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## **Women's views on partnership working with midwives during pregnancy and childbirth.**

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### **Summary**

**Objective:** To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth.

**Design:** A qualitative study was used to explore women's experience of partnership working with midwives. Data was generated using a diary interview method throughout pregnancy and birth

**Setting:** 16 women were recruited from two district general hospitals in the South East of England

**Findings:** Three themes emerged from the data: organisation of care, relationships and choice. Women described their antenatal care as 'ticking the box', with midwives focusing on the bio-medical aspects of care but not meeting their psycho-social and emotional needs. Time poverty was a significant factor in this finding. Women rarely described developing a partnership relationship with midwives due to a lack of continuity of care and time in which to formulate such relationships. In contrast women attending birth centres for their antenatal care were able to form relationships with a group of midwives who shared a philosophy of care and had sufficient time in which to meet women's holistic needs. Most of the women in this study did not feel they were offered the choices as outlined in the national choice agenda (DoH, 2007).

**Implications for Practice:** NHS Trusts should review the models of care available to women to ensure that these are not only safe but support women's psycho-social and emotional needs as well. Partnership case loading models enable midwives and women to form trusting relationships that empowers women to feel involved in decision making and to exercise choice. Group antenatal and postnatal care models also effectively utilise midwifery time whilst increasing maternal satisfaction and social engagement. Technology should also be used more effectively to facilitate inter-professional communication and to provide a more flexible service to women.

**Keywords:** Women's views, Partnership relationships, Organisation of care, Choice, Midwives,

## Introduction

The 'Changing Childbirth' Report (DoH, 1993) heralded a new era for midwives and women, offering women choice, continuity and control, and midwives a platform from which to practise midwifery as truly autonomous professionals. Since the publication of the Changing Childbirth report numerous pilot projects have been evaluated, offering women a more personalised, women centred service and midwives the freedom to manage a caseload, practising the full range of midwifery skills (Walsh, 1999; Benjamin et al., 2001; Fleming and Downe, 2007). However, this has occurred at the same time as NHS Trusts have been required to adopt a risk based approach to care, driven by policies and protocols and subjected to severe shortages of midwives and financial constraints (Beake and Bick, 2007; National Health Service Litigation Authority (NHSLA), 2013). A recent Kings Fund report revealed that whilst the birth rate in the last decade has increased by 19% the number of midwives has only increased by 12%, with a consequential increase in the workload for midwives (Sandall et al., 2011).

Whilst caseload midwifery practice and continuity of care are associated with better birth outcomes and greater satisfaction for women (Fleming and Downe, 2007; Devane et al, 2010; Sandall et al 2015), the provision of consistent care, by a competent practitioner who women can trust, has been identified by women as more important than knowing the midwife during birth (Green et al., 2000). There is a dearth of evidence in the literature demonstrating that women want to work in partnership with the midwife or to be given fully informed choices. Studies repeatedly identify that women want to be able to trust the professionals who care for them, and be involved to some extent in decision making, but many then want to 'go with the flow' and allow midwives to guide them on their journey through childbirth (Lundgren and Berg, 2007; Edwards, 2010; Leap, 2010). In order to achieve this midwifery care needs to be provided through a model that supports continuity of care.

Studies of partnership caseload midwifery care have demonstrated lower rates of induction and augmentation of labour (North Staffordshire Changing Childbirth Research Team, 2000; Fleming and Downe, 2007), epidural usage, reduced levels of perineal trauma and higher rates of normal births (Benjamin et al., 2001; Page et al., 2001; Milan, 2005; Fleming and Downe, 2007) when compared with conventional models of care. In addition, partnership schemes have been shown to achieve high levels of continuity during birth, with between 85 and 95% of women being delivered by a known midwife (North Staffordshire Changing Childbirth Research Team, 2000; Fleming and Downe, 2007; Leap, 2010).

The partnership model has been implemented across a range of midwifery practices in New Zealand, however Mander (2011) argued that there is a lack of evidence to support its implementation. Moreover, the notion of equality within the partnership model espoused by Pairman and Mcara-Couper (2006) has been challenged by some authors who argued that midwives have power over the relationship, due to their professional knowledge and their position within the maternity services hierarchy. To suggest that equality is a fundamental principal of

partnership ignores the position of power held by the midwife (Freeman et al., 2004; Leap, 2010). Moreover, midwives working in a caseload model need to establish realistic strategies to ensure an effective work-life balance, if they are to sustain this way of working, avoid burnout and manage women's expectations about what the caseload midwife can realistically achieve within her role (Sandall, 1997; Stevens and McCourt, 2002; Page, 2003; Fereday and Oster, 2010).

