An ethnographic exploration of womens midwives and obstetricians beliefs about maternal movement during labour

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Abstract

The aim of this project was to identify how cultural differences influence maternity care and knowledge acquisition about movement in labour.

A Focused Ethnographic (FE) approach was used. FE is a research method employed to investigate cultural dimensions of specific aspects of contemporary society, an approach different in scale and intensity to conventional ethnography (Knoblauch, 2005). The data were collected from one to one interviews, one group interview and field observations. Data were collected from three groups of participants: 9 women, 10 midwives and 6 obstetricians. The data gathered from the three groups were analysed by thematic analysis to develop an in depth understanding of ideological and cultural differences that influence maternity care and knowledge acquisition about maternal movement in labour. Feminist thought informed the project, acknowledging women and midwives as knowers of equal standing within maternity care services.

The main findings showed a binary in cultures of maternity care provision. Where the basic underlying assumptions of a culture are love, compassion and empathy, then relationship-based care and women's empowerment are espoused and valued. This leads to openly shared knowledge and learning around movement in labour. Where the basic underlying assumptions of a culture are lack of empathy, dignity and choice, rigid boundaries are set, medical practice maintains control and dichotomies in care provision around movement are prevalent. However, these binaries are fluid and nuanced and are not static to an area or individual.

Barriers and facilitators to implementing care that supports maternal movement are presented. This requires a shift in the way that birth is presented and learned about in obstetric practice and wider society. This will require leadership, valuing women and midwives and the knowledge they share, and a collaborative approach to birth involving women, midwives and obstetricians.

Chapter One

1. Origins and scope of the project

1.1 Introduction

This chapter provides an overview of origins and scope of this research project examining the context of knowledge acquisition about movement during labour. By taking a sociological perspective, context will be given to how movement and maternity care is viewed to address the organisational culture of birth and maternity services. Justification is given to why a feminist sociological approach is applied to the investigation and the aims and objectives of the study are outlined.

1.2 Women, labour and maternity services

Labour can be described as:

> 'A complex phenomenon of interdependent physical, hormonal and emotional changes, which can vary enormously between individual women' (Charles, 2013, p 16).

This holistic or humanistic (Davis-Floyd, 2001) view of birth moves beyond the mechanistic Cartesian interpretation of bodily functions (Moses and Knutsen, 2012). Instead, this interpretation of labour is a chain of inseparable intertwining elements, one of which is the individual and emotional significance of the experience. This holistic paradigm places women at the centre of the care and values women as a whole person and most significant within the labour and birth process (Davis-Floyd, 2001).

In the UK approximately 98% of births take place in hospital (Office for National Statistics 2011). This places birth within medical institutions, governed by the medical model of care (Davis-Floyd, 2001). A hierarchy of social order exists within medical institutions dominated by patriarchal ideology, which embeds the superiority of objective scientific exclusivity and knowledge (Foucault, 1973).

The medical model of birth (Davis-Floyd, 2001) sees birth as a mechanical process, with the purpose of midwifery care during labour being to provide objective, standardised observations to monitor a pre-determined interpretation of progress. This enables obstetric knowledge and technology to repair and improve on nature if it deviates from this standard,

thus improving safety and minimising risk to the fetus. Observing the mother and fetus in this way can inhibit women's natural instinctive behaviour during labour (Walsh, 2009, Buckley, 2003, Odent, 2001). Placing birth within the hospital environment removes women from an experiential and instinctive knowledge of birth (Kitzinger, 2001). With the obstetric bed as the focal point of most hospital labour and delivery rooms, the expectation is for women to assume the immobile passive patient role on the bed (Jowitt, 2014).

1.3 Movement during birth

Maternal movement during the first stage of labour is a natural aspect of behaviour which is available to most women (Jowitt, 2014).

Through making a woman aware of the movements and positions that encourage the fetus to adopt an optimal position for birth or by enabling a woman to move her body into a position that facilitates fetal descent, she is empowered to birth her own baby. Women's movement in labour can be used to empower or disempower and to engage women within their own birth process.

By exploring the literature regarding movement, an impression can be gained of where movement features within the current cultural context, how it is represented and the value it is given as an aspect of birth available to most women. This project explores the beliefs and knowledge about movement held by women, midwives and obstetricians.

1.4 Why beliefs not actions?

A wide variety of movements can be used to assist labour and birth. This project does not focus on movement but on beliefs and knowledge that inform care during birth. This delves beyond description to discover the deeper meaning assigned to movement and how the participants interpret this. Through exploring these beliefs, analysis will examine the justification for these beliefs. In my midwifery practice, I used and observed movement during labour. I have a good working knowledge of the physiology of movement and an understanding of how my personal beliefs around using a physiological element of labour care may influence women. My interest lies with how women, midwives and obstetricians gain their knowledge around this aspect of labour care, as in my experience, individuals from these three groups tend to have different opinions. I have traced what I believe to be the origin of my beliefs around maternity care and what I value and how I practice through reflection and

I am able to align this with the literature around maternity care. This project highlights the roots of participants' beliefs and how the culture of maternity care and the system in which it is located affects this. Giving credence and value to these beliefs provides an insight into the cultures present in maternity services and society.

A belief is something that is thought to be true by the person holding that belief and is the most basic form of social knowledge informing behaviour (Smoa, 2007). People hold many beliefs. Some beliefs almost everyone would agree with; other beliefs, such as the best action to take in a given situation, may elicit disagreement (Morton, 2003). The rational acquisition of a belief is the ability to provide a justified reason for holding that belief. Using scientific information or knowledge to inform a belief imparts credibility (Morton, 2003). However, there will always be discussion around what counts as knowledge when birth takes place within a hospital operating under a system that strives to integrate different epistemologies.

1.5 Beliefs around movement during labour

This project will focus on beliefs and knowledge acquisition of movement in labour to gain an understanding of how they influence women's experiences of labour, the care they receive, and midwifery and obstetric practice. Women, midwives and obstetricians were interviewed about their knowledge of movement, the formation of their beliefs, and how perceptions of others affect women's experiences of movement.

1.6 Obstetric and scientific influence on normal labour

Regarding maternal position and mobilisation NICE conclude:

> 'Surprisingly, there are no trials examining the effect of freedom of movement throughout labour compared with restriction of movement on outcomes such as comfort, labour progress and fetal wellbeing.' (NICE, 2014, p. 238).

This quote illustrates the dominance of the medical model of maternity care. The assumption is made that a single objective, physical element of labour can be separated from a woman's psychological and emotional self and from the context of her environment and social circumstances. In a discourse which objectifies women as 'patients' it conveys surprise that a trial has not been carried out that compares 'freedom' of movement with 'restriction' of movement. However, to apply these constraints to labouring women for the benefit of a

randomised control trial that could provide scientific evidence that proves this single element could influence outcomes would be unethical as it denies personal autonomy (Frith & Draper, 2004).

When assessing the impact of interventions, quantitative methodologies are valuable tools adding to the evidence base. Producing objective knowledge in this way can be viewed as a masculine method of knowledge production (Oakley, 2000; Sydie, 1994). Through providing a standardised description of movement and by using scientific methods to construct knowledge around a single element of labour, evidence is produced which can be verified in its objectivity, rigour and methodology to produce a truth around what is considered to be known about labour.

From the variation of results shown in the literature around movement in chapter two, the difficulty in standardising an intervention which is individual and dependant on participant and carer, it is difficult to see how a standard recommendation based on these parameters can be made. Yet attempts are made by researchers, Cochrane and NICE to collate knowledge that can be standardised and applied to all labouring women. Research methodologies which are participatory, validate subjective experience within the context of individual women's lives are not included in this validated evidence base.

1.7 Obstetric dominance and the effect on physiological birth

Obstetrics is a branch of medicine concerned with the care of women during pregnancy, labour and in the immediate puerperium (Chamberlain, 1999). In the United Kingdom the midwife is the expert in normal pregnancy, labour, birth and postnatal care. Referral to obstetric colleagues is required if events during this time become abnormal and therefore out of the sphere of midwifery practice (Nursing and Midwifery Council (NMC), 2012). Whilst midwifery practice today is informed by current scientific knowledge, the roots of midwifery are imbedded in a more social role. Historically midwives were women in the community who assisted other women using her experience and knowledge gained from being present at many births (Donnison, 1988).

There is no doubt that social and scientific advances have improved care provision for women and their babies. However, the influence of obstetric care during labour and birth can be illustrated by the internationally rising Caesarean Section (CS) rate. In China the CS rate in

2007-2008 was estimated at 46.2% (Lumbiganon et al. 2010). In Brazil it is currently estimated at approximately 82% an increase from around 47% in 2007, (Victora et al. 2011) and in the USA over 30% of births are via CS. It is suggested that health providers preference influence the CS rate in China (Huag, 2013) and in the Brazilian health care system, health care provision (Victora et al. 2011) and the culture surrounding birth (Diniz & Chacham, 2004) are affecting the growing CS rate. Birth, a physiological process has become influenced by the belief that medicine, science and technology provide better risk-free outcomes for mother and child. However, the World Health Organisation believe that once CS rate rises over 15% the risks of the procedure outweigh the benefits (World Health Organisation 2015). Unnecessary CS above this rate show negative implications for health equity (Gibbons et al. 2010).

In addition to the risks to the woman of a CS, far-reaching implications for the child and future generations have been highlighted by the lack of exposure to the woman's natural vaginal flora causing irreversible effects on the child's micro biome (Cho & Norman, 2013) highlighting the impact that obstetric practice has on society.

1.8 The impact of midwifery care and environment on normal labour

Care provider and environment have been identified as affecting labour. Environmental factors such as place of birth have been shown to have an impact on birth outcomes (Brocklehurst et al. 2011). There is a wealth of midwifery research on the positive impact of a known midwife and midwifery models of care which have psychological and emotional benefits for women's experience in addition to enhanced physical birth outcomes (McCourt & Stevens, 2009). In his ethnography on a free-standing birth centre, Walsh (2006) explored how the culture within the unit had positive impact on the women who chose to use this service. He highlighted how the midwives' beliefs, attitudes and sense of their role within the local community influenced maternity care given. When exploring midwives' beliefs around normality and risk during childbirth Copeland et al. (2014) found that the dominance of the obstetric model of care and over use of birth technologies prevented midwives practising in a way which reflected their belief in normal birth.

1.9 Political, market and financial influences on maternity care

The organisation and culture within the NHS are responsive to political and financial influences, which drive the availability of services offered (Deery, Hughes & Kirkham, 2010). Globalisation, modernising state and privatisation are three concepts, which are reshaping

and controlling the location of maternity services at a meta-level (Murphy-Lawless, 2011). These concepts are emerging in health care in countries that had a welfare state but are now moving towards market globalisation operating in a framework of entrepreneurial freedom, which is characterised, by private property rights, free markets and free trade (Ibid). Through turning health services into a commodity and into the domain of the market, it enables profit to be made and lessens the state's commitment to the health care system. This is primarily an American model that is vastly profitable and reliant on health insurance cover and does not improve perinatal mortality (Amnesty International, 2011).

At the time of writing this thesis, NHS services are in flux. Modernisation of the NHS through the influence of capitalism and health as a commodity in the market place was introduced in the late 1980's and early 1990's through the development of independent NHS hospital trusts as private companies. This led to the beginning of local services and the NHS as the sole provider of health services being dissolved, opening health and acute services to the open market inextricably linking choice with competition between trusts. Building the NHS on a business model has allowed private sector models of finance, management and planning to shape health services with worsening services and outcomes, increased health inequalities and demoralised staff (Murphy-Lawless, 2011).

1.10 Business and commissioning of services

In addition to the formation of hospital trusts, health care competition has led to legislation in the form of the Health and Social Care Act 2012 (Department of Health) which enables users of health services to be referred by their GP to 'Any qualified provider' for treatment from a specialist rather than to their local NHS provider. The governments stated that the aim for doing this was to increase quality of care through increasing patient choice (British Medical Association, 2013). Through service users choosing the best services, poorer services need to improve to compete for funding therefore driving up standards (Ibid).

As individual NHS trusts are running as independent businesses, there is freedom on how services are organised, with each trust varying in the service that they offer or which facilities they choose to invest money and resources into. Whilst this system of service provision allows for innovation in the way that government recommendations are interpreted and services are provided, it also allows a great disparity between areas; a service in one area may be vastly different to another and may not meet the needs of the individual patient/ service

user. With the change in legislation around commissioning services, private companies are now able to tender for services, adding another layer to the disparity and availability in services.

Clinical Commissioning Groups (CCGs) run by GPs are responsible for commissioning services available to the public. In the North West of England maternity services have been commissioned from a non-NHS company, enabling women to choose a midwifery service which offers continuity of midwife (One to One Midwives), and a service rarely available from the NHS. Whilst this choice of provider is available to women from 6 CCGs in the North West of England, Greater Manchester CCG took the decision to not approve referrals from February 2015 (Health Watch, Bury, 2015). Their decision for this has not been made available and in response, a campaign was set up by women to challenge this decision (Brewster, 2015).

1.11 Centralisation of services

Over the past century midwifery as a profession has had many masters. From origins of being regulated by the church and serving women in the local community, legislation in 1902 passed regulation to the law under the supervision of doctors. From the inception of the NHS in 1948, midwifery services were based in the district and funded by local councils. With the move to hospital, birth in the 1970's midwifery became under the governance and employ of the hospital.

Recently, politically motivated reconfiguration and centralisation of maternity services has taken place causing tension for staff (Davies and Rawlinson, 2012). Macfarlane (2008) concluded that the quality of care given has not been shown to be increased by the merger and centralization of maternity units, which has tended to affect the morale of management and staff, this is also supported by Davies (2006). The effects of politically driven maternity care provision and NHS expectations of midwifery work has been identified as a reason why midwives leave the profession (Ball et al. 2002). This was also an effect of the reconfiguration of services at the study site, along with staff being redeployed in different managerial or clinical areas or being placed in teams with different workloads, leadership values and management principles (Davies & Rawlinson, 2012). The merger has had the benefit of the investment made in the building and the concentration of specialist obstetric and neonatal staff. However, the belief that larger hospitals result in lower costs, better clinical outcomes and that women would prefer more medicalised care is not supported by outcomes or

research (Bones, 2005). In fact, the evidence supports smaller, community-based midwifery care (Brocklehurst et al. 2011; Walsh & Newburn, 2002; Sandal et al. 2016; Reid, Young & Gilmore, 1999). McCourt et al. (2012) show how maternity care services are managed differently between trusts, affecting the services offered and highlighting the lack of parity between services nationally.

1.12 Business, budgets and consequence

Another current issue within the NHS is cost savings. Within the current economic climate budgets have been cut and every attempt is made to keep within ever decreasing funding. The impact of this includes staff shortages which affect care, government targets not being met, low morale due to the strain this puts on staff, enforced salary freezes, pension reforms and staff downgrading.

Amidst this is the critique of NHS managed services. The Francis Report (Francis, 2013) highlighted the mismanagement of services and care provision at the Mid Staffordshire NHS Trust and how this led to preventable deaths. It highlighted the need for a change in culture from the trust board to individuals calling for more regulation, monitoring and responsibility. In addition, the Kirkup Report (Kirkup, 2015) was undertaken after serious failures in clinical care resulting in avoidable harm and deaths of women and babies in Morecambe Bay. This report critiqued the systems in place for monitoring, reporting and handling of incidents. Both of these reports recognised and criticised the systems and structures within which the context of where these incidents took place however, none of these reports recognised the systems and structures themselves as culpable. Both, whilst prevailing that a culture of blame must not be implemented, identify individual professionals as responsible for failings. The wider political, every-changing, quango governed infrastructures and systems are not challenge as though the meta-narrative is common sense.

1.13 Staff as commodities

NHS trusts are run as businesses, hierarchical structures maximising efficiency, with senior management having little or no clinical experience and divorced from the front-line staff. These political impactors shape the way care is delivered. Great emphasis is given to care and treatment that has been shown to be effective in research; policies are generated at a national and local level to ensure care received is targeted as the most appropriate in relation to clinical effectiveness, safety and cost. It is felt that clinical judgement is being eroded by

the requirements of the business to ensure that care provided is uniform and emphasis is given to recording of data to satisfy these providers rather than patient care (Murphy-Lawless, 2011).

At a professional level each Doctor, Nurse, Midwife and Allied Health Professional is responsible for their own practice, all having a duty of care to the people in their care. Individual professional bodies have statutory requirements for what is encompassed in a professional's sphere of practice and how members of each profession should conduct themselves, and in addition, professional bodies make recommendations and guidelines for encouraging good practice. However, these rules, standards and guidelines can sometimes conflict with NHS trusts policies, guidelines and working environments for implementing care.

1.14 A feminist sociological perspective on movement in labour

Feminism and sociology are used to enable an understanding of society and women's position in it (Abbott, Tyler & Wallace, 2006). Therefore, by using these perspectives an understanding of movement during labour can be gained in the context that it is used. Not just as it is experienced in the hospital environment but in wider society, from women's positionality and experience in society and all the external influences that influence the hospital services and the staff that are employed.

The claim of the research methods used in scientific studies around movement in labour are to establish facts. Using authoritative medical knowledge to underpin and justify the use of movement using this ideological justification supress's woman's bodily knowledge and midwifery experiential knowledge. Scientific reasoning aims to explain, legitimise and justify actions (Abbott, Tyler and Wallace, 2006), however this can be seen as selective, partial and contradictive as those experiencing movement may have different views. Therefore, a feminist sociological perspective will gain a more subjective view of those who experience movement during labour and therefore a more realistic, relational exploration is reached.

To enable a more holistic view to be gained Abbott, Wallace & Tyler (2006) suggest using integration, separatism and reconceptualization. While this concept relates to males-stream sociological knowledge and the need for feminist sociological knowledge within a sociological context, many of the themes they explore can relate to the binary in bio-medical and midwifery knowledge in maternity care.

Integration

Through removing the bias of the sole use of quantitative methods in guidelines and protocols, integrating qualitative knowledge gained from women and midwives can be used to reform existing knowledge bases. However, Abbott, Wallace & Tyler (2006) highlight this could be just a form of lip service and does not address the fundamental principles of what counts as knowledge. This can be demonstrated by the NICE guidelines for intra-partum care (2014). Whilst containing more qualitative research than the NICE (2007) intra-partum guidelines, focus is on defining, observing and monitoring labour. Cohort studies (Brocklehurst et al 2011) show the safety of place of birth do not influence service provision and NICE (2014) state women may choose any birth setting; Home, Free standing MLU, alongside MLU or consultant unit (NICE, 2014). Whilst most areas have a consultant unit, MLU and homebirth services are not available in all areas nationwide.

Separatism

Separatism argues that through women producing their own knowledge for themselves, from their perspective, knowledge is acquired which serves their interests. However, by separating in this way, scientific knowledge that can benefit women, especially in maternity care, can be to the detriment of women. If midwifery care did not incorporate medical knowledge, serious complications such as placenta praevia (a condition which the placenta covers the cervix) would prove fatal to women and babies. If this medical knowledge were ignored then it would perpetuate the marginality of midwifery care as women would not benefit from it, medical knowledge would be seen as separate and lifesaving and more valuable. Therefore, by including a medical viewpoint within this study women and midwives' reality is analysed in conjunction with the viewpoint which oppresses and marginalises other forms of knowledge.

Reconceptualisation

The reconceptualisation of theories is seen as necessary to revolutionise not reform existing theories (Abbott, Wallace & Tyler, 2006). It is recognised that it is necessary for midwifery and medical knowledge to be used in conjunction to address maternity care issues that incorporate obstetric and midwifery care. However, midwifery research needs to be carried out on midwifery care and accepted as authoritative in its own specialist area. Reconceptualisation rejects integration and says existing models are beyond reform. As

midwifery research can challenge medical research, a model is needed which incorporates both. One issue is that medical viewpoints may argue that there is no need for revolution. This is a view that I accept. Women's, midwives' and obstetricians' values and experiences need to be equally valued and be equal in authority to enable women to be valued and birth experience to be as optimum a measure of outcome as mortality and morbidity.

1.15 Origin of this project

The inspiration for this project came from working with midwifery and obstetric research whilst studying a Master of Research degree. Knowing the theoretical differences, frustration was experienced in clinical practice when attempting to implement practice supported by research from a midwifery perspective. I wanted to understand why knowledge produced from an obstetric, quantitative perspective was easier to implement than research from a midwifery qualitative, experiential, physiological perspective. In addition, when women expressed a preference for the types of care they received; this either was ignored or slow to be implemented. However, local severe physiological morbidity and mortality results changed practice almost immediately based on little or no substantial evidence.

To address this situation a feminist sociological viewpoint was taken in this project. Abbott and Wallace (1990) describe feminist sociology as:

> '… is one that is for women, not just necessarily about women, and one that challenges and confronts the male supremacy which institutionalises women's inequality. The defining characteristic of feminism is the view that women's subordination must be questioned and challenged. This involves a critical examination of the present and past situation of women and challenging the dominant patriarchal ideologies that seek to justify women's subordination as natural, universal, and therefore inevitable: challenging knowledge that is put forward as universal and demonstrating that this knowledge views the world from the position of men. What is necessary is a view of the world from the position of women, who have been excluded from the production of knowledge. Such a view will provide more adequate knowledge because it will seek to explain what patriarchal knowledge does not recognise as existing- the subordination of women by men.' (Abbott and Wallace, 1990, p10).

1.16 Rationale

Abbott and Wallace (1990) speak of the role feminism plays in sociology, however, this is applied to the dichotomy between obstetric and midwifery research and knowledge production. Midwifery research is not implemented as equally as obstetric knowledge. Therefore, this project seeks to question why midwifery knowledge is not seen as equal. This is done through critically examining the obstetric knowledge of movement, challenging its supremacy (Chapter two). Most of the research identified around movement in labour is from a cause and effect perspective and examines how activity affects the length of labour (Hollins-Martin & Martin, 2013; Lawrence et al. 2013; Souza et al. 2006). However, this research overlooks the women involved as people, therefore not acknowledging them as important either in the study or as participants in their own birth. From a feminist perspective, not seeing the women is subordinate. The claim of the research methods used are to establish facts, using authoritative medical and scientific knowledge to underpin and justify the use of movement using an ideological justification to supress women's bodily knowledge and midwifery experiential knowledge. Scientific reasoning aims to explain, legitimise, and justify actions; however, this can be seen as selective, partial and contradictive as those experiencing movement may have different views.

Looking at movement from the perspective of women and midwives who are excluded from the dominant knowledge base provides a more adequate view as women's and midwives experiential views are not subordinated (Chapter three).

Therefore, this project, through exploring movement in labour from a sociological perspective using a feminist lens, may gain a more holistic view of movement in a cultural context.

Previous studies and theories have identified differences in thinking and acting between obstetricians and midwives in different maternity care settings in the UK and Internationally (Davies-Floyd, 2001; Wagner, 1994; Walsh, 2002). Through including the obstetric viewpoint, a perspective will be gained on why this difference occurs by looking at how they acquire knowledge and experience women's movement during labour.

From this, what facilitates and what acts as barriers to a more collaborative way of working will be identified.

1.17 Aim of the Study

The aim of this project was to identify the cultural differences that influence maternity care and knowledge acquisition about movement in labour. To achieve this, the study investigated women, midwives' and obstetricians' beliefs about maternal movement in labour.

Through exploring the culture of maternity care and the way in which knowledge about movement during labour is acquired and used, recommendations are made for how maternity care can be reconceptualised to incorporate women's and midwifery knowledge.

1.18 Objectives

(1) Discover the positionality of participants in relation to where they position themselves within society in relation to their profession/ in relation to their birth, in the hospital context and in relation to each other.

(2) Identify how participants gain knowledge around movement during labour and identify barriers and facilitators to using this knowledge.

(3) Explore women's, midwives' and obstetricians' beliefs and experiences about maternal movement in labour and how this affects care given or recommended.

The above objectives were achieved by interviewing 9 women, 10 midwives and 6 obstetricians.

Findings from the three groups were compared, and similarities and differences were identified using thematic analysis. Analysis was based around the positionality, experience and perspective of participants as a component fundamental to feminist research (Lennon and Whitford, 2012). Findings reveal how participants gain knowledge and its relation to their perceived position within the hospital structure. This collaborative view of how women, midwives and obstetricians view each other adds to what aids or impedes collaborative working and how participants feel when situations arise that are inconsistent with their individual beliefs.

By comparing data gained from each group, the current context of maternity care can be examined in relation to the wider literature on theories and models of maternity care and the socio-political influences on maternity services.

1.19 Conclusion

This chapter has outlined the current context of maternity services and the significance of movement during labour. It justifies why beliefs about movement were used in this project and why a feminist sociological perspective was appropriate. The origins have been discussed, the rationale, aims, and objectives presented. The next chapter presents a critical review of the way in which knowledge of movement is constructed in the research literature.

Chapter Two

2. Critical review of literature about maternal movement during labour

2.1 Introduction and background

The previous chapter looked at the development of this project, providing the context for this study. This chapter presents a critical review (Grant & Booth, 2009) of the literature about maternal movement in labour. Recognition is given to the current scientific reviews around maternal movement and position during the first stage of labour, the intention is not to critique each individual piece of research or evidence, but to instead critique the way that knowledge is constructed.

Within the current context of maternity care evidence provides the tenets upon which care is based (Spiby & Munro, 2009). Evidence based practise can be seen to be necessary in a regulated health care system, such as the UK, being a method of standardising care to stabilise the health care system, control costs and ensure equity of services (Mander, 2008). In addition, the view that all health care treatment needs to be effective and free is central to the political development of health care practice (Downe & McCourt, 2008). Therefore, there is a need for synthesised summaries of evidence to aid clinicians in decision making (Grant & Booth, 2009).

2.2 Critical review

This review will critique four types of literature reviews; meta-analysis, systematic review, narrative review and literature review. A critical review of literature reviews has been used to demonstrate how knowledge around maternal movement is formed within the medical model. It will show that even with the high heterogeneity that exist between studies, literature reviews are used as acceptable forms of knowledge and synthesised to generate information which can be used to form the evidence base. All of the reviews critiqued have pooled the results from studies and used evidence where maternal movement and positions are stated as interventions.

2.3 Search methods

A strategy was devised to identify reviews of the relevant published literature around maternal movement during the first stage of labour. The review was limited to the first stage

of labour as the bio medical approach to labour defines labour in stages and a parameter was needed within which to set the search with the terms used by the approach.

The following databases were searched; Cochrane, CINAHL, Science direct, Medline and Google Scholar using the key words; ambulation, mobilisation, maternal activity, position, upright, walk*, stand*, squat*, sit*, kneel*, labour, first stage of labour and labour. Various combinations of terms were used. The search was limited from 1960 to June 2014, as this was the period of time over which maternity care became more medically influenced. Reviews included were written in English, were based on the first stage of labour, and included low risk women with a single fetus in a cephalic presentation and published in full text. Literature excluded were; individual studies, reviews which did not include search methodology, book chapters, opinion pieces and reviews not published in English.

2.4 Search results

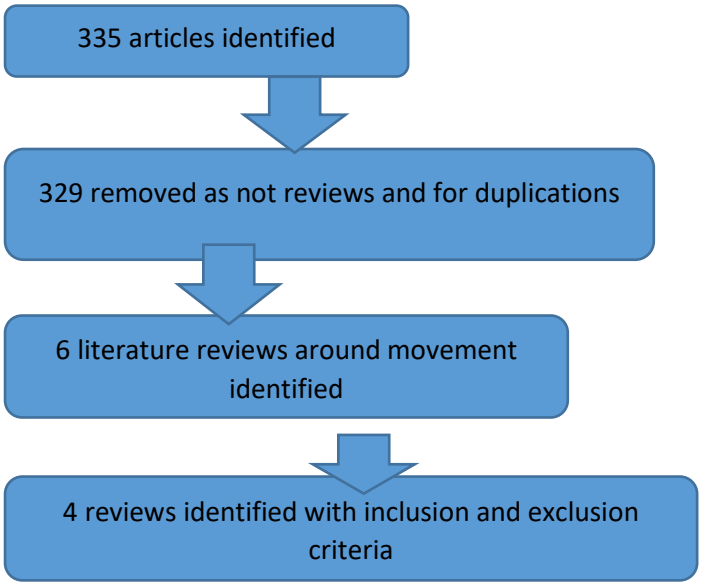

Figure 1 Literature search results

The four reviews identified for review were: Lawrence et al. (2013) 'Maternal positions and mobility during first stage labour', Souza et al. (2006) 'Maternal position during the first stage of labour: a systematic review', Hollins-Martin & Martin (2013) 'A narrative review of maternal physical activity during labour and its effects upon length of first stage', Priddis et al. (2011) 'What are the facilitators, inhibitors, and implications of birth positioning? A review of the literature'.

2.5 Randomized Controlled Trials (RCTs) and meta-analysis

A systematic literature review is defined as the most detailed, with the Cochrane collaboration (www.cochrane.org) the most well-known organisation for providing independent reviews about health care interventions (Aveyard, 2014). When assessing the effectiveness of interventions, pharmaceuticals or procedures, large multi centred RCTS are considered to provide the most scientific form of evidence (Aveyard, 2014). A clinical trial is defined as;

> 'A prospective study comparing the effect and value of intervention(s) against a control in human beings' (Friedman, Furberg & Demets, 2010).

An RCT is perceived to be the ultimate standard in quantitative study design and the most definitive method in determining if an intervention has the hypothesized effect (Ibid). Participants in the RCTs included are randomly assigned to a control group or treatment group, in an attempt to eliminate bias and assess the effectiveness of the treatment whilst taking into account variables and confounding factors. The simple method of randomisation enables the trial sample studied to represent the relevant population and remove possible sources of systematic bias. A simple trial design which ensures control in recruitment gives findings that are not 'contaminated' by confounding variables, are as close as possible to samples that are similar to each other and thus represent the relevant population as a whole (Downe & McCourt, 2004). Through randomisation participants have an equal chance of being assigned to either the control or the study group which is a process to remove potential bias in the allocation of participants. Randomisation is a way of variables and covariates between participants being distributed with a degree of probability that can be largely applicable to the general patient group and gives validity to statistical significance (Friedman, Furberg & Demets, 2010).

Cochrane combines the results of a numbers of RCTs in a systematic review, which used rigorous methodology to identify, critically appraise and synthesise results from studies and are considered to produce the most robust and detailed forms of review (Aveyard, 2014). A Cochrane review can provide the best available evidence when assessing the effectiveness of

a treatment through statistically combining individual trial data to produce a meta-analysis (Machin, Campbell & Walters, 2008). The standards, which are used by Cochrane to assess trials, provide the information required when planning new RCTs, impact on trial size and have raised reporting standards (Machin, Campbell & Walters, 2008).

2.6 The Cochrane Collaboration meta-analysis

The most recent Cochrane review around maternal movement is entitled 'Maternal positions and mobility during first stage labour' (Lawrence et al. 2013) and is a systematic review of randomised and quasi randomised trials that have assessed the effects of upright positions, including mobilisation versus recumbent positions during the first stage of labour (Lawrence et al. 2013). The review was undertaken by a team of four reviewers from Australia, UK and South Africa and used a set of standard methods for data collection, assessing study quality and analysing results (Higgins & Green, 2008).

The rationale for the review identifies that it is more common for women to labour in bed with no evidence for the advantages of this other than for the convenience of staff. The authors theorise that remaining upright increases the efficacy of uterine contractions, with this reducing the effects of the pregnant uterus on maternal abdominal blood flow and increasing women's perception of control and comfort. The stated objective of the review was to assess the effectiveness of encouraging women in the first stage of labour to assume different upright positions, which include walking, sitting, standing, squatting, all fours and kneeling versus recumbent, semi-recumbent, supine and lateral positions.

The primary outcome measures are stated as the duration of labour, mode of birth, maternal satisfaction, fetal distress and need for ventilation. The results of this review suggest women who are upright or ambulant experience a shorter time in the first stage of labour by 1 hour and 22 minutes. Women who spent time upright during first stage of labour were less likely to have a CS or an epidural. There were no other significant differences between groups for the duration of the second stage of labour or other outcomes associated with the wellbeing of mothers or babies. However, Lawrence et al. (2013) state that due to the variable methodological quality of the 25 trials results should be interpreted with caution.

Lawrence et al. (2013) describe labour as the 'condition' under study and recognise the variation in its duration between women and that many factors that influence this. Upright

and mobile positions are described as the intervention and the authors go on to expand what is meant by this.

Twenty-five studies were reviewed Lawrence et al. (2013) (see table 1) which involved an accumulative total of 5218 women. Studies included were carried out between 1963 and 2012, with data included from 13 countries. Maternity care has seen many changes over this 49-year period in which the included reviews were carried out. From the government directives that recommend 100% hospital births in the early 1970's (Peel, 1970), to the increased focus of women centred care (Department of Health, 1993), the increase in medicalised childbirth (Walsh, 2010), the focus on evidence based practice (Spiby & Munroe, 2008) and the current changes in commissioning of maternity care services to any qualified provider. The policy changes, practices, interventions, medications and social factors that impact on women, maternity care and birth that were relevant during the 49-year period may not be relevant today. Therefore, it brings to question if results from studies carried out over this extended period within differing maternity care contexts can be applied to current practice.

Author, year, country, method	Activity comment	Outcome measure	No. of participants; study/ control	Upright shorten labour	Effect of Upright position	Epi	Comments
Andrews & Chirzanowski (1990), USA, RCT	Stand, ambulating, squat, sit, walk, kneel **V.** Supine	Duration of 1st stage, comfort, analgesia amount comfort	20/20	yes	Maternal comfort assessed by carer,	no	**Inclusion;** Primip, single fetus, cephalic, 38-42, spontaneous labour, intact membranes, cx between 4-9cm **Study**; stand, ambulate, squat, sit, walk, kneel, 15 lie after meds – 5 get up, 10 minutes upright in 1 hour **Control**; supine, lateral, prone hands and knees, free to choose variation
Ben Regaya (2010) Tunisia, RCT	Authorised to ambulate **V**. confined to bed	Duration of 1st stage, MOB, pain, Admin to NICU, Perineum, EBL, duration of 2nd stage	100/100	yes	Increase SVB, reduce operative, reduce c/s	no	I**nclusion**; Primiparous, single fetus, 'term', spontaneous labour, low risk, **Study**; 'authorise to ambulate' **Control**; 'confined to bed' no standard deviation reported
Bloom (1998) Dallas,USA, RCT	Walking **V**. supine, lateral, sit	Duration of 1st, MOB, Analgesia, duration of 2nd, Perinatal mortality, neonatal ventilation, fetal distress, perineum, augmentation, duration of 2nd stage, pain	536/531	None	0 difference in SVB, increase operative, reduced c/s, opioid use increase, upright slight epidural decrease	no	**Inclusion**; Mix parity, 36-41/40 gestation, spontaneous labour, low risk, cephalic, 'active labour', intermittent auscultation, 3hrly VE, all ARM, augmentation after 2hrs no progress, all wore pedometers **Study;** walking- bed for iv infusion, epidural, 2nd stage, CTG, number of minutes recorded- 380 walked, 30 incomplete data, 8 rapid labour, 2 breech **Control**- supine, lateral or sit
Boyle (2002) Hertfordshire, UK, RCT	'Encouraged to ambulant' 15 mins. per hour **V** bed care	MOB, analgesia	199 – 145 primips, 54 multips /210- 151 primips, 59 multips		Reduced SVB, no difference operative birth, increased c/s	yes	**Inclusion;** Mix parity, 34+/42 gestation, spontaneous and IOL, active labour, cephalic, low risk **Study**; encouraged to ambulate 15 min p/h, ambulation assessed by 'Bromage scale', 69/199 IOL **Control**; bed care, 51/210 IOL No duration of labour- but states no difference, 8.74 – 9.55 minutes mean ambulation time, mean Apgar's, pooled data from primips & multips
Bundesen (1982) Goreburg, Sweden, RCT	Ambulation& telemetry - IOL	MOB, ARM	40/20	yes	Increased SVB, decreased operative birth, reduced c/s	no	**Inclusion;** Mix parity, not stated gestation, all IOL **Study**; 20 telemetry & TENS, 20 telemetry **Control**; 20 bed care All; ARM, internal monitoring Lawrence; insufficient data to include total duration to support claim (study, 8hrs prmip, 4hrs multip, control; 10hrs primp, 6hrs multip)
Calvert (1982) Cardiff, UK, quasi randomised trial	Advised to walk/sit **V** bed	Duration of 1st stage, MOB, Apgar, duration of 2nd, Maternal anxiety & pain, apgar	100- 56primips, 44multips /100- 50primips, 50multips	yes	No increase in SVB, increase operative, reduced c/s, opioid use no difference, decreased epidural		**Inclusion**; Single fetus, cephalic, 37+ gestation, low risk, contractions 1:10, cx 2.5 m dilated **Study**; telemetry, advised to walk- 45 did so between 3mins and 4hr 20mins - mean 1hr 44mins **Control**; bed care

					use, N2O increased		24hr p/n questionnaire-scale; pain, anxiety, comfort & restriction on movement
Chan (1963) Hong Kong, quasi RCT	'kept in erect' sit or walk **V** Kept supine or lateral	Duration of 1st, MOB, analgesia, duration of 2nd , Perinatal mortality, fetal distress,	100/100	no	No difference SVB, no difference operative birth, increased c/s, increased opioid use	no	**Inclusion;** Primps- no other data **Study**; kept erect sit or walk **Control**; kept supine Lack of statistics to support results, data not complete, results include breech and twins
Chen (1987), Otia, Japan, quasi RCT	'free to assume'-most sat **V** dorsal /lateral	Duration of cervical dilatation between 5-10cm, duration of 2nd , augmentation, ARM, MOB, analgesia, fetal distress	61-33primips, 28 multips /124-68primips-56multips	yes	Slight increase in SVB, decreased operative birth, no difference c/s, epidural use decrease	no	**Inclusion;** Single fetus ,cephalic, term, low risk, excluded for IOL, c/s, fetal distress, epidural, **Study**; = 41 free to assume, most sat, 20 excluded for above **Control**;=75 dorsal or lateral, 49 excluded for above All no analgesia, all arm, pooled data for primps & multips
Collis (1999) London, UK, RCT	'encouraged' 20mins per hour, walk stand sit **V** 'encouraged' stay in bed sit or lie	MOB, analgesia, augmentation, apgar	110/119	N/A	No difference in; SVB, operative birth, c/s or augmentation	yes	**Inclusion;** Primp, single fetus, 36-42week gestation, spontaneous & IOL, cephalic, low risk **Study;** 110, 19- mobile >60%, 32- mobile 30-59%, 51- mobile 30%, 44- mobile 29-1%, 15-no time out of bed (16 motor block, 25 tired, 10 told by m/w **Control;** 119 , 16 mobile, 15-mobile 1-29%, 1 mobile between 30-59% All- CTG, IV fluids, 3hr VE, ARM if not >2cm, augmented if no progress, time measured form epidural to birth
Fernando (1994), London, UK, RCT	Sit, stand, walk **V** bed	Apgar	20/20	N/A		yes	**Inclusion;** Primp. **Study;** rocking chair, standing, walk. **Control;** bed
Flynn (1978), Birmingham, UK, RCT	'Allowed' to sit, stand **V** walk. Bed	Duration of 1ststage, MOB, pain, Analgesia, augmentation, NN res	34-17primps, 17multips /34-17primips, 17multips	yes	Increased SVB, decreased; operative birth, d c/s, opioid use, epidural use	no	**Inclusion**; Spontaneous labour **Study;** walk with telemetry **Control;** lateral with external monitoring. All women; V/E 2-3hrs, analgesia when necessary, augmented when delay, 1 breech in each group
Frenea (2004), Grenoble, France, RCT	Walk 15 mins per hour or 25% of labour **V** Bed	MOB, analgesia, augmentation, apgar	30-18 primps, 12multips /31-18primips,13 multips	N/A	Reduced; SVB, operative birth, c/s, augmentation	yes	**Inclusion;** Single fetus, 37-42 weeks gestation, spontaneous & IOL, Cephalic, low risk, 3-5cm dilatation of cx. **Study;** walk 15m per hour or 25% of labour- bed at full dilatation of cx **Control**: bed
Gau (2011), Republic of China, Taiwan, RCT	Exercise ball program **V**?	Duration of 1st stage, MOB, Analgesia, Duration of 2nd , pain, Apgar	94-33primips, 15multips,46 mixed /94-22primips, 17multips, 55mixed	yes	Slight increase in SBV, decreased; operative births, c/s, epidural use	no	**Inclusion;** Single fetus, spontaneous & IOL, low risk, birth partner. **Study;** birth ball- exercise program 6-8wk antenatally, ball during labour, choose most comfortable position every hour. 46 excluded- **Control**:?

							55 excluded 57% attrition-data excluded
Haukkama (1982), Helsinki, Finland, Quasi RCT	Encouraged to sit/walk **V** bed care	Duration of 1st, MOB, Pain, Analgesia, Augmentation, ARM, Perinatal mortality, apgar,	31-13primips, 18multips, /29 12primips,17 multips	No	Slight increase in SVB, increase operative birth, reduced c/s, opioid use, epidural use, N20 increase	no	**Inclusion;** 38-42 weeks gestation, low risk, **Study;** telemetry, encouraged, sit or walk **Control**; bed care All; N2O, Pethidine, Pooled data for primips & multips, matched pairs
Karraz (2003), Evy, France, RCT	Walk, sit, semi supine **V** 'had to remain supine, lie or lateral	MOB, Pain, Analgesia, augmentation	144-97primips, 47multips /77-47primips, 30multips	N/A	Increased SVB, no difference operative birth, increased c/s, reduced pain, augmentation	yes	**Inclusion;** Single fetus, 36-42 week gestation, spontaneous &IOL, low risk **Study;** walk, sit in chair, semi-supine. **Control;** 'not allowed to sit, walk or go to loo, remain supine, lie semi supine, lateral 6 excluded Day births only
Maclennon (1994), Addelaide, Australia, Randomised trial	'encouraged' to ambulate **V** semi recumbent	MOB, Analgesia, Augmentation, Perinatal mortality, apgar, fetal distress	96-49primips, 47multips/ 100-43primips, 57multips	N/A	Decreased SVB, increased operative & epidural, slight reduced c/s, opioid use no difference	no	**Inclusion**; Single fetus, cephalic, 37-42 weeks gestation, spontaneous & established labour, able to ambulate **Study;** encouraged to ambulate, sit & lie, 37 ambulated for more than ½ hr- mean 1.8hr ambulation. Mean 4.5hr recumbent, **Control;** semi recumbent-side, All ARM, not able to use duration of 1st stage data.
Matthew (2012), Magalore, India, RCT	Ambulate & birth ball **V** bed dorsal & lateral	Duration of 1st stage, MOB, Duration of 2nd stage	40/20	yes	Increased SV, decreased operative birth	no	**Inclusion**; Primips, **Study;** 20-ambulate, 20-birthball **Control;** bed-dorsal/lateral Missing data, contraindicates reported data, not all duration reported.
McManus (1978) Glasgow, UK, RCT	'encouraged to be up & about' or sitting **V** lateral	MOB, Analgesia, augmentation, ARM, Perinatal mortality, neonatal ventilation, apgar, fetal distress, EBL,	20-10primips, 10 multips /20-10 primips, 10 multips	N/A	Increased SVB, decreased operative birth & N2O, increased opioid use & epidural	no	**Inclusion**; Single, cephalic, 38+weeks gestation, all IOL, cx 6cm+ **Study;** upright-up & about or sitting **Control;** lateral All; ARM prostin, Oxytocin. Duration =IOL to birth
Miquelutti (2007), Campinas, Brazil, RCT	Stand, walk, sit, crouch, kneel, after 30mins **V** routine; allowed to move adopt any position	Duration of 1st, MOB, duration of 2nd , augmentation, perineum, pain, satisfaction, Apgar	54/53	no	Decreased SVB, increased satisfaction	no	**Inclusion;** Primp, single fetus, cephalic, term gestation, spontaneous labour, low risk, **Study;** antenatal information on ambulation, encouraged to walk, stand, sit, crouch, kneel, if supine for 30mins encouraged to upright, Upright for 57% of time **Control;** routine care not encouraged upright but allowed to move and any position Duration as median, symmetrical distribution, median used as mean to calculate standard dev.

							No data for operative birth or c/s
Mitre(1974) Terre, Haute, USA, RCT	Sitting up **V** supine/ lateral	Duration of 1st stage	50/50	yes		no	**Inclusion;** Primips, cephalic, term, spontaneous labour, latent & active phase, low risk **Study**; ARM, sit-up, lie from time to time **Control;** supine, and side ? routine all ARM, No separation between 1st & 2nd Claimed outcome with no evidence
Nageotte (1997), California, USA, RCT	'encouraged' to ambulate- 5mins per hour **V** 'discouraged' to ambulate	MOB, pain, Apgar,	253/252		Decreased SVB, increased operative birth, reduced pain,	ye s	**Inclusion;** Primip, 36 + gestation, cephalic, spontaneous & IOL, epidural **Study;** encouraged to ambulate, minimum 5 minutes per hour **Control;** discouraged to ambulate, All had epidural
Phumdoun g (2007), Southern Thailand, RCT	Allocated CAT position alternating ½ hourly **V** assigned to remain supine in bed	Duration of 1st stage	40/43	yes		no	**Inclusion**; Primip, single fetus, cephalic 38-42 weeks gestation spontaneous labour, 18-35yr **Study**; CAT position (hands and elbows) **Control;** supine Data lost from C/S women
Tavoni (2011), Tehran, Iran, RCT	Allocated to use birth ball **V** allocated to lying on the bed without ambulation	Duration of 1st, MOB, Mat pain	31/31	no	Increased c/s, decreased pain	no	**Inclusion**; Primip, single fetus, 38-40 gestation, spontaneous labour, cephalic, low risk, cx 4-8cm at entry to study, 18-25yr Study; 29 birth ball (2 excluded) Control; 31 lying Unclear reporting of data
Vallejo (2001), Pennsylvani a, USA RCT	Ambulation & sitting **V** bed in recumbent lateral,	MOB, Analgesia amount, duration of 2nd, augment, APGAR	75/76	N/A	Reduced SVB & augmentati on, increased operative, no difference in c/s	ye s	**Inclusion;** Primip, single fetus, cephalic, 36-42 weeks gestation, spontaneous & IOL., cx 3-5cm at entry to trial **Study;** ambulation & sitting, friend or spouse, 5 minutes walking per hour, **Control;** bed, recumbent in lateral, All; epidural analgesia Duration of labour from epidural insertion to fully 9 excluded
Williams (1980) London, UK, quasi randomise d trial	Walk & info V non ambulant	Duration of 1st stage, MOB, analgesia, augmentation, duration of 2nd , apgar	48- 25 primips, 23multips /55- 30primips, 25multips	yes	No increase in SVB, operative birth, c/s, decrease in epidural	no	**Inclusion;** Single fetus, 36-42 weeks gestation, spontaneous labour, remained low risk **Study;** information & encouraged to walk, **Control**; non ambulant Pooled data from primps & multips,

Table 1. Lawrence et al. (2013) Table of results

Key; RCT-Randomised Control Trial, EPI – Epidural anaesthesia, Primip - primiparous, Multip – multiparous, MOB – mode of birth, SVB – spontaneous vaginal birth, ARM – artificial rupture of membranes, IOL – induction of labour, c/s caesarean section, cx - cervix

2.7 Combining internationally collated data

Seven studies were carried out in the UK (Boyle et al, 2002; Calvert et al, 1982; Collis et al, 1999; Fernando et al, 1994; Flynn et al, 1978; McManus et al, 1978; Williams et al, 1980), five

in the USA (Andrews et al, 1990; Bloom et al, 1998; Mitre et al, 1974; Nageotte et al, 1997; Vallejo et al, 2001), two in France (Frenea et al, 2004; Karraz et al, 2003) and one each from Australia (Maclennan et al, 1994), Brazil (Miqueluttie et al, 2007), Finland (Haukkama et al, 1982), Hong Kong (Chan et al, 1963), India (Matthew et al, 2012), Iran (Taavoni et al, 2011), Japan (Chen et al, 1987), Sweden (Bundsen et al, 1982), Taiwan (Gau et al, 2011), Thailand (Phumduong et al, 2007) and Tunisia (Ben Regaya et al, 2010).

In the UK midwifery has a strong professional background (Marland & Rafferty, 2002), with the focus on birth as a normal physiological event and the midwife as the expert providing care to woman and their families (Nursing and Midwifery Council, 2011). The International Confederation of Midwives supports the definition of midwifery professional status as defined by the Nursing and Midwifery Council (2011) globally and campaigns for the recognition that midwifery care provides safe and effective care for women and their babies (International Confederation of Midwives, 2013). However, the midwifery profession does not have the same status globally and maternity care provision is organised differently across the world (De Vires et al. 2011). Different countries can produce research and evidence, publish in peer-reviewed journals on the same subject, with seemingly robust methodology, but reach different conclusions regarding the efficacy and safety of a practice.

Kloosterman (1982) acknowledges how cultural beliefs and professional experience can create bias that distorts scientific studies of maternity care that makes identifying best practice around birth very difficult. For example Wax et al. (2010), who are American obstetricians, published a meta-analysis in the American Journal of Obstetrics and Gynaecology regarding the safety of home birth (Wax et al. 2010), with results showing that home birth resulted in a tripling of the neonatal mortality rate. De Jonge et al. (2009), who are independent researchers working with obstetricians based in the Netherlands, produced research showing planned home birth was as safe as planned hospital birth. The cultural and political context of these two studies could be seen to have affected the results reached by each author. In the USA obstetricians are the lead professionals who usually provide maternity care to women within the hospital; midwives or nurse midwives are a small professional group who assist in the process in hospital. A minority of midwives provide exclusive midwifery care at home and it is illegal to practice midwifery in some states of America. To access health care in the USA health insurance is needed which dictates the care

provided (Mander, 2008) and only allows access to maternity care offered by hospital-based obstetrics (Amnesty International, 2011). Because of the need of obstetricians to maintain their professional status, research produced can be politically influenced and biased towards supporting the medical care available (Mander, 2008). Therefore, research produced in the USA by obstetricians is unlikely to support home birth.

In contrast, the Netherlands has a home birth rate of 15.9 % (Stichting Perinatale Registratie Nederland, 2013), which is the highest home birth rate in Europe (De Vires, 2001). Maternity care in the Netherlands is publicly funded; legislation protects the status of the midwife as a health professional within a well-defined sphere of practice (Benoit et al. 2005) giving the political context for research produced here a very different perspective when compared to the USA. Maternity care for low risk women is provided by independent midwives either at home or in an outpatient centre and obstetricians only provide care for 'high risk' women (Ravelli et al. 2011). Within this system research is funded which shows the safety and efficacy of a system in which midwifery and obstetrics work together to provide care which is in the best interest of women and their families (Benoit et al, 2005).

2.8 What to include, what to exclude

Lawrence et al. (2013) give clear reasoning for their inclusion and exclusion criteria, weight the contribution of individual trials to the overall findings and provide sub group analysis for identified variations between trials such as: epidural use, parity and positions used. The authors attempt to assess methodological quality however they cite the lack of information given about the methods used in the included trials as difficult. Graphs and tables are used to display methodological quality and summarize the reviews findings. Whilst those familiar with this method of displaying data could find these easy to interpret, other professions and the public may not.

2.9 Bias and heterogeneity

Criteria for the assessment of the risk of bias in the selection methods of participants in the included studies was detailed. This included bias from sequence generation, allocation concealment, blinding of participants and outcome assessors, incomplete data, selective reporting, other and overall bias. The largest risk of bias identified over all trials was the high risk of performance bias from blinding of participants, clinical staff and outcome assessors.

When assessing the effectiveness of a natural and spontaneous phenomenon such as movement in labour, it is difficult to assess the effectiveness of one factor in a very positivist, cause and effect manner such as that required by an RCT. Participants in an RCT are randomly assigned to a treatment or control group, in an attempt to eliminate bias and assess the effectiveness of the treatment whilst taking into account variables and confounding factors. Through the process of blinding participants and attempting to apply restrictions on movement and position during labour, assigning women to a treatment or control group could be considered unethical because the researchers are restricting and prescribing movement, which does not respect women's autonomy and moral agency (Frith & Draper, 2004). Clinical staffs' duty of care is to the women they are caring for in labour and giving care that is specific to women's individualised needs.

Lawrence et al. (2013) report a high level of heterogeneity in the study situations of the included trials. Heterogeneity is the variation of effects between studies; methodological heterogeneity can arise due to differences in study design and quality, which is usual in systematic reviews (Khan et al. 2011). Statistical tests were used by Lawrence et al. (2013) to assess for heterogeneity and examine if the results occurred by chance, accepted values were given and forest plots used to display results. The methodological differences which contributed to the quality of the trials included and the data produced is reported in the results section of the meta-analysis. Allocation of participants, incomplete data, selective reporting and variation in intervention were cited as contributing to the heterogeneity.

When trials are included that are gathered from journal articles it is understandable why data published may be incomplete, to comply with publishing requirements data may have been omitted. To combat this full study reports from individual authors could have been requested if they were still accessible. In addition, if trials had been carried out in which movement had shown no significant difference when compared to the control group the trial may not have been published (Bryman, 2015) thus impacting on the weight of evidence in the meta-analysis.

Selective reporting has historically been identified when related to research around childbirth. Tew's (1998) research led her to analyse statistical data regarding the perinatal mortality and morbidity rates associated with place of birth. Despite the overwhelming evidence supporting the safety of home birth, the majority of the medical profession objected

to this and promoted their belief in the benefits of hospital birth in terms of safety, which was published in academic literature and government policy with no evidence to substantiate their claims (Tew, 1998). Lawrence et al. (2013) found this to be the case with claims made in the outcomes of some of the trials included in the meta-analysis. Little or no data was given to support claims made around the psychological and medical value of telemetric monitoring and ambulation (Bundsen, 1982), the increased comfort of women in the intervention group (Mitre, 1974), Fernando (1994) did not report any maternal outcomes and others reported no neonatal outcomes.

2.10 Heterogeneity

Heterogeneity was cited by the authors as one of the main reasons for the caution needed in the interpretation of results. Sub-analysis was used to give clarity to the results between the main differences of the trials included. Trials in which all participants used epidural analgesia and the subtler differences, those which varied in methods of control and intervention. Subgroup analysis results are displayed graphically and also use ratios.

The most consistent difference in heterogeneity between studies was the wide and varying range of definitions of mobility and positioning and the compliance of participants to their allocated group. Chan (1963) and Chen (1987) used sitting as an upright position in the study group however (Calvert, 1982) used sitting as a position in the control group, whereas the results from these studies can be more definitively interpreted within the sub group analysis, when they contribute to the overall results of the review it is clear why the authors state that caution is needed with the interpretation.

In the trial by MacLennon (1994) only 37% of participants in the ambulation group chose to ambulate for more than 30 minutes out of the total duration of their labour, 32 of the 119 participants in the control group in Collis (1999) chose to ambulate. When using an RCT to test for the most effective form of medication or treatment the parameters for the control and study group can be much easier be controlled. When trialling a drug that can be measured and quantified for a specific condition the pathology of which can be clearly defined when compared to what is known to be parameters of homeostasis, the drug used can be accurately described in dose, the effectiveness can be measured along with reduction or not of the pathology or the increases in homeostasis.

Variables in treatment can be measured and a relatively accurate prediction of effectiveness can be given. However, there are factors referred to as noise (Downe and McCourt, 2008); patient concordance with treatment and social factors that influence health, which cannot be accounted for in an RCT and therefore influence results.

When the subject of an RCT, an objective, scientific methodology for measuring the effectiveness of drugs/ treatments on pathology, is used on a subject that is considered a normal physiological process (Downe and McCourt, 2008), it can be argued the subject of study is more influenced by and suitable to a social model of research. The 'noise' largely ignored by scientific research methods (Downe and McCourt, 2008) and cannot be easily measured can have more impact on the process than the observable measurable interventions. For example, common features of labour consistent between all labouring women: uterine contractions, bony pelvis and the fetus - other variables are not. For example, physical factors such as the unique position of the fetus in the pelvis, the ligaments and muscles that line up the pelvic bones and that of the uterus and individual woman's posture and lifestyle that affect this (Simkin and Ancheter, 2011).

Additionally, environmental, cultural, psychological and emotional factors affect a woman's ability to birth her baby. For example, research has shown that women who birth under midwife care have better outcomes (Hatem et al. 2008), MLU and Home have better birth outcomes for women having their second baby, (Brocklehurst, 2011). Emotional dystocia of labour has been recognised as having an impact on the physical process of labour (Simkin and Ancheter, 2011). The recognition of these factors in the UK does not translate to the tone of research in other continents and time periods. Chan (1963) sited that the study group were 'kept erect, sitting or walking' and the control group was 'kept supine or lateral'. Ben Regaya (2010) sited that participants were 'authorised' to ambulate or 'confined' to the bed. This authoritative language used by the authors suggest the passivity of participants in the trials and does not suggest they were able to use their autonomy , whether this is due to the predominant medical culture in intrapartum care in that era in Hong Kong (Chan, 1963) or currently in Tunisia (Ben Regaya, 2010) is unclear. Most trials included in the meta-analysis describe intervention as 'encouraging' or 'supporting' mobility and positioning and report the participants' compliance to the allocated group and makes allowances for this (Calvert, 1982).

No physiological, emotional, environmental and cultural factors have been measured or accounted for in the RCTs in the reviews. Whilst they maybe of major importance to women and their progress in labour, the objective methodology used in these trials does not account for them.

2.11 Conclusion from the Cochrane Collaboration Meta-analysis

Meta-analysis, whilst providing a valid form of evidence when birth is viewed from a bio-medical approach could be considered unsuitable when birth is viewed from a social model. When viewed from the social/ humanistic model, there are multiple components related to duration of labour and mode of birth. It is therefore questionable if all these variables can be accounted for within an RCT (Bryman, 2015). Whilst movement is referenced in the rationale of this meta-analysis as being a component of labour which can shorten duration it cannot be viewed in isolation. The results of the individual trials and meta-analysis show this, especially when there is such ambiguity in what is defined as movement whether that be an upright position, general mobilisation or specific movements. In addition, whilst the results from the review suggest time in labour is reduced for women who adopt an upright position or choose to mobilise it does not say why this is.

2.12 Systematic review

Systematic reviews are a specific way of identifying and synthesizing research evidence, through following a process of comprehensive coverage of the available literature. By reviewing the quality of the evidence, following a detailed and explicit approach to the synthesis and a transparent and rigorous process justification is given to the reliability and validity of the findings (Robson, 2011). Singular studies need to be understood in context; a systematic review combining the results of other studies testing the same hypothesis in similar population's produces greater understanding (Petticrew & Roberts, 2006).

A systematic review of nine RCTs published by Souza et al. (2006) was identified entitled 'Maternal position during the first stage of labour: a systematic review'. The three authors are based in Sao Paulo, Brazil and are affiliated with the department of obstetrics and gynaecology at the University. The rationale is stated as providing evidence for an optimal alternative to the usual semi recumbent position for labour, citing that labouring out of bed has been actioned in an initiative to humanise birth in Brazil. The aim of the review is to assess the effectiveness of upright positions or ambulation on the duration of the first stage.

As Lawrence et al (2013), Souza et al. (2006) theorises that an upright position is associated with: reduced compression of maternal abdominal blood vessels, increased efficacy of uterine contractions, increased maternal comfort and a reduced need for labour analgesia.

The primary outcome measure was reduction in the duration of the first stage of labour. Upright and ambulation included was defined as; walking, sitting, standing, kneeling and squatting. Electronic data bases searched were; MEDLINE, Popline, Scientific Electronic Library On-line and the Latin American and Caribbean Health Science Information with no restriction on date or language. Proceedings of several scientific meetings were hand-checked, and reference lists screened. Eligibility and assessment were carried out by two reviewers with data extraction and statistical analysis as per the Cochrane Handbook (Higgins, 2008). The results highlight the lack of description in eight studies, inadequacy of allocation concealment and the high level of heterogeneity which impaired findings.

Souza et al. (2006) conclude that the intervention of an upright position or ambulation during labour may be safe but due to the lack of consistency cannot be recommended as an intervention to reduce duration of the first stage of labour.

2.13 Search Strategy

Souza at el. (2006) used similar search terms as Lawrence et al. (2013), however the data bases searched varied. Both Lawrence et al. (2013) and Hollins-Martin & Martin (2013) used the Cochrane Central Register of Controlled Trials (CENTRAL) to identify studies to be included within their review. The CENTRAL database contains an up to date source of published and unpublished RCTs and Controlled Clinical Trials (CCTs) relevant to specific areas of health and are managed by approximately 50 review groups. Individual review groups are responsible for the maintenance of Specialised Registers one of which is Pregnancy and Childbirth (Lefebvre et al. 2011). It is not clear why this internationally collated, freely accessible and renowned database was not accessed to identify reviews by Souza et al. (2006). In a meta-analysis by Lawrence et al. (2009), who used the CENTRAL database, published three years prior to Souza et al. (2006) 21 trials were identified, 18 of which would have been eligible for inclusion in the Souza et al. (2006) review. However, Souza et al. (2006) only identified nine trials suitable for inclusion in this review. The authors do not state their justification for their use of databases nor do they identify any inclusion and exclusion criteria for the studies reviewed. By specifying the search methods in a review bias can be reduced; by stating clear

inclusion and exclusion criteria, the selection of studies which reflect a favoured conclusion is avoided (Centre for Reviews and Dissemination, 2009).

In addition, Souza et al. (2006) do not define a comparison group. Lawrence al. (2013) identify the study group as upright/mobile and the control group as supine/semi recumbent, which provides a clear question. The question being asked needs to be relevant to the situation and aid the review to provide the precise answer otherwise the results produced will be too broad (Centre for Evidence Based Medicine, 2009). The 'PICO' tool can be used to aid the formation of a question, PICO stands for; Population, Intervention, Comparator, Outcome and ensures the question is well built and has a clear focus (Centre for Reviews and Dissemination, 2008).

2.14 Small study effect

The seven studies (Flynn, 1978; Hemminki & Saarikoski, 1983; Hemminki et al. 1985; Andrew & Chrzanowski, 1990; Allahbadia, 1992; Bloom, 1998; Miquelutti, 2006) that defined duration of labour as an outcome measure found that upright positions and ambulation reduced the duration of the first stage of labour. However, the authors believe that these results are not robust, citing reporting bias due to the 'small study effect'. The small study effect enables smaller trials, often with less methodological rigour, to show greater treatment effects in a meta-analysis when the results are graphically interpreted in a funnel plot due to the over estimation of treatment effects (Kirkwood & Sterne, 2003).

Two larger studies accounted for 76% of the total sample (Hemminki & Saarikoski, 1983; Bloom et al. 1998) and another two studies (Andrews & Chrzanowski, 1990; Miquelutti et al. 2007), provided 14% of the sample. The smaller five studies, which provided 10% of the sample, all involved less than 100 participants (Flynn et al. 1978; McManus & Calder, 1978; Read et al. 1980; Hemminki et al. 1985; Allahbadia & Vaidya, 1992), and carried a greater weight in the overall analysis contributing to a skewing of the results.

2.15 Ambulation versus Augmentation

Of the nine studies included by Souza et al. (2006) three compared ambulation with augmentation. Read et al. (1980) randomised women whose labour had been diagnosed with 'inadequate contractions' into either the 'ambulation' group or an 'oxytocin' group. Similarly, Hemminiki et al. (1985) compared ambulation in the study group to oxytocin infusion in the control group in women who were experiencing a delay in labour. Hemminki & Saarikoski

(1983) gave different packages of care to the study group and the control group, the study group were able to mobilise and did not have an amniotomy, whilst the control group did not mobilise and received an amniotomy. The authors clearly state in their rationale the aim of the review is to assess the literature for the effects of maternal position on the duration of labour but as stated earlier they do not identify the comparison group. Consequently, the review includes studies which have different aims, such as the effect of ambulation in comparison to obstetric interventions like amniotomy and oxytocin infusion when labour has been diagnosed as 'abnormal'. This questions the validity of the conclusion reached by Souza et al. (2006) as not all studies included in their review had the same objective; whilst they all assessed movement, the comparison groups were not equal as the inclusion and exclusion criteria were not clear.

2.16 Conclusion of a systematic review

This review although titled a systematic review and used methods described by Cochrane for data analysis, the data retrieved did not include trials previous identified by Lawrence et al. (2005) in their review of assessing the evidence base for the maternal position and mobility in the first stage of labour. This highlights how a systematic review can be selective in the results it produces. Souza et al. (2006) call their work a systematic review however, the process they used does not seem to be as rigorous as that of Lawrence et al. (2013) or the earlier review Lawrence et al. (2005). It would be expected that two systematic reviews with similar hypothesis would reach the same conclusion; however, in this instance it does not seem to be the case. Biased results appear to be produced by not retrieving a comprehensive enough evidence base and by not having a definitive inclusion and exclusion criteria.

2.17 Narrative review

A review carried out by Hollins-Martin and Martin (2013) gave a more inclusive approach than meta-analysis or systematic review to the evidence base by using a narrative approach. Aveyard (2014) suggests a narrative approach reviews the literature available with no defined method or without a systematic approach and the results produced can be biased. However, Hollins-Martin and Martin (2013) provided a well-defined method, identified the recognised and reliable databases, used and justified explicit inclusion and exclusion criteria. This more inclusive approach to the literature reviewed allowed RCTs, studies, which did not randomly

assign women to an activity or immobile group, and studies about spontaneous movement to be assessed.

The review was titled 'A narrative review of maternal physical activity during labour and its effects upon length of first stage' (Hollins-Martin & Martin, 2013). It sought to identify and summarise relevant research assessing the impact of movement during labour on the duration of the first stage. The rationale for this review identifies semi-recumbent positions during labour as the most usual behaviour compared to more natural behaviour of more upright or active postures. They suggest ambiguity exists around what constitutes effective type, level and extent of movement. Hollins-Martin & Martin (2013) add that within the culture of enhancing choice and control in childbearing, these inconsistencies leave maternity care staff unclear when they are providing evidenced based information to women. The objective of this review was to formulate knowledge enabling practitioners to inform pregnant women about the effect of movement upon labour progress.

The results from this review were ambiguous. Eight primary studies (Bloom,1998; Chan, 1963; Collis, 1999; Freneu, 2004; Maclennan, 1994; Miquelutti, 2007; Vallejo, 2001; Williams, 1980) and three reviews (Berghella et al. 2008; Lupe & Gross, 1986; Roberts et al. 2004) showed no alteration in the duration of the first stage of labour and five primary studies (Andrews & Chrzanowski, 1990; Diaz, 1980; Flynn, 1978; Kurraz, 2003; Mitre, 1974) and two reviews (Lawrence et al. 2005; Souza et al. 2006) suggested physical activity shortened the length by a mean of one hour. The authors conclude that this discrepancy in findings may be due to inconsistencies in how maternal activity is defined, the type of activity included, how maternal activity is measured and that the studies did not recognise spontaneous upright posture.

2.18 Cultural context of studies included

Hollins-Martin & Martin (2013) included studies from countries which are described as having comparable obstetric systems in terms of technical and clinical management; France, Finland, Japan, South Africa, UK and USA. However, what is meant by technical and clinical management is not defined, the validity of comparing research findings from international research has been addressed earlier. By not making explicit these terms when combining this data, ambiguity exists around the cultural context of technical and clinical management of childbirth. A review (Souza et al, 2006) and a primary study (Miquelutti, 2007) are included

that originate from Brazil, however, Brazil is not identified as an included country in the review. Healthcare funding, availability and standards in areas of South America are comparable to those in some areas of Asia but not like the services available in the UK. Both Asia and South America have been identified as needing to humanise childbirth by the medical systems in place (Behruzi et al. 2010). It is therefore arguable that clinical management in the UK is not similar to that of Japan or Brazil and questions the justification for the studies from these areas to be included.

The time span from which included studies were taken was recorded as 1974 – 2010 as the authors identify that from 1974 rigorous research methods were introduced, however Chan (1963) has been included in the results.

Hollins-Martin and Hollins (2013) rate the methodological robustness and the ability of the included studies to make substantive recommendations through the reporting of statistical information. Some studies do not report 'p' values, 'means' and 'standard deviations' therefore the authors state the ability to assess the accuracy and reliability is difficult.

2.19 Ambulatory Epidural Anaesthesia (AEA)

Hollins-Martin and Hollins (2013) included studies in which participants used ambulatory epidural anaesthesia (Collis, 1999; Frenea et al. 2004; Vallejo et al. 2001; Roberts et al. 2004) as the chosen analgesia did not restrict movement. Whilst the effect of epidural analgesia did not affect the participant's ability to mobilise, the effect of restrictions on activity by the accompanying medical equipment could have disabled spontaneous activity and movement and the amount of activity. Other detrimental systemic side effects of epidural anaesthesia that effect maternal physiology and transmit over the placenta to the fetus (Buckley, 2015; Eltzschig, Lieberman & Camann, 2003) cannot be accounted for in the results of the studies reviewed and as such may have affected the outcomes. The context for the use of epidural analgesia within the individual studies is not made clear by the authors. The primary outcomes for Frenea et al. (2004) and Vallejo et al. (2001) were duration of labour whilst Roberts et al. (2004) was mode of birth. None of these studies found that maternal movement or positioning reduced the duration of the first stage of labour but why this is not explored, the 'quality' of the activity and the effects of epidural anaesthesia on maternal physiology are not accounted for. When a 'working with pain' approach is taken, maternal activity and movement which is spontaneously induced by specific discomfort experienced

assists in the optimal positioning of the fetus in the maternal pelvis and can therefore affect duration of the labour (Leap & Anderson, 2008). This natural and spontaneous activity cannot take place when epidural anaesthesia is controlling the pain felt by the participants.

2.20 Conclusion from Narrative review

A narrative approach enabled a more inclusive review of the research and the authors identified that their approach was non-hierarchical. When grading is placed upon data that is produced from different research methodologies authority can be placed upon that evidence which is considered 'gold standard' or superior. Through taking a narrative approach to the review, statistical value can be given to the literature reviewed and value given on individual merits, meaning that the compiled results can be more comprehensive than that of a meta-analysis. Though a comprehensive review of the research literature, no acknowledgement has been given to the midwifery literature. If a truly non-hierarchical approach were taken validity would be given to the authoritative scientific research literature and the experiential midwifery knowledge. However, this would not be within the capabilities of two authors for a journal publication and would probably be more appropriate as a book chapter.

It would have been interesting to know if the outcome of the review would be different if the results were sub analysed into the impact of movement on the duration of labour with and without AEA.

2.21 Literature review

A literature review is an overview of selected material in a specific area that the author feels is important in contributing to current knowledge. It can vary in format and style and are not only descriptive but have a critical element and written in a way which develops an argument (Jesson, 2011). By taking this approach it is possible to produce a biased argument however, given the flexibility of this method, views may be presented, and unconnected ideas synthesized that would otherwise be excluded when using a systematic approach (Hart, 2001).

Priddis et al. (2011) undertook a review of the literature entitled 'What are the facilitators, inhibitors, and implications of birth positioning? A review of the literature'. It aimed to review the scientific evidence on the impact of birth position on maternal and perinatal well-being and what facilitates or inhibits women adopting various positions during labour. The rationale

for the review discusses the physiological benefits of mobilisation and upright positioning on the labour process. The importance of midwives' awareness of birth positions and the impact of birth environment, models of care, individual philosophies or practice of midwives on the use of upright birth positions is also stated. Physiological birth positioning was defined as any clinical, social or cultural practice and/or environment that facilitates a variety of birth positions.

Literature limited to the past 15 years, written in English was identified through; CINAHL Plus, CIAP, Cochrane Database of Systematic Reviews, Medline, Biomed Central, OVID and Google Scholar. Key words were: birth position, labour, position in labour, second stage, intrapartum care, "place of birth", birth environment, birth centre, midwife, labour stage – second, birth AND environment, labour AND second stage AND position. Research included in systematic reviews and which involved epidural analgesia was not included. Forty papers were identified: four systematic reviews, two RCTs, two meta-analyses, two secondary analysis papers, one prospective cohort study, opinion papers and book chapters.

The review found physical and psychological benefits for women utilising upright positions for birth and identified that upright birth positions occur more frequently within certain models of care and settings compared to others. In addition, Priddis et al. (2011) found that carers' preference and philosophies also impacted on maternal position adopted. They also identified a lack of research into factors and practices that facilitate or inhibit women from using different positions during labour, the impact of birth settings, and how women and midwives perceive birth positioning and how these beliefs are transferred into practice.

2.22 Research evidence included around movement and 1st stage of labour

Priddis et al. (2011) had a wide remit for this literature review and chose not to view 'physiological birth' in isolation from its context. However, the literature included around movement and positions and its impact on the first stage of labour is limited to two sources: Lawrence et al. (2009), National Institute for Health and Clinical Excellence (NICE, 2007). The review by Lawrence et al. (2009) is a Cochrane review, which used the same methods as Lawrence et al. (2013) and had a similar outcome; duration of first stage of labour was reduced when women assumed an upright position. NICE (2007) was quoted by Priddis et al.

(2011) to illustrate how movement is used in international guidelines to support women during labour.

The NICE intra-partum guidelines for the care of healthy women and their babies during childbirth is published by the Royal College of Obstetrics and Gynaecology and lists the Cochrane collaboration as a stakeholder. The definition and aim of the guideline states that it has been developed to provide guidance for clinicians within the NHS and patients in making decisions about appropriate treatments. The literature search strategy is documented, and databases used to locate evidence are listed. Despite the Cochrane Collaboration being listed as a stakeholder and as a source for literature retrieval, Lawrence et al. (2005) review on maternal position and mobility during first stage labour is not used. The evidence around movement in the NICE (2007) is used and although quotes four of the trials used by Lawrence et al. (2005), the fifth trial used by NICE; Molina et al. (1997), the results NICE (2007) publish are not the results that Molina et al. (1997) found.

2.23 Birth satisfaction, environment and carer

In this review not only does Priddis et al. (2012) review the literature on the physical effects of movement on labour but recognises also the psychosocial impact that it has on women (Rudman et al. 2006; Coyle et al. 2001; Dahlen et al. 2010a). Through Priddis et al. (2012) drawing from the qualitative literature around women's feeling of control (Enkin et al. 2000; Green et al. 1990; Green & Baston, 2003), pain management and increased satisfaction associated with position changing (Shermer & Raine, 1997; Green et al. 1990; Gupta & Nikodem, 1999) variables termed as 'noise' by trials and studies with a more positivist approach (Downe & McCourt, 2008) are given validation.

Priddis et al. (2012) also reviews the literature around birth environments (Dahlen et al. 2010b; Fahy, 2006; Lepori et al. 2008; Wagner, 1994; Fahy & Hastie, 2008; Gould, 2000; Tracy et al. 2007; Foureur, 2008; Foureur & Hunter, 2006; Simkin & Ancheta, 2003) and models of midwifery care (Coppen, 2005; Hatem et al. 2008; Freeman et al. 2006; Atwood, 1976; Walsh, 2007), to show how they impact on the ability of women to utilise physiological positions. Through giving recognition to the psychological, sociological, environmental and cultural impact that movement has on women, women are represented as a whole not separate from their body, their labour, their psyche and as part of their sociological birthing environment and carers.

2.24 Conclusion of a literature review

This review was produced by midwives and was published by the Australian College of Midwives. It took a more holistic approach to physiological positions in labour and birth as in addition to the impact physiological positions had on labour and birth, factors were recognised which facilitate or inhibit maternal movement. Priddis et al. (2011) did not view the subject of maternal positions in isolation as did Lawrence et al. (2013), Souza et al. (2006) and Hollins-Martin & Martin (2013). Whilst reviewing the literature around the impact of positions and mobility on the duration of labour stage, mode of birth, perineal trauma, blood loss, the impact on neonate and birth satisfaction, a wider lens was used to identify what influenced the use of physiological positions. Fragmenting movement from women, the context in which birth occurs and the emotional and psychological impact of labour gives a medical, objective perspective to birth and can be viewed as demeaning to women (Martin, 1989). The more holistic approach taken by Priddis et al. (2012) could be seen as more humanistic (Davis-Floyd, 2001) and be more consistent with a midwifery philosophy of care.

The primary aim of the study did not seem to reach a definitive conclusion around the cause of specific clinical outcomes, favouring physiological positions as an aspect of labour and the range of influences upon it. These influences were viewed as the variables and an appreciation was given to them and their effects, factors that neither the prescriptive methodology of RCTs, meta-analysis, systematic review or narrative review can. When viewed from a clinical scientific perspective this review is unable to offer a mathematical standardised answer to the effect of movement on labour. However, it is able to show how, if movement is an aspect of labour care that is something to be enhanced, how this can be achieved in relation to the evidence base.

2.25 Discussion

These reviews aimed to assess the impact that maternal movement and upright positions have on the first stage of labour from the primary research carried out in this area. Research outcomes form the basis for evidence informed professional practice and national guidelines (Robson, 2011). Grading the quality of research methods and placing the evidence produced into hierarchies enables consensus for their inclusion into practice guidelines (Grilli et al. 2000). Following a review which highlighted the shortcomings of six systems of grading (Atkins et al. 2004), a system was developed known as the GRADE approach that assisted in assessing

the quality of evidence and the strength of recommendations to be included in clinical guidelines (Atkins et al. 2004). The authors highlight the complexity of this system however a more simplistic framework: The Scottish Intercollegiate Guidelines Network (Harbour & Miller, 2001) identifies a hierarchy of study types (See table 2).

Levels of evidence
1++ High-quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias
1+ Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias
1– Meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias
2++ High-quality systematic reviews of case–control or cohort studies. High quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+ Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2– Case–control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal
3 Non-analytic studies, e.g. case reports, case series
4 Expert opinion
Grades of recommendation
A At least one meta-analysis, systematic review or RCT rated as 1++, and directly applicable to the target population or,
A systematic review of RCTs or a body of evidence principally consisting of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results
B A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results or,
Extrapolated evidence from studies rated as 1++ or 1+
C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results or,
Extrapolated evidence from studies rated as 2++
D Evidence level 3 or 4 or,
Extrapolated evidence from studies rated as 2+

Table 2; SIGN grading system

This hierarchy undervalues the contribution made by other research perspectives (Pawson, 2006) and values and legitimises medical authoritative knowledge (Stewart, 2001). Oakley, (1992) suggests evidence is culturally bound. Within the current context of evidence-based practice and the authority given to the scientific paradigm, the belief is held that the best evidence is gained from large trials with simple protocols and strict methods of data generation, analysis and synthesis from which cause and effect relationships can be established (Downe & McCourt, 2008). Lawrence et al. (2013) evidence a standardised strict protocol for the meta-analysis (Higgins, 2008), which is utilised by all authors carrying out Cochrane reviews giving authority to the methods used. In addition to the methods used, data gained is displayed in mathematical formats giving authority to the knowledge generated (Moses & Knutsen, 2007).

Souza et al. (2006) also give a protocol for their meta-analysis however, on closer inspection of the method used, they do not define a comparison group or inclusion and exclusion criteria. By using the authority and status that is given to the method of a systematic review and the use of mathematical formats to display the data, the knowledge generated can be accepted within the current western culture of scientific dominance, but biased results are produced. Hollins-Martin & Martin (2013) also used mathematical values to judge the quality of the evidence they reviewed and apportioned value to each piece based on the statistical information provided. Many RCTs aim to maximise certainty of the benefit of one intervention over another and this is usually expressed by using confidence intervals (Downe & McCourt, 2008). By utilising confidence intervals to show the uncertainty of the benefit of an intervention, it is acknowledged that certainty of the benefit of the intervention can be expressed.

Cochrane use the meta-synthesis of RCTs when establishing the effectiveness of treatments for pathological conditions (Friedman, Furberg & Demets, 2010). RCTs and meta-analysis could be considered unsuitable when birth is viewed from a social model of maternity care due to the different theoretical stance (Walsh & Newburn, 2002). When birth is viewed as a multi- dimensional physiological, psychological, sociological, and emotional event, all components are related to duration of labour and it is questionable if all these variables can be accounted for within an RCT (Bryman, 2012). Lawrence et al. (2013), Hollins-Martin & Hollins (2013) and Souza et al (2006) all concluded from their reviews that results were

ambiguous or to be interpreted with caution. These question the validity of quantitative methods for using a linear model of science to understand phenomena such as movement during labour (Downe & McCourt, 2008). When viewed in a social model duration of labour can be seen as complex and not under the influence of movement alone; variables that are unique to the woman and the environment where she is labouring are variables that can influence but not be limited by one causational relationship such as that of movement on duration.

Hollins-Martin and Martin's (2013) approach could be considered a more inclusive approach than that of Lawrence et al. (2013) and Souza et al (2006) as their narrative review method was able to appraise results from studies that did not randomly assign women to different groups and included studies about spontaneous movement. Whilst considering the value of other quantitative and qualitative methods for inclusion in their narrative review Hollins-Martin & Martin (2013) only identified and included quantitative literature. This could be attributed to the way in which the title of the review was framed and affected the nature of the literature retrieved. Hollins-Martin & Martin's (2013) question was very clear and aimed to retrieve literature which looked at movement and its effects on duration of labour; by the way in which this question is structured papers that took a linear approach would only be located. The intervention of movement is defined, the population is labouring women and the definitive outcome is duration of labour. Qualitative research does not take this linear approach as it does not aim to establish a cause and effect but it is more about explaining multi-layered phenomenon (Walsh, 2012).

