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## Author's Accepted Manuscript

Coping and Help in Birth: An investigation into 'normal' childbirth as described by new mothers and their attending midwives

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Title.

Coping and Help in Birth: An investigation into ‘normal’ childbirth as described by new mothers and their attending midwives.

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Abstract

Objective: to investigate how ‘normal’ childbirth is described by new mothers and their attending midwives.

Design: a qualitative, reflexive, narrative study was used to explore birth stories using in-depth, un-structured interviews.

Setting: 21 new mothers and their 16 attending midwives were recruited from the locality surrounding a district general hospital in South Wales, United Kingdom (UK).

Findings: the findings identified that the mothers wanted to cope with labour and birth, by breathing through it and using some birth interventions with the help of knowledgeable midwives. Midwives aimed to achieve ‘normality’ in birth but also commonly utilised birth interventions. Consequently the notion of ‘normal’ birth as not involving interventions in birth was not found to be a useful defining concept in this study. Furthermore, current dichotomous models and theories of birth and midwifery in particular those relating to pain management did not fully explain the perspectives of these women and their midwives.

Implications for practice: dichotomous models and theories for birth and midwifery practice and those which incorporate the term ‘normal’ birth are shown to be not entirely useful to fully explain the contemporary complexity of childbirth in the UK. Therefore it is now necessary to consider avoiding using dichotomous models of birth and midwifery in the UK and to instead concentrate on developing integrated models that reflect the real life current experiences of women and their midwives.

### Highlights

Pairs of stories from UK women and their midwives about their ‘normal’ birth were analysed and identified that:

- Women want to cope with labour and birth, with the help of knowledgeable midwives.
- They want to do this by breathing and using some birth interventions.
- Midwives aim to achieve ‘normality’ in birth but commonly utilise birth interventions in particular to manage pain.
- Normal’ birth is not a useful defining concept.
- Current dichotomous models and theories relating to birth and midwifery, separating the normal from the abnormal and non-intervention from intervention, do not fully explain the perspectives of women or their midwives.

### Keywords

Women’s views; Midwives’ views; normal birth; dichotomous models.

## Introduction

In the UK, midwives practice in all birth settings as lead carers for women throughout 'normal' childbirth, whilst at the same time working with obstetricians to provide care for women experiencing complications (Department of Health (DoH), 2010). This situation has developed throughout the 20<sup>th</sup> century and early 21<sup>st</sup> century during which childbirth has arguably taken place in what might be termed a 'contested space' (Martinez, 2004). In this context the contested space is between 'midwifery' and 'obstetrics', the 'normal' and the 'abnormal' and the 'low-risk' and the 'high risk' (Blaaka and Schauer Eri, 2008; Johanson, Newburn and Macfarlane, 2002; Liamputtong, 2005; Sargent and Bascope, 1996; van Teijlingen and Bryar, 1996). The space may be seen as being 'contested' because it appears that birth occurs "where there is a 'continuous confrontation of two or more referential codes'" (Martinez, 2005, 799). Blaaka and Schauer Eri (2008, p.345) refer to it as caring for women 'in different belief systems'; Walsh (2010, p.486) refers to polarised approaches to birth and states that 'there is mounting evidence that childbearing women's experiences of birth are often shaped in the uneasy space between the two'.

In order to make sense of the differences between midwifery and obstetrics theories and models of childbirth were constructed. These first emerged in the 1960s and proliferated in the UK in the 1980s and 90s up to the present time (Bryar and Sinclair, 2011; van Teijlingen and Bryar, 1996). The development of theories and models for birth and midwifery has not progressed in the same way or to the same level of sophistication as it has in nursing. Instead, theorists have commonly simply set the 'medical model' of childbirth against a 'midwifery model' with the former being more technocratic than the latter, which is more holistic and 'social'. Such 'dichotomous' models in which practices, philosophies and approaches are divided into two with little or no apparent appreciation of the middle ground are common in midwifery and obstetrics (Annandale, 1988; Bryar, 1995; Bryar and Sinclair, 2011; Davis-Floyd, 1987; Davis-Floyd and Davis, 1996; Hunter, 2004; Oakley, 1999; Porter, 1999; Rooks, 1999; Sargent and Bascope, 1996; van Teijlingen, 2005; Wagner, 1986, 1994, 2001).

