-ordinate and sub-ordinate themes for each individual midwife)**

# IDENTIFICATION OF EMERGING SUPER-ORDINATE AND SUB-ORDINATE THEMES FOR EACH INDIVIDUAL MIDWIFE



## **APPENDIX TEN**

**(Identification of emergent super-ordinate and sub-ordinate themes across the group)**

# IDENTIFICATION OF EMERGENT SUPER-ORDINATE AND SUB-ORDINATE THEMES ACROSS THE GROUP