Priddis et al. (2012) however frame their question to look at what facilitates and inhibits maternal position and what the implications of physiological positioning are. This question elicits information from the literature that looks beyond the simple cause and effect of movement and seeks to look at other factors that the social model would recognise as being part of labour. The literature presented in this review is not limited to certain defined outcomes but reports on the multi-factorial causation of complexities that affect movement.

Lawrence et al. (2013), Souza et al. (2006), Hollins-Martin & Martin (2013) and Priddis et al. (2012) all look at movement and include duration of labour as either an outcome measure or include the literature around duration of labour in their review. Whilst all authors state the theoretical physiological benefits of movement during labour, none of them state why

duration of labour is being used as an outcome measure. None of the authors cite evidence to suggest that duration of labour is important to woman or why the duration of labour needs to be decreased by movement. When outcome measures such as mode of birth are cited as the outcome measure the short and long term physical and psychological morbidity associated with mode of birth is implicitly understood. When citing duration of labour without citing the impact of this in terms of morbidity, physiological or psychological the reasons for its use as an outcome measure are unclear.

However, a critical feminist theory can be applied to this. To cite the outcome measure of duration of labour implies that duration of labour is important and there is an optimum duration of labour. By giving a definition to what constitutes optimum parameters for the duration of labour, if labour deviates from these parameters then labour becomes pathological when viewed from the biomedical model (Walsh, 2000). The biomedical model of childbirth sees the body as a machine which is fundamentally faulty, these faults can be controlled by 'rules' and when physiological processes step outside the 'normal' parameters medicine can correct them (Martin, 1989). When labour is viewed from this biomedical model the duration of labour can be seen to be important. By assessing an 'intervention' such as movement and its effectiveness on reducing the duration of labour a potential solution to the problem of labour that does not fit within the accepted parameters can be investigated.

Lawrence et al. (2013), Souza et al. (2006), Hollins-Martin & Martin (2013) and Priddis (2012) all clearly define the method of their reviews and all define duration of labour as an outcome measure. This gives transparency to the methods used and rigour and robustness can be assigned to the results of the review. Grant & Booth (2009) highlight the increasing use of literature reviews among clinicians to access synthesised knowledge on specific health issues. They distinguish between the typology of reviews and summarise the kind of knowledge that can be gained from them. Subtle variations exist in the degree of the review process and rigour within these differing review types, resulting in all of the reviews included here identifying and including different literature (see table 3).

Author, Year,	Lawrence et al. (2013), UK, Meta-analysis	Hollins-Martin Martin, (2013), UK, Narrative review	Souza et al. (2006), Brazil, Systematic review	Priddis et al. (2012), Australia, Literature review	NICE, (2007), UK, Intrapartum guidelines	Berghella, Baxter, Chauhan, (2008), USA, labor management review
Allahbadia, (1992)	Not included	Not included	Included			
Andrews & Chirzanowski, (1990) USA	included	Included	included		included	
Ben Regaya, (2010)Tunisia	included	Not included	Not included			
Bloom et al. (1998)USA	included	included	included		included	included
Boyle, (2002) UK	included	Not included	Not included			
Bundesen, (1982)	included	Not included	Not included			
Calvert, (1982)	included	Not , included	Not included			
Chan, (1963)	included	? included	Not included			
Chen, (1987)	included	Not included	Not included			
Collis, (1999)	included	included	Not included			
Diaz, (1980)	Not included	included	Not included			
Fernando, (1994)	included	Not included	Not included			
Flynn, (1978)	Included	Included	included		included	included
Frenea, (2004)	included	included	Not included			
Gau, (2011)	included	Not included	Not included			
Haukkama, (1982)	included	Not included	Not included			
Hemminki, (1983)	Not included	Not included	included			included
Hemminki, (1985)	Not included	Not included	included			
Karraz, (2003)	included	included	Not included			
Maclennon, (1994)	included	included	Not included		included	
Matthew, (2012)	included	Not included	Not included			

McManus, (1978)	included	Not included	included			included
Mitre, (1974)	included	included	Not included			
Miquelutti, (2007)	included	included	Included			
Molina, (1997)					included	
Nageotte, (1997)	included	Not included	Not included			
Phumdoung, (2007)	included	Not included	Not included			
Read, (1980)	Not included	Not included	included			included
Roberts et al. (2004)		included				
Tavoni, (2011)	included	Not included	Not included			
Vallejo, (2001)	included	included	Not included			
Williams, (1980)	included	included	Not included			
Berghella, Baxter & Chauhan, (2008), labor management review		included				
Lawrence et al. (2009)				included		
Lupe & Goss, review (1986)		included				
NICE, (2007)				included		

Table 3; Reviews of movement in labour

2.26 Conclusion

This review provides a critical review of the way in which scientific methods of reviewing literature can assess the impact of movement on labour and its outcomes. The reviews included provide a valid and acceptable method of knowledge acquisition around movement. The flexibility in methods of collating literature has been demonstrated and the differing outcomes between reviews shown.

How authoritative methods are utilised and validated by the included reviews is shown. A review that uses a broader scope to its questioning from a social model of maternity care, the results reached can be implemented on an individual level by practitioners and be utilised by

systems of care. When movement is explored within the literature in its context including the environment, skills and beliefs of the carer and expectations of the woman a less mechanistic method is required.

However, the justification for the implementation of knowledge acquired from varying methods can differ and could be said to be based on individual belief systems (Downe & McCourt, 2008). The role of beliefs about movement and the knowledge women, midwives and obstetrician's access or use to justify their beliefs remains largely unexplored.

Chapter Three

3. Birth Dance - Birth and Knowledge

3.1 Introduction

This chapter considers knowledge around women's movement during labour. The previous chapter took a critical approach to analysing how the current acceptable forms of scientific evidence are assimilated, justified and disseminated. This chapter identifies other sources of knowledge around movement in labour and critically analyses this through looking at historical, cultural, political and social influences that shape knowledge production about women's movement during labour. An explanation is given about how this knowledge was identified, and an ethnographic justification provided. The context of birth in the UK was analysed from women's, obstetric and midwifery perspectives.

3.2 Knowledge production and learning

At the beginning of this project I had a great deal of midwifery knowledge from my own formal and informal study and my experience as a clinical and activist midwife. I did not however, have much knowledge from a sociological perspective. The questions asked by this project came from my own experience and to understand how to structure this project it was necessary to understand how knowledge is produced and what influences this. I could then go on to define my methodology, methods and the questions I was going to ask. Therefore, the purpose of this chapter is to examine how knowledge is produced, justified and the influences upon this.

Within the context of women, obstetricians and midwives what is taken for granted as knowledge shall be analysed within the context of what is relative to each group. In this respect this chapter can be termed a sociology of knowledge as it is the construction of the possible forms of 'taken for granted' knowledge within each specific group that is being analysed (Berger and Luckman, 1966). As an ethnographic approach was chosen for the methodology, it was important to me to understand how people make sense of their world. By looking at the knowledge bases around movement in labour and analysing the beliefs which impact upon them I could attempt to understand how people within the groups relate to each other and the differences between these groups.

In addition, as I had taken an academic/scientific approach to sourcing the knowledge in the previous chapter, I wanted to take an approach to finding knowledge that would be accessible to most women and midwives: the library and the internet. It was not meant to produce an exhaustive source of information but a realistic method of finding information in a way that was accessible to me as a midwife and a woman. I used three libraries:, the first at the University of Salford which has a school of midwifery, the second a University teaching hospital health library which has a medical school and a school of midwifery and a small hospital library that is a part of a bigger central teaching hospital, accessible to the staff of my local hospital.

3.3 Women's knowledge around movement in labour

> 'The real science of childbirth teaches us that childbirth, like mothering, is an instinctive female art in which politics should play no part' (Jowitt, 1993 p13).

Historically women gave birth at home, supported by female family members and midwives (Donnison, 1988). Labouring women were free to mobilise using traditional and household objects to assist the birth process and cared for by traditional midwives; local women with experiential knowledge gained from attending many births (Boyle, 2003; Kitzinger, 2001). Knowledge around birth was gained by supporting and being present at family members' births at home, which is how some women in developing countries learn about birth (Wilkinson & Callister, 2010). Today it is unlikely that many women have direct experiential knowledge of birth gained from supporting women in their family or community as it usually takes place within the hospital.

3.4 Commodified birth knowledge

Government directives recognise the importance of antenatal education and advice that information around helping women to work with their body to help their baby be born be included (Department of Health (DoH), 2011). Antenatal education for pregnant women is a service that is commissioned by local CCG's for pregnant women (Tyler & Lead, 2012). Any qualified provider is able to provide this free service for the 700,000 women (Tyler & Lead, 2012) accessing NHS maternity services each year as part of commissioned health services. Commissioning ante-natal education as part of NHS maternity services suggests that the DoH

see this as a service that is needed by childbearing women. The National Childbirth Trust (NCT), the UK's largest parenting charity (NCT, 2015), profit from providing a range of antenatal and postnatal education courses in addition to many other smaller companies offering courses in birth preparation. The sale of this specialist knowledge of birth frames it as a commodity; information, which is not known, freely available or accessible, but is available for a price.

3.5 Birth as innate and a social process

Formal antenatal education for women have replaced traditional ways of learning around birth. Women and girls learnt about birth from the role they took in supporting birthing women and formed part of the socialisation of girls (Nolan, 2011). Nolan (1998) recognises the difficulty for childbirth educators in teaching methods of childbirth preparation where women are active and in control of their labour when the dominant medical model sees women as passive and carers manage labour. Nolan also argues that women already possess the resources they need for birth; their instinctual knowledge and the support of those who love them and will be present at birth (Nolan, 2011). Wickham (2014) reinforces the message that women already know how to birth their babies through ways of knowing that are not currently valued by scientific and modern methods supports this. This is further shown by the work of Shanley (2012) who believes that the understanding of childbirth is a result of personal beliefs. Through looking at the birth experience of women in traditional tribal cultures she illustrates the natural and commonplace occurrence of women giving birth alone, an event which appears to be pain free and safe. She claims that as women in western societies are unaware of the existence of the inner-self, through believing and listening to her inner self a woman can follow her impulses and intuition during childbirth. However, to be able to do this Shanley (2012) states that women must rid themselves of shame, fear and guilt which are unnatural emotions, to enable a more animalistic behaviour during childbirth, to be aware of our inner selves and be responsive to our intuition.

From an anthropological perspective of birth, Kitzinger (2001) describes the places where women give birth; the traditional props and methods used to aid women to be upright and mobile becoming an active participant in their birth. However, Wickham (2004) reminds us that we can never really know how ancient societies functioned and that interpretation of historical evidence can be subjective. Wickham (2004) claims that what is generally accepted

is that prior to the written word, ancient societies would have passed down knowledge through oral traditions such as storytelling, song, myth and art.

Kitzinger (2001) suggests the setting in which birth occurs affects what women do. Women spontaneously move in an environment where they are not confined nor constrained. From her interpretation of historical evidence, movement appears to be integral to how women behaved during labour in their home environment. Historically movement during birth was aided by a culmination of traditional and familiar objects used with women's shared and experiential knowledge of birth (Kitzinger, 2001). Kitzinger records how upright positions have been described and movements observed which appear to ease pain in labour and spontaneous movements made which help the physiological process. This is described in context of the environment and the central role of the woman with the support of family and birth workers (Kitzinger, 2006). Women, when in their own environment have been observed to be active, carrying out their normal daily roles, displaying little signs of distress (Kitzinger, 2001).

When birth takes place within an environment that does not disrupt the birth hormones women are able to follow their instinct; movement during labour is spontaneous (Buckley, 2003). Jowitt (2014) speculates that historically labouring women would have continued with daily tasks, moving instinctively and using whatever was at hand for support. Kitzinger (2006) discusses how movement is described as being used to offer physical support, dance like movements have been recorded across a wide time span and across many cultures. Priya and Odent's (1992) research on birth in traditional ethnic groups in Thailand, Indonesia and Malaysia uncovered traditions where women took responsibility for their own birth, outside of the medical model of birth, with the vast majority labouring in upright positions. Northrup (2010), a GP with a specific interest in women's health, suggests in the West we have been culturally conditioned to turn to experts during pregnancy and birth as women have lost touch with their innate knowledge and power and because of the medicalisation of birth we have lost our birthing wisdom. She suggests that women should tune into their bodies during pregnancy and birth.

3.6 The rational acquisition of the innate

'Innate' and 'primal' birth knowledge has been explored and advocated by French obstetrician Michel Odent (1986). His work, which spans four decades, builds on the theory that the

primitive part of a woman's brain is active during birth; this is responsible for the release of birth hormones. If women are undisturbed and able to labour within comfortable and familiar surroundings, without bright lights, noise, conversation and strangers, the rational neocortex of the brain is not stimulated, and woman naturally use instinctive movement during labour supported by her carer (Odent, 1986).

Odent's theory lies behind the work of childbirth activist and educator Janet Balask (1992). From the early 1980's Balask taught classes to pregnant women on 'active birth' in London, UK, with the belief that birth is a natural bodily function. Women are 're-educated' in the instinctive movements and postures which would have been learnt from attending the births of relatives. Whilst some pregnant women are supported in their choice for an active birth at their local hospitals, during the early 1980's some hospitals banned women from freedom of movement during their labour and birth. This action promoted the organisation of a demonstration, the 'Birth Rights Rally' on Hampstead Heath by 6000 protestors (Robertson, 1994).

The Australian birth educator Andrea Robertson's (1994) work was based on that of Balask, both taught childbirth preparation and produced literature (Balask, 1992; Robertson, 1994) which was independent of hospital influences and woman centred. Robertson describes their methods as more of a philosophical approach in which women are involved in and take responsibility for their birth environment and care, they are able follow their own instincts and women's opinions of outcomes are the primary outcome measures of success and satisfaction.

Active birth as advocated by Balask and Robertson can be described as empowering women to take control of their birth experience. Both Balask and Robertson, who have no medical or midwifery training, align themselves with a midwifery model of care, and view childbirth as normal until proven otherwise. They use Odent's theory as a rational explanation for women's behaviour and needs during birth.

Antenatal education for birth by the hospital institution could be seen as training in compliance of hospital protocol and have traditionally consisted of information the trainers have felt needed to be known and as such does not appear to benefit women (Gagnon & Sandall, 2007). The philosophy of active birth in empowering women has formed the basis of

government guidance for maternity care for many years (DoH, 1993). Whilst active birth does not fit with the criteria of evidence as viewed within the medical model of maternity care, it can be seen as part of forming women's intuitional and historical knowledge of birth which was reintroduced by women for women as a counter to medically managed birth (Robertson, 1994).

With the recognition of the importance of women-centred maternity care (DoH, 1993), using active birth methods would enable maternity services to fulfil these criteria. However, if freedom of movement was part of the birth scenario, it would disrupt the medical equipment deemed essential to modern birth within the hospital environment and be problematic when dominance is given to the information the technology supplies (Jowitt, 2014).

3.7 Obstetrics as powerful knowledge

Hunter's (2013) research highlights the problems that exist within maternity care when attempting to change practice based on midwifery evidence. She highlights how change implementation is not always related to the quality of the evidence but is influenced by barriers and facilitators related to the context in which the evidence is being introduced. The holders of the authoritative knowledge within the organisation play a major role in the sense of whether the issues highlighted by research are considered significant and how the evidence fits with their knowledge sources. If the research is accessible and they consider it robust, the allocation of resources available within the organisation can influence the change suggested by the evidence. This shows the power of authoritative obstetric knowledge as it dominates national guideline committees on normal birth (NICE, 2014) and local clinical hospital guideline committees. Shallow's (2010) experience of change implementation within the NHS as a consultant midwife demonstrates this. Shallow describes how issues of power and control within the obstetric team and clinical governance prevented the implementation of midwifery guidelines as midwifery knowledge and evidence were not treated as equitable to medical knowledge. She describes how midwives in this unit were controlled by obstetrics and how she could not implement guidelines as an obstetrician blocked them.

Empowering women to be active participants in their births is integral to the social or midwifery model of birth (Wagner, 1994; Walsh and Newburn, 2002) however when the majority of births occur in a setting where the medical model is prevalent it does not serve

the interests of the holders of the authoritative knowledge within the modern health care setting.

3.8 Electronically available knowledge – the use of the internet

Whilst active birth may be taught by some health care providers or childbirth educators and supported by midwives, other forms of knowledge are available to women. Information about birth is readily available on the internet, in books and parenting publications. Suggesting would women gain knowledge around birth using these sources of information. Clips of birth can be viewed on Youtube, movement during birth can be learnt about (Crosby, 2011) as well specific movement to address specific situations (Bryden, 2011).

The American Certified Professional Midwife, Gail Tully, has a company called 'Spinning Babies' (Tully, 2015). Using her midwifery and physiology knowledge she demonstrates movements for the antenatal and intra-partum period to enable optimal fetal positioning through movements and exercises to aid fetal rotation and reduce labour complications associated with fetal mal-positioning. The use of this knowledge is aimed at women and birth workers, women can utilise the movements and enable themselves to become an active part of the birth process. Birth support workers can gain skills in unobtrusive methods, based on knowledge of the body and empower women to become active participants in their birth.

Some of the techniques used by Tully are based on the traditional techniques from southern Mexico and are being explored for use by nurse midwives to aid with fetal positioning (Cohen and Thomas, 2015). However, this form of knowledge is not yet validated by scientific methods as no studies have been done to test them. So, whilst a woman may independently use the information gained, midwives may find they are discouraged from using forms of intervention which do not form part of the recognised evidence base and obstetrics may not align itself with unscientific knowledge. Within the policy driven hospital environment, they are not evidence based as they do not conform to what obstetrics value as evidence.

3.9 Obstetric knowledge and childbirth - Birth within the institution

Few parallels can be drawn from the home environments where women were in familiar surroundings with their family and social support to that of the restrictive and abstract nature of birth within a medical institution (Rothman, 2007). Within institutions, childbirth under the dominance of medical practice can reduce childbirth to the purely physical aspects of the

powers of the uterus, the pelvic passage and the fetus as passenger. This perspective gives little reference to the holistic view of childbirth and the multidimensional needs of the woman. Women's voices are absent to this doctrine. With most births occurring within the medical environment, it is seen by obstetrics as a medical biological process operating within a normative range and women and their bodies are under the control of the experts (Kent, 2010). Within the UK obstetrics is primarily concerned with providing medical care to women when, during the antenatal, intrapartum and postnatal period deviations from the norm occur. Obstetric care and knowledge would not generally be applicable to the care of healthy women within the UK as this would not be considered their realm of practice. Obstetric training is based on the technocratic model of maternity care and pathologically orientated (Walsh, 2008). Davis-Floyd (2008) argues the technocratic approach to birth is the wrong imposition of technocratic values.

3.10 Hierarchy of knowledge

Jowitt (2014) suggests there are three areas of scientific knowledge recognised by obstetrics today which are drawn upon to provide evidence: clinical trials, epidemiology and anatomy and physiology. However, anatomy and physiology does not appear to influence obstetrics. This can be illustrated by the use of knowledge used to inform guidelines. The use of quantitative trials forms the basis upon which the majority of recommendations are made within the national guidelines for the intrapartum care of healthy women and babies (NICE, 2014). Quantitative research is the dominant form of methodology used to inform and guide pregnancy and childbirth related practice in late modern societies based on the epistemological premise that observational data can be gathered; mathematical deduction and theorizing is then used to gain knowledge (Downe & McCourt, 2008). The NICE intrapartum guidelines highlight the lack of high-level evidence that suggests maternal movement and position in the first stage of labour affects outcomes and advises that more research is needed. As NICE place more value on quantitative research they state that more research is needed to prove the effect that maternal movement and positioning have on labour.

The recommendation from the guideline regarding movement is:

> 'Women should be encouraged and helped to move and adopt whatever positions they find most comfortable throughout labour.' (NICE, 2014, p283).

This recommendation suggests that scientific, objective evidence cannot show significant enough measurable outcomes and therefore the only use for mobilisation is maternal comfort. The NICE intrapartum guidelines (2014) provide an evidence base to inform practitioners working with women. For recommendations to be included within these guidelines evidence needs to exist to show its effectiveness. Evidence related to effectiveness is classified into specific categories and given more value if the study design used minimised bias. Unless an aspect of labour or the care involved can be formulated into a form of research it is not highly valued within these guidelines. A natural aspect of labour, such as movement, needs to be definable, measurable, and observable and the outcome of the 'intervention' needs to be measurable within a study that has minimum bias.

Evidence around physiology of birth is categorised by NICE as 'expert opinion'. Through the process of normal birth being medicalised, defined by either health or pathology with normal parameters, it has become a subject for scientific knowledge production and reduced to a cause and effect mechanism (Rothman, 2007). Social and emotional aspects are ignored, and science legitimises the definition and treatment of behaviours or conditions that have been given medical meaning (IBID). From a physiological perspective, movement during labour helps the fetus rotate and descend into the pelvis; pelvic movement during labour opens the bony outlet of the pelvis guiding the fetal head downwards in conjunction with uterine contractions (Frye, 1998). The uterus does not work in isolation, separately from the woman as the tone of the medical text would suggest, but a woman works with her body during labour, aided by hormones and in conjunction with the fetus.

3.11 The scientification of birth and movement

The scientific format and credence given to the NICE guidelines are aimed at maternity care providers, providing 'guidance on care' and a form of 'authoritative' knowledge about the birth process. The process of institutionalising childbirth has removed women from experiential birth knowledge, with care being influenced by scientifically based guidelines, responsibility for wellbeing taken by carers and women are expected to conform (Kitzinger, 2006). Prusova et al. (2014) discuss how guidelines have limitations, are not suitable for addressing choice and flexibility and therefore are not conducive for individualised care.

Obstetric textbooks refer to normal birth, position and movement during the first stage of labour. Upright positions are noted to facilitate efficient uterine contractions, shorten the

latent stage and reduce the need for analgesia; therefore, women are encouraged to move and adopt whatever position they find comfortable (Edozien, 2010). Providing an environment that enables women to move around is seen as helpful in increasing maternal comfort (Chamberlain, 1999). Whilst this book acknowledges that women should 'have a greater say' in choice of procedures and decisions, the overall information contained in the book is how to monitor and manage birth. Enkin et al (2000) recognise the lack of evidence to validate the opinion that movement effects labour. They state that supine positions reduce cardiac output and concur that upright positions intensify uterine contractions and upright positions and movement shorten labour and reduce the need for analgesia. The focus in some medical text around care in labour is around the doctor's ability to manage labour (Cohen & Friedman, 2011). The labouring woman is referred to as the 'parturient' and maternal position in labour is recognised as 'probably having little influence'. Another obstetric textbook recommends not confining a woman to bed (Warren & Arulkumaran, 2009) and the NICE intrapartum guidelines (2007) are quoted as evidence to support using movement to aid maternal comfort.

Additionally, some obstetric text focuses on the 'system'. Liu (2007) highlights evidence-based practice, research and the effectiveness and appropriateness of care as tenets of obstetric care. Systems and processes are seen as integral to facilitate communication, through enabling women to understand the given choice by specialists, childbirth is described a physiological function where squatting appears to be the best position for women during birth but it suggests women are put into the lithotomy position so that the attendant can deliver. The dominance of the equipment and expertise needed to assist the passive and immobile role women can be expected to assume within some hospitals, and the power of the hierarchy inherent within a system based on the authority of specialist knowledge does not appear to recognise women's movement in labour as a valuable aspect of care. The woman is invisible in the text. This paternalistic view of childbirth gives no value to the woman's needs or opinions and focuses on the 'system' to enable women to 'understand' what they are being told by the specialist. Northrup (2010) discusses how the dominant patriarchal culture around childbirth treats it as an emergency, maintaining the power relationship. This is reflected in the literature that comes from an obstetric viewpoint. When childbirth is viewed as only normal in retrospect (Oakley, 1990) during the potentially

dangerous time of labour, obstetrics with the technology, skill and knowledge can save lives. But whilst technology, skill and surgery has contributed to safer childbirth for women and their babies, elements of birth which do not need the acquired skill of the obstetrician do not appear to be a significant part of the birth process. Whilst diligently observing and monitoring for events to become abnormal, and the purpose that position and movement has upon the physical efficiency on contractions, the positions women take and the movements they make do not appear to be integral to the birth process within this literature. The focus of birth in the medical literature appears to be on a technical process and the body as a machine. The obstetrician takes on the role of technician and the woman appears to be passive in the process, this representation of birth as a form of production is highlighted in Martin's work (1989). Through the representation of birth within the medical literature and research around women's experience of birth, Martin explores the origins and the development of labour and birth within the medical literature and the cultural influences in aligning it with a means of production. She presents scenarios within her research which illustrate how women's retelling of their labour and birth experience align birth within the scientific definition and metaphorically as a form of production and something which is happening to them within the culture context of birth within the USA in the mid 1980's. Oakley (1990) suggests that birth as a normal event has disappeared from industrialised society due to the increasing focus on risk in everyday life. Consequently, society has lost the ability to view life positively.

3.12 Obstetrics from a different perspective

In 1933 a British obstetrician wrote a book entitled 'Natural Childbirth' (Dick-Read, 1933) which highlighted the importance of women's emotions during childbirth. This work recognised how little was invested in maternity care and how this affected humanity through the little value that society appeared to place in the health of future generations and mothers. He identified the positive emotional value women place upon birth and motherhood, and how the newly emerging obstetric culture sought to control or eliminate what they felt caused problems: pain and long labour. Therefore, within obstetrics, analgesia was offered and intervention promoted. Dick-Read observed and validated the psychological effect birth had on women (Dick-Read, 2004). He went on to develop birth carer advice that recognised optimal psychological and emotional care for women. This induced calmness and patience to the birth process resulting in a more participative theory of care for women starting in the

antenatal period for a more psychologically and emotionally positive and thus optimal birth experience for women.

Obstetrician Leboyer (1975) aligned birth with love, by seeing birth through the perceptions of the child. He presented the mechanical, medical care and practices during birth as cold, emotionless and violent. Through creating a calm, quiet and dark atmosphere and welcoming the baby into the world with love and gentleness, babies were born calm and 'happy'.

Odent (1976) used Leboyer's principles and aligned birth as mammalian and instinctual in nature, again his work describing birth in very different terms to the majority of obstetrics, taking a more holistic view. During the 1970's in his practice in France, Odent successfully formed a practice that intentionally set out to de-medicalise birth. Based upon the work of Leboyer, (1975) preparation and an atmosphere for birth were created which optimised a calming and loving transition to life for the new-born. As the obstetrician and midwife played a minimal role in birth other than that of being watchful, birth equipment was out of sight and an environment was created where women could adopt whatever position they wished (Odent, 1976).

Amali Lokugamage (2011) a Sri Lankan born, British trained obstetrician, qualified in homeopathy and acupuncture, always thought she took a humanistic view in her practice until she became pregnant with her first child. She describes her pregnancy as an experience which transformed her perspective on childbirth as she connected with her unborn baby and her 'consciousness' and 'inner wisdom' as she went through a powerful psychologically compelling physiological and cognitive transformation. This transformation allowed Lokugamage to access her innate birthing wisdom and use instinctual knowledge to make congruent decisions through her pregnancy and birth, ultimately leading to an empowering pregnancy and birth experience. Lokugamage (2011) is now a supporter and promoter of natural birth and its benefits for wider society, which includes Active Birth preparation (Balask, 1994).

The work of obstetricians Dick-Read, Leboyer, Lokugamage and practitioners such as Odent have embraced the same principles recurring over periods of time. Many of these principles have been adopted by current midwifery practice or were already entwined within midwifery practice before the advent of professionalization and obstetrics dominance, but are not

prevalent in mainstream obstetric literature. Principles that encompass the intrinsic and intuitional knowledge of women, the effect that negative and positive emotions have on childbirth, the role of hormones and the fetus during birth and how this influences women's movement during labour is absent from the majority of obstetric literature. Lokugamage (2011) states that her medical and research colleagues are unaware of the existence of these and other sources of birth knowledge.

3.13 Summary of obstetric knowledge on movement

Most of this obstetric literature acknowledges that movement during labour increases comfort to the woman but is identified as an 'intervention' (Lawrence et al. 2013), something that is done to birthing women during labour which does not compromise safety but is not recognised as integral to women's birth process.

Much of the research evidence used by the medical model focuses on the effect of movement on time in labour, yet there is no justification why time in labour is imperative. However, Kitzinger (2005) and Walsh (2004) argue that the current biomedical system of birth is based on a production model. This focuses on the need for an efficient system of processing women through the institutional birth system as quickly and efficiently as possible. This perspective intensifies the need for all births to fit within a standardised time frame and for individualised needs to be overlooked when the focus is on the overall needs of the system. This approach can be at odds with midwifery care and women's individual needs as holistic care, and all that it entails, cannot be standardised and may cause disruption to the system. This medical systematic approach to labour care views anthropological, midwifery experience and women's intuitive knowledge are described as anecdotal and not valued in medical model as it does not serve its needs.

However, midwifery experience and knowledge can form the basis of theory and science can use technology to quantify and measure it to become valid. This can be illustrated by the work done on the observation and measuring of different maternal positions (Rietter et al. 2014; Zhang et al. 2014).

Squat and supported squats have been identified as positions adopted by women in childbirth (Kitzinger, 2006; Jowitt, 2014; Odent, 1976; Sutton and Scott, 1995) however as the claims of the benefits of this position could not be supported by science, it does not appear in the

obstetric literature or childbirth guidelines as a recommendation for birth. Rietter et. al. (2014) used MRI scanning to compare pelvic diameters in pregnant and non-pregnant women in a dorsal supine position and in a kneeling squat position. The results showed that a kneeling squat significantly increases the diameter in the bony pelvis; this piece of scientific evidence gives validity to the knowledge of maternal positioning for childbirth.

In addition, Zhang et al. (2014) measured the blood flow to the inferior vena cava and aorta of pregnant and non-pregnant women in a semi recumbent position with a 15-and 30-degree tilt on the pelvis, they identified a 30-degree tilt improved blood flow.

This scientific evidence can add support to what may already be women's intuitive or midwifery experiential knowledge. However, because it has been the subject of research and outcomes have been objectively identified it can now be seen to be authoritative and adding to obstetric knowledge.

3.14 Midwifery knowledge and childbirth

3.14.1 Influences on the midwifery knowledge base

Midwifery was a female profession, midwives or 'wise women' gained their knowledge from an apprenticeship model of learning through the experience of attending births, and culturally held superstitions and what was socially deemed common sense (Donnison, 1988).

Today part of the role of the midwife is to provide evidence-based information to enable women to make informed choices regarding aspects of their birth (NMC, 2015). Since 1902 the role of the midwife in the UK has been defined in statute and regulated by a governing body which sets standards for midwifery practice (Marland & Rafferty, 1997; Nursing and Midwifery Council, 2011). The Midwives Act of 1902 gave midwifery a professional status. This was a step towards improving infant mortality and maternal health for women living in deprived areas through the social role they provided in raising public health standards within communities whilst attending home births (Hannam, 1997). The aim of the Act was to improve midwifery training and regulate their practice, midwives in the official role had to comply with regulations and faced reprimand or removal if they were not followed (Mottram, 1997). The role of administering the 1902 Act was often given to members of the medical profession, allowing midwifery practice to be governed locally by doctors (Mottram, 1997). The Central Midwives Board established by the Act controlled entry to the profession and was

also monitored by doctors (Pitt, 1997). It is suggested that the professionalisation and statutory regulation of midwifery (Oakley, 1990) and the hospitalisation of birth (Jowitt, 1993) have contributed to reducing midwifery autonomy.

Midwifery is now a graduate profession, learned through a combination of theory and practice, and based within university settings (Darrcoh and Flemming, 2014). Midwifery education moved away from hospital-based schools of nursing and midwifery into universities without evidence of its effectiveness (Mead, 2010). Degree level education was considered beneficial to midwifery as a more knowledgeable professional workforce was required to deal with the increasing use of technology, increased clinical responsibilities, the advent of evidence/research-based practice and a more knowledgeable population (Mead, 2010). With the advent of evidence-based practice, midwives are in a position where the care and advice given is based on the best available research evidence (Proctor and Renfrew, 2010). When midwifery care is based on a social model (Walsh & Newburn, 2002) it encompasses many aspects of women and their lives, for many of these aspects of midwifery practice there is little or no evidence (Proctor & Renfrew, 2010). The use of clinical guidelines, such as NICE, ensure an evidence-based approach to practice is implemented. These guidelines synthesise a level and an amount of evidence that a practitioner would probably find impossible, it also overcomes the need for practitioners to engage in the research, thus losing critiquing skills that were gained during training (Spiby & Munroe, 2009). However, this focus on evidence-based practice and the need for empirical knowledge to underpin care does not emphasise the intuitive and empathetic nature of midwifery care that is gained from knowledge and experience acquired through life, midwifery education and practice (Bryar and Sinclair, 2011).

3.14.2 Movement and midwifery knowledge

There is a plethora of midwifery text books covering normal birth and care in labour. Hand searching of these texts provide an overview of the knowledge directed at midwives around movement and position in the first stage of labour.

Evidence-based medicine/practice is prevalent in the medical systems in western medicine and is important in forming standardised policy and practice in the UK (Spiby & Munroe, 2009). Evidence-based midwifery was devised from ‘evidence-based medicine’ (Wickham, 1999). Evidence-based medicine which can be defined as:

> ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett et al. 1996).

Wickham (1999) argues that ‘evidence informed midwifery’ is very different from what is understood as evidence informed medicine, as midwifery has a broader definition of evidence than the reductionist, positivist definition that is based in the biomedical paradigm. Spiby and Munroe (2009) state that midwifery has a role within generating, synthesising and transferring scientific evidence and knowledge within guideline development and audit (Spiby & Munroe, 2009). As normal midwifery care is now governed by hospital policy and procedure, the medical model that values scientific generation of knowledge is dominant within the bulk of midwifery knowledge sources. Reflecting Spiby & Munroe’s (2009) idea of the contribution of midwifery within the production of knowledge. However, Wickham (1999) states there are many different forms of midwifery evidence that inform midwifery but argues that it is not based on this alone.

Midwifery textbooks (McCormick, 2009; Simkin & Ancheta, 2011; Walsh & Downe, 2010) recognise movement as an aspect of labour support that is included within midwifery intrapartum care.

McCormick (2009) highlights the importance of maternal position and mobility during the first stage of labour, referencing three research sources. The first quoted piece of research (De Jong et al. 1997) is an RCT comparing upright and supine positions for the second stage of labour. The author does not explain how this study applies to care during the first stage of labour as the research focuses on the second stage of labour. The second study quoted (Hofmeyr & Kulier, 2001) is a Cochrane review using two RCTs to establish the use of hands and knees position to correct malposition of the fetus in late pregnancy. The review is not applicable to care during labour and McCormick (2009) does not refer to an updated Cochrane review published in 2005 (Hofmeyr & Kulier, 2005). By using these two sources of evidence regarding maternal positioning, this textbook frames maternal positioning as an intervention that can be used to alleviate pain and avoid difficulties caused by labouring in supine or semi-recumbent positions.

The third piece of evidence quoted (Sutton & Scott, 1996) is based on experiential knowledge and work done by midwives around optimal fetal positioning. No specific recommendation is

made from this work as McCormick (2009) recognises that scientific methodology has not been applied and therefore this midwifery knowledge cannot be verified. They comment that further trials are needed to enable women to make an informed choice about positions in labour and conclude that women should birth in whatever position they find most comfortable. Despite the paragraph heading of positioning and mobility, no reference is made to maternal mobility in labour and the difference between positioning and mobility.

Simkin and Ancheta (2011) promote specific movements and positions to encourage optimal fetal positioning to encourage normal birth. Their work is based on the principle of women participating during labour to increase their satisfaction and reducing medical intervention. Information is used from published empirical research, as well as the anecdotal experiences of doctors, midwives, doulas, physiotherapists, and anthropologists. By documenting and using this experiential knowledge, midwives work with women and their individual experience of labour to advice on using movement to support normal birth. This knowledge base can be used to aid midwives when caring for women during labour and therefore aid best practice. The work illustrated in this text forms the basis for the theory and advice of spinning babies (Tully, 2011).

Mander (2009) highlights that there is little research evidence for the least invasive and low-tech approaches to help women cope with pain during labour. In her chapter 'working with the woman in pain' she quotes Simkin & Ancheta's (2005) work from the labour progress handbook and Simkin & O'Hara (2002), both advocate movement as effective in increasing maternal comfort during labour.

Schmid & Downe (2010) say that in a supportive environment, women will subconsciously respond to the cues that they are given from their baby and their body; they also advise that some women may need guiding by their midwife if they are finding birth hard or they become demoralised.

'Midwives are the major influence on whether a woman is free to mobilise' (Charles, 2013, p 16).

'*The midwife's labour and birth handbook*' (Chapman & Charles, 2013) acknowledges the impact midwives have on women during labour. Through midwives encouraging movement,

it is seen as component of midwifery care that can reduce complications caused by restricted mobility and semi recumbent postures and Lawrence et al. (2009) is cited as evidence.

Women's expectations and the medical environment are referenced as affecting movement (MIDIRIS, 2007) and evidence is cited which shows how midwives can deny women choice in position during labour (Redshaw et al. 2007). It is highlighted how midwives' knowledge of anatomy can help understanding of how different positions can help the physical process (Royal College of Midwives, 2005). When labour is diagnosed as slow, mobility is cited as reducing labour dystocia (Lawrence et al. 2009). Malposition and mal-presentation are cited as causes of prolonged labour which in some instances can be rectified by mobility and positioning. Simkin and Ancheta's (2011) illustrations and recommendations for positioning are used. This book appears to recognise the impact of midwifery care and the benefits of a variety of knowledge bases.

The overall reference to movement and positioning in this book is in context with other types of midwifery care such as massage, heat, communication skills, abdominal palpation and the support role as well as the 'medical role' of clinical observations and referral to obstetrician if outside of 'normality'. Movement and position do not appear to be something that midwives can utilise as an intervention with the necessary research evidence to validate but as an aspect of support that is part of midwifery knowledge. This book appears to be an attempt at breaking down what could be described as experiential knowledge, the knowledge that would be gained from attending births and observing midwifery care given or the behaviour of birthing women. Research evidence and midwifery text are referenced as evidence. Though midwife centric, the holistic care of the woman appears to be central.

3.14.3 Midwives' influence on women's movement

The role that the midwife has on women and the positions they use can be further illustrated by the work of Coppen (2005). In her unpublished work she first identifies the ambiguity that exists around definitions of birth positions between midwives (Coppen 2002). Coppen (2005) went on to carry out an RCT involving 235 women who were randomly allocated to two groups to establish the effectiveness of focused information on women's knowledge levels. Using a specific antenatal education program around positions during labour, Coppen sought to discover whether being informed of birth positions significantly increased women's decisions to use upright positions for labour and birth. She found that her program increased women's

knowledge and choice around positions in labour which they exercised during the first stages of labour; however, midwives controlled the decision making during the second stage of labour. This study illustrates the impact midwives have on women regarding positions during labour. Whilst the midwives delivered the antenatal education program, sharing their knowledge and empowering women, midwives also used their knowledge during birth to disempower women during the second stage of labour. This outcome is supported by Thies-Lagergren et al. (2013) which showed that supporting women's autonomy and decision-making regarding upright positions increased self-confidence by making them feel powerful and protected.

3.14.4 Midwives and movement during birth

Midwifery was originally a community-based form of helping and healing; an extension of the mothering role which drew upon religious and spiritual beliefs (Kitzinger, 1991). When speaking about holistic midwifery care Baston and Hall (2009) list individual aspects around midwifery care given within a system of care that is relevant to the current cultural context. They cite government directives which promote women-centred care, use of the best evidence, legal and professional requirements, team-working and communication, clinical dexterity, a safe environment and health promotion. The spiritual aspects of interactions between women and midwives within intrapartum care do not appear to be accounted for in many midwifery texts.

Movement and position are recognised in many midwifery texts as part of labour care; however, how this care is given or perceived in a spiritual sense is not articulated or accounted for. Hall (2001) cites where spirituality is included in midwifery terms, words such as trust, faith, support, respect, honour, empowerment, flexibility, love, talking, touch, prayer, positive-thinking, compassion, openness, instinct, individualized, sensitivity, and encouragement are used.

Spirituality within midwifery can be epitomised by the work of Ina May Gaskin (2003). Gaskin, an American Certified Professional Midwife, has worked as a midwife with her partner midwives in the same community since the early 1970's. Her seminal work on the importance of spirituality and birth, sees midwifery as a nurturing role which draws from the wisdom and compassion women intuitively experience during birth and this can make her a source of understanding and healing to other women. Her books describe birth from a woman's

perspective using individual women's voices and describes birth as it takes place within the community. Relationships with those attending the birth and the baby are described in detail, the environment birth takes place in and women describe how they feel about their experience and how they think this is reflected in their birth experience. Physical positions of the women are rarely mentioned, as physicality does not appear to be the focus of the experience. In the re-telling of their experiences, women describe the physical sensations experienced when birthing their baby and occasionally the dilatation status of the cervix is mentioned. Birth experiences are described in a positive way by the women and this comprises over half of the book, with brief sections on midwifery care. These stories are illustrated by pictures of the birthing women and show women being supported in their environment by other women in a variety of positions.

In her second book on childbirth, Gaskin (2003) describes the strong mind and body connection during labour and how allowing ourselves to tune into our primitive selves, instinctual movement during labour is enabled. Movement during labour is described through reference to traditional and ancient knowledge on how women gave birth prior to the medical profession using whatever means they had to assume upright positions considered as normal and natural (Gaskin, 2003).

3.14.5 Summary of the midwifery knowledge base

Much of midwifery text is based on care given to women within an obstetric-led context. Using research/evidence to underpin recommendations around care provided, care is based on population evidence rather than individual variation (Downe and Page, 2014). The individual variation of each birth evident to care givers such as midwives, learnt through exposure and experience, does not appear to be given the authority within the literature.

Oakley (1990) suggests that a confrontation has developed between two models and philosophies of childbearing: pregnancy and birth as a medical event inherently pathological and requiring expert management and control versus pregnancy and birth as a social event and an ordinary life experience. The midwife stands in between these two philosophies (Oakley, 1990). This is shown in the range of midwifery literature presented here and is reflected in what kind of knowledge is used and how it is used to portray the use of movement during childbirth. The existence of these competing ideologies in maternity care has been identified as having an adverse effect on midwives (Hunter, 2004) as the co-existence of

contradictory ideologies within midwifery practice create dissonance for midwives. A medicalised approach to midwifery care restricts midwifery autonomy through practice controlled by protocols and policies designed to manage childbirth and reduce related pathology that is prevalent within hospital-based practice. In contrast, a more psychosocial approach which facilitated midwifery practice that was more ideologically congruent with midwifery practice and supported confidence in physiological processes allowed midwives the opportunity to work 'with woman' (Hunter, 2004).

3.15 Social and biological knowledge

Knowledge of childbirth is more than just biological knowledge, it is also about social knowledge and particularly influenced by the predominant knowledge of where birth occurs (Lazarus, 1997). Birth is socially marked and shaped (Jordan, 1992), and can be illustrated by how movement during labour is represented in the literature. This thesis provides data from three different viewpoints and illustrates how each group, as a social group, shapes how knowledge around movement is formed, valued and disseminated.

Women's ways of knowing can be seen as intrinsic; from the intuitive knowledge women are said to instinctively have about birth, the knowledge shared with other women, to the knowledge shared in the wider public domain. Kitzinger (2006) states immobility was imposed on women by doctors in the 19th century who wanted women supine to make examination easier. This can be seen as the beginning of the loss of socially gained experiential women's knowledge around movement in labour. From Kitzinger's work, the birthing woman appears central to the birth process. When the woman's traditional spirituality, home environment, familiar props, and birth-supporters are present and considered, movement during birth appears expected. The woman as the expert in her birthing body moves into positions that she feels will assist her. The experiential knowledge and skills of the birth-attendants are used if necessary, to support movement in assisting the birth process. This is in stark contrast to the hospital environment, with often little room to move and the supine position providing the best position for the woman to be monitored. The dominance of the obstetric bed in the labour-room combined with the expectation of birth on a bed renders movement during birth as 'alternative'. Jowitt (2014) suggests obstetric birth does not recognise the influence movement has on the fetus's journey through the bony pelvis.

Whilst Balask appeared to introduce active-birth antenatal education and was deemed 'revolutionary' at the time, this was actually 'return to women's birth knowledge' (Kitzinger, 2005). However, how women today access knowledge around movement in childbirth and how this informs their beliefs is unknown.

Birth is a biological event, but it cannot be defined purely by an explanation of biological knowledge as birth takes place in a social world that is shaped by cultural beliefs and practises (Oakley, 1980). Oakley discusses the historical development of how medicine and specifically obstetrics, as a male-dominated profession, sought to remove women and women's knowledge around women's reproductive functions. In doing so, they established themselves as experts, in possession of all the resources necessary to care for and control women during childbirth.

If, as a society or institution, we are only validating objective scientific knowledge on women's seemingly natural behaviour during labour, this remains the case in current childbirth practice. Movement in labour is sometimes viewed as a soft intervention offering women comfort and should be 'recommended' or 'allowed' if conducive, but does not take precedence over such things as Electronic Fetal Monitoring (EFM). Women can be viewed as manipulable reproductive machines who inform obstetric technology that then needs interpretation. This can create a discord between medical and maternal frames of beliefs around childbirth as no recognition is given to women and their psychological, social and emotional needs.

Davis-Floyd (2001) identified three models of maternity care that influence care given; the technocratic model influences the majority of obstetric care. This system of care mechanises the body, objectifies the woman, and gives power to the practitioner over the woman as the holder of authoritative knowledge required to manage birth. This technocratic approach is evident within most of the obstetric literature by the way in which movement in labour is researched; attempting to establish a valid reason for mobility and upright positions in labour through designing research projects which aim to measure the effect on the length of labour. The obstetric literature separates movement from the woman and does not recognise it as an intrinsic part of labour but as something that aids labour or not, disregarding movement as natural and intuitive and as much a part of labour as the woman, her uterus and her child. Oakley describes how women are physiologically and psychologically defined in context to

childbirth through cultural ideals of the medical profession. Little of the obstetric literature refers to women other than in a physiological sense, the idea of labour as something separate from the woman and to be observed, measured and controlled. This demonstrates the underlying beliefs of the obstetric view of birth and is congruent with Davis-Floyd's work and the technocratic model of care.

Whilst Dick-Read, Leboyer and Odent appear to recognise the effects of environment, hormones, psychological concepts and emotion on women during labour, the practice they advocate can be seen as paternalistic. Their methods of birth involve environments or practices that are instructed, facilitated or manipulated, mostly in clinical environments constructed by carers giving them authoritative knowledge.

Odent particularly aligns women's actions during labour with natural and instinctive behaviours that emphasise the animalistic nature of birth and an irrational way of behaving; positioning himself as expert and facilitating an environment where he is the holder of authoritative knowledge. It could be argued that the concepts of relaxation techniques, gentle birth and 'primitive' birthing form part of traditional midwifery practice gained from experiential knowledge based on attending births and being a woman living within other women. However, for these practices to become valid it required doctors to systematically identify and record them, thus making propositional knowledge.

Propositional knowledge, theoretical knowledge that is written down and codified (Kent, 2000), takes precedent in the obstetric or medical hierarchy of knowledge and other types of knowledge are not deemed as valuable (do Mar Pereira, 2017; Dalmiya and Alcoff, 1993). This is evident in how movement in labour is represented in the obstetric literature and in the NICE guidelines. Movement and positions during labour are observed, compared and measured, statistical significance is specified and a decision is made as to whether this 'intervention' can be justifiably used, thus forming authoritative knowledge.

Most obstetric literature also views knowledge around movement during birth as extrinsic to the woman, attempting to define it, measure its effect and then apply it to reach a desired outcome in a way that is standardised and applicable to all, regardless of the individual and wider psychological, emotional and sociological circumstances.

Whilst a view of the obstetric literature has been provided on how women, labour and movement are represented, the way obstetricians use this knowledge and what informs their beliefs around movement in labour is unknown.

3.16 The construction of midwifery knowledge for practice

The code of professional conduct for nurses and midwives (Nursing and Midwifery Council, 2015) states that the best available evidence and best practice should be used to provide a high standard of practice and care. For many aspects of midwifery, there is little or no research to support clinical decision-making, though evidence does exist but is not put into practice (Proctor and Renfrew, 2000). Within the literature identified, much of midwifery knowledge providing the evidence-base seems to be situated within the obstetric knowledge base. This is reductionist and positivist which does not align with a midwifery/ holistic/ social model of care. Forms of knowledge that influence midwifery practice and decision-making are much more complex and are not recognised by a biomedical approach. Midwifery knowledge can include research evidence but is also informed by a midwife's professional or personal knowledge and experience of her work as a midwife and a woman, the culture and context in which she is working, her own beliefs and that of the woman for whom she is caring (Wickham, 1999; Proctor and Renfrew, 2000). All these forms of evidence, if used appropriately can be used to inform midwifery practice (Wickham, 1999). Page 1996) stated that restricting practice to only that which is supported by research evidence can be severely limiting as only approximately 12% of birth and midwifery decisions can be based on the available quantitative research evidence. Spiby and Monroe (2009) also recognises this and highlight the importance of incorporating evidence based in qualitative methodology to add to midwifery care knowledge however, it is not valued. Walsh (2007) recognises that evidence informed midwifery has evolved much evidence around normal birth does not influence care. A standardised approach to a woman's individual circumstances and experiences cannot be represented by positivism as women and birth cannot be standardised. Whilst knowledge of the obstetric research can provide valuable information, especially in respect to pathology and appropriate interventions, midwifery knowledge in relation to normal birth and midwifery is more appropriate. Drawing from wider, more relevant sources enabling more reflective, individualised care.

Prusova et al. (2014), analysed the Royal College of Obstetricians and Gynaecologists (RCOG) Green Top Guidelines and found only 9-12% are based on best-quality evidence. Similarly, Wright et al. (2011) analysed American College of Obstetricians and Gynaecologist (ACOG) guidelines and found that only 25.5% of the recommendations were based on sound evidence. The aim of evidence-based medicine was to make clinical practice more scientific and empirically grounded enabling care to be consistent, safer and cost effective, however the emphasis on experimental evidence can devalue basic sciences and the tacit knowledge of clinicians (Greenhalgh et al. 2014). Greenhalgh et al. (2014) argue that: the quality of trials can be manipulated by the pharmaceutical and technology industry to reproduce results in their interests; the volume of evidence has become unmanageable; statistically significant benefits can be marginal in clinical practice; inflexible rules and technology initiate care that is management-driven and evidence-based guidelines often do not map well to multi-morbidity. They recognise the scientific methods of evidence collection have benefited people, but healthcare is subject to many influences with an agenda focusing on populations, statistics, risk and spurious certainty and suggest a more individualistic, humanistic, relationship-based and holistic approach to collaborative health care. Healy (2012) also recognises the biased effects the pharmaceutical industry has on the scientific evidence-base and recognises that despite their experience and direct 'patient' contact, observations made by clinicians are disregarded as anecdotal and not valued.

The transition from evidence-based medicine to evidence-based practice in midwifery appears to have been made and its principles adopted within the guidelines of midwifery literature. This illustrates how an ethnocentric bias in a biomedical approach to care has been transposed onto maternity care. A principle adopted by medicine to improve 'patient' outcomes in pathology with interventions/pharmaceuticals/technology with the appropriate 'quality' of scientific evidence to support it has been transferred to normal physiological aspects of birth. When birth is viewed from a midwifery perspective, knowledge about an individual birth, with the woman in her individual circumstances, a woman and her midwife can draw from a variety of knowledge bases, however these are not predominant in the midwifery literature. Through gaining, using and sharing midwifery experiential knowledge, midwives can help women gain an understanding and make decisions that are right for them. Without using and sharing this knowledge, it could be lost. Through incorporating experiential

knowledge into practice women are retained as the experts in their uniquely female experience (Wickham, 1999).

Midwifery experiential knowledge is not incorporated into national UK guidelines for intrapartum care nor does it feature in many of the midwifery care text books. This also illustrates how objective, scientific, medical knowledge prevails in maternity care and the power and authority that is given to patriarchal methods of knowledge production (Davis-Floyd & Sargent, 1997). Within the research evidence-base there are generally accepted principles for evaluating the evidence however evaluating experiential or intuitive knowledge is less straightforward even though Wickham (2000) argues it can be more important when midwives are making decisions with women. She suggests some ways to evaluate forms of evidence other than research through knowing ourselves as midwives, reflective practice, understanding physiology and developing our intuitive processes.

Intuition can be used as a source of knowledge as recognised by Shanley (2012), Wickham (1999) and Lokugamage (2011): Knowledge, which has been recognised but neglected and denigrated by the dominant ideology of rational knowing (Belenky, 1986). Intuition is seen as irrational in a patriarchal society, being something that most men lack, therefore science maintains the exclusive ability to answer questions using verbal and symbolic meaning that illustrates rational thought. Within the technocratic birth environment, instinctive behaviour is irrational and inappropriate as it cannot translate into verbal or symbolic meaning and therefore cannot fit into a scientific form of reference (Jowitt, 1993).

Whilst forms of knowledge available to midwives have been presented, what knowledge midwives access and what informs their beliefs around maternal movement in labour is not shown in the literature. In addition, barriers midwives experience when practising using knowledge from the various knowledge bases is unknown.

3.17 Summary of birth knowledge

Knowledge around birth is not an objective accumulation of what is known, but is personally, politically, socially and economically influenced (Wickham, 2004). The status that is given to research-based evidence is apparent within the literature however, other forms of knowledge have been identified in relation to women's movement during labour. Jordan (1997) identified the existence of differing knowledge systems in maternity care, some carrying more

weight than others either because they offer more efficient explanations or because they are associated with a stronger power base, but usually both. Within these knowledge systems equalities can be given to all sources however, it is more usual for one type of knowledge to gain legitimacy and consequently others are devalued and dismissed. Jordan (1997) suggests that this construction of authorities of knowledge is an ongoing social process that reflects power-relationships but does so in a way that presents the social order it is given as natural and obvious. Historically, women were believed to hold the authoritative knowledge on childbirth as it was a female experience occurring in the home. With most births now occurring in hospitals, governed by a business model and influenced by the most powerful in the hierarchy, a very different social order is in operation. Women's needs and knowledge is not as important and influential as the needs of the institution or equal to the authoritative, scientific knowledge. If birth occurs most frequently in hospital this can be viewed as the most natural place and therefore the value of the authoritative knowledge is obvious. Jordon (1997) adds that the authoritative form of knowledge is not necessarily correct, but that all participants within the social setting collaborate to ratify and agree that it counts, as it is used to justify their actions. The scientific research knowledge appears to have been given legitimacy within obstetrics, and a good proportion of the midwifery literature as the focus of labour is to manage (obstetric) or observe and record (midwifery) it within defined parameters of scientific significance in accordance with a defined professional role in the socially accepted definition of childbirth.

It is clear from this review of the literature which forms of knowledge are given greater credence. With some forms of knowledge being presented as more valid within the guidelines and literature it generates the belief that some forms of knowledge are more valid and creates a hierarchy. The word 'evidence' used in the current context of birth knowledge can be problematic as it is commonly used as a legal word relating to the concept of 'proof' (Kirkham, 2012). When used in the context of knowledge and knowledge acquisition and use, the assumption can be made that scientific research can produce facts that are universally acceptable. However, Wickham (2014) suggests that whilst all forms of knowledge are potentially valuable, it is more important to ensure the question is effectively answered by the appropriateness of the evidence. Whilst all knowledge is subject to the perspective of the receiver and is contextual in how it is used, ultimately its worth depends on the value the

receiver places on the source (Wickham, 2014). Therefore, as midwives and women when applying the arguments that question the validity of the many forms of knowing, it raises the question of whether we actually know anything if, within the medical model, the most valuable is scientific knowledge.

3.24 Conclusion

An overview of the literature available to midwives, women and obstetricians on movement has been presented within a sociological framework and critiqued within the current cultural context in which it exists. It presents a critique of how knowledge of movement during birth is presented within a range of literature, how it influences and how some knowledge is viewed as more valid than others.

The next chapter shall cover the methodological approach used in this project.

Chapter Four

4. Methodology

4.1 Introduction

This chapter outlines the literature underpinning the theoretical framework that informed the concept of this study (Simon & Goes, 2011). The concepts of epistemology, theory and paradigm are explored and used to justify the research aims (O'Rielly and Kiyimba, 2015). The epistemological basis of the research project and the influence of feminism is explained. The choice of methodology is described and justified with reference to its appropriateness for the intention of this study.

4.2 Theory influencing the study

Theoretical work conducted around midwifery and obstetric care has identified differences in cultural values and norms between the obstetric and midwifery professions (Murphy-Lawless, 1998; Davis-Floyd, 2001; Wagner, 1994; Walsh and Newburn, 2002). This work around maternity care provision defines models of care provided by or influencing professional groups within maternity care, highlighting differences in the care provided and the ideologies in which they are based. Kitzinger (2015) states that midwifery, an emotional occupation based on the relationship between a midwife, women and families, embodies societal values across the globe. She describes how midwives support women during birth with cultural rituals, whether birth is taking place within a traditional culture in Jamaica or in a hospital in the west. However, the difference between the traditional culture, which uses symbolism - to support women - and western medicine - to disempower women – is that they are informed by ideologies from very different bases of authoritative knowledge.

In juxtaposition to knowledge which takes a holistic view of birth and transition to a family, obstetrics, which is embedded in pathology and is informed largely by objective science (Murphy-Lawless, 1998) is the authoritative voice in the majority of maternity care settings (Jordan & Sargent, 1997). How this authoritative knowledge is informed and interpreted in maternity care is highlighted within the literature reviewed within this thesis. Conflicting ideologies within midwifery and obstetrics, which have diverse values and perspectives, have been recognized as influencing occupational identities influencing midwives' working lives and consequently on the care they give (Hunter, 2004). It has also been reported that

fractured relationships between medical and midwifery staff have contributed to creating barriers in providing appropriate care sometimes with devastating effects for women, babies and families (Kirkup, 2015). Whilst it is recognised that midwives and obstetricians can have different philosophies and belief systems that influence the care they give, it is also recognized that due to exchanges of knowledge and technology it is difficult to identify practice specific to one culture that represents a monolithic value-system within midwifery (Davis-Floyd, 2001).

In addition, obstetric and midwifery staff do not practice in isolation. The previous chapters show how politics, government policy and funding, and NHS trusts as employers, influence the care provided. Kitzinger (2015) argues that childbirth is shaped by culture, whether that be in traditional societies or modern western hospitals and suggests that birth as a pathological disturbance has now become the norm where birth is regulated by the hospital.

4.3 Epistemology - What we know and how we know it

From a theoretical perspective, how knowledge is gained and what constitutes knowledge is shaped by approaches or paradigms. Within social research, opposing beliefs of what constitutes knowledge and the relationship between the research methods drive methodological choice (Ormston et al., 2014).

One view is that knowledge is acquired inductively through a 'bottom up' approach; knowledge is acquired about the world from observations and then devising patterns. This approach recognises the interaction of the researcher on the data collected and the subjectivity of this. Through multiple collections of data, consensus can be reached on the truth as a reality, this approach is predominant in the social sciences (Ormston et al., 2014).

Another view is that knowledge is acquired deductively using a 'top-down' approach. By developing a theory and either collecting data to support or dispute it, the researcher remains objective having no effect on the research or the data collected. In this way a single view of the truth can be obtained which exists independently of the researcher locating a single version of the truth, this approach is predominant in the natural sciences (Ormston et al., 2014). Deductive approaches when applied to social science are limited; methods that seek to test the applicability of universal laws do not show the effect of human will. It is impossible

to understand social phenomena without looking at the perceptions individuals have of the world (Della-Porta & Keating, 2008).

Paradigms are broadly characterised by the methodological beliefs that underpin them, and the methods used for collecting and interpreting data (Grbich, 2012, p 5).

Beliefs and methods underpinning collection and interpretation of data are shown in table four.

- Realism / post-positivism – expert researcher documenting reality from a centred position
- Critical theory – focus on class power and the location and amelioration of oppression
- Interpretivism /constructionism – mutual recognition and use of symbols and signs in construction of reality
- Post-modernism and post-structuralism – the questioning of 'truth' and 'reality' and the sources of 'knowledge'
- Mixed/multiple methods – using the best set of tools for the job

Table 4: Beliefs and methods underpinning collection and interpretation of data.

Qualitative research develops theory by using rich description, data synthesis and abstraction through a process of documentation, identifying patterns and concepts, identifying the relationship between them and then creating theoretical explanations that explain reality (Morse & Field, 1995). Theory development is the emphasis of most qualitative research in opposition to quantitative research, which is designed to test theory.

A qualitative interpretive research approach was deemed appropriate as the subject under investigation involves people in a real-world situation. Data are produced from the point of view of the participants. Within this project, reality is thought of as embedded within a socially constructed reality of the participants and within myself as a researcher through which the data is incorporated and interpreted (Grbich, 2012). In line with feminist principles, power is predominantly with the researched as they are the experts on their experiences. Taking an objective stance to this project, from a positivist perspective, and rejecting a holistic view by ignoring the effect policies, culture and context have on the setting, would prevent an understanding of the contextual issues. The generalisability of this project is also recognised, its findings are time and context bound, and therefore cannot be applied to all settings within

the UK. However, through using the literature, discoveries can be supported across context and within the field to add to the related knowledge that exists in this area.

A positivist, deductive methodology which would require a hypothesise on a causes, then test a theory by means of measuring responses, would not offer explanations from the subjective view of participants. In line with a feminist epistemology, explanations allow understanding this social situation and therefore devise strategies for change (Lennon & Whitford, 2012). In addition, Morse and Field (1995) state that:

> 'Research must eventually produce knowledge in a form that can be used to improve the practice of that profession' (Morse & Field, 1995, p 5).

This statement is in line with my personal beliefs about research and using the findings of this study not only to improve professional practice but to influence improvements in maternity care. Through offering a holistic view of knowledge acquisition and use differences and gaps can be highlighted to enable collaborative working.

Through taking a critical approach to the review of the literature, the nature of epistemology was addressed in showing how knowledge around movement during birth is constructed and used. Through taking a closer look at the interpretivist approach, reflexivity, feminism and the justification for the ethnographic methodology used, epistemological issues within these areas are looked at more closely and justified.

4.4 An interpretivist approach – the theory behind this project

Theory is used as a means of explanation. One definition of the explanatory power of theory is the development of a grand theory, an attempt to explain, though abstract and concepts, a generalizable phenomenon. Alternatively, through using a more focused approach on a specific area, a deeper exploration can be gained but its generalisability is limited, this is known as mid-range theory (Morse & Field, 1995). Using theory, knowledge is developed by identifying critical concepts and constructs and demonstrating the relationships between them (Morse & Field, 1995). Mid-range theories are predominant in qualitative research through the questions and approaches they use.

Through using a methodology that aims to discover the meanings which motivate actions from a subjective point of view, interpretivism can be used to understand how individuals

experience, perceive and feel the social world (O'Rielly & Kiyimba, 2015). Interpretivism values individuals' subjective interpretations of reality through discovering meaning attributed to behaviour and how this affects the formation of their reality of the external world. It comes from an understanding that subjects have imperfect knowledge and complex motivations that are formed through multidimensional cultural and social influences but retain an element of judgement and free will (Della-Porta & Keating, 2008). Through having a holistic focus and emphasising individual or community cases as complex, using thick descriptions and excerpts from narratives, concepts are orientated and presented as illustrations rather than universal rules. It is assumed that influences between cases share mutual origins and understanding reality involves immersion in information and empathy (Della-Porta & Keating, 2008).

4.5 Reflectivity

In line with an inductive approach, the findings are dependent on the values of the researcher, as interpretations given by individuals are in turn interpreted by the researcher (Holloway & Wheeler, 2013). From an epistemological stance, values and understanding of the context of the study are embedded in the worldview and perspectives of the researcher (O'Reilly & Kiyimba, 2015). Reflectivity is a process that can enable recognition and examination of the researcher's background, location and assumptions to understand how these can influence the research (Hesse-Biber, 2013). Denzin and Lincoln (2011) view reflectivity as a form of validity in qualitative research. However, Lincoln and Guba (1985) argue that the term validity is a term of reference from quantitative research that has been appropriated and a more suitable term for adding validity in qualitative research is trustworthiness.

O'Reilly (2012) states that the researcher's moral framework and understanding of what is appropriate influences the way research is approached. In addition, Boyle (1994) recognises that as the researcher is part of the study, they are affected by it and Etherington (2004) describes how the research process changes the researcher and reflection can be used to document the personal and professional growth.

Through the arguments presented in the initial chapters of this thesis and the inclusion of a reflectivity chapter, how this project is viewed, and my personal life perspective are presented. Reflectivity is used to recognise and document my perspective at the beginning of this project and records how the research experience changes me. By doing this, a method of

interpretation that gives transparency and clarification to the research process adds trustworthiness to the project.

4.6 Feminisms

Different categories of feminist thought – though overlapping – mark the different approaches, perspectives, frameworks and standpoints that a wide range of feminists have used to shape the explanations of and solutions to women's oppression. (Tong & Botts 2018). Though a number of feminisms exist, this project does not subscribe to one category or ideology, rather draws from a range of prominent feminist works as to avoid a monolithic discourse and to allow fluidity in thought. Influential in this project has been Sandra Harding (1996, 1991) who critiques the power, resources, influence and domination that is given to the natural sciences, quantitative methodologies and technology over humanities and social science. The formation of knowledge around movement during labour has been critiqued in the previous chapters, quantitative science and evidence is the dominant discourse within this literature. Harding's influence is appropriate in term of viewing movement from women's lives in relation to their position within birth. Defining epistemology in this way, Harding argues, makes scientific accounts more accurate and comprehensive.

The work of Ann Oakley (1980, 1984, 1990, 2000) has contributed to the theoretical and methodological understanding of this project. Her work around the medicalisation of childbirth and its location within a patriarchal structure that prioritises biomedical knowledge over women's ways of knowing is highly relevant. Additionally, Oakley's relationship-based approach to interviewing has been selected as a method that felt familiar, reciprocal and in line with the feminist methodology.

Anthropologists Shelia Kitzinger (1991, 2001, 2005,2006,2015), Bridgette Jordan (1992,1997), Robbie Davis-Floyd (1996, 1997, 2000, 2001, 2017) and Emily Martin (1989) have influenced the thinking in this project through their work on the culture of birth. Through giving a deeper understanding of the culture in which birth exists and how women are oppressed within it, the analysis of knowledge, systems, practices, politics and society have formed a basis on which the project has been built. The work of these feminist thinkers has provided an understanding on which thought can be built. However, using these sources alone as authoritative knowledge could create bias; to combat this reflexivity was used to show thinking.

The empirical work by Mary Field Belenky, Blythe McVicker Clinchy, Nancy Rule-Goldberger and Jill Mattuck-Tarule (1996) examined women's ways of knowing. Through describing how women view reality and draw conclusions about knowledge, truth and authority, they show how women's ways of knowing and self-concepts are intertwined. Belenky et al (1996) examine how the family and education both promote and hinder women's development and describe how women struggle to claim the power of their mind. This is done through culture- the institutional frameworks and societal expectations on what is seen as appropriate and not appropriate for women to gain knowledge about. The constructs that need to be challenged to facilitate and aid learning are made clear. Belenky et al (1996) show how women view birth and how they gain knowledge through a comparison between works carried out over thirty years ago and today.

The advantage of using feminist thought to influence this project is that it gives a perspective from which to critique the values, norms and practices that are dominant in patriarchal cultures. Through doing this, the need for change can be justified with the aim of addressing the societal and institutional power structures that serve to oppress women (Tong & Botts 2018).

Feminist midwifery researchers and thinkers who have influenced this project are Denis Walsh and Hannah Dahlen. Their work supported the conception, methodology and analysis of this project giving greater strength to the findings.

The disadvantage of prioritising the wisdom gained from feminist thought is to position this work as other. Simone de Beauvoir (1974) was instrumental in exposing the androcentric basis of societal norms that supressed woman. She argued that because of their otherness from men, women are oppressed. Because this work is based on feminist thinking there is a danger that it may be deemed other and oppressed in mainstream knowledge discourses as demonstrated in the previous chapters. Additionally, it could result in a binary discourse being presented in the findings, situating a feminist way of thinking in opposition to the way in which traditional authoritative knowledge is constructed and valued.

As authoritative knowledge in childbirth is perceived as obstetric knowledge, bringing the perspective of midwifery knowledge based on a feminist consciousness serves to add balance to the overall understanding of labour and birth. This is a positive addition to knowledge for

both midwives and obstetricians. It is valuable to midwives as it provides a justification for their own observations around birth and reminds them that their construction of knowledge is both valid and valuable. At the same time, it is informative for obstetricians as it serves as a reminder that women's knowledge (both that of midwives and parturient women) is a valuable adjunct to the medical knowledge, which is commonly the sole area of knowledge used to inform obstetric practice.

4.7 Why a feminist research perspective

Gendered inequality in cultures across the world can be reflected in women's reproductive health through high maternal mortality rates in low-income countries and excessive rates of childbirth interventions in high-income countries (Walsh et al. 2015). Midwifery, as a profession which focuses on supporting normal childbirth, is inherently feminist and it has been acknowledged that to challenge the factors that undermine women's agency, a feminist perspective is needed (Walsh et al. 2015).

The aim of this project is to give voice and equal value to the beliefs of women as users of NHS maternity services and to women as midwives as that which is given to the obstetric generated research around movement during labour. Research can be identified as feminist when it is grounded in a theoretical epistemology that privileges women's issues, voices and lived experience (Hesse-Biber, 2013). Feminist projects prompt thought on the nature of knowledge and how we attain it (Lennon & Whitford, 2014). By using a feminist perspective to explore a system which governs and excludes women's knowledge, powerful predicated features and activities which legitimise knowledge-claims can be exposed (Lennon & Whitford, 2014).

4.8 Feminism and knowledge production

The dominance of a bio-medical approach to maternity care has been critically discussed in previous chapters. The Cartesian model of mind-body separation adopted by western medicine in which medical students and other health professionals are educated, emphasises the physical aspects of bodily processes. This positivist, objective paradigm uses research methods that take an objective view of physical elements of labour, separating women and their psychological and emotional selves and views it without the context of their environment and social circumstances. This paradigm views knowledge that can be constructed from observation and is independent of an individual. It is a discourse which

objectifies women as 'patients' and portrays labour as something that can be controlled by the medical profession utilising knowledge produced through knowledge-claims from their legitimised methods. Producing knowledge in this way can be viewed as a masculine method of knowledge production (Lennon & Whitford, 2014; Oakley, 2000; Sydie, 1994; Etherington, 2004). The theoretical framework that produces this knowledge reflects the value-free structure of masculine principles of a world of facts that can be known and verified by science (Lennon & Whitford, 2014). In the current maternity care culture, knowledge produced is legitimised and rationalised through its inclusion in 'gold standard' scientific research and inclusion in recommendations and guidelines as reviewed in the previous chapter. The knowledge produced serves the interest of the group; it promotes their position of authority and legitimises the subordination of women through not recognising or valuing their knowledge. Scientific rationality plays a central role within the western world's cultural belief systems; these beliefs are so imbedded that faith in scientific rationality appears partly responsible for many beliefs and behaviours (Harding, 1991). However, Harding (1991) also identifies that from a woman's perspective; scientific rationality appears irrational as it is out of context with their known world and does not provide a useful explanation that can improve their condition (Harding, 1991).

Using a feminist perspective when considering how knowledge is constructed, highlights that the legitimisation of the knowledge-claims made by those using positivist methods of knowledge production around maternal movement is given domination in the literature. Through using a feminist perspective this project shall explore how participants construct knowledge within the individual groups and how their beliefs influence what participants consider to be correct and valuable knowledge. A feminist perspective also recognises and accepts alternative knowledge-claims (Mann & Kelly, 1997). Knowledge-claims that serve obstetrics as a group, use a theoretical framework within which problems are investigated from a male/obstetric/positivist perspective. In this instance, how maternal movement affects duration of labour, is constructed as a problem to be controlled, thus legitimising the process of promoting or restricting movement during labour to affect duration. This serves obstetrics as a group by promoting their position as authoritative on the subject, thus legitimising and promoting their position within the birth process. This symbolises the subordination of women and conceptualises women as purely carrying out an objective

biological function. Feminism acknowledges that men and women occupy different situations within society and that these differences are exemplified in the products of masculine produced knowledge (Lennon & Whitford, 2014). This masculine produced knowledge claims objectivity; knowledge is placed outside the knower and is said to mirror an independently existing world that does not reflect the participant who produced it (Lennon & Whitford, 2014).

4.9 Value of feminism

This project used feminism to view power relations around the use of knowledge and care provided to women during birth. By using feminism, recognition and legitimisation of women's knowledge and beliefs are given equality with the viewpoint of the obstetric participants.

Within this thesis, recognition is given to all knowledge sources and critically discussed; its objective is to validate women's knowledge around movement during labour congruent with a feminist epistemology. In line with the requirements of a doctoral level of study, a critical review of the positivist literature around movement during labour was undertaken. In addition, literature that was accessible to women on the internet and to midwives via the library was reviewed. This was to systematically review the other literature around movement that was grounded in knowledge and experience but is unacknowledged in national guidelines and reviews. De Vault (1999) states that feminism is strengthened through various methods of truth seeking which can improve empirical research. She states that:

> 'The truths of feminism are smaller, more tailored, and more intensely pointed truths than the discredited "Truth" of grand theory and master narratives. They are truths that illuminate varied experience rather than insist on one reality: they seem, to many of us, more sturdy and useful than abstract and ostensibly universal formulations.' (De Vault, 1999, p 3)

Through using data that is grounded in the experience of participants, a method of mid-range theory (Morse & Field, 1995) production is formed that is relative to women's lives and lived experience and is a basis for knowledge building. Haraway (1988) states that knowledge and truth are always part of, and inseparable from lived, subjective experience and are powerfully imbedded in relation to the cultural context in which it is lived. Through objective science

disregarding subjective values, knowledge is produced that denies bias and politics and is unrealistic and undesirable from a feminist perspective (Haraway, 1988). Scott (1999) argues that the specific conditions, circumstances, values and relations of power suffuses every aspect of social existence. Through acknowledging the participants' lived experience and acknowledging how the authoritative knowledge and the political structure of maternity care impacts upon care given, a relational feminist project is presented within this thesis.

4.10 Which Feminist theory?

I recognise that there is no one feminist theory nor that one feminist theory is more valid than another. Generally feminist thought can be said to be interdisciplinary and diverse with a structure that is non-hierarchical, leaderless and organic (Kaufman, 2004). Whilst this is an ideological expression of feminism, first wave feminist literature is said to be exclusive as the views of white middle-class women were represented, with little acknowledgement of groups of women who were queer, black or represented other social groups. Therefore, this 'feminist' knowledge was not representative of all women. In feminist research, no one woman's individual experience can be said to be representative of all women. Plurality of experience from multiple standpoints encompassing interlocking relationships between racism, sexism and heterosexism and class oppression can provide starting points from which social realities emerge and understanding can be gained. Feminist standpoint theory argues that knowledge is and should be situated in women's diverse social locations, as knowledge is affected by the social conditions within which it is produced and is grounded in the social location and biography of both the observed and the observer (Mann & Kelly, 1997). This project does not align with any one feminist theory but aims to be underpinned by feminist values.

DeVault (1999) believes that feminism is about seeking truth; truths which are found in various modes of truth-seeking including empirical investigation, but at the heart is women's experience, illuminating a variety of experience rather than claims of an abstract reality. This is the underlying epistemology of the project. The knowledge gained from this project comes from the participants - the knowers. As a woman and as a midwife I am also a knower, however, for this project I am also a researcher, through whom the data gained are processed and re-presented.

Feminism is the philosophy that I identify with as a woman, a midwife, in my academic thinking, in my midwifery teaching practice and in my social activism. I therefore feel it is an appropriate lens to apply to this study.

4.11 Feminism and reflectivity

Feminist research centralises the relationship between researcher and the researched to balance different levels of power and authority, this can be assisted through reflexivity (Hesse-Biber, 2013). I use reflection to identify my own values and attitudes by critical examination of and reflection on my lived experiences. Throughout the thesis, I identify my own beliefs and values while reviewing the literature that I draw upon, and my experience of data collection and data analysis. Through using reflectivity throughout the research process a sense of my identity is constructed and placed within the research, therefore, my influence over the choice of methodology, analysis and interpretation can be shown and how this has made an impact on me as researcher. The use of reflexive methodologies can be seen as a criticism of positivist methodologies that assume researchers can and should be objective (Mann & Kelly, 1997).

The objectivity of positivist science methodologies is questioned in the previous chapter and to what extent all research can be unbiased is discussed. Bias that is not made explicit by authors, but which is identified upon critical analysis of literature reviews as shown in Chapter two, undermine the results of claims. Furthermore, Smith (1990) and Collins (2002) argue that researchers disassociating themselves from the subjects of their studies remove scientists from people and the everyday world they encounter. A scientific world is constructed which replaces the actual social world that people experience. This is also illustrated by the way in which positivist knowledge is constructed around maternal movement in labour and how women are removed from the social, physiological and emotional elements of labour within this paradigm.

4.12 Aim of feminist research

The goal of feminist research is to support social justice and aid social transformation as feminist methodologies are rooted in social activism. This is done through studying and readdressing the many inequalities and social injustices that continue to undermine the lives of women and their families. Feminist research looks at the patterns and trends within populations of women and draws conclusion based on the varied range of women's unique

circumstances. When a feminist perspective is taken, the angle of the theoretical perspective assesses women's status within society and forms questions that might not be tackled by hegemonic ideas that reinforce the existing system of gender inequality.

This project is taking a feminist perspective to highlight women as service users and women as midwives' position within a maternity system that has been shown to be dominated by obstetrics as a male-orientated patriarchal system. The literature around the culture of maternity care show obstetrics to be prevalent within current maternity care systems. This project also includes data from obstetricians as the aim is not to present the obstetrician as the 'other' but give equality and understanding to all beliefs. Feminist research is more than acknowledging difference, it incorporates difference into our views of reality, truth and knowledge and examines the difference that difference makes. An aim of this project is to identify differences and why they occur. Through validating midwives' and women's knowledge, it is hoped that if difference occurs, it can be addressed within the wider social context to improve maternity services for women and midwives.

4.12 Why ethnography

The choice of methodology should be determined by the question posed (Denzin & Lincoln, 2011; Robson, 2002) and the approach used is linked to the aim of the research (Della-Porta & Keating, 2008). Ethnography has been chosen as a methodology as it is an approach which can give an understanding to the current cultural context of maternity care. Ethnography aims to discover understanding and meaning of individual groups or cultures, beliefs and behaviours as they are uniquely experienced within that particular group or environment (Hammersley & Atkinson, 2007). Ethnography is described as the most basic form of social research (Hammersley& Atkinson 2007). A variety of interpretations from the same physical stimulus can mean different things to different people or the same person at different times. The continuous revision of this enables discussion around the variety of the interpretations the researched place on their experience (Hammersley & Atkinson, 2007). The findings of this project display the variety of interpretation and meaning found and show the fluidity of the shared cultural understanding of participants.

Ethnography is defined as the disciplined and deliberate witnessing and recording of human events through direct and sustained contact through which the writing, respecting, recording and representing the irreducibility of human experience (Willis & Trondman, 2000). This is

done to understand the social world being studied, placing importance on the meaning and interpretations of those studied uncovering intentions, motives, attitudes and beliefs to understand the framework from which behaviour arises. To discover the nature of the social world, observation of and participation in the setting is necessary to understand the organisational life through analysis of reasons, purposes and rules, which are more appropriate than cause, effect, and law (Winch, 1958).

Ethnography is used to provide thick description of the context in which practices are used and examine the ways in which different groups make sense of and respond to them. This provides an opportunity to study and portray the diversity of cultures within the organisation from a social and political perspective and examine the social relations and processes surrounding the control systems (Sharpe 2018).

4.13 Critical realism in ethnography

Porter (1993) argues that an underlying philosophy of critical realism is need in ethnography to attempt to explain the relationship between human action and social structure as human action is enabled and constrained by social structures. In turn, this perspective reproduces or transforms these structures. Ethnographic analysis of the nature of structures is needed to understand social phenomena with the purpose of examining human agency to uncover the relationship between agency and structure, facilitating the drawing of conclusions.

The aim of ethnography is to understand the perspective of others whilst suspending the researcher'sown beliefs in order to avoid misunderstanding (Hammersley, 2018). Conversely, Bhaskar (2014) asserts that when taking a critical approach, evaluation is imperative. These views are rooted within the differing opinions of social analysis, Hammersley (2018) is of the view that sociology is mostly insulated from the subject matter, whilst Bhaskar (2014) argues social theory and reality are causally interdependent. The knowledge of social world in which agents exist may be opaque therefore differentiating between opacity and clarity can be difficult (Bhaskar, 2014).