The notion of partnership working has been critiqued by a number of authors across health and social care disciplines. Bidmead and Cowley (2005) explored the meaning of partnership from a health visiting perspective. The health-visiting model of care has close parallels with midwifery where the emphasis of midwifery led care is in supporting the woman and her family through a normal life event within a community setting. Bidmead et al (2005) also identified the power relationship in decision making, recognising that this does not need to be equal but is predicated on the notion of working together, a concept that closely aligns with Freeman's (Freeman et al., 2004) shared decision making model in midwifery. Hook (2006) concluded that whilst a number of studies identify the benefits of a partnership relationship, none of the work that she reviewed confirmed that partnership was present or how it was viewed from the user perspective.

The plethora of government reports (DoH, 1993, 2000, 2004, 2007, 2012a) and policies supporting choice for, and partnership with women, are aimed at improving the quality of care, however there is evidence of only limited implementation in some areas (Beake and Bick, 2007). Recently the NHS in its five year forward plan, has identified the need for models of midwifery care to be reviewed to support women's choice of place of birth and to provide opportunities for midwives to set up NHS funded midwifery services to support midwifery centred care (NHS, 2014). In addition, increasing focus is being placed on utilising technology more effectively to provide paperless records and a more responsive service more fitting for twenty first century care (NHS, 2014)

## **The Study**

### *Aim*

To explore whether the UK Government agenda for partnership working and choice was realised or desired for women during pregnancy and childbirth.

### *Design*

A qualitative methodology was used to explore women's views on whether they perceived that they had experienced a partnership relationship with the midwife. The dominant paradigm that underpinned this study was social constructivist (Holstein and Gubrium, 2005) which focuses on behaviour and studies how phenomena are constructed using a range of methods (Silverman, 2010) and regards social reality as constructed through social interaction (Avis, 2005). In this study I was interested in the social processes that participants engage in when forming a partnership relationship and how these are interpreted.

### *Participants*

Midwives recruited sixteen women during the initial booking interview at approximately ten weeks gestation, using a purposive sampling approach (Table 1). The Midwife gave the women a letter explaining the study and an information leaflet to take away, which provided full details of the study. If the woman indicated an interest in being involved in the study the midwife gave the woman's details to the researcher (SB). This led to a follow-up meeting where the researcher fully explained the study and gained informed consent. Recruitment continued until data saturation was achieved, identified by the lack of any new themes emerging from the data (Charmaz, 2006).

### *Ethical Considerations*

Participants were provided with written information and signed a consent form to take part in this study. Women were advised that their participation was voluntary and that they could withdraw from the study at any point. The women's anonymity was ensured by the use of a pseudonym. Ethical approval was gained from the NHS Ethics Committee (08/H0714/73) followed by local Research and Development approval at the two NHS Trusts where this study was undertaken.

### *Data Collection*

Data was collected by means of a diary-interview method, which allows researchers to clarify the diary entries to ensure a clearer understanding of the participants meaning, thereby improving internal consistency (Jacelon and Imperio, 2005). This was a solicited diary (Milligan et al, 2005) with an open format to allow women the freedom to record the issues and events that were most significant to them. Guidance was provided in the diary to ask women to include the reason for their visit, whether they had met the midwife before and how they felt after the appointment. The diary was maintained through the antenatal, intrapartum and postnatal period. The diary was returned to the researcher prior to the interviews at 34 weeks gestation and two to four weeks after the baby's birth. All interviews were conducted in the women's homes (n = 31). The interviews were digitally recorded with consent, and were semi-structured in format, following a series of prompts based on the work of Green et al (1998). Additional prompts emerged from the diary entries from comments that were considered important to the women, therefore providing richer data.

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**Table 1: Sample prompts from the Interview Guide**

Tell me about your first visit with the midwife?

How do you feel about your relationship with the midwife?

Do you feel the midwife has offered you choices?

Prompt Can you give me an example?

Is there anything else that you would like to share with me?