However, Davis-Floyd et al., (2009) proposed that dichotomous models may not be entirely helpful and stated that some midwifery philosophies and models appear to resist all aspects of the medical / technocratic` model whilst a few are less oppositional and allow for some recognition of medical/scientific influences. These latter models commonly include

what are called ‘humanistic’ approaches, which bridge the divide between a technocratic (medical) model and a holistic (midwifery) model. This paper proposes a need to abandon all dichotomous models in midwifery and to instead utilise a less polarised approach, which is more appropriate to reflect current midwifery practice and childbirth in the UK.

Dichotomous models of maternity care propose that midwives operate in an either/or way; they either adopt a clinical / medicalised approach or a more ‘with woman’ approach (Crozier et al., 2011; Davis-Floyd, 1999; Hunter, 2004; Leap and Anderson, 2004; McCrea et al., 1998; Odent, 1984). Such models were developed to increase insight and understanding in midwifery and maternity care at a conceptual level and are widely cited. However they are limited in that they are potentially only useful to explore situations at each end of two opposites (De Vries, 1993; van Teijlingen, 2005) when “in practice, a whole range of combinations of the two ways of operating can be seen. In terms of a scale from a total obstetrical practice to a total midwifery practice, all working practice is somewhere in between” (van Teijlingen, 2005, p.4).

Women’s choices about how they want to give birth have also commonly been considered in a dichotomous format, setting interventionist, technocratic delivery against physiological, holistic birth (Christiaens et al., 2013; Lazarus, 1994; Nelson, 1983; O’Dougherty, 2013; Pilley-Edwards, 2005). However, much the same as for midwives and midwifery practice, it is logical to assume that many women’s wishes for birth or their experiences of it are not completely technocratic or holistic.

One example of a dichotomous model/approach relates to pain in labour. A widely cited model was proposed by midwifery researchers Nicky Leap and Tricia Anderson in 2004. They undertook research into approaches to preparing for birth and they included women, men, midwives, childbirth educators and doulas as participants. They concluded that there were two approaches to pain in labour; the “pain relief paradigm” and the “working with pain paradigm” (Leap and Anderson, 2004, pp.32-34). The working with pain paradigm refers to how pain is a vital aspect of physiological and normal labour and that good support can help a woman to cope with this pain by using her own natural endorphins. In this paradigm the midwife’s role is to reduce sensory stimulation to the woman in order to facilitate endorphin release (Leap and Anderson, 2004). In contrast the pain relief paradigm is based on the premise that labour pain is unnecessary and even barbaric in the modern world.

It includes the belief that the benefits of analgesia outweigh any risks, and that the midwife's role is to offer appropriate relief to eliminate the pain of labour and birth (Leap and Anderson, 2004).

However, the findings of this study do not support such dichotomous models. The midwife participants appeared to know what women wanted and supported them to cope with pain in labour; the women wanted to cope with labour at the same time as expecting some pain relief. The birthing women and their midwives also seemed to want to avoid interventions whilst at times requesting and performing them.

This paper reports on the findings of a qualitative, narrative study of birth stories. It discusses the aim and the methods used in the study before going on to report the findings, which are discussed here in terms of Leap and Anderson's (2004) dichotomous model and which reflect ideas of coping and help in midwifery and childbirth. Dichotomous models are thereby shown to be not always sufficiently subtle or nuanced to fully explain the practice of midwives or the experience of birthing women in the current UK context.

#### Aim

To investigate how 'normal' childbirth is described by users of maternity services (new mothers) and their attending midwives to gain insights into current perceptions of 'normal' birth.

The World Health Organisation definition of normal birth was utilised in the study and is defined as: 'spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition (WHO, 1997 p.1).

#### Setting

In the UK the Birthplace in England Study (National Perinatal Epidemiology Unit (NPEU), 2012) reported on the outcomes of over 64,000 births from 28 sites throughout England and found that giving birth is generally very safe in the UK, and that midwifery-led units appear to be safe for the baby whilst offering benefits for the mother in childbirth (NPEU, 2012). The study informed the current National Institute for Health and Care

Excellence (NICE) guidelines for care in labour (2014), which recommend that health care providers must offer all types of birth setting and support women in their choice of place of birth. Multiparous women are advised that homebirth or midwifery-led unit birth results in lower rates of interventions with perinatal outcomes that match those in an obstetric unit whilst nulliparous women are advised that a midwifery-led unit is particularly suitable for them, for the same reasons. However the study reported here was undertaken prior to the publication of the Birthplace in England Study in a locality surrounding an obstetric-led maternity unit within a district general hospital in South Wales. At the time over 90% of women in the area gave birth in the district general hospital whether they were experiencing a 'normal' pregnancy or not.