As a midwife who has worked within maternity services for a number of years, I have had direct contact with the reality of the social world in which the participants exist. My aim is to highlight structures through experiential knowledge, description, and understanding and take a critical approach to evaluate. I am aware of the use of reflectivity to make clear my previous

experience and to limit my personal bias, additionally by taking this approach I will go beyond portraying the actions of the participants and interpret their actions to analyse the social structures in which they exist. This approach will avoid the uncritical acceptance of participants' accounts to interpret their meaning and avoid an uncritical portrayal that fails to understand the underlying structure that affects their reality.

Taking a critical realist approach assumes that cultural structures are in place that oppress those within it and that the aim is to highlight these structures for emancipation (Thomas, 1993). Foucault's (1973) theory of the control agenda on behalf of the powerful in society can be linked to critical social theory's aim of exposing oppression and power differentials. Using critical ethnography enables ethnographers to speak for their subject; through using a feminist approach this project aims to give voice to the participants but does not assume that the structures in which they work are suppressive. Therefore, a critical ethnographic approach was not taken as there is not an assumption that all structures in place within the culture studied are oppressive and those within the culture require emancipation. Though it informed the analysis, feminism was used to highlight oppression from any source.

4.14 Flexibility of ethnography

Whilst ethnography has much in common with other qualitative approaches, the boundaries are not strict, offering some degree of flexibility in the way in which it is used (Hammersley & Atkinson, 2007). This offers methods of data collection and interpretation that are flexible in the sense that many sources can be used for data and the methods of analysis are not limited by the methodology. Using whatever is available can mean a variety of information can be included; written material, text, media, drawings, field visits or other visual representation, anything which can portray the culture of the situation, often accumulated in unstructured and informal ways (Mueke, 1994). Green and Freed (2005) suggest there is a move towards greater creativity in methodology and methods, enabling the researcher to work from her individual perspective, allowing choice and autonomy to find methods that make sense to her. Whilst the methodology is true to the characteristics of ethnography, flexibility of methods enabled me to adapt to the situation and circumstances I found myself in. This permitted me to make the most of situations whilst visiting the hospital unit, data collection methods I planned at the beginning of the project could be adjusted to fit the circumstances and additional data that I came across in the process could be used.

Ethnographic methods may be used as a tool in naturalistic settings to explore issues or problems relevant to nursing or other health care professionals (Boyle, 1994). By taking this holistic approach associated with ethnography, the data that is collected in addition to interviews, can be used to build a bigger picture. By using additional material other factors involved in the building of a culture can be analysed giving greater meaning to the project.

4.15 Culture

Culture can be described as a product of humans living together which can be learned; this includes knowledge, belief, art, morals, law, custom and any other habits and capabilities acquired as a member of society (Tylor, 1871). Culture can be divided into three categories, Culture as in artistic activity, a process of development and the way in which humans learn to respond to symbols that they have created (Williams, 1983). The theory that informs the definition of culture within this thesis draws on symbolic interactionism, how the people involved choose to define and interpret situations. Within this it is recognised that people's definitions change and are open to flux dependent on their given situation, the relationship between a person's individual perspective and the social location.

4.16 Ethnography and culture

Ethnicity and nationality have been framed as culture in anthropology to form a unit of research for ethnographic research (Malinowski, 1929; Mead, 1973; Evans-Pritchard, 1937). The definition of culture has been applied to other social groups (Della-Porta & Keating, 2008) and has been used as a unit of study in sociology to understand and explain behaviour. Culture can also be expressed as an underlying system of shared ideas, concepts, rules and meaning (Kessing, 1981). The concept of culture is not fixed, it is the context in which we engage with everyday life, the collective values that shape and is shaped through individual action and behaviours (Draper, 2015). From this perspective, knowledge is socially produced (Abbott Tyler & Wallace, 2006). By using this to inform the methodology, a definition of the concept of culture is used to gain an understanding of the current social context within the institution in which this study is located. Ethnography assumes that that the concept of culture is learned and shared among group members and can therefore be described and understood (Morse, 2007) and defining the culture of an organisation is an important first stage in initiating change (Bryar & Sinclair, 2011).

Whilst ethnography is a methodology used to explore culture, this has been used in the current cultural context of birth in the UK for women and the local culture of the maternity-care provider. I describe how knowledge is gained to support beliefs of participants and what impacts upon this knowledge acquisition. Whilst the literature and my experience suggest that binary models of maternity care exist, and that the biomedical model is the most predominant, by using ethnography multiple layers are revealed and explored and an understanding gained of how approaches to maternity care are perceived by participants.

Through studying the lived experience of participants using ethnographic methodology, an exploration of representation of everyday life is possible. As a methodology, ethnography identifies differences but also highlights the taken for granted (Smith, 1998). Through highlighting the 'taken for granted' in the experiences of participants, distinct aspects of what is usually unacknowledged can be identified. As ethnography is the investigation of specific social situations which draws from a small sample size, it allows for in-depth analysis of narrative to interpret the significance and purpose of participants' behaviour (Hammersley & Atkinson, 2007). This can then be explored within the context of hospital environment in relation to each group of participants and if there are distinct cultural differences between groups, reasons behind these may be addressed.

4.17 Ethnography and maternity care

Ethnographies within nursing have generally focused on health beliefs and practices and how they relate to other social factors (Boyle, 1994). Ethnography has been used as a methodology to explore aspects of maternity and midwifery care. In her ethnography on postnatal care, Wray (2011) identified how care given on the postnatal wards was driven by institutional requirements and physical examinations to establish well-being. Postnatal care was observed to be task orientated and revolved around the needs of the institution, with the environment and advice given often not addressing the specific needs of the woman. This research highlighted the disparity between what the women wanted and what was felt to be appropriate care by service providers. In his ethnography on a free-standing birth centre, Walsh (2004) explored how the culture within this unit had a positive impact on the women who chose to use this service. It highlighted how the unique culture within the unit supported a midwifery model of care, with the midwives' beliefs, attitudes and sense of their role within the local community positively impacting upon the maternity care that was given. Similarly,

Kirkham (1987) used ethnography to research support given in labour by observing the care women received and midwives gave. Kirkham (1987) defined cultures within maternity care based on the hierarchy evident in different settings, which influenced the type of support given by midwives.

Drawing on this use of ethnography within maternity care and how the methodology enables investigation of care received and given, this project has explored movement in labour using focused ethnography in the current cultural context of childbirth. Because a description of what movement is and how this is facilitated during labour or how movement is experienced is not being sought from an outsider's perspective, a traditional ethnographic approach was not taken. Rather, movement during labour is used as a discussion point with participants to determine their perspective around this feature of labour that is common to all labours. It will be used in the context that beliefs may differ around how movement is perceived and used by women, midwives and obstetricians but all may have cultural influences which gives the subject for interpretation. From what sources practitioners access knowledge and how this knowledge is gained and implemented is explored to identify cultural differences between the participants and practitioners and link this with the existing literature.

4.18 Focused ethnography

Traditionally ethnography involves observation and the researcher submersing his/her self in the participants' environment over an extended period of time (Hammersley & Atkinson, 2007) and has been classically used to describe other cultures. Immersion within the culture of study to gain knowledge, understanding and empathy is also in-line with an interpretive approach (Della-Porta & Keating, 2008). This project will take a focused ethnographic (FE) approach because it is a research method that is used to investigate specific aspects of a known society which is culturally differentiated and fragmented (Knoblauch, 2005). FE is described as a particularistic, processual form of ethnography as it is used to describes aspects of social process in an isolatable group (Boyle, 1994) and orientated to a particular topic (Morse, 1991). Muecke (1994) distinguishes FE by the following features:

- Conceptual orientation of a single researcher
- The focus on a discrete community, organisation or social phenomenon
- Problem-focused and context-specific

- A limited number of participants
- Participants usually hold specific knowledge
- Episodic participant observation
- Conducted for development in health services

Focused ethnographies are suitable for health care research as they are considered practical and efficient as the results offer a means to improve care (Higginbottom et al., 2013). An ethnography can be considered focused when specific beliefs and practices of an illness or healthcare process is investigated (Magilvy et al., 1987; Morse & Field, 1995). Through having a specific focus on cultures or sub-cultures in a distinct context, the focus in FE is on the participant's specific knowledge about an identified problem (Higginbottom et al. 2013), rather than describing behaviour of a social group (Fetterman, 1998). The findings therefore generate meaningful and useful application to the healthcare practice that is being studied (Knoblauch, 2005) in comparison to gaining a broad description. Ethnography has been applied to understand how healthcare practice can be delivered through gaining a deeper understanding of cultural beliefs (Brink, 1982; Morse, 1984; Carr, 1996). FE has been used to understand and enhance health-related practice through its application to individual clients and professional cultures and sub-cultures (Higginbottom et al., 2015).

FE has been used in a variety of healthcare settings to explore specific healthcare experiences. Hales (2015) used FE to explore the culture and influences of caring for fat people by doctors and nurses within an intensive care setting. Fat people were considered misfits, as they did not fit the social norm, she explored how staff made the experience a positive social experience through the ways they managed the social stigma through emotional labour, behavioural regimes and face-work. Oster et al. (2014) interviewed twelve First Nation women in Canada using FE to understand their real-life experiences of diabetes in pregnancy. They found that to improve care for these women, services needed a more patient-centred approach which enhanced the women's support systems, increased their sense of autonomy and awareness of diabetes and its challenges needed to be raised. Nelson (2014), applied FE to a study of the non-pharmacological care given by nurses in a neonatal intensive care unit to infants with neonatal abstinence syndrome. She described a culture of care that decreases withdrawal symptoms for these infants to improve clinical practice guidelines. Higginbottom

et al. (2013a) used FE to explore the beliefs that affect behaviours and perceptions of refugee Sudanese women who had experience of using maternity care services. Her findings highlighted the culturally specific held beliefs that could be perceived by healthcare providers as resistance to care. All these studies explore beliefs and behaviours within a specific context with the specific aim of improving health related practice.

FE is relevant to this project as the theory and literature around maternity care presents ideological differences in cultures of care between obstetrics and midwifery. In addition, FE is a methodology that can be used to investigate specific beliefs and practices of healthcare held by practitioners and service-users (Magilry et al., 1987). The three ethnographies outlined above which explore maternity care (Wray, 2011; Walsh, 2004; Kirkham, 1987), take a broad look at an element of maternity care to describe the culture surrounding the aspect of care being investigated. Following observation of a service in this way, and taking what Wray describes as a bottom up approach from the perspective of service-users and their carers, recommendations can be made to improve maternity services. In comparison, FE identifies a problem to be explored from the beginning; most problems have a culture-based origin, whether that be from an ethnic based culture (Higginbottom et al., 2013a) or a professionally focused culture (Hale, 2015). Additionally, FE can be used to explore an issue from multiple perspectives. Kelley et al. (2011) used FE to assess the environment of an emergency department in Canada and its impact on care of adults over 75. The physical environment, social climate, hospital policy and procedure and wider healthcare system were assessed from the perspective of senior adults or their proxy decision-makers, staff and key community informants. Data were collected from interviews, observations, surveys and hospital administration data to assess how services could better meet the needs of seniors. Findings highlighted the changes to policy and practice and enhanced education that must occur to meet the needs of this specific population of healthcare users.

In these examples, FE has been designed to explore specific issues using participants with in-depth knowledge of the problem in the specific context of the defined culture. Through the investigation of the same issue from all perspectives of the people involved, a holistic view is gained of the subject in question. It does not give authority to one perspective, and all opinions and experiences are validated.

4.19 Focused ethnography and feminism

Women bring their own unique beliefs and lived experiences of movement during labour and as users of maternity services. It is not intended that the data gained from women represent all women or that their opinions offer a specific female way of knowing in opposition to that of other objective ways of knowing as represented by policy and guidelines. Women's beliefs may be influenced by a biomedical model of care as is already recognised to influence much lay thought (Martin, 1989). Rather the feminist epistemological nature of this study is to represent all ways of knowing, with women's knowledge being equal to that of midwifery and obstetric knowledge.

Midwives are women, who work with women during a uniquely female physiological process, in what can be called a female dominated feminist profession (Walsh, 2015). This project gains a deeper understanding from women's, midwives' and obstetricians' perspective of how knowledge is acquired and why the holder of that knowledge believes that to be a valid source. It is recognised in the quoted literature that midwives and obstetricians as distinct professional groups have different philosophies and belief systems that influences the care they give. However, it is also recognised that midwives and obstetricians and women, as users of maternity services, hold their own perspective. It is also recognised that there is fluidity and knowledge transfer moves in all directions.

Within the literature reviewed, research has been identified that illustrates how the effects of cultural norms in midwifery care and obstetric care affect women's experiences of childbirth, midwifery and hospital practice and have shaped the way in which care is delivered. Little research has been identified which evaluates specific beliefs of women or maternity care practitioners or makes comparisons of how beliefs affect care experience or practice.

4.20 Focused ethnography and knowledge of the field

FE requires the researcher to have knowledge of the field and involves the collection of data from interviews with participant observation being limited (Morse, 2007). With the researcher having knowledge of the field being investigated, interviews can be structured which enables the research to be focused on specific aspects and concentrates on predefined actions, interactions and situations that are being investigated (Knoblauch, 2005). It enables collection of data on specific areas of health to gain understanding and knowledge in context

of a predefined care or care processes (Higginbottom et al. 2013) and specific aspects of participant's ways of being (Cruz & Higginbottom, 2013). Whereas traditional ethnographic methods involve participants with whom the researcher has developed a relationship with over time, FE uses participants with in-depth knowledge and experience of the subject (Higginbottom et al. 2013). This has led to this method being defined as a quick and dirty method as it may unknowingly exclude what is relevant through the study being too narrow in comparison to traditional ethnographic methods (Muecke, 1994). However, I have spent an extended time in the field (Fetterman, 1998) as a midwife, therefore cognitive aspects of observation, language and behaviour, which take time to understand, has already taken place. More salient aspects of behaviour may be more difficult to distinguish as my tacit knowledge of the field can be taken for granted and not fully explored. I therefore sought data relevant to add to my existing insider knowledge and built on the already recognised academic knowledge in this area. In addition, I had the support of three supervisors all of whom are from different academic backgrounds. Of great benefit was the inclusion of a sociologist with no knowledge in this area. Through discussion throughout the project, different perspectives were brought to the project and unpicking of my tacit knowledge from the perspective of academic who is unknowledgeable in this area, reduced the chances of this.

Mueke (1994) suggests that ethnographic methods can be used to enable us to take a more understanding account of whomever we perceive as the other. Whilst this was true in traditional anthropological ethnography, in the context of this project and FE, using my knowledge and experience as a midwife and woman, I do not perceive the midwives and women as other. I have spent 13 years working as a midwife and have personal experience of childbirth, albeit 20 years ago. This position has enabled me to gain an understanding of the current cultural context of midwifery work within the NHS and UK therefore I have not come to this project from a place of unknowing. In addition, though I have experience of working with doctors, I do perceive them as other. Their training and experiences are something that I have no experience of and therefore the interviews add to knowledge in this area.

FE minimises the need for long periods of observation (Higginbottom et al. 2013). I have used short periods of observation to enable me to provide cultural context for this study of the

research site. Additionally, as the project was not intended to describe movement, but to explore beliefs of participants, observation of movement was not considered necessary.

4.21 Using focused ethnography and feminism to address the research question

Though the subject of the interviews was around movement, I structured the interview guide around the elements of positionality, experience and perspective (Lennon & Whitford, 1994) and used this to guide my analysis. By using this structure, women's subjectivity is given to the knowledge produced. Emphasising women's experience, attention to their perspective and the problems generated from women's position in society is a trait of feminist work (Lennon & Whitford, 1994). Generating knowledge through privileging the oppressed can be viewed as less distorted than knowledge that is derived from the dominant group (Hutchings, 1994). By focusing on experience, position and perspective, gaps in the accepted theory can be highlighted (Lennon & Whitford, 1994). As the project is problem-focused, a solution is sought that is relational to the participants' experience. The problem identified is the suppression of qualitative research, knowledge of physiology and experiential knowledge of physiological birth. Through exploring this through a feminist lens and using this angle, knowledge use and production from the perspective of participants and their experience of how this knowledge is used in their experience of birth can by explored through valuing their perspective. In doing so, this gap in knowledge can identify what contributes to the suppression of this knowledge in the experience of and from the perspective of participants. Hierarchy in maternity care has been identified in the literature, where participants position themselves in the hierarchy, as professionals and as women in maternity care and society. Participants were asked about their experiences as service-users and professionals. Through asking about participants' experience of their training, information about how they position themselves in relation to their profession was gained. By asking about their experience of the learning culture within units where they have worked, their experience of culture within their profession was explored. How participants experienced movement during labour and how they experience this in relation to their environment and others is explored. To gain an understanding of how they perceive themselves and others I asked them why they think others think and act the way they do. This enabled the focus of the ethnography to be about movement in relation to these areas.

4.22 Conclusion

This project gains a deeper understanding from women's, midwives' and obstetricians' perspectives about what influences care given around women's movement during childbirth. Through taking an inductive, interpretivist approach, FE is used as a method. Feminism has been used throughout the process to inform the project and acknowledge women and midwives as knowers of equal validity in labour care within the socially and politically influenced maternity care services. The next chapter shall address the research design and methods used.

Chapter Five

5. Research Design and Method

5.1 Introduction

This chapter addresses the methods used to carry out the project. It starts by providing context to the study through a brief outline of the history and current maternity service provision of the unit investigated. The physical environment of the unit in which the project was located and how participants were accessed are described. Participant information, sampling strategies and data collection are discussed, and data analysis methods are described. Finally, ethical issues associated with the study are considered.

5.2 Setting

The project was conducted at a large National Health Service (NHS) hospital in the North West of England that provides both consultant-led and midwifery-led maternity care. A single site was selected to demonstrate the commonalities and discrepancies between groups of participants concerning how knowledge is acquired and used around maternal movement during birth within the culture of one maternity unit. This maternity unit provides care for a population with diverse ethnic, social and medical backgrounds. This diversity has added to the richness of the data from the perspective of women, midwives and obstetricians who have experience of being cared for and working in this unit. My initial primary supervisor as part of a larger project for which a funding application had been submitted selected this unit. However, the funding application was not successful, and the supervision team changed as my initial primary supervisor left to take up another post.

The research site was a maternity unit within a large NHS hospital trust, it has a large neonatal unit and is on the perimeter of the hospital, separate from the main hospital buildings, but accessible via adjoining corridors. It has two specific entrances, one for the in- patient wards and another for the outpatient clinic. There has been a maternity unit on the site for over 60 years, at the time of this project the unit consisted of a consultant led unit (CLU), a co-located midwife led unit (MLU), antenatal and post-natal wards, an antenatal clinic and an antenatal day assessment unit (ANDAU). Five years ago, there was a reconfiguration of services in the area resulting in the extension and modernisation of the consultant led and neonatal unit. In

its current capacity and format, it has been providing consultant led maternity care and midwifery led maternity care for five years for 6,500 women.

Prior to the reconfiguration of services in the area all women booked for intrapartum care at the unit received care from midwives with input from the obstetric team if necessary. Currently, women deemed high risk of medical or obstetric complications or whose babies are perceived to be compromised or likely to have or develop fetal complications are cared for during the intrapartum period by midwives on the CLU. Women who are perceived to be at low risk from medical and obstetric complications and are expecting well babies are cared for by midwives on the MLU or can choose home birth. Approximately 16.5% of births take place on the MLU and 0.9% take place in the community usually at the women's home, with the remainder occurring on the consultant unit. The birth rate within these areas has been constantly around these figures over the past seven years.

5.3 Staffing of the unit

The maternity service operates a rotational model to staff the unit with midwives and employs 290 midwives. This involves all areas (MLU CLU, community and antenatal clinic) having permanently located core members of staff at a senior level (band 7) and some at a staff level (band 6). The remainder of staff rotate between the CLU, MLU and community.

The MLU has one permanent senior member of staff who is not present on every shift. During the day three midwives and a Healthcare assistant (HCA) are on shift and during the night two midwives and an HCA. Women who are booked for intrapartum care on the MLU contact them directly when they need advice about labour or if they want to attend and are admitted straight to the unit.

The consultant led unit has 11-13 midwives on duty per shift, two of which are senior midwives responsible for coordinating care and two HCAs. Women who are booked for intrapartum care on the consultant led unit are assessed for admission via a triage system that is staffed separately by two midwives. Additionally, if a woman has a problem or query with herself or baby whilst pregnant, she is first assessed in triage; if needed, she is then admitted to the consultant unit.

The hospital employs 14 consultant obstetricians, 10 registrars and 30 junior grades. Only women who have been assessed as high risk either at their booking appointment or at any point during their pregnancy, by a midwife, will receive care from the obstetric team.

5.4 Associations with the research setting

Robson (2011) states that insider knowledge of the historical development and present context of the study can be advantageous to the researcher, as the informal hierarchy of the institution are known. For example, knowing the history of the unit I knew of the tensions that some staff felt about the politically motivated reconfiguration of services that had taken place over the past few years (Davies & Rawlinson, 2012). The effects of politically driven maternity care provision and NHS expectations of midwifery work has been identified as a reason why midwives leave the profession (Ball et al. 2002). This was also an effect of the reconfiguration of services in this area, along with staff being redeployed in different managerial or clinical areas or being placed in teams with different workloads, leadership values and management principles (Davies & Rawlinson, 2012). The merger has had the benefit of the investment made in the building and the concentration of specialist obstetric and neonatal staff. Again, my insider knowledge as a feminist/midwife meant I was aware of the literature surrounding merger and I know the effect this strategy of centralising services has on midwives from midwives whom I know personally from around the UK.

Robson (2011) also suggests that, as an 'insider', preconceptions may be held and difficulties with where within a hierarchy you may be placed. The person with whom I have had the most contact at the hospital is the consultant midwife. Through my work with the midwifery teaching department, the consultant midwife is known to me, as a midwife and a member of the midwifery department and treats me as a colleague. Additionally, there is a feminist ethos within the leadership of the university department that does not portray a sense of hierarchy. I feel this is very different within the hospital; the initial visual impact of the use of uniform clearly denotes status as an employee within the hospital (Joseph & Alex, 1972).

5.5 Philosophy, atmosphere and physical environment of the unit

There is no formal philosophy of care to which the maternity unit subscribes. However, they have a midwifery strategy which is based around the 6 C's: Care, Compassion, Commitment, Courage, Communication, Competence (NHS, 2012). When interviewing an MLU midwife she

said that the MLU was a non-hierarchical environment, which aimed to work in partnership with women. This was supported by two other MLU midwives during interview.

All the midwives, during their interviews, mentioned the physical environment in which they worked providing the 'setting' in which maternal movement during birth took place. I arranged to visit the CLU and MLU and took pictures of the 'setting'. The visit initially increased my contextual knowledge of the midwives and obstetricians' work environment and the women's birth setting, giving me an increased awareness and understanding of what they spoke about. They provided a source of data and a point of reference in my analysis, as I was aware I was likely to forget some of the detail gained in a site visit. The midwives' discussion around the environments in which they worked often revolved around the difference in working environments between the CLU and MLU, therefore the photographs of both were used to give meaning and understanding to myself about the physical environment and to aid interpretation in the analysis and discussion.

Over the course of the project I visited the unit many times either to give formal presentations of my project, undertake interviews or to recruit participants. In total, I have currently spent 50 hours at the unit.

Though formal observation was not planned, I used this time to familiarize myself with the unit and observe interactions that took place between staff, the public and myself and record my thoughts about it. I recorded these in my field note/reflective journal.

Most of the midwife and obstetrician interviews took place within the hospital and between interviews or whilst I was waiting for participants, I observed interactions and spoke to the midwives and doctors on duty. I spent half an hour on the MLU waiting for a midwife participant whom I had arranged to interview. I spent five hours on the CLU, once waiting in the reception for an hour for a consultant and once in the kitchen for two hours whilst trying to recruit doctors and the other two hours conducting interviews.

5.6 The consultant led unit

The consultant unit has 15 en-suite birth rooms, one with a pool, three operating theatres and various other utility rooms. There is a reception desk usually staffed 24/7 by a dedicated maternity ward clerk, it has a high desk and only provides seating for the staff. There is a large mural of a beach on the entire left-hand wall as you walk in and on an adjacent wall a notice

board displaying information around safety and clinically relevant information. There is a main office accessible to all staff on duty, two meeting/resource offices that are often accessed by a range of staff and a staff room accessible to all consultant unit staff for breaks. There is also a specific wound clinic based on the consultant unit. Women are only admitted to the CLU if they are in labour or have an issue that needs urgent medical attention in the antenatal or postnatal period.

Access to the CLU was only allowed through a number of procedures as long as I justified to the staff my reasons for being there. Whilst I appreciated the need for security, it felt I had to fit certain criteria to be allowed in. My immediate impression of the appearance of the unit was hard; there was no natural light or view of the outside, the colour of the paint on the walls was white on the top and dark grey on the bottom, the ceiling was white and artificial, there were no soft furnishings or additions to the environment that made it personal to the women using the unit. Entering the unit, on the facing wall, information was displayed which was for purely functional reason, signs of what to do or not do and clinical information on health and safety aimed at staff. The high-level desk put an obvious barrier between staff and visitors, and the mural showed a surreal relaxing scene but was not in the line of vision of anyone entering the unit. Everything seemed to be behind barriers and directly addressing the function of medical birth and the staff providing it.

The overall feeling was one of an environment that provided the clinical function of giving birth that was clearly separate from the social and emotional aspect of birth. A functional environment providing optimum physical care of birthing 'high-risk' women through the use of technology, hidden in rooms and offices and authoritative knowledge within an area that staff were in control of. The experience of entering and being in the unit was one of restricted movement, the environment was a familiar one to me as a midwife but to me as a woman visiting it was strange and intimidating. The physical environment was consistent with the literature on the medically led, institutional and hierarchical ethos of consultant led maternity units (Hunt & Symonds, 1995; Machin & Scamell, 1997; Thorgen & Crang-svalenius, 2009; Shah & Setola, 2019) and my expectations. Though this was my first visit to the unit the midwifery staff were friendly; conversation was not initiated by qualified staff, though I did appreciate they were all busy carrying out their jobs. I was largely ignored by most doctors, who only spoke to me when I initiated conversation.

5.7 The midwife led unit

The MLU is separate from the CLU and is on another floor of the unit. It has five en-suite birth rooms, one with a pool, a variety of utility rooms, an office and a family room.

Entrance to the unit is via a windowed corridor and upon entrance, a widow reveals the hospital grounds. On entering the unit, the reception is directly in front of you, it has a low desk and has comfortable easy chairs around accessible to midwives or visitors to the unit and is staffed by a ward clerk. In the reception area, to each side and the facing wall, there are notice boards and displays showing the on-going work of the unit and the achievements of the midwives. There are many 'thank you' cards displayed on notice boards, pictures of mothers and babies and a big display showing quotes from the families who had birthed their babies there. In line with a clinical environment of a hospital, signs give information and health and safety information relevant to staff, but this is in the minority when compared with the other displays.

The furniture, units and doors are the same as on the consultant unit but the there is more of a feeling of space, on entry barriers do not confront you and the midwives tried to connect with me in a friendly and informal way.

The midwifery staff seemed display ownership of the unit through the decoration, the open layout of the reception where the staff appeared to be taking a break while there was only one woman in labour made it feel less formal and more welcoming to someone who was not a member of staff or a labouring woman. In conversation they asked about my research not just who I was and what I wanted.

The physical environment on the MLU was more consistent with the literature on midwife led care environments as ownership was displayed and a sense of the lack of hierarchy was given (Walsh, 2004). The environment contributed to making it more conducive for birth within a social model of care (Walsh & Newburn, 2002) by being more holistic and the medical function of the unit not being the sole focus. Though there was a degree of unfamiliarity in the physical environment it seemed more open and my movement was not as restricted as it was in the consultant unit. The welcoming and open attitude of the midwives made it more relaxing and non-hierarchical.

5.8 Sampling

As a focused ethnography, the sample of participants was targeted to represent the populations being studied. In this case the targeted sample were women who planned to have or had experience of labour and booked for care at the hospital, midwives and obstetricians who worked in the hospital.

Purposive sampling was used to recruit participants on a non-random basis so that those involved provided data relevant to the research question (Bryman, 2015). The intention was to include as many different experiences from participants as possible in respect of: the number of childbirth experiences and personal background of women, and a variety of clinical experience from the staff. However, the variety of experience of participants was dictated by time constraints and the willingness of participants.

All qualitative research uses non-probability sampling (Murphy et al. 1998). This means results will not usually be generalizable but will only apply to the specific population under investigation. This form of sampling can be biased, as the sample are targeted to fulfil the needs of the project (Endacott & Botti, 2007). However, the term non–probability sampling can be seen as biased in a statistical sense in quantitative research. As qualitative research only explores lived experience of a participant's world, we are unaware of all the real-world issues that all people in the group share therefore the sample could be seen as neither biased nor representative.

As with much of research requiring the explicit consent of participants, only the views and beliefs of those who have chosen to take part shall be presented and consequently, wider application of the results shall be limited. This has the potential to affect the findings as beliefs and experiences that potentially could be significant are not included (Robson, 2011). To agree to take part a certain level of personal motivation will be required; Haymen et al. (2001) found that altruism was a large part of the motivation for taking part in research. Therefore, depending on the participant's personal feelings towards research, maternity services and myself as a midwife, it likely to affect who agrees to become involved.

5.9 Access to participants and gatekeeping

Links with the hospital, the Research and Development (R&D) department and the midwifery department were already established through the University. During the ethics process it was

necessary for the hospital R&D department to approve of the documentation and processes used in this project. NHS institutions have an interest in engaging with service users and research as part of the NHS five-year plan to ensure high quality and comprehensive care (NHS England, 2014). To improve care, research needs to be integrated between practice, education and management at an individual, local, regional and national level (Proctor & Renfrew, 2000). Whilst the NHS has a commitment to engage in research, collaboration with individuals within the hospital facilitated the implementation of the project. On an individual level, agreement to individual participation and consent was necessary in addition to participants giving me their time, which could not be facilitated by the NHS as an organisation, especially as a qualitative project. Access to the organization was already formally established, however it was necessary to forge links with employees who would act as gatekeepers. The role of gatekeepers in research is valuable as this can be a means of gaining access to participants with the relevant information and facilitating the research process (Munday, 2013). Munday (2013) also suggests that gatekeepers can also deny access and exercise power over which potential participants are included or excluded from the research process. The Head of Midwifery (HoM) and the consultant midwife offered practical suggestions on recruitment and had working knowledge of the service user demographics and how the maternity services were organized. They also gave me information on who would be the best people within the organization to contact to arrange meetings and suggested which midwives and demographic of women could potentially offer good insight.

Over the course of the project, I developed a good working relationship with the consultant midwife. She advised me who to contact and speak to in the obstetric team about the project; this contact proved beneficial. After a number of emails, a meeting was set up very easily to arrange a presentation to facilitate recruitment.

5.10 Participants

How many participants to include at the beginning was a difficult decision, I needed a definitive number to state on my ethics application. In qualitative research to gain an adequate amount of data Kuzel (1999) suggests recruitment of between five to eight participants to represent a group being studied. Guest, Bunce and Johnson's (2006) research showed that major themes were identified within the first six interviews with saturation occurring within 12 interviews. I therefore decided on 30 participants: ten women, ten

midwives and ten obstetricians, however I was aware that ideally, recruitment should continue until saturation of themes had been reached giving the research 'content validity' (Llewellyn, Sullivan & Minichello, 2004).

5.11 Women (Group 1)

A sample of eleven women were recruited to the project and two withdrew. The women although homogenous through being pregnant and using maternity services at the unit, an attempt was made to include women who had different experiences to bring heterogeneity to the project. The women recruited represented different areas of life and pregnancy experience. The sample included women from a variety of age groups experiencing their first, second or subsequent pregnancy. Women from different demographics and backgrounds and women experiencing pregnancies defined as 'low' and 'high' obstetric risk were included. Women from differing ethnic backgrounds were approached but declined participation. Introducing a variety of factors enabled the data collected to be representative of as many different perspectives as possible within a small number of participants. However, as this is a feminist project, it is recognized that all women are individual, with individual life experiences and histories. Recognition is given to their unique experience and commonalities draw from the data to represent women as a collective in comparison to the collective of the other groups of participants.

5.12 Recruitment of women

Women accessing maternity services at the host site were recruited for this study. Recruitment took place after the 24th week of pregnancy as this is when a pregnancy is viable and therefore discussion about birth will be considered appropriate. Women who are entering the third trimester of pregnancy are more likely to be thinking about birth and potential plans for their labour.

I met with the community midwifery managers to discuss the study. This allowed them to ask questions about the study that they felt were relevant to them and the recruitment of women participants. The main aim of this was to alleviate any concerns that the midwives may have had regarding their part in the recruitment of women. Barthow et al (2015) found that the knowledge of the community held by community practitioners benefited the implementation of research. As I have a lot of experience as a community midwife, I have insight into the

amount of work and pressure that midwives are under during busy community antenatal clinics. I arranged with the midwifery managers the community clinics I could recruitment from, then spoke personally with the midwives responsible for that clinic. The design of the methods of recruitment to the study was done to ensure that the midwives were minimally involved in the recruitment process which could potentially increase their workload and therefore dissuade them from participating in the process. But their knowledge of the community in which they worked could be built into the methods of recruitment to increase the success of recruitment. Through my presence at the community clinics to recruit women the midwives acted as 'sign posters' to myself as a researcher and answer any questions the women may feel necessary.

Posters were designed to display in the community antenatal clinics (See Appendix 1). These were put in prominent positions on the days I was there to advertise my presence. Community midwives gave letters of invitation (See Appendix 2) to all women who fit the inclusion criteria of the study asking for their participation. Women who were interested in taking part were given a participant information sheet (See Appendix 3), by myself on the recruitment days. This information was discussed with them and an appointment made for an interview at a time, venue and date of convenience following discussion and verbal consent to take part. My contact details were made available to potential participants and an opportunity for withdrawal was given prior to, during and following interview.

Inclusion and exclusion criteria for women participants

Inclusion criteria:

- Women receiving care from the trust
- Women over 28 weeks of pregnancy
- Women fluent in speaking English

Exclusion criteria:

- Women carrying a fetus with known anomalies
- Women experiencing an inter uterine fetal death (IUFD)
- Women with a little understanding of English
- Women who have known social problems that may provide a risk to the researcher

- Women with serious mental health problems

Ethically I did not want to give women extra questioning who were experiencing a potentially difficult time with something that could appear trivial to them. In addition, due to the resources available to myself, women who had minimal understanding of English were not asked to participate as I had no access to translation services though I recognize that these women may represent marginalised populations and their experiences may be valuable.

The characteristics of the women recruited and interviewed are shown in Table 5. Some women were interviewed in the antenatal period of their pregnancy and some in the early postnatal period. Of all the groups the women were the easiest to recruit and interview due to the short time it took to do so.

Woman's given name	**Age**	**Ethnic origin**	**Employment status**	**Antenatal /Postnatal**	**Pregnancy number**	**High/Low risk**	**Partner support**
Katie	26	White British	Employed	A/N	Two	Low	Yes
Laura	31	White British	Employed	A/N	Two	Low	Yes
Maggie	39	White British	Employed	A/N	Four	High	Yes
Nicky	19	White British	Unemployed	A/N	One	Low	Yes
Olivia	29	White British	Employed	A/N	Two	Low	Yes
Pat	33	White British	Employed	P/N	Two	Low-(BBA Breech)	Yes
Quinn	31	White British	Employed	P/N	One	Low	Yes
Roma	24	White British	Employed	A/N	One	Low	Yes

Sue	34	White British	Employed	A/N	Third	Low	Yes

Table 5. Characteristics of women included in the sample

Key: Antenatal – A/N, Postnatal – P/N, BBA- Born before arrival

5.13 Midwives (Group 2)

The ten midwives employed at the hospital and recruited to the project are homogenous by their profession. However, some heterogeneity was needed to bring a variety of experience to the data, therefore midwives who were employed in different areas within the trust and had a varying number of years and experience were specifically recruited. Some of the midwives recruited had not been involved in recent intrapartum care. However, the community midwife assisted women in planning their birth in the antenatal period with advising on movement during labour as a significant part of the formal birth plan. Another midwife was involved with parent education. As part of this role she held interactive sessions with women and their partners about labour which included movement. The senior level midwife played a strategic role within the trust and had a focus on promoting normal birth within the unit. Her role involved liaising with all midwifery and obstetric staff around the implementation of strategies to promote normal birth, one of which was an initiative to encourage maternal movement during labour.

As a qualitative feminist project, it was acknowledged that individual midwives will bring their own experiences and histories, which was respected through the inclusion of their experience as women who care for other women. These individual experiences are validated within the context of the project; something that a quantitative representation of data would not do. Area of practice differed between midwives and this was intended to bring a variety of expertise and beliefs to the data. All the midwives recruited were female as there are very few male midwives in the UK. Eight midwives also have personal childbirth experience and experience of being a service user. This status was considered to explore if this influenced their beliefs. To view the characteristics of midwives included see Table 6.

Given name	**Years since qualification**	**Area of practice**	**Post**	**Personal birth experience**
Angela	23	Hospital	Managerial	yes

Barbara	40	Community	Education	yes
Catherine	8	Community	Midwife	yes
Donna	5	MLU	Midwife	no
Elizabeth	Less than 1 year	Hospital	Midwife	yes
Fiona	11	Consultant unit	Team leader	yes
Geraldine	28	MLU	Managerial	no
Hannah	37	MLU	Midwife	yes
Irene	8	Consultant unit	Midwife	yes
Jan	3	Consultant unit	Midwife	yes

Table 6. Characteristics of midwives included in the sample

5.14 Recruitment of midwives

The main method of recruitment was through the midwifery managers. Letters of invitation were designed for staff (See Appendix 4) and managers were asked to email them to midwives in their team. Posters were also designed to recruit members of staff (See Appendix 5) and managers were asked to display them in clinical areas accessible to staff. Three midwives emailed me who were interested in taking part from this method, I forwarded participant information (See appendix 6) and made appointments for interviews. I also attended a midwifery conference held by the unit, this enabled me to talk informally about my project to midwives whilst I represented another midwifery organisation.

It did take longer to recruit midwives than initially planned. Being in the unit in person and approaching midwives and talking to them either prior to the recruitment drive or following the initial email proved more successful. I visited the CLU and MLU by arrangement to speak to the shift leaders for other issues; this enabled me to speak to some of the midwives on duty, this personal contact enabled me to recruit the others required for my sample.

5.15 Obstetricians (Group 3)

The six obstetricians recruited were homogenous by their profession but brought a variety of expertise and experience based on their grade, it is usual for doctors working in obstetrics to work in many hospital sites as part of their training. In addition, obstetricians have held posts in other medical specialties such as in General Practice, which adds to their experience.

Though attempting to include an equal number of male and female obstetric participants, only female obstetricians were recruited. It was hoped that the different gender perspective of personal childbirth or potential childbirth experience or their personal experience of being a service user would be explored to find out if this knowledge influenced professional beliefs.

As a feminist project the intention is to give voice and value to women's experience and to raise awareness of women and midwives' beliefs about movement in labour as a group whose knowledge and opinion can be marginalised in medical settings (Hart, 1985). However, if only the perspective of either women or midwives were included this would provide a limited perspective in the context of it not being viewed with the comparison of the obstetric view point. Obstetricians have been included in this project so all perspectives are taken into account (Abbott, Tyler & Wallace, 2006), recognising that obstetricians' experiences may not be limited to medical viewpoint. To view the characteristics of obstetric participants, see Table 7.

Given name	**Grade**	**Years in obstetrics**	**Sex**	**Interview type**	**Children**
Tracy	consultant	32	female	Individual	No
Ursula	registrar	6	female	Individual	Yes
Val	ST1	1	female	Group	No
Winnie	ST1	1	female	Group	No
Yvonne	ST4	4	female	Group	Yes
Zoe	ST4	4	female	Group	Yes

Table 7. Characteristics of obstetricians included in the sample

5.16 Recruitment of obstetricians

Through liaison with the obstetric clinical education lead, a short ten-minute presentation was given to the obstetric staff to inform them of the study and provide opportunity for discussion. This resulted in recruiting nine participants. In addition, posters were designed to recruit members of staff (See Appendix 5) and were displayed in clinical areas accessible to staff with a contact email. Letters of invitation were designed for staff (See Appendix 4), these

were distributed through email via the obstetric clinical education lead following the initial presentation.

I gave a second presentation two weeks later in an obstetric training session, this was a more in-depth discussion of the project which mentioned the aims, rationale, literature I had reviewed as part of the project, the methodology and methods.

Giving a presentation initially appeared successful as I returned from the initial session with nine email addresses. Despite emailing them to thank them for volunteering and emailing them regularly over a course of two months to inform them when I would be on site, I only had one reply to arrange an interview. I directly approached two consultants by chance meetings on the corridor whilst visiting the consultant midwife, both declined. I do not know why the obstetric staff appeared so difficult to recruit. I discussed this with my supervision team to think of ways of improving this.

The literature around recruitment focuses mainly on recruiting members of the public to studies and highlights the lack of understanding on how to improve strategies (Patel, Doku & Tennakoon, 2003) therefore suggestions made are not applicable for my study. I attempted to recruit obstetric participants directly, in contrast to patient focused health research and therefore not facing the difficulties acknowledge by Patel, Doku & Tennakoon (2003). The patient demographics associated with lack of participation in research, such as low education, occupational and income status, high users of health care or recent poor health does not apply to the obstetric participants. Whilst Patel, Doku & Tennakoon (2003) cite experience of the researcher or clinician as affecting recruitment, I did not feel this was applicable as it did not affect the recruitment of midwives or women. Understanding of the research design by participants in relation to the validity and relevance of the study could affect recruitment (Patel, Doku & Tennakoon, 2003). This could have been an issue with qualitative research as the medical model and quantitative research has the greatest influence in medicine.

Participant perceived risks and benefits to themselves are also cited as barriers to recruitment (Patel, Doku & Tennakoon, 2003). Again, risks and benefits associated with experimental studies do not apply in regard to the effects of medication and the long time commitment needed. However, altruism of the participant could have been a factor; if obstetricians do not

value or understand the relevance of qualitative research it could have affected their willingness to offer their time and experience.

As a PhD project, I did not have to rely on other practitioners to recruit participants who may have had time pressures and lack knowledge and enthusiasm for the task (Bower et al. 2009). I maintained contact with the site and provided information using a variety of methods, always thanking potential participants for involvement as advised by Bower et al. (2009). While it is suggested incentives can be used to entice involvement with research (Robson, 2011; Patel, Doku & Tennakoon, 2003), I did not feel it was appropriate to offer lunch or cake to doctors, I did not offer such incentives to midwives and their interest was obtained easily. I considered the reason for non-engagement from the perspective of the participant as Patel, Doku & Tennakoon (2003) suggest. I am not sure their lack of enthusiasm was more fundamental. As I had identified as a midwife I was not sure if they had placed me in a hierarchy as Robson (2003) suggests as many did not engage with me on a personal level in passing conversation. Or, as the theory around obstetrics suggests, qualitative research is not viewed as valuable as quantitative (Murphy-Lawless, 1998), and therefore they did not see my project as valuable. This experience was very different from that of recruiting midwives who readily came forward in contrast to this reluctant and resistant nature of most of the obstetricians. I was also aware of the advice offered by Harvey (2010) on interviewing elites which recommends being considerate of the value of their time. In addition to the continued emails, I spent more time in the hospital and made use of the opportunities of quiet moments on the labour ward to allow doctors to be interviewed at their convenience. This was based on the methods adopted by Carpiano (2009) who interviewed participants in their everyday lives accompanying them in their familiar setting to gain data.

To fulfil the aims of my project in having the perspective and experiences of the obstetric team I decided to change my preferred data collection method of individual interviews as it provided difficult to recruit for. Accordingly, I organised a group interview prior to a training afternoon in which a medical company provided lunch. I successfully recruited four obstetricians who took part in a 40-minute discussion.

5.17 Data collection

Most of data used for this project was gained from one to one, semi structured interviews (see appendix 7 for women, appendix 8 for midwives and appendix 9 for obstetricians), demographic information (see Appendix 10) was used to show the diversity of participants' backgrounds. A reflective journal was kept and any additional information that participants offered around the subject was also used, this included the birth plans made by women and a letter from a woman to a midwife about her birth story.

5.18 Interviews

Interviews were carried out at a place and time of mutual convenience. I was able to use University and Hospital facilities for meetings in addition to participant's homes, this offered a choice of site that was familiar and easier to get to for the participants. I was aware of the influence place had on midwifery care in relationship to power roles (Lock & Gibb, 2003) and assumed this would be equally applicable in my role as a researcher. Elwood and Martin (2000) suggest much of the literature on place of interview focuses on power dynamics on the relationship between the participant and the researcher based on positionality and identity. I was able to reflect on how I felt about power relationships with participants in each location in my journal and later draw upon the information during analysis. However, Elwood and Martin (2000) suggest that the interview site influences the accounts given based on the influence it has on the participants' identity and positioning. To enable understanding to be gained from this they suggest being aware of artefacts that reveal information about participants and observing the relationships participants have with others in the environment (IBID).

Interviews lasted between 35 and 65 minutes and were digitally recorded on a small hand-held device. A semi-structured format was used as this provided more of a guide to the areas I wanted to explore but permitted the interview to be free flowing and allowed for unplanned questions dependent upon what the participant said. Semi-structured interviews were chosen as the topic of investigation was focused on movement during labour and unstructured interviews are more compatible when exploring a general area of interest (Robson, 2011). Whilst I was aware that the use of semi structured interview was imposing my line of questioning (O'Reilly, 2012), my research question was around movement. A more unstructured interview, as is more usual in ethnography, would have enabled me to learn

more about participants perspective and their view as an insider, but not about my specific area of interest.

Semi-structured interviews as a data collection tool in qualitative research methodology produce data that does not isolate participants from their social context (Wilkinson, 1998). By using narrative as data, focus is on participants lived experience, how they view themselves, how they connect with the world around them and how they link causes and events in their life (Elliott, 2005). By using narrative, it allows beliefs and views to be expressed that are embedded in experience, using example to illustrate and the reasoning process participants use to explain their experience.

One to one interviews have been chosen to allow the beliefs of a single person to be expressed without the influence of others. As beliefs can be personal, group interviews may not provide the opportunity for full exploration especially within groups of colleagues in different positions within the hospital organisation as some might find it uncomfortable having their beliefs challenged (Denscombe, 2007). This was evident in the group interview with the obstetricians as during a discussion alone with two of the senior obstetricians they spoke of their personal experience of labour and movement.

5.19 Interviews with women

It was assumed when I started this project that participants would have working knowledge of what movement in labour was therefore no further expansion of what my meaning of movement was needed.

Initially I was concerned that participants would not talk enough. However, this was soon dispelled after the first few interviews. I was conscious of how my behaviour would influence the participant's willingness to talk as I was the data collection tool (Robson, 2011). I found myself using the active listening skills I had gained as a midwife and the reflective skills I had learnt through a counselling course that reassured me I was not doing something completely unknown to me. My feminist self was also conscious of how the participant perceived the interviewer-interviewee relationship. As a midwife I felt other midwives viewed me as an equal and as someone who 'knew' their work; as I had met some prior to their participation I felt they knew a little about me and this gave a sense of equality to the relationship, an

element which is given importance in feminist interviewing (Oakley, 1990). I carried out two midwife interviews at the university. I was aware I was in an environment familiar to myself and not to the participants and this might create some inequality, however both midwives had trained at the university and I tried to make them as comfortable as I could by offering refreshments, showing them around and introducing them to staff in a grateful and courteous way.

5.20 Reflective journal and field notes

The use of reflection and the justification for this is discussed within the methodology chapter of this thesis. A reflective journal was kept and updated after every contact with the site or participants and used to reflect on observations, thoughts and feelings of my contacts to make the process of the research and research findings explicit and transparent. In addition, when I had time to think about concepts or interactions, notes were made in this journal to aid the analysis of situations, interviews and feelings. Notes made after events were not necessarily precise but added to the accounts given by the participants, through giving context to the interviews it added to the validity and legitimacy in the analysis (Bray, 2008).

Fieldwork within ethnography is said to improve and inform qualitative interviews (O'Reilly, 2012). Whilst the main data collection method was interviewing, I spent extended periods of time at the hospital. Within this time, I naturally observed what was occurring around me and therefore made notes. These observations aided me in providing a context for the research and improved my ability to build relationships with participants and potential participants. I considered this to be unofficial fieldwork as I had not planned at the onset of the project to spend time observing. These experiences and the knowledge it gave me improved my knowledge of the culture and operational context of the unit and so could be used with the data gained from interviews to explore answers given to questions.

I was conscious of limiting sources of data; I attended a British Sociological Association Human Reproduction Group meeting in which a presentation on ethnography by Dr Gareth Thomas (2014) advised that everything occurring 'in the field' is to be considered data.

5.21 Other documents

The use of patient notes was not considered appropriate for this study as an objective description of movement was not being sought. Women are routinely offered information in

the antenatal period regarding their plans for their birth (NICE, 2008). There is no standard documentation for this nationally, however, within her hand held notes each woman should have a copy of her birth plan. A standard question within this birth plan is the woman's wishes regarding active birth or position for birth.

One midwife during her interview told me about a letter she had received from a woman regarding the woman's experience of position and movement during her birth. Though I did not plan to use women's stories and I did not seek consent from the woman writing the letter, I used the midwife's narrative of this letter as evidence of 'the other' midwives and added to my data on the importance of how movement is to women's experience.

5.22 Data Analysis

Once the interview data were gained, they were transcribed and analysed as soon as possible. It is recommended that analysis in qualitative research is an integral part of the process, not a separate phase or stage. On-going analysis enables a study with a flexible design to be developed in response to the data gathered and analysed and the study to be responsive to findings (Robson, 2011; Grbich, 2012; Silverman, 2013).

5.23 Flexible study design

After piloting the first interview guide amendments were made to the wording of one of the questions. A question was then developed to ask around inspiration for choosing their profession to explore experiences or feelings from which analysis could be made to make an interpretation of individual participants' positionality. This is a benefit of a flexible study design (Robson, 2011).

Roulston (2010) advises that once five interviews are carried out adjusting the semi structured interview guide in relation to the data given will enable the following interviews to collect the relevant data. During the initial interviews, when asking about training all referred to clinical practice and how this took place, all mentioned the hospital in which this took place, and some expanded on the culture of the unit. This promoted the insertion of an additional question in the remaining midwifery and obstetric interviews around how the culture of the working environment affects learning. Though Roulston (2010) suggested adjustment after five interviews, the initial wording of the interview guide was altered following the first interview and was subsequently adjusted to expand on areas needed.

5.24 Analysis

For the analysis of the interview data I used a combination of thematic analysis and brain storming. This was chosen because thematic analysis offered a method of data analysis that was not linked to any theoretical perspective and can be used within a variety of theoretical frameworks (Robson, 2011). As I was a novice researcher it offered a method that could be used to organise the large amount of data gathered by looking at the data and coding to see how often they arose. I chose thematic analysis as it offers a method of analysis that can be used flexibly and utilises diagrams in the interpretation of the data through conceptual mapping (Grbich, 2012). Though this method did provide a summary of the emerging issues it can also decontextualize and oversimplify (Grbich, 2012). I overcame this by immersing myself in the data by continually returning to the full audio data.

Computer-based data analysis was considered however, I decided that I would prefer to manually handle the data myself, allowing me to develop a method which felt comfortable and iterative to my own personal learning style. This allowed me to use my relational memory and listening to the interviews to create mind maps; having dyslexia this worked well for me. The development of mind maps involved me extracting codes from the data, identifying categories that I had identified during transcribing, re-listening and adding notes on my initial thoughts following interviews. I then went through the transcriptions, putting quotes into the categories I identified.

I initially created hand written mind maps (4ft x 4ft) of data (appendix 11). Two interviews were transposed on to one mind map in a specific colour, connecting lines were made between the categories with another colour and ‘quotes’ or rationale for such and memos could be added as they were developed. Analysing the data in this way gave a visual representation of which categories were the biggest, how they were connected and sometimes where they overlapped.

This method offered a way in which I could become immersed in the data. I also displayed these mind maps on the walls of my home, so that after reading literature, watching a TED talk or thinking around things I was able to look at my analysis and add thoughts or ideas and develop the interpretation. However, the more interviews I did, I became overwhelmed with the amount of data. I broke down each interview into responses from the questions. From this, I organised the data into electronic mind maps, directly entering the data from the

obstetricians interviews (Appendix 11). Using this written and electronic data, I mind mapped data and the listed interview data into electronic mind maps to make categories linked to direct quotes (Appendix 12).

Miles, Huberman and Saldana (2014) describe data analysis as three concurrent flows of activity; data condensation, data display and conclusion drawing. Data condensation makes data stronger through focusing, simplifying, abstracting and/or transforming the data that appears in the full set. I drew from this in analysing the data as it made sense to me, following coding, developing categories from the full set, the categories that formed the most relevant parts of the data sets could become more focused. The displaying of the data is where the data came alive, the ability to create a display which could work for me to illustrate my analysis and enabled me to draw conclusions.

5.25 Rigour

Rigour is an essential part of the research process and plays a part in evaluating quality. However, assessing rigor in qualitative research is seen as problematic as concepts such as reliability, validity and generalisability are associated with quantitative research and there is no accepted standard for how qualitative research should be judged (Noble & Smith, 2015). Lincoln and Guba (1985) identify alternative terminology to credibility in qualitative research: truth value, consistency, neutrality (or confirmability) and applicability. (Table 8)

Quantitative research terminology and application to qualitative research	**Alternative terminology associated with credibility of qualitative research (Lincoln & Guba, 1985)**
Validity The precision in which the findings accurately reflect the data	*Truth value* Recognises that multiple realities exist; the researchers' outline personal experiences and viewpoints that may have resulted in methodological bias; clearly and accurately presents participants' perspectives
Reliability The consistency of the analytical procedures, including accounting for personal and research method biases that may have influenced the findings	*Consistency* Relates to the 'trustworthiness' by which the methods have been undertaken and is dependent on the researcher maintaining a 'decision-trail'; that is, the researcher's decisions are clear and transparent. Ultimately, an independent researcher should be able to arrive at similar or comparable findings.

	Neutrality (or confirmability) Achieved when truth value, consistency and applicability have been addressed. Centres on acknowledging the complexity of prolonged engagement with participants and that the methods undertaken and findings are intrinsically linked to the researchers' philosophical position, experiences and perspectives. These should be accounted for and differentiated from participants' accounts
Generalisability The transferability of the findings to other settings and applicability in other contexts	*Applicability* Consideration is given to whether findings can be applied to other contexts, settings or groups

Table 8: Criteria and terminology used to evaluate research findings (Noble & Smith 2015) adapted from Lincoln and Guba (1985)

Within this project, truth-value was addressed through maintaining a reflective journal, the inclusion of a reflexive chapter and regular debriefing with my supervision team to uncover bias and assumptions. These methods help with becoming reflexive and self-critical to enable accurate assessments of quality, all methods which are appropriate for doctoral study. Additionally, accurate portrayal of the data and the relationship to the overall findings was achieved through the process of in depth interviewing over time and continually revisiting findings. Methods of ensuring this included audio recording, verbatim transcribing by myself, repeatedly revisiting the data and manual and electronic mind mapping. Electronic and manual mind mapping was used as a tool to clarify thinking and link data. Judgements can be made around the final themes and accuracy to participant's accounts through using verbatim extracts form the participants, linking similar extracts and identifying extracts that conflict. On reflection, this could have been strengthened by enabling participants to comment on the research findings and themes.

Consistency and neutrality were achieved through clear and transparent outlining of the research process, clear description of the methods and detailed explanations of how the data was used to reach the findings in a transparent way (Appendix 11, 12, 13, 14, 15, 16). Displaying data in the form of mind maps for analysis is robust, as organised information is visible and accessible with connections that can be easily seen in opposition to extended text, which is dispersed and sequential and more difficult to process (Miles, Huberman & Saldana,

2014). The process of identifying patterns, explanations and propositions begins at the start of data collection and is only verified when data collection is complete and meanings emerging from the data can be tested for validity against the full data set (Miles, Huberman & Saldana, 2014). The process of displaying and analysing the data in this way in a continuous process following transcribing and prior to subsequent interviews aided with the acknowledgment of data saturation.

Grbich (2013) suggests that data analysis is not as simple as choosing an accepted process such as thematic analysis but is a combination of three areas: the researcher, the design and methods used and the findings and theoretical interpretation. Through the use of reflection, my views about the subject and research project and the choices I have made through the project are made clear, showing the impact that these have on the data collected and the analysis. The methodology section justifies why this project is suitable for the chosen design and showing why the data is valid. By clearly displaying how my findings were reached using mind maps and being clear about the theoretical interpretation that was used to analyse data, work is presented which shows transparency in its approach showing consistency and neutrality through displaying auditability.

Themes were discussed with the supervision team who had expertise in the methodological and subject area. This allowed an arena where data that contradicted my a priori assumptions could be challenged and open discussion about how I reached my findings could be conducted. This added to my ability to reach consistency in the findings and brought neutrality.

Applicability was achieved through providing details of the context and justification for the study in the current socio-political environment. By including midwives from all levels and job roles, women from different backgrounds and obstetricians of different levels, a wider perspective from different angles was gained. This ensured finding were consistent with all participants' perspectives and could be applied to similar settings. Additionally, all findings were discussed in relation to the wider literature, giving them strength and highlighting gaps in the current literature and thus showing where new knowledge has been gained.

5.26 Analysis of field notes

Through reviewing the data collected from the field note / reflective journal and constantly comparing findings, Bray (2008) suggest data are analysed scientifically. Comparison was done through discussion with supervisors, thinking and reflecting about situations and recording my thoughts, memos and connections on the mind maps. A diagrammatic recording of connections in the data from the interviews were made and memos made from recording in the field note journal. By using my observations as data, validity and transparency was given to the methods employed in this project as my experiences could be used to illustrate meaning and clarify and expand on my own thinking around the situations I found myself in. When interpreting text my reflections can explain why such interpretation was appropriate as well as why alternatives were discarded (Bray, 2008). For example, a comment made by the obstetrician following a presentation; thinking and discussion with supervisors around why this could have been made may have explained the difficulty I had in recruiting obstetricians. By using my thoughts on this comment and looking at the literature in this area I could then think of different ways to approach recruitment; the success or failure of this could then be reflected upon again to devise other recruitment strategies.

By recording my observations on the everyday environment in which the project takes place, the details of how the 'routine' is constructed by watching and listening to what people do can be understood (Silverman, 2013). The general principles of working within a hospital environment is already known to me as a midwife who has worked in both a consultant led and a midwifery led model. However, the culture of this particular unit is unfamiliar to me so this task served as an exercise in what participants took to be familiar and enabled me to elicit information from interviews and during analysis around what participants took to be every day. Experiencing the environment as an outsider allowed me to experience how a woman attending the unit may experience it.

5.27 A dynamic definition of culture

Customs and rituals are deeply embedded within a culture to create and maintain order and life within a society; that can be deeply hidden to insiders and outsiders. By selecting a lens and justifying why the lens was chosen culture can be examined. Ethnographic observation can provide clues about how individuals perceive the world and how they learn to live within the constructs of culture and society.

Schein defines culture as:

'the accumulated shared learning of that group as it solves its problems of external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel and behave in relation to those problems. This accumulated learning is a pattern or system of beliefs, values and behavioural norms that come to be taken for granted as basic assumptions and eventually drop out of awareness.' (Schein, 2017, p 6).

Schein (2017) focuses on how culture is learned and advises that it will evolve. He describes three levels of a culture (See figure 2.) which can be analysed to depict it. Whilst those visible to the observer are difficult to decipher, deeper levels are hidden, with espoused beliefs and values leaving behaviour unexplained until basic assumptions are more fully understood.

Figure 2. The three levels of culture (Schein, 2017)

Social norms evolve through living and working together; standards and values are defined and maintained through implicit rules known to the group and passed on through socialisation. Ideas, which are identifiable and hidden, are shared by the group and become basic assumptions which are taken for granted. Schein (2017) uses this definition of culture, using levels, to facilitate analysis of what can and cannot be observed by the outsider. By using the idea of 'basic underlying assumptions' deeper levels of ways of being can be explored. Having knowledge of these various levels of culture assisted me in uncovering the taken for granted and invisible. The behavioural norms of the group are based in a deeper level through their implicit shared values, which are accepted as good and right. Schein (2017) acknowledges that it is not easy to recognise the feeling and thinking that relates to these powerful basic underlying assumptions, as they are below the surface, often invisible and unconscious. They are so ingrained within the group that acting in any other way would be thought of as implausible.

Spradley (1979) uses an approach to ethnographic research analysis that categorises aspects of how the researched experience the world. Theories of cultural behaviour are drawn through categorising symbols and descriptive language and the interaction research

participants have with these elements. Spradley's (1979) methods aim to define aspects of experience in recurring social circumstances to specify the conditions in which people in a specific role are likely to act. Whilst this offers a structured and systematic approach, which can show rigour, it does not offer the depth of understanding that using Schein's (2017) frame does. Spradley's (1979) approach offers a way to label and categories that are shared among any group of people who customarily interact together. The limitation of Spradley's approach is that it is narrow. It offers a way in which to provide a descriptive account and fails to draw on any research about the underlying beliefs and values that determine the behaviour observed.

5.28 Frame for data analysis

Having identified categories I then began to explore the meaning within the existing literature. From these categories themes became emergent (Appendix 13, Appendix 14) and Schein's (2017) definition of culture was used to develop structured themes (Appendix 15, Appendix 16)

5.29 Ethics

The concept of ethics informing this research project requires the utilisation of basic principles of respecting participant autonomy, advocating justice and ensuring beneficence and non-maleficence (O'Reilly, 2012). Though it is argued that qualitative research poses less risk to participants than quantitative pharmaceutical or procedure trials within the NHS, the risks of qualitative research are hard to predict (O'Reilly, 2012). Of great importance in qualitative research is protecting participant anonymity and protecting personal data as behaviour that is unlawful, unethical or in contrary of professional boundaries may be revealed. In addition, the prolonged contact of the researcher within the field allows the collection of more personal and potentially sensitive information that may lead to identification of participants. Qualitative research can be seen as voyeuristic, further enhancing the ethical need to justify the research aims that should go beyond curiosity.

Whilst the affects the researcher has on the collection and interpretation of data has been acknowledged, the researcher has the potential to influence data collection through power relationships with participants. My role as a practitioner researcher has been explored, but the significance of this is the acknowledgement that my status as a midwife and researcher may affect participants' ability to withdraw from the study. To ensure participants did not feel

coerced into participation a cooling off period was given after initial contact was made to allow for reconsideration of invitation to participate. In addition, participants were given a choice of where they felt most comfortable for the interviews to take place.

To ensure the research was conducted in line with the standard required by the NHS, ethical approval was sought via the Integrated Research Application System (IRAS), an ethics process designed for research projects taking place within the NHS. This involved submitting my research proposal and relevant documents for ethical approval via IRAS and to the hospital site.

In line with the general principles of ethical conduct in research, voluntary participation and the right to withdraw, protection of participants through confidentiality, assessment of benefits and risks, informed consent and doing no harm protocols (Silverman, 2013) were followed.

All information regarding the project was included in the participant information sheet (see Appendix 3 & 5) which was given to participants upon expression of interest. Discussion between the participants and myself, prior to the interview took place, this was to clarify understanding and to ensure that they understood participation was voluntary and they could withdraw at any time.

To ensure that confidentiality was maintained all consent sheets and demographic information sheets containing personally identifiable data were stored securely. Interviews were recorded on an electronic voice recording device only accessible to the interviewer. Transcripts were anonymised, and any identifying information removed. Interviews were transcribed as soon as possible after recording and stored on a password protected laptop. It is possible that the electronic recording device could have been lost or stolen between recording and transcription allowing for potential breeches of confidentiality. The University's code of confidentiality, the research sites confidentiality policy and the Nursing and Midwifery Councils professional code of conduct, performance and ethics (NMC, 2011) was maintained throughout the project.

Verbal consent was gained prior to recruitment, participants were then contacted via their chosen method of telephone or email to make an appointment for an interview. Prior to the interview participants were informed that they are free to withdraw at any point, this was

reiterated following the interview as it is recognised that qualitative research may fluctuate from the research agenda and not be what the participant expected (O'Reilly, 2012).

It is recognised that qualitative interviewing may elicit an emotional response either in the participant (Tufford & Newman, 2012) or in the researcher (Pellatt, 2003). Through my practice as a midwife I am experienced in working with women and families experiencing emotional responses to situations. I therefore felt confident in dealing with potentially emotional situations that could arise during interviewing. As I had the support of the hospital and contacts within the maternity care team, I could have referred to them if I felt I was unable to deal with any situation. In addition, if I felt that I had experienced an overwhelming emotional response or a potentially unethical situation I had the support of my research supervisor team and that of my supervisor of midwives.

Chapter Six

6. Reflectivity

6.1 Introduction

Self-reflection is an essential part of the research process when carrying out a qualitative study. Personal beliefs, backgrounds and feelings are part of the knowledge construction process (Hesse-Biber, 2013). I have acknowledged my own personal biases in order to recognise how these could affect the production and interpretation of data. Reflectivity is also central to ethnographic research (May, 2002) as this methodology recognises the researcher as part of the 'world' being studied to which they bring their own experiences. Within ethnography there is a constant interaction between theory and data that cannot be separated (May, 2002). Buch and Staller (2014) highlight the critical role the self plays in generating ethnographic knowledge, reflection can identify my thought and positionality and thus show the impact on what and from whom I am able to learn and how the connections are made. In the attempt to make clear my individual perspective and how I view the project, through reflection, I am able to portray how I came to do a PhD and make aware my bias to show how the findings were reached.

6.2 Childbirth as a woman in the maternity system

I have been socialised into the hospital systems through my training and practice as a midwife. However, prior to this, I had my own experience that shaped my perspective as a woman experiencing childbirth within this system.

My first childbirth experience was of a young healthy woman in my early twenties experiencing a normal straight forward pregnancy and birth. As the first among my social group to experience pregnancy and childbirth I had little knowledge to draw from, my expectation was one of a normal, natural straight forward event filled with excitement about the new chapter of my life. My expectation was not that different from my first experience of birth and transition to parenthood. However, my second experience of birth was completely different. I experienced a normal vaginal birth and had a healthy baby. However, the way in which I was treated by the medical staff influenced me so significantly it was this that prompted me to become a midwife.

Having made an informed decision to not have my pregnancy induced at 42 weeks gestation, I felt coerced by the medical staff to comply with policy by being made to feel irresponsible and foolish. After being intimately examined by what I now assumed to be a male, Asian, junior member of the medical team under the supervision of a midwife, I was told I would be allowed to continue with my pregnancy until I spontaneously went into labour. I recall the midwife supervising was stood behind shaking her head. I was then seen by a more senior obstetrician accompanied by another Doctor. I was told I had to be induced as soon as possible, my blood pressure was taken and I was told it was high and I had to be admitted. With my now knowledge of midwifery, I question everything about this encounter. I was never told what my blood pressure reading was, I had a urinalysis test which showed ketones, and some protein. I was admitted that afternoon and was induced the following morning. I only had normal 4 hourly observations, if there was an issue with hypertension this would have been done more frequently. I had no blood tests or urine collection that are the standard tests to confirm problematic hypertension.

This experience left me disempowered, disrespected, vulnerable and manipulated since with my then lack of medical knowledge I was not given a valid reason or explanation for why these actions were necessary. I felt my autonomy was robbed throughout the process.

My second birth experience was not what I had experienced during my first labour. I spent early labour at home, well supported, eating drinking and being mobile. I laboured in privacy in a dark room when I got to the 'low risk unit' and quickly progressed to a normal vaginal birth. My second experience was completely different, I was admitted in a gown to a four bedded bay for induction with limited privacy, facilities and food and continuously monitored. I was showing signs of early labour but was administered with prostaglandins regardless. Shortly afterwards I had my waters broken by a doctor with fundal pressure by the midwife, which I still remember as the most uncomfortable and painful process during my labour.

My labour progressed very quickly in which time I was transferred via an uncomfortable wheelchair down a busy corridor to another room. During my transition stage I requested and was administered pethidine, making me very unaware during the birth and immediately afterwards.

6.3 Experience as inspiration

I see these experiences as shaping the midwife that I am today and enforcing my experiential knowledge of the maternity care models that I personally experienced. I entered my midwifery training with a woman centred ethos that was greatly supported by the culture of learning and education within the university. The midwives who mentored me through my training were a great inspiration and advocates of normal birth and women's choices and were great advocates for women. Many midwives would question doctors when they felt they were intending to intervene unnecessarily during labours that were progressing normally surrounded my experience on the ward. This strength in midwifery care was not as prevalent in the unit I worked in post qualification. If a doctor advised a plan of care, most midwives would follow unquestioningly. This was a major difference in the culture I observed between the two units.

6.4 Socialisation of a midwife

During my years as a midwife I endeavoured to place the women for whom I had had the privilege of serving at the centre of their care. Whilst my knowledge and understanding grew of the bio-medical model of childbirth my philosophical belief lies with a more holistic and social model of childbirth. This comes from my knowledge and experience of how the birth of a child affects every part of your life I found this easier to achieve when working in the community and especially whilst case loading for home births. However, this was much more difficult within the hospital environment, especially on the labour ward. I saw the women as I had been: vulnerable and powerless managed by their risk status and being processed by the system. I tried my very best to individualise their care and empower them during the short time I spent with them. By not following protocol at the choice of the woman or refusing to implement the normal interventions such unnecessary vaginal examinations led to immense pressure and conflicts with senior staff. I felt I had to explain myself to my supervisor of midwives after a passing comment that I disliked labour ward. She could not see the hierarchy as operating as I did and perceived my dislike came from my lack of confidence of normal birth. .This highlighted my frustration with the system and echoed a piece of work by an eminent obstetrician (Wagner, 2001) and supported of a social model of birth which I had read during my training entitled 'fish can't see water'.

6.5 Beginnings of a researcher

I knew that after two years working in a case loading team within the NHS that I would not be able to sustain that level of pressure and took a year's secondment to do a Masters in Research by an NHS funding body. The greatest impact this course had on me was to highlight the plethora of midwifery research and the evidence that grew from it to support a more social model of midwifery care. It was incredulous to me that a profession that is based on evidence was not implementing this. Compared to my fellow health care professional students on the course, I was accessing the evidence that they endeavoured to create and put in to practice through their studies. They wanted to create and question the bio medical evidence and give a voice to their patients and collective profession. Midwifery had done this but it is largely not implemented. I questioned why midwifery, as an ancient profession had created this sound research base but had not been able to implement it. This then took me to look at this from a more feminist and socio-political perspective. Midwifery is a mostly female profession serving women in a patriarchal society, I questioned if this would be the case in a more male dominated profession. Also questioning how much of an impact does the NHS have on midwifery care and how do things like finances, insurance requirements and government guidance impact on the availability and delivery of care that is offered. There was a strong women's voice from the quantity and breath of qualitative research on the impact of maternity care services, yet this was not implemented with the bio-medical research dominated guidelines.

6.6 Activism and feminism

From being a student midwife, I have been involved with the charity the Association of Radical Midwives. It is a non-hierarchical feminist organisation of midwives, student midwives, doulas and anyone with an interest in birth. They campaign on current issues in maternity care, raise awareness of the profession and impact of maternity care and offer support to like-minded individuals and groups. Being involved has, at times, been an emotional lifesaver during my midwifery career. From receiving support as a student when I felt overwhelmed by my studies and my home life to caring and sharing of different midwifery experiences. The acknowledgement that I was not the only midwife to feel as I do about the maternity care system and the impact it has on myself as a midwife and the women I serve. It has offered me an outlet to feel that I can be a part of something that supports my midwifery ideals and to

be able to input into challenging the current dominant paradigm of maternity care in a constructive way. Being involved with this organisation has enabled me to be continually aware of the current social and political implications for maternity care. I have gained knowledge within areas of maternity care that I am interested in that are outside the current and promoted areas within the NHS system. I have found a sense of belonging, being part of this fuelled me to empower myself to research this more and be an advocate for change in my career.

6.7 On the road to a PhD

My experience as a woman within the NHS maternity care system and as a midwife working within it has raised my awareness of the necessity for the implementation of research. My involvement with a midwifery charity has raised my awareness and contributed to my beliefs and philosophy of maternity care. My own personal attitudes towards learning and extending my midwifery reach is what I believe has brought me to this path of PhD scholarship. The reactions and thoughts to my experiences are what have sparked my interest in this PhD subject area. I feel I can understand my personal questions about how maternity care is organised and delivered by understanding the origins of the midwifery and obstetric professions and looking at birth from an anthropological and sociological perspective.

6.8 Living in patriarchy

The research project process for me was a very enjoyable one as I love to study. However, as part of my full-time funded PhD sponsorship I needed to do 6 hours teaching activity within the midwifery department a week. During the first year I also did two weekends a month in clinical practice, but this left little time for my family or myself and despite my financial need for extra income I had to give it up. I loved the teaching and being part of the midwifery team as it gave me an identity, I no longer felt like a clinical practicing midwife, yet I did not feel the isolation of a post graduate research student. Being part of the teaching department gave me the opportunity to discuss ideas with a very knowledgeable group of women and reform my identity. This made me feel supported and combated the isolation I sometimes felt spending such large amounts of time alone studying. I was fortunate I was able to do some extra teaching hours that was more financially rewarding than clinical midwifery, however, the university had limits on the amount I could do. This situation along with me having the sole financial and parental responsibility of two teenage children fuelled my passion for feminism

as I was having the lived experience of a single parent disadvantaged by my sex. It was my choice to give up a full-time job to study giving me the chance of a better career, but as a single woman without the financial support of a husband or partner I was disadvantaged. Men are rarely left to bring up children alone. This experience is allowing me to experience how women are disadvantaged in society as single parents, as their primary role is to provide for their children by whatever means with the associated cost to the well-being as mother and the impact on children.

6.9 Finding my feminist self

Though I have identified as a feminist since my midwifery training, the opportunity to undertake a feminist project allowed me to become more involved in feminism through: attending feminist research meetings hosted by the University of Manchester, attending a feminist conference and exploring more in-depth feminist academic theory. I was also keen to seek out other feminist researchers and lecturers within the university. Embodying being a feminist researcher rather than just referring to it

The feminist research meetings took place monthly through the academic year, on the occasions I was able to attend, feminist research being done locally and nationally was shared, prominent feminist academics spoke on current issues and the concerns they faced within the academic field. I learnt of the direction feminist research was taking in others research and contributed to discussion on ways we, as feminists, could work together to strengthen feminist participation in issues highlighted.

The feminist conference I attended had a very powerful effect on me. I have attended many all-female conferences over the years, particularly with the ARM as a member of the organising team. I have felt comfortable with this as I identified as a midwife at a midwifery conference and knew of most of the issues or areas being discussed. I therefore felt within my comfort zone and knowledgeable of the subject and the background of the attendees. I had never been to a conference which had such a united sense of oppression in the themes and topics been spoke about than this conference. I was made to feel welcome by the organisers, I chatted to other attendees and during the presentations everyone seemed to be roused by the speakers. Private conversations, comments by the audience and discussions during workshops reflected a strong sense of opinion and the oppression felt by many of the effects of patriarchy on women. Some issues I had never thought about but once they were

presented seemed obvious. Bea Campbell spoke of how sexual violence and violence against women and children was used in war and how this had a political motive to destroy the social fabric of the enemy. Julie Bindel feminist, campaigner, researcher and journalist spoke of her no platforming by the National Union of Students, a form of silencing usually reserved for violent extremists. Femi Otitoju, an equality and diversity trainer spoke of her work in industry, advising companies how to address institutional sexism. Julia Long gave a presentation of revenge porn, legislation and its effects on women, a local GP, Doctor Phoebe Abe, spoke of her experience of working with women who had experienced FGM. The day finished on a presentation from Valantina Nkoyo from Kenya, who spoke of her experience of FGM and her overcoming the patriarchal structures in her hometown to study at the University of York. This conference highlighted issues from a feminist perspective that I had not even thought about. Which in itself may be a mere reflection of the oppression I have experienced myself. This leads me to question how the lack of awareness of oppression gives rise and feeds it more and makes the value I place in this project more prominent. It made me realise how patriarchy influenced culture, a culture that I had accepted as normal and the way things were but continually oppressed women within a structured designed to benefit men. I left feeling vulnerable and hopeless as the undoing of such culturally accepted norms seemed immense. I also began to look at society differently, how hospital, University and political institutions were organised and how the methods they employed predominantly served men's interest, especially in a capitalist economy.

The feminist literature I went on to read reflected the issues highlighted at the conference. Prior to me attending the conference, the feminist literature seemed very passionate in its representation of how society oppressed women and in what I though was an over the top way. After attending this conference and thinking more about how patriarchy affects society, I could relate more to the feminist literature and how it seemed to be a true reflection of societal structures and how life as a woman was experienced. I began to see the media's representation of women differently as many representations of women were sexualised. Issues which oppressed women didn't seem to be reflected as such, when human trafficking for the sex industry was covered, it was shown as an issue which was terrible for the mostly women and children involved but not as an issue that wouldn't exist if men didn't use it. The representation of the effects that cuts to state benefits would have on people, not the effect

benefit cuts would have on the majority of carers who are women caring for children and vulnerable adults. This showed to me what little value society, media and politics places on women of all nationalities and unpaid caring roles.

6.10 Midwifery and knowledge production

Through my experiences as a GTA on the B.Sc. midwifery program, I am encouraged to use evidence in line with NMC. However, the PhD process increased my awareness of the lack of evidence used in many guidelines and the flaws within the research used. In addition, the differing use of what I considered to be midwifery knowledge that was used to underpin teaching. Different lecturers used different knowledge sources and gave different credence to different forms of evidence. This, again set me thinking and I thought it relevant to ask the midwives and obstetricians I interviewed about professional training. This was to explore if the ways in which courses are taught or individual lecturers influence practitioner use of the knowledge base and influence individual philosophies. However, most midwifery participants spoke of their training in relation to clinical practice and were aware they had to use evidence to underpin their practice but few questioned this. Many spoke of loving their training and how hard it was but few spoke of the influence teaching or lecturers had on them as midwives, some said they disliked the academic side of their training.

6.11 Reflection on myself as midwife researcher during recruitment and data collection

I did my midwifery training at the hospital setting over 10 years ago, although it is familiar to me there have been many changes in both the physical unit and with the staffing. I had a very positive experience there as a student midwife and I was very inspired by the midwives I worked with. Now as an experienced midwife who has worked in a consultant led unit and within a midwife led model of care my position in this research project can be seen as having insider knowledge of the work of a midwife and of the culture of maternity care within an NHS setting.

I approached the research setting with a dual identity as both a midwife and a researcher, which has presented me with both opportunities and drawbacks. I continue to maintain the professional position of registered midwife and this knowledge and experience has influenced my research interest and question. My self-identification and how I introduce and portray myself within the research setting may has also influenced others' perceptions of me. I

identify myself a practitioner-researcher, I was introduced at a doctors meeting by the obstetric education lead consultant as a “research midwife”. Having an awareness of the setting and the context in which the research takes place is said to enhance credibility of the researcher and therefore more likely to obtain more interest from participants (Robson, 2011).

At the end of the session a consultant obstetrician asked me something along the lines of ‘what do we know and what does the evidence on movement during labour say’. I was a little taken a-back by this and explained the study was more about knowledge acquisition on movement and how we work together with women as obstetricians and midwives. This made me question if my presentation was clear enough to portray adequately the purpose of the study. My initial thoughts were: was he aware of the concept of qualitative research or was he so ingrained in the biomedical model that the concept of what is knowledge is fundamentally already known to him and so my concept of where does knowledge around movement come from does not make sense to him. On further reflection, this incident added to the interview schedule for obstetricians and midwives and added to the analysis of data given by the obstetricians.

I found that midwifery managers were very slow to reply to my emails regarding the project, however as a midwife who has worked in the NHS, I know the amount of emails that are received and the small amount of time available to respond to them. Therefore, I tried to make the majority of my contact to managers via phone calls that was more direct and potentially quicker to in response. After an opportunistic meeting with the consultant midwife, I discussed this. She suggested the two main managers I need to contact and to send the emails to them personally and not via a group email, after I did this a meeting was arrange to present to the midwifery managers at their monthly meeting.

During the presentation to the community midwifery managers about my project, I was asked about my midwifery experience, I assume this was to establish my credibility as a midwife rather than a researcher with only theoretical knowledge of midwifery. Through having explained my clinical experience and the position I held at the university with the midwifery managers and informally with clinical midwives I felt this gave me a position of insider, someone who knows the work of midwifery and NHS maternity services. This is reflected in the interview data with the majority of midwives who when referring to their clinical practice

acknowledged my midwifery knowing by saying 'you know' frequently throughout the interviews when talking about clinical situations they had experienced or using commonly used midwifery acronyms and language.

Prior to interviewing the medical staff, I felt nervous because the majority of my interactions with them as a clinical midwife had made me aware of my place within a definitive hierarchy

The first extended time I spent on the consultant led unit was for about an hour when I was waiting to interview a doctor, who had been called to the gynaecology ward when we were due to meet for an interview. I took the opportunity to observe the interactions on the unit. My initial thought was to take the role of knowledgeable outsider, a researcher who has knowledge of certain aspects of the subject they are studying but is not part of the social group (Adler 1984).

