Midwifery one-to-one support in labour:
Ethnographic study of midwife-led birth environments

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Abstract

Background: This research is about midwifery one-to-one support in labour. One-to-one support in labour is associated with improved birth outcomes. Uncertainty exists however as to what it is that produces such positive birth outcomes. UK publications advocate the midwife to provide one-to-one support in labour, but research findings question their ability to focus entirely on women due to their medical, technological and documentation responsibilities. All of these studies were based within hospital environments and none were completed in the UK. This indicates a gap in knowledge concerning how midwifery one-to-one support translates into practice in the UK and within midwife–led environments.

Methods: The aim of this research was to explore midwifery one-to-one support in labour in a real world context of midwife-led care. An ethnographic approach was completed over three case study sites (Alongside midwife-led unit, freestanding midwife-led unit and women's homes) each including ten labouring women receiving midwifery one-to-one support in labour.

Findings: Two main themes: Balancing the needs of the woman and balancing the needs of the NHS organisation. Inside the birth environment midwives used their knowledge, experience, intuition and motivation to synchronise six components. These included presence, midwife-woman relationships, coping strategies, labour progress, birthing partners and midwifery support. Outside the birth environment midwives experienced surveillance and territorial behaviours which were heightened during transfer from a midwife-led birth environment to the labour ward.

Conclusion: When a ratio of one midwife to one woman was achieved, midwives were 100% available for a woman in their care. This enabled midwives to be constantly present when required and provide total focus to tune into the needs of women and synchronise their care. Although midwives balanced the needs of the NHS organisation this did not impact on midwives capability to be present with women in labour.

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List of Abbreviations

AMU Alongside Midwife-Led unit

ANC Antenatal Clinic

BAPM British Association of Perinatal Medicine

CINAHL Cumulative Index of Nursing and Allied Health literature

CTG Cardiotocography

CQC Care Quality Commission

DH Department of Health

DHSS Department of Health and Social Security

EWTD European Working Time Directive

FMU Freestanding Midwife-Led Unit

GP General Practitioner

HCA Health Care Assistant

HOM Head of Midwifery

IRAS Integrated research application system

IUD Intrauterine Death

MDGs Millennium Development Goals

MIDIRS Midwives Information and Resource Service

MLBU Midwife Led Birth Unit

MMR Maternal Mortality Ratio

MSLC Maternity Services Liaison Committee

MSW Maternity Support Worker

NICE National Institute for Clinical Excellence

NHS National Health Service

NHSLA National health service litigation authority

NMC Nursing and Midwifery Council

NPSA National Patient Safety Agency

PALS Patient Advice and Liaison

PPH Postpartum Haemorrhage

RCM Royal College of Midwives

RCOG Royal College of Obstetrics and Gynaecology

RCT Randomised Controlled Trials

SROM Spontaneous Rupture of Membranes

TBAs Traditional Birth Attendants

UNICEF United Nations Children's Fund

UNFPA United Nations Population Fund

UK United Kingdom

WHO World Health Organisation

W.T.E Whole Time equivalent

Glossary

After pains	Cramping pains often experienced by women after birth as the womb contracts.
Alongside midwife-led unit	The midwife-led unit is situated on the same site as an obstetric unit.
Augmentation	Medication given to stimulate contractions in labour.
Amniotomy	Often referred to as artificial rupture of the membranes in medical terms or breaking the waters in lay terms.
Continuous fetal monitoring	Two transducers are placed on a woman's abdomen to continuously monitor the baby's heartbeat and the labour contractions.
Entonox	Otherwise known as 'gas and air.' It is a type of gas breathed in for pain relief.
Epidural	A form of pain relief used in labour and birth. Pain relief is injected into an area of the spine known as the epidural space which numbs the nerves. The numbness subsides as the pain relief wears off.
Episiotomy	A surgical cut to the perineum, which is the area between the vagina and back passage to assist the birth of the baby.
Freestanding midwife-led unit	A midwife-led unit which is not situated on the same site as an obstetric unit.
Fibroid	Non- cancerous growths in or around the womb.

Induction of labour	A labour that is started artificially with medications.
Instrumental delivery	Refers to forceps or a ventouse delivery.
Intravenous line	A line that goes into a vein to administer fluids
Head of Midwifery	Midwifery lead for the maternity services.
Latent phase	Early labour.
Lithotomy position	A woman lies on her back with her legs separated, flexed, and supported in stirrups
Meconium	The first intestinal discharge (poo) of the newborn infant, greenish in colour and consisting of epithelial cells, mucus and bile.
Multiparous	A woman who is pregnant and has previously given birth.
Nulliparous	A woman who has never given birth.
Oxytocin	Released naturally from the posterior pituitary or prepared synthetically. It acts to stimulant uterine contractions in labour.
Partogram	Graphical record of labour care that illustrates the progress of labour at a glance.
Perineal trauma	A tear in the walls of the vagina. This can happen spontaneously during a normal vaginal birth or by an episiotomy. Depending on the severity will depend on whether stitches are required in a theatre.

Pethidine	A painkiller used in labour, given by injection.
Postpartum	Referring to the time after childbirth.
Preceptor Midwife	Is a period of transition for newly qualified midwives in which they are supported by a preceptor to help with their learning objectives.
Primigravida	A woman who is pregnant for the first time.
Retained placenta	All or part of the placenta or membranes have stayed inside the womb after the birth.
Second stage of labour	This stage leads to birth. Women gradually feel the sensation to push and when doing so their baby is born.
Shoulder Dystocia	Is an emergency event when the baby's head is born, but the shoulders become stuck
Semi-recumbent	Lying on your back with the bed elevated at 45 degrees
Skilled attendant	A skilled attendant is an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns (WHO 2004:1).
Stirrups	A support for women's legs to hold her legs in a lithotomy position which will facilitate medical examination or intervention during gynaecological examinations and childbirth.

Supine	Lying on your back, face upwards.
Syntometrine	Injection given to help deliver the placenta and also used to stop bleeding following birth.
Syntocinon	Injection given to help deliver the placenta and also used to stop bleeding.
Ventouse	A cup-shaped suction device applied to the baby's head in childbirth, to assist the birth. Sometimes referred to as an instrumental delivery.

Chapter one

Introduction

1.1 Introduction

This chapter introduces the thesis which explores midwifery one-to-one support in labour.

The introduction commences by defining the interchangeable terminologies used in place of midwifery one-to-one support in labour and then sets the scene globally and within the United Kingdom (UK). The latter discusses the relationship between attendance of skilled healthcare professionals caring for women in labour and reducing maternal and perinatal mortality rates. The structure of this thesis is subsequently outlined and introduces all six forthcoming chapters. This chapter culminates with a reflexive account which includes the foundation of my midwifery values and beliefs and conclusion.

1.2 Defining terms

There are interchangeable terms for midwifery one-to-one support in labour in the literature, sometimes referred to as surrogate terms (Burgess 2014) or closely related concepts (Hunter 2002). These terms include continuous one-to-one support, continuous labour support (Hodnett et al. 2013) labour support (Hunter 2002, 2009; Burgess 2014), social support (Hunter 2002, 2009), being 'with woman' (L. Hunter 2002, 2009; B. Hunter 2004), continuous presence (Aune et al. 2013) and presence (Hunter 2002, 2009; Burgess 2014). Labour support focuses on the activities inside the birth environment[1] which incorporates emotional support, advocacy, information giving, and advice related to coping and comfort techniques (Hodnett et al. 2013). In addition, 'being with woman' shows very similar characteristics to labour support. This is due to the inclusion of emotional, physical, spiritual and psychological presence/support (Hunter 2002). It is thought that labour support firstly enhances the physiological process of labour and secondly, women in labour feel more in control and competent.

[1] Birth environment refers to the place where women labour and give birth.

Both are thought to reduce reliance on medical interventions (Hodnett et al. 2013).

Presence means being physically and mentally with a woman in labour and is often interchanged with being 'with woman' (Hunter 2002) and one-to-one support (Gagnon and Waghorn 1999). Presence therefore enables the carer to undertake the supportive elements, although presence has also been classified as one of the components of emotional support (Hodnett et al. 2013). It has been suggested that the most important element is the relationship between the midwife and woman (Hunter 2002; Page 2003; Hunter 2008, 2009) and this is enhanced when the midwife is engaged with a woman one-to-one (Hunter 2002) as a companion and guide (Hunter 2002, 2009). Therefore it is evident from the literature, that midwifery one-to-one support in labour encompasses the elements of labour support and presence with the added specification that the ratio is one midwife to one woman (Gagnon and Waghorn 1999).

1.3 Maternal and perinatal mortality and morbidly

1.3.1 Global perspective

Midwifery one-to-one support in labour is difficult to achieve globally due to severe shortages of midwives and other health workers (Women Deliver 2009; UNICEF and World Health Organisation WHO 2014; United Nations 2015). In fact, the WHO have advised female relatives/friends to be encouraged to provide one-to-one support in labour (Martis 2007), since they can give one-to-one attention including physical and emotional support. This does not replace the presence of a skilled assistant[2] however, which is not always a midwife. Skilled attendants supervise non-trained attendants, and have specific skills to identify the onset of labour, progression of labour, birth and delivery of the placenta.

[2] A skilled attendant is an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO et al. 2004:1).

They must also recognise a deviation from the normal physiological processes which may require assistance and interventions, while at the same time offering supportive care (WHO, ICM and FIGO 2004). The presence of a skilled assistant and the access to emergency care when complications develop have been recognised as vital requirements for reducing maternal mortality and morbidity for women and their new-borns (WHO 2006; United Nations, 2015). The timing of the presence of a skilled attendant is crucial because most maternal deaths occurred during childbirth and in the immediate postnatal period when most stillbirths and new-born deaths also occurred (WHO 2010).

The presence of the birth attendant is part of one of the Millennium Development Goals (MDGs). At the turn of the century, 189 countries committed to ending extreme poverty worldwide through the achievement of the eight MDGs (Women Deliver 2009). Seventy-five countries, which represented more than 95% of maternal and child deaths, were set targets to achieve by 2015. Two of the eight MDGs included reducing child mortality (MDG 4) and improving maternal health (MDG5) (United Nation 2015). It was envisaged as part of Millennium Development Goals, that 90% of births should be assisted by skilled attendants in 2015. Reinforcing the difficulties of inadequate numbers of trained attendants, the target was not achieved. Although on average, 71% of women did have a skilled attendant at birth, resulting in one in four who do not (United Nations 2015). In Sub-Saharan Africa and Southern Asia however, where the rates of maternal and new-born mortality are the highest in the world, only 52% of women had a skilled attendant (United Nations 2015).

The MDGs target to reduce maternal mortality[3] by 75% (WHO, UNICEF, UNFPA, and the World Bank 2007; United nations 2015) had also been missed by 2015, but a reduction of 45% was obtained (United Nations 2015). Evidence has

[3] **Maternal mortality** ratio Number of *maternal deaths* during a given time period per 100 000 *live births* during the same time-period; **Maternal mortality** rate Number of *maternal deaths* in a given period per 100 000 *women of reproductive age* during the same time-period; **Adult lifetime risk of maternal death** The probability of dying from a maternal cause during a woman's reproductive lifespan (Hunt and Bueno de Mesquita 2010: 8).

consistently shown that almost all maternity deaths were preventable (UNFPA 2009; WHO 2010; Hunt and Bueno de Mesquita 2010; United Nations 2015). In addition, the technology for preventing maternal and new-born deaths already exists. This is because identical complications occur in more developed regions, but rarely result in death (Sherratt and Odberg-Pettersson 2006). Maternal death rates remain the greatest health divide between developed and least developed countries (United Nations Population Fund (UNFPA), 2009). This is better understood when examining data showing 210 maternal deaths per 100,000 women giving birth worldwide (United Nations 2015) compared to 10 per 100,000 women giving birth in the UK (Knight et al. 2014).

It should also be considered that for every woman who dies from obstetric complications, approximately thirty more suffer injuries, infection and disabilities (Hunt and Bueno de Mesquita 2010). Generally when health systems are functioning, and quality care is made available to all women, complications are avoided or treatable and maternal deaths are prevented. Thus, maternal mortality is one of the best indicators of overall health system performance (Women Deliver 2009). Another indicator is a caesarean section coverage rate below 5%, because it signals a lack of access to emergency obstetric care (WHO 2010). The recommended range of caesarean section is ten to fifteen per cent (WHO 2015).

When mothers die during childbirth, it is rare for the new-born to survive (WHO 2010). Between 1990 and 2015, the neonatal mortality rate reduced from 33 deaths to 19 deaths per 1,000 births (United Nations 2015). The majority of neonatal deaths[4] were due to preventable causes including pre-term complications (35%), complications in labour and birth (24%) and infection (24%) (United Nations 2015). In comparison the UK neonatal death rate is 2.63 per 1,000 births (Manktelow 2015). While the UK neonatal mortality rate low, it is higher than other European countries (Manktelow 2015).

[4] Neonatal death is a baby born any time in pregnancy and lives even briefly, but dies within four weeks of birth (Manktelow et al 2015)

1.3.2 UK Perspective

In the UK, women have access to skilled assistance in the form of a midwife with the support of an obstetric and anaesthetic team. Yet evidence from the Confidential Enquires (Lewis 2007; CMACE 2011; Knight et. Al. 2014) suggests that although maternal and perinatal mortality is reduced significantly, midwifery attendance is not sufficient. This is due to the substandard care demonstrated in a proportion of the maternal mortality cases. Substandard care included failure to recognise deviations from the normal, thus failing to refer to the appropriate professional. There was also a failure to perform basic observations such as temperature, pulse and blood pressure, a lack of experience and insight into the seriousness of the mother's condition particularly in complex pregnancies. This led to the wrong emergency response in several cases (Lewis, 2007; Knight et. al. 2014).

These clinical practice issues were reiterated in a report by the Centre for Maternal and Child Enquiries (CMACE 2011) with training recommendations to go '*back to basics*' (Oates et al 2011). More recently an independent investigation at Morecambe Bay showed a dysfunctional culture within the maternity services. Such culture resulted in avoidable harm to women and their babies, including unnecessary deaths. Harm was caused by poor clinical competence, a lack of teamwork, insufficient recognition of risk and midwives in particular pursuing normal childbirth 'at any cost' (Kirkup 2015:7).

Overall, it is evident from the global and UK perspectives that the attendance of a skilled health professional provides more than a presence. The skilled attendant, which in the UK is the midwife, is equipped with knowledge and skills to perform activities inside the birth environment to keep the woman and baby safe. It is also evident from UK surveys that some activities take midwives away from the birth environment. Women have reported that they had been left alone when they felt worried during labour or shortly after giving birth (RCM and Netmums, 2009; Care Quality Commission, 2013; The National Federation of Women's Institutes (NFWI) and NCT 2013).

1.4 Structure of the thesis

This thesis is presented as seven chapters.

Chapter two presents the literature review encompassing midwifery one-to-one support in labour. It opens by setting the scene with a contextual description of the UK maternity services. The literature review reveals disparities concerning the level of presence, who should perform one-to-one support in labour, when it should happen, where it should happen and what type of model of care should be applied. As one of the disparities relates to determining who should perform one-to-one support, the analysis is not confined to the midwife as the provider of one-to-one support in labour. In addition, the perspectives of midwives and women in relation to one-to-one support in labour are described. Chapter two closes with a description of knowledge gaps and the introduction of the research aim and objectives.

Chapter three describes the methodology used for this study. It begins by exploring the decision to choice ethnography as the methodology and using elements of symbolic interactionism, to explore the real world context of midwifery one-to-one support in labour within midwife-led environments. The research protocol is subsequently explained initially with an understanding of what constituted a case, the methods used for sampling, the ethical considerations, methods for collecting data and a description of the researcher's experience of fieldwork. The chapter concludes with an explanation of the methods used for data analysis and the limitations of this study.

The findings are presented within three chapters (chapter four, five and six). Chapter four sets the scene by firstly, describing the three case study sites. This includes details about the NHS organisations, the birth environments, staffing, transfers and organisational changes. Secondly, the perspectives of midwives and women regarding midwifery one-to-one support in labour are discussed.

Chapter five describes the first of two main themes in this study. The first main theme encompasses how midwives balanced the needs of the woman inside the birth environment. This main theme consisted of six sub-themes comprising of presence, midwife-woman relationship, coping strategies, labour progress, birthing partners and midwifery support. These sub-themes are explored and

referred to as the components of midwifery one-to-one support in labour inside the birth environment.

Chapter six describes the second main theme including how midwives balanced the needs of the NHS organisation. Four sub-themes comprising of surveillance, territorial behaviours documentation and transfer from the midwife-led birth environment to labour ward are also explored.

Chapter seven draws together all the knowledge from this study. The strengths and limitations of this study are also acknowledged. Recommendations are consequently made relating to clinical practice, future research and future midwifery education. A final summary concludes this chapter and thesis.

1.5 Reflexivity

Reflexivity helped discover the 'me' in this study (Chesney 2001). This process was helped by writing in the first person to locate my '*voice*' in the research process (Newbury 2011:32). It is recognised by researchers that their professional background, perspectives therefore bias can influence the research process (Chesney 2001; Kingdon 2005; Newbury 2011) so learning to be reflexive is vital when undertaking qualitative studies.

At this stage of the thesis, it is important to be open about my midwifery philosophical discourse. I am writing this thesis as a researcher with twenty years midwifery experience. I qualified around the time of the publication of the Changing Childbirth report (Department of Health (DH) 1993) which advocated 'women centred care.' At that time, I also worked with many midwives of 20-30 years' experience in the community and hospital settings, who taught and inspired my theoretical and clinical practice that I have retained to this day. Within a medicalised culture in a hospital setting, these midwives showed me how women centred care could be accomplished by adapting the environment and creating a supportive presence. Midwives would close the blinds, position examination lamps to become a soft light in the corner of the room, mats on the floor and remove all technological equipment not required. The midwives resembled lionesses, protecting women and the atmosphere which had been created. If someone knocked for an unnecessary reason or attempted to walk into the labour room without permission, the intruder was quickly escorted out

and scolded. With the women however, midwives were gentle and sensitive. Depending on the needs of women, midwives would freely chat or remain silent, reassuring when required and were motherly in their actions, to help women get comfortable and seek emotional support. I now recognise such traits as being 'with woman' (L. Hunter 2002; B. Hunter 2004; L.Hunter 2009).

The first seven years of my midwifery career provided the foundation to my working philosophy. It followed that pregnancy and labour is a normal physiological process and that routine intervention is not necessary.

Later in my career I worked as a labour ward manager. I wanted to use the opportunity in my position to recapture a permanent version of the atmosphere created within the labour room for low-risk women that I learnt at my previous hospital. This was attempted by transforming three labour rooms into low-risk environments. The rationale was to stop having to recreate a non-clinical environment in a high-risk labour room. I did not foresee however that midwives would feel anxiety, from not having the high tech equipment available within the labour rooms when women were low-risk. I would arrive on duty to find that the low-risk rooms had been transformed back into high-risk environments. Midwives said they needed the equipment 'just in case' of an emergency. This led to questions regarding midwives confidence when caring for low-risk women and their understanding of how the environment can impact on the confidence of a woman in labour.

Further questions arose when I was coordinating the labour ward and the work activity was low enough to allow all midwives on duty to provide midwifery one-to-one support in labour. Midwives approached me and asked what they should do if they stayed in the labour room most of the time. These two aspects of midwifery practice showed me how midwives practised differently. Not all midwives felt confident to be autonomous and equipped with the skills to care for low-risk women within low-risk environments.

Although I am a midwife I started, proceeded and focused on this study as a researcher. Reflexivity helped me continually recognise how my background, perceptions and values influenced my interpretations.

1.6 Conclusion

This chapter has introduced key terms which are interchangeable with midwifery one-to-one support in labour within the literature. Global and UK perspectives were also introduced to understand the impact of having a trained attendant in labour and birth to reduce maternal and perinatal mortality. The structure of the thesis was consequently outlined. This chapter concluded with a reflexive account which included the foundation of my midwifery values and beliefs.

Having introduced the thesis, chapter two provides an exploration of the literature review which ends with the formation of the research aim and objectives.

Chapter two

Literature review

2.1 Introduction

In the research and policy literature, the term one-to-one support in labour has been used in a variety of ways. In the UK policy literature, the concept has become synonymous with high standards of midwifery care, whilst internationally, one-to-one support in labour has been the focus of research comparing maternal outcomes for different models of care and skill mix. Overall there is overwhelming evidence that one-to-one support in labour has positive influences associated with birthing outcomes, but there are still questions as to why the positive outcomes occur.

Chapter two presents the literature review which critically explores government policies, opinion papers, research papers and systematic reviews concerning one-to-one support in labour and then narrows the focus to midwifery one-to-one support in labour within different contexts. Chapter one presented a global and UK perspective of one-to-one support in labour relating to maternal and perinatal mortality and this chapter builds on that information by explaining the working context of the maternity services in which one-to-one support in labour takes place. The literature review focuses on the UK perspective while comparing to the international. The broad synthesis of the literature reveals information regarding the benefits, attributes and different labour supporters in relation to one-to-one support in labour. As the analysis narrows to midwifery one-to-one support in labour the policies, research, model of care, place of birth and midwifery training are examined. This chapter ends exposing a knowledge gap which created a research aim and objectives for this study.

2.2 The process of the literature review

The process of analysing the concept of midwifery one-to-one support in labour began by exploring the search terms ‘one-to-one,’ ‘support in labour. The search then narrowed to focus on ‘midwifery.’ A literature search was conducted using a broad search of databases dating from 1980 until 2011. The databases included British Education index, British Journal of Midwifery, Royal College of Midwives, CINAHL (Cumulative Index of Nursing and Allied Health literature), Cochrane library, Medline, MIDIRS (Midwives information and resource service), and Science Direct. During the search ‘continuous support’, ‘continuous attendance’

and ‘presence’ were added as some writers interchanged the term with ‘one-to-one support.’ These terms also introduced the phrase ‘with woman.’ In addition the search revealed different formats for ‘one-to-one’ (i.e., one2one, 1 to 1, 1-1, 1:1). The references were then checked for each document to assess for more publications. The literature search provided a variety of documents (Table 1). The literature review continued to be updated throughout the fieldwork, data analysis and writing of the thesis.

Table 1: The number of papers obtained from the literature search

Research papers	2011	2015
Systematic reviews	3	3
Randomised control trials	28 (12 excluded from the systematic review by Hodnett et al. 2009)	38 (16 excluded from the systematic review by Hodnett et al. 2014)
Surveys	6	3
Cohort studies	3	1
Qualitative studies	17	3
Observational studies	5	2
Government reports	8	5
Practice guidance	22	6
Literature reviews	7	1
Opinion papers	10	2
Retrospective analysis	0	1

Literature obtained after July 2011 had a reduced impact on the research aim, objectives and design as the protocol had been submitted to the Ethics committee and the fieldwork commenced in September 2011. The two most significant studies published after these dates were the Birthplace national prospective cohort study and research from Ross-Davie. The Birthplace national prospective cohort study (Hollowell 2011; Rowe 2011; Schroeder et al. 2011; Hollowell et al. 2011; McCourt et al. 2011) is the largest prospective cohort study conducted in England. The study collected data with reference to labour care and birth outcomes for the mother and baby for over 64,000 ‘low-risk’ births in England between 1st April 2008 and 30th April 2010 and published findings at

the end of 2011. Secondly, the study by Ross-Davie (2012; Ross-Davie et al. 2013, Ross-Davie and Cheyne 2014a, 2014b) who designed a computerised systematic observation tool, the 'SMILI' (Supportive Midwifery in Labour Instrument) to study the content of labour support by enabling a trained observer to be present in the labour room to record the woman, birth partner's and midwife's demeanour, words and actions intermittently during established labour and to record the movement of the midwife and others in and out of the labour room.

It is important to note that many of the studies were completed in North America and the United States of America where they use the professional identity 'nurse' rather than midwife. Nurses provide care in labour and postnatal care. Antenatal care however is mostly provided by obstetricians. An obstetrician (not necessarily the one who provides antenatal care) is also present for the birth (Sandall et al. 2013). This differs to midwives working in UK as they are the primary carers for low-risk women from pregnancy to postpartum unless there is a deviation from the normal. If there is a deviation from the normal, women are referred to an obstetrician.

2.3 The context of the UK maternity services

Traditionally birth was a private event and took place in a woman's home where she received one-to-one support in labour by women, but since the middle of the 20th century (Hodnett et al. 2013) within developed regions of the world such as the UK, birth changed to a public event which mostly takes place in hospitals under the supervision of obstetricians (Page 2003; Department of Health, Social Services and Public Safety, Welsh Assembly Government, DH, Scottish Government 2010; Ohaja 2012; Hodnett et al. 2013; NICE 2014). The transition of the place of birth was instigated in the UK after the publications of the Cranbrook Report advocating that 70% of births should occur in hospital (Ministry of Health 1959). A decade later the Peel Report (Ministry of Health 1970) stipulated that 100% of births should occur in hospital:

> '… the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery.'

Women were persuaded that childbirth was safer in hospital. This is still evident as 87% of births occur in hospital labour wards led by obstetric consultants (Comptroller and Auditor General 2013). Nine per cent of births occur in alongside midwife-led units, two per cent in freestanding midwife-led units, and two per cent at home (Comptroller and Auditor General 2013). Statistical evidence from the 1970's showed that birth in a hospital was not safer than the home unless the woman was very high-risk (Tew 1985). It has taken thirty years for the largest prospective cohort study conducted in England to reinforce that birth for the majority of low-risk women is safer in midwife-led units and at home when compared to hospital birth. Caution is targeted for women having their first baby at home as there was 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units (Hollowell 2011; Hollowell et al. 2011).

The shift to hospital birth changed the labour support dynamics. Birth support increasingly changed from the presence of female companions to husbands/partners from the 1960s (Hodnett 1996) and continues (NICE 2014). Midwives who mostly worked in the community were transferred to hospital (Page 2003) which altered the role of the midwife making it more complex than their predecessors experienced (Johnston and Harman 2007). Kardong-Edgren (2001) argued that a generation of midwives were qualifying and practicing in an era of increased use of technology based practices which were not evidenced based such as continuous fetal monitoring[5] rather than knowing how to provide one-to-one support in labour which is evidence based. Money has been invested in technology rather than adequate staff numbers for one-to-one support in labour (Kardong-Edgren 2001). In addition innovations have advanced information technology which has created increased documentation and therefore increased workload (Ashcroft et al. 2003).

[5] Continuous fetal monitoring is used to monitor the baby's heartbeat and the labour contractions (NICE 2014)

Hospital births have also increased interventions and operative births. The caesarean section rate in the UK has risen from below 10% in 1980 (Birth Choice UK 2014) to 26.2% in 2013/14 (Birth Choice UK 2014; Health and Social care information centre 2015). Defensive practice has been blamed for contributing to the rise of interventions and operative births. Litigation is rising within the maternity services and claims have increased by 80% in the five years leading up to 2012-13 (Comptroller and Auditor General 2013). Nearly a fifth of the spending on maternity services in the UK is for clinical negligence cover (Comptroller and Auditor General 2013; DH 2013a). The two most common reasons for maternity claims are associated with management of labour and caesarean section (National Health Service litigation authority (NHS LA) 2012a, 2012b). From a medical perspective the measurement of risk is eloquently portrayed when a consultant expressed that '*A safe labour is a labour which is over and not one to come* (Department of Health and Social Security 1980: 28).'

A change of discourse was triggered in the early 1990s with the publications of the Winterton Report (House of Commons Health Committee 1992) and Changing Childbirth for the Expert Maternity Group (DH 1993). The Winterton Report (House of Commons Health Committee 1992) questioned the evidence for stipulating hospital birth on the grounds of safety. The Changing Childbirth report was published in response to the Winterton Report and became policy (Page et al. 1999) and changed the language of maternity care (McIntosh 2013). The report stipulated 'women centred care' that included choice, continuity and control for all women accessing the maternity services (DH 1993). In response a new one-to-one midwifery model of care was introduced where a named midwife followed a woman from pregnancy to the postpartum (Page et al. 1999). The language and philosophy of care from Changing Childbirth progressed into the National Service Framework for maternity services (DH 2004) and Maternity Matters (DH/Partnerships for Children, Families and Maternity 2007) (McIntosh 2013) to enhance midwife-led care. The National Service Framework also introduced midwifery one-to-one support in labour as a separate phenomenon that focused on a ratio of one midwife to one woman in established labour (DH 2004). This standard has been advocated by NICE (2014). There is now a drive from the Department of Health to provide one-to-one support in labour, reduce unnecessary interventions and provide choices for place of birth (DH 2013a). In response there has been an increase in the development of midwife-led units (87

in April 2007 to 152 midwife-led units in June 2013) and the trend continues (DH 2013a).

2.4 The benefits of one-to-one support in labour

When analysing the literature the systematic review by Hodnett et al. (2013) is the most cited research with regards to one-to-one support in labour. Hodnett (1996) highlighted that until 1980 no study had been reported that determined whether labour support influenced birth outcomes. The systematic reviews by Hodnett et al. (2013) have consistently assessed randomised controlled trials comparing the effects of continuous[6] one-to-one support in labour with usual care[7] in hospital institutions. In all instances the experimental intervention had been labour support which included (as a minimum) three activities: presence, reassurance, and comforting touch. The most up-dated systematic review (Hodnett et al. 2013) included twenty-two trials involving 15, 288 women who met the inclusion criteria within sixteen high and low income countries including Australia, Belgium, Botswana, Brazil, Canada, Chile, Finland, France, Greece, Guatemala, Mexico, Nigeria, South Africa, Sweden, Thailand, and the United States. The main results showed that the women who had continuous one-to-one support in labour were more likely to have a spontaneous vaginal birth (19 trials, risk ratio (RR) 1.08) and less likely to have a caesarean section (22 trials, RR 0.78), operative birth (19 trials, RR 0.90) and a baby with a low five-minute Apgar score (13 trials, RR 0.69). There were significant reductions in the likelihood of analgesia or anaesthesia in labour (14 trials, RR 0.90) and less reports of dissatisfaction with their childbirth experience (11 trials, RR 0.69) and more likely to have had a shorter labour (12 trials, mean difference -0.58 hours).

Hodnett et al. (2013) acknowledged wide disparities in relation to the person providing one-to-one support in labour, the presence of birthing partners, analgesia and technology such as continuous fetal monitoring. The persons providing the support varied in their experience. In nine trials the support was

[6] Hodnett et al. (2013) use the term “continuous” preceding the concept one-to-one labour support. This will be explored later in this chapter.

[7] A midwife/nurse who cares for more than one women in labour

provided by a member of the hospital staff (midwife, student midwife or nurse); in seven trials the supporter was a doula or a woman who had given birth before, a childbirth educator or retired nurses, but they were not a member of hospital staff or the woman's social network; while in six trials the supporter was the choice of the woman including a female relative or friend or husband/partner. Comparisons of the birth supporters will be later discussed, but in brief the impact of the positive birth outcomes increased when the provider was neither part of the hospital staff nor the woman's social network (Hodnett et al. 2013).

Another variation in relation to labour support was that eleven of the trials had a hospital policy permitting birthing partners while in the other eleven trials no birthing partners were permitted. In an earlier commentary, Hodnett (1997) discussed the expectation of a larger effect due to disparities relating to whether birthing partners were permitted in the labour room. In some hospitals, women in the control group had almost no support of any kind compared with women who received support in labour from lay women or doulas. This is in contrast to the effects of comparing hospital staff providing one-to-one support in labour, against hospital staff providing traditional support in labour to 2-3 women with relatives and friends being permitted in the labour room. Epidural analgesia was routine in fourteen trials and continuous fetal monitoring was routine in nine trials and not in eight. In five further trials it could not be determined if continuous fetal monitoring was used. Continuous one-to-one support was associated with greater benefits within settings in which epidural analgesia or continuous fetal monitoring was not routinely available (Hodnett et al. 2013). Lastly, the systematic review by Hodnett et al. (2013) did not include UK organisations and some of the countries included were not representative of the UK setting. No RCTs have been carried out in the UK comparing the different outcomes obtained when one-to-one support in labour is provided by midwives, lay supporters or 'doulas' (RCM 2012).

Overall the systematic review by Hodnett et al. (2013) has provided evidence of positive outcomes when women receive one-to-one support in labour and this evidence has influenced international (Martis 2007; Amorim and Katz 2012) and UK guidance (NICE 2014) to advocate one-to-one support in labour. The systematic review did not however show why the positive outcomes happen when one-to-one support in labour occurs.

2.5 The attributes of one-to-one support in labour

The next sections will explore the attributes and activities of one-to-one support in labour that occur inside the birth environment which may influence birth outcomes.

2.5.1 One-to-one support as continuity

At the start of the literature review, a large amount of documents from the early 1990's described one-to-one care as a midwifery practice model relating to continuity. The midwifery practice model is not constrained to labour, but includes continuity from a named midwife in pregnancy, continuing during the birth and postnatal periods (McCourt and Page 1996; Page et al. 1999; Page et al. 2001; Page 2003). The one-to-one continuity practice model is also referred to as case-load midwifery (Fleming and Downe 2007; McLachlan et al. 2008; Williams et al. 2010), because one midwife is allocated to a caseload of women. This model is mainly practiced within community settings (NICE 2014). Midwives follow women, rather than organisational systems within maternity departments (Smith et al. 2009). While research has shown that continuity is highly valued by women, concern has been raised about the effects on midwives working within systems designed to provide continuity of care (Sandall 1998). The effects relating to midwives has led many NHS organisations to change to a team of midwives allocated to a caseload rather than one midwife, as this was felt to be more sustainable within the hospital and community settings (NICE 2014). A recent Government Mandate (DH 2013b) highlighted that continuity is still a target for the maternity services and connected to the concept one-to-one by stipulating that the NHS:

> 'Ensures every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period…' (DH 2013b)

Notwithstanding the challenges of continuity, a non-NHS maternity organisation named 'One-to-One' is part of a changing model of maternity care in the UK involving the commissioning of private companies to provide antenatal, labour and postnatal care for the NHS. The care is free for women accessing the services (Collins and Kingdon 2014). Data from 414 births between 1st November 2011 and 31st October 2012 showed a spontaneous vaginal birth rate of 76% for all births, (Collins and Kingdon 2014) which is higher than the national

average of 60.9% (Health and Social care information centre (2015) and the homebirth rate was 31% (Collins and Kingdon 2014) which is much higher than the national average of two per cent (Comptroller and Auditor General 2013). Audits comparing birth outcomes of women who received one-to-one as continuity against standard care have historically shown that caesarean sections and instrument births are significantly decreased (Page et al. 2001) and one-to-one support in labour is more likely to be provided (Fleming and Downe 2007; Page 2003; Page et al. 2001; Page et al. 1999; McCourt and Page 1996). Much work is required regarding one-to-one as a continuity practice model since a national survey in England showed a lack of continuity within maternity services. The feedback from women showed that only 34% of women saw the same midwife in pregnancy and 27% women saw the same midwife postpartum (Care Quality Commission 2013). The following sections will now focus on the one-to-one support in labour which is an independent concept that may or may not include continuity.

2.5.2 One-to-one support as a ratio in labour

Midwifery one-to-one support in labour is most commonly described as a ratio of one midwife to one woman (Ball and Washbrook 2003; DH 2004; RCOG et al. 2007; Adams and Bianchi 2008; Hunter 2009; Gu et al. 2011). The ratio of one-to-one is in contrast to '*one-midwife-to-many-women'* (Gu et al. 2011: 3) where midwives care for more than one woman in labour. The literature shows evidence of this latter model in Australia (Brodie 2002) Botswana (Madi et al. 1999), Canada (Gagnon and Waghorn 1999; Gagnon et al. 1997), Germany (Knape et al. 2014), Iran (Kashanian et al. 2010), Jordan (Khresheh 2009), Malawi (Gerein et al. 2006) and UK (Kings Fund 2008; Stephens 2010), where ratios range from 2 to 50 women per midwife.

2.5.2.1 Workforce analysis tool

The concept of midwifery one-to-one support in labour as a ratio is not new in the UK. The Second Report from the Social Services Committee on Perinatal and Neonatal Mortality (Department of Health and Social Security (DHSS) 1980) first highlighted the need for women to receive midwifery one-to-one support in labour by advising an increase in midwifery staffing in labour wards. The report argued 'a baby that has survived nine months in-utero and then dies in labour at a time when care and surveillances should be optimal represents a failure in obstetric care' (DHSS 1980: 29). More recently in the UK the standard of *only*

one midwife to one woman in labour has been up-dated to only be applied to low-risk women as some situations require more than one midwife to be in attendance due to the complexity of the support required (Ball and Washbrook 2003, Maternity Care Working Party 2007; RCOG et al. 2007; Ball and Washbrook 2010a; NICE 2015a). Such complexities have been analysed by Ball and Woodward (2003; Ball et al. 2003a) when they designed a workforce analysis tool (named Birthrate which progressed to Birthrate plus) to calculate the number of midwives required in a NHS organisation to meet the midwifery one-to-one standard in labour that reflected clinical need. The workforce tool allocated mothers and babies to five groups according to the degree of normality of the process and outcome of labour. Of these groups Group I and II represent normal process and outcome in labour; while Group III indicates some degree of intervention, e.g. induction of labour, forceps delivery; Groups IV and V indicate increasing levels of intervention such as epidural, high levels of support in labour, neonatal complications, caesarean sections, and multiple birth (Ball et al. 2003b: 357). This work was widely endorsed (RCOG et al. 2007, Maternity Care Working Party 2007 and RCM 2009; RCM 2010a; Quality Membership Group 2010), as:

> 'active one-to-one midwifery support for all women during established labour, with midwifery staffing levels in line with the Royal Colleges' recommendations of 1.0-1.4 WTE midwives per woman in labour, depending on the case-mix category' (Maternity Care Working Party 2007: 2).

More recently the effectiveness of the workforce analysis tool has been questioned in relation to patient safety (Sandall et al. 2011) and the ability to provide midwifery staffing that provides one-to-one support in labour (NICE 2014). These questions have arisen due to the absence of evidence (Sandall et al. 2011) which has been externally validated (NICE 2014). Allen and Thornton (2012) used a computer simulation to retrospectively analyse work activity and staffing on a labour ward to test the effectiveness of the Birthrate Plus workforce analysis tool to provide midwifery one-to-one support in labour. The findings indicated that the staffing levels recommended by Birthrate Plus were not adequate to provide one-to-one support in labour for every woman during established labour. The number of women in labour or complexity of women exceeded the number of midwives available 37% of the time when using the

Birthrate Plus tool (Allen and Thornton 2012). The study by Allen and Thornton (2012) has however been graded as low quality by NICE (2014). Ball and Washbrook (2010b; Washbrook and Ball accessed 05/06/15) have continued to develop their workforce tool (Birthrate Plus Acuity) assessment which enables midwives and managers to assess and predict labour ward staffing needs on an hour by hour or shift by shift basis, therefore working in 'real time'. NICE (2014) have stated that although pilot testing has shown that the Birthrate Plus Acuity assessment tool is useable and reliable, the validity has not yet been established. Maternity staffing requirements are complex as workloads fluctuate as in accident and emergency departments (Allen and Thornton 2012). There are also variations in service design, buildings, facilities, local geography, models of care capacity and skills of midwives and women's choices and risk status which all impact on the staffing requirements (McCourt et al. 2014).

2.5.2.2 Practice standards

The practice standard that emerged for the National Health Service (NHS) maternity care providers concerning one-to-one support in labour has probably been the clearest available to date stating that:

> 'Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time (DH 2004: 28).'

This standard has been upheld by the RCM (RCM 2010a) and NICE midwifery staffing guidance (NICE 2015a) in its entirety. Midwifery one-to-one support in labour has now become an independent standard to be audited (Working Party 2008) whether continuity of the carer in pregnancy and postpartum have been achieved or not. Audits show that 78% of maternity units in England reported that they provided one-to-one support in labour for at least 90% of women (DH 2013a). Feedback from the King's Fund maternity services inquiry have advised that more midwives would allow all women to have one-to-one support in labour (Smith and Dixon 2008). The King's Fund (2008) have also suggested however that while staffing levels are important, employing more staff may not necessarily improve safety rather safe teams need the right staff, in the right place, at the right time. The Royal College of Midwives (RCM) have responded by arguing that you need the right numbers of staff to be able to be in the right place at the right time (Warwick 2011). A semi-structured observational study in the north

west of England has shown that both midwifery shortages and ineffective deployment of midwives are the basis of many adverse events and '*near misses*' (Ashcroft et al. 2003).

2.5.3 One-to-one as continuous presence

One-to-one support in labour is described not just as a numerical allocation, but also as a "*face to face*" relationship (Newell 1997: 7). The meaning here is about the exclusive focus of supporting women in labour that reflects the being 'with woman' concept described by B Hunter (2004) and L Hunter (2002; 2009). The idea of presence is a potentially defining characteristic that appears to play a role in building relationships. Midwives describe their presence as being a 'team-mate,' 'advocate' (Blaaka and Schauer Eri 2008: 348), and 'anchored companion' (Lundgren and Dahlberg 2002: 155). To be a 'companion' was to be available to the woman, to listen, to see her situation mirrored in her body and to share the responsibility of childbirth. To be 'anchored' was to show respect for the limits of the woman's ability as well as one's own professional limits. Pembroke and Pembroke (2006:326) suggest that presence should be a "*calm presence*" in the "*midst of the emotional and physical frenzy."* Presence itself sometimes consisted of no words, but meant holding a woman in an embrace to provide emotional support (Walsh 2006a). Midwives also described their presence as being with women with their head, heart and hands (Blaaka and Schauer Eri 2008) which resulted in a satisfying experience for both midwives and women (Hunter et al. 2008). Presence has been described as central to midwifery practice and support in labour (Hunter 2002, 2009). Midwives believe that continuous midwifery presence in labour promotes normal birth (Aune et al. 2013) and increases safety, because midwives are able to pick up on subtle clues when labour is not progressing normally and alert them that assistance maybe required (RCM 2010a)

2.5.3.1 Quantifying presence

The level of presence required to provide one-to-one support in labour has been quantified variously as 100% (DH 2004; RCM 2010a), to 90% (Gagnon et al. 1997), and 80% (Hodnett et al. 2002), or described qualitatively as: *'the labour attendant remained with the mother without interruption, except for toileting'* (Scott et al. 1999: 1056) or that '*a woman in established labour should not be left on her own except for short periods or at the woman's request'* (NICE 2014: 43).

The latter two percentages reflected the needs of rest breaks and responding to emergencies. The RCM (2010a) when stating 100% has also made a reference to the working regulations document (1998: sited in RCM 2010a) to illustrate that break times need to be included. NICE (2014) has acknowledged that it is not realistic that the person supporting the woman is present 100% of the time and also introduced the idea that the woman may want to be alone. Walsh (2006a:234) may offer translation into practice when describing midwives 'oscillating' between leaving a woman alone and then providing intense one-to-one support dictated by the woman rather than tasks or institution.

The stipulation for presence can be understood when analysing the variations of three Canadian (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001) and two UK (Greene and Harris 2003; Ross-Davie 2012; Ross-Davie et al. 2013) observational studies. The level of presence within the labour room in the Canadian hospitals was 21.4% (Gagnon and Waghorn 1996) to 27.8% (Gale et al. 2001). It is important to acknowledge that the ratio of nurses to women was 1:2 in the study by Gagnon and Waghorn (1996: 6) although they concluded that '*even when one-to-one care was possible the amount of supportive care did not change*. More recent research from the UK (Ross-Davie 2012; Ross-Davie et al. 2013) showed most midwives (92%) were in the labour room for more than 80% of the observation, with around one quarter of midwives present for 98% of the observation. On average midwives left the labour room six times which equated to approximately every 25.7 minutes (Ross-Davie 2012; Ross-Davie et al. 2013).

2.5.3.2 Terminology used for presence

Variations in presence may explain why researchers (Hodnett et al. 2013) and policy writers (NICE 2014) have included the word 'continuous' when describing one-to-one support in labour while others have used the word 'active' one-to-one labour support (Maternity Care Working Party 2007; Shribman 2007), 'intense' one-to-one support (Walsh 2006a) and continuous supportive presence (Aune et al. 2013). Even the use of the term 'continuous' can be confusing. Thorstensson et al. (2008: 453) explained, '*Continuous labour support included continuous availability to the woman and her partner, giving as need*ed' which appears a contradiction of terms. The DH (2004) and RCM (2010a) also state that the midwife will be '*available to care*' although it specified for 100% of the time. Available implies the midwife is accessible and at women's disposable as they are not otherwise occupied (Oxford dictionary 2011) rather than in attendance.

Overall the research and policy documents appear to stipulate that a midwife should be 100% available to be present when the woman needs support.

2.5.4 Labour support activities

Continuous one-to-one support in labour enhances the physiology process of labour and feelings of control and competence for women and reduces their reliance on medical interventions (Hodnett et al. 2013). To understand why, one needs to know what constitutes labour support. The RCM (2010b) has argued that labour support is more than a series of observations including temperature, pulse, and blood pressure. Hodnett et al. (2013: 3) described labour support as:

- Emotional support (continuous presence, reassurance and praise)
- Information about labour progress and advice regarding coping techniques
- Comfort measures (comforting touch, massage, warm baths/showers, promoting adequate fluid intake and output)
- Advocacy (helping the woman articulate her wishes to others)

The description from Hodnett et al. (2013) is consistent with the majority of quantitative and qualitative studies and literature reviews assessing labour support activities (McNiven et al. 1992; Gagnon and Waghorn 1996; Simkin 2002; Bianchi and Adams 2009; Gale et al. 2001; Iliadou 2012; Ross-Davie 2012; Ross-Davie et al. 2013; Burgess 2014). Research from Sauls (2008) however highlighted new knowledge with reference to the complexity of emotional support provided for women in labour by nurses. The components of emotional support included:

- Reassurance - instilling confidence, peace of mind encouraging positive affirmation
- Creating control, security and comfort - empower, to have control, to feel safe and involved in decision
- Nurse caring behaviours - promote comfort and reassurance, demonstrate competency and are helpful and respectful

In the study by Sauls (2008) nurses stated that emotional support played a major part of their labour support. Caution has been advised however when analysing

perceptions of practice alone as nurses have previously described components of support during interviews, but in practice only a very small percentage of supportive care (12.4%) was observed (Gale et al. 2001). Observational studies that have recoded the percentage of time nurses/midwives spent supporting women within labour rooms ranged from 6.1% -15% (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001; Greene and Harris 2003). Two further observational studies (Miltner 2002; Ross-Davie 2012; Ross-Davie et al. 2013) have shown more presence, within a labour room, but comparable data regarding percentage of support is difficult due to methodological differences (Ross-Davie 2012).

Comparisons are possible in relation to the types of supportive practices performed in the labour room. The Canadian studies (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001) showed that information and instructions were the most frequent types of labour support provided by nurses. More recent studies (Miltner 2002; Ross-Davie 2012; Ross-Davie et al. 2013), indicated that emotional support was the most frequently used component of labour support and information giving was the second. Physical support and advocacy received lower scores at all research sites (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001; Miltner 2002; Ross-Davie 2012; Ross-Davie et al. 2013). In respect to advocacy, the findings by Ross-Davie (2012) showed that when advocacy was not seen, the researchers felt it was generally because there was no requirement for advocacy rather than a lack of advocacy. In addition birthing partners mostly provided advocacy and physical support (Ross-Davie 2012).

The observation tool (SMILI) used in the research by Ross-Davie (2012) provided further findings with new insights. The new insights showed that the frequency of supportive behaviours varied between midwives. The variations in the quality and quantity of the support observed suggested that this related to the midwives' motivation and styles (Ross-Davie 2012). In addition the supportive behaviours of midwives changed as the labour progressed from rapport building in earlier stages to more verbal support, attentiveness during contractions, information giving and physical support in later labour. The support for the partner was shown to decrease as the labour progressed. Lastly, negative behaviours were seen in 11.6% of all observations.

The most frequently observed negative behaviour was 'taking control' (Ross-Davie 2012:198) which included forceful direction and presenting decisions to the couple and accounted for 3.9% of all observations. Importantly the findings suggested that midwives who spent more time out of the room, were less supportive in their demeanour upon returning and were more frequently engaged in non-support activities such as documentation. Overall documentation accounted for 19% of the midwives time (Ross-Davie 2012). It has been suggested that although midwives complain about documentation, such tasks are used to keep midwives occupied and reduce the need to be with women in their care (Johnston and Harman 2007).

2.5.6 Factors influencing one-to-one support in labour

Studies show that the working environment influences midwifery practices when providing one-to-one support in labour. NHS organisations and maternity staff have stated that the major barrier to providing presence and support is inadequate staffing (Gale et al. 2001; The National Federation of Women's Institutes (NFWI) and National Childbirth Trust (NCT) 2013). Observational studies (McNiven 1992; Gagnon and Waghorn 1996; Greene and Harris 2003) have found that whether the nurses/midwives had busy work periods or were able to provide one-to-one support in labour the amount of supportive care did not increase. Greene and Harris (2003) questioned the motivation and ability of midwives to provide psychological support and concluded that one-to-one support and continuous support were not the same.

These findings are in contrast to an observational study in the USA by Miltner (2002) which showed that the level of presence correlated to the amount of women allocated to the nurses to support in labour. Nurses spent 72.3% of the time supporting women if they had only one woman assigned to them, 50.2% if they had two women, and 26.7% if three women were assigned. The motivation of nurses/midwives to provide one-to-one support in labour has also been connected to whether a woman had an epidural. A descriptive survey by Payant et al. (2008) examined nurses' intentions to practice continuous labour support and the organisational factors which impacted on their practices. The findings showed that nurse's motivation to provide continuous labour support for women with epidural analgesia was significantly lower than for those women without epidural analgesia. The nurses' intentions were influenced by the perceived social pressures on their maternity unit which included 'making yourself

available' to help with other tasks once your woman was comfortable with an epidural. These findings may help to explain why nurses in the observational study by McNiven (1992) only spent 10% of their total time providing supportive care as the epidural rate was 80%. In-depth interviews with midwives have also shown that when shifts were busy, midwives sometimes substituted their continuous presence with a continuous fetal monitor (Aune et al. 2013).

Reasons for nurses/midwives leaving the labour room included restocking, checking or/and preparing equipment or drugs, giving or receiving reports outside of the birthing room in regards to the woman's care, checking readings on the monitors, phoning the doctor, meal times, social discussions with staff, attending meetings (Gagnon and Waghorn 1996; Gale et al. 2001) and documentation (Gagnon and Waghorn 1996; Gale et al. 2001, Greene and Harris 2003). In fact documentation and absence from the delivery room accounted for 46% of the midwives' time (Greene and Harris 2003). Gale et al. (2001) observed that nurses spent 14.6% of their time at the nursing desk and nurses were prompted to regularly return to the woman in labour by policies and procedures stipulating intervals between clinical assessments such as checking the baby's heart rate and assessment of contractions. Miltner (2002) also observed nurses at the nursing station, but suggested that it may have been an essential part of the process of care as experienced nurses shared advice and suggestions to less experienced nurses. This process also increased trust and socialisation between team members.

Whilst comparing Canadian studies (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001) showing low nurse/midwifery presence, with later studies in the USA and UK (Miltner 2002; Ross-Davie 2012; Ross-Davie et al. 2013) outlining higher levels of nurse/midwifery presence, one can question whether there is an association with changes in practice over time. The UK study by Greene and Harris (2003) however does not fit this notion as low presence was observed. Another connection could be related to the model of care as the three Canadian studies were teaching hospitals of which two had evidence of high epidural rates (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001) while the USA study (Miltner 2002) was completed within a medical centre. Conversely, the UK study was completed in a midwife-led unit offering intrapartum care to low-risk women as well as three consultant-led units (Ross-Davie 2012; Ross-Davie et al. 2013). These studies may suggest that there is a

correlation between midwife-led care birth environments and the increased use of emotional supportive techniques. The model of care will be discussed in relation to one-to-one support in labour in more detail, later in this chapter.

Overall the key elements of labour support appeared to be derived from presence of the nurse/midwife. The more midwives were out of the room the less support offered to women (Ross-Davie 2012; Ross-Davie et al. 2013). It is evident that a one midwife to one woman ratio is not adequate without the motivation of midwives wanting to be present with the woman.

2.5.7 The start and end point of one-to-one support in labour

Another variant evident in the literature is the point at which one-to-one support in labour should begin and end. In the systematic review by Hodnett et al. (2013), variations in the timing of onset of support resulted in no conclusions being drawn to make recommendations. Most literature advocates that one-to-one support in labour should start when:

- the cervix is 2-4 cms (Gagnon et al. 1997; All Wales clinical pathway 2004; Gu et al. 2011; Kashanian et al. 2010)
- the cervix is fully effaced (All Wales clinical pathway 2004).
- contractions are five minutes apart (Gagnon et al. 1997; Gu et al. 2011),
- contractions are regular (Madi et al. 1999; All Wales clinical pathway 2004)
- and painful (Gagnon et al. 1997; All Wales clinical pathway 2004).

UK publications advise that one-to-one support in labour should commence when the woman is in established labour (DH 2004; Maternity Working Party 2007; RCM 2010a; RCOG 2011 NICE 2014; 2015). There is however no universal definition of established labour, but NICE (2014; 2015) describe established labour as increasingly regular and painful contractions and there is progressive cervical dilatation from 4cm. In the updated version, NICE (2014) also advised one-to-one midwifery support in early labour assessment for all low-risk primigravida women for at least one hour to evaluate women's' needs and assess whether they are in labour or can be discharged home. Some women in

early labour do not feel supported and feel anxious when advised to go home in early labour (Hunter 2007; Magee and Askham 2007; McCourt et al. 2014).

The point at which midwifery one-to-one support in labour should stop is important as women have reported feeling abandoned once the baby was out (Magee and Askham 2007). Studies describe midwifery one-to-one support in labour from the women's perspective stopping two hours after the birth (Gu et al. 2011; Cheung et al. 2009a; Fox et al. 2013) or at least one hour into the postpartum period, because that is a critical time for the initiation of maternal-infant bonding and breastfeeding (Rosen 2004). From the midwives' perspective midwifery one-to-one support in labour should end at the end of their shift or at the end of the woman's labour whichever is shorter (RCM 2010a). From the perspective of some women they wished midwifery one-to-one continued at home postpartum (Janssen and Wiegers 2006; Aune et al. 2011).

These variations in quantifying when one-to-one support in labour should start and finish make it a difficult task to validate, investigate and measure.

2.5.8 Women's perceptions of one-to-one support in labour

UK surveys (Newburn and Singh 2005; NFWI and NCT 2013), interviews (Magee and Askham 2007) and policy documents (DH 2004) show that women want midwifery one-to-one support as it increases their satisfaction of their birth experience. A UK survey has shown that 80% of women experienced one-to-one support in labour and 13% did not (NFWI and NCT 2013). Further evidence from the UK showed that 13% of women felt alone when it worried them in early labour, 9% later stage of labour, 2% during birth and 9% shortly following birth (Care Quality Commission (CQC) 2013). Fifteen per cent of women called for a midwife's attention, but the midwife was unavailable (NFWI and NCT 2013). Presence for women was a vital prerequisite for one-to-one support in labour (Mackinnon et al. 2005; Snow 2010; Aune et al. 2011), although some women have stated that physical presence was not essential if the midwife could be available when needed (Devane et al. 2010). Presence made women feel secure (Aune et al. 2011; Thorstensson et al. 2012) and significant (Berg et al. 1996). When presence was achieved, women did not want it interrupted (Snow 2010). Absence of the midwife from the labour room made women feel that some of the security was taken away (Thorstensson et al. 2012), while other women felt neglected (Moyer et al. 2014), abandoned and unsafe (Magee and Askham

2007). The Kings Fund survey showed that women in the UK worry about shortness of staff effecting midwifery presence (Magee and Askham 2007). In fact some UK women have hired doulas to compensate for anticipated lack of labour support (NFWI and NCT 2013).

Women specified important qualities they expected in midwives who were present including competence, confidence, calm, caring and providing explanations especially in emergencies and transfers to the labour ward (McCourt et al. 2011). Women want nurses/midwives to be emotionally involved, respectful, sensitive, honest, ready to listen and respond to their concerns, keep them safe and act as an advocate and treat them as individuals (MacKinnon et al. 2005; Pembroke and Pembroke 2006). These qualities enabled women to trust their midwives (MacKinnon et al. 2005), stay calm and influenced their experience and memories of birth (McCourt et al. 2011). Not all women felt safe in the presence of professionals if there was a lack of confidence in their capabilities (McCourt et al. 2011). Women wanted to feel that the midwife had a genuine interest and cared for them (Aune et al. 2011). The relationship between the nurse/midwife and woman was fundamental to their experience (MacKinnon et al. 2005; Devane et al. 2010; Kirkham 2010; Aune et al. 2011; McCourt et al. 2011). Having one midwife for the whole labour was reassuring for women and their partners especially in the event of an emergency when more staff was summoned as it helped to have a familiar face (Aune et al. 2011). Women also felt vulnerable when a midwife's shift finished and a new member of staff was allocated (NFWI and NCT 2013).

Lastly, a UK survey showed that women valued emotional support above all other types of support (Newburn and Singh 2005). Emotional support included being motivated, encouraged and praised when doing well (Newburn and Singh 2005). Emotional support has the potential to help women 'to let go' and follow their bodies in labour (Anderson 2010). In addition emotional support can help to decrease stress hormones produced in labour such as catecholamine and cortisol which can inhibit oxytocin (Klaus et al. 1986; Hunter 2002; Rosen 2004; Odent 2008; Buckley 2015) the hormone responsible for regulating contractions.

2.6 Non-professionals as labour supporters

Non-professional labour supporters include doulas, female relatives/friends and husbands/partners. Importantly, no adverse effects relating to one-to-one

support in labour from any provider (including non-professional labour supporters) had been identified (Hodnett et al. 2013). NICE (2014:239) guidance includes non-professional labour supporters in relation to one-to-one support in labour:

> 'One-to-one care is defined as continuous presence and support either by husband/partners, midwives or other birth supporters during labour and childbirth.'

NICE (2014) has remained ambiguous within the intrapartum guidelines concerning the best person to provide one-to-one support in labour, leaving implementation open to interpretation. It implies that the recommendation for one-to-one support in labour would be achieved if a relative is present in the birthing environment whether the midwife is present or not. A more recent publication has provided clarity by stipulating that all women in established are assigned a midwife to provide one-to-one support in labour (NICE 2015b).

The following sections explore the benefits, accessibility and challenges when doulas, female relatives and partners/husbands provide one-to-one support in labour.

2.6.1 The doula as labour supporter

2.6.1.1 The benefits of a doula providing one-to-one support in labour

The findings from the systematic review by Hodnett et al. (2013) showed that the rate of positive birth outcomes increased when the labour supporter was present solely to provide support, had not been a member of the woman's social network; was experienced in providing labour support and had at least a modest amount of training. Doulas were advocated as the optimum choice to provide one-to-one support in labour (Hodnett et al. 2013). Goedkoop (2009) claimed a UK survey confirmed the positive effects of the doula in relation to birth outcomes stipulated by Hodnett et al. 2013. The survey included 140 doulas working in the UK who provided information from 735 births that they had attended. The findings showed a decreased rate of caesarean section, interventions, pain relief and a higher rate of home births and breast feeding (Goedkoop 2009).

The survey was not randomised however and all the outcomes were compared to the national statistical averages, which may or may not have reflected the hospitals in which the doulas supported women in labour. A US retrospective comparative analysis of a survey of women who gave birth with or without a doula reinforced that the continuous presence of a doula decreased the caesarean section rate (Kozhimannil et al. 2014). In particular it reduced non-indicated caesarean sections that were not considered to have a medical indication (e.g. fear of birth, concerns about the size of the baby, past the due date, long labour and small pelvis). Importantly, the reason for caesarean section however was provided by women therefore it was their interpretation used rather than clinical data within medical records. Overall the evidence is strong regarding the positive effects of the doula as a labour supporter.

When assessing why doulas provide such good outcomes, studies have described attributes of the doula. Doulas are trained to be continually present and support women through labour and after the birth (Van Zandt 2005; Amram 2013). The continuous presence of a doula has a singular focus to one woman and this is said to be the best asset (Gilliland 2011; Hodnett et al. 2013). Some doulas meet women prior to the birth so they also provide continuity (Bainbridge 2010; Amram 2013). Studies particularly emphasise the emotional support doulas provide (Pascali-Bonaro 2004; Bainbridge 2010; Eftekhary et al. 2010; Gilliland 2011; Amram 2013; Kozhimannil et al. 2014). Gilliland (2011) completed interviews with ten women and thirty doulas in Canada and found that the emotional support provided by doulas was more complex than the reassurance, encouragement, praise and explaining completed by doulas, nurses and partners/husbands. Doulas provided additional supportive behaviours which included mirroring, acceptance, reinforcing, reframing and debriefing (Table 2). These behaviours required a high level of emotional skill from the doulas which was aided by the continuous presence and the ability to focus (Gilliland 2011).

Table 2: The complex emotional support provided by doulas

Mirroring	Stating the situation that was occurring, mirror the woman's curiosity rather than giving opinions, echoed back to the woman with the same feeling and intensity
Acceptance	Verbal and non-verbal, taking the response of the mother

	without attempting to change her response or feelings, and acknowledging the facts of the situation without trying to change it
Reinforcing	To make stronger something the mother was already doing or feeling to support and encourage the woman to continue what she is doing
Reframing	Verbal dialogue between doula and woman to shift the woman's perception to a more positive outlook
Debriefing	Uses actively listening skills, focusing attention in an empathetic way to encourage the woman to talk about her feelings

With research such as Ross-Davie (2012) showing increasing levels of emotional support provided by midwives in the UK when offering one-to-one support in labour, it could be postulated that future research exploring the activities of emotional support may find that doulas are not alone when providing more complex emotional support.