## Design

A qualitative, descriptive approach was taken in eliciting narratives of women's birth stories and those of their attending midwives. The study included women who had experienced 'normal' birth, along with the midwives who attended the births. An ontological and epistemological perspective, which recognises how stories constitute and shape social reality and how the telling of stories helps create self and meaning, underpinned the study. The chosen method of narrative research and narrative analysis was heavily influenced by sociologist Catherine Kohler Riessman, who proposed that:

... 'Individuals [] become the autobiographical narratives by which they tell about their lives. To be understood, these private constructions of identity must mesh with a community of life stories, or 'deep structures' about the nature of life itself in a particular culture. Connecting biography and society becomes possible through the close analysis of stories' (Riessman, 2008, p.10).

This seemed to resonate with the research aim and the study was further influenced by the work of psychology theorist Donald Polkinghorne (1995) and Jerome Bruner's (1986) earlier work on paradigmatic and narrative thought. Polkinghorne (1995) stated that whilst the paradigmatic mode of narrative thought refers to tightness of analysis, logic, proof and reasoned hypotheses the narrative mode refers more to locating the experience in time and place. Education Professor and narrative researcher Kimberly Oliver (1998) discussed these two approaches and concluded that the former develops general knowledge, which can be



formal and abstract, but that the latter produces insight and understanding about the participants. The latter was therefore used to explore the narratives of women and midwives in the context of giving birth 'normally' in a hospital in the UK. Sociologist Arthur Frank's suggestion that people construct their own realities through sharing their experiences also infused the study (Frank, 2008). This was particularly in relation to his ideas around how the story/ies represent a world view that is typical of some people in particular social situations and how societal narratives are embedded within them (Frank, 2002b cited in Holloway and Freshwater, 2007 p. 88).

#### Ethical considerations

A favourable ethical review was received from the local National Health Service (NHS) Research Ethics Committee and approval was given prior to commencing the study. The Head of Midwifery gave her permission to undertake the study and to access the midwives and their clients for the purposes of the research. Following appropriate fully informed consent, and in order to achieve maximum recall the interviews were set up within two to six weeks of the babies' births. The new mothers were interviewed at their homes and the midwives were interviewed at the maternity unit, community antenatal clinic or at their homes, according to their wishes. All names used throughout the field notes, research journal, transcriptions and writing up are pseudonyms to protect the participants' identity and to maintain anonymity.

#### Participants

Women were eligible to be invited for inclusion if they were fluent in English, aged over 16 and had experienced a normal birth as defined above. The study was also restricted to women who had been well throughout the childbearing process. This was to ensure that participants were physically and emotionally well enough to take part and that the story they would tell would be likely to be about the normal birth and not about any complications or ill health that may understandably cause concern for them. The inclusion criteria were also set in order to protect ill or otherwise vulnerable women from taking part in the study. Suitable women were identified by community midwives at postnatal visits and 21 women agreed to participate.

Prior to the data collection period community midwives attended information sessions at which the researcher (SD) set out the aim and objectives of the study and informed the

midwives of the recruitment strategy. They were reminded of the WHO definition of normal birth (1997) and were asked to recruit their clients whom they considered to meet all the inclusion criteria. While there were no set criteria for assessment of women's 'wellness' and suitability for recruitment the community midwives were asked to use their knowledge and experience to identify suitable 'well' women. The women participants were all of Welsh/English heritage, were English-speaking, aged between 16 and approximately 36 years old appeared to be from a range of socioeconomic backgrounds. Ten women had recently given birth to their first baby, six to their second baby and five to their third baby. All gave birth at gestations between 38 and 42 weeks and all babies were born head first and without the use of instruments to deliver them. Midwife participants were required to have had at least one year's post-registration experience in the UK; in fact the participating midwives all had more than two years' experience.

If a woman consented to take part in the study and met the inclusion criteria the attending midwife was then also asked to take part; all except one invited midwife agreed to participate. In the one case where the midwife felt unable to take part, the woman was thanked for her interest and she was not interviewed for the study. See Table 1 for the list of participants and other potentially relevant information. The stories and the analysis of them refer to the use of interventions e.g. artificial rupture of the membranes (ARM) and the analgesia used; therefore this information is included in the table.

Table 1 is Participants.