The senior midwife, receptionist and two HCA all asked me if I was ok and if someone was dealing with me, they all seemed interested and helpful after I introduced myself and told them what I was doing there. It seemed busy with staff going from one area of the unit to another, stopping to discuss their work and issues they had. While I was there an emergency bell sounded and staff ran to a room, there was a flurry of activity at the desk as a senior midwife was trying to resolve a social problem with the scant resources available to her. The consultant unit appeared to be prepared for all medical problems through the physical environment, resources and staff available. I also know this as I have worked on a busy CLU. However, a social problem arouse which the hospital did not have the adequate resources to deal with as immediately as the medical problems that arose.

At one point a steady stream of doctors entered the unit, some looked familiar as I had seen them at the meetings I had attended, all walked past me. Though some had met and spoke with me on previous occasions, only one independently acknowledged me. I asked a midwife what was happening and she said they were having a meeting. As I had worked in a similar environment and reflecting on my experience of being greeted as an unfamiliar person by the midwives and support staff this lack of recognition by the doctors made me feel inferior. They mostly all ignored me, whether they did remember me after my two presentations, they did not see greeting a familiar face as part of their role, they were too busy, or did not see acknowledging someone as important is unknown.

The CLU appeared to be somewhere that was not just for women to give birth with their carers', but also appear to be a place where doctors carried out their work either clinically or in the form of meetings.

My first extended visit to the MLU was when I went to interview a midwife participant. I was let into the locked unit via the intercom system and I was greeted by three midwives and a midwifery support worker all sat in the reception area. One of the midwives was known to me from when I worked with her as a student and from her recent MSc module done at the university where I delivered a session. They were all very friendly and asked about my research, the midwife known to me showed me around the unit, showing me the equipment in the rooms and how the environment could be changed to suit the needs of the woman. She told me there was one labouring woman on the ward at that time, therefore one midwife was to be deployed to another area and the other cared for the labouring woman. The difference in the physical environment, the openness of the area, the decoration and the difference in the way the staff there spoke to me was in opposition to the CLU. There seemed to be more ownership displayed through the visual displays that directly represented the women using the unit. There was an awareness of the outside, which was not visible on the CLU, this gave the impression that it was not separate from nature or nature's representation of the passing of time thus making it less isolated from the rest of the world. The staff present made personal connections with me though this may be because it was less busy at this time. Additionally, when I did spend more time on the consultant unit during a quieter shift, the midwives made me feel very welcome and discussed their work and experiences with me.

In addition, in relation to myself as the researcher, I have work experience in other sectors as well as my midwifery experience. I have worked in sales and the service industry and spent over 20 years in promotional work, including the midwifery charity in which I have been involved in the past ten years. Therefore, I feel I have benefited from the experience of communicating with a wide range of people in many different situations adding to my interpersonal skills whilst also having the benefit of the advice from my supervision team.

6.12 Reflection on analysis

This was without doubt the most difficult part of my PhD program and where I felt that having dyslexia really impacted on my ability to think and organise my thoughts into logical coherent writing.

Reading qualitative analysis text just added to the confusion as vague descriptions of finding codes, categories and themes did not help me to pull out what I saw as an overall picture and how the interviews the midwives gave me fitted together. I used large pieces of paper and organised codes and categories into large mind maps that made sense to me and showed an overall picture of my findings. However, a more nuanced way of describing what I saw and felt about my data is what is needed in academia and to come out the other end of my PhD with a thesis. I took advice from a text which said just write, so I did. 20,000 words later, I had a document however, it was a jumble of my ideas and had no really flow with large quotes and notes for analysis.

It was not until I sat down with a supervisor, who I thought I must be driving them mad, and they said just break down all of the interviews into their question and see what the common categories are. This was a eureka moment. With the help of my mind mapping software I organised all of my interviews into individual questions and then grouped the categories.

6.12 Ethical quandaries in analysis

Whilst analysing the doctors interviews, I looked in more depth at the positioning of the doctors which I struggled with as their positioning and how I felt about my positioning as a midwife seemed conflicted from my deeply held ethical beliefs as a midwife and woman.

I wrote this to my supervisors:

> ‘I am analysing/writing up the dr. interviews and I am finding it a bit of an ethical struggle.
>
> The midwives interviews were based on connection, relationship-based care and how this enabled empowerment for women. The women's interviews were around control and what elements enabled women to feel in control, which encompassed relationship-based care. But the dr.'s interviews are a different kettle of fish. Overall, I don't want to completely disrespect the doctors but it is all about control, them in control, connecting to obstetrics as a profession with an end result of safety for women and babies. One of the obstetricians is different, showing great compassion, thought the others show compassion it is very shallow. Though I want to write this I am concerned it will look bad on the obstetricians. it's like, well you don't have a choice in what we do, but we can offer elements of choice to make it nice for you without a deep understanding of what that actually means for the woman, one mentioned a 'nice forceps delivery! It could only be the dr who would think that was nice.’

This was a real dilemma for me, I spoke to a supervisor and we discussed how it was necessary for doctors to have the disconnect that they do in order for them to be able to carry out a lot of their role.

When I went back to the literature during the writing up of the findings, I found that the majority of work around the critique of the medical model of childbirth was from anthropology, a little was from obstetricians themselves, but only a minority appeared to be from a midwifery perspective. I felt I was in difficult territory as though my work will be written in context with the existing literature. I do not want to be seen as disrespecting obstetricians. With further reading and development of my ideas I became aware that obstetricians are not trained in or have awareness of the issues in midwifery that the midwives and women interviewed and myself find important such as control and empowerment. This gave me a greater understanding of the perspectives of obstetricians and why they approach their profession as they do.

6.13 Part time PhD and working

Changing from full-time to part-time studying and working over forty hours a week was a struggle. The mental capacity and cognition need to complete my studies was very limited whilst managing the demands of a management position with a first of a kind maternity care provider. The time I allocated to study was often superseded by work deadlines. Despite this, my role gave me a unique opportunity to be part of a maternity care culture that was outside of an NHS institution and I will forever be grateful for the perspective this gave me. I have had the opportunity to work in a non-hierarchical organisation with strong midwifery leadership. Midwives are able to practice in a social model of care and be more autonomous without the bias of the bio-medical model influencing their practice. It has also given me the opportunity to experience the animosity that is often given to those who challenge the status quo and authority that is prevalent in most NHS trusts. Additionally, I have experienced the intense scrutiny by inspectors, commissioners and regulating bodies that is given to those who push boundaries and challenge the accepted way of organising and providing maternity care. This experience has strengthened my beliefs in the need for change and that maternity care can be delivered in another way. My beliefs in the importance of maternity care to society and the far-ranging impact of empowering maternity care have been strengthened as have the need for feminism in maternity care.

6.14 Emotional labour

The financial difficulties I experienced as a full-time student were only part of the extra work during the PhD process. As a woman and single parent, I also experienced an enormous amount of emotional labour throughout. Whilst dealing with the emotional turbulence of the break-up of my long-term relationship, supporting my ex-partner and two children emotionally was hard work whilst adjusting to my new role. This highlighted to me again the importance of my social support network, working within a caring department and appreciate how flexible working allowed me to care for my children when they experience mental health problems.

6.15 Changing opinions and views

The process of carrying out this research has supported some of my views and opinions and changed others.

As a woman experiencing maternity care and as a midwife working within an NHS trust I was aware of and experienced the power structures and hierarchy. I entered this project with enthusiasm, drive and passion to address what it was within these structures that suppressed the use of midwifery and women's knowledge. I believe that I have identified factors that can support the implementation of this knowledge, yet I am not the first to identify some of them. This has supported my opinion of the general suppression of midwifery and women's knowledge and how this is a feminist issue but I now have the evidence and knowledge to support this.

The opinion that midwifery and women need to engage more with the politics behind maternity care and the patriarchal structures that support it has been strengthened. The data illustrate that women have little awareness of the social and political factors underpinning the structure and provision of maternity care. This lack of awareness contributes to their disempowerment and lack of autonomy by fostering an acceptance of the authoritative biomedical model of care within which women have little control over the way birth occurs.

The biggest change in opinion I have had is in my opinion of obstetrics. Whilst some of my views and opinions were supported, I now have a greater understanding of why many obstetricians think and behave in the way they do. Through examining how obstetricians learn about maternity care and their experiences of being obstetricians I can appreciate how they

view themselves, their role in maternity care and women in the way in which they do. This has increased my empathy and understanding towards the profession as well as given me knowledge to be able to challenge this. The experience of conducting the research, has provided me with a deeper understanding of women's needs and midwives' perspectives which has given me knowledge of how to challenge the medical obstetric model more effectively. It has also given me a greater understanding of the need for knowledge based in midwifery, human rights and relationship-based care.

I also had various assumptions about obstetricians at the beginning of this project. I now have a greater understanding of obstetric knowledge and why it has the authority and dominance it does. The working environment, education, hierarchical structure of staff, use of knowledge, risk and pathology framework and the evidence used, all support a biomedical way of providing a service. All of this combines to become the authoritative discourse, within a business that is politically influenced and financially driven. However, it was my interactions, observations, data from the midwives and stories of the obstetricians who did not choose to be interviewed which also added to this knowledge of obstetrics.

As a midwife, deeply entrenched in midwifery issues, my opinion of midwives has been strengthened by this process. Just like the obstetricians, the midwives' practice and thoughts are a product of the environment in which they work and of their own personal experiences.

My opinion and view of NHS trusts as businesses and the hierarchy and power structures within which they choose to operate has been strengthened by this research. I was aware of this prior to this study and the impact that these had on midwives working within it and the women which it serves. However, my passion and dedication has grown as a result of this project to continue challenging this for the benefit of women.

6.16 Conclusion

I entered the PhD process with questions around my midwifery practice, over the five years I have begun to question bigger issues and look at the wider issues that influence society. I would now find it very difficult to bracket these feelings or separate the feminist self from my researcher self. The position of neutrality is not aimed to be achieved, like Abbott and Wallace (1990) I do not feel it possible to detach myself from my theoretical perspective. The feminist lens with which I have approached this project has been influenced by my experiences as a

woman, a midwife and by my study and therefore could be perceived as a bias. This gives me a greater awareness of the issues raised in the data from women and midwives giving a greater depth to understanding and less of an awareness to the data from the obstetricians possibly not understanding their perspective as well.

Chapter Seven

7. Connection - maternity care which uses and supports women's movement during birth

Schein's (2017) concept of culture is used to analyse the levels of culture within the maternity unit that that show connection. Throughout analysis connections were identified that showed emotional connection rooted in care, compassion and love that led to relationship-based care, empowering midwives and women during birth and that supported movement. Brown defines connection as:

"*energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship*."

Brown (2010, p19.)

This definition summarises how connection was articulated throughout the interviews of participants and is characteristic of a culture based in a social (Walsh & Newburn, 2002) and humanistic (Davis –Floyd, 2001) model of care.

This chapter describes and analyses how the women, midwives and obstetricians position themselves in the context of birth from their personal and professional perspective, identifies how knowledge about movement is gained and used.

Initially themes (See appendix 12) seen as connections were identified in eight categories:

- Emotional connections between midwives as women
- Obstetricians' influences
- Relationships connecting women and midwives
- Connections between midwives, women and birth
- Connecting emotions with knowledge and movement
- Obstetricians and movement
- Connections within the culture of birth
- Midwives and women connecting

These initial themes were further developed using Schein's (2017) concept of culture as an organising device to illuminate the data. Though using Schein's model, artefacts, espoused beliefs and basic underlying assumptions can be deciphered to create an understanding of what creates a culture that uses and shares knowledge about maternal movement during labour and birth. This chapter will examine the artefacts displayed as discussed by the participants, the beliefs that they espouse and discover the underlying assumptions underpinning these that show connection and lead to the use of maternal movement.

7.1 Artefacts

Artefacts are the physical environment and the products visible that are understood through analysing the espoused beliefs and values. Using the analysis of the underlying assumptions, values and beliefs the analysis of the environment is understood as they are so closely connected that you cannot analyse one aspect without also analysing the other.

Artefacts that were predominant in the MLU facilitated movement and supported women to move and therefore physiological birth. The midwives and the women spoke of the physical environment and how this made an impact on women's movement and women's psychological wellbeing.

7.1.1 Environment - women, midwives and movement

All participants had experience of the physical environment in which birth took place. The maternity unit was divided into two separate physical spaces: the Midwife led care area for women who had no identified complexities and a Consultant led area for women who had complexities identified. Midwives and women spoke of the physical environment and how it influenced movement.

> '*you need to have an environment that will facilitate mobility, you need to have the mind-set and belief and that needs to be present in the woman and the midwife and the obstetricians to be mobile that this is the best thing we can do for birthing'* Angela (Midwife, p.11)

To Angela (see table 6 for characteristics of the midwives) the environment did not mean the physical environment alone, enabling movement is more holistic and reached beyond one element to combine psychological elements in women, midwives and obstetricians to provide an overall environment to support movement and optimum birth.

All midwives cited the physical environment as affecting women's movement. The presence of a bed presented a distinct definition between the MLU and the CLU, the belief that movement is beneficial to woman and birth is supported and controlled by the MLU environment.

The MLU environment was described by the midwives as encouraging women to do whatever they want: the rooms are big they can walk round the corridors all of which has a different impact on them:

> *'I feel like it is just much more comfortable so the whole family seems to settle in a bit more and make it their environment'* Donna (Midwife, p. 8)

The women (see table 5 for the characteristics of the women) who had experienced birth on the MLU all commented on the calm environment and how this benefited them and their labour enabling them to be relaxed. Additionally, all women, when asked about plans for their birth all wanted to birth on the MLU as they associated this with a normal birth and more of a *'relaxed'* and '*calm*' atmosphere.

Sue felt during her third birth on the MLU that the midwives '*just let her get on with it'* but '*when I asked for help, they told me'*. Maggie recalls the midwife saying '*don't mind me, I am only here for the last bit'* as she was in the water '*I didn't think about it (Movement) much'.*

With an underlying philosophy within the MLU as birth as a normal physiological event, birth appears to happen within an environment that promotes relaxation, calmness and movement. The midwives and the women reiterate this. With the midwives advising on movement if needed, birth appears to unfold with women experiencing little direct intervention from the midwives or environment. Through how the environment is designed, women can follow their own bodily cues and use movement as and when necessary.

Katie spoke of how her birth '*just happened'* with '*my husband and the midwife there just making sure everything was ok'.*

Within this environment, birth can take place physiologically without being controlled, women benefiting from the relaxed and calm environment where movement is not inhibited. Though the midwives are present, they are still deemed necessary for advice and just in case as if women and birth have the potential to need their intervention.

7.1.2 Environments that support physiological birth

Seven of the nine women were pregnant and wanting to have their baby on the MLU area. The MLU environment was thought to have an impact on labour as they associated this with a normal birth and more of a '*relaxed'* and '*calm*' atmosphere. MLU area was perceived to influence movement by providing an environment in which women can move and therefore supported physiological birth.

Laura describes the MLU:

> '*It was lovely it was massive it was really nice it had a big window … birthing pool, bathroom'* Laura (Woman, p. 10)
>
> *'They don't have like actual beds they just have the big square cushions and big baths and being able to have a water birth I think there is more room to walk around because there isn't a bed in the middle of the room and there isn't monitors and things so it is more just that I will be able to walk around more get into the bath if I want to easily because they have them right in the room'* Olivia (Woman, p. 8)
>
> *'so it was the freedom which then I think led to me feeling more calm more in control than, than just having to go on a bed'* Sue (Woman, p. 7)

The environment of the MLU is perceived to encourage movement and contribute to physiological birth. It puts no physical restrictions on the body leading to a sense of freedom of movement.

This environment is more designed around the woman's needs and the need for movement during physiological birth. After experiencing birth on the CLU in her first pregnancy, Olivia felt that the MLU was *'It's more patient led than medically led'.*

The calm environment and equipment, are seen to influence movement, additionally giving a sense of physical freedom enabling women to be more in control and care being led by women giving them more power.

When having her baby on the MLU, Katie, though she did not expect to be on her back giving birth, and was surprised: *'I didn't expect there to be all the equipment there was in the room'*

The midwife explained the equipment and showed her what to do. Through the environment and equipment, and antenatal education Katie had an expectation of her role regarding movement during her birth, however it was the midwife who made the link between expectation and the reality.

All women planned to give birth on the MLU and although women felt that the environment influenced movement, Katie thought it was more the midwife '*trying to find all the different things to do'.*

In Katie's experience, movement was part of 'doing' in labour, something that the midwife encouraged.

When speaking of birth on the MLU the overriding theme was the positive association women had with being able to do things for themselves, the hope for a normal birth and that they were able to do this in the MLU. Women spoke of their own abilities to '*start on my own*' and '*coping*' and '*managing*' contractions as positive and something that they were proud of achieving or wanted to do.

Women recalled their birth experiences and how the midwife and atmosphere contributed to this:

> *'I was just like really relaxed and every time I had a contraction, I was just breathing through it... I just breathed him out ... the pool was lovely just dead relaxing…. they (Midwives) just leave you to it, like she kept checking me, my blood pressure and things like that but they don't really get involved it's just you'* Quinn (Woman, p. 7)

The calming environment, the midwives lack of involvement in the process and Quinn taking control of her breathing through contractions, the birth of her baby was hers.

The MLU environment was also associated with '*natural birth'*, which is what all the women wanted, or aimed for:

> *'I really do want to try and do it naturally in the water rather than sort of just be sat in stirrups and being pumped full of drugs'* Laura (Woman, p. 3)

To 'try' for a natural birth illustrates the lack of confidence women feel in their own ability to give birth. Laura, after experiencing birth on the CLU spoke of how that was not what she wanted this time, her recall of her past experience shows how she blames herself for the

problems she had in the postnatal period from being overweight, not listening to the midwives' advice and not moving off the bed. This lack of self-belief from her previous experience is carried through to this birth. By birthing in the MLU, the association with calm environment, care from a midwife, birth is supported naturally, and women have control over their birth. This is in opposition to care on the CLU which is associated with drugs and being immobile, where control of movement is taken away physically by stirrups and drugs.

For Laura the ability to stay calm will enable her to have an element of control over her birth:

> *'if you can control it that level … just being calm and letting your body naturally do what it's supposed to do moving around and helping it'* Laura (Woman, p. 15)

From Laura's perspective she can maintain a level of control over her birth when the environment is calm, having the ability to not engage her logical brain and enable her body to birth her baby through movement.

Olivia spoke of birth and how emotionally it is '*such a massive thing to go through'*. She spoke of her perception of birth on the MLU as '*calmer', 'less medical', 'less stressful' and 'less medicalised'* she felt this would contribute to her feeling '*more in control':*

> *'for me feeling more in control of your own body and knowing what you're doing what's happening, choosing your own options will make you feel less panicky with less adrenaline going through your body, it won't be as painful and it will make things go easier, it won't stall labour and make things slower, be better'* Olivia (Woman, p. 16)

Having the ability to be in control of her body within an environment that supports movement, having knowledge of birth from her previous experience and the ability to choose her own options, Olivia feels will make labour better. Having little sense of control, no knowledge about the birth experience and limited choices in her last birth, it is assumed, contributed to a sense of panic. Olivia's hope for a normal birth through being in the MLU will be realised through the environment it offers.

Olivia associated the MLU and level of control with normal birth, she had an awareness that '*things can go wrong'* and if this happened '*they can do what they want'*, relinquishing control of her body to the '*medical profession'*.

7.1.3 Obstetricians and the environment

The obstetricians echoed the findings of the women and the midwives in relation to the MLU and the environment that encourages movement. Whilst Ursula (see table 7 for characteristics of the obstetricians) thought '*everyone knows'* that the MLU area is '*better at encouraging movement'*, Tracy thought that:

> '*rooms are laid out to encourage to feel kind of at home … adopting positions that they want whatever they want to adopt and whatever mobility they want to have'*
> Tracy (Obstetrician, p. 11)

Tracy shows an awareness of how the environment impacts on women's subconscious and by providing this '*home like'* environment women want to sit, walk or adopt positions that they automatically feel most comfortable. She is aware that these specific attributes of MLU encourage movement and was aware that the CLU does not stimulate women '*to get active'*.

The environment was identified by all participants as having an impact on women's movement, the MLU manipulates the environment to accommodate movement and therefore promotes physiological birth whilst the CLU does not.

7.2 Espoused beliefs and values

From Schein's (2017) definition culture is a product of shared learning within the group being studied. This shared learning leads to identity formation that shows itself in patterns of behaviours and beliefs that give meaning to daily activities and gives the group a sense of identity. This project identified behaviours, beliefs and values in categories that showed connection (See appendix 12, 13). These behaviours, beliefs and values were further analysed and developed into two emerging themes: relationships and empowerment.

7.2.1 Relationships

Relationships between women and midwives are central to women's birth experience. All women spoke of the midwife who cared for them and how this influenced their experience. Women spoke of the relationships they had built with midwives which, they had benefited from physically, emotionally and psychologically. These beneficial relationships were formed either in the community, in the antenatal period or on the MLU: no woman spoke of the relationship made with midwives on the CLU. Relationships were based on trust; trust between women and their support networks, trust between midwives and women's and the

trust that midwives have in themselves and birth. Women and midwives valued these relationships and there is the belief that these relationships supported movement and physiological birth.

7.2.2 Women's recall of birth in the MLU

As with the midwives' interviews, women spoke of the connections they had made with midwives and how this positive experience had impacted on their pregnancy and birth. They spoke of the value of these relationships when they recalled their birth on the MLU.

Katie, Maggie, Pat, Quinn and Sue all spoke of the relationship they made with the midwife on the MLU area during their birth.

Katie spoke of the midwives as excellent and how she '*couldn't have asked for anything more'*, the midwife stayed over her shift with her and she recalls not stopping talking to the midwife '*Kept asking the midwife about her personal life and boyfriend'.*

Maggie describes a similar experience:

> '*The people in the room make a difference… the midwives… talking about her kids … cracking jokes … making it a family affair'* Maggie (Woman, p. 4)

Quinn felt her birth was '*lovely'* and '*relaxing*' through the midwives '*leaving her to it'* and not getting involved it was '*just you*'. Sue birthed her third baby in the pool, feeling '*in control'* as the midwife let her '*sort of go with it'*. Pat also describes the midwife being present but not interfering and checking occasionally '*she just sort of stayed out of the way it was really relaxed and really calm'.*

From these women's experiences of birth in the MLU, the midwives who cared for them appeared to be reactive to their individual needs: through building relationships by joking and talking about their personal lives, or by stepping back when needed, to be present and keeping the atmosphere calm. Connecting with women as necessary, building relationships based on individual women's perceived need and circumstances.

The midwife holds the power on which approach is taken. The midwife can allow women to '*just get on'* with birth or '*interfere*'. Having little experiential knowledge of birth women have the potential to be frightened: through enabling a calm and relaxed environment and not interrupting a woman if necessary, the environment is equalised as no extra anxieties are

added by interfering in the process. This can be challenging to midwives who do not care for women during birth in women's homes as it requires an understanding of the power dynamics both in the work environment and social status (Leap, 2009).

Pat spoke of the attachment she formed with her midwife during her first pregnancy and spoke of how she had a '*really good relationship'* with her, but it was not just the relationship, it was the care she gave '*if I needed her she was there'.*

The ongoing relationship and the connection made with her midwife made a positive impact on her pregnancy experience by providing physical and emotional support. A relationship had been formed but also the midwife had made herself available to Pat if needed. This enabled the midwife to connect physically and emotionally to Pat.

Maggie reflected on her second birth experience and the care she received from the midwife:

> '*if ever I could go back and find the woman and give her some flowers and say thank you and what a massive difference it made I would do, definitely I have thought about it often, I thought about it for 20 years you know what I mean, and felt that selfish, what a ungrateful bugger you know, you never got to say thank you'* Maggie (Woman, p. 15)

Maggie, after 20 years, still thinks of her birth experience, showing how birth and the relationship with the midwife affected her birth and still does after a significant period. Having had three experiences of birth: the first medical, the second on an MLU area and the third on an MLU but experiencing a transfer to CLU, the care she received from the midwife during her second birth puts the relationship into context. From not being spoken to during her first birth and the change in environment and attitude of the midwife during her transfer in her third birth. The impact of the relationship with that midwife, Maggie attributes to her positive experience, one that she is appreciative of and grateful for, but only upon reflection attributes it to the relationship, showing the intensity and the importance of this relationship on her birth experience.

7.2.3 Relationships and movement

When asked about the best source of information around movement during birth, women predominantly spoke of those who they had a relationship with, midwives, friends and family. These were valued relationships and were believed to hold the most relevant knowledge.

Roma had built a relationship with her massage therapist midwife; Maggie spoke of the '*friendly*' relationship she had with both midwives during her MLU births and Katie spoke of the relationship with her midwife during pregnancy and birth:

> *'I think it's quite nice, midwives build a really nice relationship, they don't feel like a doctor or a nurse, they feel like a friend'* Katie (Woman, p.16)

Katie thinks that midwives '*naturally*' must have, the ability to put people at ease. As a woman, who had not experienced birth before, the midwife was pivotal in her positive experience and therefore offered what Katie perceived as the best source of information. Katie built a relationship with her midwife during her first pregnancy and asked for the same midwife in this pregnancy: this relationship was evidently an important part of her maternity care.

Laura, Nicky and Quinn said they would ask friends, family members and:

> *'People… (Who) have given birth before, who have had the same experience'* Nicky (Woman, p. 5)

Olivia spoke of the midwife as the best source of information for movement, however this was based on *'It's their job isn't it, they have had training'.*

As a nurse herself, Olivia speaks of the complete trust she has in the '*medical profession'*, referring to their knowledge and experience rather than them as individuals.

All the women expressed the best source of information around movement would be from someone else. Only Nicky said that she would see what would be best at the time. Yet when Maggie, Pat, Quinn and Sue laboured uninterrupted, they spoke of moving without instruction.

7.2.4 Relationships and empowerment

> 'The most powerful thing we can do as professionals is to empower the parents of the babies at whose birth we assist'
>
> (Mary Cronk, 2000)

All of the midwives spoke of the relationships they built with women and how through doing this they believed they could empower women to have choice and control during their birth.

As a leader in the MLU, Geraldine's belief around her role as a midwife and how this affects women's ability to use movement is enabled.

> *'I think that midwives should be partners in care with women so there shouldn't be a sort of inequality in that relationship and there shouldn't be some sort of power'* Geraldine (Midwife, p.7)

Through equalising the power relationship by using her experiential knowledge of how women use movement in labour, and giving women '*permission*' to follow her own body, the woman has the power to be able to decide if she wants to move and what is most comfortable for her, making the labour hers.

Maggie spoke of her care in two MLU units. One 21 years ago in another area and the other four years ago in this unit. During both experiences, when having a physiological birth, she spoke of the midwife and how she gave care '*she didn't automatically come and do things for me I was, I was respected I suppose'.*

Through asking if help was needed, not assuming, Maggie felt respected, equalising the relationship through not infantilising her and therefore respecting her physical ability and capacity as a woman, in control of her own birth experience.

7.2.5 The perception of relationships as central to information

Information is sought from those with which a relationship is formed and have a shared experience implying that trust and empathy are important for reliable sources of information. However, only one of the women interviewed recognised herself as a source of information and though four of the women moved during labour and birth, they had used their own internal knowledge but did not recognise this. This shows the impact that the relationship between woman and midwives has on movement, whether that be to inform woman of movement if needed or to hold space for woman so that they can move as their body needs. Interestingly woman only spoke of this as happening in the MLU that suggests that relationships that support woman's movement are more difficult to establish on the CLU.

7.3 Espoused beliefs and values

7.3.1 Empowerment

Throughout the interviews midwives spoke of empowering women through using movement, women spoke of being in control, an element of which was being able to be free to move. Through being or feeling empowered midwives and women were able to use knowledge of movement, facilitating women's control over their birth through making informed decisions. By using informed consent and choice to support movement, birth was supported physiologically, psychologically and socially and thus women were empowered. The use of knowledge of movement was specific between women and other women they knew and women and midwives. Midwives were viewed as sources of knowledge about movement and thus had the ability to empower women to use movement. Empowerment also came from women's ability to use their instinctual knowledge and their own previous experience as birth was recognised as individual. Most obstetricians also spoke of the importance of control for women, supporting women's choice and human rights but did not explicitly express the idea of empowerment.

7.3.2 Empowerment: using knowledge to empower women

The midwives articulate the idea of empowerment very clearly and positively as part of who they are as a midwife and empowering women through how they give care.

> '*My primary focus is to empower women to make the right decisions for them'*
>
> Angela (Midwife, p.8)

Angela's approach involves giving women the power to control their own decisions based on what is right for them in a more holistic approach (Davis –Floyd, 2001).

Barbara spoke about helping women become strong as part of the importance of her role *'at the end who can go home feeling much stronger, much more capable'.*

Barbara defines herself as '*woman orientated'* she sees her role as having the ability to give advice to make women stronger and more capable. Through enabling women to feel positive and in control of their birth experience Barbara went on to say that she did this through enabling women to make their own choices as she has seen women *'broken'* by childbirth. However, Barbara is positioning herself as the one giving advice to enable women to make choices: if she has seen women '*broken*' from not having choices, it suggests that this is not a

normal way of working in maternity care. Barbara's experiential knowledge of how women's control is diminished during birth and the reality of how this affects them psychologically for the rest of their lives, is a motivating factor in Barbara's practice.

7.3.3 Empowerment: decision making and informed consent

Wanting to empower women was also shown when midwives were approaching informed consent in decision making:

> '*Are you happy with the decision? Have you read your leaflet? … I want you to understand'* Donna (Midwife, p.2)

Donna shows how she ensures women make decisions on whether they accept procedures through trying to make sure women engage with the information contained in the 'leaflet'. By doing this, the aim is to ensure women gain an understanding of what they are accepting.

Ursula felt that the general expectation regarding movement by women was to be immobile and if you tell women you expect them to be upright then they are more likely to do this. She also recognised that it was her role to challenge beliefs if she thought it may have a positive impact on labour and, she saw her role as encouraging women:

> '*encourage positively as much as you can from every aspect from everyone who goes into the room and meets that woman on the journey and if she still doesn't want to get up and about that then that's her right and we should respect that and tell her that's fine because at the end of the day you want to feel that she was in power and she was the one that made the decisions in Labour'* Ursula (Obstetrician, p.12)

Again, Ursula sees encouraging and promoting physiological birth as part of her role and an expectation of everyone else involved in maternity care. She also recognises a woman's rights to decline. Additionally, Ursula referred to respecting a woman's decision and making her '*feel she was in power'* and making decisions. The midwives referred to empowerment and decision-making as an element of the care they gave. Not all of the obstetricians alluded to this and often spoke of making decisions around care in the framework of safety, however this was in the context of high-risk care and not being directly related to questions about women's choice and control.

7.3.4 Empowerment: choice and control

Midwives and obstetricians all spoke of women choices and how this enabled women to feel that they had control over their birth experience.

Fiona spoke of women's birth plans:

> *'If you had got her one thing that she wanted on that, and she would feel like she wasn't completely out of control'* Fiona (Midwife, p. 3)

Whilst recognising the importance of respecting women though listening to women's choices, Fiona recognises how this has implications for feelings of control and achievement. However, Fiona sees herself as the one responsible for getting the woman what she wants not enabling the woman to get it for herself. Whilst this was said in relation to women being cared for in the CLU, where care in birth is regulated and monitored, it shows a pervading paternalistic attitude of the care given and the midwife in the position of having the ability to control, and the woman having to compromise her choices for the sake of the fetus. Whilst the choices available to women during birth can be described as a 'menu' (Leap, 2006), women's choices during birth can often hold different meaning for the woman and her care providers.

The obstetricians recognised how important control was for women for a positive birth experience. Zoe spoke of women's control and how there are not many situations where woman cannot have some control. Winnie spoke of how hard it was to take away something that a woman had chosen for her birth:

> *'the woman needs to feel like she's got control over what's happening and I think that's quite important in her enjoyment of that experience as well, sometimes I find the most difficult thing is when you've got a particularly high risk woman that may be ideally would love to go on birth suite in a pool and then you're saying, well no, that's not what we'd recommend if that's what you want then we would support you but that's not what we recommend'* Winnie (Group interview, p. 3)

Both Zoe and Winnie recognise how control makes an impact on women's birth experience and how they, as obstetricians, have the ability to support women's choice and enable women to exert some control.

7.3.5 Empowering Interactions

Interactions between women and midwives were perceived as empowering women:

> *'Her (Mentor) interaction with women was amazing, just made them feel like the centre of the world you know… I needed to see how a really skilled midwife can manage a situation and she could'* Donna (Midwife, p. 3)

Donna perceived her mentor to be efficient in medicalised birth but the attributes that made her 'amazing' was how she interacted with women and how Donna perceived her mentor made them feel. Through making women feel, she helps to make them feel in control, the centre of what was happening: connecting them to their birth experience and using midwifery skills to manage a perceived situation rather than an individual woman. Donna as a woman and a student midwife valued learning the midwifery skills which support women psychologically and emotionally, in line with a social model of midwifery care based on the interactions within the relationship between woman and midwife and how she perceived it made a woman feel.

7.3.6 Movement and empowerment

The midwives used movement as part of physiological birth to empower women through them being part of the process:

> '*How can I make you more comfortable? Where do you want to be? Whatever she wants, what can we do to help get to you that position? ... You could try this position, you could try that position ... see how you feel'* Jan (Midwife, p. 11)

Jan is designing care around the woman and her comfort, using knowledge of how women move in labour and knowledge of the environment. The woman is directing care from suggestions made by the midwife and her own bodily knowledge. Jan feels asking women about what movement and position they want is important because of the impact it has on her experience the rest of her life:

> '*she is not being told what to do, this is her experience she has having a baby ... it's about this facilitating the delivery of her baby and how you get to that is important and 'I did that' and 'I did it without this' and 'I did it doing that'* Jan (Midwife, p.11)

Jan views the midwife's role is to facilitate the birth by making the experience of birth the woman's with the woman in control. She is the one experiencing the labour, if this can be made positive and the woman felt in control by moving, she can take empowered ownership of the experience.

7.3.7 Midwives as a source of knowledge for women

Women spoke about information around movement being received from midwives during labour and birth, midwives during labour were seen by all women to be the primary source of this information. Maggie thought that this was '*a bit late when you are in labour'* and Quinn felt she '*didn't think she asked'* at the time. However, Laura thought that the midwife would give her '*choices and options'.*

There is an expectation that the midwife has the knowledge and ability to inform women during pregnancy and birth. Knowing women individually and her individual circumstances was a reason why women said they used the midwife for information. Katie spoke of her birth and how the midwife was wonderful:

> '*They had me in all sorts of positions, they had me walking around, and she was actually holding me while I was going through the contractions'* Katie (Woman, p. 1)

Pat's first baby was in a back to back position and the midwife *'told me what to do and showed me'.*

The midwife is recognised as possessing authoritative knowledge of birth and movement. Whilst women did say they used specific internet sites and apps, this was '*taken with a pinch of salt'* and was not felt to offer specific enough information.

Maggie felt it important that people '*have to know'* about their choices around movement, believing that '*no one's right, no one's wrong*' and that the midwife is the one to give this information about movement:

> '*I think it's whatever you're comfortable with…people have to know about these choices and about these variations, so they could try …So, if something is not working you don't have to put up with it there has got to be alternatives'* Maggie (Woman, p. 16)

Labour and birth are seen as individual and movement something that is integral to normal birth and comfort. As a woman, during birth, Maggie thinks there is no right or wrong way to use movement, but women must be aware of their choice around movement and how it can be used. Midwives are providing this information but ultimately the birthing woman has control over her body and how she chooses to move. Through there being options of

movement and women's bodily autonomy, '*women don't have to put up with'* staying in one position.

When women have not laboured before, Fiona speaks of how she views her role as one of support and '*trying to make it as easy as possible'*:

> *'listen to your body' and they often get very fidgety and 'your body telling you need to move let's do some dancing or whatever we need to do' and they listen to you and they try to out if they hate it they stop it'* Fiona (Midwife, p. 17)

Women who come into labour with either none or different beliefs about movement, Fiona feel's having a 'trusting relationship' with the midwife helps the women in labour through helping her listen to her body. This relationship enables the midwife to use her knowledge about birth and using movement to enable the woman to use the signals her body is sending to her.

Ursula, Val and Winnie, thought that women learnt about movement from their midwives, whether this be their community midwife or the midwife caring for them during labour. Yvette thought that women learnt about movement from the NCT, antenatal classes and posters in the antenatal clinic and on labour ward. Winnie also thought that women get information from their friends and on-line. And Yvette and Ursula thought it was from those supporting women in labour. This is like the midwives' and women's findings. However, for Yvette movement was influenced by women's own beliefs and individual personality:

> *'it's about personality and what women actually want and I think sometimes a lady can have a birth plan that actually says yes I want to be really active and then confine themselves wanting to curl up on the bed and actually that's fine …. I think sometimes they seem to have the opinion that they have to be on the bed and they can't move'* Yvette (Group interview, p. 12)

Yvette sees the choice of movement as being down to individual personal factors. Until birth is experienced it can be unknown and therefore an individual's reaction to it, dependent upon how it is perceived at the time. It could be Yvette's personal experience of birth that has given her this perspective and comes from a more individualist perspective than the population-based perspective which is evident in medical literature.

7.3.8 Woman and their instinct as a source of knowledge

Some midwives feel women have instinctual knowledge of how to move during birth, it is seen as natural and common sense, but as birth now takes place in institutions the midwives' role is to educate women on what should come naturally and enable the space for this to happen, reconnecting women with their own bodily knowledge.

Barbara thinks a woman's own instinct is what informs her of movement:

> *'it is the instinct as well of letting your body do what you want isn't it and where does everybody get that information from they have written it down because they have observed it haven't they, so it's what women do now doesn't come from the book the books come from what women have always done'*

Barbara also feels the role of the midwife is to 're-educate' women to their instinct:

> '*Why not have a bash at that? Do think this would help you? So, we are trying to re-educate women to instinct aren't we which is quite sad…that's your job isn't it'* Barbara (Midwife, p.4)

Barbara sees the position of the midwife as someone who is knowledgeable in the way in which women move during birth. The role of the midwife is to support the natural physiology of birth from being with women in labour and their formal training of anatomy and physiology. However, Barbara believes women already have this knowledge that midwives have learnt as instinct from observing many births.

Through midwives spending '*hours by the woman'* and watching and being '*with women'* midwives have learnt what movement women make during birth:

> '*because you learn from what women tell you and you learn from your experiences and watching women in Labour and watching how they behave and what she does and watching how babies are born and I think all the time ... I learn'* Geraldine (Midwife, p. 6)

Individual women viewed in a holistic model of caring enables the midwife to learn. Geraldine thinks this is valuable:

> *'working in normal birth I think because you don't realise, I suppose, how medical it is, you do something like this, and I've learnt so much about what is normal and the variations of normal'* Geraldine (Midwife, p.6)

Using her experiential knowledge of how birth is viewed, from a medical perspective, Geraldine feels she has learnt more about normal birth in the MLU area and how this has contributed to her knowledge of what is normal. This has created an insight and a wider knowing of the system, how it defines normal birth and how this is different in an area where normal birth is enabled. This tacit knowledge of maternal movement during birth can only be gained from experience in comparison to more scientific ways of knowing based on scientific evidence.

Irene sees being in an upright position as being '*common sense'* and instinct saying:

> *'you certainly don't poo in a horizontal position using all your energy and your abdominal muscles … so why would you want to be in that horizontal position to push out a baby I mean that's just plain common sense'* Irene (Midwife, p. 9)

Again, using knowledge of anatomy and physiology, relational to other body functions which is common to everyone, Irene sees being upright as commonly held knowledge. Also, she sees this as natural instinct.

7.3.9 Women's own experience as a source of knowledge

Women's perception of where to get the best information around movement was from women who had a connection to them and the experience of birth. Women spoke of speaking to their mums or sisters, friends who had had a baby. However, while women discussed their birth experience with friends and family, none of the women spoke of movement during labour and birth apart from Quinn.

Quinn spoke to a close friend who had a baby earlier in the year '*she had stood up and crouched down at the side of the bed and we had talked about moving around'.*

Whilst Katie spoke to a friend about her birth, movement was not mentioned:

> '*it's like it doesn't seem to be the important but it's the actual nitty-gritty of getting the baby out so I guess it would be, that if people would say what worked for you in labour maybe something like that would be quite nice'* Katie (Woman, p. 12)

Olivia felt that speaking to friends about their birth was more talking about:

> *'what has happened to yourself, to your body and I think it just helps to compare other people's births and get not necessarily information for people just to talk about it'* Olivia (Woman, p.12)

Most women did speak to friends and family about birth. When asked about their births for this study, the birth was recalled in relation to times and cervical dilatation, what was done for or to them by the hospital staff and how they felt about the experience. This illustrates how narratives shared between women of childbirth have taken on a medical discourse in everyday recounting of their experience, an observation also made by Neiterman (2013). Nicky felt the best source of information was from someone who had experienced birth, people who had had the same experience and who '*know what you are going though'*, whilst she looked at forums and online, speaking with her friends and sister enabled knowledge which was:

> '*More like personal really and can have more of the conversation about it …. You can have like proper conversation ask questions and get a bit deeper into it'* Nicky (Woman, p. 6)

Making information personal, something that relates on an individual level, also something that is two-way, responsive to knowledge and information needed rather than standard information that can be given from an authoritative or unknown source is what is preferred by Nicky.

Sue who had had three children thought she had got some good information on movement from books she had read, but for her, the best source of information was '*you've got that knowledge, that experience from last time'.*

Lived experience of birth and the experience of the hospital system in which she had her children had given Sue the best knowledge about movement. Knowledge of her own body and her own experience of the birth environment from her own perspective. Again, Sue showing agency and belief in her body's experience as being more superior to authoritative knowledge.

Having already experienced birth and learning from her experience following birth Olivia thinks this:

> *'makes me feel more in control this time knowing what is coming and knowing how it is going to feel …. I think I will feel more in control and more what's the word, more happy with how the labour will go because it will be me who dictates it more than the doctors'* Olivia (Woman, p.17)

Maggie, Pat, Quinn and Sue all experienced birth in a pool in the MLU: they spoke of the calm and relaxing environment and how the midwife gave little instruction, but all recall moving around in the pool.

Women spoke of how they felt they would influence movement themselves, from previous experience and research (Katie). After her previous experience, Laura felt more prepared to '*do it the way I want'* and Roma said it would be down to '*how I feel at the time*', Nicky spoke of when in pregnancy '*when I'm in pain I get up and walk around'.*

Therefore, she would do the same in labour. Roma felt that movement in labour was down to her and what she thought was comfortable at the time:

> *'it all depends on my own body really as to what happens as to how I feel how I need to move but I want to try and keep moving as much as I can'* Roma (Woman, p. 10)

Though Roma plans to use movement as much as she can, she also sees movement as depending on her body and how this will tell her how she needs to move. Despite gaining information on movement, she feels the defining factor on her movement will be her body's reaction to labour and how she feels about it.

7.3.10 Individuality of birth

Most of the women spoke of the individuality of birth, not just in a physical sense but how individual women psychologically perceive birth.

Pat thought that information and ideas gained by women impact on their frame of mind and research prepares you however:

> *'no one can never tell you how your labour is going to be but if you have got the information you are relatively prepared for it: that makes a big difference in how you deal with it'* Pat (Woman, p. 19)

Pat recognises the individuality of labour and birth and how experiences are different and how individual women deal with their experiences differently. However, information about birth helps women prepare for this, empowering themselves to '*deal with*' the physical and psychological process.

Maggie thought during birth that *'You can only act and respond to the here and now'.*

Whilst Maggie recognised the individual response to birth, she also recognised its temporality. This was in relation to how individual women use movement, and what the available research points to and how this is used depending on what is felt to be best at the time by the individual women. Considering the expert authoritative voice – research, the individual woman's choice and the circumstance at the time. Maggie also recognised 'things change constantly' how research changes, how ideas and thinking evolves and individual responses need to be receptive to everything that is happening at the time.

7.3.11 Empowerment as an effect of relationship-based care

The midwives interviewed speak of empowering women through the care that they provide. Through women being the centre and focus of care, the giving of an informed choice, explicit consent gained before procedures, respecting autonomy and the relationship between the woman and midwife, a social model of relationship-based care is facilitated which empowers women.

Involving a woman's social support network – partners, family members and friends who have personal relationships with the birthing woman puts birth within the context of the woman and her relationship with the people who are significant in her life.

Women and obstetricians view midwives as the primary sources of knowledge of movement as they have knowledge and experience of physiological birth. It is also believed by most obstetricians that women learn about movement from their midwives and one who thinks that movement is individual to the woman during her personal experience.

It is perceived by the midwives that women have an instinct to move during birth and it is the role of the midwife to enable women to do this as they have experience in observing birthing women. This instinct is related to physiology and the normality of birth as a bodily function.

Women used a variety of sources of knowledge about birth to increase their knowledge and understanding of birth, the most cited being women with whom they had a relationship who had experienced birth. Women also sited their previous experience, and their own bodily experiences of informing them of the movement they needed. Whilst women use this knowledge and understanding of birth the individuality and temporality of birth is also recognised.

7.4 Espoused beliefs and values

7.4.1 A positive working culture

Midwives and obstetricians' beliefs of a positive culture is a culture in which knowledge was shared and learning took place through discussion, collaborative working, sharing and learning. This positive culture facilitates learning and movement through a shared philosophy and values that respect women's choices and support physiological birth.

7.4.2 Learning culture

The culture of a unit was seen to have a direct impact on learning. Both Elizabeth and Hannah trained and worked in what they described as (separate) small maternity units. They describe their experience of the culture in these as being very different to the large unit they now work in. Hannah describes this as promoting 'a *culture of learning because you, you're very much all working together as a team'.* Within a smaller unit, working together as a team, with senior midwives taking responsibility for student midwives who they mentored throughout their training, contributed to a culture of learning. Hannah talks of her experience of training as different to what seems to be current practice in this unit.

Elizabeth felt the overall benefit of working in a smaller unit were:

> *'it created a better team environment having that more intimate relationship with people… they knew you better … everybody trusted each other more you could come out of your room and say oh I have got this that and the other and what should I do and you would have a discussion about it and you would get advice rather than being told what to do'* Elizabeth (Midwife, p. 1)

This enabled relationships to be built, allowing everyone to be known to each other, the ability to discuss and seek advice that has a sense of equality rather than hierarchy. This more 'collaborative' way of working was also an aspect of the culture in the MLU, Elizabeth also thinks being exposed to this as students is beneficial:

> '*We do have a lot of coming out and saying what do you think? and supporting each other and having a chat that way and bouncing ideas off each other and I think it's nice the students have all commented sometimes you don't know and you sometimes you come out and ask your colleagues and I think it's nice, it's nice of them to see midwives working in that way and working together to support each other*' Elizabeth (Midwife, p. 2)

Working in a small unit, Elizabeth and Hannah felt, contributed to a learning culture through the intimate relationships this enabled and how this contributed to teamwork, promoting an environment where issues can be discussed, and collaborative plans made. Members of the maternity care team are connected through knowing each other, trust, support, working together, more experienced staff working with students all contributing to a culture of learning. Elizabeth and Hannah having experience of this and Elizabeth working like this in the MLU, having students comment on this suggests this is not a usual way of working in all areas. This contrasted with working in a large unit or CLU.

Tracy felt that as a large maternity unit there was a '*lovely sense of working together*' and '*shared purpose*' which was '*a skill to achieve':*

> '*a good ethos ideally caring and nurturing each other in an educating atmosphere then people who are like-minded will be drawn into that, those people who value those criteria will appoint people who share the same kind of values and then from that the unit grows and likewise if there is bad attitudes … very difficult to pin that down to write a job description with those kind of things in it but it's those kind of soft factors, the human factors'* Tracy (Obstetrician, p. 8)

The atmosphere of a unit is seen by Tracy to have shared values between people, when these '*good*' values are shown it multiplies in others. The control of the '*ethos*' of the unit is down to those who employ people and the criteria on which they judge them to be suitable. How these criteria are described and shown are '*soft*' implying that they are not easily described

but within a person. An ethos represents the perceptions of the people working within a unit and the principles and traits that they have which are positive or negative and either attract people or prevent them coming to a unit. The mutual caring and nurturing between staff are seen to contribute to the culture that is gained within a unit that contributes to education.

Elizabeth and Hannah think that the elements of the culture which are visible – the size of the unit- contributes to the culture of learning but it is the shared espoused beliefs and values of the team which they state are present, elements which Tracy also thinks contribute to the positive learning culture. However, Schein (2017) states that it is the basic underlying assumptions that determine behaviour, perception, thought and feeling rather than espoused beliefs. Tracy, from the dominant profession and in a senior position on the CLU having been socialised in this environment isn't aware of the culture of the MLU and their underlying assumptions which is the driver for the midwives espoused beliefs.

7.4.3 A culture of learning and sharing knowledge

Knowledge around movement is learnt by midwives from being with women and watching and learning from individual births, this is enhanced when working in the MLU area as normal birth is the focus and all the variations of normal are observed and learnt. Because of their shared philosophy colleagues are asked to come in for '*moral support'*, 'a *different voice'* or '*different ideas*', Elizabeth says she '*values their experience and expertise'*:

> *'sometimes they will think of something obvious that you have missed or shall we do this and you say oh I didn't think of that or they back your plan, what you're thinking because at that point you are thinking, am I missing something and they may come in for a bit of backup really'* Elizabeth (Midwife, p.4)

In an area where normal birth is supported, midwives value other midwives' knowledge, either for suggestions or support. Through Elizabeth asking other midwives and questioning herself, showing '*vulnerability*' that she could be wrong, this is an open and accepted way of practice in this area.

The focus in the MLU is on normal birth and promoting physiological birth, additionally:

> *'It's quite a safe environment really for people to share things and students in particular I think they find it quite safe place'* Geraldine (Midwife, p.5)

Geraldine speaks of an approach to learning that is collaborative between all midwifery staff and students, an attitude that learning is ongoing, that midwives learn from each other within an environment which is '*safe*' enables *'things'* to be shared in a way that does not feel unsafe or unequal.

7.4.4 Shared philosophy and values

The exhibiting of philosophy, beliefs and values that are shared was conducive to a positive working culture for midwives. Geraldine said she would have left her midwifery training if she hadn't got a place with a certain midwife as she was the kind of midwife she would like to be (She was) '*very approachable and very caring nothing seem too much trouble someone that you would gravitate towards'.*

The draw for Geraldine seemed to be to someone who considered her emotions and therefore fulfilled her expectation with whom a caring relationship could be built. Geraldine's perception of this midwife was someone who appeared to show compassion as defined by Clift and Steel (2015): compassion defined as behaviours such as listening, supporting, reassuring, helping, giving time and being constant and is viewed as necessary in providing care (DoH, 2012).

Midwives sought information from midwives with the same mind-set and outlook on normal birth as themselves when on the CLU. It is not expected that the obstetricians would have knowledge on movement as this is normal birth which is distinct from medical birth. The CLU is for women experiencing complications with the dominance of medical expertise. All participants described a distinction between the MLU and the CLU and a distinction between what midwives know and their realm of practice and what obstetric staff know and their realm of practice. However, there was a difference in what knowledge was used.

Seeking knowledge on movement on the CLU midwives would ask other midwives:

> *'One's who have had a lot of experience in promoting normality and the ones who do promote normality'* Fiona (Midwife, p. 8)

> *'You know sort of keeping everything as normal as possible without having too much intervention somebody is like-minded'* Jan (Midwife, p. 10)

Normal birth appears to be an important outcome: seeking advice from someone who has knowledge of normal birth and uses knowledge around movement in labour to support normality was the ideal person to ask. Jan is aware of the effect of someone who did share her views on normal birth and how their knowledge could impact on the woman and her birth in keeping birth normal. As she was working on the CLU, she felt her views were not shared by everyone as someone who is not like-minded would use intervention rather than movement to support normal birth. Whilst working on the MLU the midwives appeared to share the same outlook on birth as a normal physiological process that is supported by maternal movement. Knowledge of birth and movement was shared and discussed between all midwives, this is reminiscent to what Wenger (1999) describes as communities of practice: groups of people sharing a concern or passion for something they do and through regular interaction, learn how to do it better. It appeared from the midwives that the midwives working on the CLU sought out midwives who they believed to belong to this community to share their knowledge and experience when supporting normal birth to get support for themselves.

7.4.5 Multi-Disciplinary Team learning

An aspect of the culture of a unit that was thought to have a positive impact was shared learning between all members of the team. Winnie felt that as part of the maternity care team there is a '*need to help each other'* as '*we all want the same outcomes*'. Tracy and Angela also reiterated this perception of the maternity care team having the same objectives.

Ursula thought that more could be learnt from the team coming together but on the CLU environment this is difficult. Val however talks of learning through communicating:

> *'talking through a situation so if it's an emergency situation you tell each other what you're doing and thinking … vocalising those fears to senior midwives I think is always helpful because then they basically know if you are worried they know to prepare the situation if things don't go straightforward and they know you are not just jumping into a situation without thinking about it'* Val (Group interview, p.9)

Communicating to have the support of your colleagues and to give reassurance appears to be a way in which trust is gained. Learning about each other's practice by sharing thinking and fear and showing vulnerability enables a culture where learning is enhanced in the team. Val

thinks optimal learning happens through working together and communicating your actions, thoughts and feelings during an emergency. This learning is about the obstetricians justifying their thoughts and action to engage the help of the senior midwives and gaining their trust through verbalising their thoughts and fears. Val recognises the senior midwives' knowledge of physiological birth and their position on the CLU. The tactics best used to engage them is show the 'common sense' behind their actions which must be gained by the midwives.

The culture of the unit was an important factor for learning for both midwives and obstetricians. Tracy thought that the culture of a unit dictates how people behave, work together and thus are able to learn. Wanting to be involved and the leadership qualities shown by the consultants was a factor that Ursula thought made her colleagues want to learn:

> *'it's about wanting to listen to people who are talking firstly, it's got to be someone that can talk and can involve people and I guess agree what people want to learn as well as a leader not just deciding yourself'* Ursula (Obstetrician, p.5)

The CLU is a place for learning for obstetricians as this is part of their progression from a junior doctor to a consultant. Therefore, learning is part of their role and teaching is part of the consultant's role. For this to be effective, skills that focus on the needs of those learning are seen as necessary.

7.5 Basic underlying assumption

Behind participants' espoused beliefs and values basic underlying assumptions were found; these assumptions were based in connection, the key cultural dimension to supporting women's movement during labour and birth. This connection was based in love, compassion and empathy based in a physical, psychological, emotional and sociological understanding of women, movement and birth as a lived experience. Understanding birth as a lived experience, understanding birth as a social event, understanding the intense emotion of motherhood added to compassion shown. Participants understood that movement was part of physiological birth and spoke of how they gained this knowledge; it was the connective themes in the basic underlying assumptions alongside the understanding and knowledge of physiological birth that enabled this knowledge to be used. This connection and use of knowledge were more prevalent in the MLU environment but were also present within individuals rather than in the culture alone.

7.5.1 Understanding of birth as a lived experience

Personal experience of birth a greater understanding of birth to participants. Some were inspired to become midwives through their expectations of what they thought midwives did from their own birth experiences.

Donna's expectation of midwifery was through a positive experience of receiving midwifery care during her labour and birth.

> 'It *was just simple little things …. I could do that... I know what a difference it made in my life'* Donna (Midwife, p. 1)

Donna referred to the things that made an impact on her most around her experience as '*simple little things*'. While emergency surgery had affected her physical wellbeing and the technology had monitored the situation, the care and compassion she had from women caring for her and talking to her is what made a difference and was motivation for her to become a midwife.

Ursula felt that it was her own experience of normal birth that enabled her to relate to women better:

> '*I can see why women want to encourage everyone to be as normal as possible because that's what benefited me in my childbirth but I can also, I think I can recognise, when things aren't going right and see that as a separate, l almost as a pre-emptive, more easily I think than perhaps if I had had three sections or three difficult labours and things I think I maybe would have veered more away than feeling I was in touch with normality'* Ursula (Obstetrician, p.2)

Ursula reported that her personal experience of birth gave her an insight into normal birth and the benefits and importance of this. This has added to her knowledge of normal birth giving context to '*when things aren't going right'* as something which is known. Ursula also feels this rather than thinks. Feeling is an aspect of knowing from a lived subjective experience, thinking is cognitive experience where knowing can be gained from a theoretical objective perspective. This feeling of normality is seen as something that can be '*veered*' away from without this experiential knowing.

Ursula also felt that her experience of normal birth contributes to her skills and knowledge as it makes her '*pro-normality'* when compared to some of her male colleagues. Because they are men and therefore haven't physically experienced birth, they lack this understanding. Additionally, the insight that being a mother and having time out of her career added to her outlook:

> '*when you come back it makes you have fresh eyes on things and makes you see, I don't know, where I think I see the women as people more than before I had children because you can imagine them at home in their other lives as well and not just these people sat in hospital which is, I think is what makes a difference around the rest of the medicine really'* Ursula (Obstetrician p. 3)

Having the shared experience of childbirth with other women, enabled Ursula to humanise women, seeing them as people functioning in society rather than patients according to the pathological biomedical approach. Viewing woman as people, connecting her experience to theirs and an aspect of why she chose obstetrics, has an impact upon how she thinks about obstetrics as a distinct field from 'medicine'.

Ursula felt that her experience helped her practice and commented that it is harder for her colleagues:

> '*I think that most of them are very good and very empathetic and do understand but I think it's harder to gain that naturally as a man so I think they have to work harder at it, I think some of them don't do very well but others do, but I think that is probably the case the for women as well'* Ursula (Obstetrician, p. 3)

Having lived experience of birth and life as a mother increased Ursula's understanding of how this can impact on other women and therefore increased her ability to be empathetic. Without this experience she felt that others have to work harder to develop the understanding which enables empathy towards women. She recognised how men might find this more difficult as they do not experience life as a woman or the experience of birth. Ursula also recognises how some of her colleagues do not use empathy in their practice as well as she does and this is potentially down to their lack of experiential knowledge of birth.

Yvette (Obstetrician) identified personal experience of birth as having an impact on her practice and how she communicated with women. Following the interview, I spoke to Yvette and Zoe about their personal experience of birth and how it made an impact on them as women. Yvette had had a normal birth in a local unit a few years ago, she said she wanted to say during the interview, but did not and how, during her labour, she just could not sit down, and from this experience she knew that sometimes, women cannot be immobile. (Journal entry)

Whilst this comment during a discussion highlighted how the experience of birth had made an impact on the obstetricians interviewed, it also highlighted the need that they felt to be objective. In the comments they made during the group interview and how, as a profession, their personal experience was not as important or as valuable as their learnt knowledge. Their experience was not considered relevant to add in a professional discussion on movement.

7.5.2 Understanding caring for women as social beings: health, families and a lived human experience

Connecting with the family and the celebratory aspect of birth and helping, caring and encouraging women were themes running through other midwives' interviews about their motivation to study midwifery. Birth was recognised as health not illness, a personal experience that was also part of family life

Angela, Geraldine and Barbara came to midwifery from nursing. Barbara said she:

> '*Didn't think about it, it was the thing you did after nursing … but I became absolutely hooked ...I was mesmerised by it'* Barbara (Midwife p. 1)

Initially Barbara had no pre-existing motive for training in midwifery other than it was what you did. However, the motivation for midwifery was built up during the course of being a midwife, this was where her motivation grew.

I asked what was it about midwifery that she thought it was that hooked her, she felt it was the more autonomous role and:

> '*It's just the family thing of it you know, people are, the healthy thing of it, you know people are healthy, well, its celebration isn't it'* Barbara (Midwife pg. 1)

For Barbara, birth had a social meaning for a family and is an event for celebration.

With young children, Catherine and Fiona found their midwifery training physically hard work, but also, they enjoyed it. Catherine perceived midwifery as '*specialised care'* and '*it was such a privilege to be at such a special time in a person's and the family's life'*

Catherine sees midwifery as a specialised area, not in the medical sense of a '*speciality*' as the medical professional being the specialist in a particular area of medical knowledge, but the position a midwife or student midwife holds within the moment of life within a family.

Birth is viewed and experienced by the midwives interviewed as a life event that has an emotional and psychological impact and thus connecting and emphasising, not just the mind-body connection, but the social connection (Davis-Floyd, 2001). Birth experience has been shown to have long term psychological impacts on women (Simkin, 1991) and on women's long-term health (Maimburg, Væth and Dahlen, 2016). The experiences described, centre on the human aspects associated with care and the psychological and emotional process of childbirth. They are cited as motivation for pursuing midwifery in the context of making a difference to other women's lives, an aspect of choosing midwifery as a 'vocation' as identified by Williams (2006) and the ability they would have as a midwife to impact positively on that.

7.5.3 The intense emotion of motherhood

Midwives and obstetricians recognised how the physical event of birth and motherhood was an intense emotional event in women's and families lives. Midwives spoke of birth as '*magical*' (Geraldine), '*special*' (Barbara) and '*exciting*' (Irene). Barbara spoke of how her midwifery training was all *'lovely'*, she described the subject of midwifery as '*fresh and new*' and '*you were learning all the time'*:

> '*All concentrated on one whole thing that you do is have a baby it was just lovely and loved it'* Barbara (Midwife, P. 3)

For Barbara, coming from a nursing background, not only was birth a physiological process, but the human life event in a socio-emotional context that gave her an intense emotional connection to her work.

Having experienced working on a postnatal ward as a student nursery nurse, Jan, found her experience on the postnatal ward '*Interacting with the patients fairly in-depth you know it was lovely really'.* Geraldine spoke of coming to midwifery because her perception of the role

was '*lovely*', Elizabeth from her positive experience with her mum's midwife as a child, whilst Irene and Hannah came from families of nurses and midwives. Most midwives spoke of the positive experience or perception they had of midwifery that drew them to midwifery. Cullen et al. (2015) who found that exposure to positive constructs of childbirth and that of the role of the midwife were motivating factors for student midwives in Australia.

These elements of birth are viewed as valuable and positive to the midwives interviewed and to what drew them to midwifery. However, Crowther et al. (2014) found that aspects of birth that are experienced as joy which encompass relationships, presence, birth environment, satisfaction and as a peak spiritual experience are largely neglected as significant themes in the literature.

Elements which inspired the obstetricians interviewed which set it apart from other specialities were the drama and excitement of the CLU (Val, Winnie and Yvette) the variety and interest (Yvette) and being part of babies being born. Yvette felt as an obstetrician she was part of a '*special moment'*, Winnie enjoyed that she got to '*catch babies'* and Val felt that it was '*a privilege'* to see babies born and even in bad circumstances such as still birth '*you can make it bearable for them'* through generally:

> '*knowing when to be quiet, be careful of the language that you use it's understandable that you remember it's their baby it's not just another patient that's had something bad happen'* Val (Group interview p.1)

Being part of something that is special and exciting and something that has an emotional response which as an obstetrician you can be part of and influence, appears to be what draws the participants to obstetrics. The midwives also had an emotional reason for being drawn to the profession, the midwives saw their role as working with women to empower them in their experience. Some obstetricians and some midwives were drawn to the emotions that fuelled excitement of the environment and being part of the childbirth process. For Val it was being involved in the 'drama' of the labour ward, Winnie found it 'exciting' and Yvette recognised that there were 'good days and bad days' it was 'always positive', 'exciting' with 'adrenaline' which made obstetrics 'fascinating'.

7.5.4 Compassion

Midwives experienced compassion and lack of compassion as women and midwives. Both midwives and obstetricians spoke of giving compassionate care. Two midwives, Fiona and Catherine, had a negative birth experience and perceived that they could provide better care than the care they received. I asked Fiona what was it about her experience that she thought she could bring into midwifery:

> '*Compassion, listening, understanding, appreciation of what small things, what massive impact that can have on the woman, not just her birth experience but post*' Fiona (Midwife p. 2)

From Fiona's experience of birth and the effect it had on her, she gained an insight into what she perceived to have been missing and how this affected her. Fiona identified how she, as a midwife, could make a positive impact on other women's lives through the elements of her care she thought were missing.

Donna, Fiona and Catherine chose a career in midwifery motivated by the effect that their own births had on them. Both Donna and Fiona call these '*simple*' or '*small'* things that stood out to them the most. Catherine had missed the whole physical, psychological experience of normal birth, and also chose midwifery as she felt '*cheated*' and wanted to do something about this. The biomedical model of maternity care does not recognise the elements of birth care that these participants felt were important as birthing women. Not experiencing childbirth in the way that was expected can be seen as not experiencing an integral part of human culture leading to Catherine's experience of feeling '*cheated*'. To improve the quality of service user's experience and satisfaction, Ballatt and Campling (2011) argue that a service that is value-based rather than organised and regulated as a commodity in an industrialised model would be more efficient.

Whilst one of the obstetricians said she had no preference for obstetrics over General Practice the others chose the speciality following their experience of working in obstetrics as medical students or junior doctors.

Ursula enjoyed her obstetric placement as a medical student and felt this was down to the unit in which she was based and the people she aspired to be like. Having a positive experience of obstetrics with '*lots of female role models*' and how they '*spoke positively about*

their careers' and how they '*help women in pregnancy and labour'* and wanting '*to do something in hospital*', influenced Ursula's choice to do obstetrics:

> '*watching consultants behave with patients and seeing them being able to encourage patients in a nice manner in terms of them choosing their own health, their journey ... from a role model point of view so it is team work, so how they treated people in the team as equal not you know, not one above another'* Ursula (Obstetrician, p.1)

Ursula's role models exhibited care that she wished to emulate, this approach involved women in their own care and non-hierarchal team work suggesting a more equal approach to maternity care. Care which increased women's agency regarding the choices they made and respect for each other in the team showing compassion between Ursula as an obstetrician, her colleagues and the women for whom she provided care.

Yvette found obstetrics fascinating as a medical student, Winnie was drawn to treating well people through a natural process and the role that obstetrics had in helping '*to do this safely'*, Val opened the discussion on how she perceives her role as an obstetrician:

> **Val**: '*we come in and introduced things it's frightening but it's also they, it's not what they were ever expecting and think you have to introduce that quite carefully to them and explain to them why you need to do the things you need to do and what you can do to keep them on that normal picture that they all knew about*'
>
> **Me:** so, would you say that's going back to why obstetrics, would you say that's an element that drew you to obstetrics?
>
> **Yvette**: '*and something that I enjoy is if you are doing a repeat caesarean or something you can make it really special do they want the screens down, do they want to see the baby being born that's lovely*'
>
> **Val:** *'and forceps delivery, they can have skin to skin and delayed cord clamping all things they've talked about antenatally trying to keep, that is obviously in a safe situation, but yes the forceps delivery when it is controlled it's nice, paediatricians are there but they are not jumping on things because everything that happens smoothly there are really nice forceps deliveries they are not all horrific as some people think they might be'* Group interview (p. 4)

All the obstetricians recognised the effect that intervention had on women. They perceived part of their role as making the intervention as good as possible for women while maintaining safety for mother and baby. The communication and interaction that this involves is seen as making the obstetric task more of a positive experience for women as well as combining elements of normal birth and women's expectation to enhance this experience. The overarching belief is of the necessity of the intervention and that this is paramount in maintaining safe outcomes. The obstetricians in this group were aware of how intervention made an impact on women emotionally, as they acted in ways that can cause fear and go against women's expectations. Intervention is seen as necessary and done by the obstetrician with a genuine belief that there are small things they can do which can reduce the physical and psychological impact of the proposed intervention. Again, it is the perception that the obstetricians are able to control this situation: the intervention, the way in which the intervention is carried out, the actions of other obstetricians all of which affect woman's birth experience.

From Val's perspective as an obstetrician, an intervention that is primarily done to preserve fetal well-being is seen in the context of how it can affect the woman emotionally. Val has the power to make this a '*nice*' experience rather than a '*horrific*' one that some people might expect. It was the women and midwives' perception that no forceps delivery was nice. Viewed from Val's perception as an obstetrician, the procedure can be made positive however this is viewed in isolation from other emotions or factors that may be occurring, which are experienced by the woman or midwife which are not conveyed or seen by the obstetrician.

The belief that how situations are introduced, how things are explained and how to make interventions such as caesarean section and operative delivery better for the woman, are expressed in the group interview, and something which draws the participants to obstetrics. It shows a connection to the role of the obstetricians and the how their obstetric skills in a time of need can be used to improve care for women.

7.5.5 Understanding and knowledge of movement as part of physiological birth

All midwives and obstetricians understood that movement was part of physiological birth and knew where to find knowledge about this. Obstetricians and midwives said they would get information about movement during labour they were similar from books, journals and the internet. Tracy, cited mainly medical journals such as, British Journal of Obstetrics and

Gynaecology, British Medical Journal, but recognised movement as something that could be in midwifery journals as did Yvette, and Ursula said she would ask the librarian. Again, these were the initial answers showing the prevalence and automatic assumption of authoritative knowledge as found in journals. Three of the six obstetricians said they would ask the midwives about movement, Val and Winnie felt that movement was an aspect of normal birth and therefore the role of the midwife as did Tracy who would ask questions. Ursula spoke of why she would talk to the midwives about movement:

> '*Midwives, generally have more opportunity during looking after a woman to get her feeling in perspective on things and I think because they get that continuity with the patients they kind of know what the patient wants and expects and they try things*' Ursula (p. 7)

Movement is seen by Ursula as something which the woman has feeling and expectations about and the midwives' role is to use movement with her. She sees the relationship that a woman and midwife build as central to this as the midwife is able to 'know' the woman an assumption is made that through this caring for a woman, a midwife is more able to gain the woman's perspective. For Ursula, information on movement is held by the woman and that is the source of information to be used: that of the woman and her own body to movement, the midwife is seen as the facilitator for this.

Fifty percent of midwifery training is in clinical practice (NMC, 2009), therefore student midwives learn skills from clinical midwives. This learning continues once qualified through collaborative working between midwives.

Irene feels knowledge around movement is '*stuff…we have inherently passed on from one midwife to another'* Learning from other midwives is something that is done through working with others with practical knowledge and experience which is how, historically, midwives learnt their profession (Donnison, 1988)

Clinical mentors during training are seen to influence what is learnt:

> '*If you've got mentors that are very proactive it is not even thinking out of the box it is just normal …. You could class abnormal which is getting them to sit on the bed*' Hannah (midwife, p. 9)

Movement is seen as a part of normal birth but also seen as using knowledge which is acted upon. This is in comparison to mentors not using their knowledge and facilitating 'abnormal', with the implementation of knowledge around movement being perceived as seeing differently.

As a newly qualified midwife:

> *'To actually go in and watch somebody else…. but that's really interesting, so if things aren't progressing what kind of things do they do…… the woman is doing something and I am like 'so why is she doing that?'* Donna (midwife, p.5)

Watching different midwives and what they do in specific clinical situations and then asking for their justification or reasoning, Donna has found a way to learn more.

Four midwives spoke of how they thought women gained information on movement from antenatal classes, both Geraldine and Donna spoke of how different women behaved in labour when they had been to hypnobirthing classes or used other information available on hypnobirthing and how this affects their movement:

> *'They seem a lot more intuitive, they seem much more connected to their bodies and will move around'* Donna (midwife p.9)

Formal and informal teaching around coping strategies for birth using hypno-birthing appears to prepare women for birth in a way that connects their mind and body and thus empowers them to take an active part in their birth, using their knowledge in an environment which enables this to happen.

Hypnobirthing is described as feeling relaxed and is:

'About sharply focused attention and peak concentration… (Which)…can be used to enhance a particular mental resource or attitude'

(Gavin-Jones and Hanford, 2016 p 16).

From the women's experience, the midwife was where most got information around movement during labour from. This varied between antenatal education, in the antenatal period and during labour.

Katie attended an NHS antenatal program and Sue a program delivered by the NCT, both women did not feel that information around movement given was of much use. During the antenatal period with the midwife, it was felt very little information was given.

As part of preparation for childbirth in the antenatal period, with the midwife, the birth plan is discussed. This should happen with every woman as part of NICE recommendations for antenatal care (NICE, 2008). Roma received extra care from a midwife massage therapist whom she felt without which she would '*know nothing about movement'*. Quinn, Maggie and Laura remember speaking to their midwife about the birth plan but they felt that there was not much discussion or information given or received.

7.5.6 The use of knowledge of movement

Using movement in physiological birth is a recurrent theme throughout the midwives' interviews:

> '*Movement and position has huge implications on the woman in Labour in terms of outcomes'* Barbara (Midwife p. 5)

Movement and positioning are perceived to impact on physical outcomes that can be observed and measured by the institution and research.

All midwives said they would use information gained in their training to support women with movement during their birth:

> '*it makes perfect sense that you would try and get something out of a tube in a vertical position than you would in a horizontal position'* Barbara (Midwife, p. 4)

From a physiological perspective with knowledge of anatomy, physiology and her clinical experience, Barbara sees the physiological advantage of being in an upright position and being mobile during birth, applying this knowledge to clinical practice she sees as '*sense'*.

Movement during birth was associated with sense by women as well as the midwives:

> *'I know it's more helpful to stand or move more freely than actually just getting on the bed because it doesn't make sense with gravity'* Sue (Woman, p.11)

Being upright, using movement, is seen as using gravity and therefore, natural, easier and adding progress:

'I really didn't want to be strapped to a bed I wanted to be able to move because that's more natural because of gravity' Sue (Woman, p. 17)

'The movement and the gravity …. That's the most natural it's the easiest on the body and it helps to you know progress labour quickly' Maggie (Woman, p. 8)

'*the whole gravity that helps the most I think it's the fact that if you are just laid down obviously you have got no gravitation'* Roma (Woman p. 3)

'If you lay down the babies got to come up before it comes down and so it's easier if you are stood up' Pat (Woman, p. 8)

'*I think it would go quicker and easier and it will be easier to push through that little bit and hopefully I wouldn't need to have any intervention'* Olivia (Woman p. 3)

Knowing that movement is helpful to birth in a sense of working with natural physiology and therefore being easier and avoiding intervention shows women's perception of what physiological birth consists of and how they can engage with this through movement. Having physical benefits of working with their body to make birth easier and progress through engaging with nature, intervention is avoided enabling women to maintain some control over their body that works with the physiological process of birth.

Movement during birth was also seen as enabling women physical comfort. Nicky reflected on her experience of pregnancy:

'*being pregnant if you sort of get up and move about you start getting a bit less tight ... but it makes it a little bit everything a little bit comfier'* Nicky (Woman, p.3)

During pregnancy it is within Nicky's physical capability to move around when she is uncomfortable, to make herself '*comfier*'. Her expectation of labour and birth is to do the same. Having not experienced labour or birth before Nicky's expectation is that during birth if she is not comfortable, she will move about and it is within her capability to do so.

Laura remembers the midwife not being '*there very much'* during the early stages of her first labour on an MLU unit. However, she also remembers the midwife making recommendations for her to get up but '*I didn't listen really… I thought I knew best'*.

Laura spoke of her difficult social circumstance at the time and how this affected her, how she just waited immobile for the birth to happen.

However, Pat spoke of her second birth, unaccompanied by medical professions. She spoke of the 999-call handler who asked her to squat however, she said, *'I couldn't have moved from that spot at the actual time'.*

Whilst the general perception of movement during labour and birth was to ease birth and to aid comfort all within woman's capacity, during her quick birth at home Pat felt though she was upright and had been very mobile up until the moment of birth she could not move, and the physical act of birth prevented her from doing so.

Nicky's perception of being asked about active birth was of it being strange:

> '*if you want to be you would be and if you weren't I don't know it seemed a bit of, I imagine I would wander about a bit anyway I don't know, if I stayed in one place all that time especially if you're in for hours, seems a bit like that, don't know, seems a bit bizarre'* Nicky (Woman, p. 4)

To Nicky, movement during labour was something she would do if that were what she wanted. By framing active birth as a choice, it implies that women can choose to use their body to physically engage in the birth process or not. Women can choose to be passive or choose to engage with the physiology, a choice that is predetermined and planned and not responsive to need at the time. To Nicky this seemed bizarre has her perception of labour and birth would be to react to it how she felt at the time. Unlike the choice of pain medication, a choice that would require thought about intervention and pharmacology, movement is within the control of the person as an everyday physical action, therefore to be asked if she was going to use her body in action or reaction to birth, to use it as she had in pregnancy appeared strange to her.

One of the obstetricians spoke of how her personal experience of normal birth shaped her perspective as an obstetrician:

'*looking at how you can bring normality into high risk situation, I think mobility is one of the things that comes integrated but all the little things we can do, how the environment,*

how you behave towards the woman can make a difference in a situation that yes it's high risk but, it's still a normal process' Yvette (Group interview, p. 2)

Yvette's lived experience of birth sees mobility and other factors as contributing to normal birth, which can be supported even in high risk situations. Movement is seen as integral to supporting the process of normal birth. Yvette uses her knowledge from her experience to implement care and support women in the birth process.

Midwives spoke of how they worked with women whose beliefs differed from their own in regard to movement during birth. Most thought that women did not know the importance of movement and how it affects their birth experience. In context of the MLU area, where movement is used as part of care around normal birth, midwives said they would encourage movement through suggesting different movements, positions or use of the equipment.

Movement during birth is viewed as right knowledge, sometimes unknown to women: midwives use different methods of communication to share their knowledge to empower women during birth.

Elizabeth spoke of how she thinks '*it's a shame*' for women who do not share her knowledge of movement and works with them:

> *'I would try my best to change, not change, but encourage them into upright positions, usually the Labour progresses … they will be encouraged from that and carry on'* Elizabeth (Midwife p. 12)

Elizabeth expresses empathy for women who do not share her '*right*' knowledge of birth positions. By using the women's experience to encourage what she believes is the '*right*' knowledge, and the 'rightness' of this knowledge being reinforced through the effects it has on labour, this has the desired outcome for women and midwives. Whether this be the effect that positioning has on the physical labour or the psychological effect movement has on the women enabling the labour to progress.

Irene spoke of how she works with women and their partners, sharing her knowledge, empowering her through explaining how movement helps the cervix to open. She does this through using metaphors and knowledge of what the woman might already know:

> *'don't want to make them feel inadequate as if by not having the knowledge actually they are at fault because they didn't have that knowledge that's not the way it should be at'* Irene (Midwife p. 17)

Women's wishes are respected when movement was not used, with the realisation by most midwives that they do not have domain over women's choices. By not using midwifery knowledge around movement it can sometimes result in women being thought to make wrong choices.

Barbara spoke of when women made decisions not to be mobile during birth that possibly contributed to a complicated or negative birth experience. As a midwife who often speaks to women as part of postnatal care about their births, I asked how she felt about this:

> *'well it's not my baby and it's not my experience at the end of the day…you tend to say well you know you all make a decision that you think that at the time are the best ones for you … I mean you still just have to, you love the woman take care of her and be always I think very comforting'* Barbara (Midwife, p 20)

As a midwife, Barbara shows respect for women's self-determination and understanding of the decisions made by women during birth and how criticism and blame are not empowering or helpful. Prochaska (2015) states that:

'The principle of human dignity is the ultimate value on which respectful healthcare depends'

(Prochaska, 2015, p 27).

Using dignity as a guiding principle situates the woman centrally in her experience as an autonomous decision maker, lack of this dignified approach would apportion blame and not contribute to the relationship between the midwife and woman.

Barbara uses love, care and comfort in her approach to provide compassionate and empowering care to women when their knowledge and belief about birth does not reflect her own.

The obstetricians did not see their role as having as big of an impact on supporting women's movement as midwives did. However, they had the knowledge that movement was part of physiological birth. Winnie felt that she could not do anything if a woman was tired and did

not want to move;if a woman was not progressing as expected, Yvette assumed there must be a physiological reason for this. However, Yvette thought:

> *'if it's a lady who is coming with her baby… was OP and she is on the large side and she just won't move then that's just a little bit different- but you're not doing yourself any favours'* Yvette (Group interview, p. 13)

In this situation, Yvette uses her clinical knowledge, experience of movement and applies it to a woman with a baby in the occipito posterior position. Whilst respecting the woman's choice and thinking the woman is 'not doing herself any favours', in this circumstance she doesn't use her position as a doctor to make recommendations as she would in situations that are perceived as high risk and could compromise safety.

7.5.7 Psychological understanding and knowledge of movement and birth

Whilst knowledge of physiology and midwifery practice forms the basis of midwifery education (NMC, 2009), other skills are required to enable the midwife to be 'with woman' and allow movement to be used in the context of midwifery care.

When birth is viewed from a midwifery perspective, it is viewed as holistic, in context to individual women and a social model of care. Catherine speaks of movement but not in isolation:

> *'it's gravity and being active and it, it's a distraction for her and its making sure she's in control of that situation'* Catherine (Midwife, p.4)

A woman being active during birth is more than a physiological aspect. Catherine saw it as a coping mechanism through being a distraction and putting the woman in control of her body during her birth. Midwives' view of movement as a part of birth can be viewed as using the midwifery skills they have gained through education and practice and the experience they have gained through their life, their midwifery education and their practice (Bryar and Sinclair, 2011).