2.6.1.2 Accessibility of a doula providing one-to-one support in labour

In most areas of the world at this time, women have limited access to doulas (Martis 2007). The doula movement started in the US in the 1990s (Goedkoop 2009) and in the UK in 2001 (Doula UK 2015). Many doulas are mothers themselves (Cheung et al. 2005) and their role has been described as a formalised version of the female companion (Stockton 2010). Having access to a doula is particularly important for women who do not have a partner, family member or friend who can fill the role of birth companion (Bainbridge 2010). Globally doulas are usually employed directly by women and are mostly accountable only to their client and do not have professional accountability to any organisation or care provider (Eftekhary et al. 2010). This has caused some cynicism as to whether doulas are making a business exploiting women to make a profit (Chakladar 2009).

2.6.1.3 Challenges for doulas providing one-to-one support in labour

There has been a concern that pregnant women in the UK are hiring a doula '*because the maternity services are struggling to provide one-to-one care'* (Silverton 2009) and women are fearful of being left without help and support by

midwives (Fearn 2015). There is also concern that doulas are trying to replace the midwife role and that some doulas overstep their boundaries causing conflict over clarity of roles inside the birth environment (Stockton 2010; Stevens et al. 2011). Globally the definition of a doula is not universal (Cheung 2005) and suggests that there is a need for regulation. In the UK a code of regulation for doulas has been created by Doula UK (2015). Affiliation to Doula UK currently remains up to the individual doula, but this could provide a way towards doulas adhering to a nationally recognised code of conduct (Stockton 2010).

2.6.2 The birthing partner as labour supporter

2.6.2.1 The benefits of birthing partners providing one-to-one support in labour

The systematic review by Hodnett et al. (2013) suggests that having a chosen husband/partner, family or friend (sometimes referred as lay supporters, but in this thesis as birthing partners) present in labour increases women's satisfaction more than any other provider of one-to-one support. Rosen (2004) in part, attributes the positive outcomes achieved with lay supporters to shared language and values and an allegiance to the labouring woman. Historically female relatives/friends have cared for women in labour and birth (Pascali-Bonaro and Kroeger 2004). In some societies where resources are low and husbands/partners are not permitted, female relatives/friends as labour supporters has the potential to achieve one-to-one support in labour at a quicker pace than the increase of midwives and doulas (Martis 2007).

2.6.2.2 The accessibility of birthing partners to provide one-to-one support in labour

Western societies prior to the 1960s were opposed to involving fathers in the birth environment (Hildingsson et al. 2011). This contrasts to the present day where most western nation's expectant fathers are encouraged to be involved and actively participate in their partners labour (Johansson et al. 2015). Globally countries such as Botswana (Madi et al. 1999), China (Cheung et al. 2010), Ethiopia (Teshome et al. 2007), Iran (Kashanian et al. 2009), Jordan (Khresheh 2008), Lebanon, Syria, Egypt (Kabakian-Khasholian et al. 2015), Nigeria (Oboro et al. 2011), South Africa (Brown et al. 2007), Russia (Bakhta and Lee, 2010) and Zambia (Maimbolwa et al. 2001) do not permit birthing partners to stay with women in labour. Birthing partners are an important resource especially when hospitals have shortages of staff which result in many women in labour being left

alone for long periods of time (Madi et al. 1999; Brown et al. 2007; Khresheh 2008).

In low income countries, birthing partners could be the only resource to help with simple tasks such as giving labouring women water to drink or calling for help when needed (Maimbolwa et al. 2001; Brown et al. 2007). In addition the presence of birthing partners has been shown to change the attitude of staff so that they are more forthcoming and friendly (Bruggemann 2007) and midwives are less inclined to use early interventions (Madi et al. 1999). The reluctance of health professionals to invite birthing partners within hospital premises has been due to fears of infection, lack of space, suspicion that the non-professional labour supporters may administer traditional medicine to labouring women, fear of being sued (Maimbolwa et al. 2001), inconvenience to staff (Cheung et al. 2005) and fear that the supportive skills of trained staff would become superfluous (Cheung et al. 2010). It has been suggested that labour supporters other than the midwife can make women feel tense, increasing adrenaline levels which then have a negative impact on women's' contractions in labour (Odent 2008).

2.6.2.3 The experience of birthing partners providing labour support

No research was found relating to fathers' experience of providing one-to-one support in labour, but there were two metasynthesis of qualitative research (Steen et al. 2012; Johansson et al. 2015) that explored father's experience of labour. The first study (Steen et al. 2012) selected qualitative data from nine countries (UK, Australia, Sweden, USA, Japan, Taiwan, South Africa, Finland, and New Zealand). The second study (Johansson et al. 2015) selected qualitative data from eight qualitative studies and involved 120 fathers from four countries (England, Malawi, Nepal and Sweden).

The findings showed that most fathers want to be actively involved in their partners labour, but there were some that felt pressured to attend and actively take part; fathers recognised that preparation was required (Steen et al. 2012; Johansson et al. 2015), but classes were women focused and completed when it was difficult for men to get time off work (Steen et al. 2012). Fathers commonly felt inadequate in their ability to support their partner and particularly struggled with seeing their partners in pain; (Johansson et al. 2015); men wanted the decision making to be undertaken jointly (Johansson et al. 2015) which was reflected in the UK and Finland studies (Steen et al. 2012). Fathers provided

comfort by calming partners when they were distressed, using talking and body contact, and being their advocate; fathers with previous birth experiences usually felt more prepared; fathers were not always prepared for the theatre however (Johansson et al. 2015). A few fathers reported that the experience of watching their partner give birth can lead to sexual and psychological scarring that can last for years. Some psychological scarring was also caused by unexpected or pathological clinical events, or by men experiencing cruel and dehumanising behaviour by staff or witnessing such behaviour towards their labouring partner (Steen et al. 2012).

Fathers were anxious about risks to their partner and baby (Steen et al. 2012); being kept informed helped fathers feel safe and inclusive. Fathers recognised that midwives were best placed to make a significant difference to how they perceived their experiences of labour. Health care professionals were not always attentive to men's needs or provided them with a high level of support which caused men to become less involved and increased insecurities (Johansson et al. 2015). Fathers tried very hard not to convey their fears to their partners.

The findings from Steen et al. (2012) and Johansson et al. (2015) appear mostly associated with anxiety provoking situations in labour. I questioned whether there were studies regarding positive events that were pinnacle moments which father's experience and could be supported by midwives when providing one-to-one support in labour. Reading the title of a survey from Sweden (Hildingsson et al. 2011) suggested a more positive perspective as the research aimed to identify the proportion of fathers who had a positive experience of a normal birth and to explore factors relating to midwifery support that were associated with the positive experiences. The research included 595 fathers whose partners had a spontaneous vaginal birth. The findings showed that the majority of fathers (82%) reported a positive experience. Support, presence and information about the progress of labour were the three most important aspects relating to a father's positive birth experience. Support seemed to be more important however for first-time fathers than fathers who had previous children. Midwifery support helped equip fathers to support their partners. Presence was highly valued. Fathers who were satisfied with the midwife's presence and the information provided were four times more likely to report a positive birth experience (Hildingsson et al. 2011).

Whether it is the presence itself, or what the midwife actually did in the room that created security was not apparent from the study. Presence has been found to be vital however even when the midwife was not speaking or physically doing something (Backstrom 2011). Some fathers experienced high levels of anxiety and worry when left alone for short periods of time with their labouring partner (Tarlazzi 2015) as fathers felt a sense of responsibility which created insecurity (Thorstensson et al. 2012). Fathers found it particularly distressful when their partner experienced an increase in pain or if something unanticipated occurred and a health professional was not present (Tarlazzi 2015). Less anxiety was experienced in the absence of the midwife if there was trust that the midwife would return if requested (Backstrom 2011). Other positive behaviours by midwives included being respectful in their actions and language, allowing fathers to ask questions during labour and scope for fathers to choose to get involved or stand back (Backstrom 2011). Fathers wanted midwives to be welcoming with a smile, spend quality time, and explain the procedures that they performed, show respect and reassurance to their partners throughout labour (Sengane 2012). Overall the importance of emotional support was valued by fathers (Tarlazzi 2015).

Not all fathers wanted to be present in labour and this appeared more prevalent in countries where the presence of the father is not the cultural norm. A descriptive cross-sectional study from Zambia using semi-structured interviews of 385 men showed that 55% of them would be willing to escort their wives to hospital, but 99% reported that they would not be present for the birth (Ngoma 2013). Some of the contextual information in studies provided clues to why some fathers may not want to stay with women in labour. In some low income countries there is sometimes no privacy so many women in labour are within one space (Chimwaza 2015; Kabakian-Khasholian et al. 2015) which some men will find personally or culturally unacceptable to be in the presence of other women giving birth. In addition, professional involvement during labour and birth is dominated by women and this has been identified as a source of discomfort for fathers (Chimwaza 2015). It has been argued that fathers should not be expected to fulfil the role of primary labour companion (McGrath and Kennell 2008) as they can feel overwhelmed by a mixture of helplessness and responsibility which can be detrimental (Backstrom and Wahn 2011). Fathers and female relatives/friends usually do not have experience providing labour

support and therefore need support themselves (Nolan 2010; Hodnett et al. 2013).

2.6.2.4 Training birthing partners

The evidence for training fathers to be labour supporters is contradicting when looking at qualitative (Tarlazzi 2015) and quantitative research (Wockel et al. 2007). Despite attending at least one meeting of a prenatal course each, all fathers interviewed said they were not really well-prepared for what happened during labour (Tarlazzi 2015) while others received training for the labour and they felt more prepared and positive about the labour experience (Wockel et al. 2007). Training needs to be delivered however at a time that fathers can attend (Steen et al. 2012) which may mean that separate training sessions are organised for fathers (Wockel et al. 2007).

2.6.2.5 Women's perspectives of birth partners acting as labour supporters

The majority of women want their husband/partner present (Magee and Askham 2007; Dahlen et al. 2008; Cheung et al. 2010) and this is reinforced in the UK as 95% of women had their partners or companions with them in labour when they wanted them (CQC 2013). Women felt more in control and not alone when their husband/partner was present due to the emotional support as it boosted their self-confidence to cope with the labour pains (Sapkota et al. 2011). In countries where birthing partners are not permitted such as Saudi Arabia, 55% women did not want their partner present (Al Mandeel et al. 2013). This may indicate a cultural link influencing women's preference in relation to the attendance of birthing partners.

Not all women wanted a labour supporter who they knew, due to concern about how that person would react to seeing them in pain, embarrassment and anxiety that the labour events may not stay confidential within the labour room (Maimbolwa et al. 2001). Some women felt that their husband/partner may lose sexual attractiveness towards them, women also had general concern for their partner's wellbeing (Maimbolwa et al. 2001; Bakhta and Lee 2010; Oboro et al. 2011; Sapkota et al. 2011) and guilt from getting annoyed at their husband/partner (Sapkota et al. 2011). A UK survey showed that 26% of women felt birth had a negative impact on their partner (Birthrights Dignity in Childbirth Forum 2013), and that the negativity increased if the woman experienced an

instrumental birth or she was a first time mother (Birthrights Dignity in Childbirth Forum 2013).

Long term benefits of the presence of husband/partner were found in a study from Nepal (Sapkota et al. 2013). The study compared continuous labour support by a husband/partner, female friends verses no support by any companion. The perspective of women was investigated using questionnaires postpartum. The results suggested that when the continuous labour support was completed by the husband/partner, the benefits were increased due to the long term relationship extending postpartum. Consequently women who had received continuous labour support from their husband/partner perceived that they received greater postnatal support at home which lowered their anxiety levels and had a positive impact on their mental health including their emotional well-being (Sapkota et al. 2013).

2.7 Trained professionals as labour supporters

The literature review in relation to trained professionals revealed that as well as government policies and research, the model of care, place of birth and training had an impact on the ability and approach of midwives providing one-to-one support in labour and women's perceptions about their care. This section ends with the recommendation by NICE (2014) to explore the future role of maternity support workers helping midwives to provide one-to-one support in labour.

2.7.1 Policy documents regarding midwifery one-to-one support in labour

Worldwide midwives are recognised as the professional of choice to support women in labour (International Confederation of Midwives (ICM) (2014). Midwives have been trained to assess and monitor the progression of labour and wellbeing which increases the safety of the mother and baby which is beyond that of a lay person (Gagnon et al. 1997). UK publications advocate the midwife as the person to provide one-to-one support in labour (DH, 2004; Kings Fund 2008; Maternity Care Working Party 2007; RCOG et al. 2007; RCM, 2009; RCM, 2010a, NICE 2015b). A guiding principle for the maternity services in the UK is that all women will need a midwife, but some will need the support of the obstetrician (DH/Partnerships for Children, Families and Maternity 2007; Department of Health, Social Services and Public Safety, Welsh Assembly Government, DH, Scottish Government 2010).

Although it recognised that the midwife should be the main provider of one-to-one support in labour, it is not achievable in many developing countries. Instead the priority is to have a skilled assistant at birth. Worldwide, one in four pregnant women gave birth without a midwife or a skilled birth attendant (United Nations 2015). Conversely, only 1% of women in the UK gave birth without a midwife or skilled birth attendant, with the most common cause being that the birth happened so fast that the woman could not get to hospital in time (Save the Children 2011). The trajectory experienced in countries such as the UK has been recommended as an option by officials in developing countries such as sub-Saharan Africa (Ohaja 2012). The sub-Saharan Africa and South Asia account for 86% of global maternal deaths and where only 52% of women gave birth in the presence of a skilled attendant (United Nations 2015).

2.7.2 Research recommendations regarding midwifery one-to-one support in labour

Research findings from Hodnett et al. (2013) are in contrast to policy documents advocating the midwife as the provider of one-to-one support in labour. The recommendations from the systematic review by Hodnett et al. (2013) suggested caution to policy makers in high income countries advocating nurses/midwives to provide continuous one-to-one support in labour with the intention to reduce high caesarean section rates as it may not occur. Hodnett et al. (2002; 2013) advised that organisational reforms are necessary to enable nurses/midwives to provide effective one-to-one support in labour. It has been suggested that nurses/midwives are constrained so they cannot entirely focus on women since they have divided loyalties including medical and technological responsibilities as well as documenting their care and working within a risk orientated environment (Scott et al. 1999; Hodnett et al. 2002; 2013). Such responsibilities have been categorised as indirect care in observational studies (McNiven et al. 1992; Gagnon and Waghorn 1996; Gale et al. 2001; Ross-Davie 2012). These are in contrast to the direct support activities including emotional, information giving, comfort measures and advocacy which have been previously discussed (section 2.5.4).

Indirect care inside and outside the labour room also included giving report, documentation, preparing and checking equipment and medication, contacting the doctor (Gale 2001). Indirect support accounted for 40.4%-52.3% of nurses/midwives activities (McNiven et al. 1992; Gagnon and Waghorn 1996;

Gale et al. 2001; Ross-Davie 2012). In the UK indirect activities would be considered responsibilities required by the NHS organisation, otherwise referred to as the 'institution'. Qualitative studies have described how midwives work with conflicting ideologies attempting to address the demands of the 'institution' against the needs of the women in labour (Hunter 2004, 2005; Thorstensson et al. 2012; Thorstensson et al. 2012; Aune et al. 2013). The reasons for conflicting ideologies will be discussed in the next section, but it is important to note that Ross-Davie (2012) challenged the assertions of researchers suggesting that midwives are unable to provide the skills and time to support women in labour. Ross-Davie (2012) suggested that most midwives in her study were motivated and equipped with highly developed supportive skills and they did not have any other responsibilities other than to provide one-to-one support in labour. Variations in the quantity and quality of support were related to the motivation and styles of the midwife rather than their professional responsibilities.

2.7.3 Models of care

NICE (2014) has stipulated that the maternity services should provide a model of care that supports one-to-one support in labour for all women. Internationally one-to-one support in labour works within two main models referred to as midwife-led care and active management. The two models work at opposite ends of the spectrum, but midwifery one-to-one support can occur anywhere within the continuum.

2.7.3.1 Midwife-led care

Midwifery one-to-one support in labour (Hunter 2007; Cheung 2011, 2010; Fox et al. 2013) or referred to as continuous attendance (Sandall et al. 2013) during labour, birth and the immediate postpartum period is considered an attribute of midwife-led care. Midwife-led care is woman-centred and based on the premise that pregnancy and birth are normal life events (Rooks 1999; Blaaka and Schauer Eri 2008; Sandall et al. 2013; Wiysonge 2009). Women are low-risk and receive autonomous care from a midwife (Devane et al. 2010). Women are regarded as an 'active partner' in their care (Rooks 1999:371). Midwife-led care includes monitoring the psychological social and spiritual wellbeing of women as well as the physical (Rooks 1999; Sandall et al. 2013). Midwives are able to choose to be present with women (Devane et al. 2010). The presence is 'time-intensive and relationship-intensive' (Rooks, 1999: 107) with flexible time frames rather than rigid (Davis 2010; Devane et al. 2010).

Midwife-led care supports normality, thus midwives try to avoid interfering with the normal processes of labour therefore unnecessary interventions are avoided (Rooks1999; Sandall et al. 2013). Understanding what constitutes normality is therefore crucial for midwives as it has been noted that midwives failure to define normality has contributed to increasing technicalisation and medicalisation of labour and birth (Gould 2000). Such midwifery knowledge comes from extensive experience and is enhanced when midwives are able to tolerate wide variations of normality in labour and birth (Davis 2010) and recognise when complications develop so that a referral is made to the appropriate specialist, usually an obstetrician (Devane et al. 2010).

No research was found in relation to midwife-led care that has directly measured midwifery one-to-one support in labour as an outcome. Systematic reviews comparing midwife-led care with 'other models of care' (medical model of care provided by an obstetrician or a family doctor or both collaborating with nurses and midwives in variable environments) have consistently shown that women who had midwife-led care were less likely to experience regional analgesia (epidural/spinal), episiotomy, and instrumental delivery. They were more likely to experience spontaneous vaginal birth, no intrapartum analgesia/anaesthesia and to have a longer length of labour and feel in control during labour and childbirth. Interestingly there was no difference in the caesarean section rate (Hatem et al. 2009; Devane et al. 2010; Sandall et al. 2013). Although continuous attendance during labour was described as one of the attributes of midwife-led care, it was not amongst the outcomes measured (Hatem et al. 2009; Devane et al. 2010; Sandall et al. 2013). These reviews included the United Kingdom (UK) and other high income countries (Australia, Canada, Ireland and New Zealand).

Improved birth outcomes were also found in cohort studies who introduced midwifery one-to-one support as part of a midwife-led care model at a midwife-led normal birth unit (MNBU) in China (Cheung et al. 2010; 2011) and a National University Hospital in Singapore (Fox et al. 2013). Both cohort studies compared the midwife-led care model with usual care. The latter included midwives supporting more than one woman per shift and birthing partners were not permitted. As part of the midwife–led care model, partners were permitted and the concept was named 'two-to-one' at one study site as one midwife and birthing partner accompanied one labouring woman (Cheung et al. 2010, 2011).

The findings of the two cohort studies showed that women were more likely to have a spontaneous vaginal birth (Cheung et al. 2011; Fox et al. 2013), be satisfied with care (Cheung et al. 2010, 2011), less likely to have a caesarean section (Cheung et al. 2011; Fox et al. 2013), an epidural (Fox et al. 2013) and interventions (Cheung et al. 2011). Both cohort studies concluded that midwifery one-to-one/two-to-one support in labour played a major factor in relation to promoting higher spontaneous vaginal births (Cheung et al. 2011; Fox et al. 2013). It was not explicit how the researchers came to this conclusion however as the level of midwifery presence had not been indicated and there were other influencing factors mentioned in the descriptions of the midwife-led care model including the care being woman centred, continuity of carer and increased motivation not intervening with the physiological processes of labour (Cheung et al. 2011; Fox et al. 2013).

An Ethnographic study by Hunter (2007; 2010, Hunter and Segrott 2010) highlighted the challenges faced when introducing a clinical pathway (which included midwifery one-to-one support in labour) to guide midwives working with a midwife-led care model for low-risk women within hospital organisations in Wales. The clinical pathway was part of a national policy initiative titled the 'All Wales Clinical Pathway for Normal Labour' (All Wales Clinical Pathway for Normal Labour 2004) aimed to decrease the caesarean section rate and increase the number of normal births. Over a two year period however caesarean sections did not reduce and spontaneous births did not increase. More recent statistics show that this trend continues (Welsh Government 2014). Contributing factors for the results included the lack of early collaboration from all parties (including obstetricians), small numbers of women entering the pathway, disagreement with regards to the inclusion and exclusion criteria for the pathway, and no clinical experts in normality as staff rotated.

Although midwifery one-to-one support in labour was part of the clinical pathway, no data was collected to measure the outcomes and a lack of data collection from the hospital overall in relation to outcomes was identified by the researchers (Hunter and Segrott 2010). A case study (Bick et al. 2009) conducted an adapted version of the All Wales Clinical Pathway in an AMU in England. The outcomes featured all challenges previously described (Hunter 2007; Hunter and Segrott 2010). Unfortunately again no data was collected to assess midwifery one-to-one support in labour. There are questions outstanding relating to why the midwife-

led care clinical pathway did not impact more positively (Hunter 2007; Bick et al. 2009). It is unclear if the issues are associated with the clinical pathway, the method that it was introduced or the transition of using new ideologies that are woman centered.

2.7.3.2 Active management

Active management is at the far end of the medical model of care spectrum. Active management includes routine amniotomy[8], strict rules for diagnosing slow progress, use of the intravenous drug oxytocin to increase contractions of the uterus and also stipulates midwifery one-to-one support in labour (O'Driscoll el al. 1993; Brown et al. 2013). This medical model in labour is led by obstetricians in a hospital labour ward. Here, one-to-one support in labour means continual presence of a midwife (O'Driscoll el al 1993; Brown et al. 2013). A systematic review (Brown et al. 2013) assessed whether active management of labour reduced caesarean section rates in low-risk women and improves satisfaction. Seven trials were selected which included 5,390 women, comparing low-risk women receiving active management with women receiving routine (variable) care. Countries included the USA, New Zealand, Europe, Thailand and Nigeria.

The findings outlined that the caesarean section rate was slightly lower in the active management group compared with the group that received routine care, but this difference did not reach statistical significance (RR 0.88, 95% CI 0.77 to 1.01). Brown et al. (2013) noted that in one study there were a large number of post-randomisation exclusions. When this study was excluded, the caesarean section rates in the active management group were statistically significantly lower than in the routine care group (RR 0.77 95% CI 0.63 to 0.94). More women in the active management group also had labours lasting less than 12 hours. There were no differences between groups in use of analgesia, rates of assisted vaginal deliveries or maternal or neonatal complications. Only one trial examined maternal satisfaction; the majority of women (over 75%) in both groups were

[8] Often referred to as artificial rupture of the membranes (Brown et al. 2008) in medical terms or breaking the waters in lay terms.

very satisfied with care. It was concluded that active management was associated with a small reduction in caesarean section rate. Caution was advised however as reduction in caesarean section could not be confidently associated with the package of active management as the systematic review by Hodnett et al. (2013) found that one-to-one support in labour lowered caesarean section rates. It is therefore possible that the caesarean section rate was lowered by this one component of active management rather than the package. NICE (2014) states that active management of labour does not reduce the rate of caesarean section as it has not been updated from the NICE (2007) publication. This indicates that the results regarding active management of labour have not been consistent.

Active management was introduced in Dublin in the 1970's (Begley et al. 2009) and described as a biomedical model which potentially leads to increased interventions and a more medicalised birth using time restrictions which causes women to have less control (Blaaka and Schauer Eri 2008). The biomedical model has been accused of focusing on the fetus to the exclusion of the woman (MacKinnon et al. 2005). Active management creates a more predictable environment by generalising individual experiences so that the uncontrollable become controlled and rendered conceptually safe and predictable which provides a sense of certainty and security for practitioners, but less power for women (Davis-Floyd 2003). Labour rooms using a medical model are set up for safety rather than autonomy of the woman (Nilsson 2014). Technological equipment can make women feel like objects under surveillance (Nilsson 2014), or provide a sense of comfort and reassurance (McCourt et al. 2011). Studies have shown that women do not like interventions (Hodnett 2002; Birthrights Dignity in Childbirth Forum 2013). The more intervention, the more likely women reported dissatisfaction (Hodnett 2002). Interventions in labour and birth can cause women to feel invaded by technology and scared when they are not adequately informed (McCourt et al. 2011). In fact 12% of women interviewed as part of a UK survey felt that they had not given their consent to examinations or procedures (Birthrights Dignity in Childbirth Forum 2013). Women also reported significantly higher rates of disrespectful treatment, greater loss of choice and control when they had an instrumental birth (Birthrights Dignity in Childbirth Forum 2013).

There are concerns that positions used for instrumental birth are being used for low-risk women. Twenty-six per cent of women gave birth lying down or lying supported by pillows (CQC 2013). There was also an increase from the 2010 survey (30% to 32%) in the proportion of women being supported with stirrups. Nineteen percent of women who gave birth with stirrups had a normal vaginal birth (CQC 2013). A survey completed by the RCM (2010b) showed that instrumental births (ventouse and forceps) and caesarean section were more likely to be associated with semi-recumbent positions during labour, while upright positions were associated with normal births. The RCM (2010b) therefore advised strategies such as mobilisation and upright positions as positive interventions.

Overall although midwifery one-to-one support in labour is a prerequisite for active management, it has been argued that increased interventions cause decreased support in labour (Zhang et al. 1996; Scott et al. 1999; Hodnett et al. 2013).

2.7.3.3 Midwives working with conflicting ideologies

Studies have shown that conflicting ideologies occur when midwives attempt to adopt the 'with woman' approach within hospital labour wards when the culture is led by the needs of the organisation otherwise referred to as the 'with institution' model (Hunter 2004, 2005; Thorstensson et al. 2012). The working atmosphere creates an '*us and them'* culture (Hunter 2004; Hunter 2005a; McCourt et al. 2011; Rayment 2011; McCourt et al. 2014). Midwives using the 'with woman' ideology were present in the labour rooms with no clinical task to perform, tuning into the needs of women (Birthrights Dignity in Childbirth 2013) as they had confidence in the physiological process of labour and acknowledged the importance of emotional support (Hunter 2004). In addition midwives focused on building relationships with women and their partners and instilled a sense of security and reassurance (Thorstensson et al. 2012). Reassurance was given at times by sharing a joke or small talk which women and partners appreciated, but Thorstensson et al. (2012) argued that such actions could be perceived as inefficient use of time under the 'with institution' ideology.

When adopting the 'with institution' ideology, the focus was to provide universal, equitable care to large groups of women. The focus was therefore '*with women rather than with woman*' (Hunter 2005b:13). Using the 'with institution' ideology

midwives were task oriented (Hunter 2004; Thorstensson et al. 2012) and felt emotionally rewarded when tasks were completed (Hunter 2004). Such tasks caused midwives to leave the labour room if they felt the task was important and birth was not imminent, even if the woman had an urge to push and did not want the midwife to leave (Thorstensson et al. 2012). UK midwives interviewed suggested that midwives who were technically competent to balance responsibilities to keep women safe while working in a busy labour ward were referred to as 'high octane trauma midwives' (Birthrights Dignity in Childbirth 2013: 19). Achieving tasks was at the expense of providing emotional support for women (Birthrights Dignity in Childbirth 2013) and instead focused on support offering information (Thorstensson et al. 2012). The experience of women reinforced the notion that the supportive needs of women and birthing partners were mostly not met when midwives adopted the 'with institution' ideology (Thorstensson et al. 2012).

Overall it appears the midwifery presence within the labour room is determined by the ideology of the midwife (Thorstensson et al. 2012) and the environment in which she/he works.

2.7.4 Place of birth

The literature shows that midwifery one-to-one support in labour occurs in four different geographical locations including an obstetric unit (labour ward), alongside midwife-led unit (AMU), freestanding midwife-led unit (FMU) and home. Obstetric units are consultant led and situated within the hospital and women give birth in a labour ward. Alongside midwife-led units are situated on the same site or inside a hospital located in the same building as an obstetric unit. Freestanding midwife-led units are situated on a site geographically separate from a hospital obstetric unit which can be several miles away. This means that if a transfer to labour ward is required transport would be by ambulance or car as required for homebirths (Hollowell 2011). AMU and FMU are sometimes referred to as birth centres (Kirkham (ed) 2003; NCT 2008; Davis-Floyd et al. (ed) 2009), a term originated from North America (NCT 2008). The environments within AMU and FMU are usually home-like (Dahlen et al. 2010; Hodnett et al. 2012) rather than like the conventional hospital surroundings. Obstetricians are not present in midwife-led units so women need to be transferred to labour ward when there is a deviation from the normal (Bernitz et al. 2011).

2.7.4.1 The influence of place of birth and midwifery one-to-one support in labour

Two UK surveys (Newburn and Singh 2005; MacFarlene et al. 2014) have included midwifery one-to-one support in labour as an outcome measurement when comparing places of birth. The places of birth included the obstetric unit, midwife-led unit (Newburn and Singh 2005; MacFarlene et al. 2014) and home (Newburn and Singh 2005). The findings showed that midwifery one-to-one support in labour was more likely in the midwife-led units (80% and 87.8%) (Newburn and Singh 2005; MacFarlene et al. 2014) and home (92%) (Newburn and Singh 2005) when compared to the obstetric units (68% and 51%) (Newburn and Singh 2005; MacFarlene et al. 2014). The study by MacFarlene et al. (2014) went further to measure the continuity of carers in labour and found that two-thirds of women who started labour care at the free standing midwife-led unit (FMU) had the same midwife with them all through their labour and birth compared with just under half of those who started care at the hospital. In addition the reason for not having the same midwife throughout labour was due to a shift changes for just over half of women at the FMU and for just under a third of the women at the hospital. Walsh (2006b) explained that midwife-led units have an advantage over obstetric units to provide one-to-one support in labour due to their small-scale, resulting in smaller numbers of women accessing the services. This means one midwife to one woman is much more likely.

2.7.4.2 The influence of place of birth and safety

In 2011 the findings of the largest maternity prospective cohort study conducted in England was published (Birthplace in England Collaboration Group 2011a; Hollowell 2011; Hollowell et al. 2011; Mc Court et al. 2011; Schroeder et al; 2011). The study aimed to compare the safety of birth by planned place of birth (AMU, FMU, home and obstetric unit) at the start of care in labour for women with low-risk pregnancies. The study information (Birthplace in England Collaboration Group 2011b) stated that midwifery one-to-one support in labour was typical within the home and midwife-led units. The study did not however include midwifery one-to-one support in labour as an outcome measure, but it did contribute knowledge regarding the safety of the places of birth where midwifery one-to-one support in labour is said to take place. The findings showed that all women (primigravida and multigravida) planning birth in a midwife-led unit and multiparous women planning birth at home experienced fewer interventions than those planning birth in an obstetric unit and more likely to have a spontaneous vaginal birth with no impact on perinatal outcomes. For primigravida women,

planned home births also had fewer interventions, but had poorer perinatal outcomes.

For women having their first baby, there were 9.3 adverse perinatal outcome events per 1000 planned home births, compared with 5.3 per 1000 births planned in obstetric units, and this finding was statistically significant. The research also highlighted the higher frequency of interventions and the relatively low proportion of normal births relating to low-risk women having their baby in an obstetric unit (Hollowell et al. 2011). These findings and recommendations were included in the up-dated version of NICE (2014).

A retrospective cohort study conducted in New Zealand (Davis et al. 2011) also compared birth outcomes and interventions within different places of birth. The study included 16,453 low-risk women who gave birth in obstetric units, midwife-led-units and home. The findings showed that low-risk women who had their babies in the obstetric units had a higher risk of caesarean section and interventions. Unlike the birth place study (Hollowell et al. 2011), the study by Davis et al. (2011) was not powered to detect significant differences in neonatal mortality or morbidity. Babies born to women who planned to give birth in the obstetric units however did have an increased risk of admission to the neonatal intensive care. The researchers concluded that rather than the model of care or the motivation of midwives, the differences were associated with the place of birth.

Prior to the publication of 'the Birthplace study' NICE (2007) advised that there was not enough evidence reviewing potential risks associated with the planned place of birth. Evidence at that time was retrieved from two systematic reviews comparing places of birth which have continued to be updated (Olsen and Clausen 2012; Hodnett et al. 2012). The first compared planned hospital birth to planned home birth (Olsen and Clausen 2012), but only one trial was available and therefore evidence is insufficient to provide any recommendations to practice. The second systematic review (Hodnett et al. 2012) compared alternative versus conventional institutional settings for birth. Alternative settings referred to environments that were more 'home-like' rather than including typical features of a hospital. Such home-like environments are often found in alongside and freestanding midwife-led units. Ten trials were selected including 11,705 women, but none of the trials included freestanding midwife-led units. The

findings showed that alternative settings were associated with reduced likelihood of medical interventions, increased likelihood of spontaneous vaginal birth, increased maternal satisfaction, and greater likelihood of continued breastfeeding at one to two months postpartum, with no apparent risks to mother or baby. Overall there was insufficient evidence to advocate to women that birth was as safe at home and at the FMU when compared to obstetric units.

2.7.4.3 Women's perspectives of places of birth

Women have different expectations in relation to hospital, midwife-led units and home (Hodnett 2002, Davis et al. 2011). Most women choosing to have their baby in hospital felt that they were reducing their risks and secure in the knowledge that the staff and facilities were immediately available when required (Magee and Askham 2007) including epidural (McCourt et al. 2014). Women who planned their birth in a midwife-led unit hoped that they could achieve a 'natural birth' by avoiding drugs and medical interventions or to have access to the pool, in an environment that was family centered, relaxing and comfortable (McCourt et al. 2014). Women have said that the AMU had the 'best of both worlds' as it was separate from the obstetric unit, but the medical facilities were in close proximity if required (Newburn 2012).

2.7.5 Midwives' experience practising one-to-one support in labour

Two UK studies have analysed the midwives' views relating to dignity (Birthrights Dignity in Childbirth 2013) and safety (Smith and Dixon 2008; Smith et al. 2009) within the maternity services have shown that midwives want to work in an environment that provides one-to-one support in labour (Smith and Dixon 2008; Smith et al. 2009; Birthrights Dignity in Childbirth 2013). Two qualitative studies from China (Gu et al. 2011) and Norway (Aune et al. 2013) described the experiences of midwives providing one-to-one support in labour. The findings showed that when continuous presence was achieved midwives' perceived themselves as 'good midwives' (Gu et al. 2011; Aune et al. 2013).

The one-to-one ratio enabled midwives to provide continuous presence, which created a greater sense of responsibility, working enthusiasm, motivation, achievement, honour, improved midwifery skills, and confidence regarding interactions with women and their birth partners (Gu et al. 2011). Mental presence was deemed as important as physical presence (Aune et al. 2013). In addition midwives believed that their continuous presence gave them a better

overview of the progress of labour and the condition of the baby and reduced women's fears of birth and potentially increased the likelihood of a normal birth (Aune et al. 2013). Midwives valued the relationships with women (Gu et al. 2011; Thorstensson et al. 2008) and this has been shown to be a major source of motivation and job satisfaction for midwives (Kirkham 2006). If the relationship between a midwife and woman did not develop positively however it had a negative emotional effect on the midwives (Gu et al. 2011). Midwives felt frustrated when women and their birthing partners did not trust them or when a long labour progressed to a caesarean section (Gu et al. 2011; Aune et al. 2013). Providing one-to-one support in labour has been shown to be mentally exhausting for midwives (Cheung et al. 2010; Aune et al. 2013). Mental exhaustion was due to the emotions and situations within the labour room (Aune et al. 2013). In addition, mental exhaustion was related to the working conditions including the hours worked to stay with a woman in labour and on-call systems which did not have fixed working hours (Gu et al. 2011).

2.7.6 Midwives' experience of one-midwife-to-many-women in labour

Qualitative research has produced the term 'juggle' to describe the coping method of midwives when caring for more than one woman in labour (Birthrights Dignity in Childbirth 2013:18). Midwives have stated that it is unacceptable to look after more than one woman in labour at one time as it is not safe (Smith and Dixon 2008; Smith et al. 2009). Caring for more than one woman causes midwives to feel they are not mentally present even when they are in the labour room due to other workload pressures (Birthrights Dignity in Childbirth 2013). Studies have shown that midwives feel inadequate if they cannot be present with women within the labour room (Walton et al. 2005; Aune et al. 2013). Providing inadequate levels of support caused one midwife to avoid women in her care as she felt she was letting women down (Walton et al. 2005). Other midwives have stayed in the labour rooms as a strategy to avoid interference from senior midwives and obstetricians (Russell 2007).

Staying in the labour room sometimes attracted snide comments from colleagues who did not value continuous presence (Aune et al. 2013). As previously discussed in section 2.5.6, the constant pressure to conform (Payant et al. 2008; Aune et al. 2013) have pushed midwives to encourage epidurals and use continuous fetal monitoring rather than offering extra support to women as this allowed midwives to leave the labour room to complete other tasks (Aune et al.

2013). The social expectations from other nurses, medical staff and management superseded evidence based practice recommendations regarding support in labour (Payant et al. 2008).

Overall such working environments reflect what Kirkham (2007) referred to as a ‘culture of coping'. Not all midwives are able to cope however and in the UK studies have shown that the main reason for midwives leaving the profession was dissatisfaction with the way they were required to practise within the contemporary NHS organisations (O’Sullivan 2002; Curtis et al. 2006). In addition UK staffing has been blamed for midwives not being able to provide one-to-one support in labour (Smith and Dixon 2008; Smith et al. 2009; Birthrights Dignity in Childbirth 2013; Aune et al. 2013). Staff shortages and unsupportive management have also been major influences for midwives leaving the profession. Midwifery management has rarely been seen as a source of support and they are often perceived to be an integral part of the problems that midwives face (O’Sullivan, 2002; Curtis et al. 2006). Midwives themselves confirmed that they were not alone feeling the pressure; women were also pressured by authoritative midwives to make the ‘right’ decision when supported in labour (Birthrights Dignity in Childbirth 2013:14).

2.7.7 Training midwives to provide one-to-one support in labour

Studies are unanimous that midwives providing one-to-one support in labour require training (Hodnett 2002; Page 2003; Thorstensson et al. 2008; Cheung et al. 2010; 2011; Fox et al. 2013), although not all training experienced has been successful. It has been argued that historically training has not prioritised midwifery one-to-one support in labour (Kardong-Edgren 2001; King 2012) and interpersonal skills (McNiven 1992; Birthrights Dignity in Childbirth 2013). A study by Payant et al. (2008) showed that 37% of nurses were not aware of the benefits concerning continuous labour support in relation to birth outcomes. Theoretical teaching alone concerning midwifery one-to-one support in labour has not been shown to be successful. Two training days from expert labour supporters including a doula were conducted in preparation for randomised controlled trials in thirteen US and Canadian hospitals comparing nurses providing one-to-one support in labour with usual care (Hodnett 2002). The findings illustrated that there was no difference in the birthing outcomes for women or the amount of time nurses spent providing support.

A qualitative study has shown that when student midwives practised one-to-one support in labour as part of their training, positive results were seen (Thorstensson et al. 2008). The study explored the experiences of eleven student midwives providing one-to-one support in labour in a Swedish university hospital. The student midwives received basic training which included touching, holding eye contact and focusing techniques. Each student midwife then offered continuous labour support to five women in labour and wrote narratives about each of these occasions which were then analysed. Continuous labour support was defined as the students being continuously available to a woman and her partner. The student midwives discovered that women did not want to be alone in labour and that their presence helped women to feel more relaxed and secure. In addition student midwives who provided continuous labour support experienced an increase in their confidence to establish a rapport with women and their partners. This confidence increased the willingness of student midwives to be present and increased their ability to offer reassurance and information to help women to feel more relaxed and secure.

The opposite was true for student midwives who lacked confidence with developing a rapport with women. These student midwives tended to focus more strongly on their medical skills and felt a sense of powerlessness especially as regards to women in great pain. It could be postulated that student midwives who are supported to be present within the labour room start to learn skills to adapt their behaviours to improve interpersonal relationships with women and birthing partners and provide support sensitive to the needs of women. It could also be envisaged that if preparation regarding one-to-one support in labour is not completed successfully within the student midwife training, the inadequacies may continue when midwives are qualified.

Qualified midwives have also shown that being with women in labour has improved their midwifery skills, including theoretical and practical knowledge, midwifery techniques and communication skills (Gu et al. 2011). Cohort studies (Page 2003; Cheung et al. 2010; 2011; Fox et al. 2013) have shown that midwives practising one-to-one support in labour for low-risk women learn and adjust their working practices over time. Page (2003) advised that midwives took 6-9 months to adjust their working practice styles. The midwives in the cohort studies experienced genuine difficulty in ‘letting go’ of routine interventions such as amniotomy (breaking the waters), augmentation, episiotomy (Cheung et al.

2010; Cheung et al. 2011) and continuous fetal monitoring (Cheung et al. 2010; Cheung et al. 2011; Fox et al. 2013) when transferring from a medical model to midwife-led care which included one-to-one support in labour. Such routine interventions are not advised for low-risk women (NICE (2014).

In addition midwives requested women to mainly use supine or semi-recumbent positions for birth, because the midwives felt more comfortable with these positions (Cheung 2010, 2011). These positions however do not promote normal vaginal births (RCM 2010b). Both cohorts (Cheung et al. 2010; 2011; Fox et al. 2013) reinforced that training needs to include evidence based knowledge concerning support in labour that encourages the physiological processes of labour. Action research completed in China (Mander et al. 2009) explored the introduction of midwife-led care that included midwifery one-to-one support in labour. The preliminary stages provided an insight into the apprehensions of midwives changing from medical to midwife-led care. The concerns of midwives included the following:

- Limited experience of non-interventive practice
- Lack of confidence in midwifery skills
- Uncertainty about the birth partners role
- Fear of litigation
- Perception of shortages of staff
- External scrutiny of the midwife-led project
  (Mander et al. 2009)

Overall there appeared to be a lack of confidence in their midwifery skills amidst a fear of appearing negligent by not performing medical interventions and being judged by colleagues due to the risk of damaging the reputation of the hospital. It is evident that midwife-led care (including one-to-one support in labour) requires a profound shift of midwifery personal involvement, responsibility, independence, and higher knowledge and skills (Page 2003; Steven and McCourt 2001, 2002a, 2002b, 2002c). Therefore it is difficult to ascertain whether improved birth outcomes are a consequence of training, experience of new ways of working using midwife-led care, continuity, one-to-one support in labour or a combination.

On the whole the evidence shows that midwifery one-to-one support in labour is not instinctive rather it is a set of skills (Hodnett 1996). The evidence also

appears to reinforce the evaluation by RCM (2010a) that skills in theory and practice are required to develop an understanding of the complexities when providing one-to-one support in labour. The complexities include relationship building, supportive techniques that are sensitive to the needs of women, emotional demands of providing support one-to-one and knowledge regarding the progress of physiological labour (Gu et al. 2011; Leinweber and Rowe 2010; Aune et al. 2013).

2.7.8 Maternity support workers helping midwives to provide one-to-one support in labour

The role of maternity support workers is to support midwives to care for women in pregnancy, labour and postpartum (RCM 2010c). In the UK, NICE (2014) have recommended research relating to standardised training programmes for maternity support workers in the intrapartum period. The research should include outcomes such as maternal and neonatal mortality, adverse outcomes, long-term outcomes, women's satisfaction and financial costs. Such research has started in England (Sandall et al. 2007). The study provided information concerning the range of maternity support workers' roles, tasks undertaken and levels of training provided.

The findings indicated that maternity support workers help one-to-one support in labour in two ways. The first is to provide one-to-one support under the supervision of midwives. The second is for maternity support workers to undertake duties that free midwives time (Sandall et al. 2007) to enable midwives to be present with women when providing one-to-one support in labour. A UK survey (Newburn and Singh 2005; Singh and Newburn 2006) reinforced that midwives are not the only providers of one-to-one support in labour. Seventy-one per cent of women had one-to-one support in labour from a midwife and seventeen percent was provided by health care workers such as maternity support workers, student midwives or a doctor.

The role of the midwife in labour is however a statutory responsibility (NMC 2012) and this cannot be delegated to another person unless the midwife refers a woman to an obstetrician due to a deviation from the normal (RCM 2010c). The RCM (2010c) therefore advises that care provided by maternity support workers should not be a substitute for the midwife, but instead be under the direction and supervision of midwives. Lastly, Sandall et al. (2011) advised

further research regarding the Birthrate plus tool to assess if it could be developed into a multi-professional tool including obstetricians and maternity support workers rather than confined to midwifery staffing.

Overall the implications when considering who is the most appropriate to support women one-to-one in labour suggest the need for a mixed economy of support. To this end, the literature review by Rosen (2004) suggested that overall, the evidence about who should provide labour support remains unclear, but advised that different stages of labour may require different types of support from various providers including the husband/partner, relative, friend, doula, midwife (Rosen 2004) and potentially maternity support workers (Sandall et al. 2011).

2.8 The research aim and objectives

There is unequivocal evidence from this literature review that one-to-one support in labour is associated with improved birth outcomes. Where the uncertainty exists is in relation to what it is about one-to-one support in labour that produces such positive birth outcomes. Knowledge relating to one-to-one support in labour has been constrained due to restricted context in which the studies have taken place. Randomised controls trials (RCT's) comparing one-to-one support with usual care have taken place within in hospital environments only and there are no UK studies included. RCT's and qualitative studies have included midwife-led units and the home, but they have not measured midwifery one-to-one support in labour as an outcome or specifically explored it.

The knowledge gained by studies that have analysed one-to-one support in labour, have shown inconsistencies with regard to the level of presence, who should perform one-to-one support in labour, when it should happen, where it should happen and what type of model of care should be applied. Despite the disparities, government policies, opinion papers, research papers and systematic reviews present one-to-one support in labour as though there is a universal understanding of what it is. One-to-one support in labour is however more than a ratio. Given the complexities, not enough is known to be able to recommend with confidence that midwives should not be the primary carer providing one-to-one support to women in labour. The unforeseen consequences of misunderstanding the context in which claims of better outcomes are made, may lead to serious errors in policy decisions about the most efficient models of care. What is needed is research to provide a fuller understanding of the activities of the

midwife when she is with a woman in labour and how these activities vary in different contexts. As there is a knowledge gap concerning midwife-led care in relation to midwifery one-to-one support in labour, the context chosen should include an alongside midwife-led unit, a freestanding midwife-led unit and the home environment where midwifery one-to-one is said to take place. Secondly, more evidence is required from women's perspective to understand their needs when midwives provide one-to-one support in labour. The following aim and objectives have therefore evolved from the literature review to address the knowledge gaps:

Aim: Explore midwifery one-to-one support in labour in a real world context of midwife-led care

Objectives:

1. Synthesize the literature regarding midwifery one-to-one support in labour
2. Observe midwifery one-to-one support within different midwife-led care settings, including alongside midwife-led unit, freestanding midwife-led unit and home births
3. Explore midwife's perceptions of practising one-to-one support in labour
4. Explore how women who have experienced midwifery one-to-one support in labour perceive their care

2.9 Conclusion

This chapter has presented a literature review that started with a broad exploration in relation to one-to-one support in labour and progressed to narrow the focus towards midwifery one-to-one support in labour. The benefits of one-to-one support in labour were discussed with regards to RCTs, cohort studies and qualitative research. As the attributes of one-to-one support in labour were examined disparities were revealed. The benefits, access and challenges of each potential labour supporter were then analysed and reinforced a mixed economy of support is required in labour. The examination of the midwife as the labour supporter revealed more complexities with reference to the model of care and place of birth. The knowledge gaps were highlighted regarding midwives providing one-to-one support within midwife-led units and the home environment.

Chapter three presents the methodology used to investigate the research aim and objectives.

Chapter three

Methodology

3.1 Introduction

Chapter three describes the methodology used for this study. This chapter starts by justifying the decision to choose ethnography as the methodology and using elements of symbolic interactionism to grasp and understand how to interpret the fieldwork**.** Subsequently reflexivity is discussed to acknowledge myself as a researcher with midwife experience collecting and translating data. The research design is duly explained starting with an understanding of what constituted a case, the methods used for sampling, the ethical considerations, methods for collecting data and a description of the researcher's experience of fieldwork. The chapter concludes with an explanation of the methods used for data analysis and the limitations of this study.

3.2 Justification for methodology

3.2.1 Analysing different methodologies

Quantitative and qualitative methodologies that have investigated one-to-one support in labour were examined prior to choosing ethnography. Quantitative data such as RCTs are viewed as the gold standard methodology and thought to produce clearer objectives for change and generalisability when compared to qualitative data (Bloor 2010). The systematic review by Hodnett et al. (2013), which included twenty-two RCTs, reinforces this trait as it is the most referenced research within the field of one-to-one support in labour. The RCTs measured predetermined birth outcomes following the intervention of one-to-one support in labour against usual care which did not involve one-to-one support. The results produced clear recommendations that have been used globally (Martis, 2007; Amorim and Katz 2012) and locally (NICE 2014).

Although the systematic review is a valuable contribution to knowledge in the field of one-to-one support in labour, the literature review in chapter two revealed a lack of consensus about what constitutes one-to-one support in labour as it is a complex concept. Variations regarding definitions have caused comparative difficulties for RCTs assessing outcomes (Hodnett et al. 2013). In addition the systematic review by Hodnett et al. (2013) left unanswered questions firstly, about what activities occur inside the birth environment that cause the improved outcomes. Secondly, there are questions regarding the effectiveness of

midwives/nurses when compared to supporters such as doulas. Hodnett et al. (2013) suggested that midwives/nurses were constrained by medical interventions, technology and documentation. When contemplating a methodology in relation to one-to-one support in labour, another RCT would not address these knowledge gaps.

Surveys (Newburn and Singh 2005; NFWI and NCT 2013; Macfarlane 2014) have asked women whether they have had one-to-one support in labour. The definition for one-to-one support however was not stipulated and the concept was interchanged with continuous care during labour (Newburn and Singh 2005). The answers from women reinforced that they did not easily understand what one-to-one support in labour meant (NFWI and NCT 2013). Other surveys have focused on the presence of the midwife, asking women if they felt alone in labour (CQC 2013). The results of such surveys have provided quantitative comparisons that have shown that less women feel alone in labour when compared to the CQC survey in 2010 (CQC 2013). It is questionable however as to what caused the reduction, how women translate feeling left alone and what are the incentives for women to take part in the survey. The contribution to knowledge concerning one-to-one support in labour provides no contextual information or meaning to the consequences of being left alone in labour. Not enough is known about the concept of midwifery one-to-one support in labour to confidently devise a survey to explore preconceived investigative themes.

The literature review revealed that most qualitative studies explored closely related concepts to midwifery one-to-one support in labour. There was only one phenomenological study (Gu et al. 2011) that contributed detailed descriptions of the lived experiences of midwives in China working in a hospital labour ward performing one-to-one support in labour. The concept of one-to-one support in labour was defined as a ratio of one midwife to one woman who provided continuity in labour and the two hours following birth (Gu et al. 2011). This study provided a sense of the positive and negative emotional demands experienced by midwives when offering one-to-one support in labour. Although the knowledge contributed to the lived experience of midwives, it did not achieve a contextual understanding of the culture and working environment. In addition the perspective of women was not included. Consequently a phenomenological study was contemplated, but the knowledge gained relating to the context and experience would have been restricted to the perspective of the midwives

providing and women experiencing one-to-one support in labour. In addition there is a potential that the inside knowledge that midwives possess in relation to their working environment, experiences and culture may blind them to many aspects of their practices. Again not enough is known about the concept of midwifery one-to-one support in labour to confidently explore preconceived investigative themes using broad interview questions. In order to gain further insights observations were required to ascertain how midwives 'do' one-to-one support in labour rather than how it is 'talked' about (Hunter 2004:263).

Three qualitative studies have revealed closely related concepts including being 'with woman' (Hunter 2002, Hunter 2009), 'continuous presence' (Aune et al. 2013) and 'continuous support' (Thorstensson et al. 2008). Although informative concerning the importance of presence in regards to the activities and relationships that occur within a birth environment, the studies do not describe the concept of midwifery one-to-one support in labour.

Overall the methodologies used to investigate one-to-one support in labour have contributed valuable knowledge. The concept of one-to-one support in labour is however used as though there is universal understanding as to what it is, when there are obvious inconsistencies. A methodology was required to provide a broad scope of investigation to gain social and contextual knowledge about the activities that occur inside and outside the birth environment[9]. It was envisaged that this would help gain an understanding of what midwifery one-to-one support in labour looked like in a real world context.

3.2.2 Ethnography

3.2.2.1 Investigating culture

Ethnography means 'cultural interpretation' (Wolcott 1990: 441) and as a methodology has its roots in anthropology (de Laine 1997; Hammersley and

[9] In this study the birth environment included the home or a labour room within an alongside midwife-led unit, freestanding midwife-led unit or an obstetric-led labour ward if a woman was transferred.

Atkinson 2007). Ethnography has a broad systematic approach which was ideal to gather data about the everyday life (Hammersley and Atkinson 2007) of midwives providing one-to-one support in labour and how that support was perceived by women. Thus the investigation had to happen within the context (Hammersley and Atkinson 2007) that the phenomenon occurred which in this study included the AMU, home environment and FMU. Using ethnography to study the real world context allowed me to understand what it meant to be part of a culture (Hodgson 2001) practising midwifery one-to-one support in labour within midwife-led birth environments. Culture in this study was understood as a set of guidelines that includes beliefs, customs, ideas, concepts, rules and meanings that individuals inherit and learn as members of a particular group and these are expressed in the way that people live (Helman 2007). Culture is learned through socialisation which is the process that people learn the norms and values within a social group or society (de Laine 1997). The aim was to reveal these cultural complexities relating to the activities and interactions concerning midwifery one-to-one support in labour. The intention was not to observe and assess midwives' practices, but rather learn from them (Spradley 1979; Kleinman and Copp 1993) to gain an insider view (de Laine 1997: xxi) otherwise referred to as an emic view regarding midwives' actions, behaviours and beliefs within a cultural and societal context (Whitehead 2004).

3.2.2.2 Methods

Ethnography requires researchers to immerse themselves into the research field to empirically investigate and then interpret the social organisation and culture (Roper and Shapira 2000; Hammersley and Atkinson 2007; Bloor 2010; Lambert et al. 2011) otherwise referred to as fieldwork (Hammersley and Atkinson 2007). Ethnography is the process and product of fieldwork (de Laine 1997). The ethnographic methods deployed in this study as part of the fieldwork included observations inside and outside of the birth environment, as well as informal and formal interviews. The methods also included drawings such as floor plans for each case study site and drawings to record activities and positions of research participants inside the birth environment and document analysis including protocols, guidelines and maternity records. Overall, such methods are standard for ethnography (Hammersley and Atkinson 2007; Munhall 2012).

These methods were dependent upon and guided by social interactions, shared experiences and being accepted by the research participants (Coffey 1990;

Munhall 2012). This meant that the methods were reliant on relationships between the research participants and myself as the researcher. Relationships have been shown to influence the information research participants chose to share with researchers (Heyl 2010). It has also been suggested that some research participants may be intent upon making sure that researchers understand the situation 'correctly' (Hammersley and Atkinson 2007).

Ethnographic fieldwork can be challenging as it takes time for researchers to establish themselves in the culture of the group (Munhall 2012). I related to this challenge as it took six weeks for research participants to allow me to enter inside the birth environment at all three case study sites. I found like other researchers that it was an essential part of fieldwork to find gatekeepers to provide inside knowledge of the setting to help plan effective strategies to follow the research protocol and help gain access to potential research participants (Hammersley and Atkinson 2007; Munhall 2012). A 'gate keeper' is a person who controls research access. Knowing who had the influence to open or block access, or who thought of themselves and/or were considered by others to have authority (Hammersley and Atkinson 2007) was vitally important within my fieldwork. In this study the first gatekeeper was the head of midwifery of each NHS organisation, but once fieldwork commenced, managers, midwives, clerical staff and MSW's also played an essential role as gate keepers.

3.2.2.3 Symbolic Interactionism

Ethnography required me as the researcher to grasp information so that I could explain the working culture of midwifery one-to-one support in labour rather than merely describe it. Using elements of symbolic interactionism helped me make the transition from describing a lived experience to explaining a culture in a real world context. Reading the works of Blumer (1986) and interpretations of his work (Prus 1996; Longmore 1998; Klunklin and Greenwood 2006; Allan 2007; Rock 2010) I became to understand the importance of interactions within fieldwork. In addition the work by Goffman (1990) aided my understanding of how individuals present themselves in such interactions. For the purpose of this research, interaction is defined by the description from Goffman (1990: 26):

> ‘Interaction (that is, face-to-face interaction) may be roughly defined as the reciprocal influence of individuals upon one another’s actions when in one another’s immediate physical presence.’

According to Blumer (1986) society is comprised of many social actors all involved in the process of interaction. Although meaning is held in the mind of individuals it is produced and exists within these social interactions (Allan 2007). This means individuals determine meanings for physical objects, other human beings, and categories of human beings, institutions, activities and situations through these social interactions (Blumer 1986). In addition emotions are social and cultural products, although again individuals have some control over them (Blumer 1986; Kleinman and Copp 1993), as individuals do not simply react (Prus 1996). Overall symbolic interactionists stipulate that there is no self without the community (Prus 1996).

Symbolic interactionism recognises that individuals have a meaning for everything around them (including themselves) based upon social and cultural influences which consist of intentions, motives, beliefs, rules, discourses and values (Blumer 1986; Hammersley and Atkinson 2007). Meanings are not only influenced by interactions with others but also the context it occurs and therefore meaning is continually modified through an interpretive process as interactions and events unfold (Blumer 1986; Hammersley and Atkinson 2007; Rock 2010). This is illustrated when considering how people act differently towards their partner, parents, employer, children, or strangers (Klunklin and Greenwood 2006; Rock 2010). Goffman also demonstrated this point when explaining how individuals present ‘front stage’ and back stage’ performances, determined by their audiences (Goffman 1990). ‘Front stage’ performances presented an expected character, like that of a professional midwife. ‘Back stage’ performances included a loss of decorum as the audience changed to those who were part of the team. In this study the ‘front stage’ performances translated to the observations inside the birth environment while the ‘back stage’ performances translated to the areas where women and their families were not regularly present such as the staff office. Later in this chapter it will be discussed how ‘front stage’ performances provided ‘staged data’ in this study when I first entered the ‘back stage’ environment in the staff office.

To interpret the fieldwork I had to understand the meanings behind social interactions (Spradley 1979; Hammersley and Atkinson 2007; Reeves et al. 2008) which enabled me to unravel situations (Longmore 1998). Unravelling such complexities had the potential to reveal meanings that had not been asked by the research participants themselves (Rock 2010) working within the AMU, FMU and the home environment. When summarising symbolic interactionism within the field, I used the translation from Longmore (1998) regularly as a mantra in my mind asking myself, how individuals think about themselves, how they relate to others and how others think and relate to them.

3.2.2.4 Learning from previous ethnographies

When searching for guidance to design the research protocol for this study and gain insight concerning fieldwork relations and writing an ethnography, I referred to previous ethnographies completed. I started with an ethnography by Whyte (1981) titled 'Street Corner Society.' This ethnographic study is referred to as a classic (Andersson 2014). The information helped me understand how you gain understanding of groups under observation, how you conduct yourself as a researcher especially in respect to asking or not asking questions, controversies concerning interactions and building relationships with gatekeepers. Such information was also attained from midwifery ethnographies providing further insight concerning fieldwork within birth environments including maternity hospitals (Kirkham 1999; Crozier 2007; Kirkham and Stapleton 2004; Stapleton 2004); FMU (Walsh 2007) and AMU (Newburn 2012).

Ultimately, the art of writing 'thick description' (Geertz 1973; Luhrmann 2015) was crucial. It was not until I read the 'Balinese cockfight' by Geertz (1973) that I suddenly understood why and how 'thick description' was more than an account of who did what and when (Luhrmann 2015). Geertz (1973) described the ritual of the 'Balinese cockfight' which communicated the meaning of behaviours including why a behaviour was done, how it was interpreted, and what the different social codes were associated with the behaviour (Luhrmann 2015). Thick description provides evidence that the researcher has grasped the social processes of the world being studied, and for those who are not familiar can understand this unknown world (Luhrmann 2015) and sense the emotions, thoughts and perceptions of the research participants within a specified context (Munhall 2012). Luhrmann 2015). Some suggested that '*thick description is unquestionable one of ethnography's richest offerings'* (Falzon 2009: 7).

3.2.2.5 The impact of ethnography

Historically, ethnographies have had less impact on policy change when compared to quantitative data (Bloor 2010). Unlike RCTs however an ethnographic studies have the potential to explain and highlight the degree of significance of the results produced from previous RCTs (Bloor 2010) concerning one-to-one support in labour. The findings from this study may help inform future RCTs and systematic reviews to validate components of one-to-one support in labour when investigating, measuring and comparing the concept. Midwifery research has used ethnography as the first phrase of larger scaled mixed methods research in which keys themes have been identified and used to help inform and design RCTs (Kirkham and Stapleton 2004; O'Cathain 2004; Stapleton 2004).

3.2.3 Reflexivity

3.2.3.1 Recording the 'me' in this study

The fieldwork in this study relied on me as the research instrument (Coffey 1999; Allen 2004), although it did not mean I was the main focus. I was responsible for the interpretation and reconstruction of the fieldwork (Coffey 1990) into findings. Increasingly it is accepted that it is impossible for any individual to have no pre-conceived notions when entering the research field (Fetterman 1989; Lykkeslet and Gjengeda 2007). Ethnographic researchers bring their cultural norms to the research field which means that they filter what they observe, hear, and feel through their own ideas, knowledge, values and interests (Spradley 1979; Riemer 2012).