Name	Gravida	Midwife	Artificial Rupture of Membranes conducted - as referred to in the story/ies	Analgesia referred to in the story/ies
Martha	II	Wendy	Yes	TENS Entonox
Eleri	I	Amanda	Yes	Entonox & Pethidine
Amy	III	Carolyn	Yes	Entonox & Pethidine
Elin	I	Carolyn	Yes	TENS & Entonox
Vicky	II	Carolyn	No	Entonox
Mel	I	Kathy	?	Tried Entonox

Anwen	I	Denise	Yes	Bath, Entonox & Pethidine
Claire	II	Zoe	No	Entonox & Pethidine Wanted Epidural
Emma	I	Zoe	No	Bath, Entonox & Pethidine
Jo	II	Alison	No	Entonox
Daisy	I	Tara	Yes	Entonox
Kate	III	Ceri	Yes	Entonox & wanted Pethidine
Sophie	I	Judy	No	Paracetamol, Bath, Entonox, Pethidine & Epidural
Rhiannon	II	Tara	No	Birthing Ball, Entonox, Pool, wanted Pethidine
Emily	I	Rachel	Yes	Birthing Ball, Pethidine & Entonox
Bethan	III	Nicky	No	Entonox
Jenny	III	Kathy	No	Entonox
Alana	I	Sian	No	Entonox & Pethidine
Penny	II	Tina	Yes	Entonox & Pethidine
Kelly	I	Sarah	No	Entonox & Pethidine
Isabelle	III	Carolyn	No	Entonox

Midwives had categorised all of the participants as having had a normal birth. This might be considered to limit the representativeness of the sample and the generalisability of the findings. However the study did not set out to achieve representativeness in which the sample represents the entire population as much as is possible so that the findings can be generalised to that entire population (Polit and Beck, 2014; Parahoo, 2014). Instead it set out to achieve theoretical generalisability or transferability (Lavender et al., 2004). Theoretical generalisability was achieved through selecting people who were able to provide the information that was needed about 'normal' birth. They were able to tell stories that could be used to make logical generalisations to support theoretical understanding of similar situations/phenomena in other times and other places (Popay et al., 1998). Through listening to their stories the women appeared to have varying levels of educational attainment and were

from different socio-economic backgrounds. Therefore the sample was as diverse as might be expected taking into account the sampling method and the small sample.

#### Data collection

All participants were asked to simply tell the story of the birth from their perspective, using unstructured interviews (Mishler, 1986). During the discussions long spells of narrative emerged. Field notes expanded the data available and a research journal helped to contextualise the data (Etherington, 2005). The study was also deeply reflexive, in which the researcher is clearly recognised as an integral part of the research process (Aull-Davies, 2008; Etherington, 2005; Riessman, 2008).

The data comprised of 42 individual interviews, with 21 different mothers and their 16 midwives (some midwives had attended more than one of the mothers). The interviews lasted between 15 and 50 minutes and were digitally recorded before being transcribed in full by the researcher.

All the participants knew that the research interviewer was a midwife and this might have affected how they told their stories (Darra, 2008). However it was thought that if the study had utilised the services of a research assistant to undertake the interviews the stories might have been different but there may also have been problems in recruiting people to the study. It was thought that new mothers would be more likely to agree to tell their birth story to an experienced midwife rather than to a researcher who is not a midwife, and this may also have been true for the midwife participants. Furthermore the women in the study were potentially vulnerable participants and the researcher's experience as a community midwife and her commitment to a reflexive approach meant that she was considered by the Ethics Committee to be an appropriate person to undertake the proposed in-depth interviews at this time in the women's lives.

#### Data analysis

Analysis of data is informed and underpinned by the approach and methodology of the study. Narrative analysis has no single theoretical orientation, heritage or standard methodology (Arranda and Street, 2001; Mishler, 1995; Priest, Roberts and Wood, 2002; Riessman, 1993, 2008) but for this study Riessman's (2008) approach was used and thematic

analysis was applied to the two sets of stories (those from the women and those from the midwives) as well as to the pairs of stories (each woman's and her midwife's).

The researcher (SD) undertook an iterative, reflexive process with the data throughout the interviews and in particular in writing the field notes and research journal (Aull-Davies, 2008; Etherington, 2005). The data were anonymised from the outset by allocating all participants a pseudonym and they were then managed by the expansion and development of ideas (Murphy et al., 1998) using theoretical sensitivity derived from knowledge of the literature on the topic and the researcher's own personal and professional experience (Strauss and Corbin, 1990). Thematic analysis was then undertaken (Holloway and Freshwater, 2007) which is commonly used by qualitative researchers as it can be applied to a single narrative or a series of stories (Riessman 2008). For this study the data was reduced throughout this process, and the inductive phase of the analysis was undertaken using this method, in which the collective story/ies eventually arose from the data themselves (Carter, 2004). The analysis was inductive and in-vivo whilst also taking into account the researcher's previous knowledge and experience.