> *'I think if they are sat down the only focus on their pain but if they move around it helps them: I am not saying it takes the pain away by moving but it helps focus their energy on something else'* Hannah (Midwife, p.15)

> *'using nature to support and enable the natural mechanics of birth, you've got gravity, you've got weight, you've got nerve endings that aren't been squashed and causing more pain, back pain, you know, you've got women's freedom of choice and all of that is around, that impacts on the psychology outcomes'* Angela (Midwife, p.9)

Movement does not just affect labour outcomes but the woman and her ability to birth her baby, her psychological well-being and her rights as a human. Movement is not seen in isolation to birth physiology, other factors which movement impacts on are the woman's perception of pain, locus of control and psychological wellbeing.

Women also associated movement with keeping calm:

> *'I think that by staying still, I think the pain is going to be more intense and I'm just going to be thinking about that pain rather than if I am trying to do something else to keep my mind occupied I think that is going to help'* Roma (Woman, p. 3)

Roma sees a psychological benefit of moving as keeping her mind occupied through her pain of labour. Roma throughout her interview spoke of forthcoming birth in relation to pain and her ability to cope with this. She spoke of physical ways to manage pain through movement and positions but mostly how she was going to manage the physical pain psychologically. To Roma, labour is not about the physical act of birth but the physical sensation of pain that she needs to manage through her 'mind'. The physical act of moving is something which she is planning to use, along with other strategies, to help her control her physical pain and her psychological ability to manage this.

Nicky sees movement as making birth less 'stressful', *'your blood starts pumping the endorphins through'.* Birth is seen as a stressful time by Nicky and something that she can physiologically manage through using movement and the reaction of natural endorphins. This release, she feels will help reduce the overall potentially negative psychological impact of stress on her birth.

7.5.8 Differing assumptions

Not all participants' basic underlying assumptions fell into binary categories and flowed the same through the interviews.

Whilst both midwives and obstetricians showed compassion in their basic underlying assumptions and their motivation for pursuing their career one obstetrician was motivated by the career that obstetrics offered. Tracy spoke of how as a medical student she took a role in maternity care that made her feel involved as opposed to other specialities in which she only observed, which she feels to some extent is true today:

> '*We were given duties, we weren't given duties in other specialties …. General surgery, it was the practicality of it, we were given practical duties to do so we felt real valued members of the team'* Tracy (Obstetrician, p.1)

Entering a profession in which as a junior member of the team, she felt involved and valued, enabled her to gain experience and learn. Whilst liking her obstetric experience as a student, the experiential learning opportunities presented her with tasks that she enjoyed. Tracey was the only consultant obstetrician interviewed and had entered her medical training almost 40 years earlier; she was the only interviewee who expressed no emotional connection to maternity care or women's health and cited the involvement and value as influencing her career choice.

Fiona's birth experience made a significant impact on her has a woman and a midwife. Whilst Fiona spoke of her birth experience and showed compassion based in love, she also expressed compassion based in safety. She had a '*really nasty forceps birth'* and her inspiration to do midwifery was *'I could do better'.* She went on to speak about her third birth as a second-year student midwife:

> *'I had a VBAC in the pool term +15 previous gestational diabetic 4.47 kg previous baby'* Fiona (Midwife, p.22)

For this birth she had her own knowledge, the support of a consultant midwife, the 'right' obstetric consultant, a case loading midwife and some strong midwives to '*fight the corner*' of midwives who enabled her to have the VBAC. Fiona goes on to say how the strength of the midwives who worked in this unit empowered the women in their care; this was done by there being no hierarchy between the women and midwives. She speaks of the importance of being supported by the 'right' people if normality was to be supported: the fight to get her wishes implemented and the strength needed by the midwives to do this.

From Fiona's experience, from her negative birth experience to her positive birth experience there needed to be: support for midwifery and women from good leadership, multidisciplinary team approach, the ability of all midwives to challenge the culture which did not support normality, to enable midwives to offer informed choice to women and support women's right to self-determination.

This experience impacted on Fiona's perception of herself as a midwife. In her practice she stated that she recognised how women's perception of their lack of control over their experience can make an impact on their sense of achievement and pride in themselves following birth. However, Fiona also goes on to say that on the CLU '*if you've got some concerns, the baby sometimes takes priority over mum'* this is in the context of a 'high risk' unit and the perceived need for CTG monitoring:

> *'if you are not picking up a good monitoring, and it is defensive practice as well you know, it's the litigation side of it it's a worry you know, if you are missing that this baby is having a deceleration potentially because you are not picking them up you know the old you've not got a leg to stand on'* Fiona (Midwife, p.9)

Whilst Fiona recognises how women's sense of control affects their birth experience, she also is aware of the control which needs to be maintained by the CLU clinicians to monitor fetal wellbeing to control labour and birth. There is a switch of focus from the importance of control felt by the woman to the control needed as a member of the CLU.

7.6 Connecting

7.6.1 Motivation for Midwifery and obstetrics

All midwives and one obstetrician interviewed expressed an understanding of midwifery and birth from their experiences of birth or midwifery. This was what led them to study and their expectation of what midwifery care was or should be or the emotional response they had to midwifery once they began studying or practicing. All the experiences expressed led the interviewees wanting to improve care for women.

From the interviews, most midwives and obstetricians came to their respective career choice through a position of love, compassion and empathy for women and birth. Both professions want to have a positive impact on women's health through their work and thus had similar motivation.

The midwives related to birthing women as women showing emotional, social and psychological awareness in the whole context of their lives and the impact that birth and motherhood has on a woman and family. Midwives see themselves as having a positive impact on women, their birth and motherhood based on their own experience of birth, motherhood or the positive relational perspective they perceive midwifery to be.

The obstetrician's perspective recognised birth as a special event in women's lives, but their experience of birth was more about learning, being part of the team, how the CLU made them feel. However, some obstetricians had a similar perspective as the midwives which identified as coming from experiential knowledge of birth and as a woman.

The obstetrician's focus of birth was on safety, often viewing events as emergencies which they have responsibility for resolving. Three who did have children felt that their personal experience and knowledge of normal birth gave them insight to what normal birth and control meant to women. Those without personal experience did not appear to have as greater an insight into what this meant for women and this had an impact on their perceived professional care as midwives. This could illustrate how as an obstetrician they are expected to bracket personal experience and feeling away from obstetric practice through depersonalisation of the self and the woman. Thus, in medicine, scientific knowledge is more valuable than experiential knowing.

7.6.2 Knowledge and understanding of movement

Movement is viewed by all participants as part of physiological birth and is recognised as having physiological effects on birthing women. Movement is also understood by women, midwives and obstetricians to have psychological benefits for women as part of the holistic experience of birth.

Movement is something that midwives learn about; during their training in theory from the scientific knowledge base, authoritative medical journals and practice from watching and being with women that they continue to learn about once qualified.

Obstetricians see midwives having more knowledge and understanding of movement than they do. However, this understanding is enhanced when they have experience of birth themselves as women.

Movement is understood by women to be within their control during birth and something which they would or would not choose to do naturally.

Midwives spoke of how they made their midwifery knowledge understandable and relational to women and their partners. Combined with the culture and environment of the MLU, midwives and women can work together during birth without either acting in a position of authority.

Midwives not only use knowledge around birth, they also have knowledge of the wider culture of birth. The use of this knowledge combined with how they communicate with women around movement can empower women and encourage physiological birth through expanding women's agency in the way they support women's decision-making (Edwards, 2010). This is further supported when obstetricians use their knowledge and experience of movement.

7.7 Conclusion

All midwives and some obstetrician's spoke of their experiences which shows a connection to the midwifery profession, women, their environment and the culture of a unit which enabled relationships to be built with each other and women which encompass care, love, compassion and an understanding of physiological birth. These factors act as facilitators to the use of knowledge of movement.

Experiencing birth enabled midwives and obstetricians to make a connection to the women for whom they cared to be made.

What contributes to the physical environment and artefacts appears to be multifaceted. This chapter has shown the elements of the culture as described by the midwives, women and obstetricians from their experience, perspective and position and shown their underlying assumptions, espoused beliefs and values which contribute to the environment which enable women's movement during labour. I have called this connectedness as participants in this culture showed connections emotionally, physiologically and physically to women and birth which viewed them holistically, reiterating beliefs which demonstrated this connectedness through giving maternity care which used knowledge of and facilitated women's movement during labour.

The next chapter will look at disconnections, a maternity care culture which impedes the use of knowledge about women's movement.

Chapter Eight

8. Disconnection - maternity care which does not use or supports women's movement during birth

The previous chapter used Schein's (2017) concept of culture to analyse the levels of culture within the maternity unit that were connective, enabling the use of knowledge around maternal movement. Throughout analysis disconnections in the culture which do not support maternal movement were identified. This chapter will explore disconnection that is characterised as a lack of humanity in the care environment, the valuing of policy, process and safety over experience, leaving people unheard and unvalued.

This definition summarises how disconnection was articulated throughout the interviews of participants and is characteristic of a biomedical or technocratic (Davis-Floyd, 2001) model of care.

Data was formed into categories (Appendix 14) that showed disconnection:

- Emotional disconnection
- The disconnecting culture and organisation of care
- Disconnecting birthing women from birthing knowledge
- Disconnection between midwives obstetricians and normal birth

Schein's (2017) concept of culture was then used to organise the data into structured themes (Appendix 16) to illustrate how a disconnected culture is formed where knowledge of maternal movement is not used.

This disconnected culture displayed artefacts in an environment that prioritises medical equipment and surveillance and does not support movement. Setting of rigid boundaries caused separation, fragmentation, the lack of relationships and supported a hierarchy. Control was maintained through the precedence of medical practice, control of services, information, the environment, knowledge and relationships. This led to a lack of empathy, dignity and choice for women. The authoritative knowledge of medicine took precedence over midwifery knowledge that integrates the physical, psychological and social aspects of birth.

This chapter will illustrate how the midwives, women and obstetricians position themselves in the context of their birth from their personal and professional perspectives. Additionally, how, from their experience, knowledge of movement is not used during birth. The development of the artefacts displayed as discussed by the participants shall be discussed, the espoused beliefs and values along with the underlying assumptions of the culture underpinning these shall be explored and analysed based on the structured themes developed. (See appendix 16)

8.1 Artefacts

Artefacts are the physical environment and the products visible which are understood through analysing the espoused beliefs and values. Using the analysis of the underlying assumptions, values and beliefs the analysis of the environment is shown.

Artefacts, which were predominant in the CLU environment, did not always facilitate movement or support women's choice around physiological birth. The women, midwives and obstetricians spoke of the physical CLU environment and culture and how medical equipment and surveillance took priority over movement.

8.1.2 Environment

The environment of the CLU gives no physical ques to the expectation of movement, a bed is central in the room and medical equipment is prevalent. Though information is displayed on the wall this is not supported by the equipment available and the physical arrangement of the rooms. All participants spoke of the environment and culture of the CLU and how this made an impact on movement.

Elizabeth, Fiona, Geraldine and Barbara see the environment as '*giving out a message'*, having a bed in a room gives a woman the automatic assumption that she needs to be on it. The midwife is able to challenge this assumption, this tactic of raising and putting cases on the bed was also seen by Catherine as a student to enable women:

> *'to be up and active so she would get all the mats out and dim the lights and makes its serene and make it a nice environment as possible'* Catherine (midwife, p. 5)

Enabling a woman to be mobile through taking away the assumption of the bed and additionally using mats and diming light in the attempt to make the environment '*nice*' and '*serene*'. This is the midwives manipulating the environment to be more like the MLU area for

the benefit of the woman. However, whilst CLU controls the overall physical environment and the midwives can manipulate this, the woman doesn't appear to have any control of the environment on the CLU.

As noted by the women and the midwives, the obstetricians spoke of how the environment between the CLU and MLU differed and how they thought this impacted on movement. While the CLU was synonymous with intervention such as epidurals, drips and opiates (Tracy), Ursula recognised the bed as impacting on movement but during the group interview the discussion was around intervention and maternity care staff:

> **Yvette**: *They (women) have got lines on each side of them and hooked up to the walls, then they have got a dense epidural but professionals can suggest it, because I think sometimes, they seemed to have the opinion that they have to be on the bed and they can't move*
>
> **Zoe:** *yes, I think definitely being upright helps*
>
> **Me:** *and is there anything that you think it impacts on that within practice*
>
> **Zoe:** *what do you mean stops people from moving*
>
> **Me:** *either stops them or helps them*
>
> **Yvette:** *I guess just whoever goes into the room encouraging them that they don't have to lie on the bed, that they can as long as they are not obviously, they can get up and walk around and sit on the birthing ball because I definitely think those things being on the birthing ball been stood up make a huge, I think they can make a really big difference and make things go much quicker and some women even can't sit down I think that's a good sign if they can't sit down if they need to be stood up as it know why I think that if a can't sit down it's a good sign*
>
> **Val:** *I think sometimes being a bit pushy with them and yet we are supposed to give them choice and say would you like but I actually think saying you need to stand up now you need to get you mobile to trying get this baby's head down or whatever it is by think it's hard and they are tired there in pain and a lot of them probably want to curl up on the bed but I think we have the opportunity to go in there and say no that's*

not the best way, stand up and obviously they can say absolutely no way leave me alone and you respect that' Group interview (p.12)

For the obstetricians, although the equipment is seen to impact on movement this is seen to be overcome through the actions and support of the staff caring for her. There is a definite belief in the group that movement has a positive impact on labour and therefore the impact of the interventions and equipment can be overcome through the staff working with women to encourage movement. However, as obstetricians they have no experience of providing midwifery care within the CLU and the therefore the experience of working with women within an environment with equipment and intervention which impacts on reducing women's movement. This lack of experiential knowledge of these situations appears to simplify the solution to overcoming the equipment, environment and the feeling, opinions and beliefs of the women through the actions of staff. Again, in an environment where the obstetricians and midwives have more power over events than the women, whilst encouragement and choice are recognised by Yvette (and Ursula), Val thinks that by being '*pushy*' movement can be used more. Laura felt this could have helped her during her first labour. The underlying assumption is of 'doctor knows best' and the belief in authoritative knowledge they have over that of the woman and the midwife caring for her. The obstetrician directs care not appreciating the consequences of intrusive technologies and restrictive environment on women's movement.

The CLU was described by women as an environment for birth which was '*hospitalised', 'medicalised'*, in which women felt they had '*no control*' and where intervention was more likely due to '*doctors seeing everything'*.

Pat spoke of her experience of her BBA, and how nice it was just her and her husband, however the ambulance took her to the CLU after the birth to a room which was '*dingy*', '*horrible'* and '*tiny*'.

Though the MLU environment appeared to encourage movement during her previous birth, Quinn's only que to movement when visiting the CLU was '*a little poster on the wall of all the positions that you could do and that was it'.*

8.1.3 Monitoring

It is Catherine's perception that all women have Cardiotocography (CTG) monitoring though some do not need it and it is the medicalised culture of the unit that promotes that. Catherine using her knowledge of birth and movement feels that it is not always necessary. Feeling frustrated and '*thinking*' not saying get off the bed, perhaps shows her lack of perception of power to challenge this. Again, Catherine's perception of a woman complying, being passive and not being part of this decision.

Angela felt that CTG as an intervention is done because it can and something which she has '*seen the ramifications of*'. Angela speaks of the increasing amount of women with more complex needs and the perception of the increasing use of '*intervention*' through CTG monitoring. Angela clearly sees CTG as intervention, she also sees the impact CTG has on movement, applying intervention because it can be done rather than applying and using knowledge around birth.

Within the CLU area doing something because you can, shows the power of authoritative knowledge and the belief of doing something is beneficial, yet with Angela's midwifery knowledge applied to the situation, the application of CTG has consequences, restricting movement, but this is not seen by those in power in the CLU.

Birth attendants who have only experienced hospital based, high interventionist, medicalised birth cannot see the profound effect these interventions have on birth and do not know what birth looks like without intervention (Wagner 2001).

Barbara thinks that when women do have higher risks it is more important to keep birth more physiological so that the risks can be avoided:

> '*they need to be upright supported you know but just because they are on monitors midwives are strapping them to bed still instead of getting on the ball'* Barbara (Midwife, p. 8)

Barbara sees the midwife as having the power in disabling or enabling movement as it is the midwife who is '*strapping them to the bed'* rather than using upright and mobile positions. Barbara's perception of this is that midwives *'just want an easy life'* complying to the expectation of CTG monitoring and the power within the CLU area rather than '*asking the*

woman what she wants and needs to do', being an advocate for the intervention rather than the women.

Fiona speaks of the need to get a '*good monitoring'* this is more important than movement when there are concerns with the baby:

> '*the baby sometimes takes priority over mum... if you are not picking up a good monitoring and it is defensive practice as well you know it's the litigation side of it it's a worry you know if you are missing that this baby is having deceleration is potentially because you are not picking them up you know, the old you've not got a leg to stand*' Fiona (Midwife, p. 9)

This description of monitoring and its effects on women's movement is very different to how movement is used on the MLU. The focus on the CLU area is on the complexities of the mother and on the monitoring is on the baby, who become the focus of the care and the *'priority'*. Through restricting women's movement, the ability to electronically monitor the baby's heart rate sounds is easier for the midwife and therefore available for the doctors to notice if it becomes pathological. The consequence of not '*picking up a good monitoring'* is the fear of litigation if something is missed. In order to enable women's movement, intervention is needed through disrupting the natural process of birth and the use of invasive technology. The overall perception of birth is the *'knowing what was going on'*. This is said as if through technology and monitoring, the ability to know what is going on is achievable.

Fiona also speaks of as a midwife, knowing how important the child is to the mother so if there are concerns about the baby:

> *'you know how important this child is to her, so if you do have concerns over this baby, you, yes you know the mobilisation would be great for the Labour, however if you have got some concerns that this baby, the impact that that something could happen to this baby would have more of an impact on her than not mobilising'* Fiona (Midwife, p. 12)

The wellbeing of the baby is paramount to mothers. Through the ever-pervading risk, potentially '*something could happen'*. Through increased observing and monitoring, thought this does not guarantee a good outcome, the perception is that through addressing the risk factors present whilst the woman and her labour are not being advantaged through the

decrease in movement. Firmly valuing technology and monitor rather than influencing physiological birth through movement.

Geraldine thinks that because of the lack of evidence of the classification of a *'second stage trace'* readings become pathological, this has changed over the years, where an experience-based knowledge of '*the trace'* was adequate. Guidelines formed from evidence provide:

> *'the only evidence that we have to go on in litigation… in a way it you can't defend it because that is the evidence that you've got'* Geraldine (Midwife, p.11)

CTG monitoring has become the means in which '*evidence*' is presented in cases which go to litigation. The evidence on the meaning of the CTG is based is absent, yet the belief that it is an adequate means of monitoring fetal wellbeing and it provides an objective basis for judgements to be made (Sartwelle & Johnson 2015) and justification for women to be passive, immobile and comes before the physical needs of a birthing woman.

Jan feels the priority is for the CTG monitoring for all women on the CLU area. Often there is '*nothing particularly wrong'* and women are asking to get up. Jan feels this is in conflict with her professionally as a midwife as she knows the impact movement has on labour and the woman and feels that she is unable to make decisions around '*making this distinction between what is needed what is wanted'.*

The medical and institutional need for the CTG monitoring renders the woman and midwife powerless. The standardised need for observation/monitoring or for the need for '*evidence*' '*just in case'* surpasses the women's need for comfort and bodily knowledge. This midwife feels unable to use her knowledge of movement in normal birth and apply it alongside the medical perception of birth. The midwife is seeing women as having physical needs such as being comfortable and being in a position to facilitate this, she also has midwifery knowledge of how birth works and how movement can contribute this. But, also having knowledge of the medical and its superiority and prevalence, she knows how the woman's knowledge and her knowledge are not needed.

8.2 Espoused beliefs and values

Culture is a product of shared learning within the group being studied (Schein, 2017). From this group identity is formed showing patterns of behaviours and beliefs that give meaning to

activities. This project identified behaviours, beliefs and values in categories that showed disconnection (See appendix 14). These behaviours, beliefs and values were further analysed and developed into two structured themes: setting rigid boundaries and maintaining control.

8.2.1 Setting rigid boundaries

The data showed how: rigid boundaries are set, separation and fragmentation happen in care practices, a lack of relationships between women and midwives and the formation of a hierarchy. These all contribute to the espoused beliefs and values of the care setting which do not support maternal movement.

8.2.3 Separating high and low risk care

The findings showed that the separation of care between high and low risk – CLU and MLU in this unit has increased the divide between medicalised and normal birth.

> '*Before we didn't have the MLU and its now, that's MLU and that's CLU and if you come … here it's high risk'* Catherine (midwife, p. 8)

Catherine sees the separation of MLU and CLU care as increasing the medicalisation on the CLU due to the dominance of risk driving care. The midwifery knowledge and power has been moved to the MLU and the doctors have the dominance in the CLU where the focus of care is managing '*high risk'*.

When women attend the hospital for birth on the CLU, if a woman is categorised as high risk the complex needs become the focus of care, Angela sees this as a challenge:

> '*the challenges for women and midwives are the medicalisation of childbirth and that's what interferes with the mobility'* Angela (Midwife, p.11)

When a risk status has been given and therefore place of birth determined, to challenge this can be difficult for a woman and a midwife. Johnson (2008) states that the medicalisation of birth positions women as objects with in the scientific discourse rather than someone with agency and knowledge and it is naïve to assume that '*defenders of nature*' (Johnson 2008 p901) can extract themselves and others from '*the technological, cultural and political dynamics of social domination*' Johnson (2008 p.901).

The culture of promoting normality in the MLU area allows movement to be used freely, whilst the CLU unit focuses on complexities and does not appear to support a culture where movement is used as part of birth.

> *'Mobility is you know it's not at the forefront of your mind I don't think as much because you have much more complexity to deal with'* Geraldine (Midwife, p.13)

From Geraldine's experience, when on the CLU area midwives thinking is on the '*complexity*' not on mobility. The midwives interviewed are required to disconnect from their knowledge on '*mobility*' as they are dealing with complexities not women in a holistic sense, the complexity requires managing. Defining the CLU area as 'high risk' categorises women birthing there as having complexities, maternity care viewed from this perspective is committed to detecting and treating complexities, even when they are relatively low (Berg 2005).

Geraldine sees the effect of student midwives spending more time on the CLU area and the difficulty they have in seeing normal birth:

> '*we have spent a long-time training midwives in the abnormal you know and I think what you have to do, understand that we talk about normal birth but that is the exception rather than the rule these days'* Geraldine (Midwife, p. 10)

Geraldine's perception of practical midwifery training in normal birth is that it has become a '*speciality'* as midwives no longer see it as frequently as they did. With the separation of CLU and MLU care, normal birth is in the minority. With 6,000 births at the maternity unit per year only 1,000 occur in the MLU area (personal correspondence with the consultant midwife). The division has seen training and skill in normal birth belong to a specialised area and midwives losing skills because of this. Therefore, midwives are being socialised in a birth environment that does not implement their skills in supporting normal birth. Within this medical environment birth is a medically focused experience that is depriving women of the opportunity to develop knowledge and awareness of birth (Healy, Humphreys & Kennedy, 2016)

Catherine see's the level of medicalisation as increasing and the consequence of this is the increase in instrumental and operative births over the past 11 years. She puts this down to

the increase in Cardiotocography monitoring which decreases mobility (See below). With a culture of '*we've always done it that way'* and '*that's how it is'* Catherine sees this as coming from '*a senior level of doctors'*:

Catherine finds this frustrating: '*you just want that woman to have something normal to be able to walk around*'.

As a midwife trained in physiological birth, as a profession that supports women's choice in a social model of care, the focus of her care is the woman and wanting normality for her. An aspect of ideal midwifery practice and genuine caring, when caring for women who are defined of as at high risk, is the midwives ability to balance the physiological and medical perspectives whilst also maintaining focus on the normalcy of birth and being sensitive to the individuality of woman (Berg 2005). This is reflected in many of the midwives interviews, a genuine desire for women to have some normality in their birth yet policy and procedure often limited how midwives could facilitate this.

8.2.4 Fragmented care

Jan spoke of her time on the CLU practising as a midwife, which she does not like. She put this down to the lack of continuity she had with women, an element of care that first drew her to the profession. Jan speaks of continuity as being able to '*know a woman really well'* which enables her, as a midwife, the ability to '*build a good picture'* and use her knowledge of the woman, her midwifery autonomy and make decisions which are based on a relationship. To Jan this makes care easier:

> ' *you walk into a labour room and you have never met the woman before and she is totally closed down and you think where do I go from here, and you keep, you know, up and the odd little bit of conversation now and again, encouragement and that sort of thing'* Jan (Midwife, p. 4)

Care based on relationships between midwives and women enables joint decision making as a relationship has been built. Decisions and care can be based on knowing the woman and all of her maternity care history.

Birth within the CLU enables a system of care which separates a woman from the rest of her maternity experience, by viewing the birth as a physiological event in isolation from other areas of maternity care or the woman's life (Davis-Floyd 2017, Kitzinger 2006, Rothman 1982).

Jan views maternity care as a '*whole picture'* based on a relationship which enables '*rapport'* built up over time. This separation requires guess work on Jan's behalf to work out how this relationship is going to be. Working with someone '*closed down'*, the woman's rational brain needs to be undisturbed during birth (Buckley 2003, Odent 1999), can be unknown, which does not enable Jan to get direct feedback from the women as to the value of the care being given.

Irene has seen changes in the culture around birth and thinks, as a midwife, you are encouraged to be with women more during labour and more information is given. Whilst this supports relationships between women and midwives, some practices she felt kept women more separated. Telephone triage by an unknown midwife keep women at arm's length by making judgements over the phone:

> '*I've never quite worked out if that's there for the convenience of the midwives and doctors, that we are holding women off so we are not holding onto women inside the building who have got a longer latent phase'* Irene (Midwife, p.5)

Whilst some elements of care are positive and increase more relationship-based elements of care, Irene feels triage does not do this. Though the evidence and Irene's own knowledge supports the theory that '*oxytocin production is reduced on admission to hospital'* it is being applied in isolation to other factors and possibly for the benefit of the hospital system.

8.2.5 The impact of separated, fragmented care on women

Maggie spoke of being transferred from the MLU area to the CLU area during her third birth as '*horrendous*'. After labouring in the MLU area, which she described as '*absolutely brilliant*' and '*lovely*':

> '*I was allowed to go to the bath, was relaxed could do what I wanted until the baby got into stress'* Maggie (woman, p. 1)

However, once the baby's wellbeing was considered to be compromised, Maggie was transferred in a wheelchair and thought: '*Oh no not this again … being confined and without any pain relief was horrendous'.*

From being relaxed and doing what she wanted in the bath, the need to manage the baby's wellbeing became priority. Maggie was confined to the wheelchair and the importance

became managing the wellbeing of the fetus not Maggie's physical and emotional needs. Through moving Maggie in a way which restricted her movement and did not consider her needs but prioritised the structure and workings of the institution, Maggie went from being a labouring woman working with her body in a conducive environment to a potential danger to her child that needed to be managed by the acute area as she and the midwives no longer had the capacity to do it.

8.2.6 Size, structure and hierarchy

The data showed that the midwives felt that how services were structured, the large scale and the hierarchy, caused disconnection. Elizabeth previously worked in a small unit with no separation between high and low risk care, in this unit she felt *'everybody trusted each other more'* and there was more discussion around clinical cases:

> *'you would get advice rather than being told what to do whereas here you are more in your room on the CLU and you get a ward round and its people coming in and it feels a bit may be as if people are checking up on you and the doctors are giving you a plan and it's not as collaborative'* Elizabeth (Midwife, p.2)

Hannah also felt working in a large CLU unit fragments care, promotes an environment where people cannot be trusted, an environment where midwives don't feel they can be autonomous or feel like they can challenge '*they don't feel they can be the midwife they want to be'* Hannah (Midwife, p. 4).

Hannah felt the influence of the hierarchical culture in the CLU impacted on midwives as a profession:

> *'there's a lack of trust in your ability and knowledge because at the end the day you were trained to be a midwife you know, you know what your boundaries are and you certainly don't need to keep telling people what you are doing in any other job'* Hannah (Midwife, p. 4/5)

Within the hierarchy of the CLU midwives, a graduate profession and an autonomous role, there is a sense of monitoring to ensure compliance, and surveillance stifles the midwife's role. Midwives are kept in their position in the hierarchy by those in control.

Zoe acknowledged that with the different consultants, senior midwives and midwives on shift the support and help available was always different but also:

> *'depends on that particular consultants individual approach and if it's absolutely worlds apart from your ideals of what you want to be doing and the professional care that you want to give then if you've got a consultant that who is very interventionist and may be doesn't quite communicate'* Zoe (Group interview p.6)

The experience of the junior doctors is one of a strict hierarchy. The consultant is in the position of power and is considered to have the most knowledge. Decisions made by them without contextual knowledge of a woman and with different approaches used by different consultants, cause conflict in beliefs and approach to care. Zoe goes on to speak of some consultants being more present than others, when a consultant is around how much of a difference it makes:

> **Winnie:** *it's really frustrating when you phone them and on the phone I always say I want to take this woman for such and such because, I always say what I want to do first before I tell them the story, and sometimes it's really hard on the phone when they say don't do that you know do an FBS but*
>
> **Zoe:** *you might have had a completely different answer if you rang a different consultant as well that's true*
>
> **Winnie:** *well if that is what you think that you need to come and look at it* (group interview p. 8)

The hierarchy is present and enforced with the higher grade of obstetricians influencing decisions when they are not present. However, the more junior obstetricians are able to challenge this.

Power and authority in the CLU rather than evidence define what is acceptable practice (Newnham, McKellar, & Pincombe, 2015) with the consequence of this being that practice which supports physiology is difficult to implement. This is despite the recommendation of developing polices and practice to support normal labour and birth to decrease medical intervention for women (Hodnett, Downe & Walsh, 2012).

Maternity care is fragmented into episodes of care relating to whether they are pregnant, in labour or have birthed their baby: if they are considered to have complexities or not, which stage of their labour they are in and who their care givers are. This has had a detrimental effect on the relationships women are able to build with midwives and therefore the care the midwife is able to provide. Maternity services are organised and have process in place which put boundaries in place between midwives and women and women's birth from rest of their pregnancy care.

8.3 Espoused beliefs and values

8.3.1 Maintaining control through medically dominated care

Medical practice dominates the CLU. Practice which is usual in management of pathological conditions is transposed onto labour care, information is controlled through standardised policy and procedure, services are prescript and relationships controlled. This has an impact on women's choice and control and midwives' practice.

8.3.2 Medical practice disrupting movement

Obstetric routine and procedure affect the use of movement through disrupting the relationship between a midwife, woman and birth. Ward rounds, a form of medical teaching, learning and assessing in acute pathological care maintains the doctor's position in the hierarchy. Ward rounds three times a day are thought to interrupt the atmosphere during birth and can be intimidating for the woman.

Donna and Elizabeth were taught to pre-empt them and tell the woman who they are:

> '*they just come in and, you know, if you have a woman semi-naked leaning on the bed, she doesn't really want eight men coming in to have a look'* Donna (Midwife, p.8)

Being naked, mobile and assuming positions which are beneficial to birth often require an environment which is comfortable enough to enable women to do this, an environment which enables women to be confident in their birthing body. Odent (1999) and Gaskin (2010) liken the environment for birth to that of the environment for sex for optimum production of oxytocin – the main hormone produced during labour. Being in an environment which is warm, comfortable, dimly lit which enables relaxation with a trusted other enables this. Within the hospital environment common maternity care practices and interventions can impact on this optimum hormonal physiology (Buckley 2015). All labouring mammals realise

epinephrine (Adrenaline) –norepinephrine (Noradrenaline) at an instinctive, subcortical level when they do not feel private, calm, safe and undisturbed. These hormones inhibit the production of oxytocin which then inhibits labour (Ibid).

8.3.3 Birth as controlled by 'they'

When speaking of their previous birth or their plans for their upcoming birth women spoke of how actions taken and decisions made about their birth mainly in reference to '*they*'.

When speaking about midwives on the MLU Katie spoke of *'they'* keeping her where she was, running her a bath, '*keeping her as relaxed as possible'* and breaking her waters, Laura spoke of being '*quiet well managed'*, in her previous birth, putting her on a drip, giving her an epidural which she felt she didn't need. Maggie spoke of her experience of having pre-eclampsia during her first labour, she found this experience frightening, felt she had no choice and she was ignored:

> *'I wasn't really allowed to move at all I was kept on the bed and given a drip …. I wasn't really allowed to move around … then even after that they wouldn't move me for 24 hours'* Maggie (Woman, p1)

During her second labour and birth, which she describes as *'a lot better'* and going '*really well':*

> *'I was allowed to move around up until a certain point and then they stopped it, you know it wasn't allowed then after that because they wanted to monitor and put them straps on'* Maggie (Woman, p. 1)

Maggie's experience of a pre-eclampsia, a medically managed birth and a normal birth with some intervention she described as two very different physical, psychological and emotional experiences. In her first birth, having no control of her physical complication of pre-eclampsia, the obstetric management of her labour and birth, nor her body, in addition to the environment and way the staff treated her, resulted in her negative experience. Moving around on the MLU area, though '*they stopped it'*, forming a positive relationship with the midwife in the '*calm'* environment resulted in a positive experience. However, Maggie speaks of her birth in relation to what she was '*allowed*' to do showing the perception that '*they'* are in control not only of managing a medical condition of pregnancy and surveillance of her baby but her body.

Olivia spoke of her birth on the CLU area, being twelve days over her due date she was induced, the '*policy*' at the time was to be '*monitored throughout'* and that they '*Wouldn't let me get off (the bed) because they wanted me to stay on the monitor'.*

Although Olivia wanted to '*keep active'* and was brought a birth ball, it was too small and deflated which she was '*disappointed*' about, having had to remove her underwear whilst on the bed Olivia:

> 'I w*anted to move but couldn't, I could but then I had to ask someone to hold the sheet and someone to watch the wires because every time I moved it was moving this stuff from my tummy and it was just and I just thought don't bother just stay still'* Olivia (Woman p. 13)

Olivia had knowledge about movement and planned to use this during her birth, however the '*policy*' and surveillance surpassed her wants through dictating that monitoring was more important than her movement. Not only did the CLU policy and need for monitoring prevent Olivia from being '*active*' during her birth it also confined her movement, in a way that made her choose between movements or maintaining her dignity. The presence of the monitoring wires and her need to cover herself made her reliant on the help from others removing her agency.

Sue spoke of her second birth and how '*they*' let her go twelve days overdue. She describes this birth as a positive experience that was different to her first birth experience. Sue describes her first birth as '*a bit of an ordeal*' 'a *bit of a shock'* and over whelming. Thinking she was a bit naïve for initially not wanting an epidural during pregnancy, she wanted one at that point, this '*slowed down contractions'* and '*they had to put me on a drip'*. Remembering being told by the midwife at 4pm she could start pushing at 5pm which she did:

> *'I mustn't have been pushing hard enough because I can remember them getting a bit panicky at one point see saying you need to go on the left side because her heartbeat was going down and it annoyed me because I was just having this contraction and I thought I can't'* Sue (Woman, p. 4)

Sue's perception of the '*panicky*' situation is that it was down to her and her ability in pushing. Though the epidural had restricted her movement and the management had restricted her

ability to manage her birth, she was now told to move. The immediate need to react to the heartbeat was to use movement. The staff put the responsibility of moving on to Sue causing her to be annoyed as she had no or little control over her movement and she was experiencing a contraction at the time. This showed little compassion to how she was feeling.

8.3.4 Control of information through policy

Women and midwives spoke of policy and how this dictated their choices. Only the information in the policy is accessed and used restricting women's knowledge of other information available and which information midwives use to inform their practice.

Olivia spoke about her previous birth experience of being induced. She hoped for a normal birth this time and was hopeful because '*the policy'* regarding induction had changed meaning if induction from a pessary was successful, she could have her baby on MLU.

Sue spoke of her previous birth and because she was 10 days over her due date, '*they wanted to monitor me*' because of the policy and her being over her due date and she did not want this to happen again, she spoke of fear and I asked why she was fearful:

> '*I think my fear about having to be strapped to a machine or being made to lay on a bed was, I thought well, all that that is just going to inhibit my Labour and could slow it down or could make it more difficult and I think because it can it was amazing really with baby number two'* Sue (Woman, p.17)

Being monitored and '*strapped to a machine'* through confining Sue's movements fulfils the needs of the hospital and not Sue's wishes for a normal birth. By potentially denying her this agency in her birth, Sue is left under the control of the hospital and its policy on management of induction of labour. To Sue movement is part of physiological birth but is not part of the management of induction. The need for monitoring is paramount as a medical intervention but knowledge around movement and normal birth is not included.

Hospital policy also affected Maggie's experience. She felt that policy regarding artificial rupture of membrane on the MLU was '*crazy*' as she was told *'she said (Midwife) we not allowed to do this we need to do it downstairs'.*

The policy dictates the actions and where these actions can be carried out and by whom, had an impact on Maggie's birth experience and '*it affected the bonding with the baby'.*

Midwife Hannah spoke of the absence of knowledge on normal birth during policy/guideline creation:

> *'historically they've always been written by doctors and that doesn't mean to say and obviously some of them are medically important and you need that medical input but certainly you can have a joint guideline where you've got your medical input as well … you can have a pathway but you need to think what of the midwives role alongside any process'* Hannah (Midwife p. 8 &9)

Policy that is designed to standardised maternity care to ensure that care received is equitable and safe does not take in to consideration individual women and professional judgement. As a result of the policy, physiological birth is impeded by the need to monitor, confinement to a wheel chair without '*pain relief*', compliance has an impact on women physically, physiologically and emotionally and the relationship between a woman and her baby. Practice relating to care which is considered to be '*high risk'* or which is not within the strict boundaries of normal birth as defined by the guidance team does not consider care which supports physiological birth or the role of the midwife. To address this requires challenges on behalf of midwives in the area to enable the midwives to practice as experienced other midwife challenge with research.

Geraldine spoke of her experience of implementing midwifery care with a focus on normality rather than risk and how this is perceived by obstetricians:

> *'it was hugely challenging; they were really scared and I think it's because they don't really know what midwives do so they think it is at best it's a bit wacky and worst a bit dangerous really'* Geraldine (Midwife p.11)

Geraldine's perception of how some obstetricians initially viewed midwifery led services highlight lack of obstetrician's knowledge of midwifery and physiological birth. Geraldine then experienced challenges when attempting to implement care that they didn't perceive to be valid as it wasn't known to them. Midwives are experts in normal birth and are able to support and care for women with medical needs. However, in an institution that cares for women who will experience physiological birth and those who need medical input, midwifery is expected to know all areas of care needed yet obstetrics does not understand midwifery.

Geraldine also experienced resistance when working with other midwives:

> '*it just struck me one day when I was at a midwifery forum and I suddenly found myself arguing with midwives … I found myself saying all these things and I looked round the room and it was just midwives in the room and why do I feel like I've got a massive fight on my hands and defending myself … I think doctors can be very challenging but if you give them a good argument then they are usually quite willing to go with … whereas sometimes midwives are just very difficult to challenge'* Geraldine (Midwife p. 7)

Geraldine was being challenged by members of her own profession that would have similar experiences but is not as accepting of a point of view based on their own knowledge base, or coming from a member of their own profession. Whereas, when Geraldine presents '*a good argumen*t' to doctors her point of view is accepted therefore respecting her midwifery knowledge though it is perceived to be unknown to them.

8.3.5 Services and relationships

Women spoke of their experiences of the services and the relationships with their midwives. Pat spoke of not knowing the midwife in hospital until you go in to give birth, which she felt was a pity, Roma, though she had a lot of information but was planning to '*just going to follow the lead of whoever is there'* Roma (Woman, p. 5)

This was Roma's first pregnancy; therefore, the experience of birth was unknown to her. Though she prepared herself with information around movement, the person who cares for her in labour is who she expecting to take the lead around her movements in labour. The midwife caring for her is expected to know which movement will help her in her individual experience. Whilst this is within the scope of midwifery practice, it is also dependant on which midwife Roma is assigned to her care and her care needs.

Sue said her midwife was '*in and out*' during her first birth and remembers:

> *'crying going I'm going to have to have an epidural but then I think right, she just went with what I felt I needed maybe another midwife you know, what I reckon you can do this let's keep going but then the midwife doesn't know me so don't know what works best'* Sue (Woman, p. 14)

After three different births, Sue recognises the difference in midwifery care in relation to how women are supported and birth is managed by individual midwives within the service.

Services are structured in a way that makes women and midwives unknown to each other until the intra partum period in hospital. In depth knowing between women and midwives is not gained. It is not until labour that women and the midwives caring for them meet. Hopes for women's' birth are not known, only in the form of a brief birth plan, where the woman wishes to birth her baby is not known, in depth knowledge of the woman and how she reacts or copes in situations has not been built therefore '*what works best*' for the woman is not implemented.

8.3.6 Choice and control

Within NHS maternity services, women's choices are restricted to policy giving them little control over which choices they are able to make. This often results in women's choices about movement being restricted and in return restricting movement.

Nicky spoke of the uncertainty of not knowing if she would be able to go MLU until she was in labour, all the women who had experienced birth on the CLU thought it gave them no choice in regard to using movement.

Having options during labour and birth enables women to use movement that works for them. Maggie felt that:

> *'if you're giving choices and options… something will appeal to somebody, somebody will think of something … something will appeal to them and then if that doesn't work then they have got another option the can try something that helps rather than just do this that's all we've got that's all you are getting'* Maggie (Woman, p.11)

Having choices and options for movement during birth was important for Maggie. The environment in which women give birth is seen to influence movement in regard to the different options it offers. If options are available, a woman is able to use what is best for her, enabling her to make the choices that are best for her and engage in her labour using agency.

Laura experienced birth on the CLU and thought that the CLU was not as well equipped as the MLU as the MLU offers options for movement. She thought the difference between the MLU and CLU was:

'*just a case of you getting on with it and not having those little assisting tools that you had like you've got at home really like you've got that comfort'* Laura (Woman, p.5)

The experience of birth for Laura on the CLU was of one that just happens, in isolation from the environment and circumstances surrounding it. This is seen as different form the MLU where the environment '*assists*' taking consideration of other things such as women's comfort. For Laura, the MLU seemed '*well equipped*' as this offered an environment that enabled her to be *'free to move'* and in the CLU this is '*taken away from you'*. To Laura the equipment that offered her options, took care of her physical and psychological needs seemed the better birth environment.

During her first birth, a midwife brought her a ball in labour, however she fell off it as it was not high enough and there were no others. This made her feel that:

'(CLU) *not used to women wanting to be up and about as much because it's normally people that are monitored'* Olivia (Woman, p. 14)

The need for monitoring surpassed Olivia's need for movement, the equipment available and the expectation of immobility for monitoring supported this. Olivia expressed her need for movement and was supported by the midwife however the equipment available limited choice and controlled her movement.

Recognition of the '*importance of control for women*' and the ability of the obstetrician to enable this was also spoken of by obstetricians. Zoe recognised the ability she had in facilitating '*little choices'* when she implemented interventions and Yvette, who felt that her experience of being a mother before an obstetrician '*shaped things*' for her after having a '*very normal experience'* and looking at '*how you can bring normality into a high risk situation*' the group discussed how this impacted on control:

Winnie: *'its control isn't it the woman needs to feel like she's got control over what's happening and I think that's quite important in her enjoyment of that experience as well sometimes I find the most difficult thing is when you've got a particularly high risk woman, that may ideally would love to go on MLU in a pool and then you're saying then, well no that's not what we'd recommend if that's what you want then we would support you but that's not what we recommend, and actually we need you monitored*

we need to attach you to this machine and that's more difficult taking away that what they have dreamt about probably since the age of God knows about how it's going to happen and you can take it away and that's almost harder really I think'

Yvette: *'been able to give some of that control back'*

Zoe: *'that's really important there are not many situations where a woman can't have at least some control and you might be saying yes I'd like to get on and ARM (Artificial Rupture Membranes) but it's up to you do you want to be upright, try to get up, do you want to try the FSE (Fetal Scalp Electrode), little choices when they are safe can make a big difference to someone's experience'* Group interview (Obstetricians p. 3)

Whilst the importance of control is acknowledged by the obstetricians and how this affects the woman's experience, it is spoken of as the obstetricians giving control or making women feel in control. Using movement and upright positions and other aspects of care related to physiological birth were viewed as contributing to normal birth and therefore enabling women to control aspects of their birth. Control is spoken of as if:

a) There is an ability to control labour

b) It is obstetricians who are able to take control and therefore give some back to women and

c) Some or little choices are the only choices women are able to have.

This ability to control, take and give control was also reflected by some of the midwives interviewed. However, in general the midwives interviewed spoke of empowering women to make their own decisions as an aspect of how they facilitated the control that women had over their birth. Women acknowledge that in order for them to be in control of their birth they needed the appropriate environment but control of birth was generally not with them but acknowledge that when they are in control of their body they fell more in control of the birth. Control was also seen as enjoyment, an emotional aspect of birth, however from the women's interviews control for women is more important for them having a lasting impact on their psychological well-being, mental health and relationships with those around them. Winnie also recognises how hard it is to take control away from women in relation to their choice and a belief in what is the best options for women. With the underlying belief that the obstetrician knows what is the best choice for individual women. Having the ability to control

choices, the removing of choices for women is appeased by giving some control back through allowing them little choices that can be manipulated as they are not significant choices which impact on what is believed to be the best course of action.

8.4 Basic underlying assumptions

Basic underlying assumptions are so taken for granted that there is little variation within a social group of which action to take in specific situations because the solution has always worked well (Schein, 2017). Basic underlying assumptions that show disconnection will be explored within the structured themes (Appendix 16) of lack of empathy, dignity and choice for women.

8.4.1 Lack of empathy, dignity and choice for women

The basic underlying assumption in the disconnected culture showed a lack of empathy dignity and choice for women as courses of action taken that maintained control, value policy, process and safety over personal experience. When authoritative knowledge is the prevalent knowledge, understanding of the physiological, psychological and social aspects of birth is lacking. Without this knowledge and understanding empathy and dignity is lost, as birth becomes solely a biomedical process.

8.4.2 Discrepancy between expectations and experienced reality of midwifery.

When speaking of their experiences of midwifery training, all midwives had experienced a discrepancy between their expectations and the experienced reality of midwifery. Their perception of the compassionate care they thought they would witness was lacking.

Donna was '*shocked'* by not only the '*stuff that happens to women'* in the sense of obstetric managed births but how women were treated. She told me of an experience of a refugee woman who could not speak English on the CLU when she was a student:

> '*I was told to VE the woman … she just didn't understand … in the end she was begging for an epidural the anaesthetist came in, and this was six hours down the road, and … said (anaesthetist) 'I am not doing this without an interpreter' and I could have kissed the woman (anaesthetist)'* Donna (Midwife p.3)

The care that Donna experienced as a woman from an empathetic midwife during her own birth was not the care she witnessed as a student midwife on the CLU. There was discrepancy between what Donna expected to see and what she experienced causing her to feel this way.

Geraldine, coming from a nursing background, found at the beginning of her midwifery training that her experience was different from her perception of how care should be provided. She felt that she would have left midwifery training if she had not been placed with a particular midwife:

> '*these tyrants (midwives) that put the fear of God into me and it was just a really, really big culture shock, wasn't how I expected it to be at all'* Geraldine (Midwife p.2)

She was also '*shocked*' at how hard the midwives worked adding '*all these women were in this terrible pain and nobody really seem to care at all'*.

Having a background in palliative care and working in a medical model focusing on illness, Geraldine saw pain as a result of pathology, the care givers role is to alleviate pain (Davis-Floyd, 2001). This is in contrast to maternity care where a working with pain approach is often used (Leap & Anderson, 2008), which is viewed as more humanistic (Davis-Floyd, 2001) or based in a social model (Walsh & Newburn, 2002) of care.

As a breastfeeding peer supporter Jan's experience of postnatal care was positive however this changed as a student midwife:

> *'suddenly you are sort of dropped in from a very great height and suddenly … you are sort of fairly aware of the circumstances and the complications and your just your ultimate responsibility for everything that you do and I think I found that the most difficult'* Jan (Midwife p.2&3)

Similarly, to Geraldine and Donna, Jan's perception of midwifery was not supported by the realities of clinical practice. Jan's realisation of the midwife's role was more in depth, with the increased awareness of the responsibility of the midwife and the emotional impact of the consequences of her actions within the culture she worked.

8.4.3 Removing privacy

Having privacy removed was an issue for women experiencing birth on the CLU. Olivia felt she had no privacy during her induction procedure:

> *'I couldn't really walk around the bed space, at the time it was visiting time so we had to have our curtains round because there were men around in the ward'* Olivia (Woman, p. 12)

Lack of space and privacy inhibited Olivia's ability to move following the induction procedure. Whilst Olivia attempted to maintain her visual privacy though closing curtains, the presence of men when she was dressed in nightwear made her self-conscious thus confining her to her small allotted space and impacting on her ability to move around when having contractions.

Olivia, as a birthing woman spoke of her experience being monitored and how this was not conducive to her personal privacy during her birth and her being able to maintain her dignity. Olivia spoke of wanting to move around by herself in her previous birth as she was '*not a patient*'. However, she could not move due to the monitor, this also affected her ability to walk to the bathroom:

> '*The leads didn't reach so I had to use a bed pan at the side of the bed …. it just wasn't very comfortable having to sit down and have a wee in front of husband and his sister and the midwife and the student*' Olivia (Woman, p. 4)

Not only did the monitoring in labour restrict Olivia's movement during labour it also removed her dignity. The need for monitoring surpassed the need for Olivia's dignity, feeling '*exposed*' already as she was in labour, having to then '*wee*' in front of those present instead of in private, removing her agency and capacity as someone who is able to make that decision for herself is taken away.

Laura's expectation of CLU was of a '*hospitalised*' birth that entailed '*not much privacy'* in an area that was '*frantic*' with '*people rushing everywhere'*. This perception of CLU was from her previous birth and an episode in triage during her pregnancy. She spoke of it as an '*eye opener*', following this experience she said:

> *'I don't want to go straight to CLU I was thinking, I don't want to be one of them women panting and sweating in a mess … I want to be able to sit and be quiet with them (contractions) and be in the pool breathe through it'* Laura (Woman, p. 12)

The removal of privacy though the use of communal rooms appears to be associated with a '*hospitalised'* birth. Not only is privacy removed, Laura feels exposed to people and an atmosphere of high emotional intensity and activity. Laura does not want to be in this environment during labour, she wants a normal birth in the MLU due to the calm environment. Labour is also a time of physical and emotional exertion; it is a time of

behaviour which does not fit with socially acceptable norms of behaviour in a public space. Laura is conscious of this and does not want to expose herself when in a '*mess*'.

8.4.4 Birth as unknown for women

Women identified the uncertainty about the trajectory of birth. Birth is not completely unknown, having seen birth on the television, had previous experiences and spoken with friends and family. But how birth will go for them is uncertain in its specifics for many women. Women spoke of their plans for their birth: their hopes and what they wanted to do. Laura spoke of wanting a '*natura*l' birth: Katie hoped everything was '*straight forward'*: Olivia said '*fingers crossed'* she did not have an induction.

Roma spoke of going in to labour with an open mind and '*depends on how bad, how long, what happens really'* as to whether she uses the pool or has an epidural, although she has:

> '*loads of hints and tips how to get gravity working on baby so am hoping that helps ease the pain and helps me get through'* Roma (Woman p. 1)

Women hope for a normal birth but there is the perception that this is not always possible. How Roma, as a primp-parous woman will feel about labour, how it will proceed and how she will *'get through'* labour with her information around movement is unknown to her. The physical length in time is unknown, how she will perceive it and if she will be able to manage it herself or need analgesia is unknown.

8.4.5 Knowledge of movement

In the previous chapter, midwives spoke of how they learnt about movement from their training and from their experiences of being with women during labour and birth. Women spoke of how they learnt about movement from the midwives.

Tracy speaks of the midwives as a '*fantastic bunch'* and recognises herself as '*not in a position to initiate'* movement as '*she wouldn't want to interfere in their plan'* as she would consider the use of movement as '*something the midwife would have thought of*' however:

> '*it's (movement) very often something that comes up because we do regular Ward rounds on the CLU and obviously stuff comes up just talking things through so that's a very valid source of information'* Tracy (Obstetrician p. 10)

Tracy recognises movement as *'important*' in contributing to physiological birth as it is discussed during ward rounds which are part of the CLU way of working. '*Talking things though'* with midwives is recognised as a valid source of information. Movement is seen as part of midwives practice, something, the midwife would use and initiate however, as part of practice on the CLU. The midwife is seen by Tracy as providing valid information on the subject as movement is not see as part of her role. There is trust that this is something the midwife would use and to advice on an aspect of physiological birth and movement would be crossing a boundary and viewed as interfering.

When caring for women who had a different belief around the effectiveness of movement on labour Winnie felt that that if she had tried to encourage movement and women did not want to there was nothing she could do. Yvette thought that dependant on a situation: progression and the presence of risk factors and a woman is not mobile, then that is fine and probably physiological however:

> *'if it's a lady who is coming with her baby that you know was OP and she is on the large side and she just won't move then that's just a little bit different'* Yvette (Group interview, p.13)

Though the obstetricians appear to want to encourage physiological birth through movement, if a woman declined then her decision is respected and the obstetricians are aware that they are not able to impact on this.

8.4.6 Knowledge of birth and movement as is seen

Tracy puts the role of the obstetrician into context of physiological birth. An obstetrician only seeing '*snapshots*' of '*poorly women'* during labour she feels it is '*difficult to say'* if movement has an impact on labour:

> *'I think it's impossible to tell, I think the midwives have the overall continuity with the woman and they will see each woman that they deal with and that will build a picture of how the movement impacts'* Tracy (Obstetrician p.13)

As Tracy's role does not involve a continuous amount of time with women during labour, experiential knowledge of movement and its impact on labour is something that is unknown to her and therefore something that she feels unable to comment. This shows a distinct boundary between the midwife and the obstetrician. The obstetrician has no experiential

knowledge of movement, therefore cannot comment on its value or worth as it is not in her area of expertise. Yet the obstetrician is the expert in abnormal labour without knowledge or experience of normal physiological birth.

However, Ursula saw encouraging mobility as something that she recommends during her role in triage during the '*latent'* stage of labour. Therefore, although not working with women during physiological birth, Ursula sees movement as impacting on the process and therefore part of her role as encouraging this. Though as an obstetrician she would not necessarily spend large amounts of time using movement as part of her practice, she has knowledge of it and therefore feels in a position to be able to advice women. Ursula, Yvette and Zoe all referred to their personal experience of birth, either during the interview (Ursula) or in discussion afterwards (Zoe and Yvette) and spoke of how their experiences had an impact on them. Only these three obstetricians' sited women as a source of information around their movement and spoke of using movement as part of their practice.

During the group interview, Zoe felt that individual doctors' experience prior to becoming a medical student, the hospitals they had been to and the placements they have had, all contributed to the experience of training. Ursula, when asked where she thought her obstetric colleagues gained information on movement thought that this would be from college as a medical student. However, she thought that experience added to this information but as obstetricians they '*don't get encouraged'* to go to the MLU area. Additionally, she felt individual attitudes affected use of movement:

> ' *if they(obstetricians) don't have the attitude that is a good thing to do in Labour then yes, going up there (MLU) being involved in normal Labour is really useful, I think the medical students get that experience so that's almost where you've got to start in terms of driving into people what is normal'* Ursula (p.10)

Whilst Ursula judges movement to be '*good*' some colleagues do not share this and thought experiencing normal birth on the MLU is '*useful*' in influencing this attitude.

Hannah spoke of asking midwifery colleges who would give suggestions in practice regarding movement but said:

Hannah: '*I can't imagine a consultant coming in and going 'why don't you get her up and move around''*

Me: *why do you think that is?*

Hannah: *'because they are medical, they are two different paths to having a baby the medical side and the midwifery side and neither the two shall meet'*

Me: *and you see that as very definite?*

Hannah: *'they should only be involved if there is something abnormal outside the realms of normal which is fair enough that is their job'* Hannah (Midwife p. 12-13)

Sharing and using knowledge on movement and normal birth appears predominant among midwives. However, most consultants, from midwives' experience or during the interviews, did not comment on this because it is not within their remit of medical / abnormal birth that the data show are separated from physiological birth. From Hannah's perspective, consultants or doctors would not have knowledge of normal birth as they '*don't see childbirth' 'it's not their job*' therefore they cannot know.

8.4.7 Movement as unknown for women

Speaking of her first birth, Kate's expectation of birth was not what she experienced. Despite attending parent craft, she thought it did not prepare her '*fully*' and '*mentally for what it actually was*'. Speaking to others about birth she thought was '*scary*' as they make you think it is going to be '*horrendous'*. This combined with watching birth on the television gave Kate perceptions that did not match her reality: '*I honestly thought I would be on a bed and not moving'*.

Kate's expectation of birth was being on the bed in the passive patient roll, birth was something which happen but not something in which she took an active part. She had no knowledge of how she was expected to move. The sources of information that she had access to did not adequately prepare her.

Reflecting on her last birth, Laura thought she knew more than last time. When her labour started in her first pregnancy she thought:

> '*Why stay at home when you're in that much pain? and then I after last time I know what they mean, I would rather be here and be able to walk about and go on the ball and have a bath and just have a wander about the house rather than be like I say sat on a hospital bed'* Laura (Woman, p. 4)

Having not had the experience of labour, birth and parenthood, Laura, did not have an understanding of how staying at home and movement affected the experience. She expected a pathological response to the pain she was experiencing. The pain she was experiencing was to be managed through intervention from medicine. Having experienced birth that was responded to in this way and the 'aftermath' she had, her intention this time is to use movement at home. In this way, she is '*able*' to move, engage in her birth in preference to being passive and taking a medical approach and therefore gain some control over her birth experience.

Information around movement in labour is knowledge which is seen to be held by midwives as only Olivia had witnessed labour that was not her own. Laura thought that if she had known more about movement during her first labour she would have '*handled it better'*. This was from a psychological perspective as she would have used movement to '*handle*' labour. Additionally, if she had known more about movement, her negative birth experience '*would have been a different story'*.

Katie thought she: '*might've lasted a bit longer at home had someone said just keep moving around at home'*.

Movement was something used in labour that was unknown to her prior to going to hospital. Katie see's movement as something that she can engage with during labour to avoid the hospital in early labour. However, 'someone' holds this information around movement and it was not given to Katie to assist her in her own labour.

Quinn thought that nothing '*verbal or written'* was given to her during pregnancy about movement. When talking about the birth plan, the midwife did not '*go into detail'* about movement and she said she would not know where to get that information. Olivia did not think she asked the midwife enough about movement antenatally and Maggie thought if she had more information on movement, she would have made better decisions:

> *'Knowing what I know now about movement if I had the information beforehand that I would have done things very differently and moving about may have helped'* Maggie (Woman p. 15)

Having experienced birth three times, Maggie only now feels that she knows about movement. It is only in retrospect with this knowledge she feels she would have used movement to help her. This position of not knowing about movement contributed to Maggie feeling helpless and unable to have an impact on her birth experience. It is only the lived experience of birth that has added to this information or motivated her to find out more. Without this information she was unable to help herself or influence her labour.

8.4.8 Authoritative knowledge

The impact of forms of authoritative knowledge is shown through the automatic response from all midwives when asked where they would find information on movement. All midwives said they would use the internet to find research or literature on movement, some mentioned specific authors: Denis Walsh, Cochrane, Simkin and Anchetta. However, Fiona acknowledged that: '*There are just not a lot of papers, not a lot of research really into it*' Fiona, Catherine said she would look at hospital guidelines, but Hannah said: '*I don't think we've got the guideline on it to be honest'.*

Through all first responses being reference to research and the literature, it shows research evidence is known but not if it is embedded in practice. When speaking of guidelines, a standardised approach that is available in the form of guidance to practice and is external from the midwives and women's knowledge is used as a form of justification to practice. Knowledge on movement is evident in the literature and in midwives knowledge however, for this knowledge to become authoritative it needs to be evidenced in research and guidance.

Catherine thinks that the perception that doctors have more superior knowledge than midwives is also compounded through a society which we are raised in which there is a belief that '*doctors know best*'. This translates into practice and labour care through the midwife being there when the doctor has gone out of the room encouraging, reassuring and explaining:

> *'the doctor sees the case, the midwife sees the person and she can sort of explain what's happened, the midwife can because the doctors don't seem to, they should do but they don't always, I think it depends on what doctor you get'* Catherine (Midwife, p.11)

Living in a culture and working in an environment that perceives doctors being authoritative and knowing more, Catherine, is very aware of her position through seeing the effect of this on the woman and birth. As a midwife, seeing the person: knowing birth as a woman and a midwife in society and the culture of the unit, knowing birthing women, knowing the environment and knowing birth from a medical perspective. Catherine uses this to inform the women: giving her knowledge and sharing her experience in a way which increases the woman's knowledge of her own birth and body. She is aware of the gaps in the knowing between midwives, women and doctors how to level them out in respect of increasing the woman's knowledge about the situation but is aware of how the doctors could know more about movement and encourage this.

After attending obstetrician's teaching session on maternal mental health, I noted:

> '*The teaching session was presented in a very dictatorial style, national and local statistics were presented as facts and the solution to the issue of supporting women with mental health issues was very vague. Advising the doctors to refer to a specific obstetrician any woman who had a history of mental health problems'* Field notes

I also attended a Royal College of Obstetricians and Gynaecologist Course on Management of the labour ward:

> '*the whole four days was about complications and how to manage them, there was some really interesting session which went over physiology of common heart problems, stillborn babies and post mortem examination. Epidurals were spoke of as if they had no side effects, forceps birth were spoken of with no reference to the woman's experience. Only a consultant midwife spoke about women when she did a session around care outside guidelines and women's choice. The stand out moment for me was when an obstetrician asked about their choices when women declined care, the consultant midwife said you make that choice when you get out of bed to come to work'* Field notes

Knowledge in obstetrics is given in a way in which gives a very narrow viewpoint, concentrating on the physiology or pathophysiology, using quantitative knowledge of population studies and applying this to all women in general. Solutions were presented as the obstetrician proving this in the form of action, technology or medication. There was no discussion around the women's wants and needs or how midwives played a part in maternity care.

8.4.9 The power of knowledge

In Barbara's experience guidelines are used in isolation as valid forms of knowledge:

> *'Just grab the bunch of information from NICE and think we will work with that …. we don't need to have taken care of women we just have these … we can tell because we know they (Obstetrics) have always had the power yet so academia has done sweet sod all for us absolutely sod all we have got no power'* Barbara (Midwife, p. 22)

Objective guidelines and authoritative knowledge on which they are based are viewed as the valid way of knowing. Barbara sees the guidelines used in isolation from knowing through caring and the midwifery '*wisdom*' gained as not being needed and therefore not valid. She feels the increase in the knowledge status of midwifery and authoritative status given to academic qualifications has not given any power to midwives.

Fiona describes midwifery as something she is passionate about and how the '*academic side'* benefits her in work as a midwife:

> '*sometimes it is a credibility thing I want to know the answers to certain things so that I could challenge because I think we are getting a lot more academic potentially than we ever have I mean a lot of the midwives who I used to work with were very good midwives it wasn't so much evidence-based as experience based'* Fiona (Midwife p. 6)

Academic midwifery knowledge, Fiona feels gives her credibility, getting to know the answers to enable her to challenge. Midwifery, as a profession based in experience, academic qualifications and knowledge is seen as moving forward and enables Fiona to have a valid voice, when challenging authoritative knowledge.

8.5 Disconnecting

8.5.1 Lack of humanity, privacy and dignity

Whilst having an overall positive experience of midwifery training, most of the midwives interviewed experienced shock when humanised care was not provided within the culture of medicalisation labour and birth care that they witnessed. The role of the midwife within this system and how this was in reality to their perceptions was different. This predominantly was in relation to the lack of humanist values some care givers showed, with lack of ability the student midwives showed in being able to challenge this. These elements of care that shocked the midwives during their training were also elements which drew them to midwifery as outlined in the previous chapter.

Women spoke of a removal of privacy and lack of dignity when labouring on the CLU, something that did not appear to be considered in this environment. What women did not express was the awareness of choice and their underlying acceptance of this as being the way in which birth happened.

8.5.2 Birth as unknown

To the majority of women birth is an unknown experience. Although there is an underlying expectation that birth is safe, as no one spoke of death of themselves or their baby, the birth experience and how women will physically, psychologically and emotionally experience it is relatively unknown as birth is believed to be an individual and unknown experience. Only when birth has been experienced do women have some knowledge of birth. Women are aware that birth is an uncontrollable and unknown experience.

Few women knew about using movement during their labour unless they had had a baby before. From a midwifery perspective, maternal movement is a part of physiological birth, something that midwives can advise and something that women can use instinctively.

Midwives are perceived to have knowledge on movement during labour and birth, this is their expected role within the birth environment, knowledge around movement, and influencing women to use movement is not viewed as a role of the obstetricians.

8.5.3 Experience influencing approaches

From the perspective of the obstetricians, lived experience and personal approaches are seen as influencing beliefs around individual approaches to giving care and what is viewed as

normal during labour. The effect of movement on labour is viewed as an aspect of someone's attitude, something that they have or do not have and therefore down to an individual. However, physiological birth is not perceived to be in their sphere of practice, immobility is not seen as a '*risk factor'* for reducing the chance of physiological birth. Management of birth when it is no longer normal or care of '*poorly women'* is viewed as their area of practice but this is a reactive approach to problems when they occur. Through not either having the experience or knowledge to what contributes to physiological birth, care around birth cannot be optimised and thus be proactive in aiding physiological birth through movement. Therefore, having the knowledge and ability to use movement in care during birth that has the potential due to maternal habitus and fetal positioning, though not an emergency or outside normal birth, would enable more collaborate working to enhance physiological birth for women.

The effect of experience of normal birth on attitudes is seen to begin with medical students, as obstetricians do not get the experience of normal birth on MLU. Through having strong formative experiences, the lived experience of being involved in normal birth has an impact on personal and professional attitudes and therefore the use of movement as an aspect of normal birth by obstetricians.

8.5.4 Use of authoritative knowledge

Knowledge on movement is made authoritative by the way in which knowledge is presented. If scientific evidence or literature is used and then politicised it becomes more powerful in comparison to women's bodily knowledge. Despite obstetricians having little theoretical or experiential knowledge of movement during birth, knowledge that is presented in a way that values scientific method becomes the most valuable and respected.

Through the emphasis of care being given based on guidelines and not on the woman, it has given more power to obstetrics and the institution, maintaining their position and not giving midwives any professional power through supporting practice with this form of authoritative knowledge.

Authoritative knowledge, knowledge that is used and recognised in the institution, is an automatic response when interviewees are asked about sources of knowledge around

movement. This knowledge is viewed as authoritative as it is viewed as the knowledge base on which decisions are made as they are associated with a stronger power base (Jordon 1993).

There is a recognition of a division between theoretical and experiential knowledge. The ability to connect experienced based knowledge/wisdom with academic knowledge is seen to be giving midwifery credibility and has the ability to take midwifery forward in being able to support midwives to support women during labour and birth to challenge those in authority.

8.6 Conclusion

This chapter outlines the culture that restricts the acquisition and use of knowledge around maternal movement. The culture outlined is predominate in the CLU area and is described as disconnection as elements identified disconnect from women and physiological birth.

All midwives, and women spoke of their experiences that show a basic underlying assumption based in disconnection to physiological birth and humanistic relationships and care. Obstetricians also recognised elements of this disconnected culture.

Approaching care with this disconnection prioritises care in which beliefs and values are shown through boundaries being set. This leads to a fragmented hierarchical model of care in which the relational aspects of care are missing. Additionally, control is maintained through medical practice and the control of information, services and choice.

This contributes to a physical environment where medical equipment and surveillance are prevalent which do not support women's choice or physiological birth. This chapter has shown the elements of the culture as described by the midwives, women and obstetricians from their experience, perspective and position. It shows their underlying assumptions, espoused beliefs and values that contribute to the environment that does not enable women's movement during labour. This has been called disconnection as participants in this culture showed a disconnection emotionally, physiologically and physically to women and birth. The lack of a humanistic approach to birth resulted in an emphasis on managing birth to prioritise safety, making women feel over-looked during the birth process. It demonstrated beliefs that disconnected from women and gave maternity care that did not use knowledge of and facilitated women's movement during labour.

The next chapter shall look at the barriers the participants identified which prevented them from using knowledge around movement and contribute to the disconnect in this culture.

Chapter Nine

9. Barriers

The culture within the maternity unit has been identified using Schein's (2017) framework for the organisation of culture. The underlying assumptions, beliefs, values and artefacts were identified which connect and disconnect women, midwives and obstetricians enabling and disabling the use of knowledge on maternal movement during birth. Barriers were identified which prevent change happening in these cultures and prevent women accessing and using knowledge around movement. This chapter will present the barriers midwives, women and obstetricians identified.

9.1 Midwives and obstetricians; perception and experience of how each other is viewed

During the interviews, all of the midwives had perceptions and experience of how they were viewed by most obstetricians and the obstetricians had perceptions and experience of how they were viewed by midwives. All of the midwives interviewed felt that on the CLU the doctors in particular took a more medicalised, scientific approach and that was their way of addressing care, if an alternative approach was presented some midwives felt they were viewed as '*hippy'* (Elizabeth and Fiona) '*Wacky*' (Geraldine) and *'a bit odd*' (Donna).

To challenge these beliefs that the obstetrician's held, Geraldine thought you would have to come up with something very scientific, measurable and give numbers and figures as midwives are different:

> *'when you are more holistic you're very much in into the empowerment of women and the process and fostering that environment… well if you wanted to incorporate into practice you would have to go, go and show them that it worked and not be afraid of some criticism in the process'* Geraldine (Midwife, p.18)

All midwives spoke of and understood their role as more holistic in the approach to birth in comparison to the obstetrician's.

Geraldine goes on to say in her experience obstetricians take a scientific approach and want something measurable, though they are getting better, they think her a '*bit wacky'* when she speaks of birth anthropologist Shelia Kitzinger, however:

> *'If you can come up with something facts and figures that said well, being mobile in Labour would do this this and make a difference then they'll be quite happy to do it'* Geraldine (Midwife p.17)

Geraldine's perception of obstetrician's knowledge is of received knowledge from a standardised quantitative base. Again, the focus is on the complexities, outcomes with no understanding of the process and how this affects the women involved. In comparison to midwifery, where there is awareness and training from a holistic individualised perspective, the woman, her psychological, emotional and sociological well-being are removed to take an objective stance focusing on outcomes. A midwife using anthropological or midwifery sources may give the impression of being '*wacky*' undermining and discrediting midwifery knowledge as not as valuable or credible. Geraldine perceived that information about the use of mobility would have to demonstrate a measurable cause and effect before obstetric practice would accept it as a recognised intervention.

From the midwives interviewed the obstetricians and some midwives did not always view birth this way; focusing on evidence that is quantitative, medicalised practice and birth being controllable in a cause and effect manner. However, they thought this was down to how they had been trained. To incorporate a more '*midwifery'* approach to birth, doctors need to be shown how this worked and the results as a form of proof to justify a change in accepted practice.

Tracy's experience as a consultant obstetrician working in many units across the country has given her the opportunity to observe different working cultures:

> '*there are units that have worked in where they have seem to have lost sight of, that is if they ever have, they have ever had sight of it, where it was a kind of them and us mentality as if it was the doctors, patients and the midwives were sort of doing a favour to do something rather than contributing to care for the patient'* Tracy (Obstetrician p. 6)

From Tracy's perspective, her sense of a positive '*working ethos*' is where staff work well together for women.

During the group interview with the doctors they spoke of a different experience of working together:

> ***Zoe**: 'it's junior doctors or midwives who are very keen to shift any blame to you and are very clear and say – 'I want you to come and sign off, I am going to put your name in the notes' and I think that that can make you feel a bit negative sometimes and I think the obvious answer to that is as well you shouldn't be worried about your notes if everything is fine in doing the right thing think it's just the culture'*
>
> ***Winnie** ' you feel like well now I feel like I'm in a really awkward situation because I don't want to barge in to this room but equally if you have said that I need to be informed that this lady is spontaneously pushing and the CTG is not good I still need to, I can't just ignore it, it puts you in a difficult position, I have not had that bad experience here, but I have worked somewhere where that happened a few times and I understand it from the midwives point of view because sometimes you know they are going to deliver and you know that baby is going to be fine and you know the CTG is not really that bad but because of it you are duty bound to kind of informed the registrar'*
>
> **Zoe** *'with the midwives that it is us and them and I think if you almost body blocked the door, you sort of stepped back a bit and you go I am actually going to be nice and I don't think the woman is going to hate me what's the problem … it takes midwives a little bit of time to actually suss you out to think you're not going to walk in and start clanking your forceps'* Group interview (p. 7)

The obstetricians see midwives as not always working together with them for what they perceive to be for the benefit of the women. The midwives show insight into why the obstetrician's may lack understanding in their role and practice. The perception from the obstetricians interviewed is that this lack of understanding is based on lack of trust. The previous chapter identified the obstetricians as coming from a position of safety and lacking knowledge, understanding and experience of physiological birth. They also lack understanding of the midwifery role of empowering women in their birth. This leads to obstetricians perceiving midwives as 'slightly odd' or having 'peculiar behaviour' and that

midwives lack trust in them. Running throughout this is the pervading culture of managing risk and blame.

However, one obstetrician is seeing a change in how midwives and obstetricians work together:

> *'I think it's probably age-old and it's probably just never left from when it was a very male dominated speciality and it will have been the Doctor knows best… I don't think it is like that anymore it's just a shame even when even when it seems like very young and reasonably newly qualified midwives have come through and managed to acquire that belief along the way,'* (Group interview*,* p.8)

The difference between midwives and obstetricians is seen as historic and coming from historic patriarchal practice. The challenges between obstetricians and midwives as described by the midwives are invisible to the obstetricians. It is noted by this obstetrician that newly qualified midwives are less trusting of them. This could be because newly qualified midwives have not been socialised into the environment and therefore maintain a different view from the midwives who have being working in a unit for some time.

It appears that a significant barrier to implementing midwifery and women's knowledge around movement is the way in which birth and midwives are viewed. In a culture that prioritises normal birth, midwifery and women's embodied knowledge is implemented and is therefore valued. It was the perception of some the midwives interviewed that obstetricians and the institution appear to value objective outcomes-based knowledge learnt from authoritative evidence (see 8.4.9). Additionally, most obstetricians have little experiential knowledge of physiological birth other than from personal experience and thus rarely see women's movement during birth. What midwives know and what obstetricians know around movement is not perceived as of equal value. From the midwives interviewed, obstetricians are viewed as superior within their position in the hierarchy. They have the knowledge and ability to preserve safety for women and babies yet they appear to have little knowledge of how to support physiological birth using their perceived knowledge. Combined with the artefacts in the environment, the values and beliefs, the underlying assumptions of a disconnected culture, which strengthens this perception, knowledge about movement during labour is not utilised. When midwives' knowledge and experience is used to support

physiological birth and empower women this situation can be improved. Yet it is also clear from the data (see 7.5.1) that obstetricians who have personal experience of birth have knowledge of movement and recognise its use in labour.

9.2 Theory practice gap- sharing and use of knowledge in practice

Midwives spoke of a theory practice gap that has always existed. Midwifery as a graduate profession is based 50% in theory within a university and 50% in practice. Three of the ten midwives interviewed qualified as midwives when training was based 100% at the hospital site within the school of nursing and midwifery. Though there is now a physical separation between where practice and theory are taught.

Geraldine spoke of the theory practice gap as a student midwife. When learning from books and journals and then going in to practice, Geraldine experienced a gap between what she was learning and what she saw:

> *'there was still a theory practice gap because a lot of the midwives were quite old-fashioned, I think and it was, it was obviously was and still is to students, you know difficult to challenge those practices that you see, your mentors want you to behave in a certain way and it it's difficult to challenge them but I did see practices that I knew I didn't want to do'* Geraldine (Midwife, p.4)

Geraldine interpreted the practice she saw during her training as 'old' due to the length in time the midwives with whom she worked were students and therefore not having current knowledge creating a gap between their practice and current theory. As a student, because of the hierarchy within the clinical area and because of how she was expected to behave, incorporating what she was learning was seen as a challenge and difficult. The mentor's experiential knowledge was more influential than the theoretical or research knowledge presented in the classroom. Once Geraldine had been qualified for a few years, she felt she could change practice, as she learnt through her experience of being a newly qualified midwife in her environment and therefore gaining power in her practice and addressing and closing the theory practice gap. This culture does not enable an open forum for discussion and debate on practice that is being observed and the practice that is being taught in University presenting a barrier.

Elizabeth struggled academically, which she put down to juggling studying and working in placement. Training in a small unit, which lessened the impact of the hierarchical structure compared to a large unit, contributed to a learning environment in which knowledge could be shared across and inter professionally. The small size of the unit enabled relationships to be built with other colleagues and knowing each other capabilities. She also witnessed what she describes as a theory practice gap during her training:

> *'the academic side it didn't always meet, there was a bit of a gap sometimes, the theory practice gap, I think there still is, and now sometimes I even I say to the students I know they tell you this in uni but, but this is practice and I think you have just got to be realistic sometimes as a student be aware of that gap'* Elizabeth (Midwife, p 3)

Elizabeth sees the gap between theory and practice as a constant, something that, as a student, you can be more aware. The theory given in university did not and does not always appear to match what she was learning as a student and teaches in practice. To Elizabeth the theory practice gap is due to the theoretical knowledge being disconnected from what is 'real' practice knowledge. This can be viewed from the position of the theory being disconnected from clinical practice, as it is not taught in context with all of the nuances, restrictions and common knowledge of clinical practice. Working in a small unit also appeared to impact on the way in which knowledge was used and shared

Irene spoke of her training in the late 1970's early 1980's learning by rote and routine. During this time, she describes procedures carried out as routine but not done using wider knowledge around the woman's circumstances during birth or theoretical knowledge. Irene spoke of current services, thinking maternity care incorporates more evidence that is shared with the women however:

> '*we triage them on the phone now which we didn't used to do that that arm's length and making judgements over the phone which we didn't use to do whether that's I don't know I don't know for whose convenience that actually is'* Irene (Midwife p.5)

Some elements of evidence are implemented which suit the needs of the organisation. Practice or services transferred from other areas of medicine (Emergency care) are implemented rather than the plethora of midwifery literature and evidence. The organisation creates a barrier through the services it chooses to implement. Relationship based care that

could address the same situation in a way that fulfils the needs of the woman in her individual situation leading to all her needs being met.

9.3 Cultural knowledge

From all midwives and women interviewed, it seems that social media, television dramatization and the popular press are key sources of women's understanding of movement and birth.

Angela thinks some women don't make the connection between '*being up and mobile'* and the effects it has on *'pain'* and '*progress*' whilst experiencing labour, but it is the midwives who encourage movement. She thinks women see One Born Every Minute (OBEM) as the norm:

> '*They don't know any different and they think that is how we should birth baby and we're going on the bed, don't need to ask about that because that's what they do on the telly'* Angela (Midwife, p. 10)

Representations of what childbirth is like has replaced women's first-hand knowledge of birth. As birth no longer occurs predominantly at home as it used to, the media portrayal of birth has become women's perception of what normal birth looks like. This is shown as women lying on a bed, if this is the predominant image of birth then what is expected of women is assumed and therefore, they do not ask for information around this.

All midwives who spoke of OBEM and said it portrayed a dramatized, edited and medicalised version of birth and this has affected women's perception of birth as women are expected to birth in hospital laid down on a bed. Elizabeth and Barbra spoke of how they address these expectations.

Elizabeth spoke of how women and their families expect a bed on the ML area and how she addresses this;

> *'I say she can give birth where she wants she can give birth standing up or on the toilet it doesn't matter babies don't need to be born on the bed and some people are very open but some people you can tell it's is as if they are like a bit, people from ladies, from other countries seem to be taken aback really in that there is no bed as if it is a bit substandard really ... change their minds as Labour progresses but other*

people are quite set, no this is not for me ... maybe it was just a bit of safety to have the bed there' Elizabeth (Midwife, p. 11)

Many women's expectation of birth is to be immobile on the bed, the midwives on the ML area, using their knowledge and experience are the first point of addressing these expectations. While the midwife's role is to support women's choice, by providing a bed if needed, educating women and their birth supporters when they attend the ML in labour, she is negotiating the way into labour for women. Through challenging what women already cognitively know from, the media or others experience using her knowledge of birth and women. Elizabeth uses her profession and status to use movement to empower women to be an active part of their birth, undoing preconceptions of immobility and passivity and what women know.

Barbara use's OBEM, despite its perceived lack of portrayal of movement, as a resource for women to use;

'make a list when you're watching that telly programme have your pen and watch who is doing what to who, what are they doing that will help you out of anything you are watching, what is your partner … what is the midwife doing, how was she helping, what does she do that, to make you strong, so be very specific about what you are watching, is there any medics involved, why are they there and are they helping you know so they can think' Barbara (Midwife, p. 10)

Barbara uses her knowledge of OBEM and how this affects women and her knowledge of birth to turn it into a positive thinking exercise for women. By asking women to take an emotional '*objective'* step back from the stories and look at what they want out of their birth in relation to some of what they see. Looking for ideas in what makes women '*strong*' and encouraging to think about what they see, they can then get ideas around their ideals for birth. This suggests to women that they do not have to conform but they have their own ideas on what will work for them, in turn taking the negative image it can portray of birth and making this positive for way as they can decide what they want and do not want for themselves. This turns the potential fear of what could happen from the dramatic experiences portrayed to empower women to say what they do or do not want to happen to them.