From the start of the study reflexivity was accomplished through a reflective diary, and written as part of the data collection from the observations and interactions. Reflexivity was pursued as an integral part of the research process when describing, analysing and translating the raw data (Wolcott 1995) and writing up the thesis. Reflexivity helped to capture my conscious thoughts (Lambert et al. 2011) by critically examining assumptions and actions of myself in relation to the data (Bonner and Tolhurst 2002). I went into the field with an identity constructed by age, race, gender, class, occupation, disciplinary knowledge and theoretical frameworks (Coffey 1990). As a researcher with midwifery experience, I also brought to the research field midwifery knowledge, skills and attributes (Borbasi et al. 2005). As part of the reflexive process

therefore I had to consider that when I started the fieldwork I had been a midwife for sixteen years. I had not worked as a clinical midwife for three years, but in the sixteen years I had worked as a team midwife within the community and hospital environments, a labour ward coordinator, clinical manager and governance midwife. These roles gave me an insider perspective of being a midwife working in a NHS organisation. Being a midwife was part of my cultural identity (Coffey 1990).

I acknowledged within reflexivity that I felt different in the researcher mode when compared to a midwife clinician. In researcher mode I became very aware of all my senses including smells, a sense of an atmosphere and interactions *(*Fraser and Puwar 2008). I was also very conscious that first impressions of the researcher were important (Goffman 1990; de Laine 2000, Allen 2004) as '*appearance sets the screen for verbal interaction to occur'* (de Laine 2000: 59). It has been argued that novice researchers who are clinicians initially observe the field from the perspective of a clinician rather than researcher and they progress to researcher mode with experience (Allen 2004; Murphy 2005; Lykkeslet and Gjengeda 2007). I continually balanced my insider/outsider status to ensure that both were supporting my role as a researcher not a clinician in the research field.

3.2.3.2 Insider (emic)/outsider (etic) debate

Both emic and etic perspectives are crucial in ethnography (Dresher 1994) and interrelated (Keating 2010). The emic perspective refers to the insider's view of reality (de Laine 1997; Keating 2010; Riemer 2012) and the etic perspective is otherwise referred to as the outsider perspective (de Laine 1997; Riemer 2012). These cannot be achieved without the researcher using their insider/outsider status.

The emic perspective in this study aimed to understand and convey the midwives and women's perspective as the insider's view of the real world context of midwifery one-to-one support in labour. This was communicated in the findings by means of 'thick descriptions' using accounts from the research participants' own words. The etic perspective is more of an objective approach aimed to understand external factors such as organisational issues including social, political and economic (de Laine 1997). In this study I aimed to understand the impact of such external factors on the cultural practices of

midwives providing one-to-one support in labour. This information exposed more than one culture regarding philosophies of care within each case study site. From an etic perspective using three case study sites also allowed comparative analysis. Comparisons were also performed using the literature to integrate the findings from this study into existing research evidence. My outsider status meant that I was completing fieldwork as someone who was not part of the culture being studied which created a more objective perspective.

My insider status helped me understand the emic perspective of midwives and women. Being a midwife gave me insider status that helped me to grasp the language, have empathy towards observations and have sensitivity for when a moment became opportunistic to ask a question (Bonner 2002; Burns et al. 2010). These attributes helped me to fit in (Cudmore and Sondermeyer 2007) and establish rapport with the research participants (Borbasi et al. 2005). I was mindful however that by using my insider knowledge of language, I did not convey a clinical midwife status on a shift. I was continually conscious that my role was that of a researcher investigating midwifery one-to-one support in labour.

There has been much debate about the benefits and disadvantages of the insider/outsider status of clinicians performing research from the perspectives of midwives (Burns et al. 2010) and nurses (Walker 1997, Bonner and Tolhurst 2002, Leslie and McAllister 2002, Allen 2004; Borbasi et al. 2005, Cudmore and Sondermeyer 2007; Lykkeslet and Gjengeda 2007). There is tension in the literature between ‘strangeness and over-identification’ (Coffey 1990:23). Studies have demonstrated that there are further challenges regarding insider status including researchers feeling like traitors as practices of colleagues are subjected to scrutiny (Cudmore and Sondermeyer 2007, Burns et al. 2010); or create risks of becoming too involved known as ‘going native’ (Chesney 2001) causing ‘cultural blindness’ (Lykkeslet and Gjengeda 2007). In addition researchers in their quest to forge acceptance have felt that they needed to offer something back to research participants in exchange for the intrusion and questioning that they are doing and data they are receiving (Alder and Alder 1987). To help combat these challenges I used my outsider status from the onset by introducing myself as a researcher which was reiterated within the research leaflets. I continually introduced myself to all new acquaintances I interacted with, including maternity staff, childbearing women and their birthing partners. I

also informed all research participants of the aim of my study so that midwives in particular understood the aim was not to assess their activities and perceptions, but to understand them within a working culture of midwifery one-to-one support in labour. I also increased my outsider status by choosing NHS organisations that I had not worked (Burns et al. 2010). In addition I considered myself an outsider due to never working within an alongside midwife-led unit or freestanding midwife-led unit and I had never worked in an environment that provided midwifery one-to-one support in labour for all women except when attending home births. Taking such precautions did not prevent unexpectedly reuniting with midwives that I had previously worked with. I am not alone in such circumstances (Hunt and Symonds 1995). This did not create difficulties however as such acquaintances acted as 'gate keepers' and helped the development of the emic perspective.

Theoretically it appears clinician/researcher identities can be separated, but essentially the perspective from Walker (1997) articulates my position experienced as a clinician/researcher being a 'border ethnographer'. That is someone who does not belong on either side, but inhabits the slash in-between the clinician and researcher illustrating a constant tension of identities. This tension however was a positive balancing act as I calibrated my researcher/clinician identity to collect and make sense of the data I was collecting within the research field and later when analysing the data and writing the findings. Reflexivity was essential to record these tensions as well as my multifaceted midwifery identity. Reflexivity also helped me to understand the working ethos that was different to my own that sometimes placed me in conflict with events that I observed. Research from Ryan et al. (2010:7) showed that there are contentions relating to the clinician/researcher identity and ethical situations around confidentiality and trust. They argued that the midwife's role, governed by her professional code of conduct (NMC 2012), must override her role as a researcher. Ryan et al. (2010:7) suggest pragmatics say that:

> '…when life is threatened a midwife-researcher is morally obliged to exchange her research hat for her professional one and act accordingly.'

Subsequently this chapter will analyse and address the ethical issues related to this study and show how the research protocol included safety measures within the research design.

3.3 The research design

This part of the chapter describes the research design including an understanding of what constituted a case, the methods for sampling, ethical considerations and methods of collecting data and analysing data. As the study has been completed, the experience undertaking the research protocol will also be explored where appropriate.

3.3.1 Identifying the 'case'

3.3.1.1 Setting the boundaries

In this research identifying the 'case' means to define the 'unit of analysis' (Yin 2003; Miles and Huberman 1994) and is not referring to the case study method. This is one of the most important stages of the research design as it portrays what is to be analysed in the study. Without it, the everyday life being investigated would have boundaries of observation and analysis almost endless (Coffey 1999). The literature review exposed conceptual and geographical boundaries resulting in more than one case of interest. The conceptual boundary of the cases reflecting midwifery one-to-one support in labour included a labouring woman who was under midwife-led care and being supported by a midwife; began in established labour (DH 2004; NICE 2014) and ended one hour after the birth (Rosen 2004). This conceptual boundary was expected in all birth environments to enable a comparative analysis of all geographical sites.

A definition regarding midwifery presence was not used within the description of the conceptual boundary as there are variations in the literature (Gagnon et al. 1997; DH 2004; Hodnett 2002; Hodnett et al. 2013) and part of the research aimed to investigate how NHS organisations translated this concept into practice. It was acknowledged that birthing partners and other health professionals would enter the birth environment, but the focus remained with the experiences and perceptions of midwives and women. At the broadest level the geographical boundary was confined to the UK. The literature review identified three geographical sites in which the concept of midwifery one-to-one support in labour took place:

1. Case one: Ten labouring women each receiving one-to-one support by a midwife in a labour room within an alongside midwife-led unit
2. Case two: Ten labouring women each receiving one-to-one support by a midwife at home
3. Case three: Ten labouring women each receiving one-to-one support by a midwife in a labour room within a freestanding midwife-led unit

The boundaries did not end here. Although the second and third cases were not geographically within a NHS hospital, the midwives were affiliated with a NHS organisation. This meant that in the event of a deviation from the normal physiology of labour or an emergency occurred during labour or following birth, the woman was transferred to the consultant-led obstetric unit within a NHS organisation. When planning the research strategy it was envisaged that resources such as the allocated budget, staffing and equipment for all three cases would be influenced by the associated NHS organisation which may impact on midwifery one-to-one support in labour.

3.3.1.2 Multiple case study sites

Once the boundaries of the cases had been determined I referred to them as case study sites one, two and three to reinforce a geographical connection. Using more than one case study site provided the opportunity to achieve a broader knowledge of the complexities concerning midwifery one-to-one support in labour and an ability to compare the culture and activities across the three geographical sites (Marcus 1995; Falzon 2009). It has been suggested that social phenomena cannot be defined when focusing on one site (Marcus 1995). This argument was applicable to this study as the findings will later show in this thesis how the activities inside the birth environment were very similar at all three case study sites, the differences were more apparent outside the birth environment.

3.3.1.3 Deciding how many labour observations make a case

Calculating the number of labour observations required was difficult as there is limited guidance regarding sample sizes in qualitative research. Marshall et al. (2013) reinforced the latter point in their research which found that out of eighty-three qualitative studies, none cited qualitative methodologies regarding

appropriate sample size. Such difficulty arises due to flexibility being advised concerning sample sizes for qualitative studies, since the aim is to reach a point when new categories, themes and explanations stop emerging from the data which means data saturation is accomplished (Marshall 1996). Morse (1994:225) has published guidance concerning sample sizes in relation to interviews and recommended 30-50 interviews when using ethnography. Morse (2000) has also recommended that these numbers are dependent on the quality of the data collected resulting in the amount of data that is usable for the research. The greater the amount of useable data, the less research participants required.

In this study it was thought during the planning stage that as the data produced from the interviews was focused on labour observations, the quality of usable data should be high. This meant that the number of observations had an impact on the numbers of interviews so this had to be taken into consideration. The calculation of the sample size was also based upon what I believed was achievable within the timing of the research protocol, and to accomplish comparative analysis and data saturation. During the fieldwork the amount of labour observations could be reduced if required. However there was not the same flexibility to increase the labour observations as permission from the ethics committee, NHS Research and Development departments representing the NHS organisations and heads of midwifery (HOM) and Consultant midwife would have had to be achieved. The final decision was made to include ten labours observations for each of the three case study sites which meant that approximately thirty interviews involving midwives, and thirty interviews involving women were anticipated. This estimation was accurate in hindsight.

3.3.2 Sample Selection

Purposeful sampling was utilised in relation to the geographical sites, midwives and women so that specific characteristics were targeted. I actively selected the most productive sample to achieve the research aim and objectives (Marshall 1996).

The first step involved finding a method of purposefully sampling the geographical sites that would become the three case study sites previously discussed. One website sourced titled Dr Foster (2007: accessed 12/02/11) assessed services and outcomes of every consultant-led obstetric unit and midwife-led unit in the UK. Dr Foster was a joint venture with the Department of

Health and research partners at Imperial College London (NHS Choices 2011; Dr Foster 2014). The Dr Foster website (2007) questioned every consultant-led obstetric unit and midwife-led maternity unit in the UK whether a midwife provided one-to-one support in labour. The website did not define what was meant by midwifery one-to-one support in labour, but requested a yes or no response. In addition the website (Dr Foster 2007) provided information about birth rates within each organisation including the percentages of homebirths. Using the information from Dr Foster, NHS organisations were targeted with higher home birth rates to increase the probability of achieving ten labour observations at case study site two, within the specified time of the research protocol. Figures in England alone have shown that home birth percentages range from 0-11% (RCM 2008). The information discussed above is no longer accessible through the Dr Foster website rather the data is accessed through 'Which?', in partnership with Birth Choice UK (Which? Birth Choice 2015).

The second purposeful sampling step concerned the midwives. The aim was to include midwives that had experience of supporting women in labour (Table 3). This meant that Band 5 or often referred to as preceptor midwives were excluded from the study as they had less than one year experience and receiving support with their clinical practice within the three case study sites.

Table 3: The inclusion and exclusion criteria for midwives

	The inclusion criteria for midwives
	Who provided consent Band 6 and above Had over one year labour support experience
	The exclusion criteria for midwives
	Undertaking preceptorship Under supervised practice

Table 4 shows that all midwife participants that were included in this study had at least one year experience as a midwife and supporting women in labour. The majority of AMU midwives at case study site one, had two to four years' experience. The community midwives covering home births and the FMU midwives, had more years' experience when compared to case study site one.

Table 4: The years of experience in relation to midwives who participated in the study

Case study site	1-11 years of experience	>11 of experience
Case study site one (AMU)	11	3
Case study site two (Home)	3	8
Case study site three FMU	3	6

The third purposeful sampling step concerned the women (Table 5). The overall aim was to ensure that women were low-risk. The decision to exclude women who did not speak English was not easy as it is important to include non-English speakers in health services research to address health inequalities and promote social justice (Plumridge et al. 2012). The presence of an interpreter, potentially, could have interfered with the dynamics inside the birth environment as it would have been an extra person present. I would have had to exchange with the interpreter throughout the labour, which could have had implications for the interactions between the woman and midwife. It would also have made it more difficult for me to blend into the background. In relation to the labour observations and interviews it would have been difficult to link non-verbal communication with the spoken words as they would have come later in the interviews (Plumridge et al. 2012).

Table 5: The inclusion and exclusion criteria for women

The inclusion criteria for women
Under midwife-led care Over 18 years old, Primigravida/Multigravida Singleton pregnancy Expected due date was within the weeks that the labour fieldwork was in progress

The exclusion criteria for women
Who had obstetric, medical, surgical, psychological, social factors that deemed women as high-risk or vulnerable adults Twin pregnancies Do not speak English

Table 6 shows that the number of women who were primigravida and multigravida were very similar at all three case study sites, although case study site two had a slightly higher number of multiparous women. Multigravida women were more likely to have a home birth at case study site two.

Table 6: The number of primigravida and multigravida women who participated in the study

Case study site	Primigravida	Multigravida
Case study site one (AMU)	4	6
Case study site two (Home)	2	8
Case study site three FMU	3	7

Table 7 shows that most women who participated in this study were British Caucasian at case study sites one and two. There was ethnic diversity within case study site three. The stipulation for English speaking may have influenced the ethnic diversity of women in this study.

Table 7: The ethnic origin of women who participated in the study

Case study site	**Ethnic origin**
Case study site one (AMU)	10 Caucasian
Case study site two (Home)	10 Caucasian
Case study site three FMU	5 Caucasian 1 African 2 Middle east 2 Asian

3.3.3 Ethical Considerations

Analysing ethical issues was an essential part of designing the research protocol as midwives and childbearing women were approached to be part of this research. The overall objectives were to safeguard the rights, dignity and wellbeing of research participants (Murphy and Dingwall 2010) while also safeguarding the NHS organisations and myself as the researcher.

3.3.3.1 Consent

Research literature including an invitation letter, participant information sheet and consent form (Appendixes I, II, III, IV, V, VI) were designed using the guidance provided by the National patient safety agency (2009). The research literature outlined the purpose of the research and included details of the study when a research participant consented to be part of the study or did not consent. It assessed possible risks and benefits when taking part, the support available if a problem arose, and who had reviewed the study. In addition to the research literature, consideration had to be given to the timing of consent and who would obtain the consent.

When designing the research protocol, consent for women and midwives had to be considered separately as they had different risks factors. The timing of consent for women was significant because women are vulnerable in established labour, therefore consent could not be gained in established labour. The

research literature (Appendix IV, V and VI) was designed to be given to women in pregnancy by the midwife at the antenatal checks, with the choice to gain more detail from the researcher using the contact details provided. In addition if a woman required a check in pregnancy within the midwife-led units, home or labour ward and were either discharged home or the midwife had left their home, they were also given the research literature. Women then had time until they went into labour to consider their consent and sign the consent form; yes or no in relation to participating in the research.

Consent could be provided to different aspects of the study, for example a woman could consent to the labour observation, but not to the interview (Appendix VI). The overall aim was for women to receive the research information in a supportive, non-coercive manner when they were not in established labour. The consent form was then placed at the front of the woman's maternity notes for the midwife to assess when a woman presented in labour. The second part of the research protocol concerning consent was checking whether a woman had consented to participate in the study. The research protocol stipulated that when the woman was assessed in labour, if the consent form documented a 'no' in relation to participating in the study, the midwife would not discuss the research further. If the consent indicated a 'yes' the woman was asked by the midwife if she was still happy to participate in the study; if yes the midwife countersigned the consent form.

Women were reassured that their care would not change in any way if they declined consent. In addition, if women gave consent their care would also not change except that they would be observed by me as the researcher in labour and would be invited to complete a face-to-face interview 2-4 weeks after the birth of her baby. The labour observation did not commence however until a midwife also consented to participate in the research.

The consent of midwives was considered away from my presence. When a midwife signed the consent form, I was then contacted and I countersigned the consent form. I was only contacted if the woman and midwife provided consent. I was not informed when consent was not provided. This was to ensure confidentiality for midwives and women and avoid their discomfort in my presence.

3.3.3.2 Harm

Having inside midwifery knowledge created statutory (Nursing and Midwifery Council (NMC), 2012) and ethical responsibilities for me as I was still bound by my midwifery code (Ryan et al. 2010). This was an area that I had to explain in-depth to the UK Ethics Committee, the three NHS Research and Development departments, heads of midwifery (HOM), midwifery managers, maternity staff, women and birthing partners. Recognising this responsibility, I was regularly asked for clarity about what my actions would in the event of an emergency or if I saw unsafe practice. I made it clear from the onset that safeguarding research participants and the hospital organisations were my priority. The research literature that I handed out reinforced that I was working in the capacity of a researcher and that I was committed to confidentiality and anonymity; if I witnessed practice that was unsafe to the mother or baby, I would summon help. I did not witness any practices that were unsafe. I did however encounter a scenario at a home birth where the baby's heart decelerated and I internally questioned whether the position of the woman should be changed to a more optimal position which may improve the situation. I did not need to step in as the midwife changed the woman's position and the baby's heart increased and the baby was born shortly after the episode. This reinforced the requirement to clarify responsibilities as part of the research design.

The research processes can cause research participants to become anxious (Hammersley and Atkinson, 2007). As I planned to observe the practices of midwives, I was aware that this may cause anxiety or may be perceived to be obtrusive by the midwives and women just being present. For midwives and women who did consent to my presence inside the birth environment I ensured that I did not stay beyond eight hours. Eight hours is the length of a shift. There appeared to be no guidance available to guide presence in the research field except two ethnographic studies. Bonner and Tolhurst (2002) reduced their observation time from eight hours to four as they thought the forma was too long. Hunt and Symonds (1995) stayed 2-8 hours in the research site. Taking into consideration midwives working 12.5 hour shifts and some women labouring more than eight hours, I felt in both circumstances there were risks that the research participants may start to find the presence of the researcher intrusive and therefore impinging on their privacy. To decrease such anxiety I stipulated in the research literature that midwives and/or labouring women could opt out of the research if they needed a break for a few minutes or they could completely

withdraw consent from the research at any time with no retribution (Rees 2011). In addition if consent was withdrawn, the data collected would not be used.

Overall in relation to childbearing women and midwives, it was agreed at each NHS organisation that the HOM would be the contact person for midwife participants to be referred to, if problems or harm was caused during the observations or/and the interview. For women, the contact was the patient advice and liaison (PALS) department at two NHS organisations and the third requested the HOM to be the contact. This information was reinforced in the participants' information leaflets (Appendix II, V). The HOM was also a point of contact at all NHS organisations if a woman disclosed questions or concerns about their care which could result with psychological or physical risk. I provided the information verbally and the participant leaflet specified that the HOM was a contact for all women to address any concerns that were not disclosed to me. No women were referred in this study.

Lastly, I had to consider potential harm to myself as a lone worker when completing the interviews in women's homes. I referred to a lone worker guideline from my place of work to incorporate safety measures. I ensured that I had a contact person who knew the location and when I was entering homes and a code was agreed that I would communicate if I felt I was in an unsafe position. There were no unsafe incidences or experiences in this study.

3.3.3.3 Confidentiality/anonymity

Throughout the processes of data collection and analysis, anonymity was secured using codes for identifying geographical sites and research participants. When the research findings were written, pseudonymous was used to continue to protect the identity of research participants. Anonymity was one of the reasons why the NHS organisations chose to take part in this study. Although such protective measures are taken there is a potential that members within each NHS organisation may recognise themselves and others (Ellis 1995).

To decrease this potential within the research design, research participants were asked if they wanted to check their transcripts to assess details that would identify them. In this study two midwives (one from case study site one and one from case study site three) requested a copy of their interview transcript but no changes were requested. Research participants were also reassured that

collated data was only used for the purposes of the research. This was communicated to midwives and women. Potentially women may have feared that the midwife caring for her would be informed of her views and the midwives may have feared repercussions from their management.

Data protection was a vital component of safeguarding the research participants and the study. The protocol included that all fieldnotes were collected on a touchscreen tablet. The touchscreen tablet was set up to require a password to open the device and a second password to open the word document where fieldnotes were typed. The touchscreen tablet automatically locked functions when not used for two minutes and therefore needed passwords to re-enter.

After each day on the field, data collected on the touchscreen tablet, including word documents and audio recordings, were downloaded onto an encrypted USB stick which was stored in a safe location. There were no audit trails of the study on computers. The only audit trail remained on two encrypted USB sticks. Data previously referenced had also been anonymised so that the names of midwives, women and NHS organisations could not be identified and associated with any of the data relating to the interviews and observations. The only identifiable data was the consent forms. Consent forms were stored in a safe location.

3.3.3.4 Peer review

As part of the preparation for the Ethics Committee and the NHS Research and Development applications for each of the NHS organisations; a copy of a proposed research protocol was sent to the Maternity Services Liaison Committee (MSLC) at two NHS organisation regions to review. The MSLC is a forum for parents and health professionals to improve and develop Maternity Services in their regions. I conducted one meeting via telephone with a MSLC lead and I attended a MSLC meeting with approximately twenty lay members present (Appendix VII).

Overall the research protocol was given positive feedback. Considerations related to the effect of the researcher's presence in the labour room as the birth environment was small at the AMU and the combination of these factors had the potential to make women feel watched. In addition, it was questioned whether my presence would provide reassurance when a midwife left and whether it

would influence the midwife's practice. As none of these factors could be changed, in response I agreed that such considerations would be written into the findings and during the research I would be aware and write, as part of the fieldnotes. One amendment however was made to the research protocol owing to the feedback from the MSLC. The timing of the postnatal interview at the woman's home was initially planned at four to six weeks. The MSLC recommended that the interview should take place two to four weeks after birth as women would be likely to forget events after this time.

3.3.3.5 Ethics committee

A favourable opinion was granted 19/09/11 (Appendix VIII) by the National Research Ethics Service Committee. Minor amendments were advised from the National Research Ethics Service Committee 22/08/11 (Appendix IX) including a statement on the consent form for participants stipulating whether they would agree to an audio recording for the interview. This was subsequently added to the participant information sheet (Appendix II and V).

Originally this study was to include a hospital in Ireland that practises active management which included midwifery one-to-one support in labour. Ethical approval from the Ethics committee in Ireland was denied. The committee did not permit researchers to present their studies at the Ethics committee meeting, meaning I could not address their concerns. The one concern generated related to me being a midwife, although the application specified that I would be present in the role of a researcher. The Ethics committee raised concern that my presence with a midwife background could be translated as a supervisory role. My presence was feared to cause confusion, as I would have been in a position to observe practices that potentially could cause harm, and then report it to senior staff on duty.

3.3.3.6 Negotiation of access

The Head of midwifery (HOM) was contacted at three NHS organisations in England prior to proceeding to the Ethics committee and the NHS Research and Development applications representing the UK NHS organisations. Approval was given by all three NHS organisations. Once the ethical approval was formalised in writing, I met with the HOM at two NHS organisation's and spoke to a consultant midwife at the third NHS organisation to discuss the working of the research protocol. I obtained brief information about their organisational

structure, systems and changes including reconfigurations of maternity staffing that were in operation. At one NHS organisation, terminology to avoid with midwives was advised due to the sensitivity in relation to staff changes. In addition, the HOM brought to my attention that home births would be stopped if bad weather occurred. I had not considered this aspect regarding my research protocol time-lines.

A meeting was consequently arranged with the community midwives at two of the NHS organisations representing the AMU at case study site one; and the home births at case study site two during the introductory weeks of the research. The discussion at all meetings considered the best method of achieving the research protocol. The most challenging aspect of the protocol discussed was the community midwives introducing the research to pregnant women within the antenatal check. Apprehensions included the time it would take within an antenatal check which was already pressurised for time. It was agreed that the research literature (Appendix IV, V, and VI) explained all the recommended details in relation to women participating in the research (National Patient Safety Agency (NPSA) /National Research Ethics Service 2009), and therefore the midwives would focus their time introducing the study and when to consider consent only.

3.3.3.7 Ongoing consideration of ethical issues during fieldwork

Following approval and access from the appropriate committees, managers, midwives and women, considering ethical issues did not stop, it was a continual process throughout the fieldwork. During the course of the research however, no adverse incidents occurred that required reporting to the Ethics Committee. One change regarding a NHS organisation was reported and the change was confirmed.

Lastly, as I continually introduced my research and reminded maternity staff that it was taking place, I had to be mindful that as I negotiated access and built relationships, participants may forget that the research was taking place as I became more invisible and staff got to know me (de Laine 1997; Hammersley and Atkinson 2007).

3.3.4 Time–lines for each case study site

It was envisaged originally that the whole research cycle per case study site would take fourteen weeks. There would be twelve weeks completing fieldwork followed by two weeks off site to consolidate the data collected, finish transcribing the interviews and prepare for the relocation to the next case study site. The first two weeks included an introduction of the study to the midwives, eight weeks collecting data and two weeks of consolidation. The latter provided an opportunity to ask any final questions and time to complete interviews, assess maternity records, and thank the maternity staff. The fieldwork for the three case study sites was completed over nearly ten months (39 weeks). The study was completed as planned within twelve weeks at case study site one and three. At case study site two, permission was requested from the HOM and the NHS Research and Development department for an extension of three weeks as ten labour observations had not been achieved. The permission was granted and ten labour observations were attained and all interviews completed. The reasons for the delay will be discussed in the next section.

The first part of the fieldwork was to introduce to the research protocol to as many midwives as possible. This was crucial as the recruitment of women to the study relied solely on the midwives. In addition, midwives needed to understand the process of checking the consent forms of women when they were assessed in labour and the implications for midwives agreeing to be in the study.

The research strategies were strictly followed at all three case study sites, but there were slight variations achieving the objectives of the research protocol due to the geographical locations and different organisational systems.

3.3.4.1 Introducing the research at case study site one (AMU)

The fieldwork commenced 24/10/11. The community midwives agreed to give the research literature (Appendix IV, V and VI) to women within the antenatal checks and parent craft classes. Posters were given to the community midwives to place in the antenatal clinics to inform midwives and women about the study (Appendix X and XI). The community midwives requested a guidance summary regarding the research objectives to disseminate to midwives. I designed pocket sized laminated cards for all the midwives which illustrated on one side guidance in relation to assessing the eligibility for women to participant in the research,

and on the other side guidance concerning midwives considering participating in the research (Appendix XII).

I also attended midwife handovers on labour ward to discuss the study and hand out the research literature following permission from the HOM and clinical managers. The labour ward handover had a large audience and it was important to gain support from the senior midwives as they were potential gatekeepers to the study due to their authority and knowledge about the organisation of the maternity services. Labour ward also had a triage system which was midwife-led with the support of the obstetric team. The midwives working for triage were also potential gatekeepers.

The triage midwife was responsible for assessing women admitted in early labour or suspected concerns. Women were either discharged home with follow-up care or admitted to one of the wards, including the AMU, if a woman was low-risk and in labour. I approached the triage midwife after each handover to introduce my study. I also visited the antenatal ward before returning to the AMU. The process helped develop familiarity and rapport with maternity staff and increased my knowledge of how the maternity unit organised the admissions of women which helped to assess the recruitment options. The knowledge ascertained showed that low-risk women were assessed in pregnancy within the AMU, labour ward, triage and antenatal ward and sent home or low-risk women were referred in labour to the AMU. It was therefore vital that all midwives caring for low-risk women were informed about the research.

3.3.4.2 Introducing the research at case study site two (home birth)

The fieldwork commenced 01/02/12 and continued for fifteen weeks. During the introduction phrase, I attended two planned community team meetings within the team leader's home and one in an antenatal clinic. The community midwives knew the women planning a home birth, so this narrowed the women to be targeted and they agreed to introduce the research to women within the antenatal clinics and home birth preparation meetings.

Following the introduction meetings I quickly found that I did not have contact with the community midwives, rather I was sitting in my residential base waiting to be called. Unlike case study site one and three, there was no outside environment to observe in relation to home births. During the introduction

meetings, the community midwives said that they worked night shifts in the midwife-led unit within the hospital where they were also on-call for home births. During week two I asked permission from the community manager and labour ward manager to introduce the study on labour ward to the community midwives starting a night shift on the midwife-led unit. I attended the labour ward 20:45 five nights a week. The meetings with the community midwives were essential for introducing the study and providing them with a copy of the research literature.

The meetings also increased rapport and familiarity between the community midwives, labour ward staff and myself and reminded all staff that I was on-call. I was also introduced to the community clerical assistants who worked weekdays, and the labour ward clerical team who worked shifts over a seven day week. The community and labour ward clerical assistants were a major resource and support as gatekeepers. The day community clerical assistants also communicated with the community midwives via text messages each morning to remind them that I was on-call. The community clerical assistants received the calls from women in labour planning a home birth and then contacted the community midwife. This meant that the clerical assistants could remind the community midwives that I was on-call. At the weekends I visited the labour ward as the senior midwife triaged the women planning home births and contacted the community midwives if a woman required an assessment.

3.3.4.3 Introducing the research at case study site three (FMU)

The fieldwork commenced 1/09/12. During the two weeks of introduction, I learned that women had antenatal checks at the FMU and some of them were low-risk and aiming to give birth at the FMU. The FMU and community midwives who completed the antenatal clinics at the FMU, agreed to give the research literature to women within the antenatal checks and parent-craft classes. The clerical staff greeted all the women attending the antenatal clinic within the FMU and suggested that they could assess the expected date of birth of women attending. If the timing occurred within the time-frame of the study, the research literature would be placed in their maternity records ready for the midwife.

At all three case study sites, as the midwives gained understanding of the research process, they started to introduce the study to the pregnant women who were within the research inclusion criteria. In addition, within the introduction weeks for all three case study sites, I started to gather data about the layout of

the working environments by drawing floor plans, looking at photos on the walls (Hodgen 2001) comment books and cards. I also inquired about staff numbers, routines, and the scope of duties of staff members (Bonner and Tolhurst 2002). This also reinforced my introduction of myself as a researcher.

3.3.5 Data collection

3.3.5.1 Observations outside the birth environment

Fieldwork included observations outside of the birth environment and inside the birth environment. In this study, outside of the birth environment refers to the accessible space within the AMU and FMU and consultant-led labour ward. This space was used by maternity staff, women and birthing partners wanting to remove themselves from inside the birth environment. This outside space consisted of corridors, kitchen, toilets, maternity staff office and the freestanding midwife-led unit also had a day room. Most of the observations were completed in the maternity office at the AMU and FMU. I observed as a 'peripheral member,' (Adler and Alder 1987) as I did not engage in clinical activity. I did however, converse with the maternity team, built rapport with staff, asked questions and wrote fieldnotes. Overall, I tried to blend into the background so that I did not cause disruption to normal activities (Bonner and Tolhurst 2002).

Some researchers have felt compelled to help out with mundane jobs due to empathy about the work pressures on staff and wanting to increase rapport (Hunt and Symonds 1995, Allen 2004), but data can be missed while completing tasks such as answering telephones (Hunt and Symonds 1995). I took the decision not to answer telephones, doors, make beds and clean so that I did not convey mixed messages about my researcher status. One task that I did participate in was making tea and coffee. Staff made it for me so I returned the favour. This was greatly appreciated as being part of the team. Sometimes I would also make tea as an excuse to give privacy to staff if I felt that my presence was intruding on a private conversation or episode and therefore could potentially cause anxiety.

I attended the AMU and FMU at different shifts, including day and night shifts. The shift patterns will be discussed in the next chapter. I was not present for longer than eight hours. Longer hours can cause risk of intrusion, as previously discussed and produce unmanageable fieldnotes (Hunt and Symonds 1995). In

total I completed 616 hours of observations outside of the birth environment. This was a result of being present on average twenty-two hours a week at the AMU, five hours a week introducing the research and reminding community midwives that I was on call for home births and thirty-three hours per week at the FMU. The decision to increase the amount of hours at the FMU was made to help develop relationships with the larger numbers of midwives who worked on-call from the hospital and community services to cover the FMU.

3.3.5.2 Observations inside the birth environment

Labour observations were completed inside the birth environment. In this study the birth environment included the home and a labour room within an alongside midwife-led unit, freestanding midwife-led unit and the consultant-led labour ward if a woman was transferred. It is a space where outsiders cannot access unless invited. When consent was provided by a woman and a midwife, I became an invited outsider. Inside the birth environment, I chose a space that was acceptable to the woman, birthing partner and midwife so that I blended into the background as much as possible. I observed as a non-participant observer while asking opportunistic questions when appropriate.

Inside the birth environment I stayed to observe the labour and birth, and one hour following birth. This was unless I was asked to leave, or over eight hours of observations had been completed. However on one occasion, during a home birth, I did ask permission to stay after eight hours when an assessment was going to determine whether a transfer from home to hospital was necessary. Consent was provided for me to stay.

Overall the achievement of ten labour observations took eight weeks for case study site one, eleven weeks for case study site two and nine weeks at case study site three. I was on call five nights a week from my residential base after leaving the research field for all three case study sites. In total 165 hours were completed for the thirty labours observations (Ten labour observations per case study site) inside the birth environment.

3.3.5.3 Fieldnotes for labour observations

Fieldnotes were written during observations inside and outside the birth environments. Initially the fieldnotes were unstructured which is common amongst ethnographic researchers (Hammersley and Atkinson 2007). Early into

case study site one however; I formulated the fieldnotes outside the birth environment to document each episode to include the venue, descriptions of observations and reflexivity and a place for an assigned code.

Inside the birth environment fieldnotes were written about the environment, the atmosphere, equipment used, activities, behaviours and emotional states of the midwives, labouring women and birthing partners. Data also included what the midwives and women said and did, what challenges they were confronted with, and how they dealt with them. I had a tick-box or description column when a midwife left the room and for what reason, when the woman had a contraction, when the baby's heart was listened to by the midwife and when the midwife was documenting. The timing of many events were also documented.

In addition, drawings were intermittently completed which illustrated the position of the midwives, women in labour and birthing partners inside the birthing environment. Initially, the focus was only to include the midwife and woman inside the birth environment. Nonetheless, the impact of birthing partners formulated a triangle of activities and communication that if not included, would lose vital contextual data and influential factors to other data collected.

All fieldnotes were typed within the observation environments using a touchscreen tablet containing applications for word, drawings and an audio-recorder. The touchscreen tablet was quiet to use and I became efficient typing very softly and quickly. The touchscreen tablet also provided a dim light source when writing fieldnotes which was vital when observing labour and birth at night, as the lights were dimmed inside the birth environment. The notes were written using abbreviations and short hand descriptions with triggers to stimulate memories. The fieldnotes were then converted into a more detailed version following each day/night on the field while events were still fresh in my mind.

3.3.5.4 Interviews

The purpose of the interviews was to help validate the translation of the observations while gaining a perspective of the midwives and women experiencing one-to-one support in labour. The interview questions were not prepared in advance of the fieldwork instead they were designed on the field which is common when undertaking ethnography (Prus 1996). After six weeks (including the two weeks of introduction) of fieldwork at case study site one,

three labour observations were achieved inside the birth environment and at this point the interview questions were developed. The six weeks allowed the development of core questions that were relevant to all labour observations while also including individualised themes observed. The core-questions related to the perceptions of midwives and women in relation to midwifery one-to-one support in labour, presence, availability, birth environment, interruptions, birthing partners, transfers, and what they would recommend regarding one-to-one support in labour (Appendix XIIIa and XIIIb).

An interview was completed for every woman and their allocated midwife or midwives per shift who were part of the labour observation. Following a labour observation the midwife approached the woman prior to discharge and checked if consent was provided for a postnatal formal interview. If consent was provided, I was given the mobile number of the woman which was stored on a separate encrypted USB memory stick. I sent a mobile text two weeks following the birth of their baby to ask if the woman was still happy to consent to being interviewed.

Women were informed that the interview could be completed face-to-face, using the telephone or skype. If consent was provided an interview was arranged in the woman's home. Telephone numbers were deleted on the mobile and encrypted USB memory stick when the interview was completed. The allocated midwife or midwives who provided one-to-one support in labour were also interviewed. The interviews with midwives were completed at a time that was convenient to them following the labour observation. All face-to-face interviews with midwives were completed within their clinical areas. Community midwives covering home births at case study site two were either interviewed when working night shifts on the midwife-led unit, or at a community antenatal clinic. The majority of midwives were interviewed within their clinical working hours, although some midwives stayed after their shift.

To increase accuracy the consent to use a touch screen tablet with an audio-recorder during the interview was requested. Consent for using an audio-recorder was provided for all women and midwives who were interviewed. The audio-recorder application also allowed notes to be typed simultaneously as the recording occurred. Thus the comments typed during the interview were connected to the verbal data recorded when played-back. The comments typed during the interview included body language, tones to voice, reflexive thoughts

and distractions. The latter was applicable to women caring for their new-born baby and other children while being interviewed and some midwives who had to be available to answer the telephone or colleagues to answer queries.

In total, 30 out of 32 midwives were interviewed following the labour observations. Twenty-eight midwives were interviewed face-to-face and two midwives were interviewed by telephone. One of the audio-recordings of a community midwife at case study site two had interference and subsequently part of the interview could not be deciphered. In addition, two FMU midwives did not consent for interviews for case study site three which were connected to three labour observations. A total of 29 out of 30 women were interviewed face to face. One woman at the FMU (case study site three) could not be contacted using the mobile number provided for the postnatal interview and therefore the interview was not completed.

The interviews lasted on average 25.9 minutes for midwives (ranging from 10-52 minutes) for case study site one; 29.2 minutes (ranging from 18-59 minutes) for case study site two; and 25.3 minutes (ranging 14-45 minutes) for case study site three. The interviews lasted on average 37.5 minutes for women (ranging from 25-48 minutes) for case study site one; 32.4 minutes (ranging from 21-46 minutes) for case study site two; and 33.7 minutes (ranging from 23-61 minutes) for case study site three. Overall the ranges of timing in relation to the interviews were very similar for midwives and women at all three case study sites.

As previously discussed, both women and midwives were offered a copy of their transcript. This provided an opportunity to step-back and assess the accuracy of what they wanted to articulate. I transcribed all the interviews starting while still on the research field, but most were transcribed following the fieldwork. Transcribing the interviews within scheduled blocks of time aided the first part of categorising and comparing the interview data.

3.3.5.5 Maternity records

The maternity notes for all labour observations following discharge were assessed if available. The analysis of the maternity records showed that women rang the midwife one to four times at the AMU and FMU to seek advice regarding labour and whether they needed to be assessed by a midwife. The documentation suggested that community midwives were contacted one to two

times. Regarding labour, the majority of documentation was associated with clinical assessments such as listening to the baby's heart-rate and handovers. A minority of midwives at all three case study sites also documented when they left the birth environment. The information attained provided another perspective of the labour observations and helped explain emerging themes during the data analysis. Two sets of FMU maternity records were not available at case study site three.

3.3.6 The three stages of fieldwork interactions

The fieldwork interactions for all three case study sites progressed through three phases: Staged data (Goffman 1990; Strom and Fagermoen 2012), becoming invisible and staff feeling a sense of responsibility towards the study. Within early fieldnotes, I initially termed the phase 'staged data' as 'self-accounts', as maternity staff shared clinical scenarios, comment books, 'thank you' cards and photos portraying positive images of their care. Goffman (1990) however, presents an explanation regarding the 'frontstage' and 'backstage' performances. The staged data I referred to was the frontstage performance. Maternity staff as a team were 'in the know' relating to the full context of their working culture when providing one-to-one support in labour, but initially as an outsider I was seeing what I was allowed to see (Goffman 1990). Allen (2004:20) also described how participants used 'careful accounts of their work' when completing ethnography.

It has been suggested that the term 'staged data' is associated with 'untrue data' (Strom and Fagermoen 2012:535). I did not consider the data shared false, as '*fronts are selected not created'* (Goffman 1990: 38) so the data was an aspect of their working culture. The staged data helped me to understand the historical context and working relationships within their NHS organisation, therefore providing me opportunities to ask questions. This phase required a large amount of listening and concentration due to the large amounts of verbal data being processed. In addition, staged data was not confined to me as staff orienting or visiting, received variations of the same accounts that were shared with me during the fieldwork.

The second-phase was becoming invisible. Fieldwork required me to be present in the maternity office for long periods of time at the AMU and FMU. I used my inside knowledge to help camouflage myself into the environment, so that I did not disrupt normal activities (Bonner and Tolhurst 2002). The most unobtrusive

place was to sit on the floor, because taking a chair could result in a staff member having no chair or you taking their 'usual seat'. The invisibility started approximately around four weeks into the fieldwork and staff were aware that I started to blend into the background:

> A community midwife came into the office and said I looked like a shadow as I was sitting on the floor … The FMU midwife explained that I am becoming part of the furniture now (FMU Fieldnotes)

My touchscreen tablet also became invisible with me which increased my confidence to type in the presence of staff. Bonner and Tolhurst (2002) however chose not to write fieldnotes in front of participants as they feared a negative reaction. As I became more invisible, maternity staff, women and birthing partners often jumped when realising my presence inside and outside of the birthing environment. As rapport and trust increased, interactions became more relaxed as again I became increasingly invisible, which allowed me to observe the 'backstage performance.' According to Goffman (1990) backstage individuals relax, drop their front, step out of character and prepare for the front stage. This is due to staff not expecting members of the audience to be present.

Backstage is a place for staff to hide, and where certain standards do not need to be maintained. In addition problems are discussed and derogatory comments are sometimes discussed about the audience. The latter point was observed at handovers when derogatory language regarding women included words like 'smelly' and 'squatter.' Lastly, I witnessed within the maternity office staff 'putting on and taking off of character' when leaving and entering the staff office (Goffman 1990:123). Both the handovers and the staff office were regarded as a backstage area by staff.

The third-phase involved staff appearing to show a sense of responsibility to help achieve the research protocol. This was an uplifting and exciting phase as the anticipation for labour observations increased. This phase was not confined to midwives, but also included clerical and maternity support staff. Within the field there was a sense of increased rapport and trust. I could sense at all three case study sites that the support for the research was increasing leading up to week six, so I felt confident, but not certain that the labour observations would start. With one exception, (one observation occurred week four at case study site two)

labour observations started by week six at all three case study sites. Towards the end of the study there was also a sense from some staff that they wanted the study to end.

Overall, not all staff went through these three phases. Some staff appeared to avoid contact and getting to know me. This was especially evident in areas where the study was not taking place, but their help was required for recruitment. Some staff at times appeared hostile. As I tried to get the attention of some staff, I sometimes felt rejected. Such unexpected emotional tensions and predicaments are recognised within ethnographic fieldwork (de Laine 2000; Fraser and Puwar 2008), because people and contexts are not predictable. Overall the interactions and rapport did increase as the fieldwork progressed.

3.3.7 Challenges to the research protocol

Ethnography continually challenged me, to be adaptable, think quickly and be creative to situations that arose. This section analyses the challenges to the research protocol and discusses the actions implemented to resolve the situations.

3.3.7.1 Out of site, out of mind

The commitment of time to the fieldwork was associated to developing relationships, as well as being down to a phenomenon I referred to as *'out of site, out of mind.'* This involved the concept that maternity staff did not think about the research when I was not present. The phenomenon was experienced at all three case study sites and resulted in two repercussions related to the research protocol. Firstly, midwives were not universally distributing the research literature to inform the pregnant women about the research. Secondly, not all midwives were checking the consent of women when they were assessed in labour. Both components were vital for the recruitment of women into the study.

Nurse researchers Leslie and McAllister (2002) found by continually making their presence felt, they gained trust amongst staff so that they could remind patients about their research. Lambert et al. (2011) also spent intensive time periods within the field as relationships were transitory. Commencing with case study site one, I ensured that fieldwork included presence accompanied by circulating to the labour ward, triage and antenatal ward before returning to the AMU. This allowed me to remind midwives about the study and increase rapport,

interactions and trust. This approach was adapted to the different environments, but continued at case study site two and three. These interactions continued until the labour observations were achieved for each case study site. The concerns in relation to the AMU at case study site one, started week four when women were not attending the AMU with a consent form in their maternity notes. In addition, a coincidental meeting the same week with a community midwife reinforced concerns which the following fieldnotes portray:

> A midwife … working in the community … said that she must admit that she has not been giving out the research literature to women. This midwife was so supportive to me when I was in the introduction weeks, so if this midwife forgot, I wonder what the chances are that others are not giving the literature out either (AMU Fieldnotes)

> A midwife at case study site three also verified my concerns on week four:
> A midwife said that it is only when I [researcher] am here that they remember about the research (FMU Fieldnotes)

Building rapport with midwives was more challenging for case study sites two and three. At case study site two the challenges were associated with restricted contact with the community midwives during the fieldwork. Daily contact with the community midwives by text and face-to-face contact at the night shift handovers did help towards building relationships with the community midwives. The longer time to achieve the ten labour observations at case study site two however serves as a reflection of the consequences of reduced rapport, when compared to the other two case study sites. As previously discussed, in relation to the FMU at case study site three, the amount of hours per week was increased to accommodate the higher numbers of transient on-call midwives covering the FMU. Although the FMU team was small their supportive network was vast across two hospitals.

3.3.7.2 Midwives asking clinical questions

Due to my midwifery knowledge, I like other researchers experienced midwives sometimes asking me clinical questions, asking my opinion (Bonner and Tolhurst 2002; Burns et al. 2010) or sounding me out (Bonner and Tolhurst 2002). Some

questions were posed spontaneously, whereas at other times I sensed a question was coming. I soon adopted a ‘vague face’ to communicate that I did not know, while at other times I reminded staff about my researcher status. As the fieldwork progressed, staff explained my research status on my behalf.

3.3.7.3 Triggering vulnerability for midwives

The fieldnotes indicated that maternity staff were more vulnerable and had an increased sense of my presence as an observer when an emergency occurred, or when events did not go to plan. During such events I kept a low profile and left the room to provide space if I sensed it was required. Overall, I had to balance safeguarding research participants by striving not to increase their vulnerability. This was while also appreciating that the information attained provided knowledge concerning support networks and emotions felt during emergencies. This showed how the dynamics inside and outside the birth environment changed in relation to the midwifery one-to-one support in labour. In addition, I was requested to leave the birth environment once when a FMU midwife at case study site three wanted privacy. The midwife wanted to discuss transfer to labour ward and the management of a perineal tear with a women. The midwife later explained that she felt apprehensive that the woman may blame her for the need to transfer. This again reinforced the increased sense of feeling observed by a researcher when events did not go to plan.

3.3.7.4 Triggering emotions during interviews

During the course of the interviews midwives and women shared emotions which for some included feeling very sad, frustrated and caused some to cry. I was not alone feeling a tremendous responsibility as a researcher for causing research participants to cry (Kleinman and Copp 1993). From the perspective of midwives, the tears were connected to working in environments where midwifery one-to-one support in labour was not achieved. Midwives recalled instances where they had cared for more than one woman in labour, and shared feelings of failure concerning the women in their care and the fear of litigation if an adverse event occurred. When women cried it was mostly associated with transfers to the labour ward in hospital. Most of the issues were related to the discontinuation of the midwifery one-to-one relationship and the changed dynamics within the hospital environment. The emotions expressed by midwives and women increased the importance of understanding the working culture of midwifery one-

to-one support in labour as the challenges exposed caused emotional distress which will be explored further within chapters four, five and six as part of the findings.

Lastly, for each midwife and woman that showed such emotions, I stayed and talked about positive topics following the interview. I also sent a text message later to the midwives and women when I thought it was appropriate to check whether further support was required.

3.3.8 Data Analysis

3.3.8.1 The process of data analysis

This study used thematic analysis as a method to analyse the research data using the guidance from Braun and Clarke (2006). The guidance from Braun and Clarke (2006) included familiarising myself with the data, generating initial codes, searching for themes; and reviewing, refining and naming themes.

3.3.8.2 Familiarising myself with the data

The first stage involved familiarising myself with the research data. This process was helped, because I completed the fieldwork, wrote the fieldnotes, transcribed the audio-recordings and analysed the data. The data analysis started from the first day in the research field which is highly recommended in ethnography (Miles and Huberman 1994; Speziale and Carpenter 2003; Munhall 2012). The continuous analysis not only facilitated the increased familiarity with the data, it also as Hammersley and Atkinson (2007) recommends, helped me to focus on the next field contact and produce questions and issues that required further clarification. This phase also required me to repeatedly read and listen to all the written and audio data sources.

3.3.8.3 Generating initial codes

Codes were generated during fieldwork when writing the fieldnotes. The fieldnotes subsequently transcribed to a more detailed version following each episode in the research field. The codes originally assigned were also reassessed. All data was then transferred, organised and categorised using the computer software program NVivo 10, which has been designed for qualitative data. NVivo 10 enabled me to store the research data in chronological order, create an audit trail of all data transferred and allowed me to organise the

research data into categories (Hammersley and Atkinson 2007). NVivo 10 did not analyse the data. This was manually undertaken by me. The data transferred onto NVivo 10 was checked line by line and a code (alternatively referred to as a node in NVIvo) was attached that represented the descriptions in the fieldnotes (Morse 1994) this is referred to as coding (de Laine 1997).

As the amount of data increased, the codes were put into the categories which 'de-contextualised' the data (de Laine 1997:260). The data was organised into the three case study sites. These categories were further divided into the observations outside the birth environment, observations inside the labour environment, midwives' interviews, women's' interviews, maternity records and diagrams. Initially a poster (three meters long) (Figure 1), was designed representing all the categories, sub-categories and the potential for further divisions. The poster was used to discuss monthly with my two academic supervisors, the coding process and the categories assigned. The discussions were essential as the codes had the potential to continue sub-dividing. Help was needed to decide when to stop the sub-divisions as it can be an infinite process (Braun and Clarke 2006).

3.3.8.4 The development of themes

The development of themes included searching, reviewing, refining and naming the themes. The process started once all the data had been collated and coded (Braun and Clarke 2006). At this point a 'thematic map' (Braun and Clarke 2006:89) was developed to include coding representing each of the three case study sites (Figures 2, 3 and 4). The thematic maps clearly showed the absence of observations outside the birth environment, in relation to home births at case study site two. The development and understanding of the themes in this study were aided by writing summary documents which is recommended (Miles and Huberman 1994; Braun and Clarke 2006). Separate summary documents were written describing the coded data in relation to the interviews, observations outside the birth environment, observations inside the birth environment and maternity records.

The summary documents were then combined to produce one document. This process enabled an analysis of the codes, which helped to decide whether codes transformed into main themes, sub-themes or discarded (Braun and Clarke 2006). In addition, the process allowed comparative analysis (Hammersley and

Figure 1: The first stages of the coding process

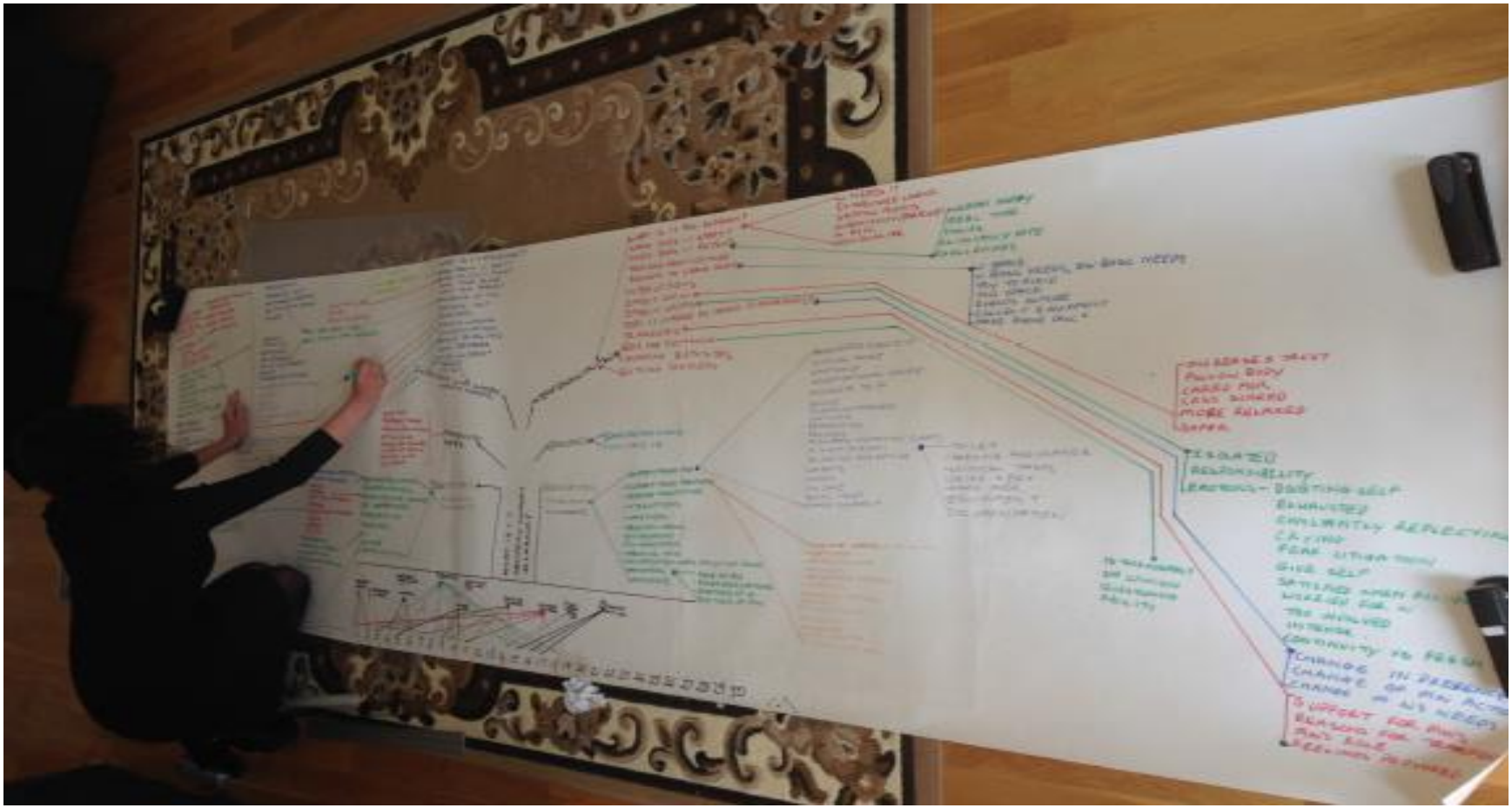


Figure 2: Thematic map illustrating the emerging themes at case study site one

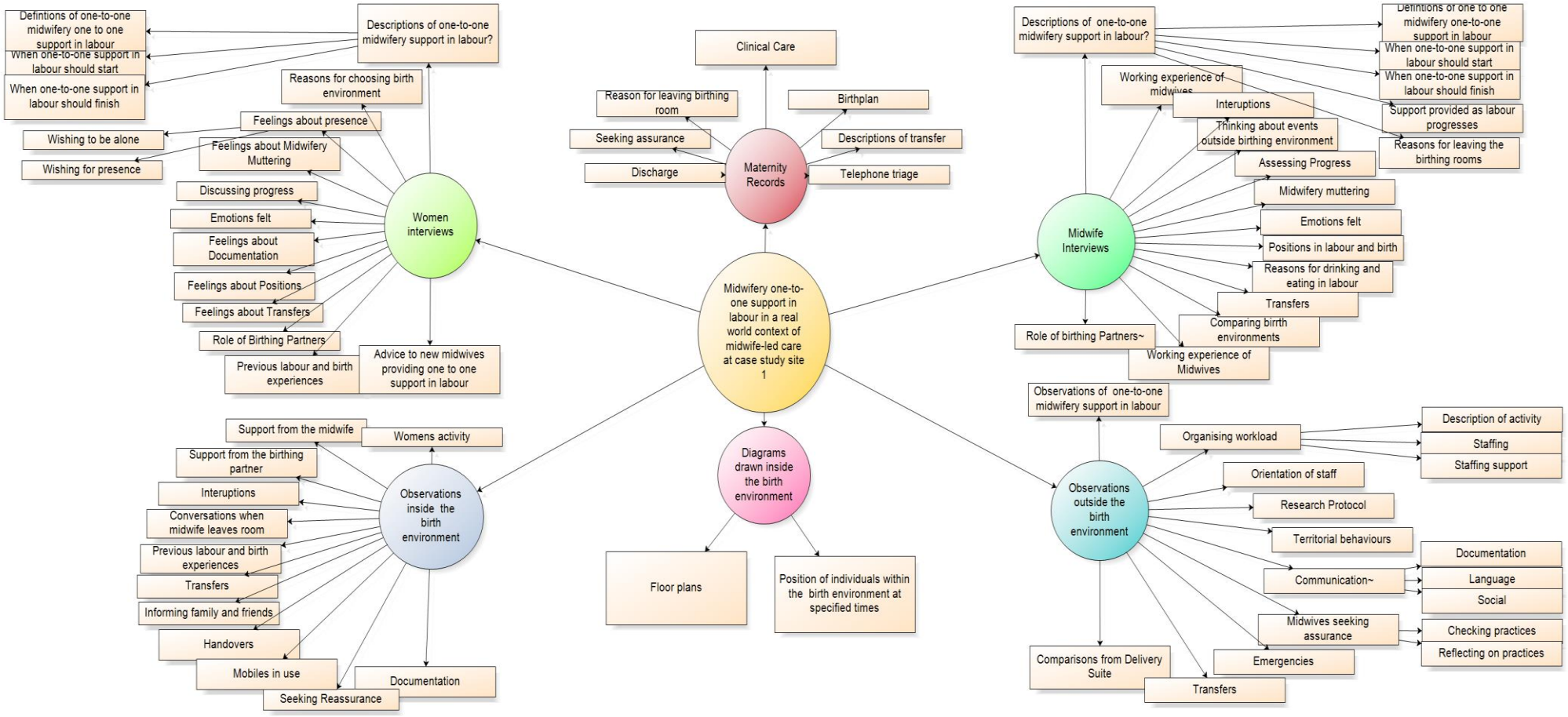


Figure 3 Thematic map illustrating the emerging themes at case study site two

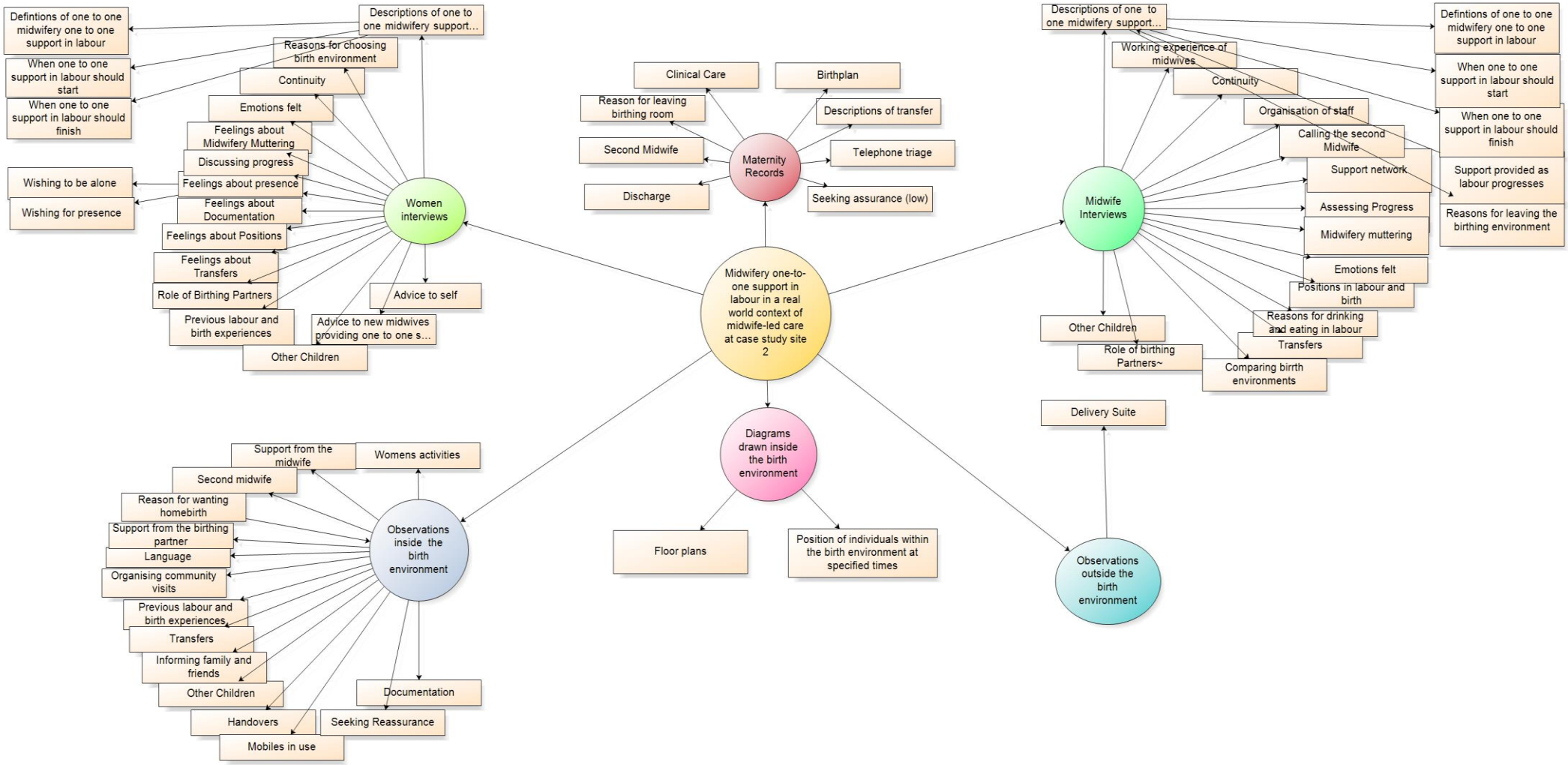
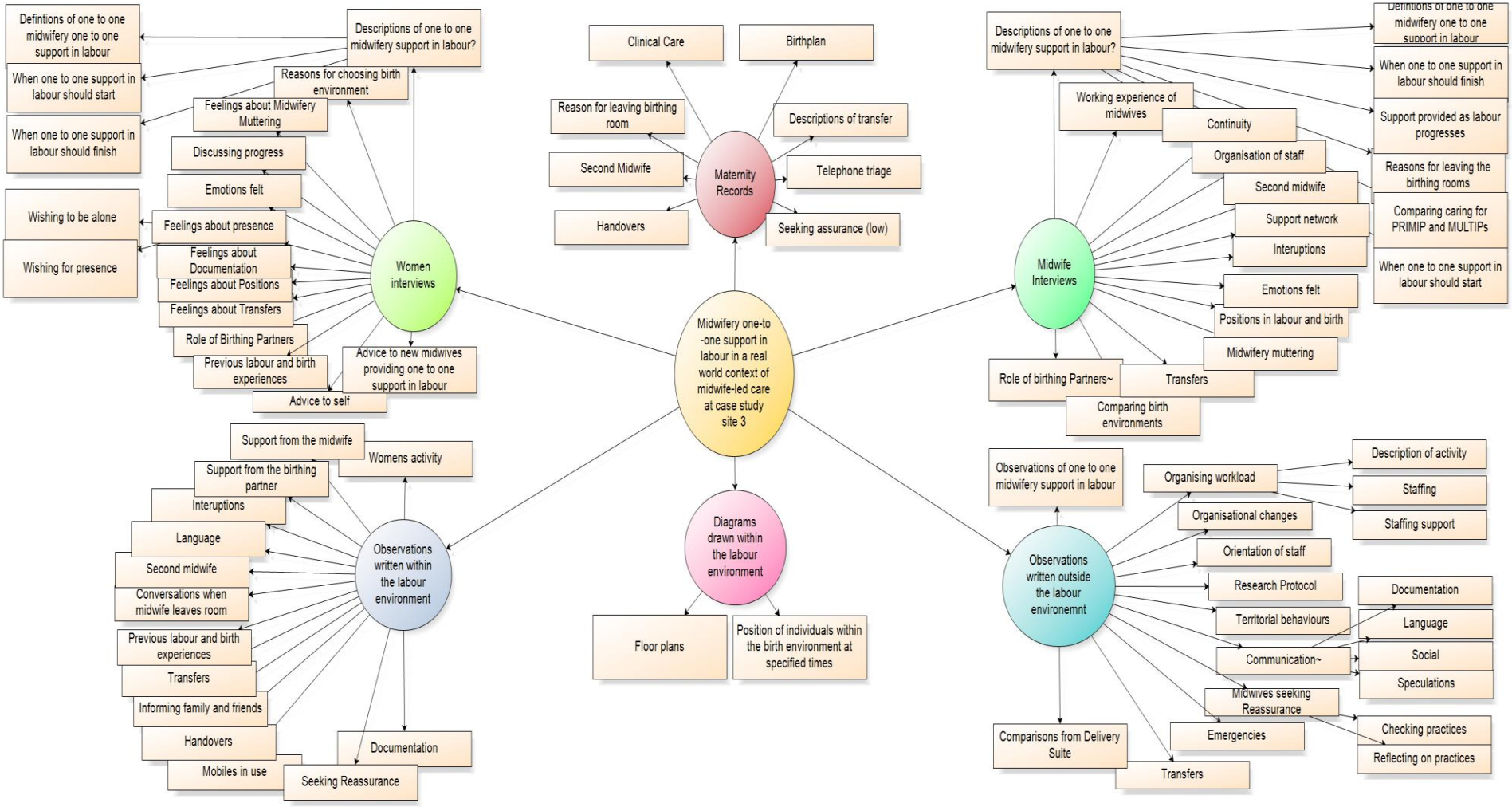


Figure 4: Thematic map illustrating the emerging themes at case study site three



Atkinson 2007) and noting relationships between the themes (Miles and Huberman 1994). The emerging themes were continually reviewed, which required at times going back to original codes to assess if the themes could be further explained and either heightened or lessened their importance. Analysis stopped when the themes produced had reached the point of `saturation' (Strauss and Corbin 1990).