Coding was followed by displaying (Miles and Huberman, 1994) or exploring the data, so that the data and the codes could be explored in a systematic way, grouping them together in different ways. Patterns emerged through iterative data complication (Carter, 2004) when creative thinking, speculation and reflexivity were used to confront the data in order to attempt to reach a new understanding about the stories that people told to construct the story that was told by the participants.

## Findings

The comparison of both sets of data revealed many similarities between the women's and the midwives' stories. Both sets of stories clearly indicated that women want to cope with childbirth but recognised that it is unpredictable and painful and that women need help with it. The findings indicated that the mothers aimed to cope with labour and birth by breathing through it whilst also using some birth interventions offered by helpful, knowledgeable midwives. Midwives utilised a number of birth interventions at the same time as aiming to achieve 'normality' in birth. Underpinning these findings were two integrated key themes of 'Coping and Help'; these will be presented here now to explain the findings.

## Coping and Help

Virtually all of the women and their midwives seemed to value ‘coping’, relaxing, breathing and not panicking. The women and their midwives trusted the women’s bodies to do what was needed, with the women also valuing the midwife’s skilled knowledge and help in this regard. Ideas of being relaxed, not ‘panicking’ and coping appeared very commonly in the stories told by the women; here are just three examples:

Emma: ‘Don’t... don’t panic though’ and ‘I know. Just don’t panic. Just go with the flow.’

Sophie: ‘it’s really hard to do like, but try and just relax and breathe []... but just try and relax as much as you can.[] But that’s what I would say just breathe and try and relax as much as you can, when you’re having them.’

Penny: ‘and just try and stay as relaxed as possible... you know [] you’re fighting against yourself, aren’t you really, you know with the contractions, if you tense you’re fighting against it, that’s how I feel, but if you’re more relaxed then you’re going with your body, rather than fighting against it....’

However, the findings demonstrate that the women also needed help to cope with childbirth, which they recognised as being unpredictable and painful. All of the women chose to give birth in hospital and all of them used Entonox in labour, which was described as if it was natural:

Nicky (Bethan’s midwife, when talking about ‘normal’ birth): ‘well then you can always say, the baby was born vaginally with no complications...that’s normal..is it normal though? I don’t know, I don’t know..all I can say is in terms of umm a birth experience Bethan, in my opinion, had a birth that required no intervention, that just relied on her body doing what it’s designed to do.’

Bethan: ‘To me I would say normal is just .....no intervention and as little pain relief as possible... umm... and obviously a vaginal delivery, but I just basically the normal, the way I perceive it is less, the less pain relief. Anything more than gas and air I feel then is you’re asking, you need help. You’re not....coping with it’

The midwives in the study seemed to be sensitive to the women’s wishes and also seemed to recognise and help the women with their own ability to ‘cope’. In Tara’s story of caring for Rhiannon Tara encouraged Rhiannon to use Entonox whilst encouraging her to stay in the birthing pool throughout most of the labour (where hospital guidelines prohibited the use of further narcotic analgesia even though Rhiannon was requesting it).

Midwife Tara (talking about normal birth): ‘I think it’s supporting the woman, not trying to do anything other than she needs to be done. It’s not saying do you want some Pethidine? Or can I make you comfortable?’

However, along with all the other women in the study, Rhiannon used Entonox even though in her case she felt that it was making her vomit. Throughout her story she vocalised her opposition to pharmacological pain relief but she still requested ‘something more’ to help her to cope with her pain:

Rhiannon: ‘I did ask Tara – just give me something, I didn’t even want Pethidine cos I knew that passed to the baby, but I think it was just the fact of you know the, in my mind as well, if I’d asked for it, I’m not going to, I don’t want it really, but it was just trying to get ..... (laughs) the pain out of my body more than anything!’

In her story Rhiannon seemed to trust Tara’s advice and the other women seemed to also value the help from the midwives, as did Emily when she stated that she felt like she was in ‘safe hands’. Emily and others relied heavily on the midwives’ expertise:

Emily: ‘Umm so just do listen to what the midwives say, you know they have been doing their job for a long time, they know what they are talking about. So for first time mums[] it’s all new to you so you think this is an alien experience but to the midwife they’ve seen somebody before you, they’re gonna see somebody after you that’s gonna go through the same thing so they do know what they are talking about... but just, just listen and be alert and just remember what you’re, what you’re in there for!’

Elin: ‘It was so reassuring because she knew what she was doing I was thinking ...Hang on if I listen to her, do what she is saying, it’ll go easier, so that’s what I done.’