All of the women interviewed commented on how the media represented birth. All seven women who had previously experienced birth said they had watched OBEM. Six of these women said that they thought that it was not a true representation of birth because it presented a medicalised view.

Maggie felt that OBEM was '*not an accurate portrayal'* as only snippets of birth were shown and felt that the program makers '*need educating' 'to get at proper cohesive look of what labour should or could be'*

Maggie, having experienced birth herself, knows that what the program is portraying is not relative to her experience and this is down to lack of knowledge by the program makers. To Maggie OBEM does not show '*free movement'* and as the program is in a documentary style, the producers are in a position to show reality.

Quin thought that hearing women screaming was '*horrendous'* and she did not want that to be her, Katie said she '*didn't want to see someone loose the plot'* as she didn't '*want that to happen to me'*. Laura felt that the women who were '*lay in a bed seemed to be having a worse time that those walking'* which portrays a negative image of birth. Sue felt that movement '*doesn't seem the norm*' from watching it and that a midwife had:

> *'medicalised that situation and I think it was because I was planning to have a baby and this woman had gone to the loo and I think she had a drip and as she was coming back she was like he's coming the baby's coming I'm going to have to push and she was leaning over the bed almost, almost leaving on all fours and the midwife was saying can you just get on the bed'* Sue (Woman, p. 10)

The women interviewed perceive the media portrayal of birth of birth as dramatic in a way that reinforces concepts of birth as horrific and in which women have no control. The women are expected to be passive, immobile and birth is seen as medicalised with the midwives supporting this. Six of the women thought it portrayed birth worse than it was from their experience, Sue particularly engaged with the actions of the midwife and how it reinforced the medical stereotype of birth.

Geraldine speaks of the effects of OBEM, where birth is portrayed as a medical emergency;

> *'if you are constantly suggesting that to yourself by watching it then you are confirming it and I suppose if you think about it, you know hypno-birthing changing your subconscious beliefs to believing it's all a terrible emergency because a lot of the Hypno-birthing that the ladies do, do extremely well because they have taken that away I think that fear away'* Geraldine (Midwife p. 15)

With an understanding of the effects that imagery has on the sub conscious, Geraldine sees how the media portrayal affects women, by using hypno-birthing, the fear that is gained from women by the media images is taken away. However, this requires acknowledgement of the imagery as '*false*' and engagement from women antenatal and maternity services and to implement this.

9.4 Women's lack of connection with other women around birth

The connections and disconnections chapter identified how women have little knowledge of birth. Women spending little time around birthing women is a barrier to knowing about physiological birth and movement.

Midwives also spoke of their experiences of caring for women coming into labour not knowing about birth, with fear or ideas of a medicalised birth as normal.

Geraldine is amazed by the number of women who come into labour not knowing anything about movement, especially with the amount of information available on the internet; she speaks of a conversation with her colleagues:

> *'maybe a part of it is not having extended family anymore people don't seem to, Ermmm to know the minutiae of it … if you had your extended family you would know you know because you would have discussed those things'* Geraldine (Midwife p. 15)

As a midwife working directly with women and families, Geraldine sees women and the role and position within their wider family and how this is changing. The perception is of a changing family dynamic and how little is spoken about birth within families.

The perception by most of the midwives working in the hospital was that many women go into labour *'completely blind'*, with not a lot of '*preconceived ideas'*, '*not knowing anything at*

all' and '*not actually thought about it'.* This then is up to the midwife to encourage, advice, educate women on movement during birth.

Midwives spoke of their experiences of how women approach birth and their perception of how they engage with it. Catherine speaks of women's shock when midwives advise women not to be on the bed on their backs;

> *'they just think everything is going to happen like clockwork and I can just lie back and take the gas and air and that is it'* Catherine (Midwife p.12)

Through the expectation that birth happens to a set mechanic like '*clockwork'* the onus of control of the physiological control of birth is something that happens to women without their input.

Katie spoke of not being '*close*' to her family and therefore birth was '*not spoken about'* and how her friends and colleagues only spoke of birth in a way that '*scares you'* and makes you think it is '*horrendous*'. Nicky had never heard anyone speak of birth only her sister who spoke of how '*horrible'* it was, Roma thought that when people spoke of birth, they just tried to scare you by telling you the '*worst bits'* making it sound a negative experience. When pregnant with her first child Laura heard stories from her friends that she though were dramatic but when experiencing labour for the first time:

> *'I had too many people with me I had my partner and my mother-in-law to be… the more the Labour went on the more I was thinking I just really want them, just want everyone to go'* Laura (Woman p. 8)

It has been identified that how women feel during birth is temporal, how women feel and who they want supporting them is not known until it happens. Few women appear to speak about what happens during birth, with the majority of information shared focusing on negativity.

As birth has been taking place in the institution since the1960's women rarely get to see how other women behave and move during labour. Women have been separated from birth, removing them from first-hand experience of supporting other women at birth and there for experiential knowledge of movement during birth. This then puts the midwife, as the carer during birth, as authoritative and holder of knowledge. Women rarely access this knowledge

prior to birth and can feel the onus is on them to get this information to enable them to know about movement and the expectations of movement. Yet, the majority of this information is gained during labour as it is not often spoken about, what is an unknown aspect of labour and birth remains unknown as women don't know about it until they are in labour.

9.5 Perception and limitations of the self

How women perceive themselves in relation to movement and birth and how midwives and obstetricians perceive women's behaviour is seen as a barrier to movement. These perceptions are explored.

Laura spoke of how she had gained four stone in weight during her last pregnancy that had affected her fitness and therefore ability to move. Though staying on the bed in an all fours position, she felt that she made it difficult for herself:

> *'I ignored her like you do and just thought I know best ……I kept saying I'll have go in a minute but I was just so big ….mum kept on telling me to get up, she kept telling me to get off the bed and I should listen to her but I kept thinking I can't, you know, you don't know what I'm feeling you know what I had to put up with, I wish I had listened to her now because she kept saying to me go get up you can be here a long time if you don't get up and I was determined just to be on all fours'* Laura (Woman, p.8)

Laura is very aware of how her physical fitness influenced her ability to move in her last labour. She blames herself for not listening to the midwife and her mum and her own strength of determination to stay still. She felt a lack of understanding from those present and a lack of empathy

Not only did Laura's physical habitus have an impact on her ability to move but also how she was feeling at the time and her social circumstances all played a part in her perception of herself, her abilities and what she wanted to do and what she thought she could and could not do. It appears that having control of her physical movement was the only thing she felt she had control over and she did not want to relinquish that. Nevertheless, it is the perception that Laura had of herself in that situation which led to her blaming herself for the events that followed in the following hours and weeks.

Maggie also sees issues external from herself influencing the ability to move during labour:

> *'it's going to affect labour, it is, can, affect muscles you can't relax because you like, that you've got cortisone which is in the brain…. I think I feel very strongly that the best way you can be is one in a very relaxed atmosphere'* Maggie (Woman, p. 21)

Experiencing interference during the birth process that makes it stressful for the woman has a physiological response in the form of a hormonal reaction which then impacts on her ability to move. How a woman interprets and perceives the situation around her during birth can affect how she is able to use movement.

Whilst Roma spoke of how her own ability to handle pain may influence her ability to move, she also spoke of how her physical symptoms she experienced through pregnancy may affect her. In the days before the interview she had experienced pain from her sciatic nerve stopped her from moving. Pat and Sue had experienced pelvic pain through pregnancy that had prevented them from being as active as they wanted, whilst Katie felt that as a person she was '*not one to sit down and put my feet up'.*

Yvette thought that wanting to be mobile during labour was down to individual personality and opinion, those supporting her and some women want to move and have stated in their birth plan. Ursula thought:

> '*if their mum said to them or the sisters said to them stay upright as long as you can you know then they are likely to do that'* Ursula (Obstetrician p. 9)

Ursula and Tracy believed that the woman's personal background influenced her movement. Tracy thought that a woman's background influenced whether she chose to move or not was more complex which contributed to her assumptions:

> *'clearly there is a huge spectrum, the various aspects of terms of levels of intelligence, levels of education, socio-economic deprivation and the opposite degrees of sense of being responsible for themselves over the outcomes and degrees of the responsibility for example her dependency, so I think yes all those relevant'* Tracy (Obstetrician p.12)

Tracy sees women's choice in birth as part of the complexity of them as individuals operating as part of their complex background, all that contribute to the individual choices she makes. Ursula thought a woman's approach to movement was influenced from her cultural and ethnic background and what they have been taught about which influence their beliefs

around what is normal and what should be done during labour and birth. What is perceived as normal Ursula felt was different from different places around the world and bring to their labour these beliefs. :

> '*I'm surprised that some ethnic minorities that we have here are more keen to lie on a bed, I would almost expect it to be the other way round, a lot of the white British people you know would be less likely to want to move and ethnic minorities more likely to move but that's not the case it's challenged my belief*' Ursula (Obstetrician P. 11)

There is a perception that a woman's background and personal beliefs influence movement. Stereotyping by health professionals based on the assumption of the influence of their culture is something that is present. However, whilst this rigid way of thinking can be held, when experiencing birth, this is challenged.

It is the obstetrician's role to make judgements from using theoretical knowledge and experience, however with little experience of normal birth and women's behaviour during birth, assumptions based on parameters used in research evidence, women's demographic information, and assumptions are made on how she will behave during labour, However, this is challenged when they experience birth personally or in practice.

Levels of understanding through intelligence and education can contribute to cognition in the decision-making process. A woman's socio-economic status shows an awareness of how social circumstances impact on decisions and also the effect that deprivation has on this. A woman's psychological perception of her sense of responsibility and dependency has an effect on how woman feels she is involved in her labour. Women are seen as part of their social environment and the impact that a women's individual psychology has on her decision making. This is perceived by midwives and obstetricians which demonstrates the integration of both knowledge of sociology, psychology with the authoritative biomedical knowledge.

9.6 Women's medicalised perception and expectation of birth

A barrier to movement was identified in the way in which women perceived birth as a medical process and the way in which this perception had on their expectations of how to behave. Six of the seven women interviewed who had given birth previously spoke of their labours in the context of medicalised birth. They all spoke of their labours in relation to a time line and how that corresponded with the dilatation of their cervix and the pain they were experiencing.

Katie, who was pregnant with her second child:

> *'my labour started at 7:15 in the morning and had strong clear pain every 10 minutes and then every five and then I went to the hospital about 12 o'clock and I was 3 cm so they kept me where I was it was really exciting but I was like in a lot of pain'* Katie (Woman p. 1)

The demarcations of the retelling of their birth is in authoritative knowledge used by the hospital. It gives a cause and effect retelling of birth in a mechanical way of how their body was functioning and the negative physical impact of this, pain.

Maggie spoke of her labours differently. She was pregnant with her fourth child and spoke of her previous birth in more of a relational way in what was happen around her and how she felt about it.

> *'the second one the room was nice and the atmosphere was better the people, the people I think the people in the room make a difference because it wasn't like the medical staff it was midwives were chatting they were telling jokes, the first to one was very medical it was all very matter of fact they didn't talk to you they didn't tell you what was going on this was done and that was done you didn't even get a choice it was just done and you got ignored really, I imagine they had a job to do'*

She describes her first birth as:

> '*it was all very crazy …. 15 minutes on my own and then it was all like manic …I remember them coming in the doors banged on the room and clattering, the lights going on it was just really very busy and hectic …. (They) just sort of kept you in the dark a little'* Maggie (Woman p. 1/2)

In comparison to the other birth stories, Maggie's surroundings and how the events during her birth made her feel were the most significant to her. This is her subjective view of her births, her lived experience that comes over as important demarcations of her births. However, these events and how they made her feel would not have been recorded or recognised from the medical perspective of birth as they are not relative to the isolated physical functionality of birth and therefore largely go ignored and not recognised. In Maggie's first pregnancy she had pre-eclampsia, labour was induced and '*the baby had to come out*', she was kept on the bed with a drip during labour and 24 hours afterwards. Her

second labour she describes as *'a lot better'*, '*a lot more chilled and relaxed'* as she went into labour naturally and '*was allowed to move around'*. Her third birth she described as '*absolutely brilliant'* as the MLU was '*lovely*' she was '*allowed to go in the bath'* and '*was relaxed until the baby got into stress'.*

Sue recognised how she retold her birth stories and the first one being described as an ordeal: '*as I am saying all this am realising not telling you any emotion about how I felt'.* Sue was the only women who was cognisant of the fact that the retelling of her story was without how she felt about the experience. Women's feelings, emotions and experiences appear to come secondary as the authoritative language and discourse is used to retell birth experience and demark events.

9.7 Psychological impact of authoritative knowledge and medical practice on maternity care

The biomedical model of birth underlies women's narrative of birth, birth as controllable by those with the authoritative knowledge is seen to impact psychologically on women.

Maggie spoke of how she '*couldn't understand'* why her waters could not be broken on the MLU, Olivia describes doctors coming into her labour room and looking at the monitor:

> *'I knew that something was wrong and that was what panicked me, that no one was telling me'* Olivia (Woman, p 1)

Intervention and monitoring are in the control of the institution, the justification for action by the institution is known by them and directed by them and the control and decisions for management of birth lies with them. However, the justification and reasons for this does not appear to be relayed or made in conjunction with women as if they were only recipients of care with no accompanying agency, cognition or emotions. The impact of the actions of the institution whilst real and visible to women appear to be invisible to the institution.

Whilst women have an emotional reaction to what is going on and feel strongly about these events, they did not challenge the situation. So, whilst Maggie felt ignored, she didn't ask what was happening to her body, nor did she ask for an explanation when she didn't understand. There was an expectation of compliance and doing and acting in a way which is expected of a labouring woman.

In addition to this, the unspoken underlying emotion that accompanies the reason for the intervention is translated to women by how they feel about birth. Laura planned to stay at home in early labour as long as she could but '*not make it dangerous'*. Pat spoke of the birth of her baby as '*Lucky*' due to her unplanned, unaccompanied birth at home:

> '*I was quite scared at the time and luckily everything went okay because it could of gone so horribly wrong but the paramedic arrived literally three minutes after she was born so if anything had gone wrong he'd been here'* Pat (Woman p.5)

Birth happened spontaneously and unaccompanied, the normal physiological process went quickly and her baby was born healthy with no complications for Pat, yet she thought this was lucky, as the underlying expectation is that physiological birth can go wrong without medical surveillance and assistance.

How birth is expected to be by women is also under laid by fear. Nicky felt that she was naturally anxious about birth as it was '*something you don't know about'*. Roma spoke of if her birth was '*not too bad'* she would stay on the MLU and Sue spoke of how '*awful'* it was when she wasn't '*dilating*'. This was not only the perception of the women interviewed but also by some of the people they spoke to. Laura felt that her friends gave a '*dramatic*' explanation of birth when she was younger, Katie, Nicky and Roma felt that talking to people they knew resulted in them being scared as they '*make you think it is horrendous'*, as people only tend to tell you the '*worse bits'* and '*negatives*'

Laura spoke of her previous birth and her expectations of labour:

> *'why stay at home when you're in that much pain and then I after last time I know what they mean I would rather be here '(at home)* Laura (Woman, p.4)

Birth is unknown, it is expected to be '*bad*' and if it does not follow medically defined expectations then the impact on women is '*awful*'. During her first labour, Laura's expectation of birth was to go to the hospital to enable them to manage it. However, after experiencing a medical birth her understanding has increased and the meaning of why non-medicalised ways of labour are advised.

Sue reiterated Laura's thinking around why people may have an automatic response to managing pain during labour:

> ''*why should I go through that pain? I may as well just have an epidural' or 'may as well do that more medical way' whereas, I don't know, you can cope with the pain, I wonder actually how empowering it is to be able, that there are so many ways that completely take the pain away, you could say it's almost saying well you can't handle it so we'll give you, these are the ways, whereas actually I think women can'* Sue (Woman, p. 18)

Sue recognises that the perception that birth as unmanageable by women can come from the actions of medicine through the availability of pain medication. Yet her experience of labour tells her as a woman she is able to '*handle*' the pain and that this is empowering to women yet it is not the main narrative that is either spoke of or promoted within society.

Fear and the danger that birth poses is relayed in the women's interviews when they speak of their birth experience and their hope for their birth.

Birth has been taken away from women in the home and has been put into the medical domain, where the environment maintains safety. The idea that this is what is normal is having an effect on women's attitudes towards birth;

> *'women have had a healthy respect for childbirth since time began haven't they but, they have never been as scared as they are now'* Geraldine (Midwife p. 15)

Birth as a physiological event belonging to women, with knowledge, understanding and admiration for its capabilities has been over taken by fear. Taken out of women's domain and its power placed with in an institution, governed as a medical event dominated by risk is outside of women's control and something that is not trusted. This imagine is also portrayed and reinforced by the media.

9.8 Conclusion

The barriers presented have an effect on the midwives and how they are able to provide care and the obstetricians and how they are able to know and understand birth and women. They also have an impact on women's birth. The next chapter will identify how these barriers can

be overcome through looking at what has been identified as facilitators of maternal movement.

Chapter Ten

10. Facilitators

The culture within the maternity unit has been identified in the previous chapters by using Schein's (2017) framework for the organisation of culture. Throughout the data midwives, women and obstetricians spoke of how they facilitated movement and other aspects of physiological birth. This chapter shall discuss the facilitators identified in the data that can influence change within the disconnecting culture to a more connective culture. Participants described experiences of challenging and leadership from everyday clinical practice, midwives in leadership roles spoke of their experiences in facilitating physiological birth from a more strategic level and women spoke of their experience in this culture which does not value their knowledge.

10.1 Challenging

Midwives spoke of the 'challenges' they encountered in practice. Challenges occurred in situations where there was a difference in beliefs and values around care provision.

10.1.1 Opposing beliefs as challenges

The previous chapters identified espoused beliefs: challenges are presented when practitioners hold differing beliefs.

Angela thought that a person's beliefs made an impact on the care they gave, some of the politics and behaviours of others in the hospital run alongside that but she felt it important to keep doing what you believed in. As a positive person, when she came upon challenges, though frustrated, she turned these challenges into *'stepping stones'*. Though she felt not everyone has the ability to do this because of either a lack of understanding or knowledge, but it is an individual's belief that makes an impact most on care:

> *'there is no one set of factor that influences it's all interwoven but I think it doesn't matter what the (general) belief is, it doesn't matter what the evidence says to some practitioners, you've got to have that belief'* Angela (Midwife, p. 24)

In Angela's experience, an individual holding a belief is what influences decisions being made, but as part of a multi-professional team everyone holds different beliefs which are complex. The beliefs held by the individual will influence the decision. Angela understands that

different beliefs are held, from her position within the organisation it is this that enables her to use her knowledge and experience to challenge them. Whilst this is done from managerial level, as an individual midwife, working alongside women and doctors on the CLU, with no authority, other midwives had different experiences of challenging others beliefs.

Catherine and Jan both said they would never challenge a doctor unless they thought their clinical practice or plans were '*really wrong'*. Fiona feels she needs academic qualification and knowledge to be able to challenge doctor's plans of care whilst working on the CLU. Angela regularly challenges doctors in her leadership role to enable more midwifery and woman focused care to be implemented as opposed to medically focused care. Angela also speaks of conversations with women, their families and the multi professional team when choices made by women are outside the standardised guidelines challenging the authoritative knowledge and practice.

Geraldine gave examples of how it was difficult for practicing midwives to challenge from her experience as a newly qualified midwife and as a midwife in a leadership role. As a newly qualified midwife, she spoke of being reprimanded by her senior colleagues as she was challenging the authoritative knowledge and practice when offering a woman informed choice regarding induction of labour and how distressed this had made her.

Hannah sees clinical guidelines as '*supporting the hierarchy*' on the CLU and MLU as they do not incorporate midwifery care alongside medical care. Hannah sees the solution to this as working more collaboratively:

> *'you can't influence anything without everybody working as a team'* Hannah (Midwife, p. 6)

From Hannah's perspective the midwife's role is not thought about alongside any medically driven guidelines. However, in her interview she speaks of the struggles to engage midwives in the process of guideline writing. Midwives can be disconnected from the processes that guide their practice when not involved with the process of writing guidelines, however what the barriers are that prevent their involvement is unknown.

10.1.2 Midwives challenging beliefs

When coming across a clash of beliefs with any practitioner when caring for a woman on CLU, Barbara expresses this as a need for challenge:

' I think you need to challenge that if you know that it is if it's working against the mechanics of the process …we all know what works so if you are choosing to go against it you've got to justify that' Barbara (Midwife, p. 20)

Barbara feels that when there is a barrier in understanding between the differing espoused beliefs identified then there is a need for challenge. What Barbara knows in relation to the mechanics of birth, her underlying assumption of understanding birth and belief of empowering women using movement, then '*to go against it'* need justification. The barrier seems to be the knowledge of what is '*helpful*' and *'going against this'*. Helpful in birth physiology and process and therefore the woman and baby, going against this is obstructing physiology and prioritising authoritative knowledge and the process and procedure of the institution.

Elizabeth spoke of when her beliefs on the benefits of movement and upright birth were looked on as '*hippy*' by other midwives and obstetricians on the CLU and how she handled this:

'*it's a fine line between I don't want to get too worked up about it but you do want to try and change their beliefs a little bit so I can, I don't let it bother me really, but I usually try and make a bit of a joke about it but say 'well it works for me' … things like that but it's trying to be light-hearted but still get the message across'* Elizabeth (Midwife pg. 12)

Elizabeth feels strongly when other midwives disregard her beliefs; she has worked out how to handle how she feels about this in a non-confrontational way to challenge through showing how using her knowledge has benefits. However, this highlights how, when knowledge that challenges the authoritative knowledge the reaction is to dismiss difference as outside convention and not as worthy. Elizabeth goes on to say that '*you can alienate people if you come across too strong*' I asked how it made her feel when this happens:

'*if I'm practising well and if the woman is happy with my practice and I know doing things that are evidenced based and do work, not just for, it's worth doing, it can change their minds and make them see it a bit differently, great, if not it is their loss really don't get upset about it'* Elizabeth (Midwife p. 14)

Elizabeth shows her allegiance to the woman, practising '*well*' and if the woman is *'happy'* and she uses '*evidence*' to support her practice. However, with a lot of experience working on the MLU where knowledge is shared and movement supported, in an environment that encourages collaborative working, Elizabeth is confident in her practice. When challenged on the CLU, she finds that this does not upset her. She is also in a position of knowing the cultures, espoused beliefs and underlying assumptions that lead to the use of knowledge of movement and the reactions to some of the practices she might be implementing. A separation between supporting normality and movement and conforming to expectations and immobility creates challenges.

10.1.3 Collaboration as opposed to challenges

One of the consultants spoke of collaborative working as way of working with other professionals. Tracy is aware of how hospital procedures and roles affect women, which was also recognised by the midwives and the women. Tracy sees how care is managed with the woman, the midwife and the obstetrician as '*crucial*' and something that should '*complement each other*'. As an experienced obstetrician who has '*thought through*' this issue, she thinks when this happens at this unit, information is gained in advance prior to seeing the woman as:

> *'if there is going to be any questions about how the management is going to be that we iron out any difference of opinion away from the room … of course it's perfectly reasonable to have different options, different points of view expressed, so that it is clear to woman a partner that there is consistent caring and compassionate line, so they know that there are in very good hands … that's crucial thing that presenting a consistent front and also ensuring that the woman and her partner have their say on what's going on so they get the opportunity to ask questions and as they may disagree with what we are saying that they feel free to be able to say that'* Tracy (Obstetrician pg.15)

The obstetrician's role is to manage difficult obstetric situations and comes from a bio medical approach that sees the obstetrician as having the power to make and execute care. However, how this is done is seen as crucial to Tracy due to the impact that this has on the woman and her partner. Tracy recognises that different opinions exist and that they are expressed and worked through away from the woman and conclusions about actions to take are made

together, not just between the midwives and obstetricians. Power differences are recognised by Tracy and how to equal these between everyone though how care is given and management approached. Tracy also recognises the advocate role of the midwife and therefore for the potential for being *'played off against each other'*. The emotional impact of issues surrounding care provided which have the potential to adversely affect working relationships between obstetric staff and the midwives and the woman and her partner is noted by Tracy. This is done with the aim of reducing confusion and providing care that is caring and compassionate through it being consistent and openly worked through.

None of the women interviewed expressed that they were involved in any challenges with staff therefore their voice is absent in this discussion. As Highlighted in the disconnection chapter, women questioned the care in retrospect but never challenged the care they were given at the time.

10.2 Midwifery Leadership

Leadership within midwifery offered a platform for challenging opposing beliefs and facilitated care that supported physiological birth and empowered women.

10.2.1 A knowledgeable leader

Angela who is in a leadership role describes doing this through role modelling, working proactively, leading and developing the service, embedding compassion into everything with the staff and women, evidence and good communication to make a positive difference on the culture. However, standing in the way of this is historic behaviours around communication, hierarchy and inability to communicate effectively, to enable this she thinks:

> *'it's around using that internal knowledge and understanding of the organisation of a culture to enable you to make a difference to the care of women'* Angela (Midwife p.20)

Angela's perception of using internal knowledge and understanding of the culture of an organisation, enables individuals to make a difference. Angela's internal knowledge of the unit and the organisation is multidimensional from her position as a midwife and a senior leader. Having a midwifery background and therefore knowledge and experience of being in the bottom of the hierarchy she also has the knowledge of the internal working of the hierarchy at the unit and the current culture of maternity care. This is affected by; '*changing*

roles and responsibilities of those in the hierarchy', '*the political agenda'*, '*footfall', 'tariffs', 'national reports', 'commissioners', department of health', 'political agenda',' improving health*' and the '*bigger drive to reduce cost*'. All these factors require knowledge of working within a position that enables insight and therefore knowledge of these factors and how they interplay within the culture of an organisation. Understanding of the culture from her senior position requires experiential knowledge of this culture, how it works and influences maternity care, this is seen as enabling. Angela also see's using this knowledge as '*making a difference to care'*, so being proactive in her role, using her knowledge of the complexities how they interact and through seeing the whole picture, making a difference to the care women receive.

Geraldine, described herself as a '*geek'* as she enjoys learning and has always maintaining her knowledge through studying. Due to her current position within the organisation, she is able to implement current research and theory. Additionally, she can audit care within the MLU area and implement practice that she can show is beneficial to woman in the current context of the unit rather than standardised national recommendations. Thus, connecting gaps between theory and practice through using her knowledge, research evidence and her leadership position.

Leadership is viewed as needing knowledge of the organisation and midwifery profession. Shaped by underlying values, used with compassion, knowledge of birth and evidence, leadership is used to challenge services for women to be improved. Strong midwifery leadership grounded in knowledge of physiological birth is needed to challenge and equalise the hierarchy present and is often seen as a source of conflict as the power is with the authoritative knowledge, the management of pathology and potential risk, government agenda and business principles.

10.2.2 A culture of leaders

Fiona trained, had a child and worked on a unit that she felt there was an expectation of normality (normal birth) at the unit, everyone promoted normality that went through to management level and there was a consultant midwife for normality in post.

Additionally, Fiona speaks of some '*very strong midwives*' in post which helped to '*fight the corner'* which Fiona felt provided very good mentorship;

> '*I'm talking empowerment, they empowered the women and also the students as well because as well you saw how to get your point across how to fight for the woman, things like that but I didn't I never felt there was as much involvement by the doctors and possibly that is because that was such a strong midwifery team at that point, at that level, so sort of coordinator level you know the, it wasn't the same it wasn't the same there wasn't a hierarchy I mean there was a hierarchy but the doctors weren't on the top of the hierarchy*' Fiona (Midwife, p. 5)

Through having care that was not split between high and low risk, strong midwifery leadership and team working, she feels, that an obstetric dominated hierarchy was not in place. Midwives, women and student midwives were empowered as they were able to '*fight*' the authoritative knowledge. Normal birth was promoted and expected through enhancing '*normal*' midwifery care.

Jan trained at a unit where the band seven midwives would support her if she diagnosed a problem. They would monitor and review problems and only if it carried on would the doctor's review and only come into the room if asked. In the CLU, ward rounds, K2 monitoring (technological monitoring of the fetal heart rate, contractions and scripted standardised electronic record keeping) are standard practice and Jan worries midwifery is turning into obstetric nursing as doctors come into the room when she is caring for a low risk woman. Here doctors only *'Won't come in if you ask not to'.*

It was expected in the unit where Jan trained which was smaller and not split into high and low risk care, that a more senior experienced midwife is able to support another midwife and doctors only became involved if asked. This is in contrast to the large CLU unit in this study where physical and electronic monitoring are used as standard, standardised record keeping and dominance of obstetrics is shown through the sense of entitlement of obstetricians to move freely in this area. When midwifery leadership is absent and midwives have less powerful positions in a unit the obstetricians assume spatial rights showing entitlement in their rights to enter a woman's birthing space and the midwife being the gate keeper to this. The CLU appears not to recognise midwifery autonomy in caring for women and only obstetrics having the authority to make judgements, even in low risk care.

Fiona feels ward rounds makes an impact on women during labour and she does not like it as it disrupts normal birth. Fiona speaks of the lack of power of doctors in the hierarchy in the unit where she trained, suggesting that midwifery and normal birth had more power. Fiona, who had a complex pregnancy and was defined as 'high risk' for birth at this unit states that during this pregnancy;

> '*because I wanted a VBAC in the pool and things like that so I needed to be in with the right people'* Fiona (Midwife, p. 5)

Though her experience of working in this unit and the strong sense of '*normality'* and support of normal birth, to enable Fiona to have the birth experience she wanted, it was her connection to the individual people within the organisation that she felt she needed. Taking control of the choices she wanted and choosing her alliances to the '*right*' people to enable her to make this choice. However as coming from a place of *'knowing'* as a midwife within this organisation, this does not present equity of knowing as a woman accessing services. How women accessing services and how they are able to have their choices met with out this presents a barrier as they are not in this position.

Ursula felt that it was leadership displayed by the consultants that contributed to a positive learning culture. Having consultants heavily involved in a unit, engaging in opportunities to teach, '*looking like they want to be involved in learning*' and:

> '*the better the leadership is … the more people that get involved ...it's about wanting to listen to people who are talking firstly it's got to be someone that can talk and can involve people and I guess agree what people want to learn as well'* Ursula (Obstetrician p.5)

From Ursula's perspective engagement from the obstetrician with leadership, teaching and learning is crucial to a positive learning culture of a unit. This is seen as the consultant obstetrician collaborating with others in the obstetric team but is a two-way relationship involving listening as well as talking. Additionally, being directed by those learning in an un-assumptive way is perceived to be an attribute of a consultant. Leadership for the obstetricians is associated with learning and how this is facilitated by the obstetric team, other elements of leadership are absent from the obstetricians interviews.

10.3 Valuing women's and midwifery knowledge of birth

Women and midwives spoke of how their knowledge of movement was not implemented appearing to be not as valuable as other knowledge.

10.3.1 Recognising women know their self and labour

Women spoke of how they themselves would facilitate their own movement during labour. Kate felt that as a person, she is '*not one to sit down'* therefore being active in late pregnancy was something she would do automatically. Laura though that as she was older compared to her friends who were in their late teens, she felt they were dramatic in their retelling of their births which was down to their immaturity but as she was older this contributed to her knowing more. Sue spoke of as she had had two children she knew '*what to expect'* and that she moving her hips in circles in early labour was influenced by her other birth experience.

Sue also knew, from her other births, how she best dealt with pain *'the way I deal with pain is when it comes is to stand still and be, go somewhere else'.*

From her previous birth experience, Sue knows how she best '*deals*' with pain during labour. Knowledge of birth, herself and her own coping mechanisms is a facilitator in how she will be in labour, acknowledging her agency in the process and what she needs to enable this.

Maggie felt that women have been giving birth for millennia and therefore it is a natural process, during her second birth, cared for by a midwife who '*let me do what I wanted'*:

> '*I was able to, move around I got great comfort from rubbing my back up and down the radiator it was absolutely brilliant yet I was just moving up and down the radiator on my back each time got a contraction'* Maggie (Woman, p.8)

In an environment and with a midwife who enabled Maggie's movement this facilitated Maggie finding solutions to address her own comfort. Having the belief that birth is natural, looking to herself and what she could do, a solution was found using the heat and shape of a radiator.

For Pat, who experienced a quick labour and an unplanned home birth (Born Before Arrival (BBA) to the maternity unit), her perception of pain during labour was not what she expected:

> *'Labour wasn't as painful either it was painful but not as painful as the last one but neither were as painful as I expected them to be so don't know whether it's just my body or I just block it out'* Pat (Woman p. 4)

Pat's perception of how she managed labour was through how her body handled pain and how her mind had the ability to block this out. The concept that labour is not painful is one which doesn't appear to be in Pat's narrative, therefore it must be the ability of her mind to block it. Her unconscious ability to block the perceived pain associated with labour, but not something that she is able to cope with easy.

Acknowledging women are the experts in their bodies, how their bodies behave and how they deal with labour will facilitate a culture in which women are able to use movement during labour.

10.3.2 Women sharing knowledge with family and via technology

Women spoke of family members and how their experiences had influenced them. Laura spoke of how influential her sister's positive birth experience had influencing her and how she had learnt from this in planning for her upcoming birth. She also spoke of how during her first birth her mum knew what was going to happen before she did. Maggie spoke of speaking with her mum about her third birth:

> '*my mum was the same with hers with my brother ... it was like I was, I'm the same as my mum it was mad it was like I was her or something, it was mad because we are like comparing notes it was mad it was quiet a female bonding time actually'* Maggie (Woman, p 18)

Following the birth of her third child Maggie spoke to her mum about the experience, it appears that the birth of her brother was something that they had not spoken of before. Only in retrospect, as the result of a bad experience, had the women come together and shared their experience. Through the women talking and sharing their similar birth experiences they have gained strength in their relationship.

Most women spoke of the use of the technology for gaining information around birth, however this information gained was recognised as vague, not individual and sometimes false. The women interviewed did find certain aspect of the internet useful for gaining information. 'Baby Centre' was found useful as it gave a visual representation of foetal growth

and how this affects women during pregnancy. Laura felt this was great as she could involve her son and he got more of an understanding. Nicky found forums most useful as:

> '*it's like mums and mums to be and things like that, so it's people who are having the same experience as you so they know what you're going through'* Nicky (Woman, p. 16)

Women find technology useful for information but also recognise its limitations, the information gained can be used for educating women and their families to gain a greater understanding of their pregnant bodies. However, Nicky uses technology to connect with other women and gain understanding from their experiences as a preferred source of knowing.

Having a society and wider culture of birth that values women's stories and enables women sharing their experience with family members or by using technology, a culture of shared learning where women direct the narrative and their knowledge of birth, enabling them to share their lived experience and become a valued source of knowledge.

10.3.3 Valuing the role of the midwife

The midwife, throughout the women's interviews was the key to care based on their individual needs, how they experienced labour, how they accessed knowledge and how they supported them.

As a woman who wanted information, Roma said she would prefer to ask the midwife as she would '*prefer to go to someone who knows'*. Laura felt that during her up-coming birth she would *'let them help me'* as she though by ignoring the midwife it had led to a negative first birth experience. Maggie thought that it was important that midwives caring for her in labour were '*approachable*' and '*willing to go the extra mile'* additionally, Maggie thinks that it is important for the midwife to have had a child:

> '*they've never actually lived it, so they're telling you to do this to feel better, how'd you know what it's like if you've never had children, you have never experienced it all those years, you've watched it been there and helped people through it, she can't actually, not proper, not know where you're coming from and you know, that understandings sort of part of her, it will be part of her, part of her will always be business you know,*

missing that, but not saying that all midwives should have kids and all that, but that experience I think it matters think it makes a difference' Maggie (Woman, p.14)

For Maggie, though she realises that every birth is different, she also thinks that the lived experience of childbirth of the midwife is crucial to her ability in understanding and supporting women during birth. Maggie is recognising the emotional impact that childbirth has on you as a woman, how the lived experience of birth feels which is separated from watching and supporting birth. She sees the birth experience as being part of you, and without it how it feels to be a birthing woman is unknown. Midwives having this experience makes the difference to Maggie as it is part of the midwife that is separate from the job of a midwife.

How the midwife approaches care which is given is seen as important, Sue felt that with her third child, she knew what she wanted and was able to ask the midwife to talk her though her contractions and helped her '*visualise*'. Olivia spoke of how she thought it would have helped having a midwife explain to her what was happening during the second stage of her labour she would not have had the diamorphine:

'If I had had someone that had sat next to me, spoke to me, spoke to me about how I was feeling helped me breathe with the gas and air you know, or without the gas and air whichever, whichever was better at the time' Olivia (Woman, p.16)

During her experience of induced labour on the CLU, opioid analgesia was used, Olivia felt that *'someone'* sitting with her, speaking to her from a place of understanding and knowing what she was feeling would have facilitated a better birth experience.

The midwife facilitates birth through coming from a place of knowing, but not just a place of theoretical knowing, but knowing about birth from experience and from knowing the woman for whom she is caring. This positioning of the midwife enables her to be able to be with women recognising their individual physical, psychological, emotional and social needs and putting them in control of their birth experience.

10.4 Conclusion

From the perspectives of the midwives and women interviewed, the ability to challenge, midwifery leadership and valuing women's and midwifery knowledge is identified as facilitating change in a disconnected culture.

Challenges are met by midwives within the culture in which they work from colleagues and from the system. Midwifery leadership has been identified as a way to support these challenges requiring knowledge and teamwork to address the authoritative knowledge present and the focus on pathology, risk and business principles. Valuing women's knowledge and the knowledge and role of the midwife are key to facilitating a culture in which women are able to use movement during labour. This valuing of women and midwives is not restricted to the hospital culture but to wider society, thus highlighting the continuing need for feminism.

The differing underlying assumptions, beliefs and values have been identifying with the disconnecting culture identified as not supporting maternal movement. With barriers that prevent change in this culture also identified how to overcome these and facilitate change has also been identified which will in turn support physiological birth and movement.

The next chapter shall discuss the findings of this project in relation to the wider literature.

Chapter Eleven

11. Discussion

The aim of this project was to identify cultural differences influencing maternity care and knowledge acquisition around maternal movement in labour. A FE methodology was used to study one maternity unit in the North West of England. Data were generated through observation, interviews and review of internal and external processes for knowledge acquisition and analysed using thematic analysis. In this chapter, the key findings will be discussed using Schein's (2017) framework for the organisation of culture to illustrate the data providing a critical discussion on how these support previous research, theoretical understanding and new insights that contribute to the body of knowledge on maternity care and its implementation during labour.

Schein (2017) focuses on how culture is learned, advises that it will evolve, and describes three levels of a culture (See figure 3.) which can be analysed to depict it. Whilst those visible to the observer are difficult to decipher, deeper levels are hidden, with espoused beliefs and values leaving behaviour unexplained until basic assumptions are more fully understood.

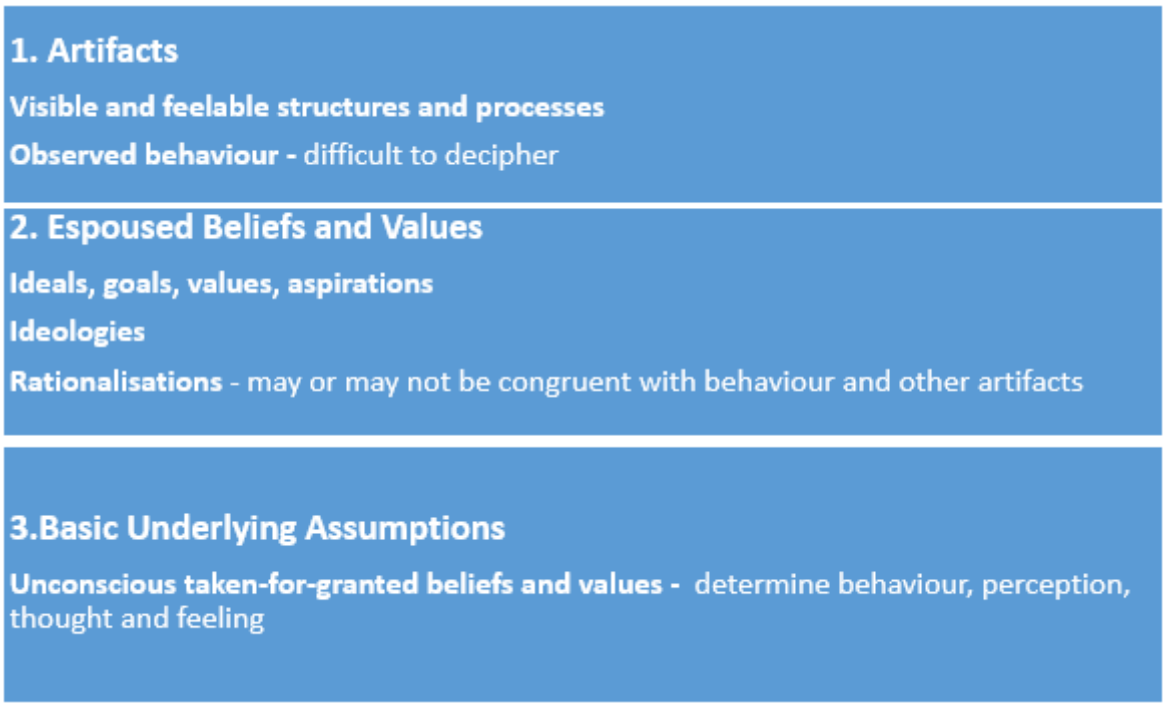

Figure 3. The three levels of culture (Schein, 2017)

This project explored how women, midwives and obstetricians position themselves in the context of their birth, their profession, in the hospital environment and to each other. This enabled me to identify how knowledge is gained around movement, within a context of women's, midwives' and obstetricians' beliefs and experiences of movement, and how this influences care.

Connections, disconnections, barriers and facilitators were identified which lead to the implementation of maternal movement. Chapter's seven and eight spoke of two different cultures (See Table 9), each displaying different artefacts, espoused beliefs and values with their own basic assumptions. The connections chapter identified a maternity care culture that uses and supports women's movement during labour and birth. The disconnection chapter identified a maternity care culture that does not fully support or use women's movement during labour and birth. Through understanding basic assumptions and how these feed into espoused beliefs, values and artefacts displayed, differences in cultures will be illustrated which influence maternity care, and how knowledge around maternal movement is acquired and implemented are illustrated. The findings presented in the previous chapters will be critically discussed, supported by previous research, theoretical understanding and new insights presented.

Connective culture	Disconnected culture
Artefacts: **Visible leadership, openly sharing knowledge & learning** - an environment which facilitates movement and supports women's choice and physiological birth	**Artefacts:** **Priority of medical equipment and surveillance** - an environment which does not always facilitate movement or supports women's choice and physiological birth
Espoused beliefs and values: **Relationships** - based on trust between a woman and her support network; trust between a midwife and woman and trust the woman and the midwife has in herself and in birth **Empowerment** - midwives' and women's ability to use knowledge of movement, facilitating women's control over their birth, informed decision making, informed consent & choice to support movement in	**Espoused beliefs and values;** **Setting rigid boundaries** - separation, fragmentation lack of relationships, hierarchy **Maintaining control** - Medical practice, control of services, information, environment, knowledge and relationships

birth physiologically, psychologically and socially	
Basic underlying assumption: **Love, Compassion, Empathy** - based within a physical, psychological, emotional & sociological understanding of women, movement and birth as a lived experience	**Basic underlying assumption:** **Lack of empathy, dignity and choice for women** -the use of authoritative knowledge and lack of knowledge and understanding of physiological, psychological and social aspects of birth

Table 9; Levels of culture (Schein, 2017) – Connection & Disconnection

11.1 Artefacts of a connective culture

Artefacts that are displayed in a connective culture provide an environment that facilitates movement and supports women's choice and physiological birth. This connective culture was more prominent in the MLU.

11.1.2 Physical environment

The environment of the MLU area can be viewed as the physical manifestation of the values and beliefs and the underlying assumptions held by the organisation. In this environment midwives, supporting women to do this, see movement as part of physiological birth. All the midwives and women spoke of the MLU area as supporting movement and physiological birth – couches, birth-pools, large rooms, birth balls and other equipment designed to support movement and upright birth, low lighting, large windows. The women thought that the MLU environment supported movement by its design. The environment was conducive to what they wanted for their birth. Some midwives however, were able to support movement in the CLU environment despite the artefacts, as it was their underlying assumptions and beliefs about birth that encouraged this rather than the environment.

'Alternative' settings for birth are shown to have a positive impact on birth outcomes. This is believed to be based on designs which decrease anxiety and fear, promote mobility and personal control (Hodnett et al. 2012). The birth environment can portray the underlying philosophy of birth purposed by the institution with the home-like environment linked to wellness (Fannin, 2003). The configuration of space has been shown to have an impact on practice (Setola & Borgianni, 2016). How birth space is configured affects relationships between women and care givers and in turn affects organisational behaviours and culture which influences outcomes (Shah & Setola 2019). However, Shallow (2003) believes that it is the individualised and family-centred maternity care that MLU units provide that emphasise

skilled, sensitive and respectful midwifery. All these elements combine to provide a multifaceted environment that supports movement within the MLU area.

The environment, underlying basic assumptions and the espoused beliefs and values of staff contribute to the culture of a unit and the approach it uses. Care based in relationships affects how birth is viewed and supported (Albers, 2007; Walsh, 2006) and women will choose which position to adopt based on what they think is expected of them, with the most common image contributing to this being in a bed (RCM, 2005). However, de Jonge et al. (2009) found that it was not the environment but the ability of the woman to be empowered to make decisions about her position, which was more reliant upon her being highly educated and older.

The environment on the MLU is designed for women's comfort, making them comfortable and therefore able to be at physical ease. Through enabling women to feel comfortable and settled and having more ownership of the space, boundaries are lessened increasing autonomy and giving more control over movement. Hodnett (1989) explored the link between birth environment and control; she found that birth in the home led to the perception of increased control, including the control women had over movement and self-expression. The role of the midwife is seen as 'extraordinarily powerful' (Leap, 2010, p 141) during birth as she has the power in creating an unobtrusive atmosphere of safety and calm to enable women to feel secure. When women feel secure (Anderson, 2010) and can build a relationship of trust with their midwife, they are able to 'let go' of their mind and thus body to relinquish control to their instinct, enabling the use of movement in response to pain (Parratt and Fahy, 2003).

She has access to knowledge of movement from the midwives or she can access her own knowledge as she is treated with empathy and love and there is an understanding that birth is a normal physiological process. Midwives learn from women and birth and from each other and the women can share this knowledge that is reflected in how the environment is designed and movement is supported.

11.2 Artefacts of a disconnected culture

The artefacts which are displayed in a disconnected culture show that the priority is given to Cardiotocographic monitoring and the surveillance of the women and her baby. This environment does not always facilitate movement or support women's choice and

physiological birth. All midwives and women spoke of the bed and the Cardiotocographic (CTG) monitoring on the CLU which interfered with movement. These were the main artefacts of the CLU which prohibited women's choice to use movement.

11.2.1 Monitoring and surveillance

Davis-Floyd speaks of the super valuation of technology (2001) over and above the woman's birth physiology; focus is on the potential risk of 'something' happening (Dahlen, 2010) rather than on the physiology which impacts upon the implementation of care that supports physiological birth (Benoit et al., 2005). This gives power and control of women and midwives to those perpetuating the medical model (Walsh, 2007). This implies that the fetus is viewed as a patient in need of protection and to do this birthing women are controlled and regulated (Beckett, 2005)

In this environment and culture, priority is given to the wellbeing of the fetus over the wellbeing of the mother (Kitzinger, 2005). The model of care provided sees birth as inherently flawed, the woman as an object, with the practitioner holding the responsibility and authority (Davis-Floyd, 2001). Women become objectified as the incubator for their babies, diagnosis of the baby's wellbeing is through the machinery and the practitioner is responsible for the operation and acts with authority in its use. Diagnosis of the baby's wellbeing is done through electronic fetal monitoring -Cardiotocography (CTG). Yet monitoring of the baby's heart rate through electronic fetal monitoring is said to have no scientific basis, with a false-positive rate of over 99%, and has not reduced the main outcome for which it monitors – cerebral palsy - through monitoring for potential fetal hypoxia (Sartwelle and Johnston, 2015). Miller et al. (2016) recognise that the overuse of technology such as CTG monitoring is driven by fear of adverse outcomes. CTG monitoring is increasingly used and has had no impact on reducing intrapartum mortality or cerebral palsy but it has increased the caesarean section rate (Sartwelle and Johnston, 2015). Dahlen (2010) speaks of a deluded trust in scientific evidence when single trails become the master and women's choice, midwives' clinical skills and judgement take second place. Becoming 'undone' by fear, and focusing on the fear of litigation, of not picking up a good trace, it gives focus to this fear, on the monitoring instead of the woman and her birth. We are framing care around the likelihood of adverse events and not seeing the whole picture as we are losing sight of trust in physiological birth (Dahlen, 2010).

11.2.2 Environment

Elements of physiological birth such as mobility seem to be enabled by the environment or invisible due to other complexities and the medicalisation needed to monitor and control these. To contest the medical control of complexities and influence aspects of physiological birth such as movement can be challenging in the CLU environment as the expectation is to manage the complexities to avoid risk to the fetus. This gives little recognition to the meaning of the experience for women, the predominant masculine and technological ideological system with industrialised values of order, predictability and control treats women's bodies as birth machines (Henley-Enion, 2009). This is evident from the predominance that is given to the bed and the technology for monitoring, recording and analysing of women and their babies.

This institutional environment for birth has led to the loss of intimacy and physicality of birth and prioritises practises that make birth easier for the practitioner rather than the woman (Beckett, 2005; Henley- Einion, 2009). The environment of the CLU reflects this; control is an important aspect for many women during birth and giving attention to the needs, values and expectations of all birthing women has the potential to increase woman centred care. Care which is focused on individual women's needs and situation (Leap, 2009) can break down the dichotomy between the medical and social models of care (Namey and Lyerly, 2010).

11.3 Espoused beliefs and values in a connective culture

11.3.1 Relationships

Relationships are central to a connective culture, they are based on trust between women, her support network and midwife. Trust that the woman and the midwife have in herself and birth are also present.

11.3.1.1 Relationships- the basis of midwifery care

Relationships based on trust were found to be the most common source of information for women and midwives.

Midwifery is seen as a privileged profession as it offers the opportunity to connect with women at a vulnerable time in their lives and has the potential to build relationships on trust, confidence and safety that enhance outcomes (Deery, 2012)

The midwife-mother relationship is described as the foundation of maternity services (Kirkham, 2010), these relationships are invisible amongst the factors such as outcomes, policies, technologies, and protocols but without these relationships, high-quality maternity care would not be provided (Hunter et al. 2008). Yet, it is the definable outcomes that are deemed important in medicalised care (Illich et al. 1977) despite the political rhetoric of implementing relationship-based care (NHS England, 2016).

How relationships are built appear to be different, during the intrapartum period, through either interacting with women or standing back. Leap (2010) describes two perceptions of care being provided. From building a rapport with a woman you have never met to gain her trust by talking, finding common ground, joking, loving attention (described as 'doing things') to 'the less we do the more we give approach' which involves stepping back, being very quiet and non-directive. Both approaches appear to be valued by women; this presence or being with women in labour is also described as a multi-facetted, complex concept that is essential to working with women and families during birth (Kennedy, Anderson and Leap, 2010). Presence has also been described as a process that incorporates intimacy, patience, respect and creating a physical and emotional space that is conducive to birth (Kennedy & Shannon, 2004). It is recognised that we can never truly know or understand another's situation; a relationship based on trust and continuity gives a deeper understanding of a woman's circumstances and being present enables the midwife to use all of her senses to gauge a woman's situation. Midwives practice based on their past experiences, and women react to childbirth based on their experiences (Kennedy, Anderson and Leap, 2010), therefore the midwives bring their perceptions of birth, their experiences and their values to how they care for women, illustrating the significance personal and professional experiences and values have.

Cronk describes the midwife relationship to women as that of professional servant – a professional providing a service. Within an institution that employs midwives, it is expected that they obey policies, implementing a power dynamic between women and midwives and an unequal relationship. Through fostering an adult-to-adult relationship, a relationship that recognises women's autonomy, trust can develop and enable partnership working in an equal relationship (Cronk, 2010).

Lundgren and Berg (2007) carried out a secondary analysis on eight sets of qualitative data, synthesising the results that explored the relationship between midwives and women. To enable the childbearing woman to surrender, trust, participate, exhibit loneliness, show difference and create meaning, the midwife's response should include availability, mediation of trust, mutuality, confirmation, support uniqueness and meaningfulness. Though other external factors are identified as influencing this, these are essential needs that a childbearing woman has, which is the midwife's responsibility to meet and answer. Though these relationships between women and midwives are multi-faceted this highlights their complexity and the actions and responses necessary for them to be successful to benefit women physically, psychologically and emotionally, which in turn empowers women. However, due to the circumstance and conditions in which midwives work and women birth, this is difficult to implement.

Working in partnership with women, building trusting relationships, with mutual respect so that both can learn from each other (Guilliland and Pairman, 1995) enables a woman to have confidence in her ability to birth her baby (Leap, 2010; Anderson, 2010). These relationships are based on the midwife's ability to be: respectful of individual women's needs during birth; non-judgemental in respect of putting values on a 'right or wrong' way to birth and be in the birth process; understanding and knowledge of the birth process and of being a woman. Empathetic through recognising women's physical and emotional perspective and communicating this in a way which recognises women's self-efficacy for a normal birth. This enables women to have a sense of control over a two-way relationship with the midwife and allows midwives to respond to women's needs without 'making it better' through connecting with women.

11.3.1.2 Relationships and movement

Though the midwife is seen as providing information on movement that is accessible through the relationship built with them, external sources of information were seen by some women as credible. A woman's community is seen as a source of information that will sustain her when the relationship with the midwife is over and therefore of importance and significance (Leap, 2010). This communicating with others is central to the process of knowing – received knowers- have faith in others who share the same experience (Belenky et al. 1996). Only one woman recognised herself as source of information in labour.

Sharing, expanding and reflecting upon experiences leads to ways of knowing and the ability to enter the life of their community; without this people also become isolated from the self and silenced (Belenky et al. 1996). Women who are silenced see authority as expecting them to behave in a certain way and do not recognise themselves as a source of knowledge (Ibid).

11.3.2 Empowerment

Empowerment was spoken of as a belief that midwives held that enabled them to use their knowledge to support women to exercise control over their birth. Empowerment also facilitated women's control over their birth through informed decision-making, informed consent and choice. This supported women's movement during labour and had an impact on birth physiologically, psychologically and socially.

11.3.2.1 Empowerment

Through the relationships they form with women, midwives aim to empower women through their maternity care. The examples they give reflect beliefs about women illustrated by Walsh and Newburn (2002) in their definition of how a social model of maternity care views women as 'users'. Additionally, through supporting women, physiological birth and facilitating them to their own decisions, within a relationship that encompasses 'mutual participation' (Rothman, 1982, p 176), goals of relationship-based care are promoted (Pairman, 2006).

The optimum outcome for women during birth includes physical and psychosocial well-being and is used by the WHO as a definition of health (WHO, 1946). Psychosocial support as well as well as physical care is valued by women (Nieuwenhuijze, 2014). The International Confederation of Midwives define the role of a midwife 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 new born and the infant. '

(International Confederation of Midwives, 2011).

Working within this definition, the midwives interviewed saw empowerment as part of their role through the care given. Yet, Leap (2010) argues that none of us can empower another person as power is not given but taken. To enable women to do this, midwives need to be self-aware (Hunter, 2004; Siddiqui, 1999) and it cannot happen when midwives are

disempowered (Thompson, 2004). Therefore, the midwives recognise that the system and culture in which they work disempowers women and that they themselves are in a position to give or take power from women.

11.3.2.2 Midwives using knowledge to empower women

Wickham (2014) talks of the many ways in which knowledge is gained as illustrated in chapter three, many forms of knowledge are excluded from the authoritative evidence base. The midwives spoke of using the knowledge they had gained during their training combined with knowledge they considered common sense. This was combined with knowledge of the environment and culture in which they worked and balanced with the emotional connection they felt to the women for whom they cared based in forming a relationship. This contributed to their perception that midwives and movement were part of normal birth and supports Bryar and Sinclair's (2011) theory on what forms the basis of midwifery knowledge.

This knowledge and experience give the midwife the ability to be 'with woman' based on her personal, empathetic and intuitive qualities to enable her to care for women in a sensitive and loving way (Ibid). These attributes are central to midwifery care (Bryar & Sinclair, 2011) and show concern for the most effective care for women. They combine midwifery skills gained through education and practice on the use of movement and empathy for working with pain and the need for control, actively involving women in their birth enabling their empowerment (Leap & Anderson, 2008).

11.3.2.3 Women's control, decision-making, choice and consent

Control is key to a positive childbirth experience (Nieuwenhuijze, 2014). Meyer (2012) identified four attributes of control in the context of birth. Control was defined as: women's access to information around events related to their birth, a sense of trust, respect and support from the carer giving a feeling of personal security and control of physical functioning described as a sense of control over their bodies, pain and emotion.

Control and choice as a concept in maternity care was recognised by government policy following the Changing Childbirth Report (DoH, 1993). This report recognised and prompted the ideals of control and choice following a review of maternity services in which these elements were found to be lacking in maternity care. However, respecting women's rights to make their own decisions based on adequate information is still found to be lacking in

maternity care, and forms the basis for higher numbers of litigation claims than issues surrounding negligence (Schiller, 2016).

Standard information is produced by the maternity care organisations and has an obligation to give all relevant unbiased information on procedures. How a standardised leaflet for women who have no medical knowledge is contested as research has highlighted the limits to women's choice due to the dominance of the medical model of maternity care (Mander and Melender, 2009). Additionally, Harris (2015) argues that objective informed choice by birth professionals is a myth, as multi-level communication needs to be understood in order for them to safeguard against this, enabling a more unbiased way of providing information. Providing information so that women are able to give informed consent is part of the midwives' code (NMC, 2015) and choice is recognised as components for the global improvement of maternity services (United Nations, 2009) yet it is evident that this does not always take place (Schiller, 2016).

Jomeen (2007) found that women who experience problems during birth found control transferred to the experts – midwives and doctors – and consequently their choice was removed, particularly within a medical model.

Choices made by women during birth often involve conflict with care providers as some believe that a woman's choices can be overridden in the best interest and safety of the fetus (Kruske et al. 2013). Edwards (2005) explored the meaning of safety for women choosing place of birth and found that the concept of safety had a different meaning for women than those caring for them, affecting their autonomy when making choices around place of birth. Choices are also offered and made within a system that prioritises bureaucratic decision-making through inflexible managerial requirements in the context of workload pressure and fear of litigation. This is combined with the perception that women are unable or unwilling to participate in decision-making (Porter et al. 2007). Legally in the UK, women have to be trusted to make their own decisions (Schiller, 2016).

It is only when relationships are made with women based in love, empathy, trust and knowledge of physiological birth that midwives can empower women during birth.

When women are cared for in a system that values relationship-based care and empowerment, the key aspects of control are given, information and choices are offered and

consent is gained. She is in control of her own body in an environment which recognises the need for movement during physiological birth.

11.3.3 A positive working culture and environment

Midwives and obstetricians' beliefs of a positive culture were a culture in which knowledge was shared and learning took place through discussion, collaborative working and learning. This was seen to facilitate movement, physiological birth and respected women's choices.

11.3.3.1 A history of shared learning between midwives and women

Historically, midwifery skills were learnt through apprenticeship; women learning from each other through observation and skills passed from one midwife to another (Donnison, 1988). There were no books, knowledge was shared through story-telling (Olafsdottir & Kirkham, 2010). Midwives were present at complex births and used rituals to keep women safe (Kitzinger, 2001). The rise of the man midwife with academic knowledge gave superiority and power to this knowledge, causing conflict between the midwife and obstetrician (Donnison, 1977) and led to a struggle for midwives to gain autonomy (Marland & Rafferty, 1997). It has been identified that ways of collaborative working and training are needed to prevent barriers between professional groups (Doya & Cameron, 2000; NHS England, 2016) and to prevent tragic outcomes in maternity care (Kirkup, 2015).

11.3.3.2 Learning that facilitates movement

In-depth clinical knowledge, described as connoisseurship comes from direct observation and care over many hours (Polanyi, 1958). Connoisseurship is perceptual knowledge of situations within the context they are occurring and the ability to recognise this. Accessing this connoisseurship within the MLU appears to be part of practice. Through midwives using their knowledge in a descriptive and interpretive way clinical knowledge is exposed. Through learning this way, clinical knowledge is gained by others in the team, in 'learning how' to become a clinician (Benner, 1984). Comparing judgement takes place naturally within nursing, and appears to on the MLU, enabling skills to be refined and to demonstrate qualitative distinctions in practice, and peer learning to take place (Benner, 1984).

Gutteridge (2016) takes the position that midwives working in an MLU need to have certain characteristics. Expert practitioners with a high degree of professionalism and characteristics such as being highly skilled communicators, contribute to an environment where colleagues can show vulnerability. Working in this way enables trusting relationships to form which in

turn leads to practice being agreed with or challenged so that learning can take place and normal birth supported (IBID).

11.4 Espoused beliefs and values in a disconnected culture

11.4.1 Setting rigid boundaries

Setting boundaries through the separation of women into different environments, depending on if they are considered high or low-risk demonstrates the belief that boundaries exist on the functioning of the body -whether it is considered pathological or not. Care given is fragmented into time periods and is not seen as a continuum and relationships between woman and midwife are not prioritised.

11.4.1.1 Separation between high and low risk maternity care.

Separating care into high and low risk environments has a detrimental effect on midwives and women's ability to use movement as part of birth, as midwives hold little power in the CLU area to facilitate this. Complexities or perceived complexities and managing them become the focus of care that does not incorporate supporting physiological birth. Students and learning about physiological birth have also become affected, as there is reduced opportunity to support physiological birth on the CLU.

A midwife employed by the NHS, as an employee, is under contract to follow policy and guidelines, needs to act within her code of professional conduct (NMC, 2015). Yet midwives often work within an area and culture which is dominated by a medical and business model of care which impacts on the birth process and how midwives are able to practice (Walsh, 2010).

Whilst midwifery led care has been shown to benefit women (Sandall et al. 2016b), government directives emphasise women's choice around place of birth (NHS England, 2016) describing MLUs as alternative settings for birth (Hodnett, Downe & Walsh, 2012). Overall, these alternative settings are associated with lower rates of medical intervention and increased satisfaction for women (Brocklehurst et al 2011) they provide environments that are designed to be more like bedrooms. However, the effect of these environments could not be separated from other aspects of care such as staffing models (Hodnett, Downe & Walsh, 2012). Whilst the impact of midwifery led care has seen improved outcomes for women and neonates globally it needs effective integration into maternity care settings and facilities

(Renfrew et al. 2014). This separation of MLU and CLU care deprives women of the aspects of midwifery care that supports physiological birth. Hundley et al. (1994) found that care in an MLU area resulted in more maternal mobility than in the CLU area showing the affect separation has.

11.4.1.2 Fragmentation

Working in a system where care is separated into high and low risk and care episodes are fragmented, does not allow in-depth knowing relationships to be built or implemented despite overwhelming evidence (Sandall et al. 2016a) and government directives (Britain & Cumberlege, 1993).

Attention is paid to the psychological and information needs of women during birth in education standards (NMC, 2009) but despite government recommendations, relationship-based care is rarely implemented in practice. This is seen as care provision and implementation that benefits the system and not the woman (Kitzinger, 2006; Mander & Murphy-Lawless, 2013).

An example of fragmentation used by the midwives interviewed was the triage service. Triage is viewed as a complex interaction which, if not carried out in a personalised way, involving joint decision-making with the woman, can lead to women feeling dissatisfied with their birth experience (Shallow, Deery & Kirkham, 2018). The support needs of women by midwives are being met by midwives once they are in labour; the information needed by women to make decisions about their care are not being met, compared with care delivery in continuity of care models (Sandall et al. 2016a). An objective judgement by an unknown health professional to triage women and their labour and assess whether the hospital criteria is being met for them to receive personal care is a medical model of care which prioritises the system.

Shallow, Deery and Kirkham (2018) identified that in the current context of maternity services, an organisation driven by operational management decisions, midwives' and women's emotional wellbeing are affected which may compromise mothers' and babies' physical safety. They identified that working in this way triggers changes in midwives' thinking and behaviour due to conflicting emotions: fear, helplessness and frustration, which stretched their personal and professional integrity (Ibid). Working in this way disconnected midwives from the women rather than focusing on their individual needs.

11.4.1.3 Hierarchy

Power and authority in the CLU rather than evidence define acceptable practice (Newnham, McKellar & Pincombe, 2015), with the consequence being that practice which supports physiology is difficult to implement. This is despite the recommendation of developing policies and practice to support normal labour and birth to decrease medical intervention for women (Hodnett et al. 2012).

The medical model, which seeks to control risk, is prevalent (Walsh & Newburn, 2002), there is a definitive hierarchy present as it is the role of the obstetrician and obstetric practices to do this (Van Teijlingen, 2005). Obstetrics have the authoritative knowledge in this environment putting midwives' practice under their control (Hunt & Symonds, 1995) with the midwives' role becoming that of technical obstetric nurse (McCrea & Thompson, 1995; Van Teijlingen, 2005). Through women being seen as a 'complexity' rather than a person, the women are separated from their condition (Rothman, 1982) and the role of the midwife becomes managing and monitoring the 'complexity' as managing complexities and associated risks is seen as more legitimate (Stewart, 2001). The medicalisation of birth and the influence of workplace culture has been found to impact on perception of risk (Van Otterloo, 2016); those midwives working in a higher intervention area have a higher perception of risk which may increase the influence of intervention and advice given (Mead, 2008). As managing complexities and associated risks is seen as more legitimate it therefore affects midwives' autonomy (Stewart, 2001).

Maternity care is fragmented into episodes of care relating to whether women are pregnant, in labour or have birthed their babies, if they are considered to have complexities or not, which stage of their labour they are in and who their caregivers are. Separation and fragmentation, which appears to serve the needs of the institution over those of the women, neglects the human impact that this has on women and midwives. This has had a detrimental effect on the relationships women can build with midwives and therefore the care the midwife is able to provide. Maternity services are organised with processes in place that put boundaries between midwives and women and women's birth from the rest of their pregnancy care. Professional power, managing complexities and a business model approach that prioritises process, enforces hierarchy that demonstrate a belief that this is the most efficient way to provide services.

11.4.2 Maintaining control through medically dominated care

How services are organised is in the control of the care provider. Care providers also control what information is produced, what knowledge is predominant and how relationships are supported between care providers and women. A standardised, medical approach to maternity care is valued and puts the care providers in control of birth. This is biased towards their perspective, affecting negatively on birth physiology and women, physiologically and emotionally.

11.4.2.1 Medically dominated care

Midwives working on the CLU feel a strong sense of medical domination through the existence of a hierarchy. This hierarchy appears to stifle the use of midwifery and normal birth knowledge in preference for medical knowledge. Littlewood (1991) makes the analogy of doctors, nurses and patients to the patriarchal nuclear family. Squire (2017) adapts this to midwifery; obstetrics is viewed as a male gendered profession in its belief system – scientific, technological, active and patriarchal with no room for individual women's needs. Midwifery is there to support the obstetrician, analogous to the wife - useful and necessary but essentially inferior and therefore passive in the hierarchy. Women are portrayed at the bottom of the hierarchy in the role of the child, passive with the expectation of being good and birthing in the hospital using all the technology offered. In a capitalist system, the Chief Executive is also in a position of power in the hierarchy as they have the power to make the decision to give women choice or take it away through the provision or withdrawal of services (Squire, 2017).

Keating and Fleming (2009) argue that the patriarchal culture within a CLU lead to difficulties for midwives supporting normal birth. Keating and Fleming base their work on a theory of ecofeminism that shows important connections between:

'*The domination of women and the domination of nature'* (Warren, 1994, p 126).

Ecofeminism has five interrelated features: (1) *Value-hierarchical (Up-Down) thinking*, which places higher value on what is gender identified as male than female, (2) *Value dualism*, organising reality into oppositional and exclusive pairs rather than complimentary and inclusive reality, (3) *Power-over conception of power*, which maintains domination and subordination, (4) *Conception of privilege*, functions to maintain power-over relations by

those ‘Up’, (5) *A logic of domination,* an argumentative structure that justifies the power and privilege of those who are ‘Up’ (Warren, 1994). Whilst Warren is referring to nature in an ecological sense, Keating and Fleming (2009) illustrate how this theory relates to midwives working within an environment that has a medical approach to birth that places doctors as powerful at the top of a hierarchy, women as passive and compliant at the bottom. This places the midwives in a no-man’s land between the women and the doctors. In this position, they belong to neither camp and therefore are unable to act autonomously to provide the compassionate care they know women need. This led to midwives feeling disempowered and frustrated, as they were unable to utilise their midwifery skills, especially as the midwifery management also subscribed to this way of thinking. Midwives reported that on night duty they felt much more able to practice a compassionate model of care that placed women’s needs over the needs of the organisation. This is due to the lack of senior doctors and midwifery managers on the unit so that midwives were able to provide care without feeling that they were being constantly monitored.

Working within a hierarchical structure on an obstetric unit, Fleming and Mander (2009) found that midwives were scared and influenced by the doctors that made an impact on their ability to support normal birth. Shaw et al. (2016) identify that maternal morbidity in high-income countries is generally low but the impact of the majority of births taking place within medically led institutions has resulted in some care being harmful. This calls for care to be provided which normalises birth for most women and provides access to care if complications develop (Shaw et al., 2016).

The control of women, movement and midwifery practice within the CLU is felt to be the consequence of the risk of litigation and the need to provide evidence.

From the data, the biomedical discourse is predominant from the woman’s perspective when speaking about their birth. Birth is discussed in medical terms and spoken of as if the healthcare professionals are in control of the events surrounding birth. Defining childbirth in medical terms gives it understanding within a medical framework, processes are defined in terms of health or illness and medical practice controls the experiences that become deviant to restore social norms (Brubaker & Dillaway, 2009). As Brubaker and Dillaway suggest, the women interviewed make sense of their birth in this way because it is ‘definable, visible and unquestioned by most others around them.’ (Brubaker & Dillaway, 2009, p 38).

Little was said around movement when women spoke of talking about birth to their friends and family. Though birth is spoken about, it is dominated by the medical discourse of measurement and time, the hospital staff play a part as the ones who instigate action within birth. Women's part in birth, 'the nitty gritty' of how women get a baby out, does not appear to be discussed apart from talking it through for therapeutic reasons which can enable women to articulate their feelings and make sense of this life-changing experience (Callister, 1995).

11.4.2.2 Medical practice disrupting movement

The medicalisation of childbirth in the CLU environment has cast women into the patient role. This places birth within a process driven environment, expecting women to comply with doctors' instructions, encouraging them to be distant in the process, hand over control of their bodies to others and take their advice (Lupton, 2012). However, we are moving in to an era with a bigger focus on women's human rights (Schiller, 2016), government directives on women's choice (NHS England, 2016) and recognition of the long term impact on women when they don't feel in control (Elmir et al., 2010) or have a subjective negative experience (Ayers et al., 2014). Compliance of midwives and women is needed in pre-empting ward rounds; how intimidating it can be for a woman when eight men come to observe her semi-naked, mobile body, is recognised by the midwife, yet the significance of this is not recognised by the institutional practices. The medical practice in the CLU is the dominant culture with which the woman is expected to conform. The woman's individual preferences and birthing physiology are not recognised as important. If a woman is clothed and sat in a bed it can be easier for observation and monitoring in a way that is more dignified for the woman and the '*men*' who come and observe her. Yet this is not conducive to physiological birth. The naked birthing woman and the physical observing of women in a public institution, can be seen as natural and normal to a midwife but not what the women want to show or the doctors want to see.

11.4.2.3 Control of services

Within the current economic climate the NHS budget has been reduced leading to staff shortages. Morale is low due to the strain on staff along with salary freezes, pension reforms and staff downgrading (Jervis, 2016). Prioritising cost efficiency over quality of care is seen as an impact of the Health and Social Care Bill (2011). This bill started the transition of the NHS from a publicly funded system which was mainly publicly provided and administrated, to a

competitive market of corporate providers which the government finances but does not provide (Pollock & Price, 2011).

Midwife led care improves outcomes for women and babies (Sandall et al. 2016b). These outcomes have a positive impact on women's and the next generation's long-term health, yet 'high risk' care is incentivised through the increased income generated (NHS England, 2016). Relationship based midwifery care has been shown to be effective. Yet cost and perceived safety from a politically driven, paternalistic, biomedical perspective drives service provision. Cost analysis of maternity care is complex; health economics provides analysis of cost benefit and cost effectiveness; however, it is difficult to know how to measure the economic worth of maternity services (Tracey, 2011).

11.4.2.4 Policy controlling information, women, midwives and choice

There have been many policy drivers for supporting women's choice over the last three decades (DoH, 1993, 2007; NHS England, 2016). Bryers and Teijlingen (2010) argue that implementation is difficult due to the perceptions of risk and intellectual and social capital is with the medical model. As outlined above, politics is inextricably involved in maternity care provision. The economic management of resources, efficiency and the processing of women through the system requires control over the women and midwives (Kirkham, 2011). This has led to a proliferation of micro-management through rulemaking in the production of policies, procedures, protocols and guidelines, to which non-adherence must be justified (Parsons & Griffiths, 2007). The consequence of this is the care provider deciding what is acceptable or unacceptable risk for women and therefore taking responsibility for the outcome (Dahlen, 2016), leading to midwives becoming fearful (Kirkham, 2011) and women becoming regulated to protect the fetus, now identified as the 'second patient' (Dahlen, 2016). Through midwives being employed by this system, bureaucratic processes are prioritised and conflict with professional values (Corwin, 1961) resulting in midwives being unable to advocate for women when their choices challenge the rules (Edwards, 2005). Through institutionalising birth, the organisation has become the most powerful, rendering midwives and mothers passive within it (Kirkham, 2011).

Biomedical beliefs, politics and managing risk transposes onto care, midwives and women. The power of this is recognised by the midwives and women interviewed but not by the obstetricians and culture of the CLU. Only recognising it as the most efficient way to manage

safety, the impact of this is women viewing birth as risky for their baby and as being controlled by others, making them compliant in their care. Yet there is a wider acceptance by women of this with few women questioning who is in control of birth. The midwives recognised this and some challenge this culture, yet they have little power to do so.

11.5 Basic underlying assumptions

11.5.1 Compassion based in love and empathy versus lack of empathy, dignity and choice for women

A culture based in compassion and love was predominant in the connective culture and was often absent in the disconnected culture. When compassion was lacking there was a lack of empathy and choice for women.

11.5.1.1 Compassion

Menage (2017) undertook a concept analysis of compassion in midwifery care as she identified that the concept had not been explored or studied. She defined compassionate midwifery as:

'*the interrelations of authentic presence, noticing suffering, empathy, connectedness/ relationship, emotion work, motivation to help/support, empowering women and alleviating suffering through negotiation, knowledge and skills*.' (Menage, 2017, p 568).

Compassion has been identified as fundamental to good quality maternity care (Byrom and Downe, 2015), a core concept in healthcare (Kneafsey et al., 2016) and part of a national vision and strategy to incorporate a culture of compassion within NHS healthcare (Cummings & Bennett, 2012). In the context of this project, it is recognised that obstetric care is different from midwifery however; both require compassion to provide quality care. Both midwives and obstetricians show empathy towards the women for whom they care, however the underlying assumptions based in emotions and motivation to support women using their knowledge and skills to deliver compassionate care shall be explored.

11.5.1.2 Compassion based in love and empathy

The midwives shared basic assumptions through learning the importance of these through their own birth experience or the value of midwifery through their experience of being a woman or midwife. These assumptions have become taken-for-granted assumptions in how they provide care.

Midwives feel connection to birth as women, they bring their experience as birthing women, their feelings about birth. Midwifery and birth were spoken about in relation to thoughts, feelings and relationships midwives had to birth.

All midwives interviewed recognised and reacted to childbirth as a special time in a person and family's life, connected to all aspects of their life and that birth is an emotional time for a woman, family and midwife. This view is based in a social model of childbirth (Wagner, 1994) and encompasses a much broader concept of health than that of the biomedical model. All midwives interviewed, from their expectations of midwifery prior to training and throughout their midwifery role, embraced a social model of childbirth. This emphasised the wider impact that childbirth has on the midwives' lives and supports the literature on childbirth as part of a social model of care with which women and midwives connect. The idea of birth as part of women's social lives is associated with societies that are more traditional where childbirth is viewed as women's territory based on social and personal relationships (Kitzinger, 2015). It is these social and personal aspects of childbirth to which midwives were drawn.

Childbirth has historically been a female domain, a uniquely female process. Women were viewed as being closer to the earth and Mother Earth: organic, providing, fruitful, and sentient an all-powerful being (Miles, 1990). Knowledge and traditions were passed on orally. With the rise of the scientific revolution and the rise of capitalism childbirth became a subject of scientific enquiry and a source of income (Donnison, 1988). This concept of birth stripped away the emotional and magical significance of birth (Arney, 1982)

Care that is outcome and process focused is predominant in maternity care (Kitzinger, 2005), ignoring the holistic needs of the women and the connection this has to birth. While Simkin (1991) found that women's birth experience has long-term impact, care outcomes alone do not contribute to a positive birth experience; the care that women receive during birth is also found to have a significant impact on what they perceive as a positive outcome (Henderson & Redshaw, 2013). Davis-Floyd (2008) terms the biomedical model of care as technocratic, based on outcomes and technology that fails to recognise the human and holistic needs of women, this has become the predominant model in the west. Additionally, Davis-Floyd (2008) speaks of the rituals of childbirth and how, from an anthropological perspective, they act as a rite of passage. Reed, Barnes and Rowe (2016) who found that women's experience of birth

is multidimensional and experienced as a transformational and empowering rite of passage support this.

As birth moved into institutions, women no longer supported other women in the social context of birth, therefore losing their experiential knowledge of birth (Kitzinger, 2001). With midwives having professional power within these institutions knowledge about birth became professionalised. With the introduction of the Midwives Act in 1902, which professionalised and gave power to the status of midwife (Pitt, 1997).

Ternovszky (2015) speaks about the love she received from her midwife and how this positively affected her birth. Caring is based on the word caritas - love (Byrom & Downe, 2015) and whilst models of compassion define the concept and behaviours inherent in compassion (Clift & Steel, 2014), none mention delivering care with love or showing the woman (patient) love. As a fundamental human emotion, approaching care with love would encompass humanised, dignified and compassionate care.

It is these wider holistic and emotional aspects of birth the midwives spoke of based on a model of health, focused on families and women's experiences. Their approach to care was motivated by love, and empathy for the woman and her holistic experience resulting in a compassionate model of midwifery care.

Midwives learnt about birth from their experiences and their training. Paying attention to love, empathy and compassion during interview and expressing what this meant to them as women and birthing women and to the women they cared for, shows their basic set of assumptions as defined by Schein (2017).

Women also spoke about their relationships with their midwives. Women entered their maternity journey with the assumption that care given by midwives would be based on a compassionate model.

11.5.1.3 Compassion based in safety and empathy

One obstetrician showed a basic underlying assumption similar to that of the midwives. Whilst emotion was a factor in the obstetrician's motivation for career choice they spoke of learning, being part of the team and how the CLU made them feel. Their focus was on safety and their responsibility for maintaining this. This was based on their experience of learning about obstetrics, though they cited how childbirth was 'special' and 'a privilege to be part of'.

The meaning of the word midwife is 'with woman', a role which historically has been performed by women. Obstetricians from the Latin 'obstare' meaning 'to stand before' tried to replace women as birth attendants from around 1890 (Arney, 1982). Midwives, historically and today, learn about birth from being with women alongside the theory, whereas obstetricians learn from science and instruction from each other (Arney, 1982) resulting in the profession of obstetrics being focused on rational, objective theory and saving women and the fetus (Murphy-Lawless, 1998). This discourse of historically male-dominated science has distanced itself from the reality of women's bodies (Murphy-Lawless, 1998) and thus the physical, psychological, emotional and social wisdom that comes from the experience of childbirth.

These methods of shared learning from the different professional groups show the difference in basic assumptions. Whilst one obstetrician spoke of her personal experience and how this had shaped her outlook to care and practice as did the midwives, the other obstetricians kept their personal experience away from their professional practice. This gives an insight to the differing ideological, cultural differences between obstetric and midwifery care. It can also illustrate how, as an obstetrician, it is normal to bracket personal experience and feeling away from obstetric practice through depersonalisation of the self and of the person. Thus in medicine, scientific knowledge is more valuable than experiential knowing, with science and rationality providing safety. Empathy is based within the preserving of life and the maintaining of safety; this is a basic assumption of the compassionate care provided by the obstetricians.