The final stage of the thematic analysis produced two main themes. The first main theme included midwives balancing the needs of a woman inside the birth environment. This main theme consisted of six sub-themes referred to as components of midwifery one-to-one support in labour inside the birth environment. These components included presence, midwife-woman relationships, coping strategies, labour progress, birthing partners and midwifery support. The second main theme comprised of midwives balancing the needs of the NHS organisation. The second main theme consisted of four sub-themes including surveillance, territorial behaviours, documentation and transfer from a midwife-led birth environment to the labour ward.

At this stage of the thematic analysis, the data was described using 'stories' about the activities inside and outside of the birth environment (Braun and Clarke 2006:92). These stories otherwise described as 'thick description' (Geertz 1973; Luhrmann 2015), included context, atmosphere and perspectives that answered the research aim and objectives.

The themes outlined will be discussed in chapters four, five and six which is the sixth and final stage of thematic analysis (Braun and Clarke 2006).

3.3.9 Transferability

The transferability of the research findings is regarded as the final stage of the data analysis, otherwise referred to as 'recontexualisation' (Morse 1994:25). Transferability implies that the findings from this study can be transferred to a similar context, situation and participants. Qualitative research such as this study emphasises individual interpretations and subjectivity (Munhall 2012) therefore the aim is not to generalise (Brink 1991). It is envisaged that the detailed descriptions provided within chapter 4, 5, and 6 regarding midwifery one-to-one support in labour, will enable readers to relate and compare the context, situations and perspectives to their own working environments. Therefore

comparisons and associations can be drawn. As this study used more than one geographical site, transferability has already occurred across the three case study sites. Chapter five and six will show that the activities inside the birth environment were very similar across the three case study sites where midwifery one-to-one support in labour occurred. Transferability regarding activities outside the birth environment however was only partially achieved due to the different working environments.

3.3.10 The limitations of the study

The limitations of this study included the lack of variation regarding ethnicity of research participants at two case study sites, the unknown effects of women being observed in labour, the lack of organisational data from the management team and lack of observations outside the birth environment at case study site two and lastly, the challenge rather than limitation regarding the quantity of research data.

3.3.10.1 Ethnicity

All the female research participants in this study were British Caucasian at case study sites one and two. There was ethnic diversity within case study site three. The stipulation for English speaking may have influenced the ethnic diversity of women in this study. The reasoning for choosing English-speaking participants has been previously discussed in this chapter (Section 3.3.2).

3.3.10.2 The unknown effects of women being observed in labour

A further potential limitation of this study concerned the methods used. I cannot be absolutely certain that my presence as an observer inside and outside the birth environment, did not affect the actions and conversations that transpired. The risk would have been minimised if a video camera was used in my place as recommended by the Maternity Services Liaison Committee. As an ethnographic researcher however, I quickly learned that observations are not only visual. Feeling the atmosphere was a crucial part of my observations including emotions, reactions as they happen, room temperature, the texture of furnishing, smells and even the occasional eye contact with midwives and women gave a sense of a moment. All these elements were absorbed by me to translate. Much of this would have been lost using a video footage.

There was also evidence that women, birthing partners and maternity staff did forget that I was present as I occasionally made them jump when they came out of a moment focused on each other. In addition I was surprised by the frankness of conversations and body language which was particularly present outside the birth environment where offstage performances (Goffman 1990) where observed. This consistently reinforced that my presence became increasing invisible as the study progressed at all three case study sites.

3.3.10.3 Lack of organisational data from management

Another limitation in this study was not conducting interviews with NHS organisation managers and the senior midwives on labour ward. This study provides the real life working context and perspectives of midwives and women when one-to-one support in labour occurred, but organisational knowledge is limited. More information could have been gained primarily by concerning the priorities of the three NHS organisations and how midwifery one-to-one support in labour fits into these priorities. Furthermore, the themes regarding activities outside the birth environment including surveillance and territorial behaviours could have been investigated from a management perspective. This would be in order to gain knowledge of whether strategies were being used to improve inter-professional relations. Such knowledge would have built on the work of McCourt et al. (2011, 2014).

3.3.10.4 No observations outside the birth environment at case study site two

The observations completed at case study site two were restricted to the ten labour observations inside the birth environment and the short introductions with the community midwives within the midwife-led unit and labour ward in the hospital. This meant that knowledge regarding organisational systems were limited to the perspectives of midwives and women rather than including observations. Observations were achieved outside the birth environment at case study sites one and three, because I could complete observations in the staff office. To achieve the equivalent at case study site two, would have required me to accompany the community midwives as they completed their antenatal clinics/visits and postnatal visits. Accompanying the community midwives was not deemed feasible or applicable to this study. It was not feasible due to the large numbers of community midwives that I would need to accompany and not applicable as the study was focusing on labour. In hindsight focus groups with

community midwives may have helped to further explore the themes that emerged from the interviews regarding organisational issues.

3.3.10.5 The quantity of research data

One major challenge was the amount of data produced from the fieldwork from the three case study sites. The amount of data did not have an impact on the method of data analysis, the issue was the amount of time getting familiar and coding the large volumes of data. The process of systemically organising the data was helped by using NVivo 10, because the software made it easy to locate categories and audit trails were created for all data transferred and coded. I have questioned if less observations would have provided similar findings. I feel that the findings would have been similar with five observations at each case study site, but the conviction concerning the associations within the data would have decreased.

3.4 Conclusion

Chapter three presented the methodology used for this study to address the research aim and objectives. The presentation started by justifying the decision to choose ethnography as the methodology. Explanations were provided reviewing previous research methodologies used in relation to midwifery one-to-one support in labour, the ethnographic methods used in this study, and how elements of symbolic interactionism were used to grasp and understand how to interpret the fieldwork. Reflexivity was also dissected acknowledging the insider (emic)/outsider (etic) status in relation to collecting and translating data. The research protocol was subsequently explained starting with an understanding of what constituted a case, the methods used for sampling, the ethical considerations, methods for collecting data and a description of the researcher's experiences of interactions and challenges in the research field. The chapter closed with a description of the methods used for data analysis and the limitations of this study.

Chapter four, five and six present the findings of this study. Chapter four sets the scene by describing the three case study sites. Chapter five describes the first main theme associated with the activities that occurred inside the birth environment. Chapter six describes the second main theme associated with the activities that occurred outside the birth environment.

Chapter four

Setting the scene

4.1 Introduction

Chapter four is the first of three chapters (chapter 4, 5, and 6) to present the findings of this study. Chapter four begins by setting the scene. The first part of this chapter aims to provide contextual details encompassing the three case study sites. Descriptions include the scale of the NHS organisations, the birth environments, staffing, transfers and organisational changes that impacted on the midwives providing one-to-one support in labour at the AMU, home and FMU. Furthermore, the perspectives of midwives and women are discussed in relation to the impact of the midwife-woman ratio in regards to care in labour.

Throughout the findings, pseudonymous have been used to protect the anonymity of all research participants. In addition, drawings have been used to help create a picture of the environment. Some abbreviations have been used due to limited space. The meanings of the abbreviations are shown in Appendix XIV.

4.2 Descriptions of the three case study sites

All three case study sites were part of a NHS organisation which comprised of a hospital with a labour ward, maternity theatre, neonatal care and antenatal and postnatal services within the NHS hospital wards and community services. In all three settings, the midwife was the main supporter for women. However additional support was also available from midwife colleagues, anaesthetists, obstetricians, neonatal and paediatric specialists, midwifery support workers (MSW) and clerical staff when required at an associated NHS hospital.

All three NHS organisations were going through reconfigurations which resulted in changes to the way the maternity services were delivered. Reconfigurations of services included departmental re-organisations, mergers and closures of departments and hospitals as well as the provision of new services. In general, reconfigurations have been required due to a number of reasons. These include changes in government policy, the European Working Time Directive (EWTD), medical and technological advances, rising public expectations and to improve the quality of care (RCM 2010d). The aim of re-configurations for NHS

organisations is to centralise maternity services into fewer hospitals, because it lowers the costs for specialist staff such as consultant-led obstetric services and equipment (Imison 2011; Imison et al. 2014). Organisational changes will be explored further in this chapter in relation to the three case study sites.

4.2.1 Case study site one: The alongside midwife-led unit

4.2.1.1 The NHS organisation

The alongside midwife-led unit (AMU) was located within a large tertiary NHS hospital which has over 6,000 births per year. At the time of the research, the AMU was new and part of the NHS organisation reconfiguration. This had been in response to a government initiative (DH 2007) to provide a midwife-led unit as a choice for place of birth for low-risk women and to create more labour rooms due to the increasing birth rate in the region. The latter reflected the trend of 44% of NHS organisations in England increasing their bed capacity (Hollowell 2011) to reduce the number of temporary closures of maternity services per year.

The closures predominantly arose due to the lack of maternity beds or insufficient staff to care for the women, due to the numbers of women or the complexity of the care required. The closures of maternity services occurred for 39% of maternity units (32% of FMUs, 35% of AMUs and 39% of obstetric units) in England for one or more occasion within a year (Hollowell 2011). The closure of services at case study site one would sometimes lead to women being diverted to the nearest hospital. At other times women continued to be admitted, but maternity services such as home births and the AMU were closed to centralise staff to the labour ward. The AMU closed numerous times when first opened as the first step to increase staff on labour ward. However, the head of midwifery stopped this course of action to increase the viability of the AMU service as a large financial investment had been made to open the unit.

4.2.1.2 Staffing

The staff allocated to AMU allowed for midwifery one-to-one support in labour, but this had repercussions for the labour ward. It was initially projected that less staff would be required on labour ward when the AMU opened as the majority of low-risk women would no longer be assessed on labour ward. Doris (an experienced midwife) explained that this prediction did not take into account that historically many low-risk women did not receive one-to-one support on labour

wards. Rather, midwives were caring for more than one woman and low-risk women enabled this to happen more regularly as less monitoring and interventions were required.

The opening of the AMU enabled low-risk women to receive a ratio of one midwife to one woman, but the amount of high-risk women did not change on labour wards and therefore pre-existing staffing numbers needed to be maintained or perhaps even increased. Senior midwives on labour wards were frequently frustrated and overtly expressed their feelings when staffing was assessed as part of the changeover of shifts. A senior midwife Beryl expressed:

> … it was not one-to-one care today, but one-to-six million on labour ward (Fieldnotes, case study site one: labour ward)

Midwifery management authorised senior midwives coordinating labour ward to book enough midwives to maintain stipulated staffing numbers, but this often resulted in further problems. These included midwives working extra shifts or relying on midwives working on a 'bank' contract that warrants them to work when the NHS organisation needs them and when they are free to work.

The first team of midwives and maternity support workers (MSW) working on the AMU put themselves forward as they were motivated and passionate about working with low-risk women and developing the service. A proportion of staff then started to rotate from the other maternity wards so that skills were increased amongst staff to care for low-risk women. There were rarely student midwives seen. The AMU was governed by the community services manager, but a senior midwife was also allocated to lead the AMU service, support staff, organise staff rotas, audit outcomes and work shifts on the AMU. Midwives were also supported by MSWs who mostly answered the telephone and summoned a midwife when the information was beyond their remit. In addition MSWs replaced equipment, organised rooms to be cleaned, got refreshments for women and their birthing partners, helped women wash and reported to the senior midwife regarding supplies. It was common that midwives and the MSWs shared all these tasks depending on the work activity and they also made tea and organised food for one another. The senior midwife mostly worked Monday to Friday 09:00-1700. The majority of midwives and MSWs worked 12.5 hour shifts. A minority negotiated with management to work 7.5 hour shifts. The AMU mostly had three

midwives and a MSW working per shift. This was mostly achieved except when staff were absent from duty (e.g. sickness), but on the occasions this was observed the activity was low enough not to summon staff to help.

At the beginning of every shift, the staff gathered in the staff room for the handover meetings where information was exchanged. This would concern women in the AMU and potential women that may attend later, as well as an opportunity to discuss important notices. Some important messages were also put on the notice board, amongst the many thank you cards from women and their families. The handover was also a time when staff decided independently or by the request of an antenatal, postnatal or labour ward sister or manager, whether they should remain on the AMU or assist another ward when activity was considered lower within the AMU.

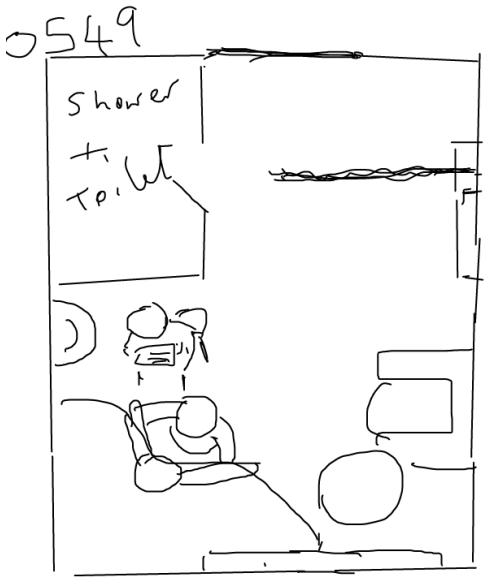
4.2.1.3 The environment

The AMU was situated approximately fifty metres from the labour ward. Hilda, like many women, felt safer at the AMU as she received midwife-led care, with the back up the labour ward nearby. This has been described as offering the 'best of both worlds' (Newburn 2012:61):

> … it was like having a home birth, but having it at hospital, having that extra security blanket, but I didn't feel that I was in hospital (Hilda, AMU)

The AMU comprised of a central corridor connecting a staff office, five labour rooms a sluice and kitchen area. The latter was used by staff, women and birthing partners. The sharing of the kitchen area was different to the labour ward as they only had kitchen facilities in the staff room that were only available to staff. All the labour rooms had a curtain at the entrance to ensure women had privacy when the door was opened. Most AMU labour rooms (Figure 5) had dimmer lights, armchair, birthing ball, a cot, IPod/radio, en-suite and a large window with a view of the hospital grounds. The exception was a

Figure 5: AMU labour room



smaller room with no windows where time could only be calculated by looking at the clock. All equipment for birth was hidden from view in a home-like cupboard. Most of the rooms also had a pool and no bed. Hilda noticed the absence of the bed immediately and seemed initially shocked as it was very different to the set-up to the hospital environment for her first child:

> I was totally in shock when I walked in. I thought there is no bed (laughing). What is this? I hadn't even thought about it. I suppose … I had a friend that three weeks ago had a home birth and I suppose when I walked in I thought oh this is a bit like a home birth situation (Hilda, AMU)

4.2.1.4 Women in labour

Women who were low-risk were often advised by the community midwives to contact the AMU in labour. If not women contacted the labour ward triage midwife who was responsible for transferring the calls of low-risk women to the AMU. The AMU never admitted high-risk women and was never requested to do so.

4.2.1.5 Transfer to labour ward

Some women required transfer from the AMU to labour ward due to complications that arose in labour or following birth. Women were transferred on a bed, trolley or wheelchair. When midwife Mildred transferred Pat it took approximately two minutes from the AMU to labour ward although Pat said that it felt a lot longer when you were the one transferred:

> I said to him [partner] were they doing laps around the hospital, because I swear to god it is two seconds away … it was literally two seconds away, but I said to him [partner] it felt like I was seeing corridors and ceilings forever, for ages. I obviously wasn't, but unless they were walking at snail pace, because it is like a two minute ride, but it really, really did feel like a long time. I think that is just panic, tired and being frightened (Pat, AMU)

4.2.2 Case study site two: Home births

4.2.2.1 The NHS organisation

The NHS organisation for case study site two had been selected as historically it had a high home birth rate, but this had dramatically reduced in recent years. The home birth rate was however higher than the national average of 2.3% for England and Wales (Office of National Statistics 2014). In addition the normal vaginal birth outcome rate for women planning a home birth was also high at over 90%. The NHS organisation had approximately 4, 000 births per year.

4.2.2.2 Staffing

Community midwives on-call for homebirths were employed by one NHS organisation. Their line manager was the lead for community services and the midwife-led unit. Community midwives worked in teams covering geographical areas. Each team had one senior midwife as a team leader. The community midwives balanced antenatal clinics, antenatal and postnatal visits, meetings and home births during the daytime. A clerical assistant based at the hospital supported the community midwives by receiving all telephone calls regarding visits required and women labouring at home and informed the appropriate midwives covering the geographical areas. When a midwife was called to a home birth, her remaining visits and clinics were reallocated to other midwives, with the help of the clerical assistant. Community midwives also rotated to work a 'twilight shift' (17:30-21:30) to cover home births, home visits and the hospital wards if required. At night (21:00) it was normal practice to have two community midwives working in the midwife-led unit while also being on-call for home births.

The labour ward coordinator delegated work to the community midwives working on the midwife-led unit which sometimes meant that they assessed women on the labour ward and the midwife-led unit. When two community midwives worked at night shift, one would hand over the woman/women she was caring for and attend a home birth. It was often difficult for the community midwives to leave women on the midwife-led unit. This was due to the formation of relationships and they were worried that leaving could be psychologically detrimental to women. Josie, an experienced community midwife, brought this challenge up at a team meeting, because she found herself having to leave a woman in the midwife-led unit when the baby's head was visible. In addition, midwives from labour ward had to take over the care of women in the midwife-led unit. This was

in order to release the community midwife to assess women at home. If the work activity was high or staffing was insufficient to allow the community midwife to leave the midwife-led unit, the senior midwife for labour ward consulted the managers to close the home birth service and requested women to attend the hospital.

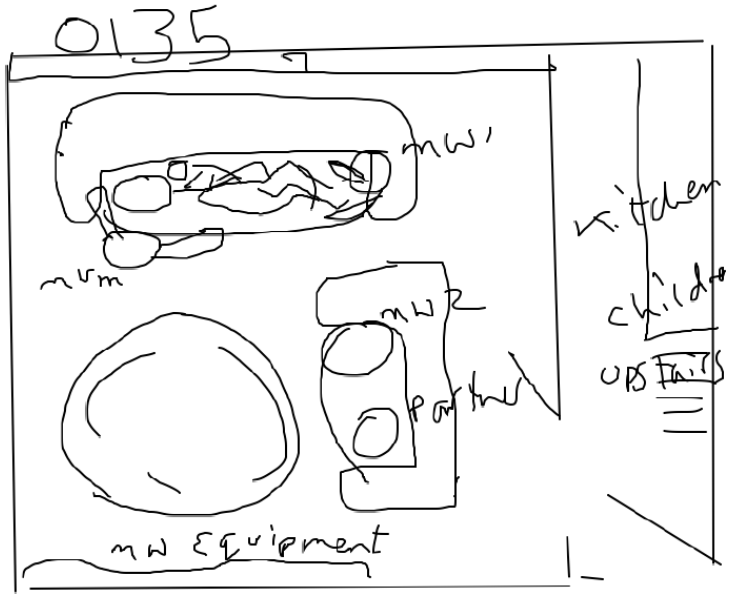
The same challenges occurred for the second community midwife working the night shift on the midwife-led unit, because they were also required to attend the home birth to ensure two midwives were present for the birth or when the first midwife needed support. When there was only one community midwife working the night shift on the midwife-led unit, which happened frequently, a hospital midwife from labour ward attended the home births as the second midwife. Due to the latter, community midwives frequently volunteered to be on-call as the second midwife for home births only. Overall staffing influenced whether the home birth service could operate or not, which is not unique to this study (McCourt et al. 2011).

4.2.2.3 Home birth environment

The midwife entered the woman's house as a guest. Many women who chose home birth did not like hospitals whether it was like Linzi having her first baby or like Cindy who had a previous experience in hospital which influenced her perceptions. Rita who had two home births stressed the importance of having her home comforts and not leaving her other children (Figure 6):

> … being able to be tucked up in bed with a cup of earl grey in my own cup and being able to walk across my landing to my bathroom without feeling like I had to put slippers on, you know having your first bath in your own bath ... most importantly when you got other children … not having mummy away from the home and being able to meet their sibling. I mean that to me, you know the time [at first home birth] when [named 1st child] woke up and met [named 2nd child] upstairs and then them both coming down [second home birth] to meet their sister, it was just the most, you know probably the two most amazing moments in my life (Rita, Home birth)

Figure 6: Rita's home birth



Rita and Cindy were also concerned about being exposed to hospital acquired infections due to previous experiences.

4.2.2.4 Transfer to labour ward

Again some women required transfer from their home to labour ward due to complications that arose in labour or following birth. The transfer occurred via ambulance which was expected to arrive within eight minutes in an emergency as specified by national guidance (NHS England 2015) and 30 minutes if not life threatening. Policy dictated that a midwife should accompany women in the ambulance. Linzi was the only urgent transfer from home to the labour ward observed and the ambulance arrived at her home within the eight minutes. Once the ambulance was on its way; Linzi, her partner Frank and midwife Ava had to ensure that they were ready when the ambulance arrived to ensure departure to the hospital was not delayed. Linzi had a hospital bag with clothes and toiletries for herself and baby:

00:53	Midwife Ava	Ambulance called
01:00		Ambulance arrived

(Fieldnotes from Linzi's labour, home birth)

4.2.2.5 Organisational changes affecting the home birth service

There were two main organisational changes that impacted on community midwives. The first included community midwives no longer being on-call from their home at night for home births. Instead they worked approximately two nights a month on the midwife-led unit while also being on-call for home births. Working on the midwife-led unit differed from case study site one for three reasons. Firstly, the location was very close to labour ward with only a shared corridor separating them. Secondly, although the midwife-led unit was managed by the community manager, labour ward staff worked in the midwife-led unit in the day and the community midwives worked there at night. This meant that in practice labour ward shared the leadership of the midwife-led unit. This was reinforced by the senior midwife also delegating work to the midwife-led unit midwives. Thirdly, women who were initially low-risk, but later required pain relief (e.g. an epidural) or intervention to progress the labour, were often not transferred to labour ward. Instead the women stayed within the midwife-led unit. In addition if there were no labour ward beds, the midwife-led unit became an extension to labour ward to accommodate high-risk women.

This is not unique to this NHS organisation (RCM 2010d). Sixteen percent of the total births occurred in the midwife-led unit, but it was not clear how many were low-risk. The midwife-led unit was not the focus of case study site two, but midwives talked about it and I experienced short observations while waiting in the corridor of the midwife-led unit and labour ward to inform the community midwives that I was on call.

The second change involved a re-configuration of senior midwives to reduce their numbers. Re-configuration led to senior midwives reapplying for their pay band and if they were not successful they were employed at a lower pay band with temporary pay protection. Midwives had the option to either interview for their existing pay band or voluntarily accept a lower pay band. Those midwives who were not happy to do either resigned. Midwives who successfully retained their pay band were allocated to the community or labour ward. The latter stopped some midwives applying as they did not want to work as a senior midwife on labour ward.

4.2.3 Case study site three: The freestanding midwife-led unit

4.2.3.1The NHS organisation

The freestanding midwife-led unit (FMU) was part of a NHS organisation that consisted of two NHS hospitals which had a combined birth rate of over 6,000 births per year. Both NHS hospitals had a midwife-led unit. The FMU was less than ten miles from the nearest NHS hospital. The bed capacity, staffing and resources were managed over the two NHS hospitals and the FMU. The sharing of resources helped to keep the maternity services open. Closure of services at one NHS hospital resulted in women being diverted to their other NHS hospital or FMU and vis-à-vis. When the FMU closed, staff had to contact the ambulance service, redirect phones, and write a note on the entrance door to alert women. Dorothy, a MSW, expressed how determined women were to have their babies at the FMU. One morning midwife Dorothy arrived at the FMU after being closed for the night, two women in labour were sitting in their cars waiting for the morning staff to arrive. The FMU had approximately 300 births a year. The birth rate had fallen from 500 births per year in recent years. Ninety per cent of women who started their labour at the FMU had a normal birth (Which? Birth 2014).

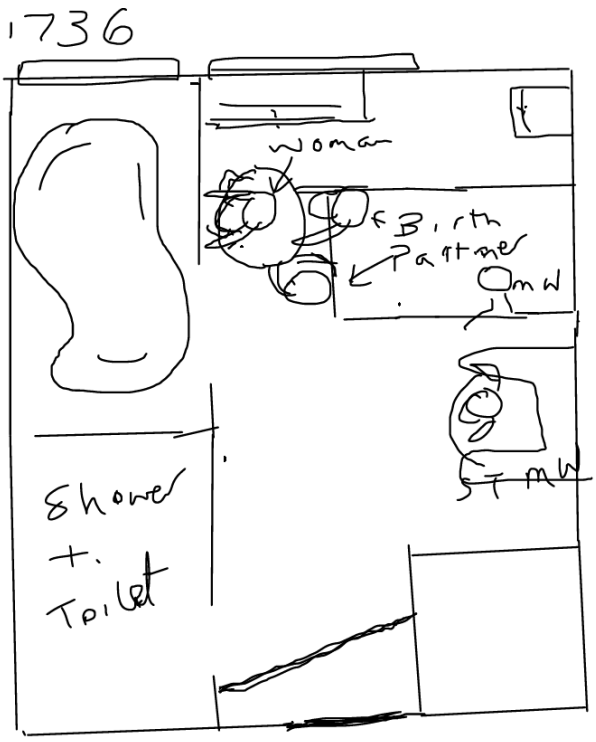
4.2.3.2 Staffing

The FMU was managed by a manager for hospital services, but was also led by a consultant midwife. The management and consultant midwife would rarely visit the FMU, but there were numerous telephone calls each day, ensuring that the equipment was checked, staffing was adequate and audits completed. The FMU staff consisted of one midwife, one MSW and one or two clerical assistants in the day. At night there was one midwife and one MSW. FMU staff worked 12.5 hour shifts starting at 07:00. All staff started a shift gathered in the staff room to handover the care of women, and discussed important notices. Important notices were also written on the white boards. FMU staff balanced caring for women in labour, antenatal clinics, parent education classes and tours.

4.2.3.3 The environment

The FMU had its own entrance from the carpark. Once inside, the FMU comprised of a long central corridor connecting a FMU staff room, a community midwife office, a dayroom, three birthing rooms, a postpartum room, three consultation rooms used for clinics and specialised assessments (e.g. Smoking

Figure 7: FMU labour room



cessation), a baby changing facilities room and a kitchen for staff, women and birthing partners. The corridor was like a gallery portraying photographs of women who had their babies at the FMU and certificates of achievements by the FMU. A closer look however showed no recent additions. Similar to the AMU at case study site one, the labour rooms (Figure 7) at the FMU had a curtain at the entrance, dimmer lights, armchair, birthing ball, a cot, IPod/radio, en-suite and windows with a view of the outside grounds. The day room and some of the labour rooms also had a television although I never saw them turned on in the labour rooms. Once again, all the equipment for birth was hidden from view in a home-like cupboard or chest of drawers. The labour rooms were large with a pool and a bed. Women such as Mira really liked the home-like features, the privacy, but mainly the freedom to have your birth partner/s stay all day and night if you wanted:

> I liked it that you had your own [birthing] ball in there, you had the pool … you had a spacious room, your bathroom and everything there, because in the hospitals you have to leave your room to go to the bathroom and what not, and yes your visitors can visit you there and yes I liked that part (Mira, FMU)

Staff also transformed a small square shaped room originally designed as a cupboard into a room for breaks with more privacy. Staff often said 'I am just off to the cupboard.' The need for the privacy was due to the main staff room being the centre of activity as it had two large desks each with a computer, lots of filing cabinets with maternity records and several equipment items. Displays included large white boards with information about women admitted, emergency contact details, staff rota, student midwife notices, equipment checks that had been done

or needed to be done, supplies ordered or needed and messages for staff from the management and FMU staff. A section of the wall was dedicated to illustrating photos of staff attending social events together. The office was largely busy during the daytime hours with handovers, phones ringing, FMU and community staff talking socially, planning their work, looking for equipment, having a break, using the computers to check blood results for women, emails, guidelines or for personal internet searches.

The staff room was particularly busy two to three days a week when booking sessions were scheduled. A booking was the first meeting between a midwife and a pregnant woman where her history and screening assessment was conducted. Women waited in the day room while an overspill often congregated in the corridor. On average 15-25 women were seen in three hours and 39-46 women were seen in five hours, although staffing was appointed to see ten women an hour. Five community midwives, sometimes accompanied with student midwives, and a MSW would congregate in the staff room and would disperse into the consultation rooms to each complete approximately two bookings per hour. The FMU staff would sometimes help if their work activity was low. Six days a week antenatal clinics were scheduled, some were allocated to the FMU midwives and others to the community midwives. At the handovers even experienced FMU staff had to check what the schedule was for that day and who was allocated to complete it.

When antenatal clinics were in progress all eyes were on the basket holding the women's maternity records at the entrance of the staff room, as a higher volume of maternity records in the basket indicated a greater backlog for the clinic. Clerical staff would gently inform the midwives of the queue once the records began to increase and would regularly inform women that the delay was due to one midwife now working in the FMU rather than two. An empty basket however showed the team were up-to-date and the atmosphere noticeably calmer. Overall, the need to offer antenatal and postnatal care within the FMU was not unique to this unit as it produces greater income due to the increased work activity (RCM 2010d).

4.2.3.4 Women in labour

Women directly telephoned the FMU to speak to a midwife if they had concerns or thought they were in labour. The calls were often answered by the clerical

assistant or MSW who would assess the urgency and determine whether the midwife was free or should make herself free to speak to a woman. The midwife and woman then decided if the woman needed to attend the FMU.

4.2.3.5 Transfer to labour ward

Similarly, some women required transfer from the FMU to labour ward due to complications that arose in labour or following birth. The transfer occurred via ambulance which was expected to arrive within eight minutes in an emergency as specified by national guidance (NHS England 2015) and 30 minutes if not life threatening. Policy stipulated that a midwife should accompany women in the ambulance. The FMU was different from the other two case study sites, because FMU midwives could not automatically transfer with women as they had to consider who would manage the FMU in their absence. Midwife Megan explained that FMU midwives had to risk assess each transfer event because if a FMU midwife accompanied a woman to labour ward, an on-call midwife would be required to lead the FMU in their absence. On-call midwives mostly worked within the hospital and community settings. Thus not all midwives were experienced, familiar and confident to lead the FMU. When the escorting midwife arrived at the labour ward, they handed over the care to the labour ward staff. The FMU midwives never continued the care on labour ward as they had to return to manage the FMU:

> I usually go with clients … The only problem is if we have a preceptor midwife here who isn't familiar with the birth centre, then depending on the situation … I might say 'ok you go'. It depends on the situation, but with somebody like this, that I have spent time with, I have got to know intimately … and there has been this amount of trauma, I would 100% ... go with them, because I think you are continuing that one-to-one care. When I transferred her to the main unit … I stayed with her … until there was an official proper hand over … (Megan, FMU midwife)

4.2.3.6 Organisational changes affecting the FMU

There were six main organisational changes. The first change occurred during the fieldwork and included a reduction from two midwives working a day shift on the FMU to one midwife. Historically two midwives worked at the FMU in the day. This change placed greater emphasis on the community midwives to provide support for the FMU midwives. The support of the community midwives

incorporated the second organisational change. Community midwives worked within teams covering geographical areas and they were allocated booking clinics, antenatal and postnatal clinics at the FMU to support the FMU midwives. Historically, the support was provided by the community midwifery team who were geographically closest to the FMU. These midwives mostly arrived within approximately thirty minutes to attend as the second midwife for the births at the FMU. The support however was centralised to include all community and hospital midwives covering all geographical sites representing the NHS organisation. This meant that midwives had to travel longer distances and not all midwives were familiar with the area which then caused further delays resulting in midwives arriving at the FMU 1.5 hours after being called for support. In addition the FMU midwives did not know all the on-call midwives and they often provided support and advice to the on-call midwives as they were not always familiar with the FMU environment and midwife-led care.

The third change involved a reconfiguration of senior midwives based at the FMU to reduce the numbers. Consequently, they had to reapply for their position at the FMU and those that were not successful were to be rotated into the community and NHS hospitals. The fourth change meant that preceptor midwives were allocated to work in the FMU. A preceptor midwife was newly qualified and rotated to all maternity units with learning outcomes. Although the preceptor midwives worked with more experienced midwives to orientate themselves to the FMU, they did eventually take responsibility for covering the FMU. In addition to this change preceptor midwives worked as part of the centralised on-call team. An experienced midwife working at the FMU could provide support for the preceptor midwives when they were summoned as part of the on-call team. Nonetheless anxiety was created when a preceptor was working at the FMU and a preceptor was then sent as the on-call midwifery support. Insights into this situation quickly gathered and preceptor midwives contacted the managers and the central on-call team and requested that preceptor midwives were not sent to provide support when they were on duty.

The fifth change regarded antenatal care for high risk women. Historically, all high-risk women were seen in the hospital antenatal clinics. This meant that the FMU midwives only saw low-risk women in their antenatal clinics. This changed so that high-risk women were also able to access antenatal care by midwives at the FMU. The sixth change occurred following the fieldwork. The change

involved an amalgamation with another NHS organisation and the closing of maternity services at one of their NHS hospitals. Speculation at the time of the fieldwork however questioned if it would be the FMU that would close. Speculation about the FMU closing was not constricted to the FMU staff, but also to the NHS organisation staff, general practitioners and women. This caused much anxiety amongst FMU staff although Betty a FMU midwife said that such threats were not new as they had experienced increasing uncertainty in the last ten years.

4.2.4 Discussion

The common feature within all three case study sites was the reconfiguration of maternity services which included centralising the maternity services and resources. Analysis to date regarding centralisation of maternity services does not show that larger hospitals are more efficient or have a lower cost base than smaller ones (RCM 2010d). There is no recommended minimum or maximum activity for a maternity unit, but the Royal College of Midwives (RCM) believe that maternity units undertaking up to 6,000 births a year, provide more personalised care and are more woman friendly than larger units (RCM 2010d).

There are fears that the push towards centralisation makes AMU and FMU vulnerable as they are potentially a quick cost-cutting measure (Kirkham 2010). The findings in chapter six will show that such fears resonated with midwives working at the AMU and FMU. In the future, any re-configurations will have to demonstrate how changes will impact on staffing and one-to-one support in labour (RCM 2010d). This study showed that outcome measures regarding one-to-one support in labour were assessed at the AMU and FMU by women (Appendix XV) as recommended by commissioning groups (Imison et al. 2014), but the results were not made available for this study. In addition the NHS organisations at all three case study sites assessed their staffing numbers using Birthrate Plus (Ball and Woodward 2003; Ball et al. 2003c) as recommended by the Royal College guidelines (RCOG et al. 2007; RCM 2009). The ratios were very similar for all three case study sites ranging from 1:31 to 1:33. Such ratios were under the recommended minimum of 1:28 full time midwives to ensure the capacity for one-to-one support in labour (Ball et al. 2003c). These three case study sites were not alone being under the recommended midwife ratios; in fact they were a reflection of the whole of England and Wales (National Federation of Women's Institutes and NCT 2013).

Although the three case study sites were different regarding organisational structure and systems, chapter five will show that fundamentally inside the birth environments; the philosophy of care, atmosphere and activities were very similar. Chapter six will show that the disparities were more apparent outside the birth environment. Midwives were powerless to stop some organisational systems such as using midwife-led labour rooms in close proximity to labour wards, when the labour ward was full. This was not observed within the AMU at case study site one. At case study site two however, my findings reinforced other research (McCourt et al. 2011) that midwife-led labour rooms were sometimes used for high risk women when labour ward was full. The RCM (2010d: 4) has warned against midwife-led units located in the hospital being used as an '*over flow facility*.'

Essentially, this section has introduced some of the activities and responsibilities that midwives had to balance when they were not looking after women in labour and how accessible they were to immediately provide, one-to-one support in labour when required.

4.3 The impact of the midwife-woman ratio in labour

This section sets the scene for the findings by describing the perspective of midwives and women regarding midwifery one-to-one support in labour. It was clear that a ratio of one midwife to one woman was the foundation of midwifery one-to-one support in labour. Without a one-to-one ratio, midwives were forced to multitask, which prevented presence and complete focus and continuity of care to one woman in labour. Some midwives and women felt that the continuity should not be confined to labour. Rather continuity should begin with one midwife to one woman in pregnancy, continue in labour and end postnatally.

4.3.1 The ability to focus

All women within this study received a ratio of one midwife to one woman in established labour. At all three case study sites this was generally recognised as the norm, although the ratio was sometimes delayed until the arrival of the midwifery support midwife, at the FMU at case study site three. In practice, midwives like Maureen and Sandra described that when the ratio of one midwife to one woman was achieved, midwives were able to focus solely on one woman without distractions. In addition, they did not have to worry about anyone else or

look after anyone else which enabled them to be 100% available for women in labour:

> ... you feel gratified about what you are doing, you feel you know happy about what you are doing, you feel like you are doing properly your job, you feel like you can give 100% of yourself and not, you don't feel guilty if you have to swap yourself in-between three ladies when you think well I should be always with all of them, so I think it is good for, I think it is really good care that we are giving here … (Maureen, AMU midwife)

> … it is very important to have one-to-one care so that you are absolutely focused on the care of that woman (Sandra, Home birth midwife)

Women felt the focus that midwives Maureen and Sandra related to. Terri having her first baby, described her care as personalised as she felt the midwife's undivided attention, but also sensed that the midwife wanted to be present. Although Terri did not have previous labour experience she had insight into the negative impact of multiple professional carers:

> I think it was just having the midwife there and rather than seeing lots of different faces at different times and having someone there for the whole duration of the whole thing, got to know me and saw how I was coping with the pain and did not have to keep passing over to the next person who did not know how I was progressing and … it just made it really personalised I think rather than me just being like another person. I felt she was actually interested (partner Robert agreeing) (Terri, AMU)

It was also acknowledged however that in the event of an emergency the ratio had to increase to be more than one midwife to one woman. Experiencing this transformation made women like Terri feel more secure:

> I knew she [midwife Lorna] was there all the time … it made me feel secure and it made me feel, you know, that things were alright and that everything was going ok ... and afterwards when I obviously had six midwives in there, I felt very safe and very looked after and that

> everything was being handled really well. So definitely it wasn't a negative thing at all it was definitely a positive (Terri, AMU)

4.3.2 One-to-many ratio

Midwives and women provided negative recollections of previous experiences where one-to-one ratios could not be provided. Sandra previously worked as a labour ward senior midwife, where it was normal to look after more than one person in labour. Sandra recalled the working conditions as though they happened recently, but she was referring to events that occurred many years ago. Sandra shared how she was multitasking while caring for more than one woman in labour, supporting colleagues while also coordinating the labour ward. One event caused an investigation which questioned her ability to be present for one particular woman and caused anxiety which was still evident at the interview:

> ... you can't give one-to-one care if you are short of staff can you? It is very hard to give one-to-one care. I have been in that position before when I have had three births in one shift and that, and I was also the coordinator and I think that it is awful, I think that's probably what ended up me going, leaving the labour ward, I think I had [clearing throat] slight burn out, because of the … having to cope you know, sorry [wiping eyes with tissue as crying] (Sandra, Home birth midwife)

During the interview Sandra regularly referred to guideline stipulations prior to sharing the events above. I questioned in my fieldnotes if this was a consequence of being more defensive in her practice.

Women such as Tess also experienced what it felt like not to receive one-to-one support in labour with her first child. The experience prompted her to write a birth plan inside her maternity records which specified that she wanted midwifery one-to-one support in labour with her second child:

> During my labour with my previous son, I felt very alone as the midwife did not spend any time in the room with us-only to read the monitor [continuous fetal monitor]. At one point the midwife told me to push properly or I will take away your gas and air. She did not talk to me about how to push properly and again left the room.

> I would therefore sincerely appreciate one-to-one assistance, reassurance and care where possible PLEASE and thank you
>
> I am hoping to give birth naturally on the … [AMU] in order that I may have one-to-one care (Maternity records of Tess, AMU)

Following the birth Tess felt the midwifery one-to-one support allowed her to get to know her midwife, and in turn the midwife got to know her. The relationship was very important. This contrasted to the midwife being described as a machine in her last labour:

> I would just say that having had the two different experiences of being on the … [labour ward] and then having the one-to-one midwife care, I definitely do feel that my labour experiences were entirely different … I felt like in my first birth my midwife was a machine that was monitoring my son … I didn't know the midwife's name or anything about her. I don't recall having a conversation with her. Whereas being on [the] midwife birthing unit [AMU] … when I was most vulnerable … instead of being surrounded by complete strangers … I was surrounded by people who I felt had got to know me and I had got to know them and I knew them by first name … so yes it was hugely important to me … the differences are just huge. I would definitely, definitely rate having the one-to-one and in my case being lucky enough to have two midwives at the end (Tess, AMU)

4.3.3 One-to-one as continuity

There were two components of continuity. The first related to the continuity of carer in labour and the second concerned continuity of the care starting in pregnancy and ending postpartum. Yani was a midwife who described midwifery one-to-one support in labour in terms of continuity. Yani highlighted that although there was a ratio of one midwife to one woman it did not necessarily mean the same midwife:

> Researcher: What does one-to-one support in labour mean to you?
>
> Yani … that's a good question. My initial response to that is having the same midwife looking after a woman

> throughout her labour, from the point of being admitted until the baby is discharged … in an ideal world that would be my concept of one-to-one care, however I think there is another concept of one-to-one care which just means that there is … one midwife to one woman throughout labour and birth which … could be a different midwife half way through the labour as long as there was still one midwife to one mother. Which, yes, it has a dual meaning to me really (Yani, FMU midwife)

Jasmine (having her first baby) thought midwifery one-to-one support in labour meant one midwife throughout labour, but having experienced labour realised that due to shifts patterns this was not possible. In reality, continuity depended on what time of day the woman went into labour, and how long the labour lasted:

> Researcher What does midwifery one-to-one support in labour mean to you?
>
> Jasmine … having a midwife with you throughout the whole of your labour, that is what it means to me … I thought … it may mean just one midwife (questioning tone) … so one throughout the whole birth, but I know in reality that is not actually practical because of the way shifts and things work, and I think that became obviously more apparent on the day … but I now understand it to be, you know, one midwife one-to-one care, so it maybe from more than one midwife, but constantly somebody with you, yes (Jasmine, FMU)

Continuity also translated as a midwife caring for a woman from the beginning of her pregnancy, supporting the woman in labour and then providing postnatal support. Instead, there were ruminants of a maternity care system where midwives salvaged what they could to provide continuity in the pregnancy and postpartum. Many junior midwives viewed continuity as an aspired concept that they had never experienced in reality; while more experienced midwives like

Venice reminisced to a time when they provided continuity from pregnancy until postpartum at the same NHS organisation:

> I think it would be really nice if we could try and do it [continuity} from their antenatal stage really to be able to have a team of midwives looking after them [women] throughout. I think they use to have it in [the] community … (Harmonie, on-call midwife for FMU)

> I am going back to my previous experience in the community for three years, when I used to care for women, I had usually met them, usually more than once, so we had started to build up a relationship which I think definitely alters things because then you tend to know about them and you have often seen them with family members before they are in pain as well (Venice, Home birth midwife)

Women like Hilda and Adrianna from all three case study sites wished, like some of the midwives, that continuity started before labour. Hilda visualised the concept as an ideal, while Adrianna did not view her care as one-to-one. This was due to not having a known midwife with whom she had developed a relationship with during pregnancy, labour and postpartum:

> … in an ideal world if you are talking about it, it would be nice to have that relationship before you actually go into labour (Hilda, AMU)

> I don't think it is one-to-one from the perspective, like the ideal way would be that the midwife supports you from the beginning of your pregnancy throughout your labour … (Adrianna, FMU)

> ... if I hear one-to-one, for me it would mean: it is a person that I know already, but it is actually not. I don't think one-to-one would be the correct expression for me, because actually it's just whoever got the shift at the time is obviously with you throughout the time and that doesn't change over, but it is not like a personal relationship of one-to-one (Adrianna, FMU)

4.3.4 Discussion

All women within the study received a ratio of one midwife to one woman in established labour as stipulated by the UK policy literature (Maternity Care Working Party 2007; RCOG et al. 2007; RCM 2009; RCM 2010a; NICE 2014; NICE 2015b). Although the ratio was sometimes delayed until the arrival of the on-call midwife at the FMU at case study site three. When a ratio of one-to-one was achieved, most midwives were able to be 100% available for women as specified by UK practice standards (DH 2004; RCM 2010a; NICE 2015b).

Being 100% available, equated to presence when required to achieve 'exclusive focus' described by Hodnett et al. (2013). This meant midwives did not have obligations to anyone other than the labouring woman in their care. Such focus has the potential to provide one-to-one support in labour which is more effective in relation to birth outcomes (Hodnett et al. 2013). While this study did not concentrate on outcome measurements, all women had a normal vaginal birth except Linzi at case study site two, who was transferred from her home to labour ward and had a caesarean section.

The perceptions of the midwives and women in this study reinforced the stress and anxiety created when midwives have to work in conditions using the one-to-many model. The latter model however was not observed in this study as all the women as previously described, received midwifery one-to-one support in labour.

Lastly, when considering continuity, none of the three case study sites had organisational systems that enabled continuity of care starting and continuing through pregnancy, labour and then ending postpartum as stipulated by government literature (DH 1993; DH 2013a, 2013b). The probability of knowing your midwife was slightly increased if a woman had a previous baby using the same NHS organisation. Although the literature review showed that knowing your midwife from pregnancy helped to build trustful relationships between midwives and women (McCourt and Page 1996; Page et al. 1999; Page et al. 2001; Page 2003), chapter five will show that in this study women and midwives were very motivated to form trusting relationships in labour even when care started once birth was imminent.

Questions have been raised as to whether continuity is fundamental to midwives forming relationships with women, as the continuity of carer has not been shown

to be a clear predictor of women's satisfaction (Freeman 2006). Rather women's satisfaction is focused on the content of the care provided (Freeman 2006). The lack of continuity however may have training issues as continuity facilitates midwives to build confidence and wisdom by learning from the repercussions of their own actions (Huber and Sandall 2009).

4.4 Conclusion

Chapter four is part of three chapters presenting the findings of this study. This chapter has set the scene, firstly describing the three case study sites. The descriptions included details about the NHS organisations, the birth environments, staffing, transfers and organisational changes. As the descriptions were discussed, activities and responsibilities of the midwives were revealed. These highlighted what midwives had to balance when they were not looking after women in labour and how accessible they were to immediately provide one-to-one support in labour when required. Secondly, the perspectives of midwives and women were discussed in tandem with the impact of the midwife-woman ratio related to their care in labour. The perceptions revealed the experiences of midwives and women, when midwifery one-to-one support in labour was achieved and when it was not. In addition, midwives and women shared their feelings about having the one midwife for the whole of their labour, while others spoke of having the same midwife from pregnancy, through to labour and the postpartum.

Chapter five now describes the first main theme in this study, which is how midwives balance the needs of the woman inside the birth environment. This theme consisted of six sub-themes referred to as components of midwifery one-to-one support in labour inside the birth environment and these will be explored.

Chapter five

Balancing the needs of the woman inside the birth environment

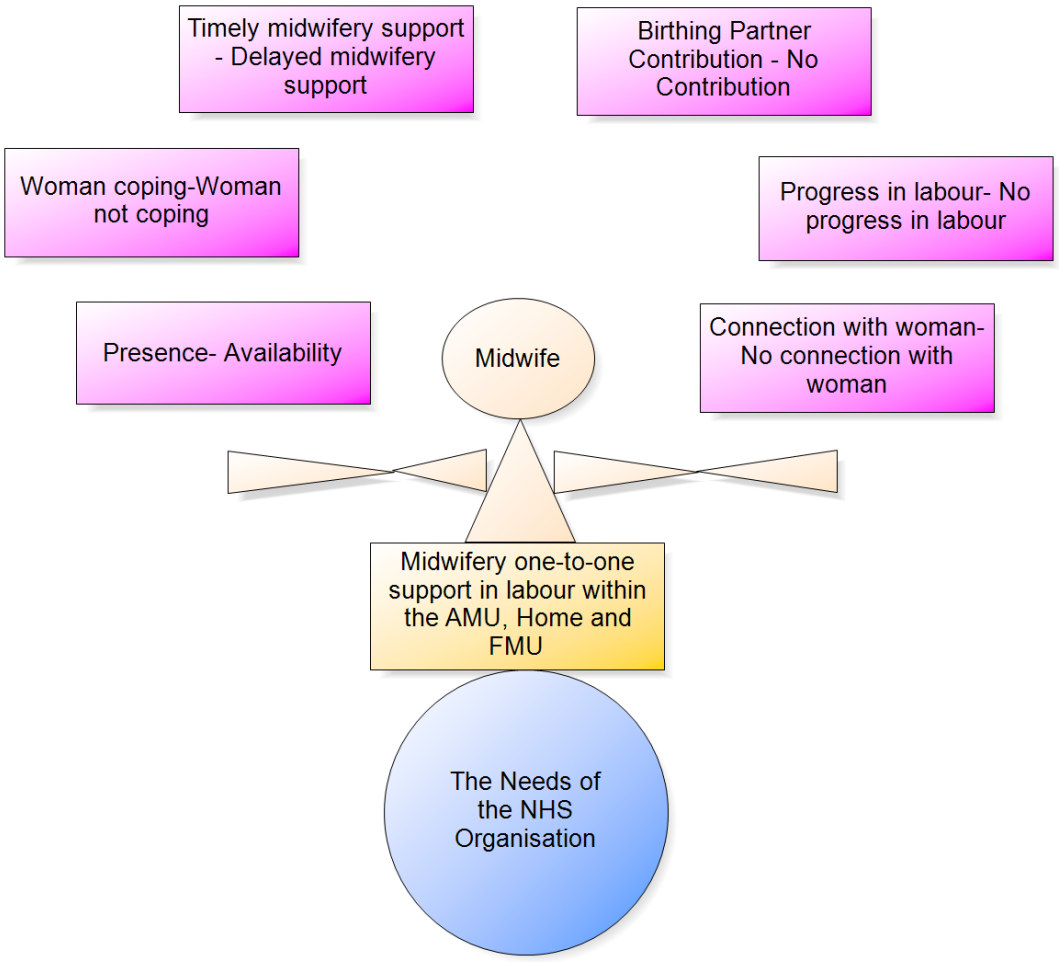
5.1 Introduction

Chapter five is the second of three chapters to present the findings of this study. This chapter describes the first main theme in this study, outlining a midwife balancing the needs of the woman inside the birth environment. This main theme consisted of six sub-themes which are subsequently referred to as the components of midwifery one-to-one support in labour inside the birth environment (Figure 8). These six components included presence, midwife-woman relationship, coping strategies, labour progress, birthing partners and midwifery support.

Each component had its own spectrum of balance and directly or indirectly influenced the other components. All six components however, were required to be specifically tuned into the needs of individual women at different stages of their labour. This was not a generic formula as the needs of all women, the atmosphere created and the way the labour, birth and postpartum 'played out' were all different. The role of the midwife was crucial as they used their knowledge, experience, intuition and motivation to provide insight into each component to help synchronous the overall balance to achieve care which was sensitive to the needs of individual women. Sometimes however if midwives did not manage to synchronise one or more components to reflect the needs of women, women readdressed the balance themselves.

This chapter uses exemplars from the research data to demonstrate the connections between the six components in relation to the individual needs of women. I have used exemplars that show the most extreme ranges of the spectrum, in relation to each of the six components. Each component has been analysed in this chapter to include a discussion section, to integrate the findings from this study into existing research evidence, while also highlighting the contribution of new knowledge from this study. Lastly, figure 8 shows that the

Figure 8: A model illustrating midwifery one-to-one support in labour



midwife was not only balancing the needs of the woman inside the birth environment, the midwife also balanced the needs of the NHS organisation. The latter relates to the second main theme and will be explored in chapter six.

5.2 Inside the birth environment

Inside the birth environment midwives had autonomy which they used to synchronise six components to provide care that was sensitive to the needs of women. Midwives also used their autonomy to create a 'cocoon' where women were protected from the outside world while experiencing a life transformation to motherhood. This analogy closely resembles what Walsh (2006a, 2010a) has described as the 'nesting' where midwives and women prepare a safe place for birth and 'matrescence' where women become mothers. Similar analogies have also been found within the literature describing midwives making boundaries to create a private sanctuary for labour and birth (Hunt and Symonds 1995;

Halldorsdottir and Karlsdottir 1996; Fahy and Parratt 2006; Walsh 2006a; Fahy et al. 2008; Page 2008) where midwives act as 'guardians' (Hunt and Symonds 1995; Fahy and Parratt 2006; Fahy et al. 2008). Women in labour also gained a sense of being in a private world (Halldorsdottir and Karlsdottir 1996; Walsh 2006a), somewhere they felt safe and uninterrupted (Walsh 2006a).

5.3 Presence

Presence was one of the six components (Figure 8) which required fine tuning inside the birth environment. The level of presence required by individual women was on a spectrum, which ranged from total midwifery presence inside the birth environment to availability. Presence meant physically being in the birth environment with the woman. This section describes the atmosphere of presence, the translation of availability into practice, the use of space between midwives and women and the timing of presence and availability.