The midwives’ stories referred to how they had supported the women and had cared for them according to each woman’s particular wishes. It was not always clear though exactly what those wishes were but the midwives commonly seemed to understand what the women wanted. Amanda (and most of the other midwives) talked about it in terms of mobility:

‘she could move about, do whatever she wanted to do but sometimes I felt that you know she needed encouragement to move about.’

Denise (and others) recognised the need to ensure that Anwen had the pain relief she wanted:

‘I mean she had the pain relief she needed and I felt she had the choice of what she wanted.’

Rachel respected Emily’s wishes to go into hospital and responded to her requests for examinations:

I said to her, is she having the baby at home or was she going into the hospital and she was adamant she wanted to go into the hospital’. []‘And she kept wandering about and I offered to examine her if she wanted me to examine her to see what she was doing... So I did that’

It is clear therefore that the women wanted to cope and the midwives wanted to help them to cope, whether it was through using ‘natural’ methods or by employing interventions. The midwives in this study seemed to understand that the women were able to choose what they wanted to do. For example Nicky recognised that Bethan (and other women) could be trusted to know her/their own body:

‘So I think you know she had been there before and experienced that herself.. which is you know, which is what she was telling me really, more than anything. And I think you know, you really have to listen to them, cos they do know better, you know, than us’ and ‘if they are happy where they are and things are progressing, then I don’t want to interfere with that because that’s where they want to be...’

However Kelly’s midwife Sarah felt the need to guide her about her desire to lie down:

‘even though she was coping really well, she was quite tired and she wanted to lie down, so not long after we got in to the room, she said she wanted to lie down so I sort of said to her it’s really best if you stay up and mobile and keep moving, but if you want to lie down, I talked about the left lateral position and she basically went into that position and probably stayed there most of the rest of her labour.’

The midwives appeared to be able to recognise and respond to women’s wishes in terms of not intervening but they also told stories about performing interventions, sometimes on request. One example of this appears in Wendy’s story where Martha had clearly stated that she wanted Wendy to rupture her fetal membranes against the standard guidance (NICE, 2007, 2014; Fox, 2004) and Wendy apparently rationalised with herself and complied with Martha’s wish.

Wendy: ‘it got to the middle of the afternoon and she couldn’t understand why she hadn’t had the baby because she was so quick last time, cos her waters had gone and everything, so I examined her again and she was 5 centimetres but she was ‘oh just break the waters cos I know I’ll deliver then’ and I was ‘I don’t know whether to or not’ Umm but because she wanted me to and because she’d, it was obviously a labouring cervix she was by then you could tell it wasn’t.. it was going somewhere umm the head was really low as well so I just ruptured the membranes lovely clear liquor and after that everything, the pains just cracked on umm and she delivered really easily.’

As demonstrated in Table 1 artificial rupture of membranes was a fairly common intervention in this cohort of women and Denise’s story began with references to Anwen’s labour as being normal but then she went on to explain that she performed artificial rupture of membranes. Her action then seemed to lead to further intervention (a need for Pethidine), as she clearly recognised.



Denise: 'So when I examined her, she was more or less the same as what she was. She was, I made her about 5-6 centimetres. Umm, so I A.R.Med her because she'd been up and mobile... and it was all clear liquor and the minute I A.R.Med her she started the contractions picked back up again and.... she wanted more pain relief so she ended up having some Pethidine as well.'

## Discussion

Some of the women's births did not strictly fit the inclusion criterion of the World Health Organisation definition of normal birth (WHO, 1997). Whilst they were telling their stories it became clear that Anwen was under shared care (De Vries et al., 2001) with her midwife and an obstetric consultant because of her low serum ferritin levels and concern about anaemia. Jo had previously been diagnosed with a bicornuate uterus, Bethan had polyhydramnios and had previously experienced a precipitate (very rapid) birth, Penny had a low lying placenta, Sophie had an epidural during labour and Isabelle had previously experienced a forceps delivery and a shoulder dystocia when giving birth to her first two children.

This echoes findings of a cross-sectional prevalence study of normal birth (Downe et al., 2001) in which, of the 956 births recorded as being normal or spontaneous, 596 actually fulfilled the definition of obstetric delivery. In their cross-sectional prospective survey of five obstetric units in England the researchers aimed to determine the percentage of what had been described as 'normal' or 'spontaneous' births that had actually included one or more of an identified list of interventions. During the study period there were 1486 eligible births and the researchers gathered sufficient data on 1464 of these (98.5%). They found that approximately one third of all women recorded as having a spontaneous or normal birth had actually experienced induction or acceleration of labour (often including ARM), which they noted were commonly accepted as being outside of the definition of 'normality'. This study reinforces Downe et al.'s (2001) concern about the accuracy of the label 'normal' birth.