Eg of specific issue from the diary

From Green (2000) – questions that may result in assessing women's experiences of the quality of their care:

. whether she ever had conflicting/confusing/inconsistent advice

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. whether there was always someone available when wanted  
. whether she felt adequately informed  
. whether she felt in control of what caregivers did  
. whether care was felt to be deficient in anyway.  
Green (2000)

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### *Data Analysis*

Data analysis is often an iterative process and whilst there is a structured process during the formal stage, themes and ideas started to emerge during the research process which were captured in a reflective journal and contributed to the formal analysis stage. A thematic approach was used to interrogate the data for categories to emerge (Charmaz, 2006) and empirical codes to be identified (Gibson and Brown, 2009). I immersed myself in the data by reading the transcripts a number of times. Areas that I identified as significant were themed and a code was attributed which described what I thought was going on. In order to maintain consistency throughout the process a memo was ascribed to each code, which described what I interpreted to be the meaning for each coded segment. MAXqda software was used to support the analytical process, enabling an electronic codebook to be developed, including coding memos and a record of decisions taken when amending or realigning the data (Gibson and Brown, 2009). It was also important to acknowledge the influence of the insider perspective, as a midwife and mother, and to recognise the impact that my experience brought to the collection, analysis and interpretation of the data (Burns et al, 2012).

### **Findings**

Following analysis of the data three main categories emerged which were identified as:

- organisation of care
- relationships
- choice

#### ***Organisation of Care***

Organisation of care described how maternity services were organised in relation to women's contact with the service and subsequent midwifery care (*knowing the system*) and women's experience of care by the midwife and the factors that impact on the quality of that experience (*experience of midwife-woman interaction*).

#### ***Knowing the System***

The frequency of antenatal appointments, particularly in the first half of pregnancy, was identified as an issue by most of the women in this study. Prior to revised guidelines on antenatal care by the National Institute for Health and Clinical Excellence (NICE), most women in the UK received an average of thirteen antenatal appointments. In 2008 it was recommended that healthy primigravid women should receive an average of ten visits and multigravida women seven. This was particularly

noted by multigravida women in the study, for whom the NICE guidelines on antenatal care (NCC-WCH, 2008) had been implemented since the birth of their other children.

*'It's just the three week thing and having that six week gap you know, I would have liked to have another appointment. The only thing I would say is that um, I don't know why or whether there is any possibility of having more frequent appointments. It would be good if they said come back in three weeks unless you think you need to come back earlier'. (Grace, third pregnancy, community midwife care at the GP's surgery)*

A reduced schedule of antenatal visits for healthy women may be economically sound and not associated with adverse physical outcomes for the mother and baby, but does not always meet women's needs for psychological support and information and is associated with lower levels of maternal satisfaction in relation to midwifery care (Dowswell et al., 2015). Grace felt that having to wait for six weeks between antenatal appointments was too long, and she would have preferred to be offered more frequent antenatal appointments. Women's knowledge about how to access a midwife between appointments was also variable. Some women said that if they wanted to contact a midwife they were advised to call the delivery suite. However, for some women this presented a barrier as they felt that they should only call the delivery suite if they had a significant issue.

*'I could have accessed the central number and left a message for her, but I didn't really feel that I should, I didn't feel that it was an emergency if I could see my GP'. (Ava, first pregnancy, community midwife care at GP surgery)*

This resulted in some women waiting until their next antenatal appointment unless they required specific medical treatment. A few women adopted alternative strategies to negotiate the system either leaving a message at the antenatal clinic for the midwife to contact her or calling the birth centre;

*'I've phoned her up on a couple of occasions when I know she's been working at the birth centre, just to ask questions and she has been very, very informative and helpful, but you know she encouraged me at those times to phone her...'*  
*(Sophie, first pregnancy, attended a birth centre for her antenatal care)*

Whilst women expressed a range of approaches that they used to access a midwife during their childbirth experiences, there did not appear to be a clear communication strategy informing women what they should do if they needed to see a midwife in between visits.