5.3.1 Subdued or interactive presence

The atmosphere of the presence was extremely important. Midwives had to gauge whether their presence needed to be subdued or interactive and assess if they needed to be near the woman or invisible in the background. Gauging a need to be subdued, midwives like Lorna not only spoke and moved around the room quietly, they also soothed the atmosphere by dimming the lights in the labour room so that the main light source came from inside of the birthing pool. In this particular labour room there was no window so there was no indication of time of day, other than the clock. Midwife Lorna put a mattress on the floor creating a relaxed space which the partner intermittently laid upon, Lorna sat documenting and it was also ready for Terri to lie on when the baby was born (Figure 9). The only sounds to be heard were gentle classical music and another woman vocalising

Figure 9: Terri's birth environment

with contractions in another labour room. Lorna embraced labour sounds and softly reassured and encouraged Terri to follow her body, which included vocalising if she felt she wanted to. Lorna, like many midwives in the study, felt women could talk themselves out of labour and stressed the importance of reducing distractions:

> I just try and say as little as possible, because I think talking can get women out of labour … if there is something to say I will say it, but in a really low unobtrusive [manner], so it almost does not register anywhere, you know just underneath their radar. I really think … silence is a really great thing (Lorna, AMU midwife)

Such presence helped reassure women like Terri to follow their bodies. Terri needed the quiet presence to enter an altered state of consciousness (Anderson 2010) to 'let go' and withdraw inwards, while trusting her body so that she became less connected with her surroundings. Midwife Lorna however also had to be tuned into when to be more interactive as Terri needed more verbal reassurance when labour became more intensive:

> … I was dealing with it myself … I had pretty much no idea who was in the room. There could have been fifteen people sitting there in the corner and I wouldn't have had a clue…I barely was aware that mum and [Robert (partner)] were there … when I was pushing I needed reassurance that things were progressing that was when I definitely needed her [Midwife Lorna] there. It was nice to know she was there and she made her presence felt every so often by helping me through the more painful contractions … I was so into my own little world … (slight laugh) (Terri, AMU)

When women focused inwards they separated themselves from others to concentrate on their contractions. Rosanna in this study explained this process as being 'away with the fairies', as her mind and body separated to cope with the labour:

> I remember hearing [Midwife Florence's] voice when I was sort of away with the fairies … it is almost like you jump out of your body and go and

stand in the corner … leave the body to get on with it the mind is going elsewhere (Rosanna, Home birth)

Cindy who also had a home birth, explained the inward focus as going into the zone and that she was not able to speak when the contractions came. Cindy's partner acknowledged this focus:

You go to a zone don't you? I couldn't talk to you (Cindy's partner, Home birth)

On the other side of the spectrum to Terri, Connie got into the zone with midwifery interaction, which included social talking and chatting (Figure 10). Chatting helped Connie to develop a relationship with her midwife Diana and helped to cope with the progress of labour, as well as pass the time. Diana also offered constant reassurance, encouragement and suggestions about positions. The atmosphere in the labour room was vibrant with the radio blaring. Connie was very active using many positions to help cope with the contractions, while tuning into the rhythm of the music and midwife Diana's voice:

Figure 10: Connie's birth environment

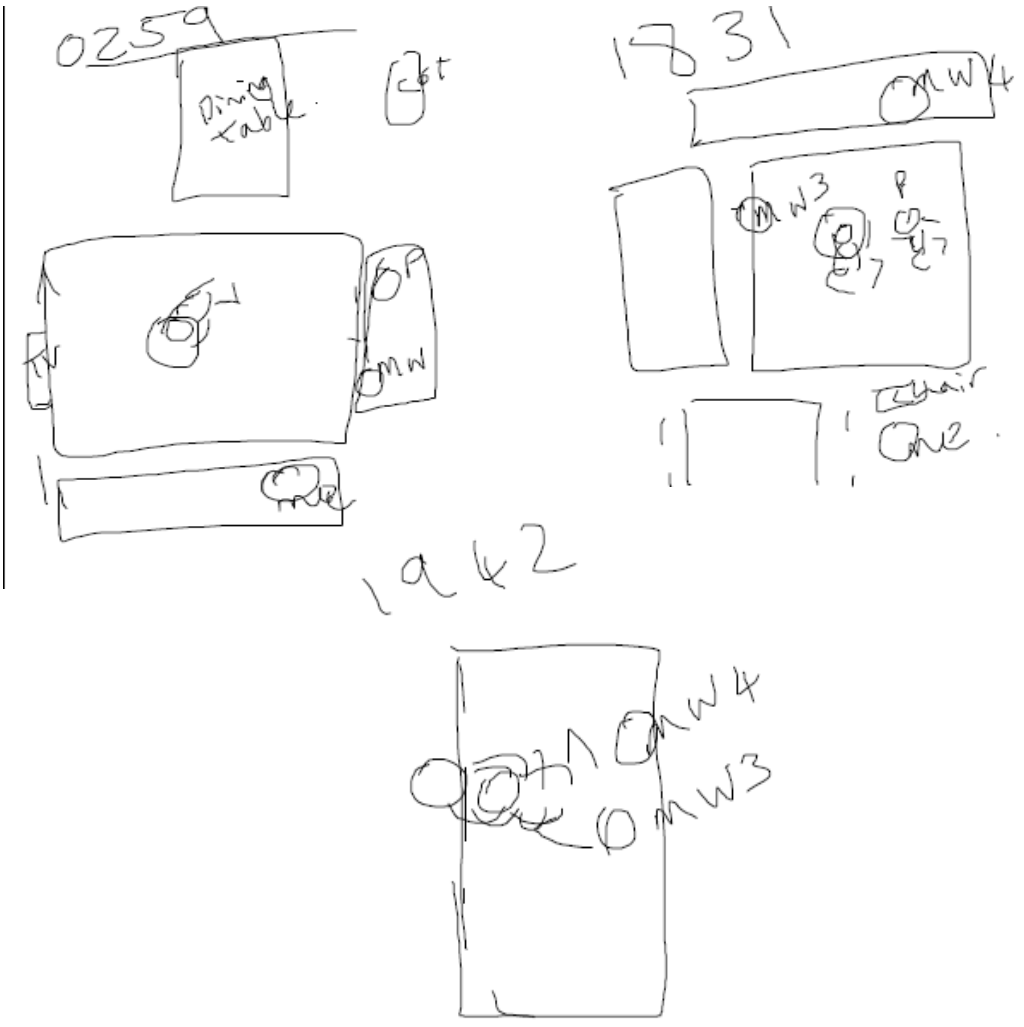
… [Diana] became my friend really like the whole way through. I felt like I had known her for ages and we found out all about her … I know you haven't got to do that, but for me personally I love to meet people and to spend all that time intensely with someone, if I had someone who doesn't really communicate … that would have changed the whole experience for me, so I think midwives who are going to give one-on-one care they need to really be prepared to sort of be really good communicators … (Connie, AMU)

Once again, Diana the AMU midwife was tuned into when Connie needed less activity and helped transfer her into the birthing pool. In the AMU and FMU, the midwives constantly assessed how they could recreate the atmosphere of the home. In the home however, the midwife was a guest and was therefore not free to dim lights and choose the rooms. The birthing partner was responsible for being tuned into creating the atmosphere, while being directed by the woman. The midwife did make suggestions however to provide food and drinks to women, put the heating on, close windows and blinds.

5.3.2 Dimensions of Space

The position of the midwife in relation to the woman changed throughout labour. In the early stages there was often more space between women and midwives, but as the labour progressed the space became more intimate, within a metre square (Figure 11). This was more evident within the home environment. Women

Figure 11: Changes in the one metre space as labour progresses



had freedom to mobilise where they wanted in their home, creating space between the midwife and themselves. This was due to the midwife's constant presence, unless they were fetching equipment from the car or taking a five minute break. It was sometimes difficult however to provide space for women in the AMU and FMU, as they were mostly confined to one labour room with an en-suite shower and toilet. Midwives addressed the need for space by being available to women rather than present within the labour room to provide privacy. Being available meant that the midwife would intermittently leave the birth environment, but could be present when required:

> ... the lady has access to call you quickly and you can be there in 30 seconds ... that means that you are almost kind of there if she is coping, but then when she has crossed the line, when she needs the support, I would probably change to an intensive one-to-one when you are like there all the time, because she needs the support (Maureen, AMU midwife)

Connie was an exemplar of women who did not feel comfortable with availability as it meant calling the midwife if they needed them. This involved disturbing the midwife when they may have been busy. Such a situation placed more emphasis on birthing partners and women's own ability to cope:

> Researcher: Do you think you would have called them [midwives]?
>
> Connie: I don't know because the thing is with me I don't like to put on people … that would have been an awful experience for me if I had been left [in labour], … it would have been a nightmare for me and you [directed at partner Simon], I would have put all the pressure on you. I would have got myself worked up and probably that's when I would have done all my heavy, over breathing and all that sort of stuff [Simon agreeing] … which is what I do when I am ill … there is no way that I would have got through all of that ... I feel like really proud of how I got through it all and it is all down to her [midwife Diana] really (Connie, AMU)

This may explain why women like Kenda did not call the midwife when experiencing ‘after-pains’ following birth. Midwife Amy informed Kenda she was leaving them to provide privacy while she completed her documentation. The lights remained dimmed and Kenda was able to lay down upon a mat with her partner, while breastfeeding. Kenda was visibly in pain, groaning and moving her hips gently so not to disturb the breastfeeding:

Kenda	[Looking uncomfortable] It feels like proper contractions …
Kenda	It is so painful [referring to after pains]
Partner	Do you want me to get her [midwife Amy]?
Kenda	No (Fieldnotes from Kenda’s labour, AMU)

Amelia was also apprehensive about availability, but it was due to being frightened of being reprimanded for calling the midwife. Amelia had previously experienced being reprimanded on a busy postnatal ward where any professional time given was rushed and judged whether it was really necessary. Amelia was previously told not to call staff again, if it was to assist to do a nappy:

> … when I need the midwife, I call the midwife, but I hope that the midwife behave good and don't be angry why you call me, like before … (Amelia, FMU)

As labour progressed midwives and women moved together within a one metre-squared space whether the woman was in the pool, on the floor, couch or bed. The space was intimate and enabled midwives to provide reassurance, eye contact while assessing how the woman was coping alongside the progression of the labour.

5.3.3 Private space in labour

Privacy was important as midwifery presence sometimes inhibited women. Mira and Hilda shared how constant presence restrained them from swearing, crying

and being vocal. Privacy enabled women like Hilda to speak more candidly about their experience, insecurities, concerns and grievances to their birthing partners:

> I would never cry in front of someone publically. I didn't cry during the labour. I suppose that is just the way I have been brought up, you just suck it up and get on with it (laughing). So having somebody else in the room yes and I certainly would not use foul language or anything, so even though you are in the throes of labour you are still conscious that there are other people in the room and have to keep a sense of decorum (Hilda, AMU)

> I think everyone around effected my behaviour, because if I was by myself then I could scream and shout, but because everybody, my sisters were there and then the midwives were there and stuff so it yes it definitely effected my behaviour. If I was in a room by myself I would have been swearing much more (Mira, FMU)

Yani, a midwife at the FMU, highlighted that she had frequently experienced women seeking privacy. Privacy was achieved with or without their partner in another room or the toilet/bathroom. Yani felt availability of the midwife was at times important rather than presence to provide privacy for women:

> … some women … find the presence of a midwife all the way through labour quite intimidating and would rather her not be there some of the time, some women actually hide from the midwife when they are in labour, they go into another part of the room or go to the toilet for long periods of time ... I have experienced that a lot, where they just want to be on their own, or with their partner and they don't want the midwife there constantly (Yani, FMU midwife)

In this research, if the midwife or birthing partner was present when the woman required privacy, women readdressed the balance by taking themselves away from the gaze of the midwife. This happened with or without their birthing partner. Women such as Hilda went into the bathroom/shower room to seek privacy. This was observed at all three case study sites:

I just cheated and used the bathroom (Laughing and gesturing as if she has done something crafty) (Hilda, AMU)

… sometimes you need a wee bit of alone time as well … to discuss your options and (slight laugh) what we did … [partner name] came into the toilet one time and starting chatting and saying what do you think? Do you think you can do this? Do you think you need pain relief? (Hilda, AMU)

5.3.4 Private space following birth

Time for bonding was protected for all women at all three case study sites, to enable women to spend time alone with their baby and partner. Midwives at the AMU and FMU dimmed the lights and collected all the equipment that was required, so that they would not have to disturb the couple. In the home, women mostly went to the bathroom following birth and then either stretched-out on their sofa, or got into bed.

When the midwife left the birth environment, the partner often came closer to the woman, getting into bed, on the mat or sofa. The room was charged with love. Couples kissed, hugged, and talked to their baby while inspecting from head to toe. Couples reflected on the birth with intense eye contact, reliving the moments and confirming the events with each other. Partners expressed how proud they were of the women. For parents who had previous children, they envisaged reactions from siblings and discussed comparisons. These reflections were shared with family and friends via telephone, social media and skype. Listening to the telephone conversations such as Kenda's, it was evident that time spent reliving the birth and sharing this with relatives and friends was important for bonding and was a time to enjoy the feeling of pride associated with their achievements:

Kenda gesturing to talk to her mum on the phone. Kenda near to tears saying baby is on my boob already, proper water birth. Best birthing experience. Room is gorgeous. Did it all myself. No pain relief. Pushing for about 10 minutes. Describing baby. Dark hair etc. Came out in the water and then onto my chest. It was intimate. I trusted my body. Cannot believe how quick it was. It was amazing. Asked about son (Fieldnotes for Kenda's labour, AMU)

5.3.5 Synchronising presence

The timing of presence to suit each individual woman was crucial. Midwife Betty reinforced how some women may need one-to-one support before established labour:

> I think it is really individual to all women … some women need one-to-one care from early in the labour and even in the latent phase they need that support, others don't need it until later on, so it really, to me depends on the women and how their labour is and how she is coping with the labour (Betty, FMU midwife)

Women who attended the AMU and FMU in latent phrase (early labour) received availability from the midwife when required, but within the home environment women received presence. Cindy outlined the heightened sense of being watched when a midwife was present in early labour. Cindy adjusted the need for privacy with frequent trips to the bathroom with her partner. In hindsight, Cindy wished the midwife attended later in her labour:

> … when nothing was really happening … I guess I was feeling a bit more … just trying to be polite … I don't think that Rebecca [midwife] perhaps needed to be here to begin with … when me and Steve [partner] went upstairs when Natalie [second midwife who took over next shift] was here I kind of felt … when I wasn't in established labour, that I was holding people up and they are all waiting around for me, yes so I [slight laugh] probably wanted the midwife to go to be honest, yes because nothing was really happening (Cindy, Home birth)

Cindy also reinforced how women felt inhibited when feeling a sense of being watched. Cindy explained how she felt free to go to sleep, once the midwife left her house. The presence of the midwife felt different however when Cindy was in established labour later that day, as her focus related to the contractions and her baby:

> … after [midwife Natalie] left and she said get some sleep … it was quite nice to have a little bit of a break and to have a sleep, because I think perhaps if I had fallen asleep when someone was here I would have felt a bit guilty, because I still felt I had to entertain people to begin

with … but later on I didn't because all I was concerned about was the pain and getting the baby out … (Cindy, Home birth)

Very infrequently midwives were not in the labour room when women wanted them there. Midwife Harmonie was working with a student midwife looking after Jasmine in labour. Jasmine's contractions were coming frequently, so it made it more challenging to locate and hear the baby's heartbeat for one minute following a contraction. The midwife left the birth environment to get a straw for Jasmine. When the student midwife also stepped out of the room, agitation was felt inside the birth environment that both the midwife and student midwife were not present:

Jasmine	Do you want to call the nurse quickly to listen to heartbeat?
Partner	Has the student midwife gone as well?
Sister	Yes.
Partner	Tuts (appears annoyed)

(Fieldnotes from Jasmine's labour, FMU)

When the FMU midwives were balancing caring for a woman in labour and continuing an antenatal clinic, their presence was more likely to be linked to clinical assessments such as needing to hear the baby's heartbeat. This continued until either the on-call midwife took over the care of the woman in labour, or the FMU midwife delayed the antenatal clinic and stayed with the woman:

… one-to-one care doesn't mean that you are with the woman all of that time … because you know the reality is there are other things that need to be done, and as long as you are going back and giving her the support and listening to the fetal heart every fifteen minutes, as long as she is coping and happy in those periods of separation that is still acceptable care … until the labour gets more established and you can't leave the room, because something might happen within fifteen minutes (Yani, FMU midwife)

None of the women in this study said that they required more presence than they received when asked. Overall, midwives generally were successful in their attempts to gauge presence and privacy that reflected the needs of individual women:

> I felt like they were there when they needed to be there, I don't know how they knew when they needed to be there, but … they were there when they needed to be and weren't when I didn't want them (Mira, FMU)

Midwives like Yani, Gloria and Venice at all three case study sites perceived that they used their knowledge, experience and intuition to gauge the level of presence:

> I know that you can never predict something is going to happen, but most experienced midwives can see when labour is advancing to a point when you shouldn't leave the room. You rely on your experience and judgment upon those occasions (Yani, FMU midwife)

> It's a lot … about instinct and gauging with the woman and I would openly say you know ... do you want me to be in here? (Gloria, AMU midwife)

> I don't know whether it is instinctive or whether it is a gut instinct, I don't know. (Venice, Home birth midwife)

5.3.6 Discussion

Based on the findings of this study midwifery presence inside the birth environment was attainable firstly due to the one-to-one ratio. The literature review (chapter two) however, showed that a one-to-one ratio does not always equate to continuous midwifery presence. Midwives in this study were also motivated to be present with women, since they had an understanding that their presence was important to women. They used their knowledge, experience and intuition to gauge whether they should be present or available for women in their care. Presence was more complex than physically and mentally being present with a woman. When present, midwives made decisions whether they should be subdued, interactive and whether to be in close proximity to women or in the

background. The quantity and quality of midwifery presence influenced whether women felt safe enough to focus inwards and separate themselves from the outside world. This study reinforced previous research findings that midwifery presence is a vital prerequisite for women in labour (Berg et al. 1996, Gale 2001; Kennedy et al. 2003; Mackinnon 2005; Hunter 2009, Aune et al. 2011; Reed 2013; Sjöblom et al. 2015).

5.3.6.1 Presence creating atmosphere

I observed midwives in this study using their presence to mediate an atmosphere inside the birth environment which supported other studies (Kennedy et al. 2004; Walsh 2006a; Lungren et al. 2009; Sjöblom et al. 2015). Midwifery presence created an atmosphere on a continuum of subdued and interaction. When the atmosphere was subdued, it did not mean that the midwife was not attentive and ready to act (Sjöblom et al. 2015). It meant that the midwife was being 'with woman' (Hunter 2002; Hunter 2004; Walsh 2006b; Hunter 2009; Cooper 2011; Sjöblom et al. 2015). Being 'with woman' is when the midwife minimises disturbance, directions and inventions (Leap 2010) and instead midwives watch and wait (Cooper 2011). This has been described as the 'art of doing nothing' (Kennedy 2000, 2002, 2009; Kennedy et al. 2003; Kennedy and Shannon 2004) or 'active-passive' (Sjöblom et al. 2015:2) . Leap (2010) suggested that the 'less we do, the more we give.' Midwives who are being 'with woman' believe in the ability of women to give birth and follow their instincts (Leap 2010). Home births (Sjöblom et al. 2015) and FMUs (Walsh 2007) have been shown to be more conducive to midwives being 'with woman.' My study reinforces and builds on these findings by adding that the AMU as well as the home and FMU were conducive to being 'with woman.'

I identified women in this study that wanted interaction with their midwives as part of being 'with woman.' In this study, interaction did not mean completing tasks, providing directions and interventions. Rather an interactive atmosphere was relaxed, although lively and included a lot of chatting. Chatting was found to be a natural event when midwives and women shared the same space at a FMU in an ethnographic study by Walsh (2006b). Significantly, in relation to atmosphere, this study reinforced that midwives had to balance when to make noise, when to be quiet (Kennedy 2000), when to step in and when to stay back (Leap 2010). The atmosphere created inside the birth environment was crucial as it

determined whether women felt calm, trust and safe in labour and birth (Kennedy et al. 2004; Sjöblom et al. 2015).

5.3.6.2 Power dynamics and the use of space inside the birth environment

Space in relation to the proximity of the midwife and woman inside the birth environment was also an important aspect of presence. This study found that in early labour the midwife and woman were more likely to have distance between them, but as the labour progressed and birth became imminent the midwife and woman occupied the same one metre space (Figure 11). Presence in close proximity was permanent unless the midwife was urgently summoned. In such instances, the time away was short. Studies exploring the use of space inside the birth environment, have connected space to the power dynamics in relation to the midwife, woman and birthing partner (Fahy and Parratt 2006; Walton 2009). Walton (2009) suggested that the space inside the birth environment can be used to increase midwifery power (Figure 12) when midwives dominate the space. In such scenarios, midwives occupy more space and have more freedom of movement to undertake their observations and care activities, while restricting women's movement to a bed and partners are placed so that their space is also confined. The findings from (Walton 2009) showed that space was not private. In addition the use of the continuous fetal monitor was viewed as the ultimate symbol of the surveillance as it continuously monitored the baby's heart rate, but excluded the parents as they could not translate the recordings. Such descriptions reflect the disintegrative power described by Fahy and Parratt (2006) which not only constricts women's space physically, but also undermines women's confidence to trust their bodily sensations. Walton (2009) suggested for women to gain power inside the birth environment there was a

Figure 12: The space occupied in a hospital labour ward (Walton 2009)

need for home births to increase. One must remember however, that the study by Walton (2009) was completed in a hospital labour ward.

My findings showed that the distribution of power inside the birth environment at the AMU and FMU were very similar to that experienced inside the home environment. The findings in this study contrasted therefore to the findings from Walton (2009) as the power dynamics between midwives, women and birthing partners identified more closely to the 'integrative power' (Fahy and Parrett 2006; Fahy et al. 2008; Hastie and Fahy 2011). This is where power is shared between women and midwives inside the birth environment and midwives act as guardians to protect the atmosphere and boundaries. In addition, women in this study were made to feel in the AMU and FMU that the labour room was their space and the drawings completed inside the birthing environments reinforced this. Chapter six will show that when women were transferred to the labour ward although the layout was quite similar to that described and shown by Walton (2009) (Figure 12) and women were mostly confined to the bed, the dynamics between the midwife, woman and partner were quite different. The partner and midwife were often on the same side and midwives constantly provided reassurance regarding equipment used such as the continuous fetal monitor.

5.3.6.3 The timing of presence

Midwives in this study at all three case study sites could be 100% present with women if required when a ratio of one midwife to one woman was achieved. This is in contrast to other research findings within hospital labour ward settings (Hunter 2004, 2005; O'Connell and Downe 2009; Thorstensson et al. 2012; Aune et al. 2013; Birthrights Dignity in Childbirth 2013). Balancing the needs of the NHS organisation did not dictate the presence of midwives inside the birth environment in this study once a woman was in established labour.

Clinical guidelines regarding intrapartum care (NICE 2014) and this study have verified that some women require midwifery one-to-one support prior to established labour. My findings add new knowledge by showing that some women in early labour experienced a sense of being 'watched' if constant midwifery presence was instigated too soon during one-to-one support. These findings reinforce the importance of midwives being tuned into the needs of

women to recognise cues that may be indicating that women need less or more presence and support inside the birth environment.

This study found that privacy was valued by women. I observed women retreating to the bathroom and toilet to readjust the balance for privacy if midwives did not synchronise their presence to provide privacy when women needed it. Midwives mostly provided privacy for women at the AMU and FMU by leaving the birth environment so that the midwife was available to women. In the home environment women readdressed the balance for privacy by using different rooms in the home away from the midwife.

Whilst privacy inside the birth environment was crucial for most women, for some, privacy meant being alone and that made women feel anxious. Some women were apprehensive about disturbing the midwife when they required support. The culture of the maternity services described by Kirkham et al. (2002; Kirkham and Stapleton 2004) reinforced that women do not want to 'trouble midwives' even when they are very worried. Although Kirkham et al. (2002; Kirkham and Stapleton 2004) was focusing on antenatal screening, the concept of not summoning help from a midwife was similar to my labour observations. This was particularly apparent in this study for women suffering 'after pains' following birth.

5.3.6.4 Women going into the 'zone'

When the midwifery presence reflected the needs of women, they felt safe and secure to focus inwards. Women in this study showed what the literature refers to as 'altered states of consciousness' (Anderson 2010:119). Studies have described this process as needing to 'let go' (Mackinnon et al. 2005:32), 'trance-like' (Machin and Scamell 1997:82), 'on another planet' (Odent 2008:132) and being in a 'zone' (Dixon et al. 2014). Dixon et al. (2014) explains that women need to focus inwards when their contractions are more intense and frequent. To do this women needed to feel safe and able to focus only on the contractions to get through each one. This led women to become detached from outside events (Anderson 2010; Dixon et al. 2014). It has been suggested that women are physiologically programed to enter such mind states (Odent 2008) and is used as a coping strategy (Anderson 2010).

5.3.6.5 The relationship of presence and synchronising the six components

This study builds on previous research that has explored activities that midwives can achieve using presence inside the birth environment (Hunter 2009; Aune et al. 2013). The new knowledge from this study includes how midwives use presence to synchronise six components inside the birth environment. Presence allowed midwives to build a relationship with women and their partners, assess how women coped and provide support in response, assess the contribution of the birthing partners and assess the progress of the labour and their need for midwifery support. Presence was the prerequisite for all six components including presence itself. By revealing the complexities of synchronising midwifery presence, this study provides a new insight into why midwives find it stressful when trying to care for more than one woman in labour. The one-to-many ratio resulted in midwives not being able to be physically and mentally present inside the birth environment. When midwives are not present they could miss valuable information that could promote a normal birth (Aune et al. 2013).

Previous studies have recognised that midwives use knowledge, experience and intuition to support women in labour (Kennedy 2000; Sjöblom et al. 2015). It has been suggested that midwifery one-to-one support in labour enhances midwives' intuition as they are focused on one woman's birth process and not disturbed by other tasks (Sjöblom et al. 2015). These attributes were also crucial within this study when midwives gauged presence and availability, as well as the other five components. My findings take a step further to suggest that motivation is also essential. Motivation was influenced by the midwife-led philosophy of care held by midwives.

5.3.6.6 Summary

Overall this study contributes new knowledge relating to how midwives synchronised their presence and availability inside the birth environment. The synchronisation included the timing of presence so that privacy was provided when required. When the correct balance was achieved, women felt safe to focus inwards to concentrate on the contractions. My findings also reinforced previous studies in relation to how midwives used their skills to create an atmosphere inside the birth environment to meet the needs of women and empower them to use the space inside the birth environment freely. Lastly, midwifery presence in this study was not dictated by addressing the needs of the NHS organisation

outside the birth environment. This meant midwives were 100% available to be present when women needed them.

5.4 The midwife-woman relationship

The midwife-woman relationship was on a continuum where on one side, trustful connections were made and on the other they were not. When there was a trustful relationship between midwives and women, midwives were more likely to stay in the birth environment and partners were more likely to bond with the midwife. Women were also more likely to cope and feel less anxious with the labour which helped the progression of labour and therefore reduced the requirement of a second midwife until birth was imminent.

5.4.1 The makings of a positive relationship

When a trustful relationship was made, the connection was equal as the expertise of each party was acknowledged. The midwife had professional knowledge and skills and women had knowledge concerning their bodies and needs:

> … let them [women] understand that they are the ones that lead the labour not me … I am a midwife I have … skills to understand if the progress is going on or not, but it's to … let them understand that they can feel it without me saying something … (Diana, AMU midwife)

> I trusted them, I trusted that they … knew what they were doing and to go with it really. Yes, it's amazing, how in a very short space of time you immediately, if you have the right midwives, I think that you … immediately can build a rapport and you're completely in their hands in a way. It is powerful. It is an amazing job (laughing) (Kenda, AMU)

Inside the birth environment, midwifery presence created an atmosphere where midwives and women emotionally connected. Women and midwives felt free to talk informally which resembled the description by Walsh (2006b:1334) as ‘chatting.’ While chatting, midwives gained a clinical history, but it did not look or feel like a consultation, because women were not seen as patients. They appeared like friends in an intense conversation, sharing their contributions to the events that were happening and the aspirations for what was to come. There was eye contact within close proximity, but unlike a normal conversation it was

interrupted by contractions. The focus was to the extent that although the birthing partner/s was present, women sometimes felt like it was just the midwife and themselves:

> It was intimate and she [midwife] didn't have to worry about anyone else, she just found out all about me, she found out all about how I wanted to do things, she was, she just got in the zone really of my mind set really, it was just wonderful … it was just intense, me and her and it was as if no one else was really there, … yes I felt like I totally trusted one person and I felt totally … safe with her … (Connie, AMU)

Midwife Lorna acknowledged that she gave a lot of herself within her care which included her knowledge, skills and a need to maintain a balance of support rather than take over. Due to the level of dedication given, midwives like Lorna described feeling drained which increased when events did not progress normally:

> … sometimes I feel numbed when I leave a shift especially when it has gone pear shaped and I had to transfer someone and there is a bad feeling at the end … I just find it really it's really deep because you are giving a lot. You are there, you are using all of your skills, all of your wits, everything to give, give, give. But not to take over … not to make this into something that you have done or that it is your achievement … it is about helping a woman on a journey … only she can do that but you are doing all you can to help her get over there ... it is like coaching someone doing a sport I suppose… You end up absolutely drained by it (Lorna, AMU midwife)

Women emphasised the need to feel the midwife behaved like a friend. Connections happened the moment it felt like the midwives and women were friends:

> …literally it was like friends had come around … (Steve, Cindy's partner)

> … a midwife to sort of sit back and not get involved … I don't think I would like that ... it would make me feel more like they didn't want to be

> here so yes just to be really friendly and ... I needed to feel like they were my friend as well rather than just someone doing a job (Cindy, Home birth)

Rita added that the midwife felt like part of the family:

> I don't know, it's just immediately… it just feels more special, it feels like they are completely dedicated to you, they [midwives] are in your home, you sort of welcome them as, I don't know, they are just part of the family for a few hours (Rita, Home birth)

Friendship alone however, was not enough for women within a one-to-one relationship. Trust was also an essential component of the bond they shared. Trust was earned from the confidence in the midwives' professional knowledge and skills, sometimes within a very short space of time. The trust was visibly seen through the intimacy shared between midwives and women such as eye contact, reassuring words, massage or touch offering comfort and women going into the 'zone' aforementioned:

> Sandra [home birth midwife] was brilliant, I remember … grabbing hold of her and hugging her and her hugging me back and [saying] 'you know you are doing really well', so the encouragement and being tactile definitely, because that is the kind of person I am, so just being a warm, understanding person and giving off a real aura of knowing what they are doing, because at the end of the day, I don't know how many babies she has delivered, because for all I know she could have been a trainee [laughing]. You don't know do you, when they walk through the door? (Rita, Home birth)

Trust earned could be lost if women did not continue to connect with midwives as the labour progressed. Cindy had a trusting relationship with her first midwife Rebecca as she knew her from pregnancy. This trust was lost however when the midwife's assessment at home showed that Cindy was in established labour. Gradually Cindy and her partner started to doubt the assessment findings as her contractions became less frequent and the intensity reduced. Cindy and her partner did not communicate their doubts until they were confirmed by the next midwife Natalie when the shifts were changed:

> I felt confident, but it got to a certain point in the early hours of the morning like you [Cindy] said we didn't really want her [midwife] to be here, and that it no disrespect to her I just, the confidence just went and I just sort of felt that you know, 'I am glad she is going in a few hours' (Cindy's Partner, Home birth)

5.4.2 The timing of midwife-woman connections

The relationships between midwives and women were mostly formed when meeting for the first time in labour as the majority had not previously met. The timing of the relationship development impacted upon how they could communicate with each other, since women's energy levels varied as did the intensity of their contractions. Most women described labour and birth as a sequence of emotions:

> … initially I think you are sort of anxious and excited and then by the end of it, you are just shattered and you don't really know what to do with yourself [laughing], you just want to get the baby out (Linzi, transferred to hospital from home)

Seeing the progression of emotions it could be postulated that it would be better for midwives and women to meet earlier in labour. However this study showed, that even when one-to-one support in labour started when birth was imminent, midwives and women were very adaptable and motivated to build relationships. Midwife Florence arrived at Rosanna's home one hour prior to birth. In those sixty minutes, Florence made time to get to know Rosanna through chatting, while preparing for the birth with no sense of rushing. Both midwife Florence and Rosanna felt a good connection was made. Midwife Florence stressed the importance of trust, as it was needed if an emergency occurred as the midwife would require the woman to trust her guidance if she gave instructions to improve and resolve the situation:

> I wanted to spend time when I got there, not rushing in … she was labouring on nicely while we were having a nice chat and then it was all hands to the pump umm, so it wasn't ideal, but I think in that very small space of time we managed … to get a reasonable rapport going …, because they don't know you from Adam, so they don't know if you're trustworthy, or if they can rely on you. So you want to establish that, so

> that when you do ask them to do something, or in the event of something, that hopefully they will go with you (Florence, Home birth midwife)

> … it was amazing, I was relaxed we were having a giggle, we were chatting … messing around so yes it was really nice … you know she was there every single step, even held my hand, bless her, so she was lovely. It was brilliant having that, so yes, it [one-to-one support] was very good (Rosanna, Home birth)

5.4.3 Balancing the emotional needs of women and midwives

Within the midwife-woman dyad, midwives felt empathy that often went beyond their professional role. This was due to spending time with women, as a result of the one-to-one ratio:

> I think the one-to-one care was ... really important in that case [supporting Connie] and also for me, because it helped me to feel empathy, because I think empathy comes from both sides … it is not only a one way link (Diana, AMU midwife)

As in a friendship however, midwives such as Carol were affected if women did not have a good experience. Midwives felt emotionally hurt by the experience:

> I put so much passion … do everything, help her in the best possibility I can … but after that I am so bonded with her, that I feel bad for her if something wrong happens. This is the worst thing about one-to-one care, that I think it is really intense and … can hurt you, but I would not want to change that. It is beautiful like that, it fine (Carol, AMU midwife)

Midwife Megan added that women such as Isabelle also felt responsible when the experience and/or outcome was not good, and was subsequently reflected in Isabelle's interview. Within the one-to-one relationship, both midwife and woman invested expertise, effort, emotions and trust in one another. This was in order to have a good experience and outcome:

> … she was apologising to me … but it was me that felt bad, I felt, I felt that I let her [Isabelle] down (Megan, FMU midwife)

… even now my husband and I are like ‘oh, should you have pushed, shouldn't you have?’ … yes there were … things ... I shouldn't have done certain things (Isabelle, FMU)

Carol was an exemplar of midwives, who reinforced that one-to-one support in labour was intense. Thus, midwives sometimes needed to refresh their energy levels within their shift to protect their emotional well-being:

… you need to refresh your mind, we are not robots. I told you that one-to-one care is so emotionally intense that sometimes you just need to … take a breath and come in, back again (Carol, AMU midwife)

In the AMU and FMU, midwives left the birth environment and became available. Sometimes within their availability, midwives released frustrations upon entering the staff office, which they had concealed inside the birth environment:

Midwife Megan came into staff office and said in a loud stressed voice, ‘*that was the worst birth that I have ever had*’ (Fieldnotes from Isabelle’s labour)

In the home environment, midwives Daisy and Charlene explained how they gave themselves space with the permission from the woman and partner by going into another room or outside but remaining available for the woman:

I will take myself out of it, even if I go to another room or say can I go and sit in your lounge for a little bit. Otherwise I would be like her, I would be dehydrated. I would be lagging, because I am hungry and my mind wouldn't be fresh, so I had to go (Daisy, Home birth midwife)

... four [o’clock] in the morning and then maybe I might sort of say ‘I just need to go and stand on the doorstep for five minutes for some fresh air’ or something like that … (Charlene, Home birth midwife)

5.4.4 Shift changes

Due to the midwife-woman connections, midwives often found it difficult to leave women at a shift change. This was particularly difficult when birth was imminent, since women were often at their most vulnerable. Midwives tried to prepare

women by informing them that the shift change was approaching. The atmosphere often became tense and some women such as Connie begged her midwife Diana not to leave her. Diana did not always stay when such a situation arose, but when caring for Connie, she did stay. Diana felt a connection with Connie and knew it was not one way. Midwife Diana also really believed Connie could birth naturally, and believed that the change of staff might negatively affect the birth outcome.

Diana like many midwives struggled with the dilemma of staying for Connie's emotional well-being or leaving to enable a fresh midwife to take over and allow Diana to go home after working twelve hours. Connie was transferred to the labour ward, as there were concerns about the baby's heart beating faster than normal. Diana tried to recreate the atmosphere they had on the AMU, but they were continually interrupted by labour ward and AMU midwives knocking on the door, checking if Diana wanted to go home. Connie sustained a perineal tear after a normal vaginal birth which Diana initially feared was more severe than it actually was. Midwife Diana questioned and reflected whether she should have performed an episiotomy. Midwife Diana reviewed her judgement as she was tired, which caused her to be visibly emotional following the birth:

> I didn't feel that was right to change midwife at that moment, because I could see the head …
>
> …I thought afterwards when I was at home, was that probably I made a mistake of staying longer, I don't know, because I felt at the end that … I wasn't fresh enough to be safe for her. I don't know if it was, because they were keep knocking on the door, but … I felt really upset, that was why also I cried, because I was tired and because it was just a release of … tiredness, of adrenaline probably, but also because I felt that if I was fresher, I would have protected that perineum … (Diana, AMU midwife)

Midwife Diana showed the importance of reflection when working through emotions experienced following a midwife-woman relationship in labour. In addition, Diana showed how the midwife-woman relationship and labour events created dilemmas as to whether to stay with women following the end of their shift:

> … I felt really involved and I, I, I was still crying the day after when I was talking about her and I didn't understand why really … I really wanted that she had a normal labour and delivery, I really umm trusted in her that she could do it and probably at a certain point I was worried that it wasn't going to happen and that worried me … I cried, because I was too tired … I wasn't sure that was the right thing to stay over the time, but you know these are the kind of things that ... you don't have answers you just do what you feel and then … now I think that if I [speaking louder] had the same situation, I would have done the same thing, because I know myself and I know that this is not only a job for me that ... there is something more, there is something that I put, in what I do more than being a midwife so, but I am not sure that is always good [very gentle laugh] (Diana, AMU midwife)

Sometimes midwives did go home if they felt they were safeguarding women by allowing a fresh professional to administer the care, because they were too tired to practice safely after their shift. Charlene had previously stayed late, but on this occasion she did leave:

> In one way you are tempted to think … should I just do this [stay] … yes, in one way it is nice to leave somebody's home with them all in bed and all nice and everything done or wherever she is going to be on the sofa or wherever. But in another way I felt that…I was tired and she would benefit from somebody else who hadn't been up all night (Charlene, Home birth midwife)

Charlene's decision may have been eased by a community midwife taking over that she knew and they had a good rapport. They also shared a similar philosophy of care and values. When Amy took over from Carol in the AMU, they both sat within a one metre squared space of the woman. Both used the same words for reassurance for Kenda to follow her body and they both used the mirror in the birthing pool to follow the progress for the parents and themselves. The transfer of care was experienced as seamless, from the perspectives of Kenda and midwife Amy:

> Researcher How does it feel to provide one-to-one support in labour when birth is imminent?

Midwife Amy Hmm. I think it is, to be perfectly frank it depends on who you are taking over from. I find it much easier to do that when you take over from someone who had a similar ethos, philosophy of care to you so in this case the midwife who was caring before me were very, very similar … in our approach, and our beliefs and in the way we care for people so that's much easier. When you're taking over the care from someone who has a quite different approach to you, that's more difficult, because the woman's kind of adjusted to the way of that person has interpreted and explained labour … so then to come out from a different ... angle is quite … difficult I think. [It is] confusing for the woman really, because it is mixed messages. That's the advantage (raising voice) of working here because in general, most of us have a similar kind of ethos in our approach, I think, I like to think (Amy, AMU midwife)

I think I was slightly panicked to begin with because, [Carol] the first midwife … was there for only about I think she had to leave about 19:30. It was such a shame because she was born at 20:05, but because we had built up a real rapport to begin with, I was quite sad when I knew that she had to go, but it was brilliant, that she was there for the first bit, but then equally when [midwife Amy] took over … yes I felt, I was obviously further into the labour by then and I felt that you know, she did a fantastic job and … it was quite natural [the] transition from one midwife to the other … (Kenda, AMU)

5.4.5 Closure of the midwife-woman relationship

The midwife-woman relationship sometimes came to an abrupt end either at the end of the midwives' shift, a few hours after the birth or if the woman was transferred to the labour ward or postnatal ward. Transfers to labour ward will be discussed later in this chapter and chapter six, but in relation to transfer to the postnatal ward, women found it difficult to adjust from one-to-one support to one-to-many:

> It was a massive kind of, contrast and shock I think for me when I moved from there [AMU] onto the [postnatal] ward [nervous laugh], I think … from that one-to-one to one to ten [partner laughing] … I think that is probably the only thing for me that it would have been nice if I had obviously seen it through in that unit [AMU] (Cecelia, AMU)

Midwives sometimes readdressed the balance for women and themselves by visiting women on the midwife-led unit, postnatal ward or at home to bring closure to their relationship. Closure often included reflecting on the birth and women saying thank you to the midwife. Such gestures reinforced to women that they were not just another case to the midwife, but that their one-to-one relationship and experience was meaningful:

> … Jayne [midwife] popped in [to the postnatal ward] … to see how we were, … it felt really nice, almost like a special little follow up, which she didn't have to do and she was seeing how we were doing and breast feeding and the stitches. She gave me some advice and then … she made me feel like, I did really well and she was very complimentary about how my sister and my husband were, it felt good to have that actually (Jasmine, FMU)

> I think … that one-to-one for me should extend … a little bit more and luckily Natalie [Home birth midwife] came back, I think two or three times after I had [named baby] and I actually felt sad saying goodbye to her … Natalie actually gave me a cuddle and said you know, you have done really well and that was really nice because it does make you remember ... and give you that nice feeling (Cindy, Home birth)

5.4.6 Discussion

This study showed that presence allowed midwives and women to focus and invest time building their one-to-one relationship. Studies have shown that midwives who are ‘pressed for time’ cannot relate well with women (Kirkham 2010:262). My findings indicated that midwives were motivated to build relationships with women at all three case study sites. However, they also recognised that the one-to-one relationship was ‘draining’ and they sometimes needed ‘time out’ of the birth environment to re-energise. Other challenges for

the one-to-one relationship included when the experience and/or outcome did not go to plan, shift changes and the end of the relationship.

5.4.6.1 Factors influencing the midwife-woman relationship

My findings reinforced other studies that the contributory factors effecting good midwife-women relationships included midwifery presence inside the birth environment (Aune et al. 2013) and the place of birth (Kirkham 2003; Walsh 2010a; Deery and Hunter 2010). When midwifery one-to-one support in labour was accomplished, time spent in the birth environment was not rushed at all three case study sites. This therefore reaffirms that midwives were not constantly watching the clock (Walsh 2010a). In relation to the place of birth, the home and midwife-led units such as the AMU and FMU in this study have been considered more conducive to meaningful relationships when compared to labour wards within the hospitals due to the small scale. Small scale allows time for relationships (Kirkham 2003; Kirkham 2007; Deery and Hunter 2010; Devane et al. 2010; Walsh 2006a, 2006b; 2010b). This study adds to this knowledge by showing that the relationship building within the AMU and FMU was very similar to that observed inside the home environment.

Most midwives and women in this study met for the first time in labour. The high numbers of women not knowing their midwives in labour in this study reflected a survey undertaken in England and Wales, where eighty-eight percent of women had not met their midwives prior to labour. Sixty-eight percent of these women felt that it did not have an impact on their labour experience while twenty percent felt it did have a negative impact (NFWI and NCT 2013). In this study both midwives and women were motivated to build a relationship despite meeting in most instances for the first time in labour. The motivation was influenced by the one midwife to one woman ratio and a midwife-led philosophy of care. Evidence also suggests that another motivator is that the midwife-woman relationship provides satisfaction and confidence for midwives (Kirkham 2010:256; Lundgren et al. 2009) and women (Cornally et al. 2014).

5.4.6.2 Attributes of a good midwife-woman relationship

I observed that the making of a midwife-woman relationship was vital inside the birth environment which reaffirms other research (Kennedy and Shannon 2004). This study also reinforced previous research findings that good one-to-one

relationships felt like a friendship (Walsh 1999; Kennedy et al. 2004; Walsh 2006b; Gu et al. 2011), although it has been stressed that such friendships are professional (Walsh 1999; Kennedy et al. 2004; Walsh 2006b). Professional friendships were vital to women in this study as they wanted to be treated as an individual rather than another case. This finding reinforces previous research (Berg et al. 1996; Kennedy 2000; Kennedy et al. 2004; Lundgren and Berg 2007; Lundgren et al. 2009; Wilkins 2010). Evidence has shown that for some women it is devastating not to have a relationship with their midwife (Lundgren et al. 2009).

My findings demonstrated that most relationships were equal as midwives recognised that although they had professional knowledge and skills, women also had knowledge concerning their bodies and needs which endorsed other studies (Kennedy et al. 2004; Hunter 2006; Walsh 2006b; Leap et al. 2010; Pairman 2010). The equal relationship reflects the reciprocity described by B. Hunter (2006) where there is 'give and take' from both the midwife and woman. This study reinforced that such a relationship is rewarding for both midwives and women (B. Hunter 2006) and helped midwives become more tuned into women and their labours (Page and Mander 2014). My findings build on this knowledge, as the equality of the one-to-one relationships relied on all six components inside the birth environment being in balance. Later in this chapter when exploring labour progress, the changing dynamics of equality within the one-to-one relationship will be discussed when the midwife changed to 'instructor mode.'

5.4.6.3 Balancing emotional attachments

Midwives in this study revealed that midwife-woman relationships could be 'draining' at times. Midwives concluded however that they would not alter the dynamics of their relationships. Feeling drained was also reported by midwives in China providing one-to-one support in labour, but this was mostly connected to the long shift patterns (Gu et al. 2011). In this study, it was the intensity of the one-to-one relationship itself which caused midwives to feel 'drained.' This feeling has been described as 'positive draining' (Deery and Hunter 2010:43). The positive drainage is due to positive energy, dedication and time, some of which is the midwives' own time (Deery and Hunter 2010), all of which this study reaffirms.

It has been emphasised that midwives need to balance emotional attachments and detachments as it is very important for midwives' well-being (Kirkham 2010).

Midwives in this study highlighted new insight regarding the dilemma of staying attached or detaching from the one-to-one relationship when birth was imminent and their shift was drawing to a close. For those midwives who did stay, they often found themselves exhausted and scrutinising if they did the right thing. The fact that women in such circumstances were often begging midwives to stay, made it more challenging for midwives to leave when they had a good midwife-woman relationship. Such a situation could be translated as an 'unsustainable exchange' when using the model of reciprocity from B. Hunter (2006:316) regarding midwife-woman relationships. 'Unsustainable exchange' occurs when both midwives and women are giving, but the woman wants more, which causes midwives to cross boundaries to accommodate women (B. Hunter 2006).

Midwives sometimes crossed a professional boundary when staying after their shift. Midwives are not expected to work after their shift therefore they are working in their own time. This action caused midwives like Diana to reflect and become emotional and one could question her 'over-involvement' (B. Hunter 2006:316) within the midwife-woman relationship. This study showed that although midwives like Diana became exhausted and emotional following such a relationship, they would not change the dynamics. They considered the investment justified the emotional reward which transpired.

Research has revealed that midwives felt continuous presence promoted normal labour (Aune et al. 2013). My findings reinforce this notion but adds to this knowledge. When a midwife like Diana made a commitment to stay after her shift, it was linked to synchronising all six components. Midwives like Diana recognised that leaving the birth environment when birth was imminent may negatively impact on the labour progress.

5.4.6.4 Challenges for the midwife-woman relationship

This study showed that the dynamics of a good midwife-woman relationship can change when the labour and/or events do not progress as anticipated or go wrong. This can lead to misunderstanding and misinformation about birth decisions which can result in women such as Cindy losing trust in their midwife. Once women lose trust they question the midwives judgment and are reluctant to accept their advice (Hauck et al. 2007). When things do not go to plan, midwives in this study felt a sense of guilt. Other studies have confirmed this sense of guilt

(Hunter and Deery 2005; Leinweber and Rowe 2010). The guilt is sometimes manifested as a consequence of midwives feeling involved with women. The brief abstract from my fieldnotes showing midwife Megan's frustration aired in the staff room, reflected a build-up of tension that can accumulate. Such tensions should be taken seriously as studies have shown that midwives are at risk of experiencing secondary traumatic stress when women experience a traumatic birth (Leinweber and Rowe 2010).

Stress and frustrations were also shown by midwives providing one-to-one support in labour in the study by Gu et al. (2011). Such emotions mostly originated from misunderstandings and distrust. These sometimes stemmed from women and partners trusting the advice of doctors rather than the midwives, particularly when an operative birth was required. The latter was also identified when Linzi (who had wanted a home birth) was transferred into hospital and following many hours, had a caesarean section. Linzi shared that the doctor advised that she would never have been able to have a normal birth because her baby was too big. Although Linzi respected her midwives, this statement by the doctor undermined her confidence in the midwives staying with and supporting her during a twelve hour labour at home.

5.4.6.5 Closure of the midwife-woman relationship

Finally, women sometimes found it difficult to adjust to the abrupt end of the midwife-woman dyad relationship. One woman in a study by Kennedy et al. (2004) discussed the sense of loss she felt when the relationship with a midwife came to an end. For some women in my study, midwifery one-to-one support finished when the woman was discharged home or to the postnatal ward or the home birth midwife left the house following birth. Transfer to the postnatal ward was difficult for women from all three case study sites since they had to adjust from a one-to-one to a one-to-many ratio. Some midwives foresaw that women may find such a transition difficult and so visited women on the postnatal ward to provide a short period of one-to-one attention. Women sometimes took the initiative and requested the midwife to visit them at home postnatally. This created an opportunity to prolong the relationship so that they could to talk through the labour with someone who was present and to take an opportunity to thank the midwife. The latter findings reinforced previous studies (Janssen and Wiegers 2006; Aune et al. 2011).

5.4.6.6 Summary

Overall this study builds on research findings that stipulate the importance of the midwife-woman relationship and the positive impact that midwifery presence and the environment have on the one-to-one relationship. It also builds on the research concerning emotional attachments between midwives and women in labour. However this study offers new knowledge regarding the midwife-woman relationship during one-to-one support in labour. This includes how midwives manage their commitment to sustain the midwife-woman relationship while also maintaining and safeguarding their own well-being. In addition the trust and equality within the midwife-woman relationship relied on all six components inside the birth environment being in balance. Lastly, a new insight was provided regarding the motivation of midwives and women to form relationships, and the anxiety and frustrations felt when things did not go to plan.

5.5 Coping strategies

Midwives providing one-to-one support in labour helped women to cope with labour through a variety of techniques. These included using midwifery presence, reassurance through 'midwifery muttering' (Leap 2010:24; 2013), encouraging women to mobilise, change positions, eat, drink and to use massage, birthing pools and if required pain relief. When midwives were not able to readdress the balance to help women cope, women searched for assurance that birth was imminent. If assurance was not provided, women tried to readdress the balance to increase their ability to cope by requesting interventions. These might include vaginal examinations to verify labour progress, or interventions to speed the labour process. At the far end of the continuum, some women found an inner resilience by giving themselves a talking to that enabled them to except the situation without outwardly panicking.

5.5.1 Midwifery muttering

Midwifery muttering was a tool used by all midwives in this study. Midwifery muttering was performed with midwives in close proximity to women. The tone was gentle, quiet and the words were repeated. The muttering provided positive feedback such as 'you are doing well, keep going.' Hilda felt like the voice of the midwife muttering was inside her head due to the softness of the tone:

> [Maureen was saying] you are doing well … keep breathing, yes go with it, yes, there was a lot of that, but it was quiet … it almost felt like they were inside my head … they were not shouting at you with a mega phone, saying 'come on- you can do it!' … (Hilda, AMU)

Women like Connie said that they needed frequent interactions with their midwives and became reliant on hearing their midwives' voice as a way of coping. Connie got into a rhythm where she anticipated midwife Diana's muttering with every contraction and she incorporated the rhythm with other movement such as rocking:

> After she did it the first time, I then waited. I looked forward to that, I pre-empted that for every single contraction and, as you know, the contractions were pretty much every 2-3 minutes for … the twelve hours ... I kind of almost waited for her voice, because I then had a system going as I breathed through every contraction, I knew her voice would be there and it was so reassuring and I needed that basically and she didn't miss one [laughing] I don't think, bless her heart. Poor woman, but … it meant everything her saying that to me … yes it was just brilliant hearing her voice (Connie, AMU)

Connie appreciated midwife Diana's commitment to consistently undertake the muttering and again this was interpreted as loyalty to their one-to-one relationship which increased Connie's trust in what Diana was saying through the muttering. The reassurance and midwifery muttering had to feel real for women. Casey showed how the trust had to be gained as she gave the impression that she did not believe the midwife was sincere:

Midwife Summer	You are doing really well
Casey	I bet you say that to everyone (Agitated tone)
Midwife Summer	I don't (Fieldnotes from Casey's labour, FMU)

Mira highlighted another obstacle to believing and following the midwifery muttering. Mira previously gave birth in a consultant led labour ward. In this study Mira gave birth to her second baby in the birthing pool at the FMU (Figure 13).

Figure 13: Mira's labour

The lights were dim and the only sounds heard were the voices of Mira and midwife Yani exchanging midwifery muttering and reassurance about sensations Mira was experiencing. Mira found she could not fully focus on the midwifery muttering from Yani which was encouraging her to follow her body. The voice of the midwife from her previous labour had cast doubt in her mind that her body would be telling her the right information. Although Mira's body wanted to push, she could still hear the voice of her previous midwife instructing her that her body was wrong wanting to push. Yani persisted with her reassurance and midwifery muttering which helped Mira to follow her body:

> I had the other midwife in my head, the previous one from my first labour. I had her in my head just telling me don't push, you are not ready, but because she [Yani] was there saying 'no, you are ready, your body is telling you, you are ready'. She [Yani] had the mirror down there saying you are opening, so it made me much more confident to push, to listen … to her voice and what not, she made me feel much more comfortable, and she made me feel like she knew what she was doing. So that relaxed me a bit more, definitely (Mira, FMU)

5.5.2 Assurance

Midwifery muttering came naturally to midwives in this study, but the same could not be said about providing assurance to women. Assurance was more challenging as women wanted to hear that the birth was imminent. This was because they became exhausted, frustrated and desperate for the labour to finish and at the most extreme, women felt they were going to die. One and a half-hours prior to Isabelle giving birth, the atmosphere progressively became

intense as Isabelle began to lose faith in her ability to achieve a normal birth. Isabelle became increasing irritable concerning activity around her and she could not get comfortable in the pool. Although midwife Megan was present within the labour room and had created a calm environment Isabelle started to disbelieve the midwifery muttering:

00:07	Midwife Megan	You are so calm
	Isabelle	Disagreeing
	Midwife Megan	[Helped Isabelle into different positions]
	Isabelle	I do not like positions, sorry.
	Midwife Megan	Do not worry. Repeating reassuring words …
00:19	Isabelle	[Contraction] So uncomfortable, I feel like I am going to poo. My back! [shouting]. What are you doing? [Distressed voice]
	Midwife Megan	Removing a bit of waste using the sieve
00:21	Isabelle	[Contraction] I need gas [Cried out]. I just do not want to do it. I am going to die right now [Distressed voice] (Fieldnotes from Isabelle's labour, FMU)

Community midwife Venice acknowledged like many, that the midwives' actions needed to change from passive to interactive when women became more distressed and lost faith in their ability to give birth naturally:

> … things can change, if people become more distressed … or discouraged or feel that maybe they can't cope anymore, certainly the way you would interact with them can change. I think, because you may have to be more proactive and make more suggestions to try and divert them from their pain and try and help them cope with their pain … so I think it can change from literally doing very little at all and being very, very passive … other than doing the routine observations … then you might have to become much more active and involved if the situation dictates as the labour progresses (Venice, Home birth midwife)

When midwifery muttering was not providing the reassurance, women such as Isabelle and Casey attempted to gain assurance by questioning their midwives about timelines to birth. Midwife Megan answered, trying to communicate that timing could not be predicted:

Isabelle	I know all must ask this, but how long will it [labour] go on for?
Midwife Megan	How long is a piece of string? (FMU Fieldnotes)

It could be questioned whether such answer could come across as quite dismissive. Midwife Summer attempted to provide a timeline for Casey, but in such circumstances unless birth was imminent the timelines provoked more anxiety as the timings stipulated were always too long for women to mentally cope with. In addition, such assurances were a calculated guess:

22:50	Casey	Let go of me [directed at partner with an agitated tone] …
	Casey	How much longer?
	Midwife Summer	You will be an half an hour to an hour
	Casey	I don’t believe it, I want to go

	to hospital
Midwife Summer	You are nearly there
Casey	I want an epidural. I can't take it, I have had contractions all day
Midwife Summer	You are really near to having your baby
Casey	Requesting to go to hospital
Midwife Summer	You are very nearly there. Let's make a deal. Midwife Summer explained that she doesn't think that Casey will make it to the hospital so give it half an hour (Fieldnotes from Casey's labour, FMU)

Casey had a normal birth at the FMU shortly after this conversation, therefore it did not have a negative impact that assurance was not provided. It could be postulated that when women requested assurance, this could be a time that midwives providing one-to-one support in labour need support from colleagues to help re-address the balance inside the birth environment. The support could help midwives remain positive to continue to communicate that they have faith that the women have the ability to give birth naturally.

5.5.3 Women requesting interventions

If women did not receive the assurance from midwives, women attempted to re-address the balance themselves, by requesting interventions that would help them estimate a timeline to birth and/or accelerate labour. Interventions requested included vaginal examinations and breaking their waters. Fiona having her second baby at home requested a vaginal examination, which her midwife Venice performed and the information gained enabled Fiona to make the decision to stay at home rather than transferring to hospital for pain relief:

> … it was really nice I could kind of say I wanted one [vaginal examination], rather than a midwife going ‘we are only going to check you every four hours’ which they do in hospital unless you are really adamant that you really want to push, then they might check you … (Fiona, Home birth)

Ruby also requested a vaginal examination, but her midwife Gladys (rather than performing a vaginal examination) continued to reassure Ruby that birth would happen soon. In hindsight, Gladys was correct as Ruby gave birth quickly and so Ruby was happy with Gladys’ decision. It may have been different if the labour had not progressed so quickly:

> I think I said to her, I wish I knew how many centimetres I was and she actually said to me ‘well judging how it’s going and what you are doing, I don't think it is going to be much longer’. But in midwife terms that could be … ten minutes or three hours … I can't really moan about any of it, because it was so quick (Ruby, FMU)

Lena was an exemplar of women who wanted their waters broken and shocked to find that the midwife-led philosophy of care did not perform such interventions when labour was progressing normally:

> What I didn't realise is that they don't break your waters for you, do they? … I found that hard, you know … I think I was begging, please break my waters (Lena, FMU)

Lena was not alone, as women from all three case study sites requested to have their waters broken. Again Lena’s labour progressed quickly so there was not time for the request to be pursued. Midwives however also instigated the thought that the labour would progress once the waters broke:

> Midwife Silvia said ‘once the waters go, baby will come’ (Fieldnotes from Lena’s labour, Home birth)

> Midwife Jayne explained ‘just need that bag to burst to push things along’ (Fieldnotes from Jasmine’s labour, FMU)

5.5.4 Women finding inner resilience

If midwives did not readdress the balance so that women felt they were coping, women sometimes gave themselves a talking to when they were on the brink of panic. Women appeared to be able to reason with themselves that panicking or losing control would not help the situation. Hilda said that she found an inner-strength in labour that she did not know she had:

> There was a moment when she [midwife Maureen] went for lunch ... the contractions were really getting quite, oh my god and … I was saying to [named partner] 'I can't do this, I can't do this' and he said 'do not be ridiculous' and I was using the gas and air … but at a certain point actually I dug down deep and found something that I didn't think I had within me ... that was the only point I was actually left … (Hilda, AMU)

Similar to Hilda, Cecelia also had a moment of panic where she felt she could have lost control and got upset when she was informed that she needed to go to theatre to have her perineum stitched following a water birth. Outwardly it was not apparent, but Cecelia inwardly gave herself a talking to, to calm her own reactions so that she could cope with the interventions ahead:

> I think there was a moment where I probably could have gone and lost it a little bit, not lost it, but I was kind of, a bit upset about that I think. It was literally, a second in my head and I kind of said to myself 'you know well this is what you have got to do, so nothing you can [do]', you know getting upset about it is not going to make a difference (Cecelia, AMU)

5.5.5 Discussion

This study affirms that midwifery presence inside the birth environment helped women feel confident to cope with labour and birth and enabled midwives to support women's coping strategies (Aune et al. 2013). Women who were coping were more likely to be progressing in labour, to have a good relationship with their midwife and receiving emotional support from their partner. This study found a range of coping strategies used by women. These included reassurance from midwives and the birth environment, assurance from midwives that birth was imminent, requesting interventions and finding inner resilience.

5.5.5.1 Midwifery muttering

'Midwifery muttering' (Leap et al. 2010; 2013) was used in every labour observation at all three case study sites. This study supports that midwifery muttering provided a powerful message that the midwives had faith in the women (Leap 2010, 2013); affirmation of the efforts made by women (Roberts et al. 2007); and that the physiological changes experienced were normal (Aune et al. 2011); and showed normal progress of labour.

The midwife's voice helped most women feel safe and it was women's only attachment outside of themselves (Leap 2010). The midwives' words had the potential to influence women's interpretation of their pain (Ayers et al. 2015) and help them feel in control. For many women, feeling in control was a vital part of coping with labour and this has been reinforced in other studies (Bluff and Holloway 1994; Halldorsdottir and Karlsdottir 1996; Waldenström 1999; Newburn and Singh 2003; Hauck et al. 2007; Deery and Hunter 2010). I observed however that not all women welcomed midwifery muttering. Some women were irritated by the reassurance following every contraction. Kennedy et al. (2010) explains that such irritation could be due to women feeling that midwives were not listening to them when they sought, for example, pain relief.

Most women accessing midwife-led care did not expect to be rescued from the physiological processes of labour and birth (Cooper 2011). The midwife-led philosophy of care complimented the perspective of women to work with the pain (Leap 2013) (Table 8) at all three case study sites. Working with pain in this study meant that midwives used midwifery muttering and the facilities inside the birth environment to provide reassurance for women. None of the women in this study required transfer for pain relief. This may have been a reflection of the success of the midwife-woman partnership, as good relationships have been shown to be the main influential factor for women coping in labour (Leap 2013).

In contrast the motivation to use the pain relief approach has been suggested to be connected to midwives wanting to save women from the pain (Leap 2013) (Table 8). Alternatively, Mander (2010) indicated that midwives are not able to tolerate the noise of women coping with pain. The latter approach was also in contrast to what I observed in this study as midwives were very comfortable with the sounds of labour.

Table 8: Midwifery perspectives of pain (Leap 2013)

The pain relief approach	**The working with pain approach**
Ensuring adequate pain relief	Women can cope with contractions in uncomplicated labour
'You don't have to be heroic'	'Normal and abnormal pain.' The need for pain relief is associated with malposition/dystocia
'In this day and age, you don't have to suffer…	Pain as a stimulator of endogenous opioids-minimising disturbance
It's far more work being with a woman who is agitated and making a noise especially if you're looking after more than one women in labour	Pain gives clues to [labour] progress

5.5.5.2 The birth environment

The birth environment has also been suggested to influence the experience of pain experienced by women (Escott et al. 2009; Cheung 2010; Ayers et al. 2015). This study reaffirmed that women giving birth at home and within the AMU and FMU, valued facilities such as a large birth environment, birthing ball, private shower and toilet and calm music (Newburn and Singh 2003). Such facilities are less likely to be available within hospital labour ward environments (Newburn and Singh 2003). Women in this study also reinforced that they found it helpful to labour and birth in water (Newburn and Singh 2003; Kennedy et al. 2010). It was a prerequisite that all women wanting to labour in the pool, had to have one midwife allocated to one woman at all three NHS organisations. Due to the midwifery one-to-one ratio at all three case study sites, all women were able to labour in a pool, if a pool was available. The use of the birthing pool and Entonox was high at all three case study sites, although the pool was not available for all women at home, therefore the numbers were slightly lower (Appendix XVI). In addition, only one woman at home was administered pethidine (Appendix XVI).