11.5.1.4 Need and effect of compassion

Being cared for and receiving affection has a neurological effect making us feel a sense of safeness, reassurance and calm (Gilbert, 2015). Kindness, support, encouragement and compassion for others influence our sense of well-being (Ibid). Physiological birth is dependent upon an orchestration of hormones that enables birth to progress with ease and safety and be a positive experience (Buckley, 2003). To enable these hormones to be released optimally, the birth environment needs to be private, feel safe and the women needs to feel unobserved. Therefore, compassionate care focused on a holistic knowledge of women and helping and supporting birth with these skills is essential.

11.5.1.5 Lack of empathy, dignity and choice for women

Menage (2017) defines the elements of compassionate midwifery care to which the midwives aspired to provide. Yet, their experience of being a midwife or a student midwife, specifically when being involved in medicalised birth, this was not what they witnessed.

Midwives witnessed care which did not allow dignity or enable women to exercise autonomy and choice, care which is against basic human rights (Schiller, 2016). Poor, disrespectful care has been identified by student midwives around women who cannot speak English (Davies & Coldridge, 2015). While human rights violations in childbirth occur in developing countries (Bowser & Limbu, 2014), the experiences of women in the UK highlight that it is not just an international phenomenon (Schiller, 2016). Hospitals can be viewed as social systems with rigid hierarchies. This allows dominance over others with abuse and mistreatment likely. 'Reform is unlikely without investment from all stakeholders' (Goer, 2010).

Witnessing events such as these can have a negative emotional impact on carers (Figley, 1995). When the empathy that forms the basis of midwives / women's relationships is absent, conflicts between ideology and practice arise. Midwives experience stress because institutional policy and practices do not reflect the empathy-based care they strive to provide. Observing traumatic events and feeling powerless to intervene or protect women can lead to psychological trauma and emotional difficulties for midwives (Sheen, Slade & Spiby, 2013; Rice & Warland, 2013). A conflict in ideologies arises when a midwifery model of care (Guilliland & Pairman, 1995) and a medical model clash, as the power imbalance causes midwives to feel powerless in their ability to provide care that is in line with their philosophy (Rice & Warland, 2013). Student midwives are even more vulnerable to witnessing trauma as they identify strongly with the women but have no formal acknowledgement of their position and receive little support or debriefing (Davies & Coldridge, 2015).

Women's experience of this culture during birth in the CLU or being transferred from the MLU to CLU reflects the experience of the midwives. With removal of privacy, lack of dignity and a lack of awareness of choice, women appear to have learnt that when problems during labour and birth occur they must acquiesce to the system and passively accept interventions. This reflects the underlying assumption of the CLU in the bio-medical model where there is a separation between the mind and body, and primary concern is the body being a machine that needs repair from dysfunction by the practitioner, (Davis-Floyd, 2001). It also reflects

the experience of the women showing underlying assumptions that women are not worthy of respect, rights or choice and women do not feel powerful enough to express this.

This is the system in which the midwives and obstetricians have learnt how to deal with complexities or 'problems' during labour and birth and the way in which women have learnt to experience maternity care. Women experiencing labour and birth on the CLU have complexities that need to be managed. This takes precedence over the need for compassion based in love and empathy that recognises women's holistic needs and human rights and prioritises compassion based in safety.

Providing care based on these principles provides a dichotomy in ideology and therefore care provision. Both aim to provide compassionate care however, the skills needed for this are different, resulting in different outcomes which are detrimental to women's experience.

11.6 Basic underlying assumption in a connective culture

11.6.1 Knowledge and understanding of birth physiology and psychology

In a connective culture there is knowledge and understanding of the physical and psychological effects of movement and birth as a lived experience. Movement is viewed by women and midwives as part of physiological birth and something that has physiological and psychological benefits. How midwives and women gain knowledge and understanding of birth is explored in context of the wider literature.

11.6.1.1 Midwives gaining knowledge and understanding of movement

Movement is recognised as a fundamental activity of living, along with other essential activities which are used together to contribute to nursing plans of care to support well-being and guide practice (Roper, Logan & Tierney, 2000). Though this is a well-recognised tool in nursing, similar tools do not exist in midwifery to assess that all caregivers are meeting all physical, psychological and emotional needs as part of a plan of care. Labouring and birthing women are not ill and are experiencing a normal physiological process, no formal acknowledgments are made that there are fundamental aspects of care that need to be provided to support overall physical and psychological functions and rights. Movement during labour and birth is recognised by midwives as an underlying assumption that contributes to physiological birth and by women as something that they would or would not do naturally.

However, some obstetricians and the system do not recognise it as a fundamental aspect of physiological birth.

Midwives also recognise how movement has an impact on women's right to freedom of choice and how these can be affected in a restrictive environment, not just effecting labour but her ability to exercise choice. Limiting a woman's choice and not respecting her decisions not only infringes her human rights (Shiller, 2016) but can also have long-term negative impacts on her psychological health (Elmir et al. 2010).

Midwives gain knowledge of movement during their midwifery training and ongoing understanding through learning from women during birth. Obstetricians recognise that midwives have more understanding than they do, however, their own understanding is enhanced when they have personal experience of birth.

During midwifery training theory and practical skills are gained, Benner's (1984) work provides an understanding of how knowledge and skills are acquired and applied to practice. For a novice midwife, working alongside experienced practitioners in clinical situations enables the holistic development of skills to become proficient.

Perceptual awareness of a situation is used by experienced practitioners, learnt from their extended experience (Benner, 1984). This embedded knowledge can be deeply rooted within the midwife gained from all their senses, their theoretical knowledge and so contributes to her intuition (Berg, 2005). The skill of the midwife of knowing when and where to move and how to act through connecting with the woman, is central to care based in relationships. Whilst Sandall et al. (2016a) state that while the precise mechanisms of relationship-based care which are particularly of benefit are unknown, trust plays a part. Knowing a woman, knowing birth, trusting women and trusting birth, these all contribute to the knowledge.

11.6.1.2 Women and instinct as a source of knowledge

Culturally in the west, women have been disconnected from birth as a normal physiological process and social event happening within their home environment (Davis-Floyd, 2000). Women no longer observe instinctual movements used by other women during birth, knowledge that could be described as tacit since it had been observed many times (Benner, 1984). These instinctual movements inform midwives and 'books' and the midwife's role is to then re-educate women, re-connecting women to their instinct. Viewed as instinct, Wickham

(2004) proposes that this knowledge could be natural maternal reflexes or gained from a psychological or spiritual level that is discredited and rarely accepted by rational methods of knowing.

Savage (2006) defines preparing for childbirth as:

'*any experience in which a woman acquires knowledge about the birth process. To formulate a foundation for the acquisition of knowledge that women possess surrounding the uniquely gendered perspective of giving birth, concepts are derived from experiential knowledge that are transferred from narratives (e.g. birth stories), social interaction, and culture.'* (Savage, 2006, p 11).

Having relationships with other women and sharing knowledge in the form of birth stories is seen as essential to the birth experience for women and is recognised as an effective way in which women learn about birth (Savage, 2006). Storytelling creates a bond and a shared history between women (Lindesmith & McWeeny, 1994) and is viewed as a need to explain the unknown, lessen fear, and obtain a sense of control over childbirth (Zwelling, 2000). These relationships and ways of receiving knowledge from others provide women with experiences of mutuality, equality and reciprocity that can enable them to separate their voice from others and develop their own capacity for knowing (Belenky et al. 1986).

11.6.1.3 Women's own experience as a source of knowledge

Movement is understood by women to be something that they would do naturally with their bodies during birth, something that their lived experience of their bodies has told them that they have control of.

Barbour (2002) explored embodied ways of knowing as she acknowledged a lack of consistency between her lived bodily experience as a dancer and academic knowledge in the same field. Offering a way of understanding knowledge acquisition that is different from reasoning as described by Belenky et al. (1986) she theorises an epistemological strategy that progresses to embodied knowledge. This is described as:

'person views all knowledge as contextual and embodied. The person experiences him/herself as creator of and as embodying knowledge, valuing her/his own experiential ways of knowing and reconciling these with other strategies of knowing as s/he lives out his life.' Barbour, 2016 p234).

This theory of knowing gives an understanding of knowledge that is constructed from something that is embodied, experienced and lived, creating individual ways of knowing. As described by the women interviewed, the knowledge they need or will need about movement during their labour and birth will come from their bodies at the time. An embodied experience gives women a unique, personal and sensual experience, giving new meaning which alters established medical ideals (Neiterman, 2013). Barbour (2016) does acknowledge that using embodied knowledge as an alternative understanding to forms of dominant knowledge can create personal challenges and tensions. By living through these experiences, resolution does not come from rationalisation or intuition but from living out the possibilities, evaluating the knowledge gained and disregarding knowledge that is found irrelevant or not liveable to the individual. This gives women an embodied solution to any knowledge of movement they may require during their birth.

With the professionalisation of midwifery and moving birth into institutions, birth knowledge has been claimed, with women in need of re-educating on how to birth. Professional formal knowledge is for educating women about birth, as women are unable to share their own knowledge through learning from each other's direct experiences. While birth knowledge can be viewed as a commodity and specialist, it is only available to those seeking it in the antenatal period. With a general lack of continuity-based models of care (Jervis, 2016), it is down to the midwife during birth to address women's lack of experiential knowledge around birth.

11.7. Basic underlying assumption in a disconnective culture

11.7.1. The use of authoritative knowledge

The data showed how biomedical knowledge was predominant in the CLU with a lack of knowledge and understanding of physiological, psychological and social aspects of birth and movement. This shall be explored in context of the wider literature and theory.

11.7.1.1 The use of authoritative knowledge

The concept of authoritative knowledge recognises that different knowledge systems exist and by consensus, some have more power than others do. This is because either they have better efficacy, or they are associated with a stronger power base (Jordan, 1997). Whilst equally legitimate knowledge systems exist which can be moved between, one gains legitimacy and becomes authoritative whilst others are devalued. Seen as an ongoing social process that builds and reflects power-relationships it is done in a way which is seen as natural

and obvious (Ibid). Knowledge of birth anatomy and physiology by doctors originally came from cadavers, supine dead women (Donnison, 1988). Along with the representation of birth in medical textbooks as inanimate illustrations, birth knowledge from a medical perspective, does not represent active birth knowledge gained from being present at births (Jowitt, 2014). Midwives have observed women during birth for centuries, but this knowledge is not documented (Wickham, 2014). The medical knowledge of birth which is based on medical text and science has become dominant in the CLU and in wider culture and therefore, authoritative. What appears to be 'common-sense' knowledge to midwives and women from sensory knowledge, embodied or instinctive knowledge of normal birth has not transpired to the medical setting and therefore is not usual practice. Thus, this knowledge has become devalued through the legitimising of bio-medical knowledge. In cultures and environments where medical knowledge is not authoritative, movement is not restricted, and women can use their instinctive knowledge (Jowitt, 2014; Kitzinger, 2001).

Authoritative knowledge is used to challenge practice as other forms are not based in research or scientific evidence. What and how much knowledge around movement is already embedded into midwives' knowledge from training is unknown. The knowledge around movement is qualitative and experiential and an aspect of birth which does not have a large quantitative research base. The power given to quantitative authoritative knowledge is therefore not available and so unable to support midwives and women in movement during birth when at odds with the power of technology and the focus on managing complexity.

Using a feminist approach in analysis of nursing literature reveals the dominant discourse in nursing theory and research is biased towards a medical authoritative approach (Huntington & Gilmore, 2010). This can also be said for much of the research around movement as evidenced in the quantitative literature review. Scientific knowledge in the form of research, national and hospital guidance support the belief systems and culture within the hospital. Relevant up-to-date evidence supports the aspirational idea of progress and factors that support the location of agency in who has the knowledge power, therefore increasing control and status of people in the hierarchy and highlighting the consequences of those who do not comply (Mander and Murphy-Lawless, 2013).

11.7.1.2 Power of authoritative knowledge

Ginsburg and Rapp (1991) illustrate how powerful actors and institutions shape conflicting demands placed on women around how reproduction is governed. The power of the state has given rise to the medical profession and industries, global markets, pharmaceuticals ideologies and policies that link economic development to control over the population. Whilst giving access to obstetric care to women in the West that improve outcomes, the technologies and increased scientific knowledge that enable regulation of reproductive practices have come at a cost. Medical homogony and moving birth from home to the hospital has reduced the power of knowledge passed down through generations of women leading to the loss of midwifery knowledge. However, it is recognised that midwives both appropriate and resist the dominant professional discourse in their geographical area (Ginsburg & Rapp, 1991).

In 1999, the UK Central Council for nursing and midwifery aimed to elevate midwifery and nursing through making it a graduate profession in an attempt to increase professional status (Bower, 2002). Recognising the need for an educated and academic midwifery workforce, government directives (Chief Nursing Officers (CNO) England, Northern Ireland, Scotland and Wales 2010, NHS England 2016) acknowledge the influence midwives have in improving women's outcomes and experience. The directive published under the Conservative/Liberal Democrats coalition (CNO 2010) recognised how educated midwives, in a culture of lifelong learning increases capacity and leadership and role development. The way for this to be achieved is with adequate funding and support through effective planning and delivery of midwifery development, and education programmes in partnership with service-users, commissioners, Higher Education institutes and service-providers. Yet the current government have cut all funding available to midwives for training and continuing professional development, highlighting the state and its role in midwifery services as it is the state who sanctions how services develop (Mander & Murphy-Lawless, 2013) according to the agenda and ideology of the government of the day.

11.7.1.3 The proliferation of authoritative knowledge

Medical education focuses on pathology (Lokugamage, 2011). Not all medical students spend time with midwives and rarely have the opportunity to experience birth within midwife led areas or home (Lumsden & Symonds, 2010), and obstetricians mainly see problem pregnancies or emergencies (Lokugamage, 2011). Coming from this perspective most doctors

focus on safety, complexity or risk. As human rights and the understanding of psychobiological factors on a woman's birth are not included in medical or obstetric training (Lokugamage & Bourne 2015, Lokugamage & Barbira-Freedman 2016) it is understandable that knowledge around movement and how it impacts on woman's birth is unknown to most doctors.

Authoritative knowledge lies with obstetrics thus giving it power. The natural order of thinking, within the CLU bio-medical knowledge has 'cultural authority' (Starr, 2008) meaning that the obstetricians have the facts and thus have the authority.

The way in which obstetricians are taught and how birth is learnt about in their practice proliferates their narrow understanding of birth. Knowledge that is gained from our senses is subjective to personal experience, when this knowledge is unambiguous to us it secures our beliefs and leads to the common-sense theory of knowledge developed by Locke, Berkley and Hulme (Popper, 1972). Popper refers to the bucket theory in which the mind is an empty bucket into which knowledge is poured. He opposes this, arguing that sense data are encodings of complex reality that only appear easy and natural to us after we have learnt to decode these through constant practice. The bucket into which this knowledge is poured is not empty, therefore, having prior experiential knowledge of birth and observing birth is seen through our perceptions of experience. When knowledge about birth is experienced in context to something of which we have sensual knowledge, whether this be as an observer from a risk-based safety perspective as observed in the CLU or experiential knowledge of birth as a woman or midwife, a mental programming of thought occurs (Hofstede, Hofstede & Minkov, 2010). Culture is collective learning from a social environment, different levels of culture which can be learnt from our childhood environment, profession and the organisation we are employed by contribute to our values, rituals, heroes and symbols which spread across practices (Ibid). The knowledge learnt becomes common sense or a set of shared values and is reproduced within that culture. There is an identifiably different way in which midwives and doctors are taught, and their perceptions and experiences of birth perpetuate their beliefs within their own common sense view of knowledge around birth.

11.8 Barriers to changing the culture

The data identified barriers to the implementation of knowledge of movement. Whilst the connections and disconnections chapter outlined the predominant cultures, the midwives interviewed identified why they thought midwifery care and knowledge about movement was

difficult to implement. The identifying and understanding of barriers women and midwives face enable the feminist aims of this project to be addressed. Naming the barriers in order to recognise them diminishes their power and from this we can build alliances and strategies to overcome them (Kirkham, 2016).

11.8.1 How midwives, women and obstetricians view each other

Midwives spoke of how they were viewed by their obstetric colleagues when alternatives or adaptations to the obstetric management or care were presented in a way that undermined their knowledge. Though this has been identified as a clash of beliefs, the obstetric knowledge and viewpoint is in a position of power and devalues midwifery knowledge. The struggle for whose knowledge is the most valid is historic (Donnison, 1988). Midwifery has struggled for professional recognition (Marland & Rafferty, 1997) and has been under the surveillance of doctors since the 1902 Midwives Act with the aim of protecting the public. Combined with how obstetricians are trained and their lack of training in physiological birth, midwifery aspects of care such as movement are unknown to them and therefore seen as irrelevant or not seen at all. However, from the 6 obstetricians interviewed these perspectives could be changing as one recognised the importance of movement and working with women during birth as opposed to managing risk to maintain safety.

11.8.2 Theory practice gap

Disparities exist between best practice and values that are taught and those which are seen as a barrier. The power which is inherent in the hierarchy present the use of objective knowledge which does not take into account individual need, and practice which serves the needs of the institution is seen to contribute to this. The midwives have little power to implement knowledge that they have. This barrier exists within the culture of the unit but also in the current context of maternity service and the profession of the midwife.

Midwifery grounded in relationships with women and colleagues, needs professional autonomy to implement midwifery values, values that are imbedded in theory but are difficult to use in practice.

11.8.3 Childbirth and culture

Birth has been taking place in the institution since the1960's, thus women rarely get to see how other women behave and move during labour. Women have been separated from birth, denying them first-hand experience of supporting other women at birth and experiential

knowledge of movement during birth. Midwives perceive that women gain information about birth from the media; however women who have experienced birth realise that this information is dramatized and unrealistic.

Roberts, De Benidictis and Spiby (2017) argue that there is not enough empirical evidence to counter the argument from commentators from the birth community that the portrayal of birth on television is creating fear of childbirth amongst women. The women interviewed in this project are aware of the dramatization portrayed by television such as OBEM. Yet this is not the experience of midwives, who see women coming to birth fearful and having little knowledge of the process. Leachman (2017), through her work as a therapeutic coach, argues that the media perpetuates childbirth myths and feeds women's fear around birth.

11.8.4 Women's medicalised perception and expectation of birth

The domain of childbirth is claimed by the medical profession and has become an area of social control (Illich et al., 1977) in the name of protecting the fetus from risk. The evidence shows the positive outcomes for women of midwife led models of care (Sandall et al. 2016a), relationship-based care (Sandall et al. 2016b) and MLUs as place of birth (Walsh & Downe, 2004) compared to CLUs. Whilst birth at an MLU are recommended for women with no known complexities, the principles and practice that form the basis of this care could be incorporated to CLUs.

This shows the power of obstetric practice and how it influences care provision. It is seen as the common-sense way to organise care provision despite government recommendations for relationship-based models of care for everyone (Jervis, 2016). Yet this might be an over-simplistic view as despite recommendations for alternative care provisions maternity care exists in a wider political, financial, social and legal network. Fahy and Hastie (2008) argue these gendered networks consciously and unconsciously act upon women, midwives and doctors which limit and direct birth and the environment in which it occurs at a local level; at a social level these powerful networks reproduce medical domination and women's and midwives' submission.

Women's perceptions of how they view their birthing body does not appear to have changed since Martin's (1989) work thirty years ago highlighting that medical dominance is still prevalent. Not only does this perception affect how they view their birthing body but how

capable they feel within their birthing body. Within a patriarchal system, the biomedical dominance takes responsibility for maintaining safety, infantilising women, dominating the environment and acting as a barrier to women's movement.

11.8.5 Women's lack of connection with other birthing women

Jowitt (2018) argues the necessity of maternal movement during labour and birth, as women need to respond to fetal movements and move themselves to aid the fetus in progressing through the maternal pelvis. This a theory based on knowledge of physiology which shows there is still little known or understood about the mechanisms that movement plays during birth. The majority of knowledge about movement and the physiological and psychological effect it has on birth comes from the embodied experience of birth, through experiencing birth as a woman or spending time with women who birth in an environment where physiological birth is supported. Historically this knowledge was shared between midwives and women predominantly during the time of labour and birth through the relationships midwives and women share (Chapter three). Midwives aim to empower women through movement as their contextual knowledge of birth is absent due to the institutionalisation of birth, obstetric domination and lack of experiential knowledge. Objective standardised physical measures of maternity care, which monitor individual aspects of women and devolve midwives authority separate women form their own lived experience of birth and women from midwives.

The contextual knowledge of the culture of the environment in which birth occurs affects what knowledge of birth is used. Through the great theoretical advances in obstetric knowledge, knowledge that is used and valued is based on science and quantitative research evidence (Chapter two). It appears to lack wisdom defined as knowledge without comprehension and feeling (Russell, 1954). Wisdom as knowledge gained through understanding and theoretical knowledge of birth gained from research and literature, combined with experiential knowledge of physiological, psychological and social aspects of birth and women as midwifery knowledge. These elements are fostered in the MLU area and create an environment for the use of wisdom within physiological birth. Within in the CLU or medicalised areas the super annulation of technology and adherence to rigid protocols does not foster the creation or co-creation of knowledge between the woman and the midwife.

This creates a barrier for women in connecting with birthing knowledge and other women and birth.

11.9 Facilitators in changing the culture

The data also identified facilitators in changing the cultures identified. Midwives and obstetricians identified ways in which they influence change to use maternal movement. Women and midwives spoke of how women were expert in their bodies during birth yet this is not seen to be valued.

11.9.1 Challenging

The culture of the CLU is based on espoused beliefs around the amplification of risk with significance placed of the likelihood of adverse outcomes (Dahlen, 2010). The culture on the MLU is based on espoused beliefs of women's empowerment and knowledge and understanding of physiological birth. The obstetric gaze of primarily seeing birth from an interventionist perspective has hidden the childbirth experience rendering women passive within it (Hynan, 2018). This represents a challenge for midwives and women. Midwives are socialised in the CLU hierarchy that is based on fear; midwifery knowledge, based in physiology, knowledge of women, human rights and women's choice are fundamentally not as powerful as authoritative obstetric knowledge, the institutional obligation to manage risk and business priorities.

For midwives to challenge the medical culture within the hierarchy on the CLU would require the midwife to be assertive with medical staff but they can be seen to be suppressed for their gender and due to medical dominance (Dargon, 1999). Timmins and McCabe (2005) found that nurses and midwives often lack the confidence and knowledge to challenge due to the fear of retribution and other's responses that prevents them from acting as they wished. The socialisation process during midwifery training and working life is recognised as aiming to produce obedience and unquestioning conformity (Parsons & Griffiths, 2007). Midwives showed in the data the difficulty of challenging practice that they did not feel was appropriate, yet some overcame this.

The obstetricians had experience of being challenged by midwives; the senior obstetrician viewed this as a difference of opinion and something that was crucial to planning care, citing collaboration as key. Downe et al. (2010) define effective collaboration as:

‘a dynamic interaction between organisational and personal characteristics. Initiatives that actively and consciously foster trusting and mutually respectful relationships might create positive feedback loops into the system that alter the fractal structure of existing organisations’ (Downe et al. 2010, p 253)

This definition of collaboration requires characteristics to be present for success, including mutual trust, acknowledgement of interdependence and acceptance of shared responsibilities. This project highlights the lack of trust between some obstetricians and midwives. Combined with the lack of knowledge and understanding of physiological birth and the patriarchal systems in place to control birth and services, significant work needs to be done to ensure collaboration.

11.9.2 Leadership

Leaders communicate the beliefs, values and assumptions they hold, embedding them within the culture, creating the conditions for formation, stabilisation and evolution (Schein, 2017). In order for the assumptions and beliefs to be embedded, they need to be articulated; the connected culture espouses the beliefs of relationship-based care and empowerment of women. The current culture of clinical practice sits within a business model of NHS delivered care, maternity care seen as a commodity (Murphy-Lawless, 2011) within a system that is driven by efficiency. Both contribute to a fundamental contradiction of the values and beliefs of midwifery care (Kirkham, 2018). Midwifery leadership has been recognised as fundamental in transforming midwifery services for the future (Warwick, 2015) and the need for midwifery leadership to improve services is recognised in government directives (NHS England 2016; DoH,2009). Byrom and Kay (2010) acknowledges the traits, styles and nature of leadership within maternity care services, whilst offering theoretical background on how leadership in maternity care can shape and support midwifery. However, none of this can be achieved without power. With authoritative knowledge being with the bio-medical model and the needs of the business led model becoming more prevalent drivers of care, midwifery values and beliefs do not take precedent. Bannon et al. (2017) argue that the reporting of the ineffectiveness of midwifery leadership is down to gender, challenges to their authority and autonomy, the absence of managerial development positions for clinicians combined with the removal of midwifery supervision. Midwifery leadership needs to be present at a strategic level to enable change in culture and services. To enable this leadership to be implemented,

maternity services, midwives and women need to be valued and given the power they deserve.

11.9.3 Valuing women and midwives

The disconnecting culture does not appear to value women and the midwives working within it. The culture of bio-medical maternity care has often been referred to as a production line (Kitzinger, 2006; Walsh, 2004) combined with the commercial model of NHS provided care (Mander & Murphy-Lawless, 2013), women are processed through birth by the workers who are the midwives. This is seen as a fundamental clash of values (Kirkham, 2018).

As a species we thrive on kindness and compassion which affects our physical and psychological well-being (Gilbert, 2015). However, when in social groups with competing priorities, such as the fear and risk evident the disconnecting culture, compassion can be lost (Gilbert, 2015). Kirkham (1999) highlights the disempowering culture for midwives in the NHS with Hunter et al. (2018) showing how this continues resulting in significant levels of emotional distress. Ongoing lack of support from the midwifery regulator, the NMC, for midwifery issues (Stephenson, 2018; Jervis, 2016) combined with political restraints on maternity care provision (Beech et al., 2018) results in compromised working conditions and therefore sub-optimum care for women. This shows the lack of value placed on women and midwives in society.

11.10 Conclusion

This chapter has discussed and analysed the findings in relation Schien's (2017) framework for the organisation of culture. Using the existing research and theory to discuss meaning in relation to prior knowledge and wider society.

The findings are presented as a binary connective and disconnected cultures when using Schein's (2017) framework yet it is acknowledged that there is fluidity within them. This shall be discussed in the next chapter and analysis how these binaries have evolved in the wider socio-political culture.

Chapter Twelve

12. Beyond the binary

The findings chapters presented models of the culture studied using Schein's (2017) model to organise the data. The discussion chapter analysed the findings in the context of the literature and theory. This adds to the body of knowledge on maternity care and illustrates how a culture is formed which utilises and shares knowledge that supports maternal movement during labour as part of physiological birth and women's holistic birth experience. The model of culture used causes a binary presentation of the data. However, while there were some binary elements, the data was more fluid and nuanced showing cross over between espoused beliefs and values and underlying assumptions. This chapter will present data to show how some elements are binary, but also that participants are positioned along a continuum. The macro culture in which maternity care exists is critically discussed to show how the cultures within the maternity service researched have formed in the wider socio-political context to give understanding to its current form.

12.1 The problem of framing care in binaries

Previous theories (Davis-Floyd 2001; Wagner, 1994; Walsh & Newburn, 2002) have situated models of maternity care as dichotomous discourses. These have been discussed in relation to this research and have been shown they are still significant; however, it is misleading to construct them as dichotomous. Framing them as such can lead to exaggerating the inscriptive power of assigning a behaviour or belief into a category and making the fluidity and nuances invisible. This undermines the personal agency of professionals as they negotiate the culture and environment in which they work and does not explore the wider issues in society and what has led to this. Exploring the wider influence of maternity care from a historical and political perspective can give an understanding of how the predominate cultures of maternity care have developed and the significant impact that political influence has on public services. This study and the individual participants exist within this wider culture, and all participants have learnt the social functioning from the cultures in which they have lived, trained and worked.

12.2 Binary cultures

This research found binaries within the cultural context of the maternity service. The main binaries were based in the artefacts; staff structure, how the environment supports physiological birth. However, there were binaries identified in practices that highlighted the contrast in the beliefs of the individuals in the culture and the beliefs of the organisation. These cultures were consistent with previous theories of maternity care. The connective culture was consistent with a social model of care (Wagner, 1994, Walsh and Newburn, 2002), the disconnecting culture was consistent with a technocratic/biomedical model of care (Davis-Floyd, 2001) or a business model of care (Kirkham, 2018). Many of the values, beliefs and underlying assumptions of the professionals who participated were based in connection, showing a more fluid culture and signalling change in the previously identified theories of models of care.

All midwives and obstetricians spoke of the culture of the unit in which they worked throughout their interviews. Schein's (2017) concept of the levels of organisational culture provides a useful tool to decipher how the basic underlying assumptions form the beliefs and values of a culture that then transfer to the artefacts. However, in this project the cultures were not static.

Angela thought the culture of an organisation affects the approach taken by the midwife and movement:

> *'Whether you subscribe to a technocratic approach and it depends on, it depends on how things are sold in terms of supporting the woman with her contractions'* Angela (Midwife p.11)

Through the culture directly affecting the midwife and the information given to women, this has an impact on whether the medicalised approach of removing or managing pain or a more holistic approach of supporting a woman with her contractions is used, directly affecting movement.

All midwives interviewed referred to knowledge of movement from their training and from observing normal birth. Barbara spoke of midwifery education and how this should influence midwives, women and care:

> *'They (midwives) all know that movement and position has huge implications on the woman in labour in terms of outcomes, so the whole process, so they are beholden to encourage women to be in the best possible position… my job is to make sure the women know because I don't actually trust that the midwives will'* Barbara (Midwife, p. 5)

From Barbara's perspective, all midwives should know about movement and how this affects birth from their training and as part of their role should encourage this. Whilst women who birth in the MLU have more upright positions, women who birth in the CLU tend to give birth in a recumbent lithotomy position (Source: Hospital data), Barbara feels '*midwives are doing this to the detriment of women*'. All women are cared for during labour by a midwife therefore all midwives know and, women have access to someone who knows about movement and upright positions during birth. As this does not happen, Barbara does not trust other midwives in not fulfilling their role as she sees it. She sees her role as giving women knowledge about movement therefore putting them in a position of knowing. Barbara sees this as something that is within the midwife.

When talking of her experiences of working with midwives on a CLU, Ursula stated:

> '*If you've got a load of midwives who you are working with who insist patients stay in bed then you are not going to learn there is anything other'* Ursula (Obstetrician, p.10)

Although it is recognised that midwives know about movement as part of their role, Ursula also recognises that not all midwives use this knowledge. As a '*junior doctor'* working with midwives who do not use movement as part of their practice it is an aspect of normal birth that obstetricians would not therefore learn.

Maggie spoke of her experience of labouring with her third child in the MLU environment and then being transferred to the CLU for foetal distress where the midwife's personality shifted from caring to a little bit cold:

> '*There was a shift, there was a total shift in personality which I wasn't expecting which threw me… she had gone from being a very nice good caring… you know, being nice, to being a bit little bit cold really and that was what I found, that was difficult as well because I wasn't expecting that'* (Maggie, pg. 16)

How the midwife changed from one area to another – from supporting a woman with a physiological birth to then having to manage potential foetal compromise – from being '*nice*' to being '*cold*' made a difference to Maggie's perception of her birth experience. This reaction from the midwife was potentially not based on her beliefs and values but to her reaction to the situation. Whilst being predominantly safe to give birth in the UK, the midwife's role is to constantly evaluate for safety – when an event happens which suggests potential foetal compromise, an action by the midwife is required which caused a perceived change in how she behaved towards Maggie.

The obstetricians spoke of the culture of a unit and how it affected their working relationships with midwives and their learning.

The group interview recognised the blame culture in which they worked:

> *'Some members of staff, whether it's junior doctors or midwives, are very keen to shift any blame to you and are very clear and say I want you to come and sign off, I am going to put your name in the notes… and I think that that can make you feel a bit negative' Group interview* (Obstetricians, p 7)

There is a culture of blame that pervades both obstetricians and midwives. A belief that if decisions are made and another clinician does not agree this then has the potential to have an untoward outcome resulting in someone being blamed. The undercurrent of risk to the woman and her baby and to the midwife and obstetrician is evident. When it is assumed that birth can be controlled and complexities and risks managed by medical care, then failing to act or making a wrong decision about care can put the people in control of the medical care at fault.

12.3 Binaries in cultures – binaries in individual beliefs

The midwife holds values and beliefs that have an impact on care given to facilitate movement. Midwives are trained in theory based in midwifery knowledge and expertise alongside complex care. Midwives have underlying assumptions based in compassion and empathy, utilising their knowledge of physiological birth and underlying assumptions based in compassion and safety, taking care to manage risk. The basis of these underlying assumptions has an impact on beliefs and on care given. Being socialised in a culture where the beliefs are different from their own also has an impact on their actions.

Actions may not be reflective of a carer's underlying beliefs or assumptions but to a clinical situation. If a clinical situation induces fear in the carer, their reaction could not show compassion towards the woman but compassion towards the safety of the baby and compassion to the self to avoid blame.

Within the current context of maternity care, maintaining safety is predominant in the CLU as safety is compromised by the complexities the women have which pose a potential risk to her child. Within this environment, accountability for actions or in actions for managing the complexities is predominant creating an atmosphere of fear and blame and therefore creates friction amongst midwives, obstetricians, staff and institutional policy and practice.

These actions and inactions show the fluidity of beliefs of the participants and the how their environment impacts behaviour and practice. The binaries identified that the espoused beliefs and values of the midwives were not static to an environment. The CLU was predominantly a disconnected culture and the MLU was predominantly a connective culture in the way in which knowledge around movement was used.

Fahy and Parratt's (2006) theory of birth territory identifies who has control in birth environments and identifies concepts in terrain and jurisdiction. Terrain incorporates the physical birth space and is considered as either a sanctum or a surveillance room. In jurisdiction, a woman possesses integrative power or disintegrative power and the midwife can promote either guardianship or domination. Midwifery guardianship promotes the woman's intrinsic ability to birth through activating her own power, being undisturbed and feeling safe. Midwifery domination weakens the woman's ability to birth through diminishing her power and giving up her own embodied knowledge and becoming docile. Fahy and Parratt's theory is similar to the findings of this project in respect of how the midwife uses guardianship to practice midwifery and embody the woman through knowledge of birth, contrasting with domination, diminishing the woman's power.

If the terrain is a surveillance room, midwifery guardianship – compassion based in love, empathy and midwifery values and beliefs of empowerment – can be used but will require a significant change in culture.

12.4 Understanding culture

How humans interpret their environment and how they adapt to this is how culture can be defined. Culture is also a product of shared learning (Schein 2017). To understand the learning that has taken place over a time span; under what kind of leadership; and how participants form their identity, their patterns of behaviours and beliefs can be identified giving meaning to their daily activities.

Durkheim argued that the goal of anthropological research was to find the collective social function, looking at social rules and how this was interpreted to form social order, identifying that this is open to adaptation and change. Oakley (1980) argued that everything that is done to and by women during pregnancy and birth has a cultural base. How reproduction and childbirth is defined by culture and wider society is closely linked with its articulation of women's position. Cultural attitudes to women and reproduction are marked by paradigmatic representations; common sense understandings are bound in medical, psychological and medical science and are seen as scientific.

The aim of this research was to aid understanding of childbirth, what happens, why and consequences in current cultural context. It acknowledges this takes place within a system that is heavily influenced by socio-political pressures and led by elements such as medicine, finance and business ideology – health as a commodity, blame and consequence. All participants have learnt the social functioning from the cultures in which they have lived, trained and worked. They have been informed from the position which they hold within these cultures and their experiences, forming their identity and beliefs which have been explored in this project.

12.5 Political influence of the macro culture of maternity care

Foucault (1973) identified how health care systems provide meta-narrative – hegemonic regimes of authority use surveillance to exercise power. The roles of patient or professional are assigned to those who enter the domain and are policed through this surveillance. This is similar to the technocratic model of care as illustrated by Davis-Floyd's (2001) work, a paradigm of maternity care that separates the mind-body and sees the body as a machine. This model of care is representative of western society's core value system that is based in science, technology, economic profit and patriarchal governed institutions (Davis-Floyd, 2001). Elements of this have been identified in this project through; the discussion in the

critical review of the literature around movement in chapter two, the participants experience of working with standardised policy and protocol, the super valuation of research that is deemed more authoritative than others, the prevalence of CTG monitoring and the hierarchy identified. These elements of care are significant within the political culture of maternity care as a government funded public service.

Government directives shape maternity care provision. Historically, recommendations for maternity care were not evidence-based and women's views were not considered (Ministry of Health 1970, House of Commons 1979-80). Hospitals were identified as the safest place to give birth, labour wards were modelled on intensive care wards, the number of obstetricians and continuous foetal monitoring increased (House of Commons 1979-80). Hierarchy with obstetricians at the top governed the implementation of medicalised, hospital-based birth.

The Maternity Services Advisory Committee (MSAC), (1982, 1984, 1985) produced guidance on how to provide a good standard of maternity care; all supported hospital as the best and safest environment. However, Marjorie Tew (1985) argued that statistically, a causal relationship between the fall in perinatal mortality and hospital confinement could not be found.

The Winterton report, the first report based on evidence from; regional services, professionals and what women wanted (House of Commons 1991-2), concluded that maternity care should not be driven on a medical model of care based on unproven assertions and it was unjustified recommending all women should give birth in hospital (House of Commons, 1991 -2). The first government policy document to recommend how maternity services should be organised and delivered was Changing Childbirth (Department of Health, 1993). This was influenced by the Winterton report and recommended that the driving principles of maternity care should be choice, continuity and control. Schemes were funded and set up nationwide (Walsh 1999, Stevens & McCourt 2001, Reed & Walton, 2009). However, recommendations never became the standard model of maternity care, despite evidence of improved outcomes (Sandal, Davies & Warwick, 2001).

Twenty-three years after Changing Childbirth, another major review of maternity services was undertaken: Better Births (NHS England, 2016). Independently led, a panel of experts and representative bodies assessed maternity care provision and advised how they should be

developed. Continuity of carer was recommended despite already been identified as improving outcomes for over 30 years (Sandal et al., 2016a) and being identified as an ideal by previous reports (Ministry of Health, 1970; House of Commons 1979-80; Maternity Services Advisory Committee, 1982, 1984, 1985). Maternity care based on relationships, was never implemented nationally despite the strong evidence – the medical model of childbirth was implemented on un-evidenced opinions. This demonstrates the power of authoritative knowledge that dictated the standards of care for women based on the opinion of those in power, not on evidence.

12.6 The NHS as a business and the commodification of maternity services

Contemporary healthcare providers view maternity care as a commodity; this capitalist interpretation ignores the value of relationship-based care (Kirkham, 2018). The political, market and financial influences on maternity care are discussed in chapter 1.9.

Trusts compete with each other and the private sector for business; this has encouraged a culture of a secretive nature and non-sharing of resources, ideas and innovation. Everything is given a monetary value; resources are scarcely allocated and fiercely guarded. The NHS as a business model allows private sector models of finance, management and planning to shape health services resulting in poorer services and outcomes, increased health inequalities and demoralised staff (Kirkham, 2018). Davies (2019) argues that maternity services are malfunctioning internationally at a systemic level due to the free market ideology of neoliberalism that has influenced service provision. This has diminished care based in a midwifery philosophy that surpasses professional disciplines, improves outcomes for women and babies (Renfrew et al, 2014), and has created a binary between business principles and midwifery values.

12.7 Business and commissioning of services

NHS trusts run as independent businesses giving freedom to how services are organised. This allows for innovation in the way that government recommendations are interpreted and services are provided but leads to variation in investment of services and facilities with services offered nationally lacking parity (McCourt et al, 2012). Alongside the change in legislation around commissioning services (Department of health, 2012), private companies

who do not have the organisational restrictions of NHS bureaucracy and hierarchy tender for services, but add another layer to the unequitable provision of services.

Clinical Commissioning Groups (CCG) run by GPs are responsible for commissioning services available to the public. However, CCGs are unaccountable, as they are under no obligation to commission services that are supported by evidence but commission services that they believe will improve health outcomes. Beliefs held by individuals with a predominantly medical background and no experiential knowledge of the services or profession influence commissioning. Freedman (2016) recognised that globally, gendered, cultural and power-laden hierarchies influence what research findings get implemented, privileging some voices and silencing others. This shows disconnect between those that directly receive and provide services and the little influence they have in services implemented.

12.8 NHS as a government funded business

Politically driven cost saving within the NHS is having a significant impact on services. NHS trusts are run as businesses, their hierarchical structures maximising efficiency for minimum cost that creates a fundamental clash when compared to midwifery values (Kirkham, 2018). Political drivers shape the way care is delivered and creates a binary between the care that midwives want to provide and the care that they are able to provide. The effect of the management of the NHS as a political pawn has resulted in the lack of support available to midwives from managers, as they are ineffective at providing the solutions needed and staff shortages affecting midwives' ability to fulfil their role as they see it (Mander & Paterson, 2018). The implication of working in a way in which prioritises efficiency is having an impact on midwives' mental health (Hunter et al., 2018) and the way in which care is delivered (Shallow, 2018).

12.9 Standardised care

Standardisation through an agenda of evidence-based care has resulted in emphasis placed on care and treatment shown to be effective by research produced by authoritative knowledge. Policies are generated at a national and local level to ensure care is targeted as the most appropriate in relation to clinical effectiveness, safety and cost, giving a narrow view and disregarding individual women's circumstances. This leads to an erosion of clinical judgement due to requirements to ensure that care is uniform; clinical staff must record data to demonstrate compliance with protocols and reducing time available for patient care

(Murphy-Lawless, 2011). Midwife led care based on relationships and the individual needs of women has been shown to improve outcomes for women and their babies (Sandal et al., 2016a; Sandall et al., 2016b). These outcomes provide a positive impact on women's and the next generation's long-term health. They have been shown to be cheaper than hospital managed care (Schroeder et al., 2017) and sustainable outside of the NHS as an organisation (Wainwright & Collins, 2015). Yet the bureaucracy that pervades maternity systems in the guise of cost saving and managing through standardisation is prevalent rather than the more efficient and effective midwifery value-based, connective models of care, creating yet another binary.

12.10 Managing efficiency and risk versus women

The management of efficiency and risk is predominant within the wider context of maternity services. Focusing on known risks has reduced maternal and new-born mortality globally (Shaw et al., 2016) but fear driven by risk aversion has caused an increase of intervention that when used inappropriately has caused harm from medicalisation of normal birth (Miller et al., 2016). What women want from maternity services is not the driver of service provision. Women want control over their experience, choices that reflect who they are and to be treated with dignity and respect (Downe et. al., 2016). Women want a positive birth experience that includes safety and supports psychosocial wellbeing (Downe et al., 2018). The World Health Organisation (WHO) advice is implementation of maternity care that is in accordance with a human rights-based approach empowers women to access care that they want and need (Oladapo et al., 2018). This research and advice signals the recognition that a positive experience is important globally and shows the binary that exists in the way that services are funded, promoted and organised and what care is implemented. Priority is given to perceived efficiency and managing perceived risk as opposed to what women want and midwifery led care. Kennedy et al (2018) call for research investment on care which is individualised, weighs benefit and harm, advances equity, is person-centred, works across the continuum and is informed by evidence. However, this evidence exists and while Kennedy et al (2018) call for investment and acknowledgement of implementation science to enable; women and midwives are disempowered by patriarchal structures and professional, socio-cultural, and economic barriers; midwifery's role and scope is misunderstood and evident at policy, health services, academia, and funders level (Renfrew et al., 2019).

12.11 Conclusion - Individuals working in a system

This chapter has explored the elements contributing to the meta-narrative and wider socio-political culture in which maternity services exist. The culture in which all the participants have experienced maternity care is facilitated and led by an institution providing a public service, influenced by political and government will and policy. The organisation of health and maternity services is disconnected from the reality leading to service provision that is theoretically based on business and efficiency models – requiring technology to monitor, policy and protocol to regulate, statistics to govern, care to be standardised and therefore efficiency focused, outcomes to be measured and service users experience to be of less value. However, the culture that has been explored in this study is made up of individuals with their own position, perspective and experience. Seeing participants as individuals within the culture studied gives a more nuanced and fluid representation of the findings, showing the cross over between underlying basic assumptions and espoused beliefs and values.

All of the professionals interviewed worked in maternity services to benefit women and their families. Individual midwives and obstetricians brought their own personal experience of childbirth to their knowing of birth that makes a difference to how they give care. This gives them a connectedness to women, birth and their intuition. This knowing gives them a perspective as women and makes a difference in the sense of humanising and personalising care. Obstetricians were drawn to the family element of the profession. Unless they had personal experience of birth, they had a different perspective of knowing and mostly relied on midwives' experience of birth. Obstetricians do not learn the physiology of normal birth in a holistic sense, the majority of births they see are complex therefore some lack theoretical understanding. Obstetricians and midwives want the same thing but they do not all arrive there by the same way of thinking, seeing and knowing. Most notably in this project, there is an absence of perspective and experience of male obstetricians. This would have provided a valuable insight.

The midwives and one obstetrician came from a more connected and relational perspective based on their experience of birth. From this, they recognised the importance of empowerment for women. This came from seeing women and birth from their own perspective and from their lived experience of being a woman and mother in society. From

either experiencing empowerment or not during their own birth, it contributed to connectedness in their underlying assumptions and espoused beliefs and values. However, this connectedness in the relationship between midwives, obstetricians, woman and birth is not present in between all maternity care staff and the women for whom they care. From the data presented and the experience of some participants, a disconnected way of providing care is evident which serves the needs and culture of the institution.

The current national structure of maternity care systems is influenced by historic and current political will and opinion. Through learnt behaviour and how it is led, a culture exists which has; beliefs and values based in the over amplified benefits of technology; belief in the economies of scale; the belief that someone else is the best person to determine a woman's risk status and the belief of increased rule making and bureaucracy to provide safe outcomes for women and their babies. At a macro level a consequence of this system is the ever-pervading risk and fear, which benefits from increased risk status of women financially and through ensuring compliance from midwives and women to maintain this, it is a barrier to connected relationship-based care in the NHS's institutionalised and politicised systems. This leads to a disconnected culture that suppresses relationships and the empowerment of women. Evidence and recommendations are in line with a connective culture of maternity care yet wider social structures and political influences drive a disconnected culture of care, causing a binary.

The previous chapters showed difference in espoused beliefs and values. To facilitate change in beliefs challenges are necessary, though resistance to change by some has been identified and a lack of midwifery representation, involvement and power is evident. Whilst there is evidence of different cultures – most predominantly a difference between the MLU and CLU – the underlying assumptions and espoused beliefs to which approach individuals subscribe to is not only based on environment or profession but on individuals.

Chapter Thirteen

13. Conclusion

13.1 Introduction

This chapter provides an overview of the project and its main findings. It demonstrates why this research was needed, the aims and objectives of the research and the original contribution of knowledge that has been made. How the methodology and methods have met the aims of the study is shown and the limitations and recommendations are presented. This is done to explain how the research question was reached and how the study has met its aims and objectives. Recommendations are made for clinical practice, training, organisations, wider society and future research.

13.2 Overview of the project

This research, which explored women's, midwives' and obstetricians' beliefs about maternal movement during labour has demonstrated that dichotomies in care provision exist which either support the use of maternal movement during labour or prevent it. The research has revealed cultures that show the connection and disconnection that exists between women, midwives and obstetricians. The research demonstrates how these cultures are formed from the basic underlying assumptions of the participants, derived from beliefs and values and resulting in artefact use during labour. The findings show how basic underlying assumptions were expressed and how this connected and disconnected participants. How espoused beliefs and values were interpreted in the way in which practice was delivered and experienced is made explicit. The findings show how these assumptions, beliefs and values justify the use of the artefacts evident in the environment that either support maternal movement or suppress it. The findings also show that these cultures are not static, with midwives and obstetricians bringing their assumptions and beliefs from a culture, which enables movement to an environment that prevents it. The findings also highlight barriers and facilitators to changing the culture where movement is not used.

13.3 Origins of the study

As a midwife and clinician, a problem was identified in clinical practice that was reinforced by my experiences in postgraduate study. Evidence, knowledge and research from an obstetric, objective, quantitative basis was easier and quicker to implement than from a midwifery,

qualitative, experimental, physiological perspective. In addition, women's choices on the care they wished to receive was often overlooked or slow to implement. This premise formed the basis for my thinking about this project and identified the problem of the suppression of qualitative research, knowledge of physiology and experiential knowledge of physiological birth. Maternal movement during labour was chosen as a subject as it is an aspect of physiological birth available to the majority of women, something that is based in the physiology of birth and forms part of recommendations and skills for facilitating birth.

As this project was problem focused, a solution was sought from the perspective of the participants. As birth is a uniquely female experience with midwives, a predominantly female workforce who care for women during this time, a feminist lens was selected as being the most appropriate. A methodology was chosen from sociology to look at the problem from a cultural perspective, examining the culture within the unit and in the wider context of birth.

13.4 Aim of the study

By using focussed ethnography as a methodology that focusses on a problem the aims of this study were met through identifying cultural differences that influence maternity care and knowledge acquisition about movement in labour. Women's midwives and obstetricians were interviewed; data collection also included field notes and observations. Data collected enabled an exploration of the culture of maternity care to discover how knowledge about maternal movement in labour is gained and used. An understanding of culture can offer a way in which maternity care can be reconceptualised in line with the aims of feminist research outlined by Abbott et al (2005).

13.5 Objectives

The objectives defined to reach the aims of the study were:

(1) Discover where participants position themselves within society in relation to their profession/ in relation to their birth, in the hospital context and in relation to each other.

(2) Identify how participants gain knowledge around movement during labour and identify barriers and facilitators to using this knowledge.

(3) Explore women's, midwives' and obstetricians' beliefs and experiences about maternal movement in labour and how this affects care given or recommended.

The objectives were reached, and the findings presented using a model of culture defined by Schein (2017).

13.6 Literature and the formation of knowledge

To add to the understanding of this project the literature was reviewed to critically examine the way in which the knowledge available on maternal movement in labour is constructed. Other knowledge around movement in labour was also critically analysed through looking at the historical, cultural, political and social influences that shape knowledge production about women's movement during labour.

13.7 Contribution to knowledge

This research makes an important contribution to maternity care by providing new perspectives and understanding in the way that knowledge on physiological birth is interpreted and used. Through using maternal movement during labour, how knowledge of this aspect of physiological birth is implemented or supressed provides understanding of how other knowledge of physiological birth is implemented or suppressed. Highlighting the culture that exists in the maternity care setting and in society around maternal movement in labour, midwifery knowledge and practice, women's knowledge and experience of maternity care and obstetric knowledge and practice, adds to theoretical knowledge in this area. This research is also unique in that the positioning, perspective and experience of women, midwives and obstetricians has not been used before to explore knowledge and experience of maternal movement during labour.

Connections (Chapter six) were found in the culture which recognised and utilised the knowledge of movement. These connections were based in care that encompassed love, compassion and understanding of physiological birth and the physical, psychological, social and emotional impact of birth on women. These elements were found to be basic underlying assumptions that lead to beliefs and values of relationships between women and midwives and how birth should be an empowering experience for women. These beliefs and values underpinned the care given to women in the culture in which knowledge of movement was supported and implemented. This was evident in the artefacts in the environment and the way in which the women and midwives utilised the artefacts. Other connections were found which showed care based in compassion, however compassion based on safety, whilst most prevalent with the obstetricians, resulted in care being given that was based on the belief that

risk was being managed for the wellbeing of the fetus. The belief that the well-being of the fetus is the priority results in lack of utilisation of aspects of care that support physiological birth such as movement.

Disconnections (Chapter seven) were found in the culture that did not recognise or utilise knowledge about movement. These disconnections were based in care that demonstrated lack of empathy, dignity and choice for women. This was shown through the experiences of women interviewed, the care experienced by the midwives as service users and the midwives as care providers. The use of evidence based in objective, quantitative research, standardised policy and guidance was shown to be authoritative with the basic underlying assumption that this is the knowledge that should be used. Knowledge and understanding of the physiological, psychological and social aspects of birth are not shown as underlying basic assumptions. This was revealed in the beliefs that were espoused through the setting of boundaries, lack of relationships, hierarchy, maintaining control through medical and business dominated care. The results of these beliefs culminate in an environment that prioritises medical equipment and surveillance. The experiences of the women and midwives show that within this environment knowledge and understanding of movement is not facilitated, as it is not seen as a priority.

Midwives and obstetricians within the current context of birth within an institution and society that aims to manage risk and maintain safety and as a result induces fear are part of this disconnected culture. This results in a failure to implement knowledge and understanding of women's movement during labour.

Throughout this research barriers were identified (Chapter eight) that prevented midwives' use of knowledge of maternal movement and women using or accessing this knowledge. Binary cultures were identified predominantly between the MLU and CLU. Obstetric, objective knowledge was seen as superior and experiential knowledge was not seen as of equal value. A theory practice gap was identified caused by the presence of hierarchy, midwifery theory not taught in the context of clinical practice and the power and influence of the organisation that has control over the implementation of services. Media influenced culture was thought to influence women's perceptions of birth, yet, women who had experienced birth knew this as false. Women gain the majority of information around movement during labour from midwives during labour. How women feel physically,

psychologically and emotionally combined with women's sense of responsibility and dependency affect movement and her decision making around this. Women's feelings, emotions and subjective experience came secondary in the re-telling of their birth stories revealing that the authoritative language and discourse around women's birth experience is the bio-medical model. The psychological impact of these barriers has shown that the uniquely female physiological experience of birth has been placed within an institution that retains the power to govern birth as a medical event. It is an event that is dominated by risk, out of women's control and is not trusted.

To overcome the barriers that interviewees identified, facilitators were identified to enable the use of knowledge of physiological birth and movement. These consisted of opposing beliefs being viewed as challenges with collaboration and discussion being used to overcome. Knowledgeable, strong midwifery leadership to challenge the hierarchy is seen as necessary to overcome possible sources of conflict as when leadership is absent midwives are viewed as less powerful in the hierarchy. For obstetricians leadership is associated with learning; other elements of leadership were absent from the interviews with obstetricians. This research also proposes that valuing women's knowledge and midwives' knowledge around birth, and supporting individualised care, will facilitate the development of a culture in which women are able to use movement to support physiological birth.

The key findings were explored using the literature and theory as part of the discussion (Chapter ten). Schein's (2017) model of culture was used to provide a critical discussion of how the findings are supported in previous research, to develop a theoretical understanding and to show new insights.

Findings were presented within a framework that supported a binary interpretation; fluidity and nuances between cultures were however acknowledged. Cultures are never static as they are made up of individuals who have been socialised in wider society, are influenced by their individual experiences, and are affected by the political climate within institutions and the nation.

13.8 Contribution of methodology and methods

This study contributes to the focused ethnographic methodology and methods of data collection through showing the appropriateness of this method in addressing problems that

have been identified within maternity care service delivery and offering solutions to overcome them as identified by the participants. This was a strength of study as it was a research approach that elicited specific knowledge of experiences of maternity care users and those who provided the service. This gives strength to the findings as data from all perspectives was validated through supporting data from service users and providers. The use of interviews as the primary data collection method allowed positioning to be identified and what underpinned beliefs and self-reported actions. This approach offers insights into the evidence of maternity care culture and how assumptions, beliefs and values make an impact on behaviours experienced and witnessed.

The findings from this study are supported by findings from other ethnographies. As a methodology ethnography is able to highlight the disparities in the culture of maternity care. Wray (2011) showed the gaps between the services that women want and the service which they receive. Walsh (2004) revealed the benefits of an alternative model of maternity care that contrasted with more traditional models and Kirkham (1987) showed how environment and culture defined the care that midwives were or were not able to give.

This focused ethnography defines the problem of the suppression of knowledge that supports midwifery care. Through exploring and defining the culture within which women, midwives and obstetricians receive and give care the culture can be defined and solutions to the problems expressed can be proposed. These solutions are grounded in the data and come from the participants and inform the way in which reconceptualisation of services can be designed.

13.9 Methodological critique of the study

A limitation of this methodology is that whilst assumptions, values, beliefs and self-reported behaviours were explored, behaviours were not observed. As a researcher adopting the position of an outsider, I also hold insider knowledge as a midwife. Therefore, some of the experiences and perspectives I have experienced myself validate the experiences of the participants. None of the data collected from the women or midwives gave me reason not to think it was not representative of their experiences and behaviours from this insider knowledge that I hold. My own reflectivity has made my potential bias transparent and my supervision team have overseen that my analysis and findings are supported by the existing literature. Yet I have had the most influence on the interpretation of the data. If this project

had been carried out by a researcher with no insider knowledge the findings could have been seen differently.

Another limitation of this study was the use of one study site. Other maternity services in the North West of England have different resources and ways of delivering care that does not permit the generalisability of finding to other maternity units. This has been addressed by including participants' experiences as service users of other units and as service providers in other units. Contextual information regarding the study site, methodology and methods of analysis has been provided and findings have been discussed in context of the existing literature to allow the transferability of findings to other units. Through using one study site this research offers depth rather than breath of understanding of the culture of maternity care and the acquisition and implementation of knowledge of maternal movement during labour.

13.10 Implications and recommendations for maternity care practice

Implications for maternity care practice and training have arisen from this study. To address this practitioners' knowledge of physiological birth and movement during labour needs to be further developed. There is a lack of understanding and knowledge of physiological labour and birth from the majority of obstetricians. The majority of services are designed to ensure safety and view birth from a pathological perspective that highlights risk. This is not a balanced view as knowledge and understanding of physiological birth are often not implemented. The findings suggest the predominant culture in maternity care is one that shows lack of empathy, dignity and compassion towards women. Through building recognition of the psychological, emotional and social impact of birth into multi-professional training, services can be developed to support these needs. Additionally, the clash in espoused beliefs between obstetrics and midwifery needs to be addressed to equalise the authority of knowledge bases between the biomedical model and a more social model of care. Power differences between professionals and women is shown in which knowledge is seen as authoritative, how movement is utilised and how birth is interpreted by women. Finally, training needs to be developed which address the relative challenges of the implementation of best practice into the clinical setting to minimise the theory practice gap.

To address this:

- Obstetricians and midwives need to train together before qualification to gain greater understanding of each other's roles and knowledge bases. Obstetricians need to understand physiological birth and the impact of psychological, emotional and social aspect of birth before they go on to practice deviation from normal. The aim of this should be to give obstetricians a greater understanding of how risk-based practice affects women in all aspects of their lives recognising its meaning and giving credence to women's subjective experience. Additionally, this should address the power differentials between midwifery knowledge and the bio-medical assumptions that are currently viewed as authoritative in the CLU.
- Midwifery and obstetric inter-professional training should be delivered in context on site where the challenges of implementation can be acknowledged and services developed with clinicians, academics and organisations.

13.11 Implications for maternity care organisation

Recommendations for maternity care organisation have arisen from this study. The belief in relationship-based care that has arisen from this study is a model of care that is well documented in the literature as improving outcome for women (Sandal et al 2016(a), Sandal et al 2016(b)). Implementation in-line with an approach that supports women's right to self-determination and autonomous midwifery will foster a culture that empowers, supports women, and supports physiological birth and movement. Through supporting midwifery led models of care where women and midwives work together in a less patriarchal way, women, birth and midwifery will be strengthened.

The organisation needs to recognise how the culture of the CLU affects physiological birth and movement. The organisation must base care needs of women and services on the wide range of theory derived from a deep understanding of the physiology of birth, qualitative evidence and the experiential knowledge of midwives and women. Supporting physiology and women's psychological, emotional and sociological needs must be seen as important and valuable as managing risk.

Maternity care organisations must foster an environment where challenges can be made and genuine collaboration between obstetricians, midwives and women is welcomed and supported. With a fundamental clash in belief systems between obstetric and midwifery,

operating within the restraints of an organisation, competing interests will occur. Until this is acknowledged and openly accepted with none having overall authority, challenges will arise that need to be addressed.

To enable; midwives to support physiological birth in a culture which is in contrast to their beliefs; to foster a culture in which women are valued during their maternity care experience; to acknowledge that women are experts in their own bodies; to enable to role of the midwife to be valued within the organisation, there needs to be investment in midwifery leadership.

To address this:

- Services need to be organised around a social model of care that values relationship and equality between care users and care providers. These models need to ensure all women, regardless of determined risk status, receive compassionate care, women's self-determination is respected and physiological processes around birth are supported to enable women to be empowered.
- All birth environments need to be organised to support physiological birth, recognising elements of the birth culture that may have an impact on this.
- Challenging and collaborative working are seen as necessary and important to address issues related to differences in professional discourse. Time, space and work are allocated to manage this.
- Financial investment and power need to be given to leadership in midwifery to support and drive forward the recommendations coming from this study.

13.12 Implications for wider society

Recommendations for wider society have arisen from this study.

Cultural representations of birth is cited as showing unrealistic and fearful images of birth. Whilst women recognise this as being unrealistic compared to their experience, midwives notice the impact it has had on women over the years.

The research has shown that women are removed form first-hand experience of birth and unless they have birthed before have little knowledge until they are in labour, receiving this knowledge from the midwife.

This study has highlighted the importance of midwifery care in supporting women during labour and as a source of information, yet midwives and the knowledge and experience they bring is often overlooked.

To address this:

- Media needs to work with midwifery advisors to present a more realistic imagery of labour and birth.
- Ways in which women can connect with other women to share knowledge of birth need to be promoted. Organisations such as The Positive Birth Movement, Maternity Voice Partnerships and online resources such as Facemums or mumsnet can help women build a more positive image of birth as well as raising awareness of support available outside of local maternity services.
- Maternity care organisations, governing bodies, unions and regulators should value and support the work of midwives to celebrate and strengthen the profession that touches everyone who is born.
- Women as co-contributors of their care need to be more involved in the organisation of services that is for them, have more of a voice in policy, guideline and service information and delivery. This needs to be adequately funded by maternity care organisations and government.

13.13 Recommendations for future research

Further research needs to be carried out on cultures of maternity care to establish if other elements prevent the implementation of evidence and knowledge of physiological birth and to identify if the results of this study are replicated in other maternity units. Additionally, more research needs to be undertaken with obstetricians, this project identified them as a difficult to engage group. Their opinions and views need to be sought on how more collaborative working can be implemented, how they can increase their knowledge and understanding of physiological birth, thus breaking down the barriers that prevent a more balanced culture of care delivery.

13.14 Conclusion

This chapter gives an overview of the research project. It draws together the findings of a project that sought to address the problem of the suppression of qualitative research,

physiological and experiential knowledge of physiological birth. It identified cultures that support or deny the use of maternal movement during labour as an aspect of physiological birth. Barriers to using knowledge and facilitators to using it were identified by the research and from this, recommendations for practice, training, maternity care organisations and wider society have been made to support the reconceptualisation of maternity care that supports women.

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Appendix 1

Women recruitment poster

University of Salford MANCHESTER

Research Project;

Women's, Midwives and Doctor's beliefs around movement in labour.

Would you like to help in research around what you think about movement in labour?

- Are you having a baby at Royal Bolton Maternity unit?
- Can you spare an hour to speak to our researcher about birth?
- If you are 28 weeks or more pregnant please speak to your midwife or contact the researcher on the details below.

Researcher; Bev Jervis
Email; B.K.Jervis@edu.salford.ac.uk

Appendix 2
Women's invitation to take part

Research project: An exploration of women's, midwives and doctors beliefs around physical movement in labour

I would like to invite you to take part in a research project that has been designed to explore how beliefs around maternal activity impact on labour and compare beliefs from different viewpoints. Taking part in the study is entirely up to you. Before you decide whether you would like to take part the researcher will go through the information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. The process of providing information and going through informed consent should take about 20 minutes. During the process, if you decide you would like to participate, we will arrange an interview time at a venue and date of your convenience. Please feel free to talk to others about the study if you wish.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part. Once you have read it and think you may be interested in participating, the research midwife will give you more detailed information about the study and what it entails.

Please ask the person who gives you this information if anything is unclear, or Email the address below

Thanks for your time

Bev Jervis

B.K.Jervis@edu.salford.ac.uk

Appendix 3
Women's Participant Information

Participant Information Sheet for Women

Research project: Women's, midwives and doctors beliefs around movement in labour

You are being invited to participate in a research study as part of my PhD studies. Before you decide whether or not to participate, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and feel free to ask if you would like more information, or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Purpose of study

Research has been carried out into how the place of birth, environment, supporters, emotions, previous experience and health affect labour. However, there is little research that has looked at women's activity when they are in labour.
The Royal College of Midwives (RCM) advises that women are active during labour (RCM 2005) with midwives advised to encourage movement during labour. There has been shown the need for more studies in this area.

Finding out more about activity and movement in labour will help maternity care staff and women improve understanding about what women think about being active in labour.

Participants

As you are pregnant and a user of maternity services at The Royal Bolton Hospital, you are able to provide a valuable insight in to some of the reasons what women in the UK think about being active in labour. It is hoped that 10 women, 10 midwives and 10 doctors will be kind enough to offer to share their experiences and talk to the researcher. Your involvement is voluntary and there are no financial rewards or reimbursement for participating. You are able to withdraw at any point without any compromise to yourself as a past or future user of maternity services.

Study method

Your participation will involve being interviewed once for between 60 to 90 minutes. The interview will be done by myself, Bev Jervis, it will be in your home or in a private room in the hospital at a time convenient to you. The interview will be around your personal beliefs around labour and the experience of planning your birth. If you have already had a baby the interview will also be about if being active in labour helped to make you feel better or if you wanted to and couldn't be active, how this made you feel. Before the interview you will be asked to fill in a short questionnaire asking about personal information relating to your background, pregnancy and birth, but you do not have to answer any of the questions if you prefer not to.

All interviews shall be confidential, you may have a friend or family member with you if you wish. All of the interviews will be digitally recorded with your consent and later transcribed. The student researcher will also take notes during the discussion to aid with interpreting, all of which shall be anonymous. All audio and shall be destroyed once transcribed, and the transcribed discussion shall be made anonymous and stored securely. Once the project is complete all transcribed data and information given shall be destroyed.

Risks

Talking about your hopes, expectations and experiences of childbirth may be distressing for you as it can be a highly emotional time for some women. If at any time during the study you find the experience difficult or distressing this will be accepted by the researcher in an understanding and caring manner and you are under no obligation to continue. Withdrawal from the study can take place at any point and you are free to take a break or stop the interview. If you have any issues following the interview please remember you are able to contact the researcher or her Supervisor; Prof. Greg Smith, whose contact details are provided below.

Benefits

There are no direct benefits to you form taking part in this study, but it is hoped that the information you give will improve understanding and highlight areas for future research projects.

Problems

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated, the normal National Health Service complaints mechanisms are available to you.

Confidentiality

The interview will be audio-taped using a digital recorder. This recording will be stored securely before being transcribed and will then be deleted. Information will be kept anonymous and no personal identifiable data will be used on any material. Any data stored electronically will be password protected and only the researcher and the supervisor will have access to this material. Ethical approval has been given for this project from the University of Salford and NHS ethics.

Results of the study

The results will be written up into a project and a copy of any articles produced will be given to participants. No identifying information will be included in the project in order to maintain confidentiality. The results of this project will be part of a research thesis, information gained will also be used for articles published in midwifery and health journals and used for conference presentations.

Withdrawal of involvement

You may withdraw your participation at any time during this study without explanation and any information gained will be destroyed.

Further information

If you have any other questions, please contact;

Bev Jervis
Post Graduate Research Student
M. Res, BSc (Hons), RM
School of Nursing, Midwifery and Social Work
College of Health and Social Care
University of Salford
Frederick Road
Salford
Greater Manchester
M6 6PU

B.K.Jervis@edu.salford.ac.uk

Or
Contact details of supervisor
Professor Greg Smith
Allerton Building (Room L507)
School of Nursing, Midwifery, Social Work & Social Science
College of Health and Social Care
University of Salford
Frederick Road
Salford, Greater Manchester
M6 6PU
Email: g.w.h.smith@salford.ac.uk
Telephone: 0161 295 4706

Appendix 4
Staff's invitation to take part

Research project: An exploration of Women's, midwives and obstetricians beliefs around maternal movement in labour.

I would like to invite you to take part in a research project that has been designed to explore how beliefs around maternal activity impact on care in labour and compare beliefs from different viewpoints. Taking part in the study is entirely up to you. Before you decide whether you would like to take part the researcher will go through the information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. The process of providing information and going through informed consent should take about 20 minutes. During the process, if you decide you would like to participate, we will arrange an interview time at a venue and date of your convenience. Please feel free to talk to others about the study if you wish.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part. Once you have read it and think you may be interested in participating, the research midwife will give you more detailed information about the study and what it entails.

Please ask the person who gives you this information if anything is unclear, or Email the address below

Thanks for your time

Bev Jervis

B.K.Jervis@edu.salford.ac.uk

Appendix 5
Staff recruitment poster

University of Salford MANCHESTER

Research Project;

Women's, Midwives and Obstetricians' beliefs around movement in labour.

Would you like to help in research around what you think about movement in labour?

- Are you a midwife or obstetrician working at Bolton Maternity unit?
- Can you spare an hour to speak to our researcher about your practice and experience?

If you are interested please contact the researcher on the details below.

Researcher; Bev Jervis, Email; B.K.Jervis@edu.salford.ac.uk

Appendix 6
Staff participant Information

Participant Information Sheet for midwives and obstetricians

Research project: An ethnographic exploration of Women's, midwives and obstetricians beliefs around maternal movement in labour.

You are being invited to participate in a research project as part of my PhD studies. Before you decide whether or not to participate, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and feel free to ask if you would like more information, or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Purpose of study

Research has been carried out into how the place of birth, environment, supporters, emotions, previous experience and health affect labour. However, there is little research that has looked at women's activity when they are in labour.
The Royal College of Midwives (RCM) advises that women are active during labour (RCM 2005) with midwives advised to encourage movement during labour. There has been shown the need for more studies in this area.
Finding out more about activity and movement in labour will help maternity care staff and women improve understanding about what women, midwives and obstetricians think about being active in labour.

Participants

As you are a midwife or obstetrician employed by The Royal Bolton Hospital, you are able to provide a valuable insight in to what care providers believe about maternal activity in labour and how they use activity in their practice. It is hoped that 10 women, 10 midwives and 10 doctors will be kind enough to offer to share their experiences and talk to the researcher. Your involvement is voluntary and there are no financial rewards or reimbursement for participating. You are able to withdraw at any point without any compromise to yourself as an employee.

Study method

Your participation will involve being interviewed once for between 60 to 90 minutes. The interview will be done by myself, Bev Jervis, it will be in your home or in a private room in the hospital at a time convenient to you. The interview will be around your personal beliefs around labour and your experiences caring for women during labour and birth. Before the interview you will be asked to fill in a short questionnaire asking about your profession experience.

All interviews shall be confidential, you may have a friend or family member with you if you wish. All of the interviews will be digitally recorded with your consent and later transcribed. The midwife

researcher will also take notes during the discussion to aid with interpreting, all of which shall be anonymous. All audio shall be destroyed once transcribed, and the transcribed discussion shall be made anonymous and stored securely. Once the project is complete all transcribed data and information given shall be destroyed.

Risks

Talking about your experiences of caring for women in labour may be distressing for you. If at any time during the study you find the experience difficult or distressing this will be accepted by the researcher in an understanding and caring manner and you are under no obligation to continue. Withdrawal from the study can take place at any point and you are free to take a break or stop the interview. If you have any issues following the interview please remember you are able to contact the researcher or her Supervisor; Prof. Greg Smith, whose contact details are provided.

Benefits

There are no direct benefits to you form taking part in this study, but it is hoped that the information you give will improve understanding and highlight areas for future research projects.

Problems

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated, the normal National Health Service complaints mechanisms are available to you.

Confidentiality

The interview will be audio-taped using a digital recorder. This recording will be stored securely before being transcribed and will then be deleted. Information will be kept anonymous and no personal identifiable data will be used on any material. Any data stored electronically will be password protected and only the researcher and the supervisor will have access to this material. Ethical approval has been given for this project from the University of Salford and NHS ethics.

Results of the study

The results will be written up into a project and a copy of any articles produced will be given to participants. No identifying information will be included in the project in order to maintain confidentiality. The results of this project will be part of a research thesis, information gained will also be used for articles published in midwifery and health journals and used for conference presentations.

Withdrawal of involvement

You may withdraw your participation at any time during this study without explanation and any information gained will be destroyed.

Further information

If you have any other questions, please contact;

Bev Jervis
Post Graduate Research Student
M. Res, BSc (Hons), RM
School of Nursing, Midwifery and Social Work
College of Health and Social Care
University of Salford
Frederick Road
Salford
Greater Manchester
M6 6PU
B.K.Jervis@edu.salford.ac.uk

Prof. Greg Smith
Email: g.w.h.smith@salford.ac.uk
Telephone: 0161 295 4706

Thank you for your time

Appendix 7
Women interview guide

Research project: An ethnographic exploration of Women's, midwives and obstetricians beliefs around movement in labour.

Semi structured interview topic guide

Women

Informal introduction, consent form and demographic information collection.

Firstly, thank you for taking time to be part of this research, I really appreciate your time.

Tell me about your last birth / what plans do you have for your birth

Do you believe that movement has any influence on labour?

Thinking about movement in labour what do you know about being active in labour? (Use of RCM imagery of positions for normal birth)

Where did you get your ideas/information about movement?

How do you think you get the best information around movement in labour?

Thinking about your future/past labours what would you say influences movement in labour?

Have you ever had differing information about movement?

How does this make you feel?

Thank you for taking part

Appendix 8
Midwives interview guide

Research project: An ethnographic exploration of Women's, midwives and obstetricians beliefs around maternal movement during labour.

Semi structured Interview topic guide

Midwives

Informal introduction, consent form and demographic information collection.

Firstly, thank you for taking time to be part of this research, I really appreciate your time.

What inspired you to become a midwife?

Tell me about your training.

If you wanted to find out about something related to your practice around movement during labour what information would you use?

Why would you use that source?

Do you think there are any factors that influence movement in labour?

Do you think information around movement is used during labour?

Do you believe that maternal movement has any influence on labour?

Where do you think others (women, midwives & obstetricians) get there information from?

Do you think there are differences in beliefs around movement in labour?

How does this make you feel if it happens?

Thank you for your time

Appendix 9
Obstetricians interview guide

Research project: An ethnographic exploration of Women's, midwives and obstetricians beliefs around maternal activity in the first stage of labour.

Semi structured Interview topic guide

Obstetricians

Informal introduction, consent form and demographic information collection.

Firstly, thank you for taking time to be part of this research, I really appreciate your time.

What inspired you to become an obstetrician?

Tell me about your training.

If you wanted to find out about something related to your practice around movement during labour what information would you use?

Why would you use that source?

Do you think there are any factors that influence movement in labour?

Do you think information around movement is used during labour?

Do you believe that maternal movement has any influence on labour?

Where do you think others (women, midwives & obstetricians) get there information from?

Do you think there are differences in beliefs around movement in labour?

How does this make you feel if it happens?

Thank you for your time

Appendix 10
Demographic information

Demographic Sheet: Women

Research project: An ethnographic exploration of Women's, midwives and obstetricians beliefs around maternal activity in the first stage of labour.

Participant Number…….

Contact details

Telephone…… Email……..

Age……

Please tick the boxes which apply to you;

What is your ethnic origin?

……

Are you?

Employed ☐ Self-employed ☐ Student ☐

Unemployed ☐

How many children have you had?

This is your 1st ☐ This is your 2nd ☐ This is your 3rd ☐ This is your 4th ☐

Is your pregnancy ;

Low risk ☐ High risk ☐

Do you have the support of a partner?

Yes ☐ No ☐

Research project: Women's, midwives and obstetricians beliefs about physical activity in labour

Participant Number…….

Contact details;

Telephone;…… Email;……..

Age;…….

Please tick the boxes which apply to you;

What is your ethnic origin?

White British ☐ Asian ☐ Other……

How long have you worked for The Royal Bolton NHS Trust?.....

Where is your main area of work?

Community ☐ Birth centre ☐ Delivery suite ☐
Managerial ☐

How long have you been a midwife?

Less than 3 years ☐ 4 – 7 years ☐ 8 – 15 years ☐ more than 15 years ☐

Do you have children?

Yes ☐ No ☐

Research project: Women's, midwives and obstetricians beliefs about physical activity in labour

Participant Number…….

Contact details;

Telephone;…… Email;……..

Age;…….

Please tick the boxes which apply to you;

Sex

Female ☐ Male ☐

What is your ethnic origin?

……

How long have you worked for The Royal Bolton NHS Trust?.....

What is your Grade?

Consultant ☐ Registrar ☐ Senior House Officer ☐

How long have you been in obstetrics?

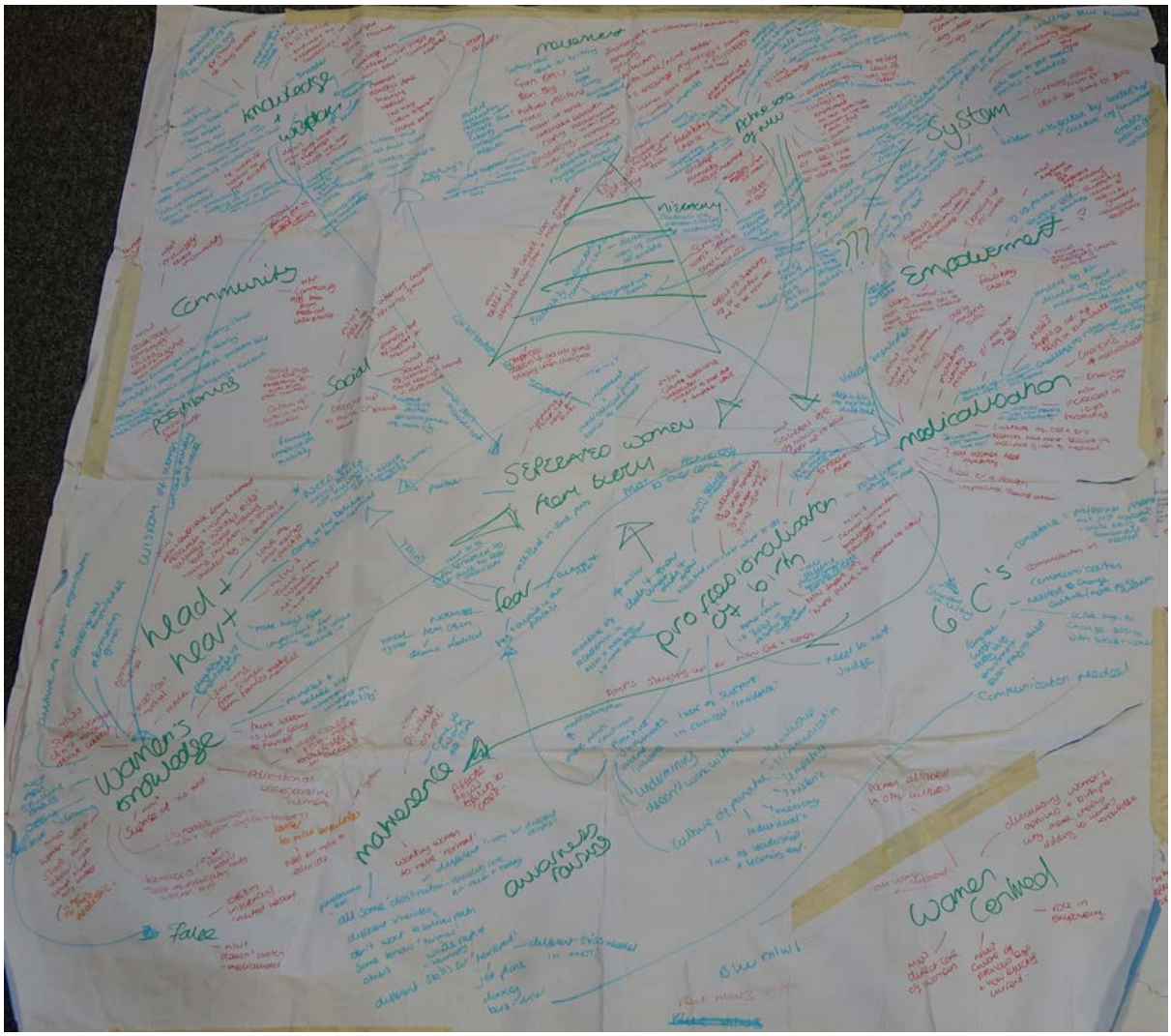
Less than 3 years ☐ 4 – 7 years ☐ 8 – 15 years ☐ more than 15 years ☐

Do you have children?