Whether the births could be accurately defined as 'normal' or not the women and their midwives in this study appeared to value non-intervention, an emblem of the midwifery/holistic model, whilst also frequently undertaking interventions such as artificial rupture of membranes. This may be considered anathema to the midwifery/holistic model and

more characteristic of the medical/technocratic model. In relation to pain in labour in particular, Midwives Nicky Leap and Tricia Anderson's (2004) dichotomous pain paradigms theory, two opposite paradigms are presented. However, the findings from this study suggest that a more subtle or nuanced approach to pain in labour exists. All the women valued 'coping' very highly but they also readily requested pharmacological analgesia and some interventions such as artificial rupture of membranes. It was also striking that they perceived such interventions and analgesia as 'natural'.

The recent NICE guidelines for intrapartum care (NICE, 2014) mean that more women are likely to be giving birth in non-obstetric settings in the UK in the near future and consequently more midwives are potentially going to be working more autonomously and/or in teams of midwives in birth centres without obstetricians present. Midwives and women will therefore need to work together to ensure that there are appropriate levels of intervention and maternal satisfaction in birth in such settings.

The findings from the analysis of the women's stories indicated that they wanted to avoid panicking, shouting, screaming or losing control. Such references to remaining in control of oneself and 'coping' in labour are reflected in other research with childbearing women (Copstick et al., 1986, Escott et al., 2004; Lally et al., 2008, 2014; Leap et al., 2010; McCrea and Wright, 1999; Pilley-Edwards, 2005; Slade et al., 1993). Researcher and member of the Association for Improvements in the Maternity Services (AIMS) Nadine Pilley-Edwards (2005) also referred to this in her study in which she followed thirty women through pregnancy and up to eight months after the births. Her findings seem to be reflected in this study as several of the women in her study frequently referred to "letting go - but not losing the plot" (Pilley-Edwards, 2005, p.230) highlighting that there was a fine line between letting go and screaming / panicking.

The midwives also recognised the need for women to cope in labour and birth and from the analysis of the midwives' stories it was clear that their exhortations to 'stay as relaxed as possible' and to 'breathe' were reminiscent of a longstanding approach to labour, which was popularised over 50 years ago by obstetrician Grantly Dick-Read (1960). However the midwives also frequently recommended and administered pharmacological pain relief. Women's ability to 'cope' in labour can understandably be related to pain and in the

UK, women in labour may seek information about and request any of several forms of pain relief that are available in the setting where they are giving birth. They may also refuse the offer of any form of pain relief and none can be given against their will (NICE, 2007, 2014; NMC, 2015; The Human Rights Act 1998). Midwives are with women at a time when they are likely to be experiencing pain and possibly anxiety and fear (Crowe and van Baeyer, 1989, Dahlen, 2010; Gamble et al., 2007) and whilst the pain of childbirth might not always be categorised as barbaric as described by Leap and Anderson in 2004 it is clear that it is significant, and childbearing women must be trusted to categorise its intensity and nature, with some of them even feeling that it is barbaric (Kitzinger, 2006).

The challenge for midwives is therefore to be able to respond appropriately to women's wishes and to help them when they are in pain in labour. The midwives in this study demonstrated that they were generally able to avoid using pharmacological pain relief methods but that at times they also saw the need to offer it. Leap and Anderson's pain paradigms theory (2004) therefore does not seem to fully explain the phenomenon that midwives and women in the study displayed - of valuing 'coping' whilst also using some analgesia. It appears that dichotomous models such as that proposed by Leap and Anderson (2004) do not fully explain what was happening in the study. As an exemplar Tara's case demonstrates that her care met the requirements for the 'working with pain' paradigm at the same time as reflecting the 'pain relief paradigm' (Leap and Anderson, 2004). Midwife and birth activist Verena Schmid in 2011 noted something similar when she explained that dichotomous models have been useful to explain the medicalisation of childbirth. In common with Downe (2004) she recommended that midwives should move away from a dichotomous approach and towards a 'salutogenic' way of being. This way of being in midwifery and childbirth (Schmid, 2011; Downe, 2004) is founded on theories proposed by American sociologist Aaron Antonovsky (1979, 1987) in which a sense of coherence is a key concept replacing illness and risk. Schmid (2011, p.147) called for midwives to: "Work towards accepting and practising care, which combines the physiological systems with appropriate medical care and, which honours women's needs and choices". Anthropologist Robbie Davis-Floyd (2011, no page number) also offered a way forward when she suggested that:

...By adjusting our critical lens to see birth within the larger and more holistic context of cross-cultural and evolutionary perspectives, we can combine the best of what technological innovations we have to offer, whilst also embracing the wild beauty and instinctive power of the big bad wolf in the birthplace.