5.5.5.3 Resynchronising midwifery labour support

Women's coping strategies changed, as labour progressed. For some women, midwifery reassurance and the environment stopped providing the means to cope in the labour. As midwives were present inside the birth environment in this study, most midwives tuned into this change and attempted to resynchronise their care by becoming more interactive if they were previously creating a subdued atmosphere. This has been shown to be an effective distraction for women (Escott et al. 2004).

As labour progresses, studies reveal that coping can be more challenging as labour pains become more intense leading to women feeling anxiety, fear (Dixon et al. 2014), moments of panic (Leap 2013; Dixon et al. 2014) and despair (Simkin 2002; Roberts et al. 2007; Bergstrom et al. 2010). Some women feel they are going to die (Halldorsdottir and Karlsdottir 199). Many women also become increasingly tired and sleepy between contractions (Dixon et al. 2014). Due to exhaustion some women feel that birth seemed to be never-ending (Halldorsdottir and Karlsdottir 1996). All these sensations were expressed and observed in this study which caused some women to become uncertain whether they were capable of giving birth.

5.5.5.4 Seeking assurance

If resynchronising their midwifery care to provide increased interaction and reassurance did not improve women's coping abilities, women attempted to readdress the balance themselves by seeking assurance that birth was approaching. Bergstrom et al. (2010:41) referred to this as a 'progress query'. In this study assurance came in the form of timelines and requesting a vaginal examination to indicate that birth was imminent.

Escott et al. (2004) found that focusing on pain duration, was one of the most frequently used coping methods in labour. Women increased their coping ability by telling themselves that the pain would not last forever. I observed a few midwives who attempted to answer the questions regarding timelines and they did not succeed in achieving assurance for the women. This was due to the timelines provided being calculated guesses and did not indicate that birth was imminent. For most women, this was not a problem as birth followed shortly after the quest for assurance. For other women, birth was not imminent so they

continued their attempts to readdress their coping capabilities. This was attempted by requesting interventions to accelerate the labour. Such requests were mostly refused due to the midwife-led philosophy of care. Bluff and Holloway (1994) however suggested that some women in their study thought breaking the waters was a necessary intervention. This was reflected in this study too, but midwives also instigated the idea that the labour would progress with interventions such as 'breaking the waters.' I suggest that when midwives use such language, it has the potential to cause women to become fixated; that the intact waters are slowing the labour down and they could take this message to subsequent labours. In addition, I postulate that this could be a time that midwifery support might be summoned to re-energise or/and re-evaluate re-synchronisation of the coping strategies and the other five components (Figure 8).

5.5.5.5 Inner resilience

Some women in this study found an inner resilience if midwives were unable to readdress the balance for women to cope with stressful situations. Some women 'gave themselves a talking to' as a means of coping with unexpected situations. This was echoed in a study by Escott et al. (2004) who found that women told themselves to calm down as a coping strategy to decrease their anxiety levels. When considering resilience, one woman in a study by Newburn and Singh (2003) said that she found reserves within herself to cope, from the supportive environment at home due to it being familiar. In this study such resilience was particularly required when the labour did not go as planned or/and transfer to labour ward was needed. Midwives providing one-to-one support, are in a position to tune into women's' heightened anxiety resulting from emergency treatments and transfers. However midwives also need to be educated that women use such strategies so that they can enhance the calmness and ability to cope that women strive to achieve.

5.5.5.6 The impact of previous labour experiences

This study identified that one-to-one support in labour enabled midwives like Yani to provide consistent focus to override the experiences of a previous labour. Mira, when attempting to follow her body as midwife Yani was reassuring her to do, started to hear a louder voice from her previous labour in her head. The voice informed her that she should not follow her body as it was misguiding her. All women who had such experiences had a previous labour in a hospital labour

ward. These previous labour experiences identified with a study by Nilsson (2014) who found that in hospital environments, even when the midwife was present, they were not always caring. Furthermore, they were made to feel like objects of surveillance, dependent on technology which caused women to feel incompetent and fearful of childbirth.

5.5.5.7 Feeling a sense of pride

Finally, the findings from this study affirm that birth was a time that women realised they had coped with labour (Dixon et al. 2014). Following birth, my fieldnotes revealed (section 5.3.4) that women such as Kenda were proud that they had accomplished the birth with no pain relief. This reinforced the notion that women felt strong and confident, with a sense of pride (Leap et al. 2010).

5.5.5.8 Summary

Overall, this study builds on research findings concerning how midwives use reassurance through midwifery muttering and the birth environment to help women cope in labour. My findings provide original knowledge concerning how women readdress their coping capabilities if midwives have not resynchronised their support, when reassurance and the use of the birth environment no longer help women to cope in labour. Understanding what women are trying to achieve when using coping strategies in labour is vital since midwives providing one-to-one support, have the opportunity to tune in and resynchronise the care. The latter may also require assistance from midwifery colleagues, which will be explored later in this chapter.

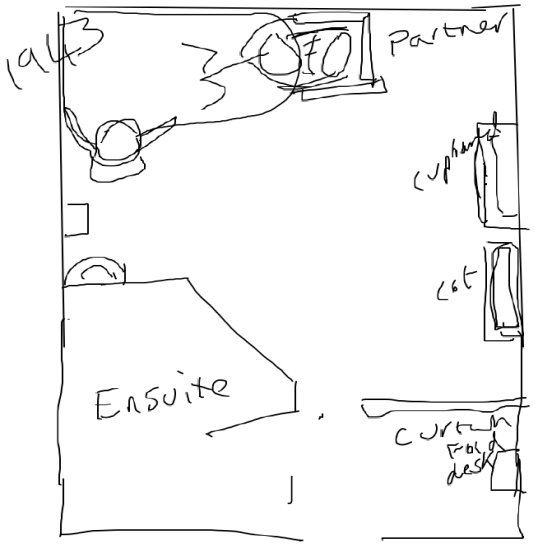
5.6 Labour progress

The continuum for labour progress centred on the activities inside the birth environment, when there was labour progress and when there was no labour progress. When labour progress was normal, the midwife-woman dyad reassured each other as equals. When there was no labour progress however, the equality in the relationship became unbalanced as midwives went into ‘instructor mode’ and women and partners became anxious and obeyed the instructions of the midwives. The latter was an attempt by the midwife to readdress the balance to improve and resolve the situation, so that transfer to the labour ward was avoided if possible.

5.6.1 Normal Labour progress

Assessing labour progress was a two way relationship inside the birth environment. Midwives used their professional skills to ask women, when appropriate, to confirm their perceptions of the labour sounds heard from women as well as the behaviours observed during and in-between contractions. When midwives were present, women frequently questioned the midwives about the sensations following each contraction, to gain reassurance that it was normal and whether the sensations, translated as progress. This process was intensive because contractions occurred approximately every 2-5 minutes in established labour. During a contraction the labour room or home was filled with heavy breathing sounds and vocals including 'hmmmm, oooooo, ouch, argh' sounds or shouting descriptions of sensations felt or people's names. The sounds varied in loudness and intensity. Kenda and midwife Amy (Figure 14) were an exemplar of this interchange between midwife and woman in labour:

Figure 14: Kenda's birth environment



19:33	Kenda	[Following contraction] I felt a little push with contraction, but I didn't push
	Midwife Amy	That is ok, follow your body
19:37	Kenda	[As contraction builds up] It is feeling different. What shall I do if I feel I want to push?
	Midwife Amy	Follow what your body tells you to do [Voice softly spoken]

19:39	Kenda	[As contraction builds up] I am pushing [voice anxious and loud]
	Midwife Amy	Well done [softly spoken]
	Kenda	[Following contraction] What if I am not ready to push? [voice anxious]
	Midwife Amy	Your body knows better than any of us
	Kenda	My waters haven't gone, is that ok?
	Midwife Amy	Yes, sometimes … [Interrupted by contraction]
1943	Kenda	[Blowing out and then pushing] It's burning! [shouting]
	Midwife Amy	[Using mirror to observe progress in the birthing pool] I can see things are starting to open, you are doing so well [Calm gentle voice]

(Fieldnotes from Kenda's labour, AMU)

The exemplar from Kenda and midwife Amy shows the importance of one-to-one support enabling midwifery presence and the development of trust within the midwife-woman relationship. I suggest that if Amy the midwife had not been present she would have missed opportunities to reassure Kenda. For Kenda to keep coping with the contractions, she also had to believe in what midwife Amy was saying to her. Women often said that the midwife was the 'expert.' At first glance it may appear that Kenda had less to contribute than the midwife, but in fact the descriptions of the sensations provided by Kenda gave reassurance to midwife Amy, that progress was occurring. Progress in labour was very important to both midwives and women, so both parties invested energy to reassure each other. Connie said that she was aware that her midwife needed information about her body:

> … It made me feel … almost that she was trying to reassure me that we were getting somewhere … she was obviously the expert, but she would constantly ask how I was feeling and constantly ask what sensations I was feeling and … did I feel the urge to do anything and things like that … so it would make me get in tuned with my body really, and just, she was obviously pushing me to keep communicating with her, constantly about any changes or anything that might be happening in my body … so I felt free to kind of express any feelings that I had really to her at any point, she really encouraged that (Connie, AMU)

The midwives' trust in women's ability to labour and give birth transferred to women. Kenda (in an interview) validated the sense of reassurance and empowerment for women to listen to their body in labour:

> I felt both midwives made me feel that I was doing a good job and that they were there in case any problems arose, but they weren't taking over. It was very much … led by me and what my body was doing at the time which again was different [to my last labour]. It was hard to begin to trust my body, because I think this time they didn't examine me at all … it was a bit unnerving almost when I felt I needed to push, I was so shocked because it was so quick I almost didn't trust my own body … the minute they said yes if you want to push just push, then it made me relax and think ok this baby is nearly here you know. I think they empower. They have the power to empower women you know. They never offered me any pain relief so I didn't think to ask for any (laughing) you know I could do it by myself which is amazing (Kenda, AMU)

Lastly, when labour was progressing normally women mostly led the decision making regarding positions, activity, eating and drinking with suggestions by midwives when requested or from subtle cues.

5.6.2 No labour progress

Midwives appeared to change their stance from following the woman's body to following the midwife's instructions when a line was crossed stipulating where normality exchanged into abnormality. These were scenarios which potentially

could end in a poor outcome for the woman or/and her baby. The line dividing normality and abnormality was not clearly defined, but appeared to be linked to an interpretation of local clinical guidelines regarding labour care. At all three case study sites, midwives mostly started with providing advice to enhance the physiological process. However, if the labour progress was going outside the guidelines of normality, the support became more medicalised and dictatorial.

5.6.2.1 Enhancing the physiological labour process

Midwives encouraged the physiological labour process by helping women to use different positions and mobility to improve gravity, increase the diameter of the pelvis and stimulate contractions so that labour would progress. When the labour was perceived by the midwife to be bordering abnormal, women were advised to get out of the birthing pool. They were encouraged to use positions such as standing, all fours, squatting, lying on their side, sitting on a birthing stool/ball, or elevating one leg with the support of furnishings. Midwives also encouraged increased activity including rocking, walking and climbing stairs. The AMU at case study site one introduced an initiative called “Spinning babies” (Tully 2015). This focused on specific positions that enhanced the rotation of baby into the ideal position for birth. Food included honey, toast and jam, biscuits, sweets and chocolate. Drinks included water, honey in water, juice and isotonic drinks. Midwives at all three case study sites reflected the views of midwife Terri using personal examples of the benefits of eating and drinking in labour rather than using research evidence:

> … I mean it [hydration] is important whenever you look after a woman in labour, but especially being in a pool and being on the low-risk birth unit, because obviously we want to keep women low-risk, so we know it is essential … to maintain good contractions. It is not like on … [labour ward] where if we become dehydrated we put up a drip […]

> … also prevention of intervention … and also for her energy levels. It [fluids] is important ... I have had several women who have had squash with some honey … and they have said, I feel better now (Terri, AMU midwife)

At the AMU Gloria was one of two midwives observed who also advised women to use nipple stimulation to increase contractions:

> Talking about the contractions. Gloria saying she feels sure the contractions are doing the job, but if they do go off it would be good to massage colostrum from the breast to stimulate contractions (AMU fieldnotes)

5.6.2.2 Midwives as instructors

Somewhere on the continuum concerning labour progress, midwives changed from being woman-led to instructors. I referred to the latter as 'instructor mode.' This was due to a loss of faith in the ability of certain women to progress physiologically in labour and give birth. Such loss was triggered by a fear of not complying with local guidelines which stipulated the boundaries of normality in labour and birth. Heather showed how midwives were fearful of litigation. The anxiety experienced by midwives increased the motivation to achieve progress leading to birth:

> I felt after a 1.5 hours of pushing and there was no signs of descent, because there was nothing visible ... I did think it was appropriate to get a bed over to prepare (emphasised) for possible transfer to … [labour ward], because I was concerned that the … [baby's] heart was not going to … remain in normal limits and I was concerned that she was not going to push this baby out … (Heather, AMU midwife)

Providing instructions was the midwives' last attempt to readdress the balance to improve and resolve the situation, so that transfer to the labour ward was avoided if possible. Instructions concentrated on 'directed pushing' and the position of women when pushing. The AMU midwives at case study site one had an additional option to use the lithotomy position (Figure 15) due to the close proximity of the obstetric beds on a labour ward. This option was not available to midwives working in the home environment for case study site two or the FMU for case study site three. Midwife Tanya at the AMU considered the use of the lithotomy position within the AMU as an option when there were concerns about labour progress:

> I was thinking that perhaps if we got the delivery bed over, when Heather [midwife] mentioned it. I thought well, yes, perhaps if we got the delivery bed over and got Tess into lithotomy position and you know

really encouraged her to push that baby might come a little bit quicker. But as it was we didn't need it, we got her in a decent enough position to get the baby down (Tanya, AMU midwife)

The lithotomy position is controversial for low-risk births. The literature review showed that it is considered to be a medicalised practice, but midwife Mildred helped Pat into lithotomy when transferred to labour ward as a last attempt to achieve a normal birth (Figure 15):

Figure 15: Pat's labour including deviation from the normal

I tend to use it [lithotomy] as a last resort … it is often the way … women push in lithotomy, is a way that they don't like to push. There are different positions you can get them in, in the room standing or squatting that … achieves the same effect, but often the ladies don't like to do it; and … I would use it [lithotomy] as a last resort if I knew that would get the baby out and have a vaginal birth (Mildred, AMU midwife)

When midwives were in 'instructor mode', directed pushing was advised. This is also controversial as considered to be a medicalised practice, but observed at all three case study sites. Language changed too to include terms such as 'hun, sweetie, sweet heart, darling, love, luvie and good girl':

Put your chin on your chest and push like you are doing a big poo … Push into bottom. Hold behind your legs. … We need this baby out sweetie (Fieldnotes from Tess's Labour AMU)

Many women like Pat and Tess did however; welcome the midwives' instructions, which in their minds led to a normal birth within the AMU. Tess, from the beginning of her labour, had doubts about her own ability to give birth, but she became more relaxed due to the calm birth environment created. When the calm atmosphere was replaced with instructions concerning positioning and how to

push and breathe, Tess listened and followed the midwives' instructions. Tess felt without the instructions she would not have known what to do:

> I was stressed and anxious, because I knew I had been up for two nights already and I was going to struggle … the birth pool… really helped me … being in that nice dark lit room … in the warm water and, like I say, talking to the midwife, it made me forget that I had been worried and anxious before ... I remember saying at one point I am really scared, I don't know what to do and that's when the midwife said to me 'you need to take deep breaths before your contractions' and then 'push down and hold it for a long time.' So those instructions really helped and they kept reiterating the instructions to me, … it was reassuring me that I was doing the right thing … all the time … so her saying to me constantly 'wait for the build-up, take lots of deep breaths' and then telling me to 'push down hard' … I think that really helped because I was never told that before with my son, I was never told how to push or how to breath or anything so it made all the difference having someone there who knew how I should be doing (Tess, AMU)

Midwife Heather's reflections of her one-to-one support in labour for Tess showed that she remained apprehensive about the alternative poor outcomes that could have occurred rather than the normal birth that was achieved:

> I found it very, I found it quite concerning when nothing was happening. I know the outcome was excellent- she gave birth vaginally. But if we had any problems and I know that is defensive, but if we had had Shoulder Dystocia or if we have had … a deep bradycardia [baby's heart rate lowers], it would have been very difficult to defend and I think that is what you are thinking, I think that is what you are thinking at home with a homebirth and I think that is certainly … on my mind there [when caring for Tess] (Heather AMU midwife took over from midwife Tanya)

The second example extends further to the other end of the continuum and concerns Isabelle, her partner and midwife Megan. Midwife Megan started her one-to-one support in labour reassuring Isabelle to follow her body. The room

was calm with dimmed lights coming from the birthing pool (Figure 16). A CD was playing messages from Isabelle's' hypnobirthing training to 'trust your body' and her birthing partner was repeating the messages. Isabelle and midwife Megan discussed leaving the birthing pool to warm the water and perform a vaginal examination at 01:00. Following the vaginal examination the atmosphere changed within the labour room to one of urgency, to progress the labour to facilitate birth. Midwife Megan became dictatorial in her instructions. Megan and Isabelle were no longer equals communicating progress. It was clear that midwife Megan had a restricted time for pushing in her mind and she encouraged Isabelle to be motivated to facilitate birth by informing Isabelle that the aim was to avoid her baby becoming stressed. Isabelle struggled not being able to listen to her body. This example showed not all women were grateful for midwifery instructions:

Figure 16: Isabelle's labour

01:12	Isabelle	Oh my god I just want to die, it is horrible [raising voice]. I feel like I am pushing all the time. I just want a breather please [Shouting with contraction]
	Midwife Megan	Push down in your bum. I wouldn't say that normally, but I know you want it over with …
01:20	Isabelle	It is taking so long [Contraction]
	Midwife Megan	It is important to push as we give a certain time to push baby out, so baby doesn't get stressed
01:21	Isabelle	[Isabelle on birth stool] I just want to lie down on the bed, it is so

		painful [Contraction]
01:23	Isabelle	[Contraction starts and Isabelle cries out] It is burning, my back is killing me
	Midwife Megan	Push without the gas. That is where I want you to push [Megan has two fingers touching the posterior part of Isabelle's vagina]
	Isabelle	Why are you doing that? [Distressed voice] I just want to get up. My bum hurts! I feel like my a*se is ripping!
	Midwife Megan	You need to push now Isabelle, again and again
	Isabelle	I want to do it for you so bad, but I am struggling
	Midwife Megan	[Asks second midwife for help with suggestions who advises all fours position on the bed] (Fieldnotes from Isabelle's labour, FMU)

The interview with Isabelle reinforced that Isabelle was aware of the changing dynamics inside the birth environment which changed from calm, to one of urgency and risk. Isabelle shared the impact on her partner, who also became anxious to the extent that he did not speak up as her advocate:

> … in the pool, I was kind of allowed to do what I wanted within reason ... and then when I came out [of the birthing pool] I had to do what other people wanted me to do, so it wasn't as nice … I felt like when I got out there was like this urgency, I had to have the baby within the next hour and if I didn't, something bad was going to happen. So I felt like there was some huge risk … I was so exhausted … I couldn't think straight and then my husband was scared for me. So I think he just didn't say

what we wanted to do, so we just went along at that point … (low voice) (Isabelle, FMU)

Reflecting on the labour, Isabelle had prepared herself for labour from pregnancy using a philosophy that followed and trusted the woman's body. Yet when midwife Megan started giving instructions during labour, Isabelle began to doubt her preparation for birth. Instead Isabelle tried to follow the instructions of Megan, thinking that she was the expert. After the birth however, Isabelle was unsure if following the instructions was the correct choice for her and whether the midwife really understood how she had prepared for labour and birth:

... my husband and I did a hypnobirthing course and we really were against the whole idea of go for it push, push, push … but … I don't think they read my birth plan. I had written … I didn't want people cheering me on, I wanted a quiet, calm atmosphere ... I didn't do the breathing the way I wanted to, because she [midwife Megan] told me to do breathing through my mouth … When you are in that moment you just think I will do what they say, because they are the expert and I am not. … the same with the pushing … I was taught on my hypnobirthing course … not to push … I think maybe she [midwife Megan] told me to push, because I had been in labour for 24 hours, and I was exhausted and she knew maybe … it could take hours more, … but even now my husband and I are like 'Oh should you have pushed, shouldn't you have', but now we don't care, because we have a baby … (Isabelle, FMU)

Following the birth, Isabelle and midwife Megan acknowledged that the labour and birth did not go according to Isabelle's plan. Midwife Megan was left feeling guilty while Isabelle was left disempowered and blamed herself when talking to Megan:

I tried to soothe her [Isabelle], I tried to, you know, say 'you know, it is one of those things', it's, because, you know, she was apologising to me … but it was me that felt bad. I felt, I felt that I let her down (Megan, FMU midwife)

> …all I could think of that day was that I did not get the birth that I wanted … (tears start to fall) (Isabelle, FMU)

5.6.2.3 Making the decision to transfer to labour ward

Women did not verbalise in labour regarding anxiety about the prospect of transfer in this study until risks were evident. It was apparent that transfers were on the minds of midwives inside the birth environment. The decision for transfer was one of the last choices available for midwives and women to readdress the balance to improve and resolve the situation, so that transfer to the labour ward was avoided if possible. This was completed while continually assessing the safety for the woman and her baby. Across the three case study sites, the reasons for transfer to labour ward included progress in labour, concern regarding the baby's heart rate, meconium at birth, postpartum haemorrhage [bleeding] and perineal trauma.

The discussion and decision about transfer to labour ward occurred inside the birth environment. Interestingly, discussion about transfer was more frequent at the home births (eight out of ten women), although only two women were transferred to the labour ward. Midwife Silvia explained that she brought up the subject of transfer due to her concerns that the placenta may not deliver. Nonetheless, it did and transfer was not required. Silvia wanted to prepare Jo, so that if transfer was required Jo would be less likely to refuse. Silvia also showed that midwives do hope that transfer will not occur:

> I was just hoping. I know I prepared her [Jo], just in case so she didn't suddenly go 'I am not going in'… but in the back of my mind I was thinking 'I hope you don't have to go in', because it is half out, so it should come out (Silvia, Home birth midwife)

Other midwives like Megan and Tanya brought up the subject of transfer as an incentive for women to push themselves a little more. This was part of a last attempt to try and readdress the balance to achieve labour progress:

> Midwife Megan said to Isabelle '*I don't want to transfer you, because you can do it. I can see you are holding back*.' (Voice assertive) (Fieldnotes from Isabelle's labour, FMU)

> Midwives Tanya and Heather discussed how long Tess had been pushing. Tanya said to Tess that they need to see this baby, otherwise they will have to go across the way [labour ward] (Feld notes from Tess's labour, AMU)

Sometimes, the option of transfer was considered more than once during labour. Linzi was having her first baby and stayed at home in labour for over twelve hours. In that time, transfer was offered or discussed five times by three different midwives. Once transfer was mentioned, it did not dominant the atmosphere. Linzi, her partner Frank and the midwives throughout the day and night; did a circuit using the bedroom, bathroom and hall way upstairs (Figures 17a and 17b). The midwives supported Linzi to use different positions, provided reassurance and encouraged Linzi to eat and drink, and supported the use of the Entonox.

Figure 17a: Linzi's labour

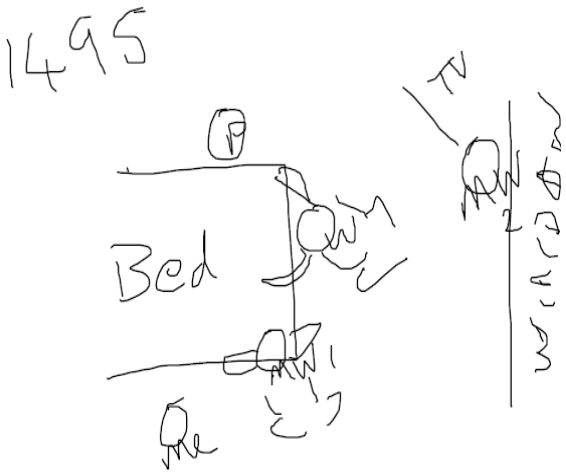


Figure 17b: Linzi's labour

None of the five midwives went into 'instructor mode.' This may have been a result of two midwives being called to support and relieve the first midwife Daisy for a break, and it also gave an opportunity to discuss the labour progress. Frank was anxious about the home birth and agreed to it, to support Linzi. Frank stayed with Linzi as she did her circuit, mimicking the words of the midwives and whispered terms of endearment in close proximity. At 17:30, the tensions increased in the rooms as Linzi became more exhausted. The increasing anxiety of Frank was shown when he informed the midwife that he felt better after drinking a beer. The midwife gently informed him that he may need to drive to the hospital.

The first time transfer was mentioned, Linzi failed to acknowledge the question. The second time she said a stern ‘no’. The other three times, Linzi accepted that if there was no labour progress she would transfer to the labour ward. The labour progress was within the normal limits according to NICE (2014) stipulating cervical dilation of 0.5cms an hour, until the assessment at 00:38. At this time Linzi, her partner Frank and midwife decided to transfer to labour ward:

16:31	Linzi	I am so tired [contraction starts. Cries out then ‘Shh’ sounds heard when blowing with contractions]
	Midwife Mona	It is hard. We will try everything to help if you want to stay at home or it would be a trip to the hospital
	Linzi	No response …
17:30	Frank	I am ok now as I have had a beer.
	Midwife Daisy	What if you have to drive to the hospital?
	Frank	I only had one
	Linzi	I cannot do this
	Midwife Daisy	Are you saying that you want to go in?
	Linzi	No [Assertive one]
	Midwife Daisy	You will be fine once we get the Pethidine …
18:05		
	Linzi	[Shouting loudly and then screams]
	Frank	Breath

	Linzi	It hurts so bad [Crying]
	Midwife Daisy	I would like to examine you before the pethidine. If no progress you will need to go in [to hospital]. If there is progress I will administer the pethidine. If there is no progress however, I recommend going in
	Frank	It is up to you [Linzi]
	Linzi	I have no choice. I have to go in, if I am not progressing
	Frank	What will they do in the hospital?
	Midwife Daisy	Explained about syntocinon and the epidural …
22:47	Midwife Ava	[Telephoned the labour ward informing them that she will repeat the vaginal examination in two hours. If there is no progress they will transfer …
00:38	Midwife Ava	[Completed vaginal examination]. You are still about the same, but the head is turning round. I would advise transfer into hospital so that they can start syntocinon and good pain relief … not many women get to 8 cms at home, you have done so well [Left room to call labour ward]
00:44	Linzi	[Talking to Frank] I am so disappointed
00:53	Midwife Ava	Ambulance called

01:00 Ambulance arrived

Following the birth Linzi had time to reflect on the birth. She appreciated that although she wanted to have her baby at home, during the course of the day she began to lose faith that she could progress physiologically. Consequently Linzi became more acceptant that she would need help on a labour ward:

> I was quite upset initially, because I really wanted to have him [baby] at home, but, also I was tired I knew that I had to do something, because he [baby] wasn't going to come out whilst we were at home and I needed that help, so it was just a bit of a mixed emotion sort of, at first it was 'I don't want to', but I think in hearts of hearts I knew I had to go in to get him out really (Linzi, Home birth)

Lastly, inside the birth environment midwives were apprehensive that women would blame them for the reason for transfer. This was more prevalent with perineal tears at all three case study sites. Midwife Megan requested me to leave the birth environment so that she could explain the need for transfer in private. Megan later explained that she was apprehensive that Isabelle would blame her.

5.6.3 Discussion

Midwifery one-to-one support in labour enabled midwives to be present inside the labour environment so that they could assess the progress of labour. All midwives started their care with equality within the midwife-woman relationship and a belief that women could give birth. As the birth played out, labour sometimes stopped progressing. This caused the actions of the midwife to change to 'instructor mode' and the dynamics of the midwife-relationship became unequal.

5.6.3.1 Following the woman's body

Midwives started their one-to-one care by being present in the birthing environment. In this study, midwives reinforced a belief that their presence promoted normal birth (Aune et al. 2013). Midwives' presence inside the birth environment encompassed trust and a belief to follow the body of women in labour. Evidence shows that this belief is a vital starting point when providing care to low-risk women in labour (Kennedy and Shannon 2004; Kennedy and

Powell 2002; Anderson 2010; Leap 2010) unless proven otherwise (Kennedy 2002).

Midwives' trust encouraged women to 'go with the flow' (Page and Mander 2014:32) in labour. My findings reinforced other studies that when midwives trusted the women's knowledge, instincts and body; women were also more likely to listen and trust their own bodies (Kennedy and Shannon 2004; Lundgren and Berg 2007; Anderson 2010). When women are supported to follow their body and intuition they are said to possess 'integrative power' (Fahy and Parratt 2006; Fahy and Hastie 2008). Integrative power supports women to feel good about themselves even when the birth outcome was not as the women expected (Fahy and Parratt 2006; Fahy and Hastie 2008).

This study reinforced that women required more verbal reassurance as the labour progressed (Berg et al. 1996). As midwives were present, they synchronised their care to increase reassurance when required. This was primarily in order to promote their trust and that the labour was progressing normally, while also asking questions about what the woman was feeling. Questions asked by midwives in this study were uncomplicated and this is recommended, otherwise the neocortex of women can be stimulated which then impacts negatively on the contractions and therefore progress in labour (Odent 2008).

5.6.3.2 Constructing the boundaries of normality

Midwives in this study appeared to mostly possess what Kennedy and Shannon (2004:556) has referred to as a 'tolerance for wide variations of normal.' Page and Mander (2014) suggested that the complexity of defining the boundary of normality, starts with the interpretation from each midwife. This was because they determined normality using their own values, beliefs, tolerance of uncertainty, which in my study was guided by their midwife-led philosophy of care at all three case study sites. In addition the way each labour played out was also unique (Page and Mander 2014), causing more variations in relation to boundaries of normality.

My findings indicated that midwives appeared to be mostly comfortable to work with the uncertainty of normality at all three case study sites. The findings from Page and Mander (2014) also explored uncertainty in the hospital environments

and found that uncertainty was less tolerated when compared to midwives working in the community, AMU and FMU. This study reinforced that higher tolerance of uncertainty regarding normality was attributed to the close midwife-woman relationships (Page and Mander (2014). This was because the decisions about what was normal, were shared between midwives and women.

This study also reinforced the notion that midwives constantly questioned and reconstructed definitions of normality, since there was a pressure to calculate correctly the point at which normality changed to abnormality (Page and Mander 2014). This chapter will proceed to show how midwifery support helped midwives in this study to also reconstruct definitions of normality. Evidence shows that for women, normality is not as complicated as they are more likely to define their labour as normal. This was provided the outcome was a vaginal birth and they were happy (Kennedy et al. 2010).

5.6.3.3 'Instructor mode.'

Midwives at all three case study sites synchronised their actions to offer instructions if they felt there was concern about the labour progress. Midwives firstly offered advice to enhance the physiological process of labour. However, if this did not work midwives changed to 'instructor mode', where instructions included medicalised interventions. There are no clear definitions about what constitutes intervention as even providing reassurance has been said to be the first level of intervention (Anderson 2002). Yet Simkin (2002:726) emphasised that the first rule of supportive care in labour is 'do not meddle,' implying that midwives should not provide any advice when women are making progress and coping.

In this study interventions were associated with midwives offering advice or instructions and changing their stance from following the woman to following the midwife in 'instructor mode.' When midwives changed to 'instructor mode,' they gave instructions regarding positions, food and drinks, as well as pushing. Directive pushing and the lithotomy are controversial practices within midwife-led care as considered to be a medicalised practice. In addition midwives did not only provide verbal instructions they sometimes became more invasive by putting their fingers into women's vagina to direct where to push. Roberts et al. (2007:137) explained that such invasive measures and instructions are used to expedite the labour process which is reinforced in my findings.

Studies advise that women sometimes require instructions inside the birth environment when women are showing signs of despair and looking for help from the midwife (Simkin 2002; Roberts et al. 2007; Bergstrom et al. 2010). The ‘take charge routine’ stipulated by Simkin (2002) (Appendix XVII) and reiterated by others (Bianchi and Adams 2009; Leap 2013) includes repeated instructions regarding positions, breathing and rhythm. This was in order to assist women to regain the ability to cope with their contractions, as the despair Simkin (2002) suggests is usually temporary with the right support. The ‘taking charge’ routine (Simkin 2002) appears to be a tool for midwives to help women psychologically cope when women show signs of despair. The incentive for ‘instructor mode’ in this study was different to the ‘take charge’ routine (Simkin 2002) as instructions focused on achieving a normal birth or readdressing the balance to attain normality as a last attempt to avoid transfer to the labour ward.

The findings by Ross-Davie (2001) also identified a supporting behaviour ‘taking control.’ This behaviour was categorised as a negative attribute and included interventions without consent, warning or indication and directions were forceful without discussion and pain relief was recommended. This behaviour appears to have some similarities to ‘instructor mode’ in my findings due to the unequal nature of the midwife-woman relationship, the instructions being forceful at times and consent was not always obtained. Consent was complicated when midwives were using ’instructor mode’ as it was not always clear if the woman was agreeing to instructions rather than providing consent. One difference identified however from Ross-Davie’s findings, is that midwives did not recommend pain relief when using the ‘instructor mode.’

I observed that midwives providing instructions to women was exhausting as midwives assumed more responsibility as women stopped contributing on equal terms and instead tuned into the next instruction. I suggest that midwives cannot tolerate the ‘instructor mode’ for long periods due to the energy required, the increased responsibility and the anxiety of an adverse outcome.

Latsly, evidence suggests that when midwives are not able to be present inside the birth environment, and there is a poor midwife-woman relationship, midwives become more hesitant and more likely to intervene in the birth process (Aune et al. 2013).

5.6.3.4 The use of language

The midwives language sometimes changed when using 'instructor mode.' Midwives used 'pet names' such as 'hun, sweetie, sweet heart, darling, love, luvie' and 'good girl'. Language is a powerful tool (L. Hunter 2006) and can reflect who has the power in a relationship (Ralston 1998). Researchers (Hunt and Symonds 1995; Cronk 2010) have analysed language using transactional analysis (Berne 1961, 1964) to portray how some midwives relate to women as parents and women as children rather than both communicating as adults. Anderson (2010:128) explained that when women were referred to as being a 'good girl' it was an indication that she was successfully doing what the midwife instructed. Using such language has also been suggested as patronising and offensive, although it has been questioned whether they are used as terms of endearment (Hunt and Symonds 1995). I suggest that when midwives are in 'instructor mode' they use language as a terms of endearment and to give positive feedback to counter balance the vulnerability they sense from women when obeying their instructions.

5.6.3.5 Women's perspective of midwives' instructions

Studies indicate that although women may follow instructions in labour, they are not always happy with that choice (Bergstrom et al. 2010) and sometimes feel inadequate (Anderson 2010). Isabelle in this study questioned whether she should have listened to the midwife regarding how and when to push, which led her to believe that she did not get the birth she wanted. This is an example of disintegrative power (Fahy and Parratt 2006; Fahy and Hastie 2008). Disintegrative power undermines women's confidence to trust and follow their own bodies in labour and their decision-making skills. This can lead to what Fahy and Parratt (2006:47) have referred to as 'midwifery domination.' 'Midwifery domination' appears to reflect midwives using the 'instructor mode.'

Not all women felt disempowered by midwifery instructions. Tess was an example that felt the midwives' instructions helped her achieve a normal birth. Tess and her birthing partners were very happy because she felt that the midwives were providing the instructions she needed. The support provided to Tess initially followed her body but when the midwives felt the labour progress was bordering abnormal, they resynchronised their care to 'instructor mode' while reassuring Tess. I suggest that as Tess had a normal birth with no complications, this may have influenced her positive perception of her care. In contrast, Isabelle

sustained a perineal tear that required transfer to hospital and surgery. It could be suggested that if the perineal trauma had not occurred, they may have felt more positive about the midwifery instructions in hindsight.

5.6.3.6 The decision to transfer to labour ward

Midwives described in the Morecombe Bay report were reported to have pushed for normality at any cost (Kirkup 2015). This is very different to the observations in this study where midwives were constantly balancing normalcy against risk and this sometimes led to transfers to hospital. Transfer was on the minds of midwives at all three case study sites when there was a deviation from the normal. Although women having homebirths had the lowest transfer rate when compared to the AMU and FMU, the community midwives discussed the prospect of transfer more frequently with women, when compared to the AMU and FMU midwives. Midwives at the AMU and FMU reinforced the findings from Patterson et al. (2015). This showed that midwives were more likely to confer with colleagues rather than women, when determining variations of normality and the requirement for transfer. Discussing with a colleague was said to provide perspective and stopped midwives willing a prolonged labour to be normal and giving women a false sense of security (Patterson et al. 2015). Community midwives did not always have a second midwife in attendance when first thinking that there may be a deviation from the normal, which may have contributed to their discussions with women. It could be postulated that community midwives think about transfer more often as they mostly work on their own. Community midwives in this study also explained that they sometimes discussed transfer as soon as a concern arose. This was because they wanted to assess the response of women, to check that they would not refuse to transfer. Once again, I suggest that the concern originates from the prospect of managing a woman refusing to transfer on their own until midwifery support arrived.

From the perspective of women, this study reinforced other research findings that the decision for transfer provoked disappointment, anxiety and uncertainty (McCourt et al. 2011; Rowe et al. 2012; McCourt et al. 2014), anger, frustration while other women blamed themselves (McCourt et al. 2011). This study will subsequently show in chapter six, that women such as Terri were also grateful for transfer when emergency treatment was required. This exemplar supports other research findings although the reasons for feeling relief to be transferred was most frequently associated with prolonged labour (Rowe et al. 2012). I did

not observe women at any of the three case study sites verbalise concerns about the prospect of transfer in labour until a risk was identified. The findings from Rowe et al. (2012) may explain why as they found that many women did not anticipate transfer would happen to them. This is in contrast to research findings in pregnancy. There is evidence from qualitative research from the birthplace study to suggest that transfer to the labour ward was a major consideration for women when making a decision about place of birth (McCourt et al. 2011).

5.6.3.7 Summary

Overall, this study reinforces the importance of presence to assess the progress of labour. This study offers new insight regarding the progression of midwives' care starting with a trust to follow women's bodies when labour was deemed to be progressing normally; to following the midwives instructions as a last attempt to readdress the balance to achieve a normal birth and avoid transfer labour ward. This study also reinforced that pet names are still used within maternity services, but also contributes new knowledge regarding the context that this language is used.

5.7 Birthing partners

The support provided from birthing partners was on a continuum. On one end of the continuum, birthing partners were confident to provide support and collaborated with midwives and partners also mimicked the midwives' words. Yet on the other end of the continuum, birthing partners felt helpless and needed time away from the birth environment. Similar to the other components, midwives could not always re-address the balance inside the birth environment. Sometimes women had to readdress the balance to receive the support they required. All women in this study were supported by their partner. Many women also had their sister, mother/in-law and/or a friend to provide support to them and their partner. The high prevalence of birth partners, supports other studies (Ross-Davie 2012; CQC 2013).

5.7.1 Working in collaboration

When midwives were sensitive to the needs of partners, they worked in collaboration to support women in labour. This could be reassuring for women combining the expertise of the midwife and the trustful relationship of the partner. In addition, the inclusion of a partner's inexperience and untrained eye

sometimes provided added reassurance in situations when the partner saw the baby's head. This was regarded as a clear sign that birth was imminent, due to his limited knowledge:

> Midwife Betty said she can see a bag of water. Partner added 'it's [referring to baby] coming sweet heart if you could see it darling you would know you can do it'. Betty repeatedly said well done (Fieldnotes of Michelle's labour, FMU)

Such collaboration however, was translated by Hilda as 'ganging' up on her. Although Hilda quickly said she was joking, the description did highlight the possibility of women feeling vulnerable, if the partner became an advocate of the midwife rather than the woman:

> … it felt like they were ganging up on me at one point (laughing). I felt I was being … being victimised (laughing) to a certain extent … No I am kidding. There was a moment that I thought 'yes you two … you are not the one giving birth' (laughing) …, they did seem to work in tandem. I do not know if it is because he [referring to partner] is a [named occupation], he has that, verbal praise going on you know, you are doing really well and I am saying 'no I am not' (raising pitch of voice) (laughing) (Hilda, AMU)

Not all partners felt such an alliance with the midwife providing support. It was evident that partners felt vulnerable when they did not have trust in the midwife and their professional abilities. Steve was an exemplar of a partner, who lost the trust towards the midwife supporting them. This made him feel nervous about the care Cindy was receiving at home. He did not challenge the midwife, but he was wishing for the shift change to allow another midwife to support them:

> … I was slightly nervous … the confidence just went and I just sort of felt that, you know, 'I am glad she [the midwife] is going in a few hours,'... I kind of, sort of felt a bit on edge … (Steve, partner of Cindy, Home birth)

5.7.2 Confidence

5.7.2.1 Experience of the birth partners

Two elements appeared to impact on the confidence of birthing partners when providing support. The first related to their previous experience and the second was place of birth. When partners had experience of supporting in labour, they had insight into the women's coping strategies and were more relaxed. Michelle's partner used his experience to help inform the midwife about how Michelle was coping and was in a better position to act as an advocate:

> Gary [partner] explained that Michelle did this last time within twenty minutes of giving birth (Fieldnotes of Michelle's labour, FMU)

Partners who had previous experience regarding labour support and within the home environment, appeared much more confident when compared to case study sites one and three. Part of the confidence was created by the comfort of being in a familiar environment with all of their own amenities.

5.7.2.2 The host

Steve previously supported his wife Cindy in hospital with their first child. Their second baby was born at home. Steve answered the front door to the midwife inviting her in as a guest. Steve acted as a host towards the midwives, ensuring they had drinks and food, while also having freedom to go where he chose. Steve completed household chores and frequently checked their young daughter sleeping upstairs. He had the freedom to leave Cindy for short periods while still being immediately available if needed. Steve was also responsible for creating a safe and private environment for birth which included closing the windows, blinds, and doors:

> … obviously there was quite a few people here at one time … trying to be, like, hospitable as well, because it is our home and we want people to be welcome when they are here. So you know obviously … I think while, being at home, you have got all of your amenities and stuff literally at hand and I think when you are at the hospital you don't have any of the luxuries you have got here … so you kind of sort of, I don't know, in-between your contractions, I was just 'quickly put something in the dishwasher' and then I will come back in. You are trying to sort of, because it was a hell of a long time, wasn't it really? I just sort of felt

> that, I wanted to keep myself busy, because I think [laughing] if I sat down too long I would probably fall asleep (Steve partner of Cindy, Home birth).

5.7.2.3 Practical tasks

Within the home environment, partners also prepared the birthing pool when used. This would include inflating, filling the pool with water and then maintaining the water temperature as specified by the midwife and deflating the pool after use. Preparing the birthing pool and maintaining the water at the AMU and FMU, was the responsibility of midwives. Nonetheless within the home it was the responsibility of partners, although midwives checked the temperature of the water. This activity kept partners at home very busy. Midwives therefore had additional time to focus on the women. Rita also explained how undertaking practical jobs helped men like her husband, as they are practical men:

> His role … his is a practical role rather than anything else. Isaac … my husband is not, generally speaking … not one to, … panda to me and stroke me and mop my brow and, you know, fuss over me. He's much better in those situations being practical. I think he is far more nervous than he would let on actually (Rita, Home birth)

5.7.2.4 Mimicking midwives

Partners at all three case study sites mimicked midwives by replicating their advice regarding food, hydration, massage, cold flannels, using their body to help the woman to adapt positions, helping women to get comfortable, including pumping pillows, playing music, holding the Entonox and tying hair back. Robert like many other partners also quietly and gently mimicked midwife Lorna by repeating the muttering and reassurance she was iterating in close proximity.

When Terri reflected on Robert's reassuring role in labour, he was surprised to hear that the reassurance he provided was not considered as reliable and trustworthy as the midwife. Terri regarded the midwife as the expert and therefore the reassurance was meaningful, unlike the inexperienced and untrained reassurance from Robert:

> Robert I think you listened on a subconscious level, but you definitely were not conscious of her saying it [midwifery

muttering] … because me and your mum were saying it as well. We were reassuring you, but you had no idea ...

Teri — No I do remember you saying it. I wasn't going to say It, but, but I am not being funny, I don't mean to sound harsh, but when you and mum said it [referring to muttering], it was meaningless (Guilty gesture) to be honest (nervous laugh)

Robert — Its fine.

(Terri, AMU)

In the absence of the midwife, the untrained eye of the birthing partner could sometimes cause more anxiety for women when they were seeking reassurance. Cecelia was alone with her husband following birth lying on a mat on the floor and her partner was pacing the room with their baby in his arms. Cecilia felt very uncomfortable in her perineal area and attempted to gain more insight and reassurance from her husband Alex. Alex appeared to lack the sensitivity used by midwives when providing feedback which they have gained through their clinical practice:

Cecelia — Did the [perineal] tear look big?

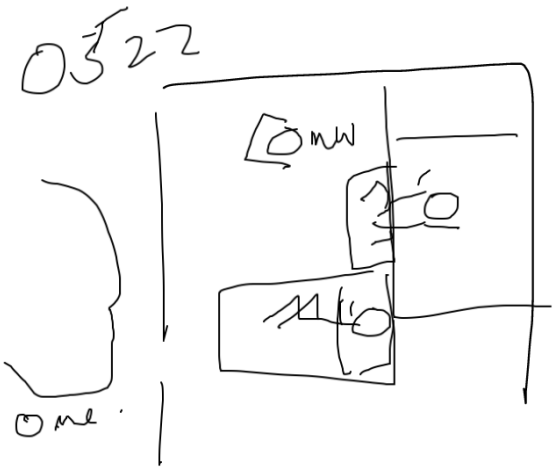
Alex — It looks big, I am not going to lie to you.

(Fieldnotes from Cecelia's labour, AMU)

5.7.3 The need to sleep

Birthing partners did get tired, but they often divulged this information to the midwife, but not to women. Having the freedom in the home environment, Frank quietly asked the midwife Daisy if he could disappear for an hour to sleep. Frank had been at the side of Linzi, from the early hours of the morning and asked the midwife at 23:00. Frank shared that they only had three hours sleep. In hindsight this may have helped in his supportive capacity as birth occurred at 08:00 the next morning. In another observation at the FMU, Michelle and her partner Gary were unusual as they planned that Gary would sleep in the early parts of the labour. This was planned so that Gary would have energy to look after the other

Figure 18: Michelle's labour with partner sleeping



children when Michelle returned home with their baby (Figure 18). Midwife Betty prepared a bed in the labour room for Gary and his snoring could be heard in between the contractions. Michelle then woke Gary when she had the urge to push. Gary had been present for the birth of his other two children, so there was a sense of partnership immediately when Gary woke:

Michelle … I know that having two kids [is] already enough so knew that obviously, it is tiring … I knew it [labour] was going to be a very long one. So I said to him [Gary] 'get some rest', so that he had the energy to be able to, you know, if anything, once the baby is here he can take over a little bit and bond with his daughter, and then I could just relax for a little bit, because I hadn't had the chance to

Researcher And did it work out like that later?

Michelle Yes, perfect, yes absolutely perfect. Soon as the baby was here … yes it was amazing and he took over, so that was really good.
(Michelle, FMU)

5.7.4 Women's perspective of their partner's support

Women's reactions regarding the support of their birthing partners, was also on a continuum. On one side, women did not want their partners to leave the birth environment even when the midwife was present:

22:27 David [partner] went to leave. Isabelle quietly said 'come back.'
(Fieldnotes from Isabelle's labour, FMU)

Women often became more reliant on their birthing partners when midwives left the birth environment. When other birthing partners were present the emphasis on the partner was relieved:

> Yes, like, even my husband was like 'you don't need me to be here', because … both my sisters came … they were wicked (Mira, FMU)

On the other side of the continuum women such as Pat felt frustrated by her partner's supportive activities. Pat felt like she was under observation when she was at home in labour, as her partner was constantly asking if she was ok and attempting to reassure her. Pat re-addressed the balance by going into the AMU:

> … when I was here [at home] on my own, no disrespect to my husband cause I love him to bits, but he didn't say anything and he just kept saying 'you are going to be alright', but I felt like saying 'no I am not!' He spent a lot of time looking at me which again drove me mad (Pat, AMU)

5.7.5 Primed for labour

Some women pre-empted that certain activities from their birthing partners would cause agitation. To safeguard against this, they primed them prior to labour to ensure that birthing partners knew what the women expected of them. Although Terri was having her first baby, she had insight into her coping strategies. Therefore she shared with her partner and mother activities which would cause her stress and frustration. Acknowledging Terri's instructions, Robert and Terri's mother did not ask Terri questions or attempt to be interactive. Robert remained present with Terri, but moved around the labour room quietly, keeping a calm presence. All parties were in agreement following the birth that the birthing partners had followed the guidance of Terri:

> … (Very assertive tone) I had severe words with both of them before they went in … I did have severe words with my mum especially … [I said] 'if you are going to be in there getting upset or panicking, it is not going to be doing me any help at all … I am not going to want you fussing around me, talking to me, just sit there' … and they both did really well. So part of that was because I had severe words with them (laughing) (Terri, AMU)

Not all partners however, had the confidence to follow through plans made for labour. Isabelle explained how her partner did not speak up as planned and that he was traumatised from the labour and birth experience. Such feelings may have long term consequences:

> I think, yes, obviously afterwards when I was on the bed, he was like, I lost all that blood and I was all ripped up and I think he saw down there and he was like 'Oh my god' even now he thinks back to, I don't think he thinks about it as much, but when we were in hospital and stuff he was like 'ohhh, I couldn't see you go through that again' (Isabelle, FMU)

Isabelle also showed that plans made in pregnancy could change when labour was experienced. Isabelle primed her husband that she would be happy for them both to be left alone in labour. Yet when labour established, Isabelle realised that she was reassured by the presence of the midwife regarded as the expert:

> I was thinking 'I would just want to be on my own', well with my husband and them [midwives] just coming when they need to come in, but all of a sudden when you are properly in labour, you don't really care, you kind of want them there, because you don't know what is going on. I think the sensation of labour was completely different to what I expected (Isabelle, FMU)

5.7.6 The partner-woman connection

Overall, a birthing partner had knowledge of the woman that a midwife would not be able to develop within their short relationship. Hilda summed it up well when explaining that couples know each other, therefore a partner can feel and see how a woman is coping in different situations:

> … we have just done so much together that I think you know he knows when I am getting panicked … he knows me and I know him without having to communicate verbally really (Hilda, AMU)

It was evident that midwives could further enhance the couple's bond by leaving them alone following the birth to give them time to bond with their baby, reflect on the birth and make plans about going home and introducing their baby to their

other children, family and friends. During the reflections, partners were very emotional, complimentary and affectionate with women:

> Partner has tears in his eyes and cannot speak.
> Couple kiss with eye contact
> 'So proud of you darling' partner says
> (Fieldnotes from Venice's labour, AM)

5.7.7 Discussion

This study reinforced the notion that the support of partners was on a continuum describing the variations of their involvement (Bäckström et al. 2011; Thorstensson et al. 2012). Studies have indicated that partners want to be present inside the birth environment (Lundgren et al. 2009; Steen et al. 2012; Tarlazzi et al. 2015; Johansson et al. 2015) and this may have contributed to why every woman in this study had their partner present. This study highlighted the factors that influenced the support of birthing partners, such as previous labour support experience, place of birth, type of support required, trust for the midwife and the need for rest. Some birthing partners were primed by women prior to labour so that support was sensitive to the needs of women.

5.7.7.1 Factors that increase the confidence of birthing partners

We know that the first fundamental attribute to improve the interaction of women and their partners is connected to the presence of midwives inside the birth environment (Hildingsson et al. 2011; Bäckström et al. 2011, Hildingsson et al. 2011). This study supported the idea that women and partners are recognised by midwives as a 'labouring couple' (Chandler and Field 1997:19; Bäckström and Wahn 2011:70). It has been suggested that variations of involvement appear to be a conscious decision from birthing partners to know when to be actively involved and when to step back (Bäckström et al. 2011). When birthing partners had experience, they were more confident and comfortable to step in. Longworth (2006) explains this is due to partners recognising that they knew the women better than the midwives meeting them for the first time in labour.

This study builds on the assertion that fathers with previous birth experience usually felt more prepared to support women in labour (Johansson et al. 2015). Hence, observations reinforced that partners who were first time fathers, needed more support from midwives (Hildingsson et al. 2011). The influence of previous

experience was particularly visible at case study site two as partners were observed to be busier and more confident within the home environment when supporting women in labour when compared to partners at case study site one and three. This study suggests that this is due to partners being in their own environment, which also allowed them to be instantly available or present.

Many of the responsibilities of birthing partners were practical which provided achievable goals (Bäckström et al. 2011). The most time consuming practical task for partners at home was preparing and maintaining a birthing pool as these birthing pools were purchased by the couple and maintained in labour by the partners. This was different to the AMU and FMU as it was the responsibility of the midwife to prepare and maintain the birthing pool. Even when there was no birthing pool in the home, partners were still busier playing the host, completing household chores and supporting the women.

This study reinforces the notion that partners with previous children often requested information about the progress of labour (Hildingsson et al. 2011). Such knowledge in this study was used to collaborate with midwives about reassuring women about labour progress. This information was also observed to be vital to help midwives tune into the needs of women. The information was also used by midwives to help birthing partners to participate with supporting women as evidence shows that most partners want be involved (Bäckström et al. 2011; Thorstensson et al. 2012), informed (Bäckström et al. 2011), provide emotional support (Tarlazzi et al. 2015), act as an advocate (Bluff and Holloway 1994; Johansson et al. 2015), complete practical activities and give encouragement (Lundgren et al. 2009).

5.7.7.2 Midwives and birthing partners working in collaboration

This study showed that although partners sometimes mimicked the midwives' supportive activities, women valued the professional knowledge of the midwives more superior to that of their partners. When midwives and partners worked in collaboration to provide support that was sensitive to the women's needs, this had a positive impact on the other five components inside the birth environment. In contrast, when birthing partners did not trust the midwife, it had a negative effect. This reinforced that trust was lost by birthing partners when midwives did not appear competent which then increased the anxiety levels of birthing partners (Chandler and Field 1997; Bäckström et al. 2011). Research has suggested that

trust is also lost when midwives did not listen to women (Bäckström et al. 2011). I suggest that the latter could be experienced by partners when midwives changed to 'instructor mode' (section 5.6.2.2) although the experiences from all partners were not ascertained in this study.

5.7.7.3 Priming birthing partners for labour

Studies have suggested that birthing partners need preparation for their role in labour (Wockel et al. 2007; Tarlazzi et al. 2015). In this study, preparation for birthing partners came from women. Women used their previous experiences of pain to prime their birthing partners regarding their needs in labour. I observed that this technique worked very well when all the six components inside the birth environment were synchronised to be sensitive to the needs of women and there were no complications in the labour or birth. When the six components were not balanced however and/or complications occurred, partners sometimes found it difficult to carry out their role as planned. This was seen when the midwife changed to 'instructor mode.' Partners such as Isabelle's did not speak up as an advocate as planned, because they became very anxious in the labour and joined women following the instructions of their midwives. The study by McCourt et al. (2011) reinforced that partners struggle to act as an advocate, which left one woman feeling angry with their partner for not supporting her, when she felt obliged to have an unwanted intervention. From the research by McCourt et al. (2011) and my observations in this study, questions are raised as to the long term implications for relationships between couples when partners have not fulfilled their duty to safe guard women as an advocate in labour as planned.

5.7.7.4 Factors that boast the energy levels of birthing partners

Partners at times needed to readdress their balance in relation to coping by leaving the birth environment. This study reinforces previous research that fathers need time out to 'recharge their batteries' and appreciated midwives who gave them permission to do so (Pugh and Millgan 1993, Tzeng et al. 2009). It has been suggested that partners may lose energy due to unfamiliar environments and situations. In this study, fatigue was particularly associated with long labours. Longer labours have been connected to partners feeling tired (Capogna et al. 2007). I suggest that some of the tiredness experienced by partners is connected to anxiety. Studies have shown that partners do get anxious in labour, but they try to hide their anxiety from women as they do not want to transmit their fears to women (Chandler and Field 1997). Women have

said however that they sense the emotional state of their partners in labour (Sapkota et al. 2011, 2013). I also suggest that midwives being present inside the birth environment provide an opportunity for them to sense the anxiety from partners to resynchronise their care.

This study highlighted the importance of more than one birthing partner as additional birthing partners take the onus from the woman's partner. Partners need energy to support women and take on the role of fatherhood (Tzeng et al. 2009). One couple, took the usual step by planning for the partner to sleep until the birth was imminent. This was so that the partner could support the woman when she most needed it, helping to care for the baby and other children following birth. This observation reinforced that previous experience provided insight into their future needs.

5.7.7.5 Women's perspective of birthing partners

Lundgren et al. (2009) suggested that when women did not form good relationships with midwives, women relied on the partner as their most important support. Partners were highly valued in this study as the emotional support for women. In particular following the birth, midwives provided privacy and partners used this time to acknowledge the efforts of women. Studies suggest that women and partners have felt that their relationships with each other have improved following their shared experiences in labour (Chan and Patterson-Brown 2002; Longworth and Kingdon 2011). This may partly be due to the confidence of women being boosted when partners acknowledged women's' efforts (Sapkota et al. 2011). The potential long-term impact to the relationship between women and partners reinforced the importance of midwives being present to tune in and synchronise their care to support birthing partners.

5.7.7.6 Summary

Overall most research regarding the role of birthing partners in labour, as illustrated in the literature review (section 2.6.2), have focused on the anxieties of birthing partners and their expectations of midwives. This study offers original knowledge in relation to birthing partners' contribution and the factors that help and hinder their contribution when a midwife is providing one-to-one support in labour. This study also included new insight into how women prime their partners to support them in labour to help them readdress their coping strategies. The latter also provided a new insight into long term implications for

relationships, when partners did not provide the support particularly as an advocate as planned.

5.8 Midwifery support

Midwifery support was recognised as an important element of midwifery one-to-one support in labour. Midwifery support offered reassurance and re-energised midwives caring for women in labour and also provided the second midwife at birth. The following discusses how midwifery support was utilised and how the midwives readdressed the balance to feel supported to care for women in labour.

5.8.1 The reasons for needing midwifery support

Within the first three weeks of the fieldwork at case study site one I started to observe that midwives often left the labour room to seek support from their peers within the staff room. Seeking support was not confined to the AMU however, it also occurred for home births and at the FMU, although midwifery support was more easily accessible and familiar within the AMU. The advice requested at all three case study sites, included specific questions about medical and pregnancy related conditions; positions to aid rotation and decent of the baby, labour progress, vaginal examinations, vaginal loss, baby's heart rate, haemoglobin levels, bladder care, pain relief, possible transfers, perineal tears, or asked 'can I run this by you.' Sharing provided the opportunity for colleagues to comment, as well as being a method of sharing the responsibility too. Midwives also recognised that they requested support from each other to help promote the physiological process of labour:

> 1330 Midwife Gertrude came into the staff room from the labour room. Gertrude asked me about my research and said 'I hope you have noticed that we pass things by each other much more over here' to try and question how we keep this normal, rather than on labour ward there is pressure to deliver the baby (Fieldnotes, AMU)

Midwife Amy explained that although one midwife was allocated to one woman, it took more than one midwife to make the decisions about one woman's care for a whole shift. Midwifery support helped to re-energise midwives to feel more optimistic and gain a fresh perspective about a woman's progress. This was because some midwives spent long periods of time inside the birthing

environment at all three case study sites, which for some midwives was over a twelve hour shift:

> I think it is important to recognise that you can only give one-to-one support well if you are supporting each other, because it is very difficult to stay in the room and give, you know, optimal one-to one-support for a twelve hour shift with no breaks and with no additional input. And I think one of the advantages of working on this unit [AMU] is that often we do have a situation when we can have two midwives in a room to support each other, for a break for fifteen minutes to rejuvenate and come back with a fresh pair of eyes (Amy, AMU midwife)

A fresh perspective included new ideas which was appreciated by midwives when they had exhausted their own clinical resources inside the birth environment. A fresh perspective was requested by midwife Megan when supporting Isabelle one-to-one at the FMU. I previously analysed the transition of how Megan changed from being 'with woman' to being an 'instructor.' Midwife Megan was observed asking her midwifery support for suggestions to help Isabelle. She reinforced how midwives do get tired supporting women one-to-one in labour therefore it could be postulated that midwifery support from colleagues with a midwife-led philosophy may help prevent midwives going into instructor mode:

> … when you have been looking after somebody for that many hours … you know there's no denying that you do get tired, and you just think 'did I miss something?', or 'should I have done this?' You do doubt yourself, … I do a lot of self-analysis, … I talked to my colleagues, I find them a great source of reflection really (Megan, FMU midwife)

Midwife Megan also highlighted above how midwives utilise the midwifery support to reflect on their practice. Midwives at all three case study sites, were reflective following births. Midwives like Diana wanted reassurance that they had performed the right actions:

> I don't know, I am just thinking … if someone else would have done something different (Diana, AMU midwife)

5.8.2 Two-to-one ratio

There were times that midwifery support made a room seem crowded. Midwife Heather took over the care from midwife Tanya. Tess begged midwife Tanya to stay as they had been together for twelve hours and developed a relationship. Tanya stayed over an hour extra which meant that Heather and Tanya were together providing labour support for approximately two hours. In that time, midwife Heather did encourage Tess to try different positions, but she found it difficult to form a relationship with Tess, because Tess was more tuned into midwife Tanya's voice. It was evident that having two midwives inside the birth environment, sometimes caused confusion to determine what their role was:

> She [Tess] had a midwife for twelve hours that she clearly bonded with. From my point of view, if the midwife had gone, gone completely I would have taken over … but as the midwife hadn't gone ... It made it very difficult to take over, because the woman was still hearing her voice and still knew she was there and still depended on her to give her instructions, … I found that quite difficult really … as I said if the midwife had left the room completely Tess would have listened to me, because she would have had no choice. (Heather, AMU midwife)

5.8.3 The experience of midwifery support

The experience of the midwifery support was an important factor for midwives at all case study sites, but caused the most concern at the FMU. Preceptor midwives such as Harmonie who were part of the centralised on-call team, were anxious regarding their level of experience working in the FMU. This meant FMU midwives had to make themselves available to provide support:

> When the day on-call midwife Harmonie came, she said she was a preceptor and very stressed. She said she had not cared for a woman in water … the FMU midwife Betty explained how she had to provide constant reassurance to Harmonie and was called regularly to check vaginal examinations and fetal heart when the Harmonie could not find it. Betty was doing this while seeing women in the ANC. Betty added that she is sure that the preceptor midwife's anxiety was passed onto the woman (Fieldnotes, FMU)

FMU midwives could not provide the support for on-call preceptor midwives if the FMU midwife was also a preceptor. This situation caused anxiety for FMU preceptor midwives, as they wanted midwifery support which was more experienced than themselves:

> A preceptor midwife came in at 07:30 for an early shift. The midwife was working alone today and when she checked she had a preceptor midwife who had just qualified on-call for her. The night shift FMU midwife was not happy with this and started writing emails and said that she would call the manager at 09:00. The night shift midwife also advised the preceptor midwife to call the midwifery supervisor (Fieldnotes, FMU)

To readdress the balance of support, community midwives (local and familiar with working at the FMU) regularly offered to be the midwifery support for the FMU midwives:

> Two community midwives came into the staff office. One community midwife gave the maternity support worker (MSW) their telephone numbers so that the FMU midwife could call them for midwifery support if required, because they said they were the nearest. One community midwife asked if this was the FMU midwife's first day. The MSW informed them that it was not, but she was a band 6 and it could be difficult with some decisions as they did not have the experience. The community midwife asked why she is on her own and who was doing the antenatal clinic. The MSW said the FMU midwife is doing the antenatal clinic. 'That is bad' said the community midwives … (Fieldnotes, FMU)

Women also recognised the experience of midwives. Jasmine had two midwives looking after her, over two shifts. The first midwife, Harmonie, had just completed her preceptorship and cared for Jasmine in the early part of labour. The second midwife, Jayne, had many years of experience and cared for Jasmine as the labour intensified. When midwife Jayne took over the care, she immediately found Jasmine had a temperature and that the water in the pool was too warm and that the contractions were irregular. Jasmine and midwife Jayne discussed a plan to reduce Jasmine's temperature down and increase contractions.