*Experience of midwife: woman interaction*

Many of the women in this study talked about the midwife *'ticking the box'*, and some suggested that the midwife spent so much time completing the midwifery records, that there was no time left for anything other than the physiological measurements:

*'...all the way through it has felt very much like a very medical exercise so it's like, we've got to get your history, we have a number of very basic checks we've got to do, we've got to check your blood pressure, your urine, we've got to check any swelling etc, like tick, tick, tick, so very functional, very medical in that respect, not anything that was different from that, anything more emotional...'*  
(Lily, second pregnancy, community midwife care at GP surgery)

Women recognised that midwives needed to complete certain medical checks, but identified that this did not give them any space to talk about the things that were important to them. This was compounded by the fact that most women were only allocated between five to ten minutes for the antenatal appointment;

*'I felt a bit like I'm on a production line'. Go in, yes your blood results are fine, keep taking tablets, hear the baby's heartbeat, blood check, blood pressure check and right you're gone, she just wants to see you, get you out of the room and go onto the next patient, in the quickest possible way...'* (Ella, first pregnancy, shared care between Consultant and community midwife)

Women frequently described the antenatal appointment as functional or related the experience to feeling like they were on a production line. Women described the antenatal appointment in relation to the medical aspects of the appointment but did not describe the interaction with the midwife as meeting their psycho-social or emotional needs.

## **Relationships**

In this study a partnership relationship was defined as:

*'A dynamic relationship that recognises the autonomy of both partners and I based on mutual co-operation and shared responsibility. It enable reciprocity and facilitates shared decision making through a process of negotiation based on trust and respect, recognising and valuing the experiences that each partner brings to the relationship'.*

The two sub-categories identified within this theme and discussed in this paper are 'women's perspective' and 'interpersonal interactions'.

### *Women's perspective*

This encapsulated the aspects of midwifery care that women identified as important to ensure a positive childbirth experience. The most noteworthy was the extent to which women experienced



continuity of care from a midwife with whom they were able to build a trusting relationship. Whilst ten of the women in this study received continuity of care, only five of these women felt that they had formed a relationship with the midwife;

*'...really that they are there to support me in my choices and what I want to do, accepting that, you know, that they're the medical people so if there's something then I totally accept what they're saying or what they want to do... it was very much 'we want you to have the experience that you want to have, and we'll help you to do that, and we'll do it together', so there was a lot of, I guess, 'how do you feel? What do you want to do? Have you thought about this? Have you thought about that?' (Evie, first pregnancy, attended a birth centre for her antenatal care)*

Women attending the birth centre did not always see the same midwife. Continuity of care in this scenario was provided by midwives who had a shared philosophy of women centred care, adopting a social model of care (Kirkham, 2003). Continuity of carer alone did not necessarily result in the development of a partnership relationship with the midwife. Some women described the lack of emotional support that they experienced during pregnancy despite achieving continuity:

*'I think she's met it in terms of the mechanics of it but maybe a bit lacking in the, the emotional sort of thing... maybe it's my unrealistic expectation of what a midwife is supposed to do, you know, they might think, 'I'm not an agony aunt, I'm not a counsellor'.... (Jessica, first pregnancy, community midwife care at the GP's surgery)*

Women who did not receive continuity of care or carer were unable to form a relationship with the midwife during the antenatal period:

*'I sort of hoped that you would see the same midwife..., but because I keep seeing different people they are just all very functional, and I think I expected more of a relationship; ...so I think that's the thing I found the most frustrating is, you just never see the same person so it's very difficult to build any kind of rapport with anybody...' (Ava, first pregnancy, community midwife care at the GP's surgery)*

A number of women received care from the community midwives attached to the GP surgery and seemed to be frustrated with not having the same midwife providing all of their care; the care they received was fragmented, medically focused and did not meet their emotional needs. A few women experienced continuity of care or carer from the community midwife or at the birth centre, where the philosophy of care was consistent, and these women described a positive experience of their care.

### *Interpersonal interactions*

Interpersonal interactions encapsulated the extent to which the midwives' style of communication met the women's needs in relation to information exchange, advice and response to questions. When women talked about where they got their information from, nearly everyone talked about the internet and using childbirth forums or 'Google':

*'I should probably ask the midwife because getting all your information from Google is probably not the best, but there are certain websites like midwife centre where you do get midwife consultants...'* (Grace, third pregnancy, community midwife care at the GP's surgery)

Women who received their antenatal consultation in a birth centre environment were generally allocated much longer appointments than women being seen by a community midwife in the doctor's surgery or health clinic. As a result of this, these women identified that they could go to the birth centre with a long list of questions and would feel that by the end of the appointment all of their questions had been answered:

*'I go in armed with quite a lot of questions. C and I will talk about things and we will make notes... I suppose now I am keen over the next couple of weeks to maybe really pump the midwives for as much information on labour and any bits of advice they can give me really.'* (Sophie, first pregnancy, attended a birth centre for her antenatal care)

Women receiving care at the GP surgery identified that midwives responded at an appropriate depth and breadth to the questions they were asked but did not instigate discussions specifically related to the woman's stage of pregnancy or preparation for birth.