The 'big bad wolf' is a metaphor for nature and in this study the midwives and the women seem to have adjusted their critical lens to see birth in the way that Davis-Floyd suggests; combining what medicine has to offer with an awareness of the power of nature in childbirth. The findings from this study also seem to reflect van Teijlingen's (2005, no page number) suggestion that: "In reality people borrow aspects from both perspectives, despite the fact that, logically, they are mutually exclusive."

Whilst recognising that the findings from this study are specific to the locality in which it was set they have the potential to contribute to the midwifery knowledge base and debates around practice and service provision. A particular perspective on birth has emerged from the synthesis of the findings, as follows:

- Women want to cope with labour and birth, with the help of knowledgeable midwives.
- Women do this by relying on themselves and breathing whilst also using some birth interventions that are undertaken by their midwives.
- These findings suggest that current dichotomous models and theories of birth and midwifery have limitations. In separating the normal from the abnormal and intervention from non-intervention the perspectives of women or their midwives are not fully explained.

#### Limitations

All of the women in the study had been identified by their community midwives as having had a 'normal' birth. When they were interviewed they all knew that they had been invited to take part because the birth had been 'normal' and it is possible therefore that they were likely to express positive feelings. The labelling of the study as being about 'normal' birth and the inclusion of this label in all the invitation letters, information sheets and consent forms might have led all the participants to internalise the idea that the birth had been 'normal', with all the positive connotations that this label depicts. In future similar studies a researcher might consider not signposting the concept of 'normal' birth quite as emphatically as this may have an effect on the stories that are told.

## Conclusion and recommendations

In relation to midwifery practice the findings of this study recognise the contribution made by earlier dichotomous models of birth and midwifery, but point to a need to now move on to other less dichotomous ways of thinking about birth for midwives and for pregnant women.

This study has shown that relying on dichotomous models or ways of being are not sufficient to fully explain the complexity of women's needs or midwives' practice; this has been demonstrated through a closer examination of the use of a dichotomous model to explain how women cope and deal with pain in labour. It has shown that women want to cope in labour and that many trust their own bodies whilst also commonly relying heavily on the help and interventions offered by midwives. It has also shown that the idea of 'normal' birth does not appear to be a useful defining concept for those people most closely associated with it (new mothers and their midwives).

One might especially need to consider the findings in the environment that pertains following the Birthplace in England Study (2014). It is therefore now essential to re-consider models for midwifery and birth and to ensure that they more fully and satisfactorily explain the range of experiences and expectations of women and their midwives in the UK. Any model must result in an adjustment of midwives' "critical lens", to integrate the best of technology at the same time as "embracing the wild beauty and instinctive power of the big bad wolf in the birthplace" (Davis Floyd 2011, no page number).

In terms of education, these findings may lead to the development of new models for midwifery practice and if these were implemented into midwifery education it would affect how future midwives think about their practice. The proposed new models should aim to assist student midwives to critically evaluate their experiences in practice in which a whole range of combinations of obstetric 'technocratic' or midwifery 'holistic' ways of working exist. Pregnant women might also benefit from learning about how birth is not always completely normal or abnormal, that it is not always accompanied by high levels of intervention or by none at all. Therefore, if this study results in the development of new, less dichotomous models of birth and midwifery it has a potential to have an impact on the education and preparation of mothers-to-be.

Finally, this study points to the need for research into (and practical solutions for) how midwives and women work together. A larger study of this type might further add to the knowledge base through allowing for stratification, perhaps according to birth setting, parity and social status of the women and according to the personal and professional experience of the midwives.

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#### Highlights

Pairs of stories from UK women and their midwives about their 'normal' birth were analysed and identified that:

- Women want to cope with labour and birth, with the help of knowledgeable midwives.
- They want to do this by breathing and using some birth interventions.
- Midwives aim to achieve 'normality' in birth but commonly utilise birth interventions in particular to manage pain.
- 'Normal' birth is not a useful defining concept.
- Current dichotomous models and theories relating to birth and midwifery, separating the normal from the abnormal and non-intervention from intervention, do not fully explain the perspectives of women or their midwives.