Jasmine felt an instant trust for Jayne and her labour progressed to a normal birth:

> I was glad that change happened (shift change] when it did … I don't know if I felt the second one [midwife] was more experienced or … whether because the second part of the labour was obviously a bit more intense … but I do feel glad that this one [Jayne] came in when she did. She seemed to kind of, you know, 'hang on a minute the water is too hot, we have to cool it down' … yes, I definitely felt the change, it was for the better I think (Jasmine, FMU)

5.8.4 The challenges of feeling supported

Midwives such as Heather felt isolated inside the midwife-led unit and felt more secure when support from labour ward was immediately available:

> Internally, I think, internally you are worried. [I] think on the … [AMU] you are very isolated. You haven't got the immediate access to an obstetrician; if for example she had a bradycardia [baby's heart rate reduces] or if the baby got stuck, if there was any shoulder dystocia. I was concerned about a lot of things really (Heather, AMU midwife)

Emergency events had the potential to cause midwives like Yani to feel less secure about the quantity and quality of midwifery support available. Yani was caring for a woman at the FMU when following a normal birth, the woman haemorrhaged. The midwifery support staff was present and the woman was quickly transferred to hospital via ambulance and made a good recovery. The experience however, made Yani more anxious firstly about the midwifery support being delayed as she felt the help of the MSW and midwives was vital in this situation. Secondly, Yani explained how her preparation for a normal birth had changed to include emergency preparation for a possible haemorrhage. This example highlighted the importance of midwifery support to not only to provide presence, but also support reflection and future support to help midwives like Yani, feel less anxious following emergencies situations:

> Yani … in the birth centre … they keep the equipment in the room to a very sparse minimum which for my own personal practice at the moment isn't

enough. So I would leave the room to go and collect other things that make me feel safer, delivering the woman.

Researcher: Could you say some of those things?

Yani: Syntometrine, Syntocinon, syringes, postpartum haemorrhage tray, the things that, a catheter, oxygen, suction, [medication and equipment required for a haemorrhage] things like that. That was just outside the door … what happened to me recently has never happened to me before, so my experience is now changed to how I was, … it might be that in a few months' time I might feel perfectly fine again, and it is just a temporary wobble, a natural response to a recent event (Yani, FMU midwife)

Trust in the midwifery support was so important that midwives would sometimes contact midwives from their own team when they were off duty to seek reassurance rather than speak to someone they did not know. Midwife Olayemi contacted a FMU midwife although she was off duty to gain reassurance after experiencing delayed midwifery support. Olayemi could not locate a baby's heartbeat which caused an ambulance to be summoned, but the birth occurred rapidly and the baby was born in good condition:

> 1215 Olayemi on the phone to one of the FMU midwives who is very experienced, but not on duty. Olayemi is sounding off (Fieldnotes, FMU)

5.8.5 The timing of the midwifery support

The timing of midwifery support was important to midwives. Inconsistencies caused anxiety. This was only observed at the FMU, at case study site three. FMU midwives discussed that the timing of the midwifery support arrived 1.5 hours after being called:

> There have … been changes in the community staffing levels so that there was less staff on call. The community midwife explained that this

means that sometimes it will take midwives 1.5 hours to get to FMU (facial expressions shows FMU midwife is not happy with this) (Fieldnotes, FMU)

Observations witnessed that midwifery support at times did indeed take 1.5 hours to arrive. Olayemi was caring for a woman in labour when she started her shift at 07:30. A clinic was due to start at 08:00. Olayemi was concerned since she knew that she would not be able to perform the antenatal clinic and look after the woman in labour as she was progressing. When Olayemi was informed that the midwife would be delayed, she made the decision that the antenatal clinic would need to be cancelled if the midwifery support did not arrive in time:

Olayemi asked who the on-call midwife was coming from the hospital. The on-call midwife said that she maybe sometime due to the area she is coming from, but she was on her way about 08:20 …

09:45 the on-call midwife acting as midwifery support arrived saying she got stuck in traffic due to an accident. She also said that she has never worked at FMU, but appeared jolly to get on … 'but it is different now,' I overheard the on-call midwife say I love the job, but not the politics. (Fieldnotes, FMU)

5.8.6 Making the decision to call midwifery support

The midwife inside the birth environment had to make the decision when to call the second midwife. The role of the second midwife was mostly to assist birth and they helped with documentation and caring for the baby, but they also attended in labour to bring more pain relief, relieve the first midwife for a break or provide a second opinion.

Once again, due to the uncertainty of the arrival of the midwifery support, the FMU midwives assessed each situation. They calculated if they needed to alter their usual practice and call the midwifery support earlier, to ensure they arrived on time for the birth:

Researcher … what informs you to call the second midwife?

Midwife Betty	See my practice has probably changed quite recently about that because our on-call system changing. So before, when I knew that midwives were coming from locally, I would probably leave it until quite close to second stage … knowing that they [midwifery support] were only kind of a little bit away … however now because we have on-calls from further away I probably do call them in a little bit earlier … for a MULTIP [multigravida] in established labour, I would call them even if I thought she was coming into established labour, because you never know how quickly they are going to be … for a PRIMIP you see I would say I tend to use my instincts of when they are probably coming up to second stage, … involuntary pushing, all those kind of things that they do just before coming into second stage. See, I probably trust my instincts … when to call a second on-call (Betty, FMU midwife)

5.8.7 Midwifery support making the decision to attend

Gladys working at the FMU highlighted another challenge including how colleagues did not always act supportively. Midwives providing midwifery support sometimes dictated that a vaginal examination had to be completed by the FMU midwife, before they would attend the FMU. Gladys expressed that she has felt bullied to undertake an intervention that she did not deem necessary. It could be questioned whether this is related to midwives lacking trust in the abilities of midwives they are familiar with. Such a situation could de-stabilise the balance inside the birth environment due to the midwife changing her stance and requiring confirmation of progress rather than trusting the woman's body and midwife's skills:

Researcher	What informs you to call the second midwife?
Gladys	… it can be tricky … you have a woman come in and some midwives will insist that you do an

> internal examination before you call her, but because I know that, I was quite annoyed, … sometimes you knew that the woman is contracting, you knew that the woman is reacting, you know that she is in strong labour, and the midwife saying 'I am not coming in [doing voice of midwife] until you tell me how many centimetres dilated she is' … really … you are being bullied to do an internal quickly, just because she wants to know, sometimes you don't really need to do it … and that can be really, really annoying (Gladys, FMU Midwife)

5.8.8 Discussion

This study reinforces the assertion by Kirkham (2010) that midwifery support is crucial for midwives. Midwifery support in this study ranged from being consistently available, familiar, experienced, contributing positive energy and shared similar philosophies of care. At the other extreme, midwifery support arrival times were uncertain, midwives were unfamiliar, inexperienced and made demands to be achieved before they would provide their assistance.

5.8.8.1 Positive attributes of midwifery support

My findings like Bedwell et al. (2015), found that midwives' confidence inside the birth environment increased with midwifery support. Bedwell et al. (2015) explains that some of the confidence was due to colleagues demonstrating trust in the ability of midwives. Mutual trust between midwifery colleagues was essential to midwives at all three case study sites. Such relationships have been referred to as 'mutually supportive' and 'reciprocal' because midwives felt the support encompassed trust and empathy which made them feel safe (Hunter and Warren 2014:930). Evidence also suggests that midwives, who worked with 'like-minded' professionals, cared about their colleagues (Walsh 2006a; Hunter and Warren 2014). Being valued by colleagues has been shown to demonstrate an increase in midwives job satisfaction (Kirkham 2007) and resilience (Hunter and Warren 2014).

These attributes may explain why the AMU midwives at case study site one, appeared to be the most content concerning their midwifery support, when

compared to the home birth and FMU midwives at case study sites two and three. AMU midwives mostly worked with 'like-minded' colleagues who were instantly available in most situations. The AMU midwives also had additional midwifery and medical support in close proximity on labour ward if required.

Not all AMU midwives felt more confident however with the instant availability of AMU midwives as support, when there was a question concerning whether a labour or birth was within the normal boundary. A minority of AMU midwives were only reassured by having the instant availability of doctors when working on the labour ward.

5.8.8.2 The benefits of midwifery support

My findings reinforced that midwifery support helped midwives to 'tolerate uncertainty' related to the normal physiological processes of labour (Page and Mander 2014:33). This was achieved by discussing labour and birth events with midwifery colleagues utilising them as 'sounding boards' to ascertain whether events were normal or not (Page and Mander 2014:33). The discussions between midwives and their colleagues in this study also confirmed that the responsibility of labour care was shared and therefore removed the onus from individuals to 'get it right' (Page and Mander 2014:33). My findings build on this knowledge to suggest that midwifery colleagues sharing the same philosophy of care also helped re-energise midwives to keep their assessments fresh and innovative after spending long periods of time inside the birth environment. Midwives valued this support at all three case study sites.

Midwives were observed supporting colleagues to reflect over labour and birth situations that did not go to plan at all three case study sites. This reaffirmed the research from Hunter and Warren (2014) concerning midwifery resilience, which revealed that when colleagues offered empathetic opportunities to reflect, this helped midwives to learn and move forward. Chapter six will also reveal, as in the study by Page and Mander (2014), that discussions with colleagues were also used to rehearse in preparation to speaking and justifying their care to senior staff when transferring women to the labour ward. I suggest midwives in this study used these discussions to help pre-empt how their care would be interpreted by labour ward staff using a medicalised philosophy of care as their analytical lens. Midwives in this study found these interactions stressful.

5.8.8.3 Midwives' anxieties concerning midwifery support

This study builds on research within midwife-led units which asserts that relationships with colleagues were improved when working small scale (Kirkham 2003; Kirkham 2007; Deery and Hunter 2010; Devane et al. 2010; Walsh 2006a, 2006b; 2010b). This study adds new knowledge concerning the impact of collaborating centralised systems with small scale midwife-led units. Although the core staff and the environment of the FMU at case study site three were small scale, the midwifery support was provided by a large centralised on-call service. The on-call midwives worked over large geographical areas. This caused variations concerning arrival times, level of experience, and many of the staff were unfamiliar to the FMU midwives. Such inconsistencies caused the FMU staff to be the most anxious about their midwifery support when compared to case study site one and two. Such anxieties caused many FMU midwives to summon the on-call midwives earlier than what they would consider their usual practice.

When midwives did not feel trust towards their colleagues they were observed at the FMU to contact midwifery colleagues on their days off to obtain verbal support that they trusted. The study by Page and Mander (2014) also found that midwives selected midwifery support from whom they trusted.

The fear of not attaining midwifery support was heightened with the prospect of an emergency situation. Midwives, like Yani, were anxious that they would have to manage an emergency alone at the FMU, if the midwifery support did not arrive in time. This caused Yani to change her practice to be more prepared for women bleeding following birth. This action however, involved bringing medical equipment inside the birth environment for all low-risk women in her care. This went against the midwife-led philosophy of care, but made her feel she was providing safe care. It has been recognised that critical moments such as an adverse incident with a suboptimal outcome, causes midwives to feel the constraints of organisational systems more intensely (Hunter and Warren 2014). Yani's actions may have been an attempt to gain control in this situation, as she could not influence the organisational system of the centralised midwifery support.

5.8.8.4 Gatekeepers to midwifery support

Not all the challenges regarding midwifery support originated from the centralised on-call systems, since midwives themselves also played the role of 'gatekeeper' to midwifery support. Midwives, like Gladys, shared that they felt bullied when colleagues stipulated over the telephone that a vaginal examination had to be completed before they would attend and provide support to assist as the second midwife for a birth. I suggest that there was a lack of trust at times from colleagues because this behaviour appeared to imply that they did not believe their support was needed. I postulate that midwifery support staff may have been assessing the risk of being sent back home. If the midwife was sent home after not being needed, there was the possibility that they would still be required to work the next day. Most of the on-call midwives had worked a full day shift and had the anticipation of working another shift starting the next morning. When demands were made, such as requesting a vaginal examination to be performed, I feel, this may have been a way of 'self-protection' (Hunter and Warren 2014:931). Kirkham (2007) affirms this by suggesting that bully behaviours are a coping mechanism resulting in frustration, desperation and misdirected envy.

It was evident that in such situations, midwives like Gladys had a potential to lose their autonomy to put the woman first unless they refused the demands of the midwifery support to complete a vaginal examination.

5.8.8.5 Two-to-one ratio

This study provided new insight regarding two midwives working within one birth environment. This situation did not always feel supportive for midwives. In fact the autonomy of one midwife was sometimes compromised. Such situations arose when staff stayed after their shift, but allowed the next midwife to take over, so that they could leave when they needed to. It was evident that two midwives in the birth environment could not synchronise the six components together as women mostly tuned into one midwife.

5.8.8.6 Summary

Overall, this study has contributed to the understanding as to why midwifery support is highly valued by midwives providing one-to-one support in labour. This study however, offers new knowledge regarding the availability of midwifery support for midwives practising one-to-one support within the AMU, home and FMU. The knowledge in relation to the availability of midwifery support included

the impact on the midwives confidence in regards to timing, experience, philosophy of care and motivation of the midwifery support. All of these concerns potentially had a negative impact on the autonomy of midwives practising one-to-one support inside the birth environment. The ideal midwifery support was available within a short time, familiar, and shared their philosophy of care resulting in a mutual trust. There was also an appreciation for medical support when labour or/and birth had deviated from the normal, which will be further explored in chapter six.

5.9 Conclusion

This chapter presented the first main theme in this study analysing how a midwife balances the needs of a woman inside the birth environment, when providing one-to-one support in labour. The presentation commenced by exploring six sub-themes (referred to as the components of midwifery one-to-one support in labour) which occurred inside the birth environment (Figure 8). These six components included presence, midwife-woman relationship, coping strategies, labour progress, birthing partners and midwifery support. Exemplars from the research data were provided to show how each component had its own continuum which directly or indirectly influenced the other components.

The synchronisation of each of the six components was also explained. This included how midwives used their knowledge, experience, intuition and motivation to provide insight into each component, in order to help synchronous the overall balance to achieve care which was sensitive to the needs of individual women. The explanation of the synchronisation subsequently showed how women readdressed the balance themselves, when midwives did not manage to synchronise one or more components to reflect the needs of women. Each component analysed ended with a discussion section, to integrate the findings from this study into existing research evidence, while also highlighting the contribution of new knowledge from this study.

Chapter six now describes the second main theme in this study, which includes how midwives balanced the needs of the NHS organisation. This theme consisted of four sub-themes and these will be explored.

Chapter six

Balancing the needs of the NHS organisation

6.1 Introduction

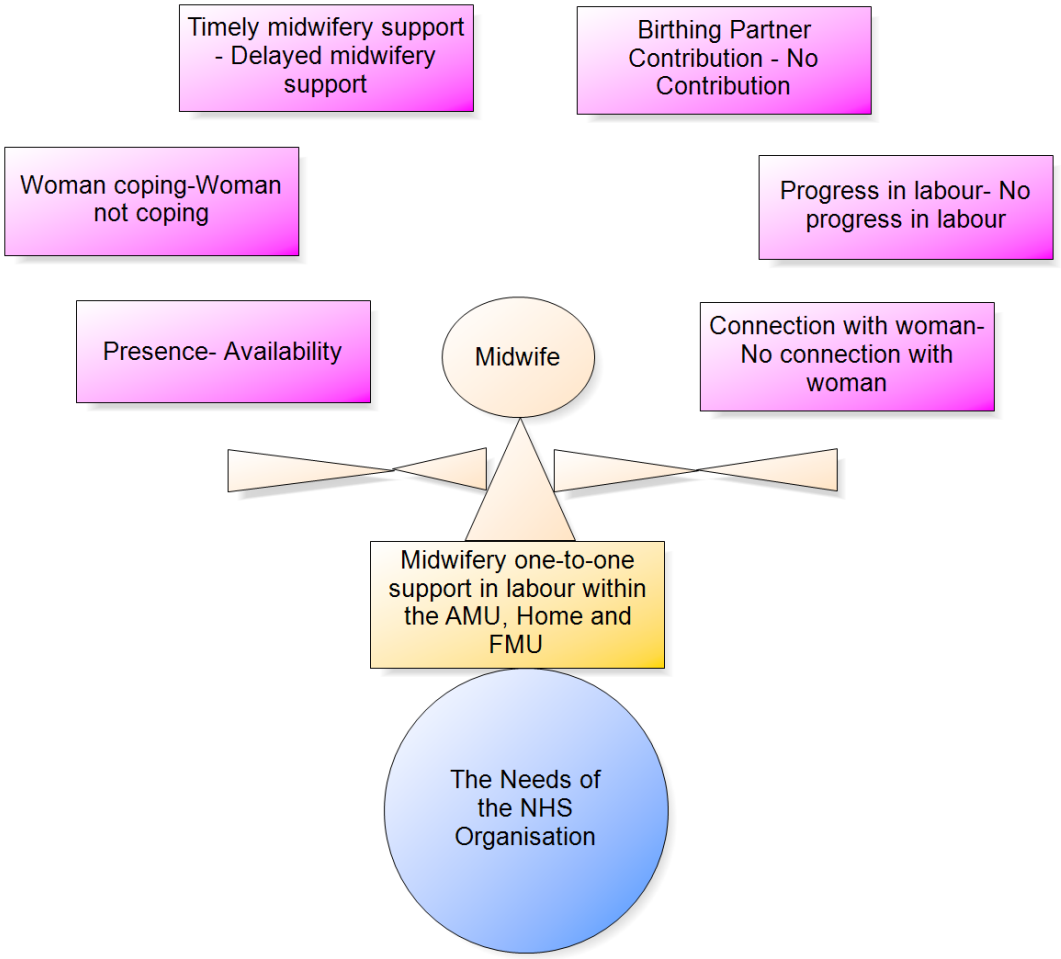
Chapter six is the third of three chapters to present the findings of this study. This chapter describes the second main theme which entails the midwife balancing the needs of the NHS organisation (Figure 8). This main theme consisted of four sub-themes including surveillance, territorial behaviours, documentation and transfer to labour ward. This chapter uses exemplars from the research data to demonstrate how midwives address the needs of the organisation. The sub-themes have been analysed in this chapter to include a discussion section to integrate the findings from this study into existing research evidence, while also highlighting the contribution of new knowledge from this study.

6.2 Outside the birth environment

This chapter discusses how midwives' autonomy was challenged outside the birth environment, when addressing the needs of the NHS organisation. Each of the three case study sites was part of an NHS organisation providing standardised care to large numbers of women and babies. Hunter (2004) argues standardised care aims to reduce risk, and increase efficiency and effectiveness. In this study, to achieve standardisation, regular surveillance of work activities of all midwives was completed to ensure that the workforce was placed where needed. Territorial behaviours amongst midwives working in all maternity wards was observed, in relation to shared resources such as staffing and equipment.

The scrutiny of clinical practices and documentation caused midwives anxiety. This was heightened when women were transferred to labour ward. Midwives became anxious with the prospect of their labour care being scrutinised by staff using the analytical eye of the medical model. Overall outside the birth environment, midwives providing one-to-one support in labour within midwife-led birth environments felt they had to demonstrate and justify the viability of their services.

Figure 8: A model illustrating midwifery one-to-one support in labour



6.3 Surveillance

Surveillance centred on the assessment of equitable and safe performances across the maternity services. Assessments were completed concerning work activity, staffing numbers, checking of equipment, clinical decisions and birth rates. Surveillance was completed face-to-face or via the telephone by managers, senior midwives; obstetricians, supervisors of midwives and midwifery peers. Regular face-to-face surveillance was only seen at the AMU. Outside the birth environment the AMU staff room and corridors acted as a semi-permeable area as it was restricted to authorised staff. Some staff used these semi-permeable spaces to perform face-to-face surveillance. Surveillance rarely entered inside birth environments at all three case study sites, unless a woman was transferred to the labour ward.

6.3.1 Surveillance inside the birth environment

Staff rarely interrupted the birth environment at any of the three case study sites to perform surveillance. Midwife Carol explained that interruptions at the AMU were minimal, because midwives protected the birth environment and they trusted one another. The latter meant that midwives did not routinely knock on the door to ask about labour progress:

> … [Interruptions] can stop the magical atmosphere that there is in the labour … during the labour it is important to keep everything so calm and perfect … If we get interrupted it is for something that they really need to ask you, but not for, I mean for stupid reasons or for a doctor that is waiting outside, not at all. We believe in each other so if there is something wrong we know that this midwife in the room will ask another midwife. I think it is a good team work (Carol, AMU midwife)

Midwives felt that this trust was being challenged however, at the AMU because all the AMU staff received an email reminding them to update their team about the progress in the labour rooms:

> 15:25 A midwife caring for a woman in labour came out of her labour room for first time since I have arrived today [at 14:40]. The midwife said that she was just letting her colleagues know the progress in her room as she wants to make sure she is '*communicating*.' Another colleague remarked *'yes we must make sure that we are communicating*.' A third midwife asked '*ok what has been happening*?' The first two midwives shared that an email that had 'gone round' asking AMU midwives to communicate what is happening in their labour rooms. The third midwife said '*you are cruel. It was not meant like that. I know that one you mean*' (Fieldnotes, AMU)

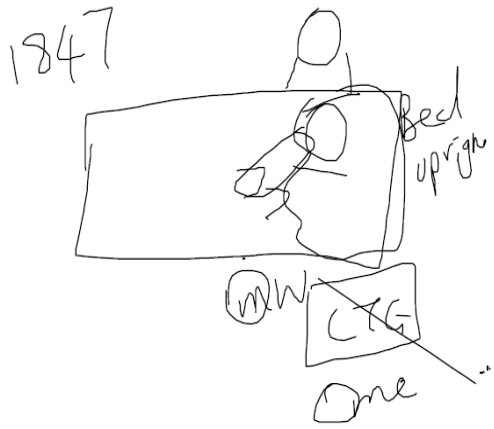
The FMU also protected the birth environment. The interruptions at the FMU mostly occurred when midwives were working alone with a maternity support worker (MSW), so midwives were called to answer telephone calls mainly from women who had concerns, or were in labour. FMU staff counterbalanced this by ensuring that when the birth environment had to be interrupted to summon the midwife, the staff was mindful not to disturb women:

> … If it is a night shift it [a knock on the door] might be one of the midwifery assistants saying that a client has phoned, you know they might be in early labour… those would be the only things that they would knock on the door for and disturb me. But … they do it very gently and everything is trying to keep the same sort of atmosphere … because you get into a mode and you don't want to break that, the atmosphere in the room (Megan, FMU midwife)

Face-to-face interruptions within the home environment were rare and only completed by family and friends. Partners took responsibility as hosts, to make the decisions about whether they were birth supporters or whether they should leave.

Surveillance in the form of progress reports and assessments of clinical practice decisions did enter inside the birth environment when women were transferred to labour ward at case study site one. Diana transferred Connie to labour ward as the baby's heart was beating faster than normal. In a short time the heart rate returned to normal and Diana and Connie were left alone in the labour room. Diana tried to recreate a calm atmosphere by dimming the lights and helping Connie to get into the all fours position (Figure 19) using the be and pillows as they had done in the AMU. Connie had the urge to push so midwife Diana made the decision to stay after her shift to continue her care for Connie. There were frequent interruptions by the labour ward senior midwife to check the progress of labour and clinical decisions. Mostly labour ward midwives, but also included AMU midwives asking when midwife Diana was going home:

Figure 19: Connie birth environment on labour ward



18:38 Knock on the door and someone walked in and asked if Theresa was in the labour room. I said

only midwife Diana was here and the midwife said ok and left …

18:51 Knock on the door. Can hear senior midwife asking if the waters have been broken and was the baby's heart rate ok. Diana asked Connie and her partner if it was ok if the senior midwife came in. The senior midwife checked and signed the continuous fetal monitoring print out …

19:22 Knock on the door. Diana answers the door and a midwife is asking if she is going home as they will take over the care …

19:36 Knock on the door. Diana could not answer as listening to the baby's heart beat …

19:37 Knock on the door. Midwife asked for Diana to speak to her outside the labour room …

19:57 Knock on the door. Midwife asked Diana if she has the keys

19:59 Knock on the door. Diana goes to the door. Diana explained to Connie that she may need to go soon as the night shift midwives kept knocking. And they would continue to do so as they want to take over. Diana said that she does not want to go.

…

20:26 Knock on the door. Diana went outside the labour room to update the labour ward midwives

20:46 Baby born spontaneously with Connie in all fours position …

(Fieldnotes from Connie's labour, AMU)

The surveillance to obtain up-dates caused regular interruptions inside the birth environment on labour ward. Midwife Diana felt that these interruptions took her away from her one-to-one focus with Connie, contrasting with the atmospheres described in chapter five. It could be argued that the labour ward staff attempted to provide midwifery support for Diana as they knew she had worked more than her twelve hour shift, but midwife Diana at the time did not feel supported:

> Yes, when I was in … [labour ward] and they kept on knocking on the door asking what was happening and if I wanted to go home, but also they wanted to know about the progress. There I really felt that I was disturbed, I mean the one-to one-care was disturbed. I felt upset, because I felt it was a really important moment. I couldn't follow her as I would have done, because I was continuously going out, in and out, in and out. Luckily anyway, there was progress (Diana, AMU midwife)

6.3.2 Surveillance of work activity

Face-to-face surveillance regarding work activity was not seen inside the home environment or the FMU. Regular face-to-face surveillance was only seen at the AMU. The surveillance occurred in the staff room and corridors and correlated to the work activity and staffing needs across the maternity services. This meant that when any of the maternity wards were busy, surveillance increased. Surveillance of work activity included a member of staff talking to an AMU midwife about what the midwives and women were doing. A request for help was then expressed if required and AMU midwives were available:

> 14:45 A senior midwife from the postnatal ward came into the staff room and explained that the postnatal ward only had three midwives on duty and asked if AMU could help. There were three AMU midwives in the staff room, but the AMU senior midwife explained that two of the AMU midwives were on an early shift so they were late going home (Fieldnotes, AMU)

Midwives working at all three case study sites were very versatile to work in any maternity ward. AMU midwife Lorna demonstrated however that midwives were

not always enthusiastic to help other wards, and sometimes there was resistance, but midwife-led care midwives never refused to help at any of the case study sites:

> 11:50 Midwife Lorna arrived saying ‘don't say I have to go to labour ward.’ Lorna explained that she had a horrible shift there the other day and long. Lorna explained that she will relieve the … [AMU] staff first for their breaks and then go over [to labour ward] (Fieldnotes, AMU)

Surveillance of work activity also occurred via telephone at the AMU, home and FMU. Telephone surveillance was very similar to the face-to-face. The FMU midwives experienced similar work activity and staffing assessments to the AMU at the start of shifts when there were two FMU midwives working the day shifts. This was due to FMU midwives regularly being requested to work within the hospital environment when the activity at the FMU required one midwife rather than two. This practice reduced however when the staffing at the FMU reduced to one FMU midwife per shift.

When it came to home births however, telephone surveillance was mostly associated with labour progress. This was because it gave an indication of when the community midwives would be finished at a home birth, to return to work at the hospital or continue their community workload. Midwife Philippa was called during the early hours of the morning, as she was covering as the second midwife for Carmen’s homebirth. Midwife Philippa arrived at 01:06 and Carmen had a normal vaginal birth at 01:21. Fifty minutes after arriving, midwife Philippa became conscious that she must leave soon due to fearing that the senior midwife from labour ward would telephone her and ask where she was and when she would return:

> The second midwife Philippa said that she is leaving in a minute otherwise … [labour ward] will think she is skiving (Fieldnotes from Carman’s Homebirth)

6.3.3 Surveillance of checking procedures

Checking equipment was also a trait of surveillance, but was only observed at the FMU. There was no apparent known reason why the surveillance regarding

checking equipment had commenced. However, it was an expected daily ritual for the FMU midwife to report to the supervisor or manager to communicate that they had completed the mandatory checks including equipment:

> Yani asked the MSW if she could bleep the midwifery manager to say that the equipment check has been completed. Yani explained that she got told off recently for not ringing in (Fieldnotes, FMU)

6.3.4 Surveillance of clinical practices

Surveillance included questioning the clinical practices of midwives. Midwives at all three case study sites were apprehensive how their clinical practices would be reviewed by staff outside the midwife-led birth environments. Such apprehension was heightened during emergency situations and transfers to labour ward. This was reiterated in a day shift at the AMU. The AMU senior midwife Claudine was called into the birth environment as midwifery support, because there were concerns about the baby's heart rate.

After ten minutes, Claudine requested the MSW to summon emergency support. The MSW was not provided the correct terminology to use on the telephone to request neonatal support. Support quickly arrived from the maternity wards and the paediatric services, rather than the neonatal services. The baby quickly recovered. A neonatal nurse quietly and sensitively advised the MSW to request the neonatal services in future, in such circumstances. The MSW was then apprehensive that she would be reprimanded:

> Maternity support workers (MSW) came into staff room and said 'heads will roll.' I [researcher] asked why and the MSW explained that she did not say the right thing when she requested the emergency support. The MSW said that the senior midwife Claudine did not specify what to say (Fieldnotes, AMU)

Senior midwife Claudine apologised to the MSW following the emergency as she advised that she did not specify to the MSW whether the emergency was obstetric or neonatal. Claudine shared the lessons learnt with all the AMU staff through handovers, meetings and discussions. Posters were also put up on the staff room walls. A week later Claudine felt despondent because she was still

being requested to review the events with staff outside the AMU when she had worked hard to ensure that staff and herself had learnt from the incident:

> Senior midwife Claudine was speaking about how staff have been approaching her and asking details about the emergency call that occurred the other day. Claudine said that she knew what had to be improved and learned vital lessons, but [named specialised midwife] and others kept approaching her and going over the events (Fieldnotes, AMU)

6.3.5 Surveillance reducing autonomy

The centralisation of organisational systems appeared to increase surveillance and reduce the autonomy of midwives in this study. Midwives sometimes did not have the autonomy outside the birth environment to resolve challenges. This created a dependency on the management team or supervisors of midwives to resolve certain situations. It was very apparent at case study site three in relation to midwifery support. Geraldine was an exemplar of a midwife requiring midwifery help while working a 12.5 hour shift at the FMU. At 17:30 midwifery support was required as two women in labour were on their way to the FMU, one primigravida and one multigravida. Midwife Geraldine rang the on-call service, but she was informed that there was no one available to provide midwifery support for the FMU. Geraldine then contacted the supervisor of midwives at 17:50 as she was very anxious about being alone with a MSW to support two women in labour.

The supervisor advised that she would organise help. There was no indication how the supervisor organised the help which meant that the midwife could not estimate timelines or learn strategies for the future when organising midwifery support. Geraldine was totally reliant on the supervisor of midwives. In that time, another woman rang and spoke to midwife Geraldine. The woman was not in labour, but her waters had broken. Geraldine advised the woman to go to the hospital as she felt she could not cope with three women on her own in the FMU:

> 18:19 Midwife Geraldine was speaking to the senior midwife on labour ward and said '*never mind about the politics, I have no cover so it is not safe*.' The MSW then informed Geraldine that a woman was on the telephone saying that her waters had broken. Before answering the phone, Geraldine said that she could not cope with

> three women … Geraldine spoke to the woman and explained that she needed to go to the hospital rather than the FMU. '*No I am not joking*' midwife Geraldine said and explained it would not be safe to come to the FMU as they had women in labour. Geraldine's voice was loud. When Geraldine put the phone down she said '*I can't have two MULTIPs [multigravida] and a PRIMIP [primigravida] here delivering at the same time*.'
>
> 18:45 The supervisor of midwives was on the telephone with midwife Geraldine. The supervisor questioned why Geraldine sent the multiparous woman to the hospital when she had previously said she would send help to the FMU. Following the conversation midwife Geraldine said that she could not cope with three women within the FMU on her own with no support (Fieldnotes, FMU)

The atmosphere was tense in the office. Geraldine's voice was loud and anxious. When the supervisor of midwives questioned Geraldine's decisions this increased her anxiety. Geraldine felt she would be reprimanded for advising a woman to go straight to the hospital. Midwife Geraldine telephoned a colleague and discussed the events, justifying her actions while looking for reassurance that she did the right thing. The night shift FMU midwife Betty arrived at 19:20 and Geraldine informed her of the situation, since they had two women in labour. Midwife Geraldine stayed over her hours to support Betty as the midwifery support did not arrive until 20:43 (nearly three hours after summoning help).

6.3.6 Surveillance of birth rates

Lastly, surveillance was achieved using quantitative data to calculate birth and transfer to labour ward rates. The statistics caused some midwives at the AMU and FMU to become anxious about the viability of the midwife-led units. AMU and FMU midwives calculated estimated numbers of births required to ensure that the midwife-led units were viable, otherwise as midwife Yani explained, they would be running at a loss:

> A midwife looked over the number of births in the register and said that they needed to have approximately forty births by the end of the month so that the AMU could achieve one hundred births per month. The midwife then calculated that approximately eight births per

> twenty-four hours is therefore required until the end of the month (Fieldnotes, AMU)

> Midwife Yani explained to a community midwife that the FMU is running at a loss at the moment as it needs at least one birth a day (Fieldnotes, FMU)

Unlike the AMU, the FMU had historical data to compare the current births of twenty-three per month, but this resulted in greater anxiety and speculation as the births rates had reduced quite dramatically:

> The MSW said that the FMU use to have approximately forty births per month (Fieldnotes, FMU)

Maternity staff were also conscious that their transfer rates to labour ward also questioned their viability:

> Midwife Yani said 'Well if someone is looking at the [FMU] activity from a strategic level they will be looking at the high transfer rates. It gives evidence to close us down' (Fieldnotes, FMU)

Midwives recognised that the surveillance of reduced birth rates at the FMU caused the reduction of midwifery staff:

> Midwife Amba explained that having one midwife on site at the FMU per shift was due to not having enough births (Fieldnotes, FMU)

Midwives counteracted the quantitative data with qualitative data in the form of a comments book at the AMU. This was alongside photos of women having their babies at the FMU and achievement awards displayed. Both midwifery-led units also had thank you cards displayed in the staff offices. Qualitative data reminded work colleagues and managers that their services were appreciated by women who attended the midwife-led units

6.3.7 Discussion

This study reinforced previous research findings that midwives working within the home (Bedwell et al. 2015) and FMU (Walsh 2006b) experienced less surveillance. Surveillance was observed to be much more prevalent at case study site one. This study reinforces that this was associated with the close proximity of the AMU to the other maternity wards including labour ward (McCourt et al. 2014).

6.3.7.1 The impact of surveillance

Evidence from this study reflects other research that suggest that surveillance causes midwives to feel a sense of being watched and assessed (Davis and Walker 2012; Reed 2013). Surveillance is a disciplinary power (Foucault 1982) where promises of rewards for compliance and punishment for non-compliance are given (Fahy 2002). My findings suggest that surveillance ensured that midwives were addressing the needs of the NHS organisations otherwise described by Hunter (2004) as meeting the needs of the institution. Midwives in this study were observed to balance the 'co-existence of the conflicting ideologies' including being 'with woman' and 'being with institution' within their practices (Hunter 2004: 270).

Surveillance in this study, did not trigger women to stop receiving midwifery one-to-one support in labour if it had been started, at any of the three case study sites in relation to midwife-led birth environments. Staff were only relocated to work in another ward or hospital if they were not caring for a woman in labour. Face-to-face or telephone surveillance did not have an impact on the midwifery presence inside the birth environments at any of the three case study sites. This contrasts to studies focusing on midwives working on labour wards providing care to low-risk women (Hunter 2004, 2005; O'Connell and Downe 2009; Thorstensson et al. 2012; Aune et al. 2013; Birthrights Dignity in Childbirth 2013). Midwives in these studies had to constantly balance the needs of the organisation against the needs of women which regularly took the midwives away from the birth environment to complete tasks. This led to women being left alone in labour.

6.3.7.2 Surveillance inside the birth environment

Inside the birth environment, midwives had the autonomy to support women in labour using the 'with woman' ideology (Hunter 2004). Midwives were also able to protect the 'cocoon' they created inside the birth environment from surveillance

and this was supported by their immediate midwifery colleagues who shared the same midwife-led philosophy of care. AMU midwives at case study site one were concerned they were being challenged to communicate more details of their labour support. This they feared would be the first stage of surveillance entering the birth environment in the future to ascertain progress in labour and assessments of clinical decisions.

6.3.7.3 Surveillance within semi-permeable areas and via telephone

Within semi-permeable areas and via telephone, midwives could not protect themselves from surveillance. Such surveillance outside the birth environment has been referred to as 'indirect surveillance' in the study by Reed (2013: 143). Reed (2013) reinforced that 'indirect surveillance' was connected to serving the needs of the 'institution.' Surveillance in my findings implied that midwives were not trusted to offer their services to help other wards when free; check equipment or follow clinical guidelines. Midwives subsequently were at times unable to exercise their own initiative. Questions are raised however in relation to needing surveillance. Rayment (2011) observed that midwives were never seen to offer their help to maternity areas that were busy and colleagues were even noted to dissuade midwives from volunteering. The frequent assessment to provide help to other wards was only observed at case study site one. My findings are in contrast to Rayment (2011), because although reluctant at times, many midwives did rotate voluntarily around the wards including labour ward when their work activity was low. It could be questioned however, whether these midwives felt obliged to help before the senior midwives performing surveillance suggested that they helped the ward areas.

6.3.7.4 Surveillance on the labour ward

This study reinforced that when women were transferred to the labour ward, they became the object of surveillance (Nilsson 2014) otherwise referred to as the medical 'gaze' (Foucault 1980). Using Foucault's concepts, Fahy (2002) suggested that submitting to the medical surveillance was rewarded by the medical team providing assessment and treatment using technical equipment and medications. This is applicable to women transferring to the labour ward in this study. As women were vulnerable, they were more likely to comply with the medical instructions (Fahy 2002). In addition this study suggests that midwives

were also vulnerable due to their reduced autonomy which made it difficult for them to act as an advocate.

I observed that the autonomy of the AMU midwives was challenged on the labour ward. Fahy (2002) explains that midwives are not normally advocates for women during medical encounters, because medical knowledge is viewed as superior to midwifery. Using the interlinked central themes of power/knowledge from the work of Foucault (1980), I suggest that midwives' power/knowledge reduces when women are transferred to labour ward. This is due to midwives entering the medical domain physically and professionally with women who present with a deviation from the normal. The power/knowledge of obstetricians is therefore more dominant.

This was reinforced by midwives like Diana who attempted to guard the birth environment and increase their power/knowledge on the labour ward when the deviation from the normal resolved. Although midwifery/medical support was not required, they still entered inside the birth environment unannounced, often no introductions with the aim to assess and monitor labour progress and clinical decisions. Midwives had no power on labour ward to stop the constant interruptions. The labour ward culture did not nurture privacy inside the birth environment and trust that the midwife would call for help if needed. Such intrusion inside the birth environment has been referred to as 'direct' surveillance' in the study by Reed (2013:145). The surveillance on labour ward was in contrast to my observations inside the midwife-led birth environments at all three case study sites.

It has been suggested that surveillance is part of the biomedical discourse by which midwives practices are 'judged' (Davis and Walker 2012: 604). The medical discourse has more power of influence in society (Fahy 2002; Davis and Walker 2012) including healthcare, social and judicial contexts (Davis and Walker 2012). This leaves midwives with less power (Fahy 2002), as midwifery care is regarded as substandard when using the medical analytical lens and this pressurises some midwives to perform interventions or defensive practices (Davis and Walker 2012). This may help to explain the actions of some midwives using medical interventions when changing to 'instructor mode', previously discussed in chapter five. Such power dynamics may also explain the feelings of

trepidation experienced by midwives when preparing to justify their clinical practices to midwifery and medical staff when transferring women to labour ward.

6.3.7.5 The impact of centralised organisational systems

My findings build on the assertion that as organisational systems become more centralised, the autonomy of midwives decreased (Hunter 2004) while surveillance increased. The loss of autonomy was particularly seen at case study site three, when midwifery support became centralised. FMU midwives previously had the autonomy to negotiate with the local community midwives who provided the midwifery support. In addition historically, the FMU midwives were also confident that the support would arrive in a short time. Organisational changes resulted with a centralised on-call system which transferred the autonomy regarding midwifery support to the managerial team and supervisor of midwives. Midwife Geraldine showed that when midwifery support did not arrive, the only power that FMU midwives had in relation to midwifery support was to refuse further admissions to decrease the need for further help.

6.3.7.6 Statistics providing data for surveillance

Lastly, surveillance included the auditing of birth and transfer rates. It has been suggested that rates of transfer are not necessarily indicators of quality of care or a potential for adverse outcomes (Blix et al. 2014). However, in this study transfers were viewed as a negative reflection of clinical practices at the AMU and FMU. This study indicated that midwives working at the AMU and FMU felt a constant threat that the midwife-led units would be closed due to the birth and transfer rates. This caused uncertainty and anxiety for many staff which has also been reflected by midwives working in AMU in the research by Rayment (2011). Such uncertainty in this study led to speculation, thus further increasing anxieties.

6.3.7.7 Summary

Overall this study has provided new insights regarding the process of surveillance and its impact in relation to midwives providing one-to-one support in midwife-led birth environments. My findings suggest that surveillance did not dictate the midwifery presence within the birth environments at any of the three case study sites. This is in contrast to other studies completed in labour ward environments. In addition surveillance rarely entered the midwife-led birth environments at all three case study sites. Midwives however did not have the autonomy to stop

surveillance within semi-permeable areas, via telephone or entering the birth environment when transferring women to labour ward. Finally, my findings indicate that surveillance is increasing as organisational systems become more centralised. This process had a negative impact regarding the autonomy of midwives in this study.

6.4 Territorial behaviours

Territorial behaviours included feelings of jealousy encompassing workloads, criticism regarding efficiency and possessiveness regarding resources shared between maternity wards and different hospital sites. In response, staff showed protective behaviours towards their own environment and team members. Territorial behaviour was a very strong theme at case study site one within the AMU, due to the close proximity to the other maternity wards. Territorial behaviours were also observed at case study sites two and three, but to a lesser degree.

6.4.1 Working as a maternity team

The midwives working at the FMU and the community midwives covering home births were mostly detached from the hospital activities unless they were summoned or rostered to work in the hospital. This was in contrast to the AMU at case study site one, since their work activity was partly referred from the labour ward. They also worked closely with the postnatal ward, as women and babies who could not be discharged home were transferred to the postnatal ward. This meant that the work activities of all maternity wards were very much connected.

There was a perception from many of the AMU midwives that midwives from other maternity wards did not value their contributions and therefore they only came to see the AMU midwives when they needed their assistance:

> One AMU midwife described staff working within the AMU as the 'poor relation' (Fieldnotes, AMU)

> *'*We are like lepers here. No one wants to know us until they want us to help elsewhere*'* (Fieldnotes, AMU).

Midwives at all three case study sites showed loyalty to their working teams and this was encouraged:

> The team leader advised a new team member that if she had any problems, they will sort it out within their team. The team leader advised not to go outside the team if possible (Fieldnotes, Community midwives meeting at case study site two).

6.4.2 Competing to be the busiest and most efficient

6.4.2.1. Comparing workloads

AMU midwives suspected that colleagues working in other maternity wards felt that the AMU midwives did not work as hard. An email sent by the AMU senior midwife Claudine to all the AMU staff, verified that their apprehensions were correct:

> Midwife Elsie was catching up on her emails in the staff room and then asked midwife Amy about one particular email sent from senior midwife Claudine. Elsie said that it insinuated that there was a perception that staff on the AMU did not work as hard as other maternity areas. Tanya explained that it had come about due to what people were saying (Fieldnotes, AMU)

Another discussion concerning the same email was observed a week later. Although the staff did not share the full content of the email it was evident that the message taken away was that AMU midwives did not work as hard as their midwifery colleagues in other wards. AMU midwives believed that they did work hard, but their midwifery colleagues did not understand the support required to care for low-risk women one-to-one:

> Midwife Deirdre was catching up on her emails in the staff room and then asked midwife Tanya '*what is going on*?' Tanya explained that the email was sent by the AMU senior midwife which said that there is a perception that staff on AMU do not work as hard as those in other areas. There was a discussion by the AMU midwives in the staff room that people do not realise how hard it was to look after someone who is normal. They stressed that it could be harder looking

after someone normal as high-risk women have their pain relief on labour ward (Fieldnotes, AMU)

6.4.2.2. Birth rates

Birth rate numbers caused territorial behaviours, although midwives at all three case study sites had guidelines indicating which women were suitable for midwife-led care (Table 9).

Table 9: Women suitable for midwife-led care

Women suitable for midwife-led care
Women aged 18 to 40 years
Women who are between 37 and 42 weeks along
Women having only a single baby in this pregnancy
Women with a maximum of 5 previous babies
BMI between 18.0 and 35.0
Baby must be head down
No complications in a previous pregnancy
No complications in this pregnancy

Both AMU and FMU midwives felt that some of the responsibility for lowering birth numbers was due to community and hospital midwives not promoting and supporting the midwife-led unit services:

A midwife commented that low-risk women are still staying on labour ward rather than coming to the AMU. The midwife gave an example saying that the other day labour ward was really quiet and a midwife asked if they could keep a low-risk woman on labour ward so that their student had a woman … The AMU midwife offered them to come over to the AMU, but they declined and said that they had a birthing pool on labour ward (Fieldnotes, AMU)

> Yani asked the MSW why the FMU was not as busy as before. The MSW explained that not everyone is selling this place. The MSW added that they know this is true, because the women tell them (Fieldnotes, FMU)

The labour ward handover at case study site one however showed that the labour ward staff contested this latter theory. The labour ward handover was a time when territorial behaviours concerning work activity and efficiency were communicated to over fifteen staff members including midwives, student midwives, and MSWs and sometimes doctors. The mood of the handovers was very much led by the senior midwives. Staff squeezed on to the comfy chairs in the centre of the staff room, two of which were occupied by the two senior midwives covering different shifts. The remaining staff sat on the hard chairs around a table near the back of the staff room. It was the responsibility of the senior midwife to check the work activity from all the maternity wards including the AMU, and have it ready to report at the handover.

All attention was on the senior midwives sharing the work activity assessment who also had to share notifications from the midwifery management. The language and tones of the senior midwives on the labour ward sometimes gave the impression that they did not always respect the midwife-led interventions completed on AMU. Comments sometimes had a sarcastic tone which caused some listeners to laugh:

> The senior midwife from the early shift handing over to staff. The reasons for the AMU transfers were described:
> One for epidural
> One for no [labour] progress and now on syntocinon
> One was *span to death* [in reference to the 'spinning babies' initiative] and then came over here and delivered. The senior midwife added '*I think the walk over to labour ward did it.'*
> (Fieldnotes, labour ward, case study site one)

The notification shared at one handover included instructions that the labour ward midwives must ensure that all low-risk women are transferred to the AMU. One of the senior midwives noted that this notification had not gone down well, when communicated at previous handovers. This may have been a way to increase

alliance to influence the views of staff listening to it for the first time. When discussing the work activity on this occasion, it was also noted that two low-risk women were refused admission to the AMU because they were full. There was an insinuation that the AMU had refused women, when they could have accepted a referral and this was in fact one of the reasons why the AMU birthing numbers were low:

> The senior midwife handed over the details of two women who could have been admitted to the AMU, but the AMU was full. The oncoming senior midwife questioned this information as she had checked the work activity recently and the AMU had two labouring women and one postnatal. The early shift senior midwife commented that the AMU may have had more women in labour earlier in the shift. The oncoming senior midwife did not look convinced and said, '*but after what was said … about making sure the low-risk women go to the AMU*.' The early shift senior midwife said the message had not gone down well. The late shift senior midwife said that she thought that the AMU could take four women (Fieldnotes, labour ward case study site one)

6.4.3 Working with different philosophies of care

When staff rotated to new maternity wards they had to learn the new culture of the environment. A MSW who had previously worked on labour ward was rotated to the AMU at case study site one. On her first day the MSW assertively approached the senior midwife Claudine and informed her that she had advised the birthing partners that they could not stay. Claudine informed the MSW, that the AMU did not restrict presence to one birthing partner:

> The MSW said to senior midwife Claudine that she told the relatives that they could not stay. Claudine said that '*it works different here they can stay if the woman wants it.'* Claudine explained that she asks women at certain points e.g. vaginal examination if the woman still wants her birthing partners present or to wait outside … (Fieldnotes, AMU)

6.4.4 Sharing resources

6.4.4.1 Sharing equipment

Within the AMU and FMU office, staff discussed events as they happened and went over situations with staff that had not been present. The events shared included territorial behaviours in relation to obtaining equipment. One AMU midwife shared how upset she was after collecting equipment from a maternity ward as the midwife insinuated that they were using the heater for babies frequently. This was translated as questioning the competence of AMU midwives to keep their babies warm:

> One AMU midwife brought an overhead heater [device used to warm babies] for a baby from one of the maternity wards and told the MSW that the staff commented '*you are taking the heater again.'* The AMU midwife felt they had an attitude and added that '*this is what it is like when you get equipment from the cupboard on their ward'*.
> (Fieldnotes, AMU)

The AMU and FMU were also protective about their equipment and blamed other maternity wards and community staff when equipment went missing. Unlike the AMU however, the FMU did not have accessible equipment to borrow when it could not be located:

> Midwife Yani said that she heard from a midwifery manager after she had written her concerns about equipment going missing at the FMU ... Yani read out the email, saying that the manager was not aware that the community staff had been using the FMU equipment. The manager replaced all the sonicaids [hand held heart monitor] at the hospital midwife led-unit. Yani asked those present if that meant that the community staff were also taking the hospital sonicaids and now that they have run out they were taking from FMU (Fieldnotes, FMU)

6.4.4.2 Sharing staff

Loyalty to a team was increased when territorial behaviours caused divisions between wards, especially where a team or teams were reprimanded by management. Midwife Sonia described a shift when she was working at the AMU and there were three midwives and three women having water births. Birth was

imminent for all three women. This meant that none of the midwives could leave their labour rooms to support the other. Midwife Sonia requested the MSW to ask for midwifery support, as the second midwife at the births. The maternity wards each responded that they were too busy to offer help. As the first birth occurred, midwife Sonia pulled the emergency bell and staff rushed into the birth environment from all of the maternity wards. With everyone in attendance, midwife Sonia informed them that she now needed midwifery support for the other two births that would soon follow:

> Midwife Sonia described events from last week when she was on duty and there were three midwives on AMU and three women in labour. She became aware that all three women were going to give birth closely together. Sonia had knocked on her colleague's door asking for her to be the second midwife for her water birth, but the midwife said that she could not leave her room. Sonia then asked the MSW to ask for a midwife from the maternity wards, but the MSW was told they could not provide anyone. Sonia explained that it is hospital policy to have two trained midwives in the room for birth. Sonia took the decision to pull the emergency bell and then all the midwives from the maternity wards came over. Sonia then told staff that she needed someone from labour ward for the other two rooms too … (Fieldnotes, AMU)

Later that day at the labour ward handover, the senior midwife shared a summary of the work activity on AMU and insinuated, verbally and through body language that the AMU staff had over reacted:

> The senior midwife on labour ward commented that there had been an emergency reaction on the AMU and raising her eye brows. Insinuating that they had made a big fuss (Fieldnotes, AMU)

This event was still being discussed within the AMU staff office eight weeks after it occurred. The events on one occasion had added one more water birth:

> In the staff office talking about scenario when they had three or even four water births and the maternity wards refused to be a second

midwife. Discussed how the situation was unfair as the AMU staff help the maternity wards (Fieldnotes, AMU)

6.4.5 Discussion

Based on my findings, I suggest that surveillance and the organisation of workload contributed to territorial behaviours which was more prevalent at case study site one. This study builds on the research findings concerning 'territorial behaviours' within maternity services (McCourt et al. 2011; Rayment 2011; Hunter and Segrott 2014; McCourt et al. 2014). Territorial behaviours were mostly apparent between midwives in this study. Research findings have also shown territorial behaviours between obstetricians and midwives (Hunter and Segrott 2014), but in my study territorial behaviours only involved obstetricians, when women were transferred to labour ward.

6.4.5.1 Contributory factors for territorial behaviours

Much of the territorial behaviours were connected to work activity. This study reinforced other ethnographic organisational studies focusing on AMUs (McCourt et al. 2011; McCourt et al. 2014) and FMUs (McCourt et al. 2011), that midwives providing one-to-one support in labour within midwife-led units were deemed by labour ward staff not to work as hard as other hospital wards. Midwives working in AMU have been perceived to get an 'easier ride' (McCourt et al. 2011:59).

I suggest that such insinuations were based on the fact that midwives in midwife-led care environments cared for one woman in labour. In contrast, midwives working on labour ward at case study site one, often discussed how they had to look after more than one woman in labour. These opinions have been shown to create resentment by midwives, particularly between the AMU and the labour ward (McCourt et al. 2011). Although resentment was also observed in this study by staff working in the antenatal and postnatal wards at case study site one.

Various reasons have been suggested for territorial behaviours. This study supported the view that the co-existence of conflicting ideologies including midwife-led philosophy of care and the medical model caused much of the disharmony and frustrations between staff (Hunter 2004; Prowse and Prowse 2008). Within the medical model of care, high technology skills are viewed as more valuable than the low technology skills of midwife-led care (McCourt et al. 2014).

It has been suggested that territorial behaviour is part of the process required to shift the balance of professional power from the medical domain to midwife-led care (Hunter and Segrott 2014). Midwives separating themselves from obstetrics creates tensions (Steven and McCourt 2002a; Prowse and Prowse 2008; Hunter and Segrott 2014; McCourt et al. 2014). Such tensions may help explain the increased territorial behaviours at the AMU at case study site one as the unit was newly opened and new to communicating their midwife-led care boundaries. Each case study site in this study however reinforced their boundaries using clinical guidelines to distinguish normality and abnormality.

Another reason for territorial behaviours comes from McCourt et al. (2014). Their study suggested that some of the hostility targeted at AMU midwives reflected fears and a lack of familiarity and confidence in the skills required to work within the AMU. This was also observed in this study when hospital midwives were requested to provide midwifery support at the FMU and home births. Overall, it was evident that midwives at all three case study sites had difficulty empathising with the working experiences of midwives in different wards and hospital sites which has also been found in other studies (McCourt et al. 2011; McCourt et al. 2014).

6.4.5.2 'Us and them' culture

This study reinforced the notion that territorial behaviours included midwives acting defensively and they lacked trust and understanding of each other's' roles, which made it difficult to work together (McCourt et al. 2014). These territorial behaviours created an 'us and them' culture (Hunter 2004; McCourt et al. 2011; Rayment 2011; McCourt et al. 2014). This study also supported the principle that community midwives providing support for home births, also experienced the 'us and them' culture when working with the hospital services (Hunter 2004). Overall, this study reinforced that territorial behaviours created a competitive working environment to be the busiest (Rayment 2011). This led to conflicts over workloads (McCourt et al. 2014) and increased speculation that other wards or hospital sites dramatised their high workload and took advantage when help was provided. As territorial events played out, recollections were also interpreted and discussed very differently within other maternity wards. This latter findings has also been recognised in the study by McCourt et al. (2014).

Organisational systems promoted rotation at all three case study sites which was evident as midwives were versatile to work in most areas of the maternity services. In this study however, being versatile did not increase empathy for other midwives roles and it did not prevent territorial behaviours. The rotation of midwives has not been shown to decrease territorial behaviour, because staff became loyal very quickly to the ward in which they worked (Rayment 2011).

6.4.5.3 Summary

Overall, this study builds on the existing research regarding territorial behaviours including traits and causes. This study shows how outside the birth environment, many midwife-led care midwives felt they had to justify their clinical activities and the midwife-led care services. Midwives particularly at case study site one, felt they were perceived not to work as hard and not to be as efficient as their maternity colleagues. Such perceptions were confirmed to be held by midwives working in other ward areas and shared at hand over meetings.

6.5 Documentation

There was a dichotomy between how the midwives and women perceived documentation. Midwives felt there was too much documentation which impacted on their care inside the birth environment, while the women felt they hardly noticed the documentation being completed by midwives.

6.5.1 Midwives perception of documentation

I observed midwives complaining about the amounts of documentation regularly at all three case study sites:

> Community midwives discussed about having too much documentation to complete. One midwife said that when a certain midwife [named midwife] took over the care from her, she was so scared that this midwife was going to be checking her documentation (Field notes; community midwives meeting for home births)

Midwives felt that documentation impacted on their clinical care inside the birth environment. They felt their documentation was under scrutiny from other colleagues, audit purposes and if an investigation was required due to an adverse outcome:

Researcher	And what do you think about the documentation in a home birth situation?
Florence	We all have to be very, very … alert and on the ball about our documentation and it does sometimes feel that it takes over from giving care, and if we have written it down that you have done it, then that's proof, … I would say the home situation, sometimes the paper work does take a back seat, … there are times when I would rather be with the patient then sitting and filling in numerous dotting and stamping and dating and ticking every box so, but I will always make sure my paper work is sound before it leaves the house (Florence, Home birth midwife)

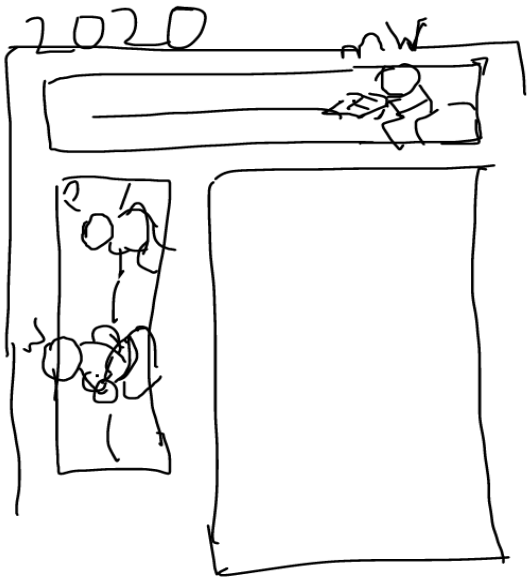
Midwives also used documentation as a line of defence if advice was declined by women:

> Midwife Gladys said that fluids were offered to Amelia, but that she declined. Judie the midwifery support advised midwife Gladys to document that (Fieldnotes from Amelia's labour, FMU)

6.5.2 Documentation completed inside the birth environment

Inside the birth environment midwives balanced their labour support and documentation. Midwives mostly achieved a balance so that women did not feel that the documentation took the midwives' attention away from them. Documentation was written inside the birth environment at all three case study sites using furnishing such as a sofa, stool, mattress, bed, cupboard and chair in close proximity to the woman (Figure 20). Most women such as Cindy had been unaware that midwives were documenting in labour or following birth. Like many women in this study, Cindy recalled the midwives documenting, in her last labour which took place on the labour ward:

Figure 20: Cindy's birth environment with midwife documenting



Researcher

Were you aware of the midwives documenting?