*'I think talking; the real benefit I would get out of the midwife as opposed to the medical support would be just talking about birth. Because that's ultimately what you're building towards and I felt like that's the only thing we didn't really, talk about particularly.'* (Lily, second pregnancy, community midwife care at the GP's surgery)

A significant factor in forming a partnership relationship was having enough time to make an emotional bond, which occurred for the women receiving care in the birth centre. Where midwives were constrained by surgery appointment times consultations were generally identified by women as much shorter and described as a very mechanistic experience with the midwife generally not having time to answer questions, leaving women feeling that they were not being adequately prepared for becoming mothers.

## Choice

Choice has been a central concept in health care policy within Britain over the last two decades, ostensibly as an attempt to give service users a sense of control regarding the care options available to them (Symon, 2006). This study explored women's experience of choice, particularly around the 'choice guarantees' within the 'Maternity Matters' document (DoH, 2007), and to determine the extent to which women either wanted to be involved in decisions, or contributed to decision making during their pregnancy and birth.

### *The extent to which women were offered choice*

The women in this study did not remember being offered a choice regarding who would provide their antenatal care; it was just assumed that it would be the midwife attached to her GP's surgery:

*'I don't think that I was actually offered a choice. I don't know that I was actually sort of told, well you can see this person, or you can see that person. I think I was probably asked are you happy to have shared care with the GP'. (Ruby, third pregnancy, shared care with Consultant and community midwife)*

The women who specifically talked about choice of carer generally mentioned this in relation to being offered shared care, however, they all stated a preference for midwifery led care because this was perceived to be more pregnancy focused:

*'I like the, even though I've said it's quite a medical focus through the midwives, I still prefer the midwives than the GP's. I think there's something about seeing a GP which makes it feel like a medical condition, whereas, I think it happens to be the GP's surgery where I have the appointments but its midwife led definitely and makes it feel pregnancy related rather than illness related'. (Lily, second pregnancy, community midwife care at the GP's surgery)*

This is an interesting distinction and raises questions of what it is about the consultation that is seen as a medical focus and whether this is different from a medical model of care? Women described the physical care undertaken by midwives as medical, for example the physiological measurements of blood pressure. However, Lily describes it as the focus on pregnancy as opposed to illness that makes this distinction between midwifery led care and GP care.

Most of the participants did not discuss place of birth with the midwife. It was assumed that they would give birth in the local maternity unit. A further issue for some women was that they were asked to make the decision about place of birth at the initial booking appointment at around ten weeks of pregnancy, without any information on which to make a decision:

*'...they said, 'well, which hospital do you want to go to?' and I said, 'well, I'm not from the area so how would I make a decision about which hospital? How do I find out information about it?' 'Well they're all good or bad, they're much of a muchness really'. (Megan, first baby, community midwife care at the GP's surgery)*

Women also would have liked to revisit those discussions later in the pregnancy, when they had a clearer idea about what the options were. When discussing postnatal care women talked about the reduced schedule of home visits after birth and women's experiences of attending postnatal clinics as an alternative to the midwife visiting a woman at home. Many women viewed the clinics negatively, identifying the stress of transporting themselves and their new baby to a clinic so soon after giving birth as unsupportive:

*'...the pressure to also come in to the clinic to see somebody rather than them come for home visits, yes she was putting a lot of pressure, I just thought on the one hand you're saying to new mothers make sure you get lots of rest, take it easy and then you want me to come in to the clinic'. (Emily, second pregnancy, attended a birth centre for her antenatal care)*

However, a small number of women appreciated having control over the timing of the visit at the drop-in centre whereas when the midwife was visiting the home the women had no idea what time the midwife would arrive:

*'That's another thing actually that I found really frustrating, um that you are just told that it's going to be between eight and six, that is no help at all, because you can't, you want to be at least, up and washed, you know, even if you are not dressed, you know...'(Daisy, first pregnancy, community midwife care at the GP's surgery)*

#### *Influences on decision making*

In maternity units, where medical power is at its most dominant, the doctors and midwives are perceived as the experts and argue that interventions are necessary to ensure a safe birth for both mother and baby. This use of coercive power ensures that women comply with the wishes of obstetricians and midwives (Horton-Solway and Locke, 2010). This experience was illustrated by Emily who had planned to birth in a standalone birth centre, but, because of post maturity was transferred to the Maternity Unit, for her labour to be induced as dictated by hospital policy:

*'...things you're told is that they're the medical people and you basically must listen, um to what they're saying and they decide certain things and that really*

*was determined I guess the way we behave and you know again what happened at my labour as well. They're the professionals and even though I kept asking they decided. Um, so that is generally the impression that most people get is you don't have much choice, they decide on your behalf'. (Emily, second pregnancy, attended a birth centre for her antenatal care)*

Emily felt strongly that her pregnancy was low risk and she was unhappy about the rigid application of the twelve day rule, without being provided with an opportunity to discuss alternative options. Most of the women in this study talked about the midwife guiding them to make decisions and viewed this positively, largely because they felt that they did not have the knowledge and experience to decide themselves:

*'I know the midwives are there to, you know, to help you through it and I know they're there to guide you. And I will take every single bit of help and guidance that they give'. (Amelia, second pregnancy, community midwife care at the GP's surgery)*

Women are more likely to want the midwife to guide care when they have a relationship of trust which is associated with knowing the midwife providing care (Edwards, 2010). Sometimes women felt under pressure when the midwife made assumptions about the decisions they would make. Isabelle described a conversation with the midwife about how she was going to feed her baby:

*'But they, I know they always try to sway you in one direction anyway. Like for the breastfeeding, I think, I don't know if I wrote it down but um...the first midwife I saw was like, 'you are going to breastfeed obviously?' you know...'. (Isabelle, first pregnancy, community midwife care at the GP's surgery)*

Isabelle had not considered breast feeding as her mother had bottle fed all of her children. It was this conversation that prompted Isabelle to research the benefits of breast feeding over artificial milk feeding and following this she did decide to breast feed her baby. Isabelle commented however, that she felt the midwives should present both options to women. Women described feeling empowered to contribute to the decision making process and make informed choices when they were provided with sufficient information to help them to make a judgement:

*'I felt that I was fully informed actually and also I felt if there was anything that I wanted to look into a bit more I was quite happy to ask about that and I was never fobbed off, I was always told that that was an option to look into and where to get the information from...'(Ruby, third pregnancy, shared care with Consultant and community midwife)*

Most of the participants were able to cite examples of where they felt that they had been fully informed to contribute to the decision making process. However, this did not always occur and sometimes there was an issue of whether the information was provided in a timely manner. Where women were provided with written information in advance and this was supported by a discussion with the midwives, women felt empowered to make informed decisions.

## **Discussion**

This study set out to explore whether the UK Government's agenda for partnership working was realised or desired by women, and if this facilitated informed choice to support shared decision making. The midwife:woman interaction was influenced by the organisation of care and the cultural environment that care was provided in. Women in this study described receiving a more woman-centred approach to care when they attended a midwifery led unit (MLU) for their antenatal care than when they received care in the community, at the local surgery, supported by the community midwife. Whereas historically community midwives provided continuity of care during the antenatal and postnatal period, this study identified that community midwives were increasingly unable to provide continuity of care to women. In addition, community midwives were constrained by appointment slots, unlike midwives working in MLU's, resulting in consultations of between five to ten minutes in length. In this time constrained environment women felt that whilst their medical needs were met, their psych-social and emotional needs were not. The pressure of time and the strategies the midwives used to complete the task in the timeframe available, resulted in women not asking questions and midwives only seeking to find out answers to the medical aspects of care. Hunter (2006) has argued that when midwives are unable to provide a reciprocal relationship with women they respond by becoming professionally detached and work in a task orientated manner in order to provide emotional balance.

Most women described care as functional and used the term '*ticking the box*' to describe their interaction with the midwife. This mechanistic process was described as similar to a production line or conveyor belt, metaphors that have been described in medical approaches to care (Arney, 1982; Martin, 1992; Oakley, 1993, Bryson and Deery, 2010). The medical model of care was predicated on the belief that childbirth is inherently risky and led to the shift from community to hospital where care was managed by doctors (Benoit et al, 2010). The medical model was described as a rationale scientific approach to care that was perceived as only normal in retrospect. Care was provided in the controlled environment of a Consultant unit under medical scrutiny because childbirth was perceived as a medical event (Van Teijlingen, 2005; Bryers and van Teijlingen, 2010). This is despite evidence that supports a midwifery model of care that recognises childbirth as a normal physiological process and is based on a partnership relationship, which supports women's choice and autonomy (Bryers and van Teijlingen, 2010; Pollard, 2011, Soltani 2012). The safety and cost effectiveness of midwifery led models of care and home birth has been recognised (Hattem et al, 2008, Hollowell, 2011). In addition, midwifery led care is associated with reduced levels of

intervention, higher rates of spontaneous birth, improved maternal satisfaction and comparable rates of neonatal morbidity and mortality compared with obstetric led care (Sandall et al. 2015).