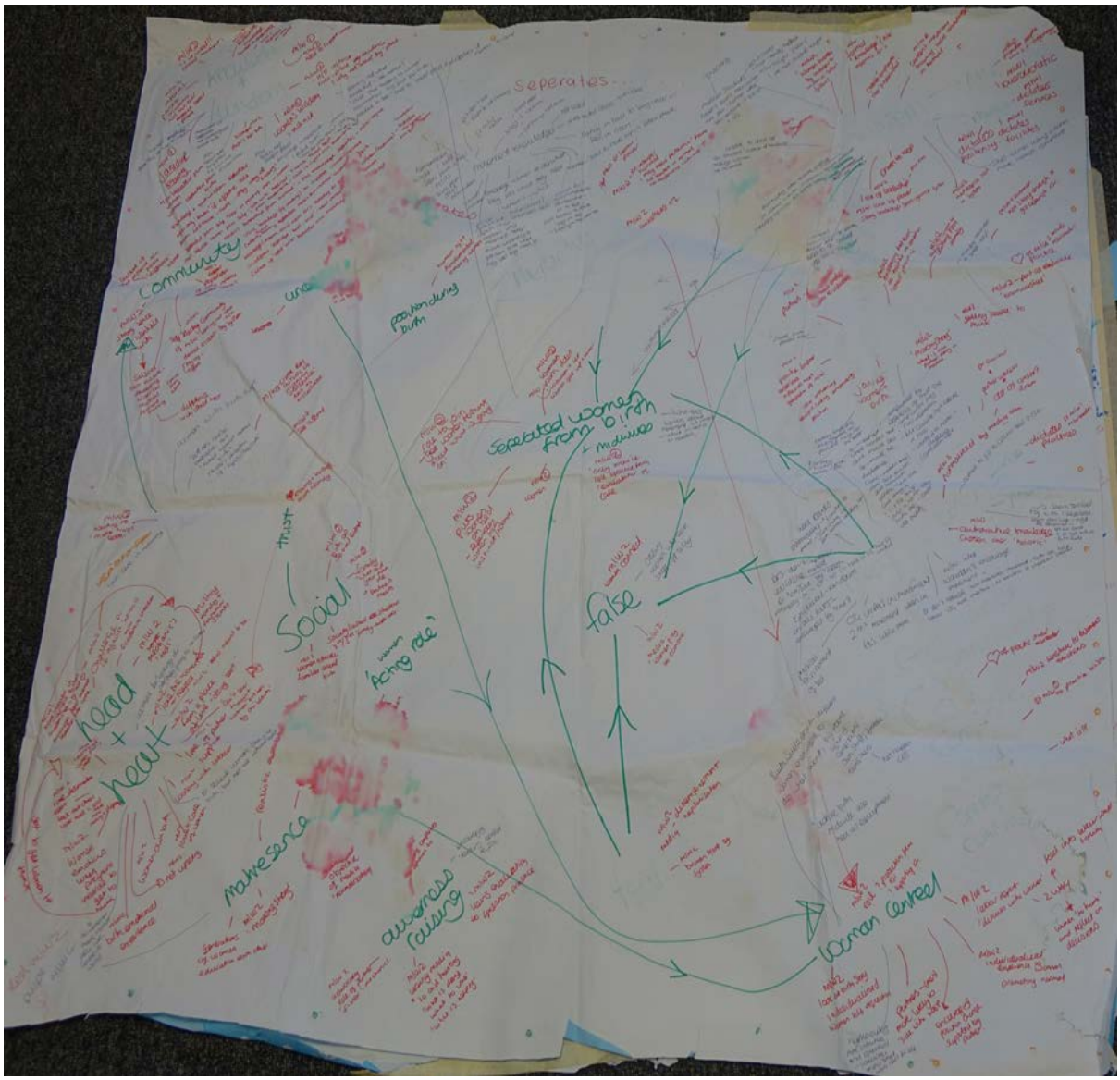
Yes ☐ No ☐

Appendix 11
Interviews - raw data mind maps

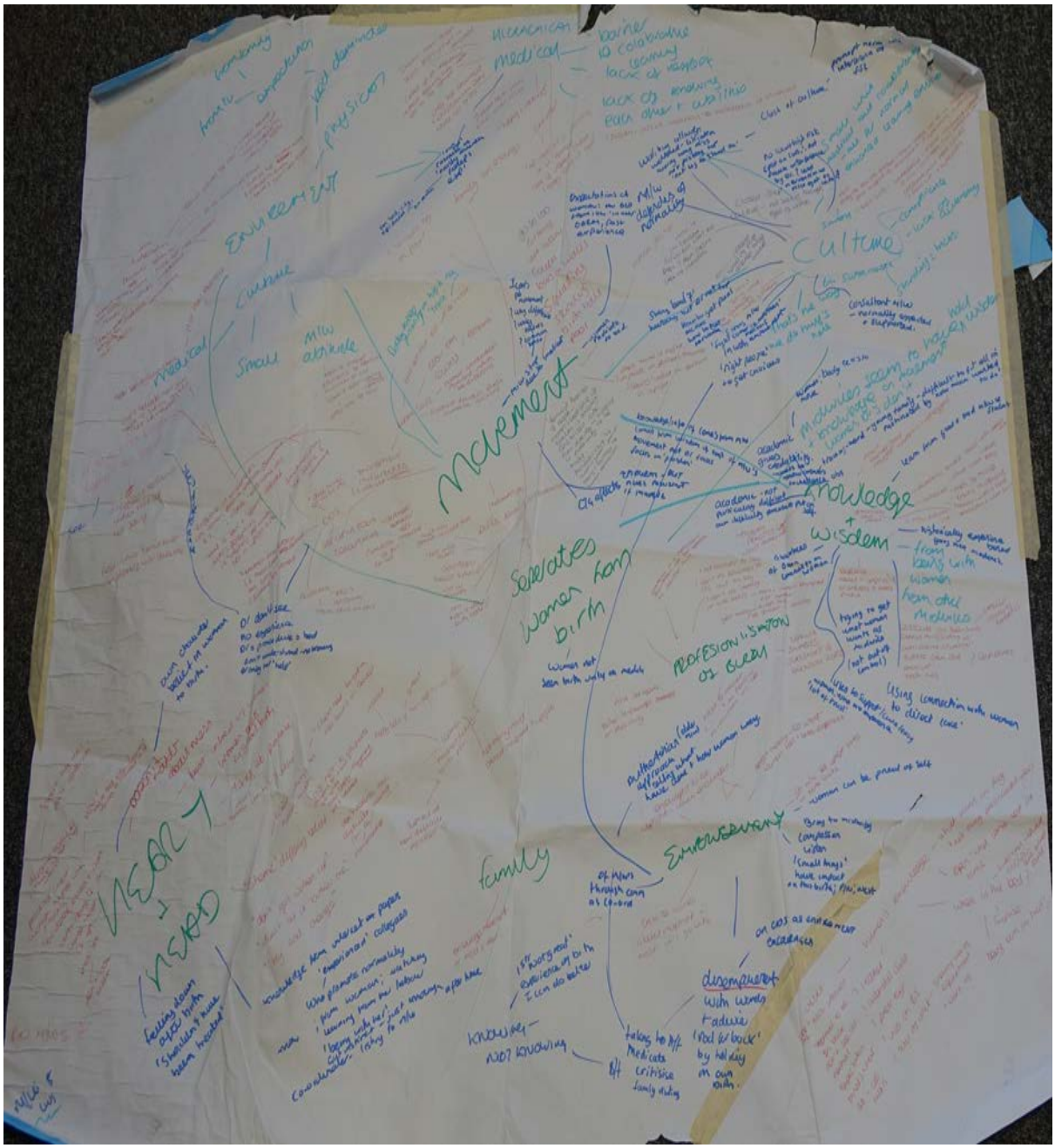
Midwives one and three raw data mind map



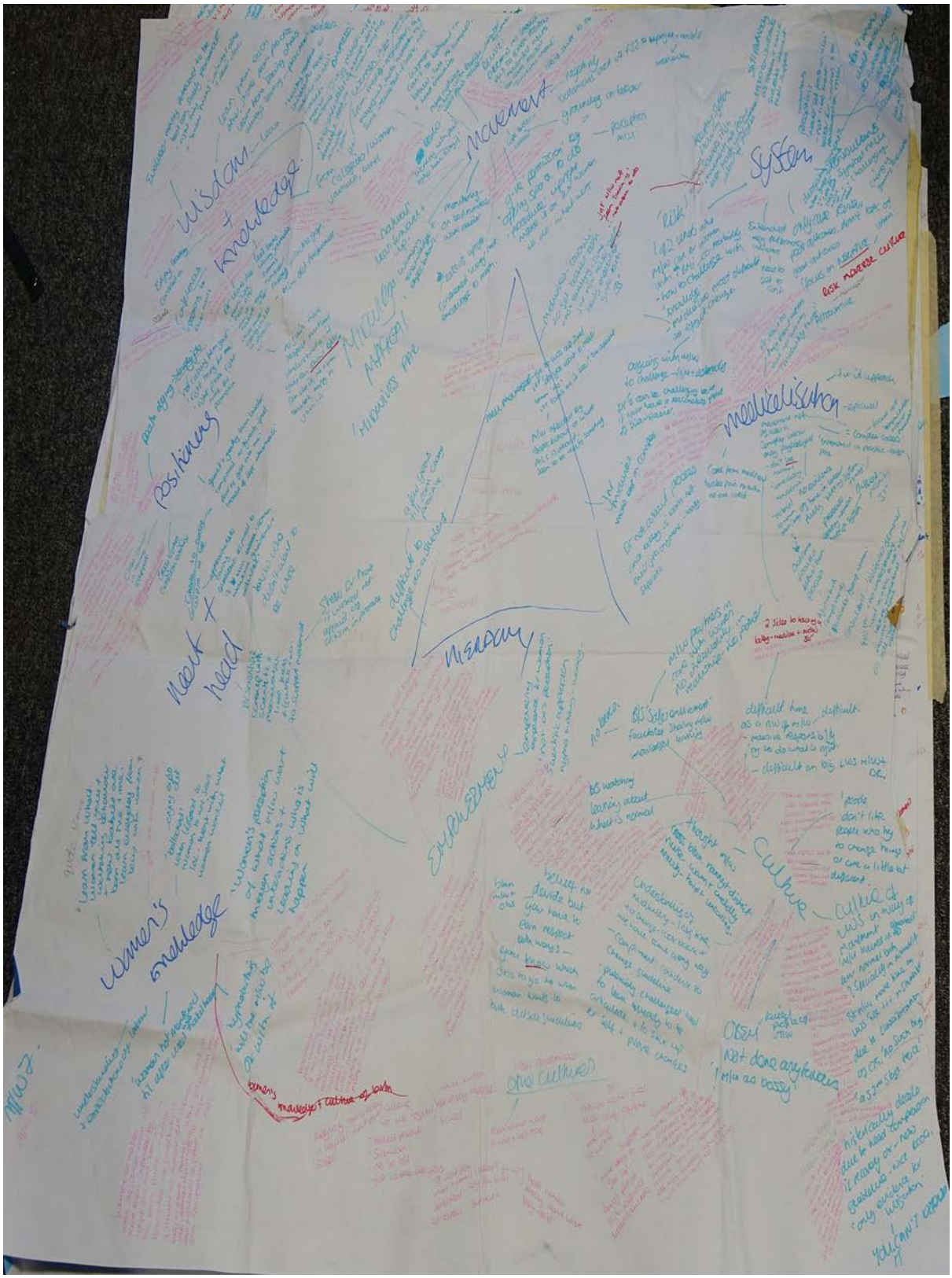
Midwives two and four raw data mind maps



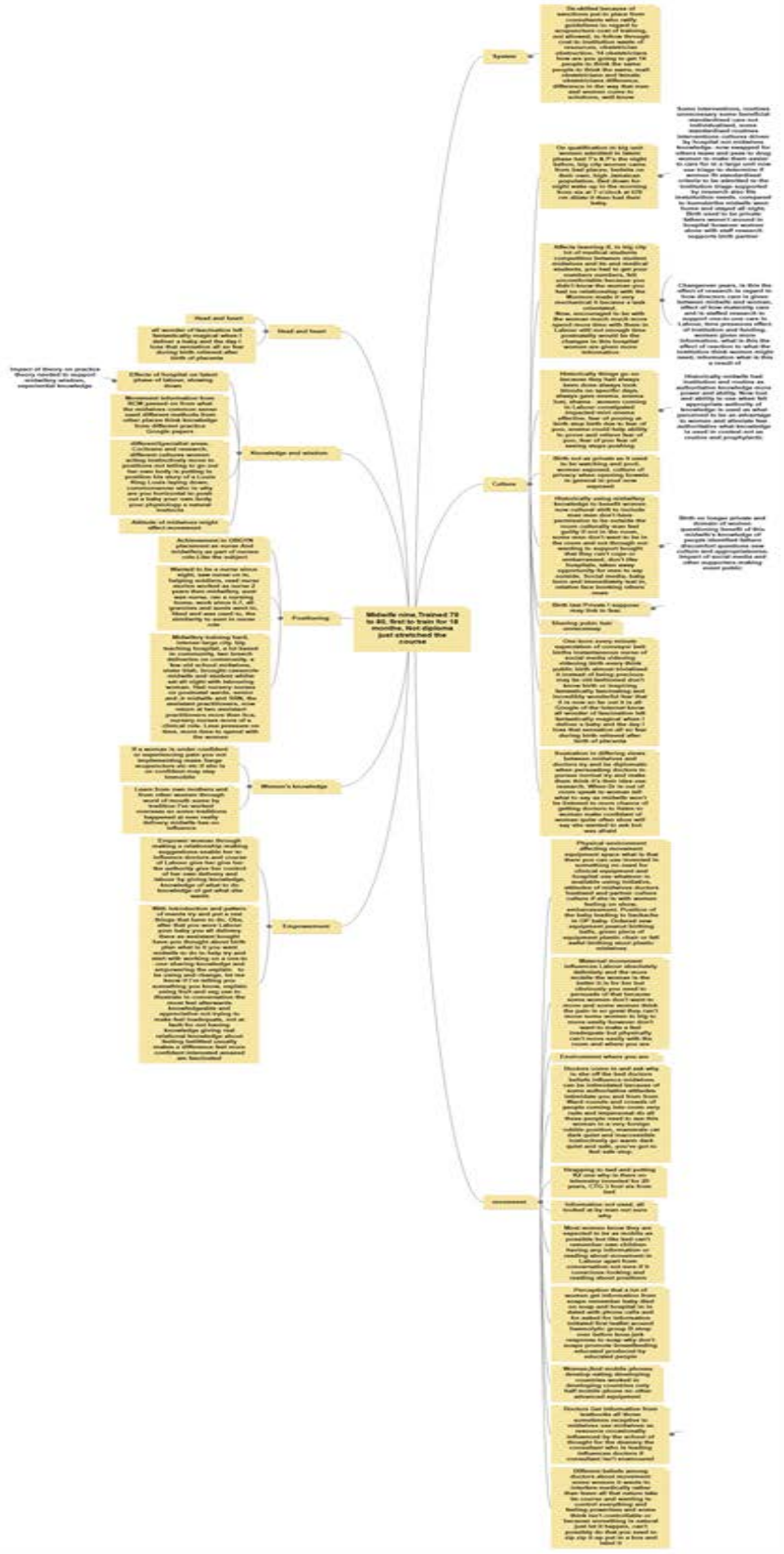
Midwives five and six raw data mind maps



Midwives seven and eight raw data



Midwife nine raw data mind map and list



1. System

1.1. De-skilled because of sanctions put in place from consultants who ratify guidelines in regard to acupuncture cost of training, not allowed, to follow through cost to institution waste of resources,

obstetrician obstruction. 14 obstetricians how are you ging to get 14 people to think the same people to think the same, mail obstetricians and female obstetricians difference, difference in the way that men and women come to solutions, well-know

2. Culture

2.1. On qualification in big unit women admitted in latent phase had T's & P's the night before, big city women came from bad places, bedsits on their own, high Jamaican population. Bed down for night wake up in the morning from six at 7 o'clock at 678 cm dilate it then had their baby.

2.1.1. Some interventions, routines unnecessary some beneficial standardised care not individualised, some standardised routines interventions cultures driven by hospital not midwives knowledge. now swapped for others tease and peas to drug women to make them easier to care for in a large unit now use triage to determine if women fit standardised criteria to be admitted to the institution triage supported by research also fits instuituition needs. compared to homebirths midwife went home and stayed all night. Birth used to be private fathers weren't around in hospital however women alone with staff research supports birth partner

2.2. Affects learning if, in big city lot of medical students competition between student midwives and its and medical students, you had to get your numbers numbers, felt uncomfortable because you didn't know the woman you had no relationship with the Mormon made it very mechanical it became a task orientated. Now, encouraged to be with the woman much much more spend more time with them in Labour still not enough time postnatally would be the changes in this hospital women are given more information

2.2.1. Changeover years, is this the effect of research in regard to how directors care is given between midwife and woman, effect of how maternity care and is staffed research to support one-to-one care in Labour, time pressures effect of institution and funding, women given more information, what is this the effect of reaction to what the institution think women might need, information what is this a result of ..... Error! Bookmark not defined.

2.3. Historically things go on because they had always been done always took bloods on specific days, always gave enema, enema lost, shame - women coming in Labour constipated impacted mini enema effective, fear of pooing at birth stop birth due to fear of po, enema could help ability to prove and relieve fear of poo, fear of poo fear of seeing stops pushing

2.3.1. Historically midwife had institution and routine as authoritative knowledge more power and ability. Now lost and ability to use when felt appropriate authority of knowledge is used as what perceived to be an advantage to women and alleviate fear authoritative what knowledge is used in context not as routine and prophylactic

2.4. Birth not as private as it used to be watching and pool, women exposed, culture of privacy when opening bowels in general in pool now exposed

2.5. Historically using midwifery knowledge to benefit women now cultural shift to include man men don't have permission to be outside the room culturally man feel guilty if not in the room, some men don't want to be in the room and not through not wanting to support bought that they can't cope or embarrassed, don't like hospitals, taken away opportunity for men to say outside. Social media, baby born and immediately text in, relative face booking others news

2.5.1. Birth no longer private and domain of women questioning benefit of this midwife's knowledge of people identified fathers discomfort questions new culture and appropriateness. Impact of social media and other supporters making event public

2.6. Birth last Private I suppose may link to fear,

2.7. Shaving pubic hair unnecessay

2.8. One born every minute expectation of conveyor belt births instantaneous nurse of social media videoing videoing birth every think public birth almost trivialised it instead of being precious may be old-fashioned don't know birth or inspiring fantastically fascinating and incredibly wonderful fear that it is now so far out it is all Google of the Internet know all wonder of fascination left fantastically magical when I deliver a baby and the day I lose that sensation all so fear during birth relieved after birth of placenta

2.9. frustration in differing views between midwives and doctors try and be diplomatic when persuading doctors to pursue normal try and make them think it's their idea use research. When Dr is out of room speak to woman tell what to say as midwife won't be listened to more chance of getting doctors to listen to woman make confidant of woman quite often shoe will say she wanted to ask but was afraid

3. movement

3.1. Physical environment affecting movement equipment space what is that there you can use invented in something no need for clinical equipment and hospital use whatever is available using initiative, attitudes of midwives doctors husband and partner culture culture if she is with women feeling on show, embarrassment. Position of the baby leading to backache in OP baby. Ordered new equipment peanut birthing balls, given piece of equipment plastic chair or fall awful birthing stool plastic midwives
3.2. Maternal movement influences Labour absolutely definitely and the more mobile the woman is the better it is for her but obviously you need to persuade of that because some women don't want to move and some women think the pain is so great they can't move some women to big to move easily however don't want to make a feel inadequate but physically can't move easily with the room and where you are
3.3. Environment where you are
3.4. Doctors come in and ask why is she off the bed doctors beliefs influence midwives can be intimidated because of some authoritative attitudes intimidate you and from from Ward rounds and crowds of people coming into room very rude and impersonal do all thse people need to see this woman in a very foreign rubble position, mammals cat dark quiet and inaccessible instinctively go warm dark quiet and safe, you've got to feel safe stop.
3.5. Strapping to bed and putting K2 one why is there no telemetry invented for 20 years.
3.6. Information not used, all looked at but not sure why
3.7. Most women know they are expected to be as mobile as possible but like bed can't remember own children having any information or reading about movement in Labour apart from conversation not sure if it conscious looking and reading about positions
3.8. Perception that a lot of women get information from soaps remember baby died on soap and hospital in undated with phone calls and for asked for information initiated first leaflet around haemolytic group B strep ever before knee-jerk response to soap why don't soaps promote breastfeeding educated produced by educated people
3.9. Doctors Get information from textbooks all those sometimes receptive to midwives use midwives as resource occasionally influenced by the school of thought for the deanery the consultant who is leading influences doctors if consultant isn't enamoured
3.10. Different beliefs among doctors about movement some want to interfere medically rather than leave and let nature take its course and wanting to control everything and feeling powerless and some think it isn't controllable or because something is natural just let it happen, can't possibly do that you need to put in a box and label it

4. Empowerment

4.1. Empower woman through making a relationship making suggestions enable her to influence doctors and course of Labour give her give her the authority give her control of her own delivery and labour by giving knowledge, knowledge of what to do knowledge of get what she wants
4.2. With introduction and pattern of events try and put at rest, things that you have to do, Obs, after that your Labour, your baby, your delivery there to assistant but have you thought about birth plan what is it you want midwife to do to help. try and start with working on a one-to-one sharing knowledge and empowering the explain to be using and change, let me know if I'm telling you something you know, explain using fruit and veg use to illustrate in conversation the most feel afterwards knowledgeable and appreciative not trying to make feel inadequate, not at fault for not having knowledge giving real relational knowledge about feeling belittled usually makes a difference feel more confident interested amazed and fascinated

5. Women's knowledge

5.1. If a woman is under confident or experiencing pain you not implementing massarge acupuncture etc etc if she is confident may stay immobile
5.2. Learn from own mothers and from other women through word of mouth some by tradition I've worked overseas so some traditions happened at every delivery, midwife has no influence

6. Positioning

6.1. Achievement in OBGYN placement as nurse And midwifery as part of nurses role-Like the subject
6.2. Wanted to be a nurse since eight, saw nurse on tv, helping soldiers, read nurse stories worked as nurse 2 years then midwifery, aunt was nurse, ran a nursing home, work since 6-7, all grannies and aunts went to, liked and was used to, the similarity to aunt in nurse role Error! Bookmark not defined.
6.3. Midwifery training hard, intense large city, big teaching hospital, a lot based in community, two breech deliveries on community, a few old school midwives, sister blah, brought casserole midwife and student

whilst sat all night with labouring woman. Had nursery, nurses on postnatal wards, senior and Jr midwife and SRN, the assistant practitioners, now return at two assistant practitioners more than hca, nursery nurses more of a clinical role. Less pressure on time, more time to spend with the women

7. Knowledge and wisdom

7.1. Effects of hospital on latent phase of labour, slowing down

7.1.1. Impact of theory on practice theory needed to support midwifery wisdom, experiential knowledge

7.2. Movement information from RCM passed on from what the midwives common sense used different methods from other places think knowledge from different practice Google papers

7.3. differentSpecialist areas, Cochrane and research, different cultures women acting instinctively move to positions not telling to go with her own body is putting in position. This story of a Louis King Louis laying down, commonsense, why are you horizontal to push out a baby your own body your physiology a natural instincts

7.4. Attitude of midwives might affect movement

8. Head and heart Error! Bookmark not defined.

8.1. all wonder of fascination left fantastically magical when I deliver a baby and the day I lose that sensation also fear during birth relieved after birth of placenta

Doctor's interviews – Listed mind map data

I. 1) Inspiration to be a dr

A. Tasks

1. Student took a role - feel involved T
2. even SB you can make it bearable for them V
3. Treating well people W
4. Obs fascinating Y

B. Role model

1. Student enjoy, unit enjoy, people aspired U

C. Babies

1. Nice to see babies born, privilege, V
2. Catch babies W
3. Part of Special moment Y

D. Atmosphere of CL

1. drama excitement cl V
2. Exciting W
3. God day, bad day - always positive, exciting, variety, interesting, special moment, adrenaline, obs fascinating Y

E. Ability to give control to women

1. Mother 1st, shaped things - very normal - look how bring normality into high risk- all the things we can d, how you behave- normal process - elements of normal at any birth - give control back U
2. Importance of control for woman Z

II. 2) Tell me about your training

A. Hard, long hours, more exposurre, expected to do more - med students delivers & suturing, sho- forceps-c/s- ture deep learning facilitated by going out and doing T

B. Experience of birth, relate to women better U

1. Can see why women want to encourage normal as normal as possible- benefited me - in touch with normality- experience - make them feel more on their level

C. How do you experience it- massive question T

1. Everybody different depend on experience Z

III. 3) Culture impacts on learning

A. Ethos-

1. dictates how people- behave, come across, learn - some units work together- others lost sight - them and us T
2. Important work on relationships- trust works both ways W
3. Trust - knowing and trusting colleagues Y

B. Leadership

1. Being involved, looking like they want to be involved helps learning and engaging regularly U

C. Shared learning

1. Mdt coming together- could do more - difficult on CL U
2. Able to talk through emergancy- vocalising fears to mw- they know to prepare situation if things don't go straight forward - they know not jumping in without thinking V
3. All doing same job, need to help each other, all want same outcomes W

IV. 4) Info on movement

A. Journals T

1. BJOG, RCOG, google scholar, google - origin - check (Disconnect*), BMJ, dr net, midwifery articles T
2. Search - written, articles, books librarian U
3. Evidence Y

B. Midwives

1. Comes up on ward rounds(movement)

2. Midwife V

3. Mw W

4. Fantastic bunch- Movement, talk about, important- not in a position to initiate- midwives- wouldn't wan tot interfere in their plan T

C. Talk to mw/patient U (Connect*)

1. Talk to mw= opportunity

2. Women/ strong feeling one or another - first/big priority- encourage

D. Posters V

V. 5) Impact on movement

A. Intervention T

1. Epi, drip, opiates

B. Environment

1. MLU & CLU- rooms + home =lounging - the CL doesn't stimulate to get active, T

2. Environment U - could not have bed- push bed to side - Everyone know MLU environment better in encouraging movemen

3. Equip, modern bed- sitting with epi Z

C. Attitudes of mw & medical T*

1. DR U - Dr going in saying movement- try

2. Dr being pushy- but choice T

3. Mw encouraging U

D. Women's own beliefs

1. Womans own assumptions- education & scoi economic, agency and not, responsibility T

2. Woman U Woman, thinks right or not, fatigue, respect wishe

3. Backgrond U Mum sisters- say stay up more leikely

4. Woman Y - Personality, what women want, birth plan - sometime have opinion want to be on bed can't move – whoever in room encouraging, Women her self- if can't sit down good sign

E. Birth partner

1. Encouraging, U

2. Who in room, encouraging Y

VI. 6) Movement on labour

A. Unseen

1. Difficult to say, mw has continuity, build picture, we see shapshots, never see low risk, no experiential knowledge subliminal- based on experience over years T –(disconnect)

B. Latent - yes

1. Triage- keep moving

VII. 7) Where do other get info

A. Training/Edu

1. From college, people coming to teach U - dr & movement
2. NCT classes, posters in ANC, CLU

B. Experience

1. Mw work with patients in bed then not going to learn anything than that U
2. Ml- dr don't encouraged to go- V

C. Personal attitude

1. Person- if don't have attitude good thing to be move in labour - med students MLU experience - got to start there in driving normality U
2. Women- what taught, own background,different ethic beliefs, cultural beliefs, what is normal, what 'should' be done, ethinc people lie on bed - white British move - challenged my beliefs U

D. Mw

1. Wmn- community mw, U
2. Mw study days - refresh new ideas V
4. Mw W
5. In depth at uni - better training Y

E. Self

1. People brought with them - birth partners, friends family, own experience U
2. Y & Z personal experience

F. Friends

1. W

G. Internet

1. Netmums - lots of posts W

VIII. 8) Difference

A. Interaction btwn mw & DR T

1. Mw=121, dr ward round intimidating therefore different

2. Dr & mw compliment each other- sometime instinctive- handover discuss- 'iron out' difference of opinion - never suggest conflict to woman - consistent care compassion T

3. If everyone believed the same then do same thing- challenge if you think positive impact on labour U*

B. Women

1. Expectation - Immobile- seem to be what expected - if tell them expect upright more likely- other peoples stories U

2. Situation - not progression no risk not bothered - probably a physiological reason & everything fine- big & OP & won't move- not doing self favors Y

C. Role of dr-

1. Job to encourage women- encourage positive - empowered - decision U

2. Don't know if feel anything- if tried don't want- that's it what can you do W

Appendix 12
Categories mind map data

Doctors and Midwives connection

I. **Environment**

A. Physical

1. Outside room-observation
2. Equipment-Observation-All MW
3. Signage-observation
4. Setout - Observation

B. Size

1. Small - enables relationships to be built, E
2. Small = culture of learning, B, E

C. Supportive and safe atmosphere

1. Same philosophy, open discussion, 'can ask for back up' I, J, E, T
2. Knowing and trusting colleguesY
3. Importantance of relationships- trust works both ways W
4. All doing same job, need to help each other, all want same outcomes W

II. **Knowledge- Between midwives & midwives**

A. Knowledge- midwives sharing practice

1. From supportive and safe environment (above), E,F,G
2. Looking beyond clinical- holistic - midwives part of normal birth B,C, D, F, G, H, I, J

B. Midwives sharing and controlling practice

1. From leadership A, B,G, F
2. Guidelines & Challenging A, B, D,E F, G
3. MW experience& training of normal birth All DR

III. Between Dr, midwives & women

A. Women empowered by midwives- control over movement

1. Perception that mw should be using movement when woman on CTG B
2. Equal relationship between mw & wm, enables wm to follow her own cues G
3. Midwives ask women how do they want to move? B
4. Encourage women to spk up about movement C
5. Trusting relationships with women, J
6. Using love care and comfort as part of care, B

B. Drawn to profession from experience

1. Little things amazingD
2. Things were said and done- i could do better F
3. Felt cheated of normal birth C
4. Role models,D , G, E, T,U

C. Empowerment

1. Advice but allowing woman to make decisions -Making women strong- Barbara
2. Making a difference-Angela
3. Wanting women to have something normal - Catherine
4. Partnership working with women - enviro allows – g
5. Speak up about their choices b,c
6. Women making the right decisions for them angela
7. Encouraging jan
8. Women read info Donna
9. CL area midwife 'get one thing' f
10. Mw empowering self through training c
11. Give control to women U, Z
12. Talk to woman about movement- encourage U
13. Women's own assumptions/beleifs influence movement T, U Y

D. Midwives as part of normal birth

1. Having holistic knowledge which includes movement (physical, psyc & Emo) & supporting women, B, C, D, E, F, G, I, J, H , All DR
2. Role defined in statute rules etc f
3. Training in normal birth,B, E, I J
4. Midwives as enabling women to act on instinct, B, E, G, F
5. MW learn about Normal birth all DR

IV. Knowledge

A. Of culture, All MW & DR

1. Ethos dictates how people learn T

B. Of movement, All MW & DR

1. Dr encourage movement T, U

C. Learning through experience-wisdom - connects women and midwives, All \MW

D. Theoretical knowledge growing and challenge =better care, A,B,C,D, G,

E. Shared learning

1. talking through hand over T
2. MDT learning U
3. Vocalising fears, talkthrough emergancies V

V. Midwifery/birth as special - emotional connection to woman and families

A. Emotional connection to midwifery from own experience, All midwives

B. 'special time in families lives, All MW and dr's

C. Learning concentrated on one things B

D. Obs, excting facinating, adrenaline Y

E. Treating well people W

F. Babies - special V, W,Y

G. Making Sb, Forceps bearable, V, W

Doctors and midwives disconnection

I. Hospital birth- women separated from birth

A. Authoritative knowledge& hierarchy

1. No faith in mw checking, E
2. Mw unable to use her knowledge, ctg predominant, I
3. CL hierachy evidident A,B,C,D,E,F,G,H,I,J

B. Women separated from the physicality of giving birth

1. Increased complexities, F
2. Increased bmi, G
3. Pain, tiredness, exhaustion

C. Women separated from midwives

1. Women chose not to disclose hypno birth g

II. Environment

A. Physical- gives out message –B

1. Bed, E, I, J, B , G
2. Equipment, E, G, F,B,J,H
3. Ward rounds E J

4. Little control of physical environment, J, I
5. Whole set up based on acute & emergency A, B, C, G, J

B. Large size B, E, T

C. Focus on complex needs

1. Managing risk All MW

D. CTG All MW

E. Intervention, Drip, epi, opiates T

F. CLU enviroment doesn't encourage movement All Midwives, T,U,Z

III. Media

A. OBEM, B, C, D, E, F, G, I, J

B. Internet B, C, D, E, G, I, J

IV. Culture

A. Technocratic approach

1. Hierarchy, A, B, C, D, E, F, G, H, I, J
2. Focus on monitoring B, E, F, I, J,
3. Disregarding other needs F, J
4. Focus on managing equipment not enabling movement, H, J
5. Fragmented care B, G, I, J
6. Triage, I
7. Pathological -systems imposed A, B, G, I, J

B. We don't do that here

1. Individuals in culture A, B, E, F, G
2. Individual philosophy of mw A, B, G E, I, J, W

C. Separating high and low risk

1. Cl train students in abnormal,B, C, D
2. DR power on All MW
3. Cl medicalised,A, B, G, E, F, I, J
4. Woman and mw expect to comply with culture, B, J, F, I

D. DR perception of midwifery

1. Wacky – Geraldine
2. Hippy- donna

3. Mad- Elizabeth
4. Always knows best- Catherine
5. Lack of trust W
6. JNR DR negative feedback of MW T

E. Training midwives in abnormal
1. Don't see and train in normal, B
2. More time on Cl, H
3. Midwives learn how to be from culture f

F. Litigation
1. Need for evidence G, F, H
2. Prevalence of ctg monitoring B, D,E, F, I,J, H
3. Culture of fear A, B, E, J GI

G. 'Modern' impacts on women's life
1. Complex health needs F
2. BMI, G, H

V. Knowledge

A. Increased focus on academic knowledge- b

B. Care based on objective guidelines has power, E

C. Trust in tech need for evidence- wisdom lost, A

D. Academia not experience giving creditability with obs F

E. Theoretical knowledge not used in practice E

F. Knowledge implemented that suits organisation B
1. Triage, I
2. Fragmented care, J

G. Society dr knows best, C

H. Dr not encourage in MLU

I. Knowldege on movement authoritative T,U.Y

Women Connection mind map list

I. Recall of birth in ML

A. Relationship with midwife

1. Mw excellent - not asked for more K
2. Very positive- happy to help, didn't make me feel panicky, didn't rush me. Not Tell off - doing right or wrong- friendly personable K
3. People in room make a difference - midwives- chatting telling jokes, friendly, talking right through it all M
4. The one you started was who you finished - stayed till baby born K
5. Stayed over shift until placenta O
6. Mw= relaxed and chilled this is how birth should be - breathing through it P
7. Asked mw what to do - just get through this M
8. Mw telling me what to do - explain equipment - they know best K
9. Wanted the same midwife as last time, -informative, friendly and nice K
10. Kept me well informed, kept it interactive- nice experience K

B. ML environment

1. Chilled and relaxed K
2. Lovely M
3. Room and atmosphere make big difference O
4. Pool lovely- dead relaxing S
5. Wanting pool R
6. Lovely room - massive- pool- wish i used it L

C. Holding space

1. Just happened with mw there Q
2. Didn't interfere, new there, talk occasionally, checked occasionally - stayed out of way- relaxed and calm P
3. Mum- kept clam L
4. Mw - just leave you to it - checking - but just you S
5. Mw - sort of just let me go with it K

D. Self

1. Started on my own- alot better S
2. Could do what i wanted- not automatically do things for me M

3. Not what expected - less pain, coped better K
4. Proud of myself- i managed to do without pain relief P
5. 2nd less pain- neither as painful as expected- my body block it out - strange M
6. Felt great afterwards Q
7. BBA- scary at the time - nice me and my husbandP
8. Breathing- relaxed and calm - breathed baby out Q
9. Go somewhere else in my head - cope with contractions S
10. Doubt- but i actually managed it Q
11. More control - knew 'where i was up to - pulled out from between legs S
12. Left to my own devices - been through it before M
13. Never thought about it- thought it was just a normal thing a normal everyday thing Q
14. Might of lasted longer at home if someone had said just keep moving L

E. Positive experience

1. Couldn't have asked for more K
2. Fantastic experience Q
3. Great - induced felt more in control S
4. Epidural - took pain away - amazing L

F. Movement

1. Moved around a lot M
2. Midwife had me in all positions K
3. Midwife showed me what to do- moved hips- baby back to back M
4. Mw showed equip & showed in labour Q
5. Mw advised to move L

II. Plans for next birth – normal

A. Control - katie, laura

1. Hopefully don't need interference- hope straightforward K
2. Control by having ml birth L

B. ML area

1. Natural in water not stirrups and drugs K
2. Nicer, more homely, determined for pool L
3. Water, gas and air - rather bath than bed - logic N
4. Water go on own R

5. Be upright than in stirrups, move around O
6. Water M

C. Relaxed

1. Important for relaxed atmosphere in room K
2. Water, relaxing and more natural M
3. Massage, oil, movement, ball,with partner, gravity, relax cd - stay focused - partner calm R

D. 'open mind'

1. Midwife lead K
2. Depends what happens how long R

E. Want to be different

1. I want to try and do as much as i can N

III. Know about Movement

A. Feel more in control L

B. Better experience M

1. Last labour not been half as bad if i had been active L

C. Passes time

1. Keeping busy trying different things L

D. Calming

1. Moving more calming, l

E. Natural

1. Trying to do what felt right- didn't know if i was doing it right or wrong - moral judgment not knowing about birth in 1st preg/early labour K
2. Most natural and easier on body, helps progress, gravityR

F. Easier

1. Nothing mentioned or written to say movement makes easier prior to labour, Q
2. Perception makes birth easier O
3. Push through that last bit and not need intervention, M
4. Lay down - up before down- easier stood up - keeps moving down, L

G. Progress

1. Never explained but helped progress, K
2. Push it along a bit,M

3. Make it go quicker, L

H. Just knew

1. Dancing to bring labour on - moving hips S

I. Takes mind off

1. Less stressful as blood pumping and endorphins go R

J. Comfort

1. Moving to get comfortable, M
2. Trying to find most comfortable position for contraction to happen, R
3. Pregnant - moving makes things comfier N
4. Dependant how comfortable you feel- couldn't have moved from spot, P

K. Relaxed

1. Help stay relaxed - mind over matter - staying still pain more intense R

L. Makes sense – gravity

1. More helpful to stand move freely- on bed makes no sense no gravity Q

M. Keeps baby in 'right ' place L

N. Antenatal edu

1. Ideas from parent craft - not much, K
2. Nct - plug natural - not realistic first time, S

O. Specific sites

1. Boots M
2. Net mums L
3. NHS sites O
4. Baby centre, katie and laura
5. Forums K
6. App on phone L

P. Google

1. Pinch of salt dr google, S
2. Reduced movement S
3. Reliable sites- lots of unreliable, S

Q. Friends and family

1. Cousin K
2. Mum L,M

3. Friends after labour K, L , P, N
4. Sister L, N K, P

R. Other peoples experience

1. Other peoples stories, L
2. Vlogs, N
3. Talk to mums - no labour are the same M
4. Real life experiences N, R
5. Asking people who have done it, N

S. Midwife in labour

1. Given choices and options K
2. Bit late when you are in labour, N
3. Good when in active labour K
4. Told a little bit, K
5. Follow lead - there to help me in the best position, O
6. Mw- training, that's what they do that what they specialise in - its their job, help you move, if you get pain in certain places, O
7. I don't think i asked them enough or got enough information at the time, Q

T. Books

1. Written by mw, mums 'pregnancy for dummies, L
2. Borrowed books N
3. Read biased towards natural because that what wanted, S

U. TV

1. Water birth R

V. Midwife antenatal

2. Birth plan N
3. Massage therapist R
4. Mw- not worked labour for 20 years, M Error! Bookmark not defined.
5. Talking to mw - think they give you a leaflet N
6. Mw don't really go into detail - don't go through, should talk more not fully discussed R

W. Environment

1. Equipment to make me move around, K

2. Things to help you keep moving, L

X. Self

1. Experience, of the first time coming and having a baby S

IV. Influences on movement

A. Environment

1. Trying all the different things to do, K

2. Room - lovely, massive, big window, pool bathroom- light bright airy- really nice - closed down, L

3. Staying at home K,L

4. MLU comfortable, no beds, big cushions, baths, water birth, more room to walk, no monitor, walk around more- just more comfortable to move around - quieter dr on cl with intervention - like my own space, M

5. MLU more patient led- lead it myself- when my body wants to push, when i want to relax, rather than having to be examined - more relaxed environment, O**Error! Bookmark not defined.**

6. MLU - Freedom to move quieter, mw there all the time , Q

7. MLU whole environment- you lead this, we are not going to tell you what to do- let me get on with it but when i asked for help they told me Q

B. Midwife

1. Let's try this, lets try that - all done in my time K

2. Tried to get me going, L

3. Spoke to mw3/4:10 didn't dream you could stay at home that long, K

4. If mw says get off the bed and moving - i need to,L

5. Don't mind me = only here for the last bit - approachable, friendly, let you do what you want, what you happy with, nothing too much trouble- massive part especially second time- she has children as well,-2nd labour telling me about her relationship developed quickly - see why in job – perfect M

6. Follow guidance of mw R

C. Equipment

1. Pool - might of helped to get in different position, L

2. Just me and hubby - relax L

3. Flashing lights, special cushion, tools and gadgets, option to have a rock on seat or walk, pool, nice lighting to calm down and make it easier- just a case of you getting on with it having those little tools assisting like you've got a t home, you've got that comfort, K

4. Pool get in if want don't like get out, N

D. People

1. Mum M,L

2. Partner S

3. People who their massive L

E. Self

1. More prepared- can do it the way i want O

2. Let them help me- bit defiant - trying to do my way- understand they know more than me L

3. Pain - when in pain get up and walk around - bit of a wander and stretch N

4. Down to me - feel comfortable then don't so move around- something might feel good for a couple of mins - massage feel good then say get off R

5. How i am feeling and experiencing - depends on my body - what happens to my body as to how i feel, how i need to move but i want to try and move as much as i can R

6. Something to focus on - move left move right,R

7. Sciatic nerve - difficult to moveR

V. Differences

A. Ability to control-

1. Ability to staying calm letting your naturally do what it is supposed to K

2. Fell more in control now know what is coming - i think i will feel more in control because it will be me who dictates more than dr – O

3. Movement important - your body, your sense of self your child - being in control - if need to put me to sleep O

4. In control of body- feel less panicky- labour go easier - less stressful - less problems afterwards - having more knowledge O

5. 'you can actually cope with the pain'- important that you have choice, pressure for ,no pain relief important to have choice S

B. Individual

1. 'no one is right no one is wrong - it is what ever you are comfortable with - all fours crouching, ball -PEOPLE HAVE TO KNOW ABOUT THESE CHOICES if something is not working - you don't have to put up with this M

2. Listen to body - Read, diagrams, 'lay on your back is not the best - not helping your body to do anything - obvious from ML tools and gadgets M

3. Can only act and respond to here and now M

4. Everyone experience different - labour not same for any woman - look same but different M

5. Info and ideas impact on mind - research and info prepare - no one can ever tell you how labour is going to be - info then prepared and that makes a big difference how deal with it P

C. 'others' informing

1. Don't tell you, only recently telling - health profs M

2. Research - always changing - a bit of 'research and a bit of experience M

3. Midwives info ask questions - dr have a bit more to deal with N

D. Emotional

1. Massive thing to go through- you need help and support- things can go wrong M

2. Relationship with mw - hard going to cl and not knowing - 1st mw form attachment P.

3. Glad have massage else no info R

Women disconnection mind map lists

I. Tell me about your birth

A. Birth in control of – they

1. They kept me where i was, they ran me a bath, they tried to keep me as relaxed as possible, they broke my water, they were wonderful, kept coming and checking - she said don't need to push -i definitely need to push- i think it is a bit soon - yes, mum kows best - they weren't telling me off because i wasn't doing it right K

2. I was quiet well managed up to the end - mw got cons. Cons in meeting- 5 at once, they put me on drip - dilate me quickly- gave me an epidural- didn't want one - when i was ready to push - couldn't control - 'i couldn't control the birth well - mw turned back and i decided to push not controlled - mess - didn't need epi L

3. 1st -Life threatening PE- baby had to come out - wasn't allowed to move, kept on bed, drip- crazy- allmanic - for 1 hour, dorrs banged, lights busy hectic- nobody told you - kept you in the dark- didn't tell what going on - no choice- ignored THEY HAD A JOB TO DO - frightened no one knew what was happening - 2nd 'allowed to move- then stopped wasn't allowed- wanted to monitor 3rd allowed to go in bath - baby stress, waters not broken - left and left 'they should have seen the signs - couple of hour's she wasn't seeing signs, 'we've got to get you downstairs - section - they popped waters- they should have interfered earlier- taken off G&A - leave me string me along- difficult to deal with M

4. They are controlled by protocol – Aren't allowed to pop waters M, Mw annoyed- she hadn't put gloves on and 'you must stop(pushing) now M, Monitored throughout- policy O, Had to get out of the water because they had to check something P, IOL 3cm - 'check wether allowed ARM S

5. Realise breech 999- he guided husband through - scary lucky went ok P

6. 2nd-They let me go 12 days over, sweep 10 - IOL, pessary- next day - we will ARM - good - they could of sent me to ward - they only let you go in pool at 7cm 1st- you can start to push - musn't of been pushing hard enough- them gettig panicky - i had to go on left side- just get her out - ordeal - shock - what the hel is going on - overwhelming S

7. Women controlled by policy - Policy changed - pessary for iol can go yo ml O

8. Don't see mw in hospital till giving birth P

9. 2nd time left to own devices- not as much support - nice to have more appointments to talk P

10. Follow lead of whoever is there, they help me to get into position R

11. Not know till the day if able to go to ML N

12. They wouldn't let me get off bed - stay on monitor On bed- lying on side, wanted to move but couldn't - ask to hold sheet and watch wires - every time moved stuff moved- thought don't bother - just stay still O

13. 10 days over - they wanted to monitor me S

14. Empowering- you can cope with pain- so many ways to take pain away- almost saying you can't handle it so we give you these= actually women can S

15. Hospital - epidural - easier for them- lay on labour ward - didn't feel calm - bright lights drip and stuff S

B. Birth remembered in times, cx cm, pain

1. Overdue - pain, time cx cm K

2. Very long- home 7hrs, 2cm - i didn't have baby for 30 hours - caused a lot of problems L

3. Bad - length, aftermath (infection) put on 6 stone - swelled up L

4. 3rd - labour 2-3 - hosp 8am transfer- pain horrendous- falling out of chair experience excruciating - popped waters 10 mins there no pain relief, - mw promised- anxious-didn't get any- over 1/2 hr over in 10 mins M

5. Iol - 40+12, 24hrs pessary, con 19-20hrs, ve 2100 - 4cm, CL at 2200, diamorph 1.30-born 2.30 O

6. Painful and long - start, 8.45 hosp born 12.45 P

7. Woke early - 7.10 - 3:15, 8.30show, srm 10mins baby P

8. Due date- braxton - woke03.30, pain worse, husband 06.30, 07.30 hosp, 2cm, home, worse, 10.30 hosp - 4cm, 10.45 pool - pushed out in 3pushes 20 mins Q

9. Mday sweep - 1900 mlu, 2015 - 3cm born at 11.15 S

10. 6 days over, hosp - 7/8am stayed 1200 - went home - next day 7am - 7cm, ve - 1cm 3hrs - i wasn't dilating - epi- 1600 remember saying push at 1700 S

C. CL

1. Oh no not this again M

2. Bothered - ask mw what wrong- mw everything is fine- knew wasn't - panicked - no one was telling me - drs paeds didn't know why, didn't know forceps - nobody told me what was happening O

II. Plans for next birth

A. Control

1. Hopefully don't need interference K

2. Not make it dangerous L

3. Ml- to control birth- consultant said - labour water, crowning out 'control it to make sure you don't rip again L

4. Rather on own than iol O

5. Couldn't wear anything to cover myself up properly - got myself a skirt - so can move around O

6. Can only control self - in situation N

7. Sister controlled person good with pain, sensible - didn't have trouble with hers - successful L

8. Shown loads of positions- if not seen her wouldn't know R

9. If move, think not feel panicky through transition - 'i think i would of felt more in control of my body R

10. Feeling in control important, body - sense of self - being in control- knowing what doing, choosing own options - feel less panicky-less adrenaline- not as painful- easier won't stall O

11. No control - get home- could of done this, if they had not done that' if had that instead, more knowledge, already been through - easier - able to understand O

B. Logical

1. Age- each time (3) had intervention at end- no matter what horrendous birth - better with a baby at the end than a really nice birth and not have one - so got to think logically - better off in hospital

C. Birth unknown

1. Hope it is straightforwardK
2. Get baby out naturally as much as i canL
3. Fingers crossed not iol O
4. Wanted to do same but out of window P
5. Depends on how bad or how long what happens, could change - whatever happens at the timeR
6. Luckily baby in right position O
7. Birth could be any day O
8. Everybody different- different people different experiences - some straight out some complications - friends can't say O
9. Last time told stay at home - when in pain - why?? Now know - move L
10. If more informed handled it better K
11. No labour and no children sameM
12. People who have given birth scare you- worst bitsL
13. Birth disappointment - i wanted everything to be just right L

III. Know about movement

A. Didn't know

1. Didn't move - think if i had known - different L ,M
2. If had information - i would have made better decision - never been explained M
3. Nothing written or verbal to say Q
4. Not expect to move around K
5. Didn't expect equipment K
6. Not prepared mentally K
7. Mental block- here say K
8. Mw in labour - no other information Q
9. Expect worse thing ever Q
10. Wouldn't know where to get that information Q
11. If known - might have lasted longer at home- K
12. Don't think asked mw enough antenatal O
13. Mw don't go into detail, talk birth plan - mentioned - not fully discussedQ
14. Thought if i stayed there he would come L
15. Couldn't get in position without asking the midwife L

B. Ante natal ed

1. Nct unrelatable to experience S

IV. Influence on movement

A. CL

1. On monitor couldn't move - Couldn't get in position, wanted to be over the bed 'i just want to lean over - on monitor , if move no diamorphine – walkedO, Couldn't go to bathroom leads didn't reach - not ideal - exposed - not comfortable wee in in front of husband, mw and student O, Move around myself not a patient O, Straight on monitor- hindered moving, couldn't wear nightie- leads, bothering - took off O, 10 days overdue - they wanted to monitor - fear = being induced end up strapped to a machine which means can't move S, Fear- made to lay down, inhibit labour- slow down make difficultS, Not really much you can do hooked up to machines M

2. No options -Just do this, that's all we have gotM, If you want something, not available ' world crashing down M, Don't think as well equipted- ml options- lights free to move, gadgets, if you want to rock walk, pool - all taken away from you if not there- case of getting on with it without assisting tools - like at home L, Wanted to keep active, mw bought ball - fell off not high enough -couldn't use - cl not used to women wanting to be up and about O

3. If cl disappointed - Hospitalised, not much privacy, rushing about, rushing everywhere, bit frantic, waiting for it rather than being able to go and get myself prepared L, Don't want to be one of them women panting and sweating and in a mess on triage - want to go straight to ml L

4. Transfer - Confined to wheel chair M

5. Cl - intervention - monitors central - dr see everything - more likely to come and have a look, like personal spaceO

6. Medically led- no control over any part of it O

7. 4 bed bay - no room - couldn't walk - visiting time, curtains - men - didn't want to be out having contractions where other peopleO

8. Holding sheet, monitor, gas and air - hindered movement O

10. Diamorphine close to birth O

B. Woman's circumstances

1. Too many people - wanted everyone to go L

2. Not good set up- partner not supportive - unsettled atmosphere L

3. Grown up - know different choices you can make L

C. Mw and women relationship

1. Mw not there much S

2. If mw not had children - seen it but not lived it- how do you know- not knowing where you are coming from- relate better not a divide, relate 100% if not more if a job - shared experience M

3. Mw changed to business when weren't going right M

4. Relationship with mw, hard going to cl and not knowing mw P

V. Differences

A. Others different experiences

1. Don't want to see someone loose the plot on tv becasue i don't want that to happen to me K

2. Sister , more experience - painful but successful - more sensible than me- calm, thinking, organised knew what she wanted - if you can control at that level - calm - letting body do natural - moving around – L

3. OBEM- mw medicalised- woman standing wanting to push told her to lie down S

B. Everyone different

1. No one right - no one wrong - whatever you are comfortable with M

2. Everyone different - labour not same for any woman- look same but completely different experiencesM

3. Info & ideas has big impact on mind, prepares you but 'no one can tell you how your labour is going to be- if info makes difference on how you deal First...S

C. Research always changing

1. Combination of everything going hand in hand - research and experience M

D. Birth natural

1. People give birth for millennia - stress affects labour N

2. Affects muscles & hormones - atmosphere affects and staff - experience in life with children - midwifery relaxed and go extra mile- mw extra factor M

3. NCT give unrealistice expectation of natural birth S

E. Dr

1. Dr not concentrating on movement, have a bit more to deal with N

2. Knowing more - self will be able to dictate not doctors O

F. Emotional

1. Massive- need help and support- amazing – wonderful M

2. Until go through self - you don't know M

3. Some- labour traumatic - bit traumatic but nice me and husband at home S

4. Empowering- you can cope with pain- so many ways to take pain away- almost saying you can't handle itso we give you these= actually women can S

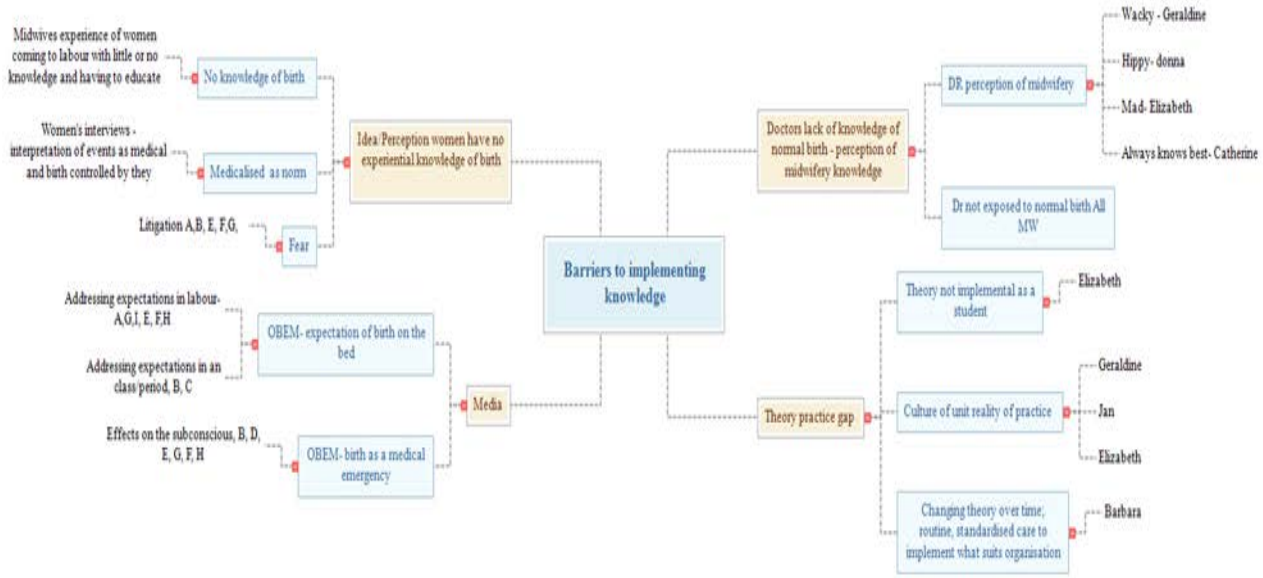
5. Midwife not always there S

G. Different enviro's

1. Labour ml 1-2-1, ward after surgery, didn't know going on, mum husband left - never had a baby- don't know what doing- unknown, understaffed- left on own L

2. If natural more encouraged on cl maybe less complications - why does it have to be seen as separate all medical if you are on their S

Midwives Barriers mind map and lists



I. Doctors lack of knowledge of normal birth - perception of midwifery knowledge

A. DR perception of midwifery

1. Wacky - Geraldine
2. Hippy- donna
3. Mad- Elizabeth
4. Always knows best- Catherine

B. Dr not exposed to normal birth All MW

II. Theory practice gap

A. Theory not implemental as a student

1. Elizabeth

B. Culture of unit reality of practice

1. Geraldine
2. Jan
3. Elizabeth

C. Changing theory over time; routine, standardised care to implement what suits organisation

1. Barbara

III. Media

A. OBEM- expectation of birth on the bed

1. Addressing expectations in labour-A,G,I, E, F,H
2. Addressing expectations in an class/period, B, C

B. OBEM- birth as a medical emergency

1. Effects on the subconscious, B, D, E, G, F, H

IV. Idea/Perception women have no experiential knowledge of birth

A. No knowledge of birth

1. Midwives experience of women coming to labour with little or no knowledge and having to educate

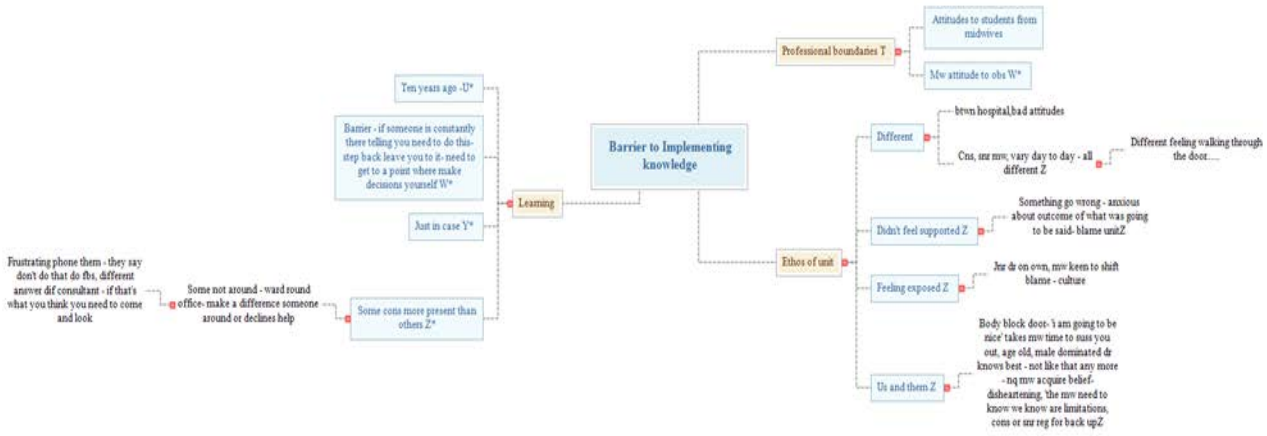
B. Medicalised as norm

1. Women's interviews - interpretation of events as medical and birth controlled by they

C. Fear

1. Litigation A,B, E, F,G,

Doctors barriers mind map and list



I. Professional boundaries T

A. Attitudes to students from midwives

B. Mw attitude to obs W

II. Ethos of unit

A. Different

1. btwn hospital,bad attitudes T

2. Cns, snr mw, vary day to day - all different Z

B. Didn't feel supported Z

1. Something go wrong - anxious about outcome of what was going to be said- blame unit Z

C. Feeling exposed Z

1. Jnr dr on own, mw keen to shift blame – culture

D. Us and them Z

1. Body block door- 'i am going to be nice' takes mw time to suss you out, age old, male dominated dr knows best - not like that any more- nq mw acquire belief- disheartening, 'the mw need to know we know are limitations, cons or snr reg for back up Z

III. Learning

A. Ten years ago -U

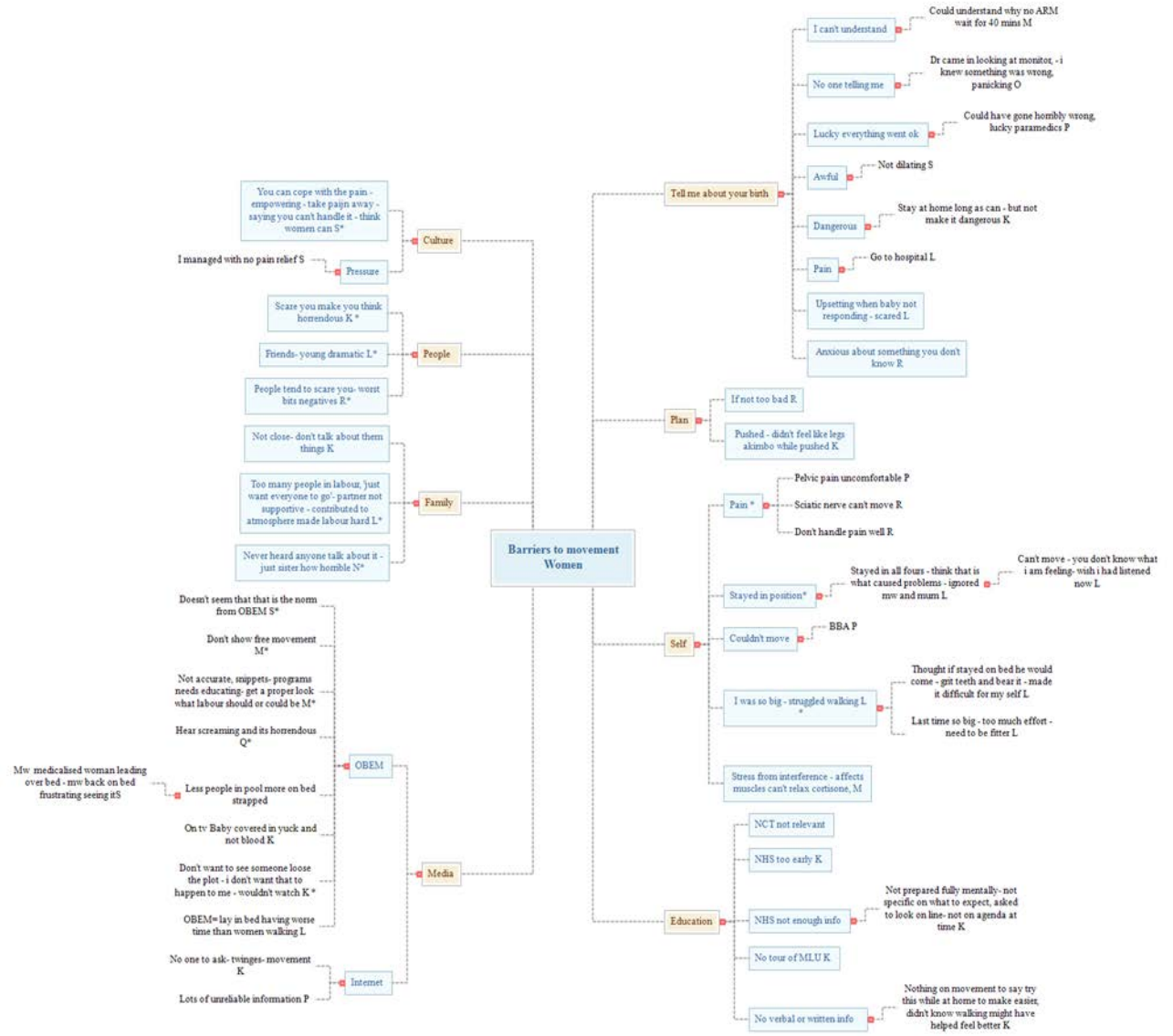
B. Barrier - if someone is constantly there telling you need to do this- step back leave you to it- need to get to a point where make decisions yourself W

C. Just in case Y

D. Some cons more present than others Z

1. Some not around - ward round office- make a difference someone around or declines help

Barriers women mind map and list



I. Tell me about your birth

A. I can't understand

1. Could understand why no ARM wait for 40 mins M

B. No one telling me

1. Dr came in looking at monitor, - i knew something was wrong, panicking O

C. Lucky everything went ok

1. Could have gone horribly wrong, lucky paramedics P

D. Awful

1. Not dilating S

E. Dangerous

1. Stay at home long as can - but not make it dangerous K

F. Pain

1. Go to hospital L

G. Upsetting when baby not responding - scared L

H. Anxious about something you don't know R

II. Plan

A. If not too bad R

B. Pushed - didn't feel like legs akimbo while pushed K

III. Self

A. Pain

1. Pelvic pain uncomfortable P

2. Sciatic nerve can't move R

3. Don't handle pain well R

B. Stayed in position

1. Stayed in all fours - think that is what caused problems - ignored mw and mum L

C. Couldn't move

1. BBA P

D. I was so big - struggled walking L

1. Thought if stayed on bed he would come - grit teeth and bear it - made it difficult for my self L

2. Last time so big - too much effort - need to be fitter L

E. Stress from interference - affects muscles can't relax cortisone, M

IV. Education

A. NCT not relevant

B. NHS too early K

C. NHS not enough info

1. Not prepared fully mentally- not specific on what to expect, asked to look on line- not on agenda at time K

D. No tour of MLU K

E. No verbal or written info

1. Nothing on movement to say try this while at home to make easier, didn't know walking might have helped feel better K

V. Media

A. OBEM

1. Doesn't seem that that is the norm from OBEM S
2. Don't show free movement M
3. Not accurate, snippets- programs needs educating- get a proper look what labour should or could be M
4. Hear screaming and its horrendous Q
5. Less people in pool more on bed strapped Q
6. On tv Baby covered in yuck and not blood K
7. Don't want to see someone loose the plot - i don't want that to happen to me - wouldn't watch K
8. OBEM= lay in bed having worse time than women walking L

B. Internet

1. No one to ask- twinges- movement K
2. Lots of unreliable information P

VI. Family

A. Not close- don't talk about them things K

B. Too many people in labour, 'just want everyone to go'- partner not supportive - contributed to atmosphere made labour hard L

C. Never heard anyone talk about it - just sister how horrible N

VII. People

A. Scare you make you think horrendous K

B. Friends- young dramatic L

C. People tend to scare you- worst bits negatives R

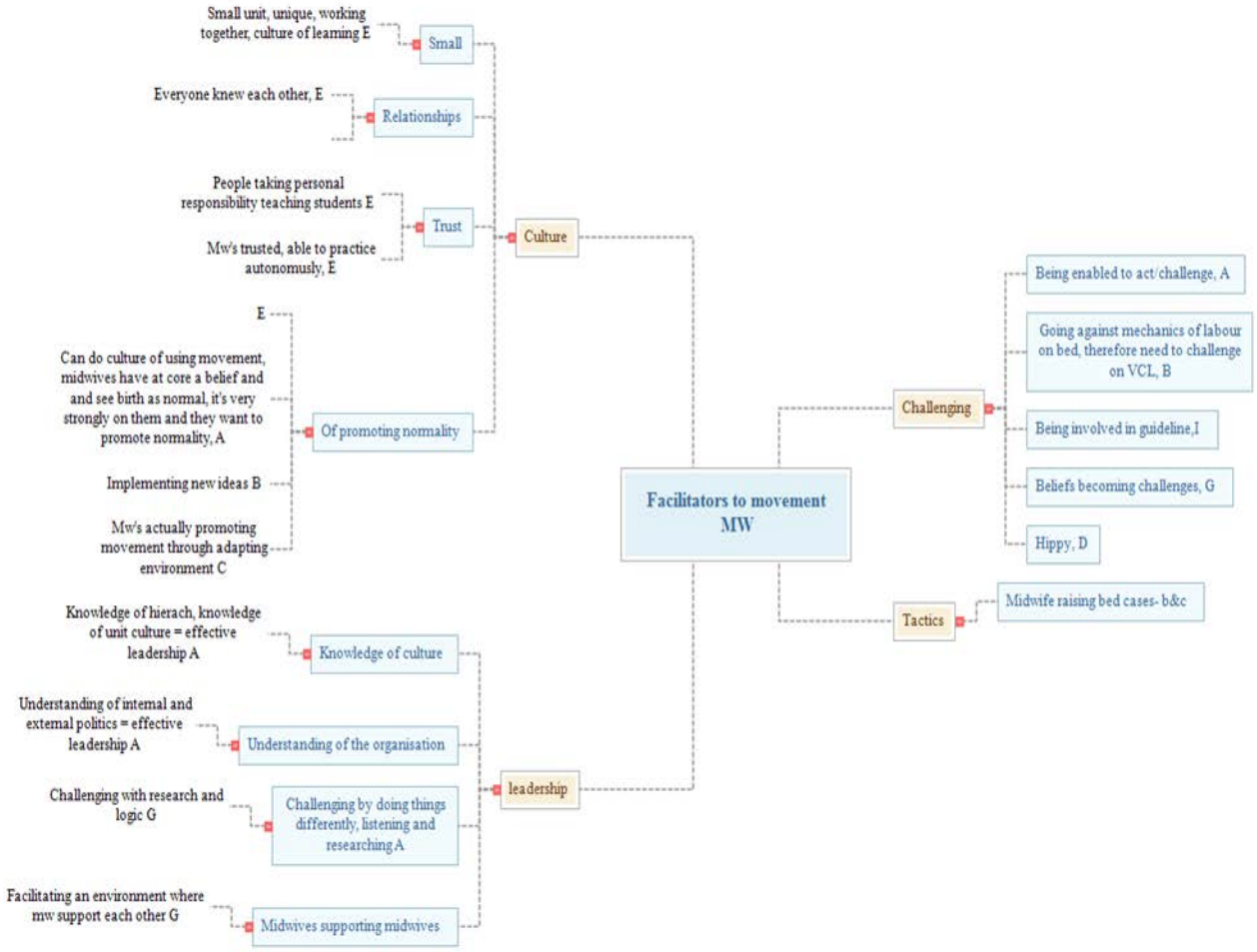
VIII. Culture

A. You can cope with the pain - empowering - take pain away - saying you can't handle it - think women can S

B. Pressure

1. I managed with no pain relief S

Midwives facilitators mind map & list



I. Challenging

A. Being enabled to act/challenge, A

B. Going against mechanics of labour on bed, therefore need to challenge on CL, B

C. Being involved in guideline,I

D. Beliefs becoming challenges, G

E. Hippy, D

II. Tactics

A. Midwife raising bed cases- B,C

III. leadership

A. Knowledge of culture

1. Knowledge of hierach, knowledge of unit culture = effective leadership A

B. Understanding of the organisation

1. Understanding of internal and external politics = effective leadership A

C. Challenging by doing things differently, listening and researching A

1. Challenging with research and logic G

D. Midwives supporting midwives

1. Facilitating an environment where mw support each other G

IV. Culture

A. Small

1. Small unit, unique, working together, culture of learning E

B. Relationships

1. Everyone knew each other, E

C. Trust

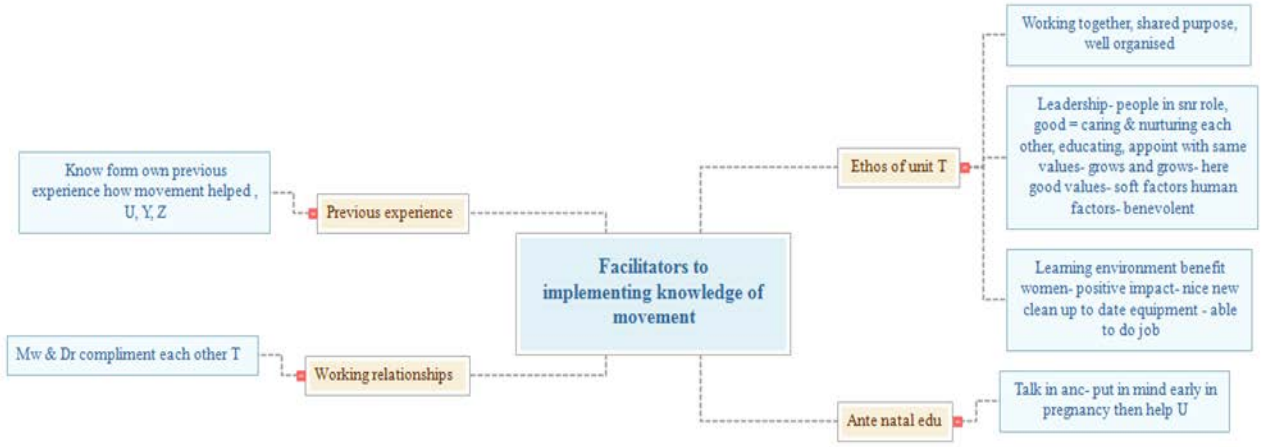
1. People taking personal responsibility teaching students E
2. Mw's trusted, able to practice autonomously, E

D. Of promoting normality

1. E, F
2. Can do culture of using movement, midwives have at core a belief and and see birth as normal, it's very strongly on them and they want to promote normality, A
3. Implementing new ideas B

4. Mw's actually promoting movement through adapting environment C

Facilitators doctors mind map and list



I. Ethos of unit T

A. Working together, shared purpose, well organised

B. Leadership- people in snr role, good = caring & nurturing each other, educating, appoint with same values- grows and grows- here good values- soft factors human factors- benevolent

C. Learning environment benefit women- positive impact- nice new clean up to date equipment - able to do job

II. Ante natal edu

A. Talk in anc- put in mind early in pregnancy then help U

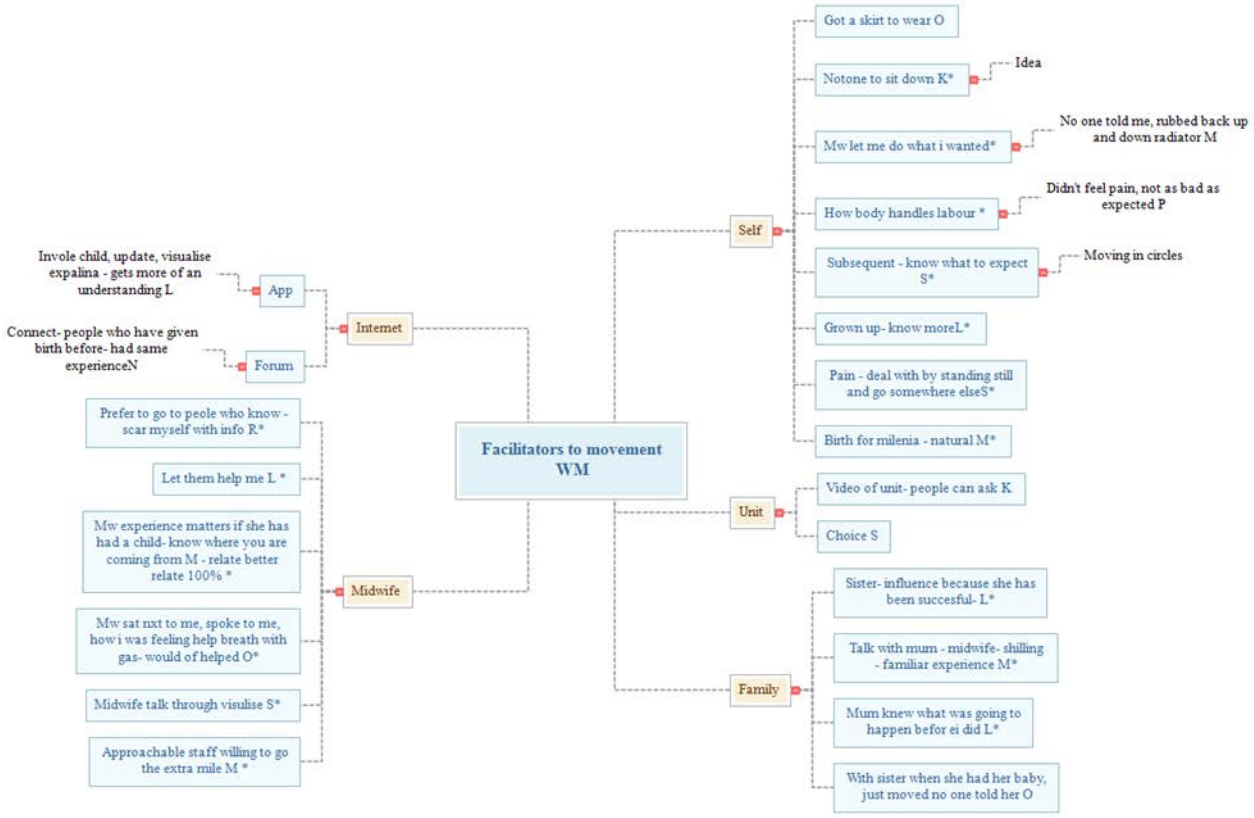
III. Working relationships

A. Mw & Dr compliment each other T

IV. Previous experience

A. Know form own previous experience how movement helped, U, Y, Z

Women facilitators mind maps and lists



I. Self

A. Got a skirt to wear O

B. Not one to sit down K

C. Mw let me do what i wanted

1. No one told me, rubbed back up and down radiator M

D. How body handles labour

1. Didn't feel pain, not as bad as expected P

E. Subsequent - know what to expect S

1. Moving in circles

F. Grown up- know more L

G. Pain - deal with by standing still and go somewhere else S

H. Birth for milenia - natural M

II. Unit

A. Video of unit- people can ask K

B. Choice S

III. Family

A. Sister- influence because she has been succesful- L

B. Talk with mum - midwife- shilling - familiar experience M

C. Mum knew what was going to happen befor ei did L

D. With sister when she had her baby, just moved no one told her O

IV. Midwife

A. Prefer to go to peole who know – scare myself with info R

B. Let them help me L

C. Mw experience matters if she has had a child- know where you are coming from M - relate better relate 100%

D. Mw sat nxt to me, spoke to me, how i was feeling help breath with gas- would of helped O

E. Midwife talk through visulise S

F. Approachable staff willing to go the extra mile M

V. Internet

A. App

1. Invole child, update, visualise expalina - gets more of an understanding L

B. Forum

1. Connect- people who have given birth before- had same experience N

Appendix 13
Categories to emerging themes - connections

From categories to Emerging themes

Connections

Categories

Emotional connections between m/w as women
Midwives as birthing women
Midwives connecting with caring health family& lived experience
Midwives connecting with intense emotion of motherhood

Obstetrician's influences
Influential colleagues
Obstetricians connecting to birth

Relationships connecting women & mw
Women's recall of birth on the ml
Relationships and movement

Connections between midwives, women and birth
Using knowledge to empower
Empowerment decision making and informed choice
Empowerment and choice
Empowering interactions
Movement and empowerment

Connecting emotions with knowledge and movement
Movement as part of physiological birth
Obstetrics and movement
Psychological impact of movement
Midwives sharing knowledge about movement- connecting women and midwives
Midwife as source of knowledge for women

Obstetricians and movement
Connecting like-minded midwives
Women connecting with themselves
Women and instinct as a source of knowledge
Women and obstetricians
Women's experience as a source of knowledge
Individuality of birth
Midwives gut instinct

Connections with the culture of birth
Culture and connection
MDT learning
Environment connecting women midwives and movement
Obstetricians and environment
Calm environment

Midwives and women connecting
Relationships and movement
Ml area, relationships, calming and control

Antenatal education connecting women and movement
Midwives connecting with compassion

Positioning – love, compassion Empathy based in a physical, emotional and sociological understanding of birth
Relationships – based on trust between a woman and her Support network, trust between a midwife and woman and the trust the woman and the midwife has in herself and birth
Empowerment – midwives and women's ability to use knowledge of Movement, facilitating women's control over their birth, decision making, Informed consent and choice to support movement and physiologically, Psychologically and socially
Culture – a positive working culture and environment, strong leadership Sharing knowledge and learning that facilitates movement and respects women's choice and physiological birth

Appendix 14
Categories to emerging themes - disconnections

From Categories to Emerging themes

Disconnections

Categories

Emotional disconnection
Between the idea and reality of midwifery
Removing privacy

The disconnecting culture and organisation of care

Separating high and low risk care
Culture
Cultural differences
Fragmented care
The impact of separated fragmented care on women
Size structure and hierarchy
Environment
Birth as controlled by 'they'
Controlled services, information, relationships, knowledge, choices
Lack of privacy
Medical practice disrupting movement
High risk medically dominated care
Technology and movement – CTG monitoring
Environment disconnecting women and movement

Disconnecting birthing women from birth knowledge

Separating knowledge and wisdom
Birth as unknown by women
Movement and not knowing
The power of knowledge
Authoritative knowledge

Disconnection between midwives obstetricians and normal birth

Knowledge of movement
Knowledge of birth and movement
Movement as unknown for women

Emerging themes

Positioning – lack of empathy, dignity and choice for women, the use of 'authoritative knowledge' and lack of physical, psychological and social understanding and knowledge of birth
Rigid boundaries – separation and fragmentation lack of relationships, hierarchy and focus on technology
Maintaining control through; medically dominated care, control of information, relationships, services and choice
Culture – environment designed around pathology and managing risk, restricting movement

Appendix 15

Emerging themes to structured themes - Connection

Emerging themes to structured themes - Connection

Emerging themes

Positioning – love, compassion Empathy based in a physical, emotional and sociological understanding of birth
Relationships – based on trust between a woman and her Support network, trust between a midwife and woman and the trust the woman and the midwife has in herself and birth
Empowerment – midwives and women's ability to use knowledge of Movement, facilitating women's control over their birth, decision making, Informed consent and choice to support movement and physiologically, Psychologically and socially
Culture – a positive working culture and environment, strong leadership Sharing knowledge and learning that facilitates movement and respects women's choice and physiological birth

Structured themes based on Schein (2017) definition of culture

Appendix 16

Emerging themes to structured themes - Disconnection

Emerging themes to structured themes - Disconnection

Emerging themes

Positioning – lack of empathy, dignity and choice for women, the use of 'authoritative knowledge' and lack of physical, psychological and social understanding and knowledge of birth
Rigid boundaries – separation and fragmentation lack of relationships, hierarchy and focus on technology
Maintaining control through; medically dominated care, control of information, relationships, services and choice
Culture – environment designed around pathology, managing risk and restricting movement

Structured themes based on Schein (2017) definition of culture