The medical model of care is in conflict with a philosophy of care recommended by numerous Department of Health reports which promote the importance of midwives building a relationship with women and working in partnership (DoH, 1993, 2000, 2004, 2012a). The conflict of trying to establish a relationship with women whilst keeping an eye on the clock, knowing that the consultation has only been allocated five to ten minutes, places even more pressure on midwives who are expected to work in a bureaucratic environment whilst meeting women's needs to develop personal relationships (Bryson and Deery, 2010). The dominant perspective is from the masculine medical model which uses time as a powerful tool to control and disempower women versus the feminist midwifery model which uses time to support women's activity (Simonds, 2002). Midwives working under the time constraint enforced by the availability of surgery time, ultimately adopted an 'industrialised conveyer-belt model' in an attempt to meet their work needs, fully recognising that they were not meeting women's relationship needs (Finlay and Sandall, 2009).

In order for a partnership relationship to develop both parties need time to get to know one another, to understand what each partner brings to the relationship and for the midwife to find out what the woman wants from this experience (Fahy and Parratt, 2006). The majority of the women in this study did not form a partnership relationship with the midwives caring for them because there was insufficient time during the antenatal period for this to happen, even though ten of the sixteen women described achieving continuity of care from the midwife.

The findings from this small scale exploratory study, suggest that the majority of women do want to be cared for by a small number of midwives with whom they can form a relationship. In order to achieve this, women need to be cared for in an environment where there is sufficient time for them to ask questions and to be seen by a small group of midwives who share a philosophy of care which is women centred, or within a partnership caseload model where the woman gets to form a relationship with one or two midwives. Women's experience of maternity care has been seen to be enhanced if they are cared for by a known midwife and form a relationship of support and trust with that person (Edwards, 2010; Wilkins, 2010). In this environment, women appeared to feel more in control because they felt that the midwife would endeavour to provide care in response to their wishes as far as possible (Green et al., 1998).

Maternity care in this study was provided in a prescriptive 'one size fits all' model and most of the women in this study were unable to participate actively in care decisions or empowered to be partners in their care. The exception to this was where women were seen for all of their care in the midwifery led unit; where care was provided within a woman centred philosophy and women were given time to actively participate in decision making.

Most of the women in this study talked about not knowing that there was a choice in relation to place of antenatal, intrapartum or postnatal care. If women are to be empowered to share in decision making then they need information, provided in a timely manner and the opportunity to discuss the ramifications of the options available to them. The recurring theme of a lack of time, identified by both the women and the midwives in this study, appears to be a significant factor hindering women's choice.

### **Limitations**

It is acknowledged that the findings of this small-scale study cannot be generalised more widely which is in keeping with a qualitative research methodology. This study provided rich descriptions of the women's experience of midwifery care, but it is recognised that it could not capture the full range of women's experience in the UK or the full range of midwifery care settings. Moreover, the midwives acting as gatekeepers to the women recruited to the study, may have selected women in cognisance of the fact that an exploration of the partnership relationship could reflect on their own practice. However, whilst it is not possible to determine the extent that this may have occurred, the women in this study appeared to present a very balanced view, identifying positive and negative aspects of the midwifery care that they received.

It is also important to recognise that the interpretation of the data are inevitably subjective and that a different researcher analysing the transcripts may have identified different themes and applied a different interpretation of the findings. However, during the process of analysis I frequently reviewed the coding tree to ensure that coding of sections from the transcripts was consistent over time. Also robustness was demonstrated by using verbatim quotes from the participants to illustrate emerging themes, which enables others to judge the trustworthiness of the findings for themselves. In addition examples of disconfirming evidence were presented when they emerged during the research process.

### **Concluding Remarks**

This qualitative study has provided a small group of women, with an opportunity to identify the issues that are important to them, from the perspective of the relationship that they form with the midwife providing their care and the extent to which they are offered choice in relation to their care. The concept of partnership working has been promulgated for almost twenty years and whilst a number of studies have addressed women's satisfaction with maternity care, this study contributes a perspective specifically on partnership relationships from the women's point of view. Women in this study wanted to experience midwifery care that was personalised and provided by a small group of midwives. Whilst the benefits of midwifery led continuity of care are known (Sandall et al, 2015), this study contends that despite political support for partnership relationships and informed choice, women in this study were predominantly not experiencing a partnership relationship or information on which to contribute to the decision making process.



Despite the guarantees outlined in '*Maternity Matters*', in relation to the four national choice guarantees, most of the women in this study were not offered choice in relation to the personnel or the place that care would be provided (DoH, 2007). The women in this study were predominantly articulate middle class women, but despite this they were unable to negotiate the system to engage fully in their care. In addition to this, midwifery promotes itself as being predicated on a social model of care but the women in this study identified that the care provided by community midwives was mechanistic, bio-medically focused and time bound, therefore more in line with a medical model of care (Van Teijlingen, 2005; Bryers and van Teijlingen, 2010). Partnership relationships are founded on a shared decision making model where both partners have autonomy and where the women's views and expertise are valued. However, the lack of time for midwives to provide information to women and to discuss options, made it very difficult for many of the women in this study to engage at a level of partnership or to be offered informed choices.

Further research is needed to identify clearly what is meant by partnership and if a relationship between a health care professional who holds coercive power can ever be equal to that of the service user receiving care from that professional.

### **Recommendations for future practice**

That partnership caseload models should be adopted more widely as these are associated with improved outcomes and levels of satisfaction for women, are safe and appear to be economical when compared with traditional care models (Walsh, 1999; Page 2003; Devane et al., 2010). Whilst shortages of midwives are used as an argument for not adopting this model, Sandall et al. (2011) argued that redeploying staff and using support workers effectively would enable midwives to concentrate on the role for which they have been prepared.

That technology is utilised more effectively to enable maternity records to be accessed online, which would also facilitate inter-professional sharing of information (DoH, 2012b). The increased availability of tablet computers could save midwives time, enabling maternity records to be reviewed beforehand, thereby providing more time to concentrate on the woman's needs during the consultation. In addition, text based technology could be used to send women a text giving a short time slot when the midwife is likely to attend for home visits (Table 2).

That group antenatal and postnatal care is implemented more widely as this has been shown to provide a more meaningful experience for women and make better use of the time available to midwives (Walker and Worrell, 2008). This CenteringPregnancy® approach was originally introduced in America and was recently piloted in Australia where it was found to increase maternal satisfaction and provided opportunities for social support, friendship as well as education and care (Teate et al, 2011).

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**Table 2: Biographical Data of Study Participants**

Pseudonym	Age	Parity	Occupation	Socio-economic classification <sup>1</sup>	Partners Occupation	Ethnicity
Ruby	37	P2	Phlebotomist	L12.3	Sales Advisor	Caucasian
Olivia	41	P5	Hairdresser	L12.2	Hairdresser - (own business)	Caucasian
Jessica	36	P0	Lecturer	L3.1	Lecturer	Caucasian
Chloe	21	P1	Hairdresser	L12.2	Electrical Engineer	Caucasian
Emily	37	P1	Investment Banker	L2	IT Consultant	Black African
Sophie	38	P0	IT Service Manager	L2	Heating engineer	Caucasian
Lily	36	P1	Marketing Director	L2	Finance Director	Caucasian
Evie	40	P0	Finance	L2	Finance	Caucasian
Grace	33	P2	Journalist	L3.1	Journalist	Caucasian
Amelia	35	P1	Nursery Manager	L7.2	Security Manager	Caucasian
Daisy	29	P0	Paediatric Nurse	L3.2	Airport Security	Caucasian
Isabelle	32	P0	Relocation agent/student	L9.1	Mature student	Caucasian
Megan	36	P0	Head of Marketing	L2	Genetics Researcher	Caucasian
Ella	29	P0	Property lawyer	L3.1	Publishing	Caucasian
Lucy	31	P0	Bar Worker	L12.1	Retail Manager	Caucasian
Ava	30	P0	Industrial Engineer	L3.1	Construction Site Manager	Caucasian

<sup>1</sup> ESRC Classification L1-6 – Class 1: Managerial and Professional; L7 – Class 2: Intermediate; L8-9 – Class 3 Small employers and self employed; L12-14 – Class 5 working class

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