Cindy

No I don't remember this time around. I remember the first time around in hospital … it was quite a big issue, the woman [midwife] was sitting there, flicking through and writing, but no I was not aware of it here. (Cindy, Home birth)

Some women such as Connie were aware of midwives documenting, but because it did not get in the way of the support they received, they didn't perceive it as a problem. On the contrary, some women felt reassured (like Connie) that the midwife had been writing detailed reports about their labour:

> I read some of her notes and it was so detailed, but I remember her doing that and I felt really reassured … I had no idea that they wrote everything down … I just felt safer to be honest with you, knowing that she was doing it [documenting]. She didn't ever sort of like, I always came first and if I needed her she would be straight at my side you know and then she would go back to them [maternity records] (Connie, AMU)

Isabelle was the only woman in this study who was very aware of the documentation, something she regarded as excessive. Isabelle however, considered the documentation as an important part of the midwives' role:

> Researcher Was you aware of the midwives documenting their care?

Isabelle	… I was surprised how many notes they wrote but ... but at the same time not really, like I said I was quite out of it, … When I saw them writing notes especially at the end, she had the other midwife writing the notes … I saw them writing and I thought oh my god they have to write so many notes…
Researcher	… how did it make you feel?
Isabelle	It didn't bother me, … I know it is an important part of the job … [It] is quite funny, because you are kind of sometimes in a high stressed situation where you are delivering a baby and you have to pop over to the side and write your notes (laughing), so it is quite funny … (Isabelle, FMU)

Overall the ability of midwives to balance documentation and support in labour was thought to improve with experience:

> Student midwife shared that this was the first time that she really felt that she was there for the woman, but that her documentation needs to improve. The student midwife explained that she was rubbing the woman's back and comforting her, but she was not able to write as good as she knows she needs to. A midwife reassured the student that it will come with practice (Fieldnotes, FMU)

6.5.3 Documentation completed outside the birth environment

There were components of the documentation concerning labour details that had to be completed on the computer at all three case study sites. At the AMU and FMU, the computers were within the staff offices and midwives completed the documentation while women were bonding with their babies and partners. The community midwives following a home birth however, had to go back to the hospital to complete the computer details. This was a time that documentation had to be finalised. Although I observed that midwives were documenting inside

the birth environment, it was evident that not all midwives achieved this and therefore wrote retrospective notes following the birth:

> A midwife said that she had five hours of notes to write as she did not like writing when she was caring for a woman in labour (Fieldnotes, AMU)

6.5.4 Clinical details transcribed

Documentation by the midwives mainly focused on the physical signs of labour progress. These included frequency of contractions, clinical monitoring completed to check the well-being of women and their babies; the coping strategies and positions women used; activities such as having food, fluids, going to the toilet, breast feeding; and any advice or assistance provided by the midwifery or medical support.

Part of the documentation also included the completion of a partogram. A partogram is a graphical representation summarising the changes that occur in labour, including all the clinical observations completed in labour and birth. The maternity records highlighted that many AMU midwives did not complete the partogram at case study site one. In contrast most midwives at case study site two and three did complete the partogram.

6.5.5 Discussion

This study showed that most midwives achieved a balance regarding documentation to record the statuary requirements (NMC 2009) to provide evidence about the amount of care and any treatments provided. This was achieved while retaining focus that was sensitive to the needs of women experiencing midwifery one-to-one support in labour. Adhering to the statutory requirements also ensured the needs of the NHS organisation were also addressed.

6.5.5.1 Statutory guidance for documentation

Guidelines regarding documentation in labour at all three case study sites were mainly guided by the NMC (2009) statutory record keeping guidance for nurses and midwives and the NICE (2014) intrapartum guideline. NHS organisations therefore expected documentation to include written assessments and progress reports to enable planning of future care and continuity of care (NMC 2009;

Beach and Oates 2014; Griffith 2015). Documentation is therefore a reflection and evidence of clinical practices and decisions taken. Part of the documentation included the completion of a partogram. Midwives were also expected to document any risks or problems that have arisen and show the actions taken (NMC 2009).

6.5.5.2 Documentation practices of midwives providing one-to-one support in labour

Most midwives were observed in this study to have one set of maternity records to complete at one time due to supporting only one woman in labour. The amount of writing should have been minimal as women were low-risk compared to documenting the care of high-risk women. However, midwives at all three case study sites complained about the quantity of documentation required within the maternity records and on the computer. Most midwives in this study were observed to write contemporaneous notes and they finalised their documentation while women were bonding with their babies and partners.

A minority of midwives at all three case study sites wrote their notes in retrospect following the birth. The reliability of documentation has been suggested to increase if it is written contemporaneously or immediately following any events (Griffith 2015). The NMC (2009) also stipulates that records should be written as soon as possible after events have occurred. Retrospective records have been reported to have been written several days later in an investigation from Morecombe Bay. This resulted in poor clinical records and jeopardised vital transfer of information to professional colleagues and contributed to poor outcomes which included three maternal deaths and sixteen babies at or shortly after birth (Kirkup 2015)

Research by Bailey et al. (2015) found that midwives providing one-to-one support in labour were more likely to complete a partogram. This was reflected by the community midwives covering home births and the FMU midwives, but contrasted to my findings at the AMU. Documentation analysis of the maternity records indicated that the majority of midwives at the AMU did not complete the partogram, although they did write details concerning labour events. The reasons for this omission were not evident in this study. Some midwives however did write retrospective notes following birth. This may have indicated that midwives,

when synchronising their support; recognised that some women required more interaction from the midwife and that became their priority, rather than documentation, including the partogram.

Karkkainen et al. (2005) also suggests that practitioners are less inclined to complete documentation if they do not consider the documentation important. It is possible that some AMU midwives may have viewed the partogram as having no clinical purpose for low-risk women, because there are debates regarding the use of partograms within midwife-led units (Osbourne and Lavender 2005). It has been suggested that partograms do not fit all stereotypes of normality; therefore partograms are not conducive to tolerating variations of normal progress in labour (Osbourne and Lavender 2005). It has also been argued that if used correctly, the partogram can help midwives to use their skills to promptly recognise deviations from the normal and transfer women appropriately (Osbourne and Lavender 2005).

In this study, many midwives also felt that some of the checklists were not applicable to low-risk women. At all three case study sites, the checklists firstly included a risk assessment to check that women fulfilled the inclusion criteria for midwife-led care. The remaining checklists assessed the risks for infection, clots and pressure sores. These were not always completed at all three case study sites and again this may have reflected a lack of time or considered irrelevant. It should be considered however that the failure to complete risk assessments was identified in the investigation from Morecombe bay as an accepted part of their maternity culture. Such culture caused a failure to recognise and monitor risks and contributed to poor outcomes (Kirkup 2015).

6.5.5.3 Incentives for documentation

Midwives in this study at all three case study sites were anxious about having their records scrutinised, in particular as part of an investigation. This appeared to be a major motivator for midwives in this study to complete comprehensive records. Surtees (2010:88) explains that midwives ensured they left an audit trail using their documentation, just in case they are 'called to account' regarding their clinical practices in the future. This may have accounted for why midwives in this study were observed to document when their advice was refused, to evidence omission of care since they feared they would be held responsible. The NMC (2015) Code of professional standards supports documenting when women

refuse care. The NMC guidelines (2009) also stipulate that the written words in the records are legally binding as they can be used before a court of law or the Nursing and midwifery council (NMC). In addition, governing bodies such as the NHSLA (NHSLA 2012c) and CQC (CQC 2013) require the NHS organisations and themselves to regularly assess documentation as a way of assessing clinical practice against clinical guidelines. Such measures have been taken to promote a proficient documentation culture. This is because working cultures tolerating poor documentation, have been connected to poor clinical outcomes within maternity services (Kirkup 2015).

It has been advised that professionals who document 'a wait and see approach' need to ensure that they include evidence as to why they felt action or referral was not required (Griffith 2015). This would be appropriate for midwives providing midwife-led care as they assess variations of the normal processes of labour. This may contribute to midwife-led midwives feeling nervous when their documentation is scrutinised again by the medical analytical lens when transferring women to the labour ward.

6.5.5.4 Women's perceptions of documentation

Based on my findings, most women were not aware of midwives documenting inside the birth environment, although the study observations showed that this occurred. When women did notice the documentation, they did not feel the documentation took the focus away from them and some women felt reassured that midwives were documenting about their labour in such detail. Only one woman noted a large volume of writing which had an impact on the atmosphere inside the birth environment.

6.5.5.5 Summary

Overall, this study has provided a new insight into the culture of documentation within midwife-led birth environments, when midwives practise one-to-one support in labour. Although most midwives had one set of records to complete at one time, the amount of documentation created anxiety. Midwives may feel reassured by the findings in this study that show that women do not perceive the writing of their maternity records inside the birth environment to be a problem. This was provided that the documentation did not remove the focus from women. These findings were in contrast to women reflecting on previous labour and births

which occurred on the labour ward, where they felt the midwives' attention was focused on writing and technology.

6.6 Transfer to labour ward

Midwives, providing one-to-one support in labour to women at all three case study sites, transferred women to labour ward to gain medical assistance during labour or immediately following birth when there was a deviation from the normal. Across the three case study sites there were eleven transfers to the labour ward (Five AMU transfers, two home birth transfers and four FMU transfers).

This study showed that transfer to the labour ward was an anxious time for midwives and women. Most midwives and women were anxious about the well-being of women and their babies. Midwives were also anxious about their labour care being scrutinised by labour ward staff. My findings revealed how midwives and women coped with these anxieties and suggested innovations to improve anxiety provoking situations.

6.6.1 Midwives' anxieties about transfer to labour ward

Midwives such as Ava, Lorna and Megan were concerned about their care being scrutinised when they transferred women to labour ward. Ava had started her labour care at Linzi's home at 21:00 and just after midnight, transfer to labour ward was arranged. Ava tried to predict the elements of her care that may be questioned by labour ward staff which could be attributed to reduced progress in labour such. These included a full bladder and lack of nutrients and hydration. This led Ava to feel more pressurised to encourage Linzi to drink and eat in labour:

> I tell all my women, I say if you are dehydrated in labour then it [labour] is not going to progress, because you haven't got anything to burn to help your body to do all that hard work, because it is like running a marathon, you need to eat while you are doing it'. I think she [Linzi] actually got annoyed with me [slightly laughing] in the end trying to say to her 'have your chocolate buttons' [laughing] she was saying 'no I don't want chocolate buttons'. Yes I knew that emptying the bladder is quite important and I knew that when she would get into hospital you know they would test her wee straight away and say

> ‘you know that she has got ketones, the midwife hasn't been working hard enough’ [putting on voice] and I was [laughing], I was trying to shove the chocolate buttons down her mouth (Ava, home birth midwife)

Some midwives appeared vulnerable and close to tears at the thought of being questioned by the labour ward staff. Midwife Megan’s stress was very evident when she stormed into the staff office with a warning on her face that she was going to shout out as a release to built-up tension:

> Midwife Megan came into office and she looked like she wanted to air off and I gestured to cover my ears and she said f***ing hell (Fieldnotes from Isabelle’s birth, FMU)

Midwife Megan showed that the tension was partly due to the disappointment for the woman, because she needed to be transferred to labour ward for a perineal repair; but Megan was also tensed due to the potential scrutiny of the labour ward staff. While feeling such tensions, midwife Megan continued to provide support to Isabelle, her partner and baby. She encouraged bonding while they had privacy, with the help of the on-call midwife and MSW. Midwife Megan also monitored Isabelle’s condition, arranged the ambulance for transfer, informed labour ward about the transfer and wrote her documentation. The latter was vital as midwives needed to be up-to-date, prior to handing the maternity records over to labour ward staff:

> Midwife Megan explained that she is not looking forward to going in [to labour ward] as she feels if anyone says anything she will burst into tears. Megan looks close to tears … Megan added ‘I can’t believe I am back tonight’ (Fieldnotes from Isabelle’s birth, FMU)

Although midwife Megan accompanied Isabelle in the ambulance, her full focus was not on Isabelle. Instead, she was reflecting on her actions and questioning if she had caused the perineal tear sustained:

> I think, it was … What else could I have done? But even in the ambulance … I go through things and think, is it my fault, what could I have done, there is nothing I could have done, and I was doing that

> pretty much all the way, as well as … you know talking to Isabelle (Megan, FMU midwife)

6.6.2 The 'us and them' culture witnessed by women

The reflections from women such as Hilda showed that midwives' anxieties about hostility between midwife-led care midwives and labour ward staff was sometimes visible to women. Hilda was transferred to the labour ward, because she kept bleeding following the birth of her baby. When Hilda was checked, a small perineal tear was seen, which midwife Maureen felt did not require stitches when she checked in the AMU. The obstetrician disagreed however and Hilda observed a discussion between the obstetrician and midwife. Hilda showed that she had a sense of loyalty towards midwife Maureen, but she felt she needed to follow the obstetrician's advice:

> … she [midwife Maureen] thought that the tear would have healed up, but then when the surgeon came through, he felt that it needed stitches. So there was this huge discussion for a while and actually I was quite happy to go along with what the midwife wanted, but I felt he was pulling rank for a little bit, so for the sake of three stitches or whatever, so that was a bit annoying. And Maureen [midwife] explained 'you know this is what he thinks and this is what I think', both points of view are just as valid, but I kind of felt that I had to go with the surgeon, as there was so many people in the room at that point, sort of thing (laughing) (Hilda, AMU)

I suggest that this situation also showed midwife Maureen fighting to keep her autonomy in front of Hilda, who had trusted her all through labour and birth. Hilda however, felt that the tension had not been confined between the obstetrician and midwife Maureen, instead there was a general tension between the AMU and labour ward staff:

> Yes, no I thought there was a bit of tension just between the midwife and just the way the whole discussion kind of went. It felt there was tension between the midwife unit and the labour ward (Hilda, AMU)

Hilda also felt that the autonomy of midwife Maureen being challenged because the team implied that they had to repair what the AMU midwife did not:

> I think there … was an element of … 'we will sort out your mess'… and it wasn't mess as far as I was concerned. You know that is how I felt … but I mean the girl [labour ward midwife] who actually stitched me, was very nice (Hilda, AMU)

The tension was not restricted to the labour ward. Hilda said she also felt tension from the postnatal staff towards her, as she was taking a postnatal bed. If there had been no complications Hilda would have gone home from the AMU, a few hours following birth. She would not have been transferred to the postnatal ward:

> They said basically 'they [women from AMU] are taking up our rooms'. I got that sense of taking up space and they didn't agree with that … so anyway, I wasn't there after having a caesarean section. I was taking up less time than most … (Hilda, AMU)

6.6.3 Promoting positive transfer for women

Some women like Terri had positive recollections of how their labour, birth and transfer to the labour ward played out. Terri explained three main factors that helped her cope with the transfer to a new environment, interventions and meeting different professionals. These three factors appeared to have an impact on all women experiencing transfer at all three case study sites. The first and most important factor was that midwife Lorna accompanied Terri to labour ward. She stayed with her until she was ready to transfer to the postnatal ward. The continuity of seeing the same familiar face was reassuring. Terri understood that the dedication of Lorna that day and the organisational system, worked in her favour, hence allowing Lorna to stay with her and this was really appreciated:

> I think she [midwife Lorna] did really well with me personally as she stayed with me all the way through up until going to theatre ... Which was brilliant and bless her as she had not stopped for a break … she stayed with me ... liaised with the surgeons … I was really, really impressed with her because she didn't just, you know, say 'you have

had the baby see you later'. Yes, and she could have done, because I was transferred from the AMU to the main hospital, so I would have expected to have been ... handed over to somebody else, but … She came with me and stayed with me and did everything so I had the same face … I can understand that it is not necessarily practical for it to last that long, but the fact that it did in my situation was really, really good and I really, really appreciated that … and that really helped me having the same face all the way through (Terri, AMU).

The second factor that helped Terri cope with the transfer to labour ward related to having a private room to adjust to the situation, along with having time to bond with her baby and partner Robert. Midwife Lorna not only provided the continuity, but also had the skills to work with the obstetrician, organise and set up the equipment and medication which kept the environment private and intimate:

… even if it were for 15-20 minutes if … it's a case like for me that you have had a traumatic few minutes and you are being transferred … just fifteen minutes to acclimatise yourself and calm down before you go on a ward full of people definitely really, really helps … but the main thing was that [midwife Lorna] … came with me … (Terri, AMU)

A third factor that helped Terri to cope with the transfer to labour ward was that all staff introduced themselves to Terri and described their roles in relation to the planned surgery. This process helped Terri's mental transformation from one-to-one care with Lorna to one-to-many carers including a surgeon, anaesthetists, theatre staff, porters and another midwife. Interestingly, Terri did not mention the surgery, or whether she was separated from her baby. Instead she focused on the activities that occurred within the two hours she spent within the labour room with her birthing partners, baby and midwife Lorna:

I went into that little room on my own and … it was calm and very quiet and it was actually a nice couple of hours being in there … Me, you [partner Robert] and my mum, Lorna and a couple of people came in and out. The surgeon came in, didn't he? To look at my tear again … He had a student with him… and then I had someone come to prep, he was another surgeon wasn't he [directed to Robert] and

> then … I don't know if she helped with the surgery but she came in just to discuss what was going to happen … so yes it wasn't a lot of people, one at a time sort of thing and it was quite nice, because they all sort of made themselves known and explained why they were there and what they were doing it wasn't like who is this person? … (Terri, AMU)

Connie was another woman who reflected positively on her labour and birth following transfer. The experience differed slightly because Connie was transferred to labour ward when she was in labour. Midwife Diana accompanied Connie and stayed with her until the baby was born normally. Diana then handed Connie over to the labour ward midwife. Connie acknowledged there was a point where she could have panicked when she was informed transfer was necessary. However, midwife Diana continued to provide one-to-one support on the labour ward, so Connie felt determined and kept her faith in her capability to give birth naturally. Connie's three objectives included firstly that her baby would be ok, secondly, she would have a normal birth and thirdly, midwife Diana would stay with her until the birth occurred:

> … she [midwife Diana] just kept me calm the whole way through, and I thought 'there is no point, if I get stressed now and if I get upset now, this is going to make it worse for the baby' … I just thought 'well I have got to … just get on,' business like really, and not get all emotional about it and … I remember feeling more and more tired … but I felt determined the whole way through. I thought I am not giving in. We have got to carry on (Connie, AMU)

Midwife Diana had an insight into the continuity of her presence, in relation to Connie achieving a normal vaginal birth. Diana was determined to stay with Connie on labour ward as she acknowledged that the midwives' role is to help women to make that transition from one-to-one support in the AMU to one–to-many on labour ward:

> I thought that she [Connie] was so good, really she was so great all day long without giving up. I felt worried that she could feel something different there [labour ward] and then scared. That is why I didn't want to leave her, because I felt that continuity was the only thing that

> could remind her about the natural. It was like a link between the two worlds, because I was the only … the only point that remained in common between the two worlds, so … yes I was afraid that they didn't allow me to carry on with the one-to-one care (Diana, AMU midwife)

Following the birth, the labour ward staff immediately entered the labour room as midwife Diana handed over. The intimacy and privacy created and protected in the labour, disappeared in an instant. Faces appeared around the curtain, different conversations were heard between staff and to Connie, while at the same time a large lamp was brought in and Connie's legs were placed into stirrups. Connie was also holding her baby and talking to her partner while thanking midwife Diana and responding to the staff that were asking for consent to manoeuvre her legs and start the repair of her perineum.

Connie coped with this transition very calmly and happily because her baby was well after a normal birth and her midwife Diana stayed with her for the birth. Continuity did not just mean a continuation of care, it included an emotional and professional connection. Following the birth, the atmosphere changed leading to an end in continuity and privacy. In addition not all of the people asked permission and introduced themselves. Connie however kept her positive opinion regarding her birth and the change of circumstances:

> ... even when all those doctors came in and the spot light came in and I was up in stirrups, stitching and all of that, well by that point, I didn't really care obviously anyway, because the baby was out and you know and at that point it was kind of funny really, because I couldn't feel anything down there and this man popped his head around the curtains, didn't he? And said [directed at partner] 'you know, I am really sorry, but I need to …', and I said ahh fill your boots, you know I thought God. You know by that point I thought well, you know (Connie, AMU)

6.6.4 Circumstances causing a stressful transfer to labour ward for women

Women on the other side of the spectrum felt a sense of loss and sadness when transfers were not sensitive to the needs of women. When the one-to-one relationship did not continue to the labour ward, women like Jasmine, who

required transfer to repair a perineal tear were transferred with a complete stranger in the ambulance. Midwife Jayne, who had cared for Jasmine in labour, assessed the situation at the FMU and decided it was safer for the on-call midwife to accompany Jasmine to the labour ward. This was due to her feeling that the on-call staff would not be confident on their own to manage the FMU. The ambulance left shortly after midnight. Jasmine held her baby in the ambulance and her sister and the on-call midwife accompanied her while her husband followed in a car. Jasmine felt that the midwife was present only as an escort to hand her over to the labour ward staff:

> It was nice that the midwife came with us to [named hospital], … but it felt like … she was a bit more of an escort, really. [It] didn't feel like she was there for us. She needed to be there, that was the protocol, … she was there holding my files and she was going to transfer the care over … so I think it would have been nice, and I know it would have been impractical, it would have been nice for this midwife [Jayne] to come with me, because it did feel like, … oh my god I have got this baby, and now we are in another hospital, they don't know me, they don't know what I have been through and they are going to send me to theatre now, give me these stitches now and I have to be away from the baby'. It was all a bit (tears streaming down face) … sorry (Jasmine, FMU)

On labour ward, Jasmine was placed in an unfamiliar room away from her baby and partner while she waited for the surgeon to be free. Jasmine also struggled with the surgical repair of her perineal tear. The whole situation contrasted to the trusting one-to-one relationship, with constant reassurance within a private and safe environment, experienced at the FMU:

> Yes, it was just after having such a good experience, even though it was quite painful … it was very strange being somewhere that was very unfamiliar, the staff don't know you, what you have been through … then I had to go to surgery and I had to be away from her [baby] so long, and they kept me there because the doctor was busy and I couldn't get back to her [baby], and she was hungry and yes it was not that great … Yes … waiting for an hour, I think…before the doctor came, all that time I was away from her [baby]. So that was

> quite difficult … but yes, in that respect it would have been nicer, had that midwife [Jayne] been with me, but obviously that is not possible (Jasmine, FMU)

Isabelle also found the experience of the transfer and surgery challenging. Like Jasmine, she did not receive the continuity of one-to-one support, once she was in the hospital. Nonetheless, her midwife did escort her to the hospital. Secondly, like Jasmine, she was separated from her baby and this had a devastating impact on Isabelle's reflections of her experience. In addition, the staff that took over her care did not listen to Isabelle and this resulted in her vomiting on herself while on the theatre table. This was not cleaned prior to her baby being handed to her. Isabelle's experience also highlighted that her feelings may have been very different if her baby had been allowed to stay with her:

> … I think the surgery was terrible … I kept saying to the anaesthetist I feel sick, I feel sick, I feel sick and he was no, no you won't be sick you haven't eaten for twenty-four hours and I vomited like five times during the surgery and they wouldn't undo me, obviously because they are doing surgery, so I aspirated my vomit … I was covered in vomit when I came out to see my baby and I hadn't bonded with him like, … it was 0700 am when I came out of thingy [theatre] and he was born at nearly 0200 in the morning, so it had been five hours and I thought I didn't even know my baby, I wouldn't recognise him kind of thing (tearful) (Isabelle, FMU)

> I just felt sad that I didn't even know this person (tearful) who had been alive for whatever five to six hours at that point and I didn't even know him (Isabelle, FMU).

6.6.5 Discussion

Initially when completing the literature review for this study, transfer to labour ward did not feature as a connection to one-to-one support in labour. This was due to women no longer receiving midwifery one-to-one support and they were no longer low-risk. Based on my findings however, midwifery one-to-one support in labour was very much connected to transfer to the labour ward. Firstly, chapter five (section 5.6.2.3) showed that inside the birth environment transfer was very on the minds of midwives when there was a deviation from the normal identified.

Secondly, the one-to-one relationship meant that when things did not go to plan, midwives as well as women were emotionally hurt. Thirdly, organisational systems determined whether midwives could accompany women to the labour ward and whether the midwife could continue the labour care. When organisational systems enabled midwives to continue the labour care, the one-to-one relationship also continued. This was despite the care changing to a one-to-many ratio due to midwifery and medical support. Transfer for midwives and women was a stressful time and this study provides information about the triggers for anxiety and possible innovations to improve anxiety provoking situations.

6.6.5.1 Making the decision to transfer to labour ward

Studies have demonstrated that from the time midwives telephoned the labour ward to inform them that a transfer was necessary, they experienced anxiety about potential conflict (Bedwell et al. 2015). Potential conflict started with the decisions for transfer (Harris et al. 2011; McCourt et al. 2014). I observed on the AMU that there were fewer questions on the telephone about a transfer, if the AMU midwife was accompanying and staying with the woman on the labour ward. McCourt et al. (2014) found that AMU staff were under pressure from the labour ward staff to avoid transfers of women to the labour ward. In addition, conflict regarding transfer between AMU and labour ward staff appeared to be associated with a lack of trust between staff groups, amidst tension over resources and a burden of care (McCourt et al. 2014).

I did not observe labour ward exerting pressure at any of the three case study sites to dissuade transfer of women to labour ward. At case study site one, this may have been due to most of the midwives accompanying and staying with the women on the labour ward. In addition the midwife also stayed with the one woman who was transferred in labour at case study site two. In this study, most of the anxiety from midwives concerned the potential scrutiny about their labour care. As previously discussed, midwives feared that the labour ward staff would use the analytical lens of the medical model to assess their midwife-led labour care. This study provides a new insight into how midwives rehearse in their minds the possible line of questioning they will receive from labour ward and ready with their justifications concerning their labour care.

6.6.5.2 Organisational systems determining the midwives they could escort women

Organisational systems concerning transfer to labour wards determined whether midwives could accompany women and stay with them to continue the one-to-one relationship. This study was not alone outlining different organisational systems regarding whether midwives should stay with women when they were transferred to labour ward (McCourt et al. 2011). This study demonstrated that the organisational systems at case study site one and two mostly allowed the midwives providing one-to-one support in the midwife-led birth environments to transfer with women to labour ward. Subsequently many of the midwives also continued the care on the labour ward. Community midwives at case study site two however were not able to stay on labour ward and continue care if they were needed in the community to complete clinics and visits.

Due to the organisational changes at case study site three, staffing was reduced to one FMU midwife and many of the midwives on the centralised on-call team were not familiar with the FMU. As a result, each transfer situation had to be risk assessed, in terms of whether it was safe for the FMU midwife to leave the management of the FMU to an on-call midwife. This situation is in conflict with recent NICE (2014) guidelines that stipulate that in order to maintain the one-to-one care, the woman's attending midwife should accompany her when she is transferred from one birth setting to another. This ensures a face-to-face handover of care, while also reducing women's anxieties and increasing safety (NICE 2014). At the time of the fieldwork however, the intrapartum guidelines (2007) did not make such stipulations in relation to transfers.

I observed at case study site one that although most midwives did transfer with women to the labour ward and continue their care, not all midwives wanted to and this reinforced the findings from McCourt et al. (2014). I contend that this was partly due to the change in the working culture experienced on the labour ward and the territorial behaviours previously discussed when compared to the midwife-led environments.

6.6.5.3 The transfer to labour ward

The ambulance journey from the home and the FMU has been shown to add to women's' apprehensions about transfer (Rowe et al. 2012) as it is a time of 'limbo' due to the fear of the unknown (Rowe et al. 2012; McCourt et al. 2014).

The state of ‘limbo’ for women was described by Rowe et al. (2012) as being between the midwife-led birth environment and labour ward, between midwifery carers and between midwife-led care and a more medicalised approach. This was while also being concerned about their partner and what would happen when they reached the hospital. My findings add to this knowledge as women being pushed on a trolley, wheelchair or bed from the AMU to the labour ward also experienced this state of ‘limbo.’

Some women in this study and other research have felt that the midwife acted as an escort to the labour ward rather than a carer (Rowe et al. 2012; McCourt et al. 2014). Such descriptions were mostly used in this study when the midwife was unfamiliar to them. Evidence has shown that knowing the midwife who escorted them to the labour ward, improved the transfer experience (Edwards 2010; Macfarlene et al. 2014; McCourt et al. 2014) and helped women remain focused on the labour (Edwards 2010).

This study provides new knowledge by showing that the ambulance journey can be a state of limbo for midwives too. This was because they reflect and question whether they could have completed different actions with different results and how the labour ward will view their labour support. Midwives, like Megan in this study, show how midwives reflect on their practices and blame themselves. Based on my findings, I question whether midwives such as Megan are too vulnerable themselves to be in a position to support women when transferring them to labour ward. Such vulnerability is being created due to the sense of being scrutinised when reaching labour ward. This was heightened when midwives did not have immediate support of midwifery colleagues with the same philosophical approaches to care. McCourt et al. (2011) found that the transfer process improved when there were good communication systems involving trust, confidence and respect between all staff groups.

Overall, this study has provoked questions regarding how midwives can be supported more effectively when things do not go to plan and when transfer is required. My findings suggest that midwifery colleagues with similar philosophies of care are a valued resource for support by midwives. Utilising these colleagues maybe an effective first step while also analysing the cultural divisions that create territorial tensions within maternity services.

6.6.5.4 Competing philosophies of care

My findings showed that transfers from a midwife-led birth environment to labour ward was not only a physical change of space, but also a culture change due to the different philosophies of care. Midwife Diana reinforced this when she considered her continuity of care on labour ward to be '*a link between the two worlds*.' Midwives in such positions were observed acting as mediators between the midwifery/medical support and the women. This study showed that midwives were not alone feeling the tensions on the labour ward. Women felt the 'us and them' culture previously described in this chapter (section 2.7.3.3) between midwife-led care and labour ward. The comment from Hilda insinuating that labour ward said 'we will sort out your mess' resonates to another study (Rayment 2011: 231) where the AMU midwife stated the words used by labour ward staff which included '*oh they've brought the cr*p around again'*. There is a notion of labour ward saving the day which also reinforces the same study describing the labour team as 'medical heroes' (Rayment 2011:232)

6.6.5.5 Women's perceptions *of transfer to labour ward*

This study reinforced the notion that women go through a dramatic transformation once transfer is instigated. Most women who had been very active in their participation inside the birth environment, changed to one of a 'passive participant' when transfer began (Rowe 2012:10).

This study also reinforced that many women had not considered that there would be a change of midwife when they transferred to the labour ward (Rowe et al. 2012). Evidence has indicated that women have felt abandoned when handed over to the labour ward staff (Rowe et al. 2012). This study reinforced the principle that the continuity of the one-to-one relationship on labour ward after transfer was the most important element to improve their transfer experience (Dixon et al. 2012; Rowe et al. 2012). My findings support studies showing that good midwife-woman relationships helped women to cope better with transfers as they felt safe and informed (McCourt et al. 2011; Rowe et al. 2012; Macfarlene et al. 2014; McCourt et al. 2014). Although the care still changed from one-to-one support to one–to–many women; the one-to-one relationship in this study reinforced the importance of having that one familiar face (Aune et al. 2011; Rowe et al. 2012).

The findings from McCourt et al. (2014) showed that sensitive and supportive

care and preparation for the need for transfer, helped women to adjust to their changing circumstances. This study builds on this knowledge with four specific innovations that women have found, that helped the transition to labour ward care. Although continuity of the carer was the most important element to improve the transfer experience for women, this study also found three further elements. These included having a room to themselves on labour ward with their baby and partner, not being separated from their baby for long periods of time and that all staff introduced themselves.

My findings showed that women found it devastating being separated from their babies as they recognised that the time could never be regained. Women spoke as though they were grieving for the time they had been separated from their babies. The recommendations from this study demonstrate that even if the one-to-one midwife-woman relationship could not continue on the labour ward, the experience of women would still improve with the last three innovations. Essentially, there would be no cost implications for the latter three recommendations to improve the quality of care.

Following a transfer, studies have shown that women want to understand why they were transferred. Women appreciated talking about their transfer experience to make sense of it (McCourt et al. 2011; Rowe et al. 2012; McCourt et al. 2014). None of the women talked about wanting a debriefing session relating to their transfer in my study, but it was evident that women like Jasmine and Isabelle may have benefited by talking through their experience.

6.6.5.6 Summary

Overall, this study provides a new insight about the culture of the labour ward when providing care for women transferred after receiving midwifery-one-to-one support in labour. This study also builds on previous research relating to the transfer by ambulance, along with the anticipation and anxiety of midwives and women arriving on the labour ward. Midwives may find it helpful however, to know that when they stayed with women on the labour ward and continued their care, women noticed and appreciated their dedication and energy to their care and relationship. This impacted positively on their perception on how the labour, birth and transfer to the labour ward played out. Lastly, this study has provided new knowledge about how the care of women can be improved when they are transferred to the labour ward. Adhering to the recommendations may have the

potential to increase the quality of women's experiences.

6.7 Conclusion

This chapter presented the second main theme in this study. It analysed how a midwife balances the needs of the NHS organisation, outside of the birth environment when providing one-to-one support in labour. Chapter five showed how midwives in this study, mostly had autonomy and felt good about their care inside the birth environment. This chapter showed how in contrast, many midwives experienced reduced autonomy. They found themselves having to justify that they worked as hard as their midwifery colleagues in other wards or hospital sites; while also justifying the services of the midwife-led birth environments.

This chapter commenced by exploring how midwives experienced surveillance about their workload, clinical practices, documentation and birth and transfer rates outside the birth environment as part of their role to address the needs of the NHS organisations. Territorial behaviours were described and were more prevalent at case study site one. This was due to the close proximity of the AMU to the labour ward and other maternity wards. All case study sites experienced increased territorial behaviours however, when they accompanied women during transfer from the midwife-led birth environments to the labour ward. Overall, this study suggests that the centralisation of organisational systems appeared to increase surveillance and reduce the autonomy of midwives outside the birth environment.

Chapter seven now concludes this study and thesis.

Chapter seven

Conclusion

7.1 Introduction

Chapter seven is the final chapter and concludes this thesis. This chapter presents the impact of new knowledge derived from this study inside and outside of the midwife-led birth environments when midwives provide one-to-one support in labour. The chapter ends with recommendations for future clinical practice, research and education and a final summary.

7.2. Balancing the needs of the woman inside the birth environment

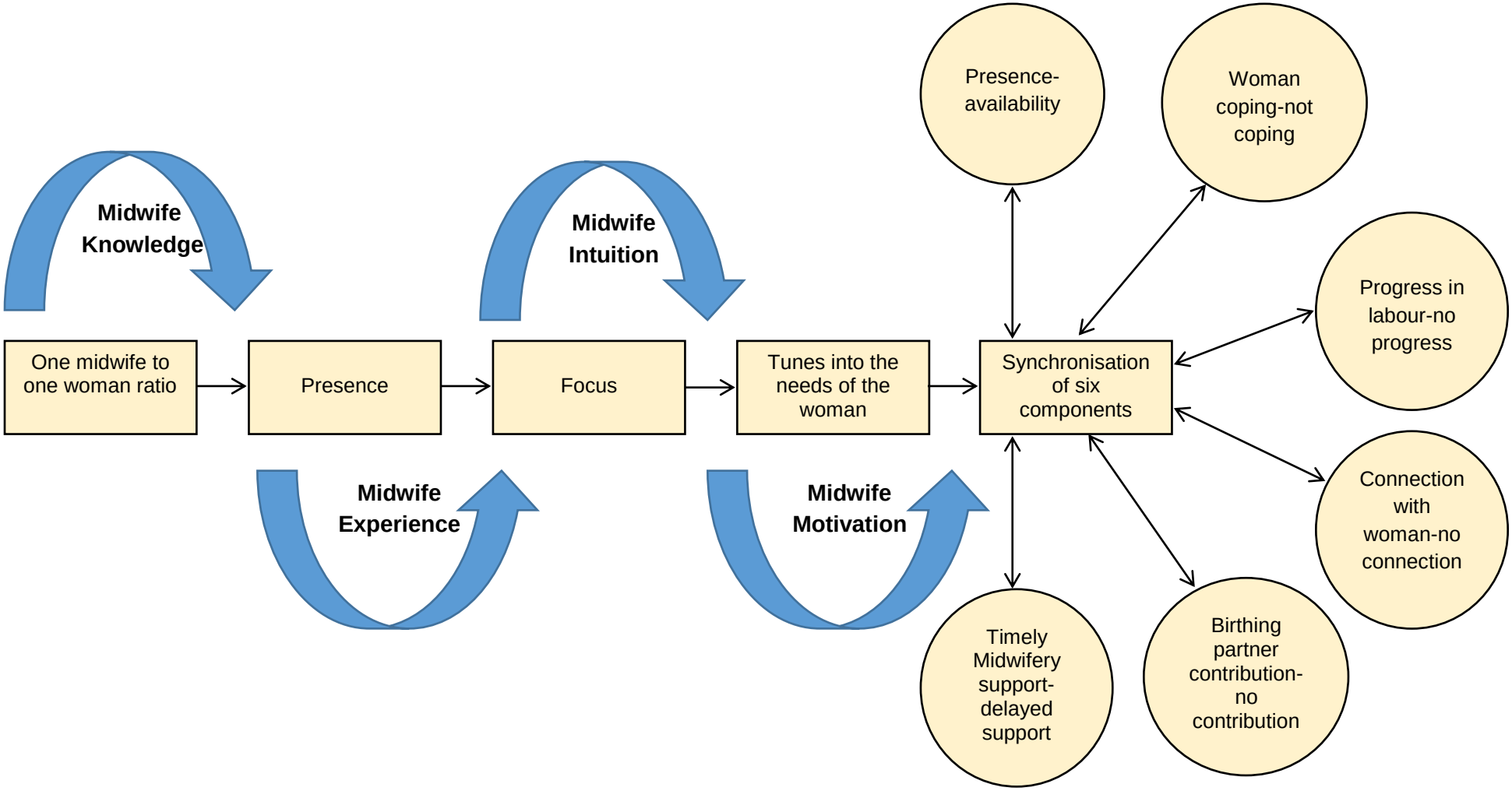
Overall this study demonstrated that midwifery one-to-one support in labour is more than a ratio, it is a balance. Midwives balanced the needs of a woman inside the birth environment while outside the birth environment they balanced the demands of the NHS organisation. Overall the needs of the organisation did not impact on the midwifery presence inside the birth environment.

7.2.1 The prerequisites of midwifery one-to-one support in labour

This study presents a theoretical framework (Figure 21) illustrating the essential prerequisites of midwifery one-to-one support in labour. The framework portrays a sequence of activities, intertwined with the skills of the midwife (Figure 21). This is the main contribution to new knowledge that this study offers.

Midwifery one-to-one support in labour started with a ratio of one midwife to one woman. The one-to-one ratio enabled midwives to be present with women inside the birth environment. The quality of the presence was essential. Presence was the ‘make or break,’ and the ‘alchemy’ of midwifery one-to-one support in labour. Midwifery presence had the capability to transform the atmosphere and activities that occurred inside the birth environment, to be more sensitive to the needs of women in labour. Without presence, midwives were less able to proceed to focus, tune into the needs of a woman and then synchronise six components (Figure 21). The six components included presence, midwife-woman relationship, coping strategies, labour progress, birthing partners and midwifery support.

Figure 21: A theoretical framework showing the prerequisites of midwifery one-to-one support



These activities could not produce care sensitive to a woman's needs, without the skills of midwives. Midwives working within midwife-led birth environments used minimal technological equipment. Midwives possessed only a device to measure the blood pressure and a portable handheld device, to listen to the baby's heartbeat. The main tools of the midwives were in fact, themselves. The midwives' skills included their knowledge, experience, intuition and motivation. These skills helped midwives gauge the needs of a woman in their care while proceeding through the sequence of activities included in the theoretical framework (figure 21) when providing midwifery one-to-one support. The information attained from synchronising the six components helped midwives make the decision when to start one-to-one support in labour, as some women required it before established labour. The process of synchronisation then continued until care was completed following birth.

7.2.2 The six components of midwifery one-to-one support in labour

Most of the six components are not new to midwifery literature, regarding support in labour. The way they are interconnected within a theoretical framework in this study however, offers new knowledge in relation to midwifery one-to-one support in labour.

7.2.2.1 Presence

Presence had two dimensions within the theoretical framework. The first was described in section 7.21. The second included presence as one of the six components which required synchronisation. Due to the one-to-one ratio midwives were 100% available to a woman in their care which enabled midwives to be present when required. Midwives synchronised presence and availability. When the correct balance was created women felt safe to focus inwards while receiving adequate privacy when needed.

The drawings completed inside the birth environment illustrated new insight as to how midwives synchronised their position in relation to a woman in labour. As labour progressed, midwives and women shared the same one metre space. The freedom experienced by women to determine the space they occupied inside the birth environment within the AMU and FMU, were very similar to that experienced inside the home environment. My findings also reinforced other studies relating to

how midwives used their presence to mediate an atmosphere, oscillating from subdued to interactive, depending on the needs of women.

This study also revealed new knowledge about how midwives synchronised their presence to balance their own capabilities. My findings showed that being constantly present was intense for midwives. Midwives readdressed the balance by becoming available, rather than present. This provided the opportunity to seek support from colleagues outside the birth environment. This strategy helped to keep midwives' clinical assessments and decision-making fresh and innovative.

7.2.2.2 The midwife-woman relationship

The midwife-woman relationship was one of the six components which required synchronisation. Midwives synchronised their involvement from professional friendship to detachment. If the synchronisation of all six components was sensitive to the needs of a woman, trust and equality increased within the midwife-woman relationship. Although professional relationships, trust and equality are not new to research relating to women in labour, their connection to the synchronisation process in this study to establish the midwife-woman relationship is a new contribution to existing knowledge.

Previous studies have recognised how midwives need to balance involvement and detachment concerning the midwife-woman relationship. This study provided new insight regarding the decision-making process when midwives stayed after their shift to provide continuity when birth was imminent. Midwives used the information ascertained from synchronising the six components, to make a decision whether they should stay or allow a 'fresh midwife' to take over. This study raises questions about whether it is safe to allow midwives to stay after their shift. Midwives often scrutinised their practice after staying. They also questioned whether they should have stayed as they were exhausted. The outcomes for women were good however regarding birth outcomes, emotional well-being and resilience. This leads to questions about whether midwives need support when making a decision to stay after their shift to ensure that they synchronise their well-being as well as that of the woman. In addition if midwives do stay, what supportive measures could be put into place? Alternatively, this study has shown that midwives appeared more relaxed leaving women at the end of the shift if the midwife taking over the shift was similar to themselves. This

meant they had a similar philosophy of care, skills and created similar atmospheres inside the birth environment. These findings also raised questions about whether a midwife can become too involved when providing one-to-one support in labour and what are the cues for a midwife becoming too involved.

My findings add new knowledge to the understanding of the intensity of the one-to-one relationship. Midwives in this study were emotionally hurt when things did not go to plan. This revelation poses questions about how midwives can be supported, when things do not go to plan. It must be considered however that although midwives in this study had insight that the one-to-one relationship could cause hurt, they would not change the midwife-woman relationship dynamics.

This study provided new insight regarding the motivation of midwives and women to invest energy into the midwife-woman relationship. This was particularly apparent when the relationship started when birth was imminent. After experiencing a good midwife-woman relationship however, some women in this study found it difficult for the relationship to end after their care in labour, or at the end of a shift.

Overall my findings affirm that the AMU, home environment and FMU were all conducive to relationship building.

7.2.2.3 The coping ability of women

Midwives providing one-to-one support in labour synchronised their care to help women cope in labour and birth. This study showed how all midwives used 'midwifery muttering (Leap 2010),' the environment and ways of working 'with pain' (Leap 2013) to reassure women and help their coping ability in labour and birth. When these methods were no longer effective, my study provides a new insight into how women attempted to readdress their coping abilities. This began with women seeking assurance from midwives that birth was imminent by requesting timelines. Midwifery muttering came naturally to midwives in this study, but the same could not be said about providing assurance to women. My findings indicate that midwives may need support when women seek assurance. Midwives who continued to provide reassurance with greater intensity were shown to be mostly successful. When midwives were pressurised to provide a calculated guess, they did not provide assurance to women as the answer was

never the one that women wanted to hear, which was that birth was definitely imminent.

I suggest that birth was imminent in most circumstances so the anxiety for assurance did not last long. For those women who did not receive assurance and labour persisted, they attempted to readdress their coping ability by asking for interventions to accelerate the labour such as ‘breaking their waters.’ This was a difficult situation for midwives because intrapartum guidance (NICE 2014) and midwife-led care philosophy do not advocate’ breaking the waters’ when labour is progressing.

This study provided new insight that some women believed the waters around the baby were stopping them from giving birth and this information had been based on previous births. The language used by midwives in my findings also showed how there is an insinuation by some midwives that once the ‘waters go’ birth will occur. This raises the awareness of how language can influence women’s perceptions and these perceptions are carried forward to future births.

Women had one more strategy identified in this study to readdress their coping ability which included inner resilience. Women ‘gave themselves a talking to’ which was particularly useful when stressful or/and unexpected situations arose. There is research regarding the resilience of midwives (Hunter and Warren 2014; Warren and Hunter) but very little information regarding women (Escott et al. (2004). This study adds new insight into how women ‘gave themselves a talking to’ as a way of synchronising their coping abilities to avoid outwardly panicking and calming themselves.

Lastly, this study affirms that women felt a sense of pride, strength and confidence when they felt they had coped with labour.

Overall this study suggests that midwives providing one-to-one support have the opportunity to tune into and re-synchronise care to help women’s coping abilities with the help of their colleagues when required.

7.2.2.4 Labour progress

My findings offer new insight about the progression from following the woman, to following the midwife in 'instructor mode.' Midwives at all three case study sites started with a trust to follow women's bodies when labour was deemed to be progressing normally. Instructions started when there were questions related to labour progress. Midwives' instructions started with an attempt to enhance the physiological labour process, but subsequently changed to a medicalised approach. The medicalised instructions included positions in labour and birth (e.g. lithotomy), directive pushing and the use of 'pet names'. The use of medicalised instructions is not new to research, but the reason for using them in this study provides new information. The 'instructor mode' was a last attempt by the midwife to readdress the balance of normality to avoid transfer to labour ward.

When the outcome was good, women were mostly grateful for the instructions. This study raised questions however, concerning women seeking instructions as it was very evident that they did not have faith in their ability to achieve a normal birth when following their body. Women conveyed a belief that they needed to be told what to do. In contrast, women who did not experience a good outcome reflected on their labour and birth and questioned whether they should have followed the instructions of the midwives. This study raises questions regarding the long-term impact for women experiencing poor outcomes, after following the midwives' instructions.

Lastly, I did not observe women at any of the three case study sites verbally convey concerns about the prospect of transfer in labour, until a risk was identified. As part of balancing normalcy against risk, transfer was on the minds of midwives when deviations from the normal were presented. My findings provided a new insight into how midwives continued to synchronise the six components with the help of their colleagues, to make a decision and prepare for a transfer to the labour ward.

7.2.2.5 Birthing partners

Most research regarding the role of birthing partners in labour have focused on the anxieties of birthing partners and their expectations of midwives. This study offers original knowledge in relation to birthing partners' contribution and the

factors that help and hinder their contribution when a midwife is providing one-to-one support in labour. The factors that influenced the support of birthing partners included previous labour support experience, place of birth, the type of support required, and the trust for the midwife and the need for rest. The comparisons between the AMU, home environment and FMU also provide new insight.

Partners supporting women at home were more confident than those at the AMU and FMU. The increased confidence may have also been connected to previous labour support experience, performing practical tasks and having the ability to be available at times, rather than constantly present with women in labour. All three factors were more likely to occur at home. Such insights, raise questions in terms of what can be learnt from partners supporting women at home, which could be transferred to the midwife-led unit.

As the AMU, home and FMU did not restrict the number of birthing partners, this study provides new information about how additional birthing partners took the onus away from women's partners. There was lots of laughter and chatter that women in early labour connected to and served as welcomed distractions. As the labour progressed however, the midwives led the focus to the one metre space and the atmosphere became much quieter and focused on the woman.

This study offered new knowledge about how couples think 'outside the box' to address their coping abilities. One couple pre-planned at the FMU that the partner would sleep until birth was imminent. This had a successful outcome for the couple. Another method utilised by women was priming their birthing partners from pregnancy to provide support that was sensitive to their needs in labour. This proved to be a successful technique when the birthing partners provided the support as planned and the labour and birth progressed normally.

In contrast, if partners did not provide the support as planned, because the labour did not progress normally and/or there were complications, this study questions the long term implications. Such circumstances were observed in this study when partners followed the instructions of the midwives rather than acting as an advocate for the woman as planned. There is much research concerning the trust between midwives and women, but this study asks what about partners and women and how could this impact on their relationship long term? De-briefs

may help couples talk through such experiences, so that blame isn't directed at the partner.

Lastly, this study offered new knowledge to suggest that birthing partners couldn't take the place of midwives. In the event that partners mimicked midwives, women expressed that they valued the reassurance from midwives more due to their professional knowledge.

Overall, this study shows partners can influence the synchronisation of the six components inside the birth environment, by collaborating with midwives when providing one-to-one support in labour.

7.2.2.6 Midwifery support

Research has acknowledged the importance of midwifery support (Kirkham 2010; Bedwell et al. 2015), but otherwise the literature is quite sparse in this area. The knowledge presented in this study provides new information about midwifery support. My findings indicated that midwives valued the support from midwifery colleagues. Midwifery support offered reassurance, re-energised midwives and helped determine the variations of normality and deviations from the normal.

Midwives at the AMU, when compared to the home environment and the FMU, appeared the most content regarding support from their midwifery colleagues. This study indicates that this was due to colleagues being consistently available, familiar, experienced, and shared similar philosophies of care. In contrast, the FMU was the least satisfied. This appeared to be connected to the midwifery support being provided by a large centralised on-call service. The on-call service incorporated large numbers of midwives, who covered large geographical areas. This was in contrast to the small scale working philosophy of the FMU.

The centralised on-call service created anxiety for the FMU midwives, because midwifery support was sometimes delayed, unfamiliar and inexperienced in relation to working in the FMU. Such uncertainties led some FMU midwives to change their practices. The first identified change included FMU midwives summoning midwifery support earlier then they would in their normal practice. Secondly, if midwives did not have staff that they trusted available they sought

verbal support from colleagues even when they were on their day-off. Thirdly, one FMU midwife changed her clinical practice, so that she felt more prepared if an emergency arose. The change in practice included taking the equipment required for a haemorrhage into a low-risk room at birth. This is not a normal working practice for low-risk care. This midwife however feared that midwifery support would not arrive on time therefore she wanted to be prepared in the event that she would manage a haemorrhage with minimal support.

This study also revealed that some on-call midwives acted as gatekeepers of midwifery support by requesting FMU midwives to perform a vaginal examination before they would consider attending as support. This made some FMU midwives feel bullied to perform invasive interventions so that they would receive midwifery support. The request for a vaginal examination also placed FMU midwives in conflict with their midwife-led care philosophy following and trusting women's bodies rather than intervening. This study could not provide conclusive evidence why the on-call midwives requested such demands. It was considered however that the on-call midwives had mostly worked a day shift and then were on-call for the night and expected to work the following day. The latter occurred unless the midwife worked a certain number of hours over the night. The findings from this study therefore considered whether the behaviour of the on-call midwife was a method of 'self-protection.'

This study suggested that sometimes the presence of midwifery support did not feel supportive. If there were two midwives within a birth environment, the autonomy of one was sometimes reduced. Such situations arose when staff stayed after their shift, but allowed the next midwife to take over, so that they could leave when they needed to. It was evident that two midwives in the birth environment could not synchronise the six components together.

Lastly, some midwives only felt support from having medical colleagues instantly available, as well as midwifery colleagues.

7.2.3 Reconceptualising midwifery one-to-one support in labour

Understanding the prerequisites of midwifery one-to-one support in labour helped to reconceptualise it. Although each labour was different there were three situations identified in this study in relation to reconceptualising midwifery one-to-one support in labour. These included achieving care that was sensitive to the

needs of women, women feeling anxious that they were alone in labour and women feeling disempowerment. The latter was connected to women following the midwives' instructions, rather than their bodies.

7.2.3.1 Synchronising care that is sensitive to the needs of a woman

When there was a ratio of one midwife to one woman, midwives could achieve presence, which allowed total focus for a woman in their care. This enabled them to tune into the needs of a woman. Balance inside the birth environment was achieved (Figure 22) when midwives were mostly present, but provided privacy when needed; the midwife-woman connection was equal and based on trust; the labour progressed normally; the woman was coping with the labour; the partner was also coping and working in collaboration with the midwives; and the midwifery support helped behind the scenes to energise and reassure midwives regarding the physiological process. Midwives had to have knowledge, experience, intuition and motivation to assess the changing situations of the labour as it played out and have insight into the potential needs of a woman in their care.

The processes of midwifery one-to-one support in labour could not guarantee that midwives always gauged every component correctly. Sometimes women needed to readdress the balance of a component or more for themselves. This was part of an equal midwife-woman relationship. When the synchronising of the six components was tuned into the needs of women, they were satisfied with their labour and birth experience even when it didn't go to plan.

7.2.3.2 One-to-many-ratio

When a ratio of one midwife to one woman was delayed, such as the FMU at case study site three, the synchronisation of balance inside the birth environment was more difficult to achieve (Figure 23). The one-to-many ratio meant that midwives were mostly available rather than present. However when present, it was a physical presence because the mind was thinking of the activities outside the birth environment, referred to as 'absently present' (Berg et al. 1996:13). This had a negative impact on midwives' ability to focus on a woman and tune into their needs.

Figure 22: Synchronising care that is sensitive to the needs of a woman

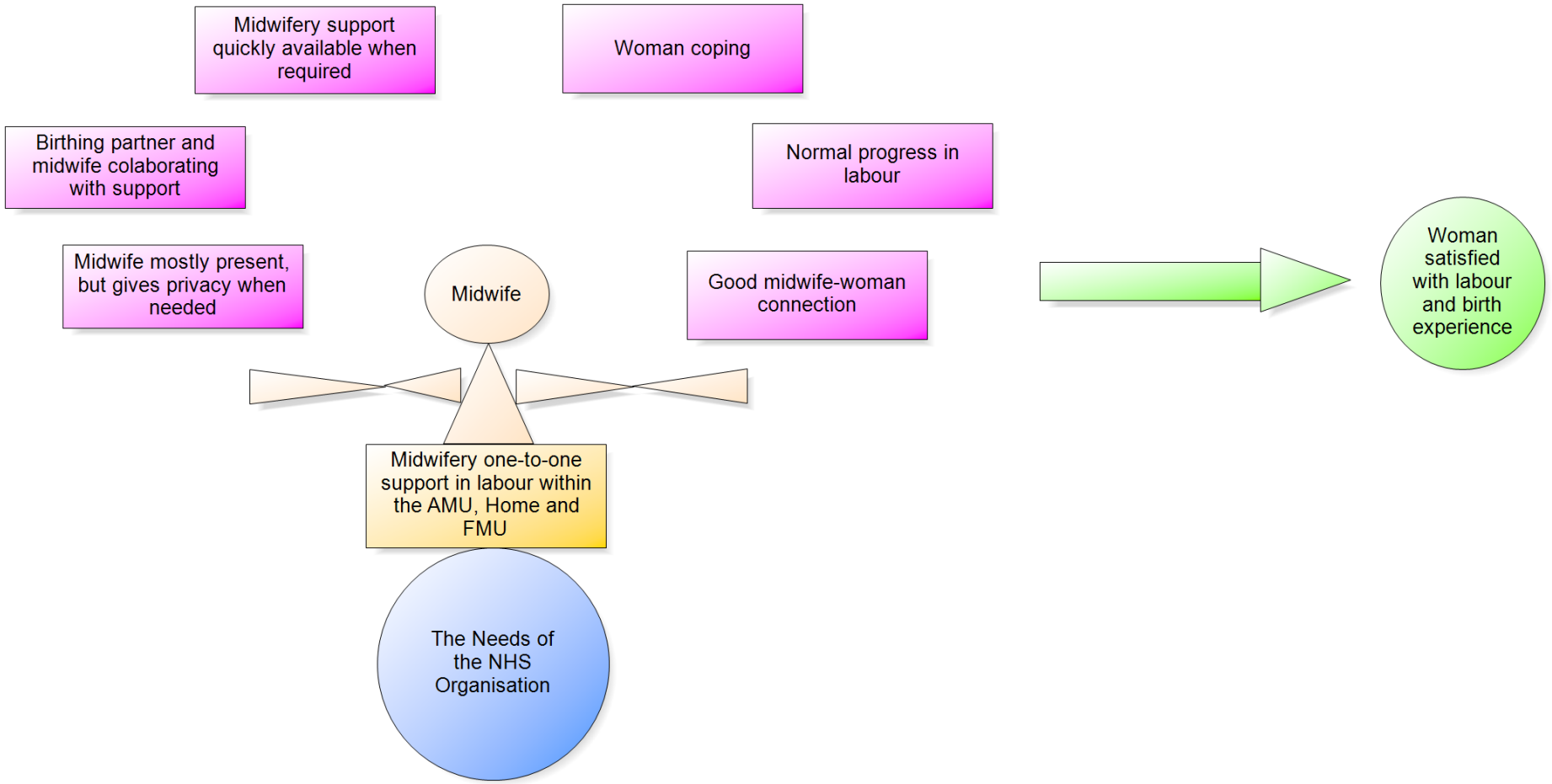
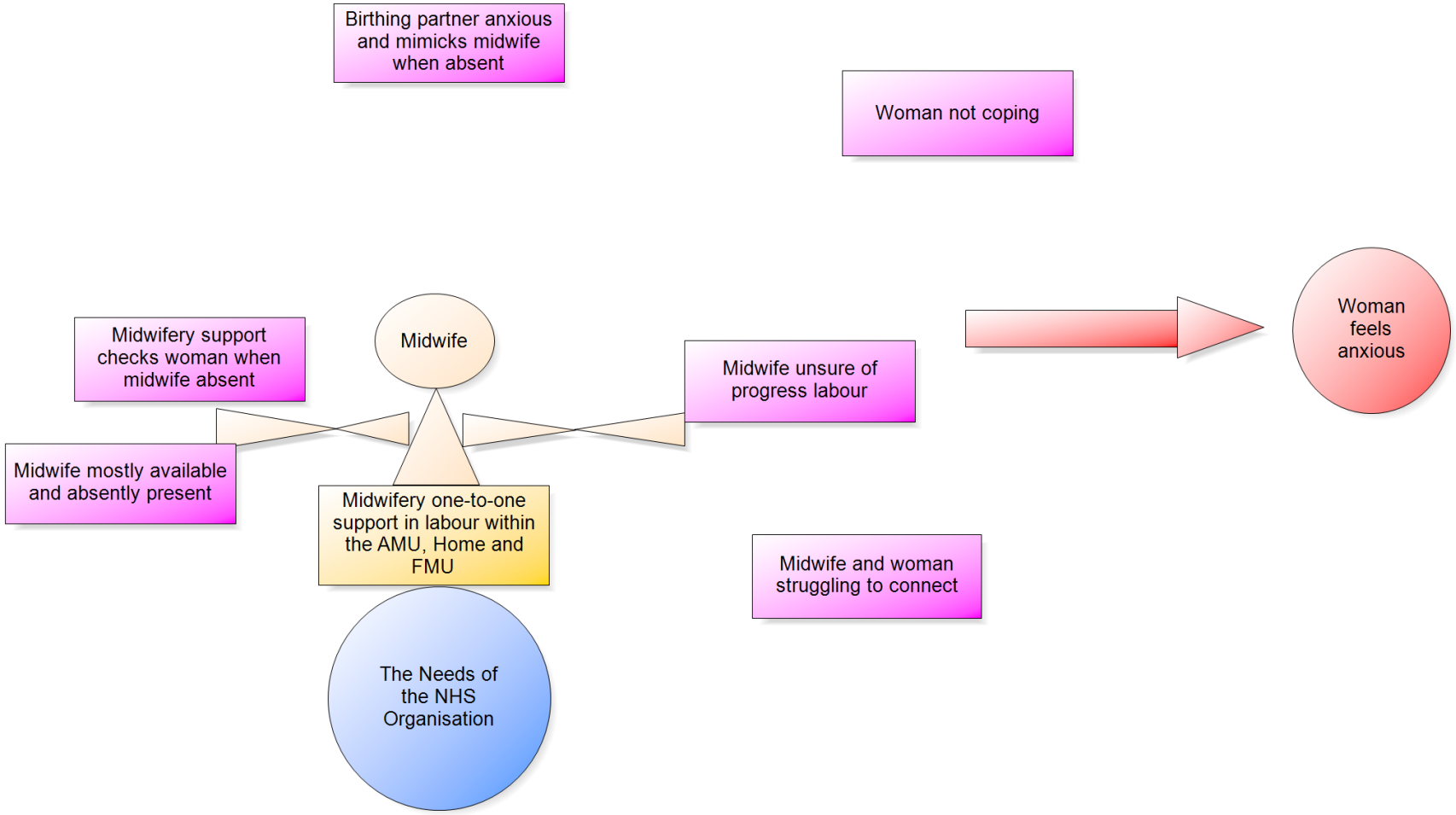


Figure 23: One-to-many ratio



The midwife-woman relationship struggled to connect due to the lack of midwifery presence and focus; it was also difficult to establish whether the labour was progressing; women and partners were more likely to become anxious, although partners often attempted to provide reassurance that they observed the midwives perform; continuity was disrupted as midwifery support helped undertake checks that the woman and baby required when their allocated midwife was not available. This situation made it very difficult to gauge the needs of women because the information obtained was fragmented. This made it challenging to synchronise the six components to meet the needs of women in labour.

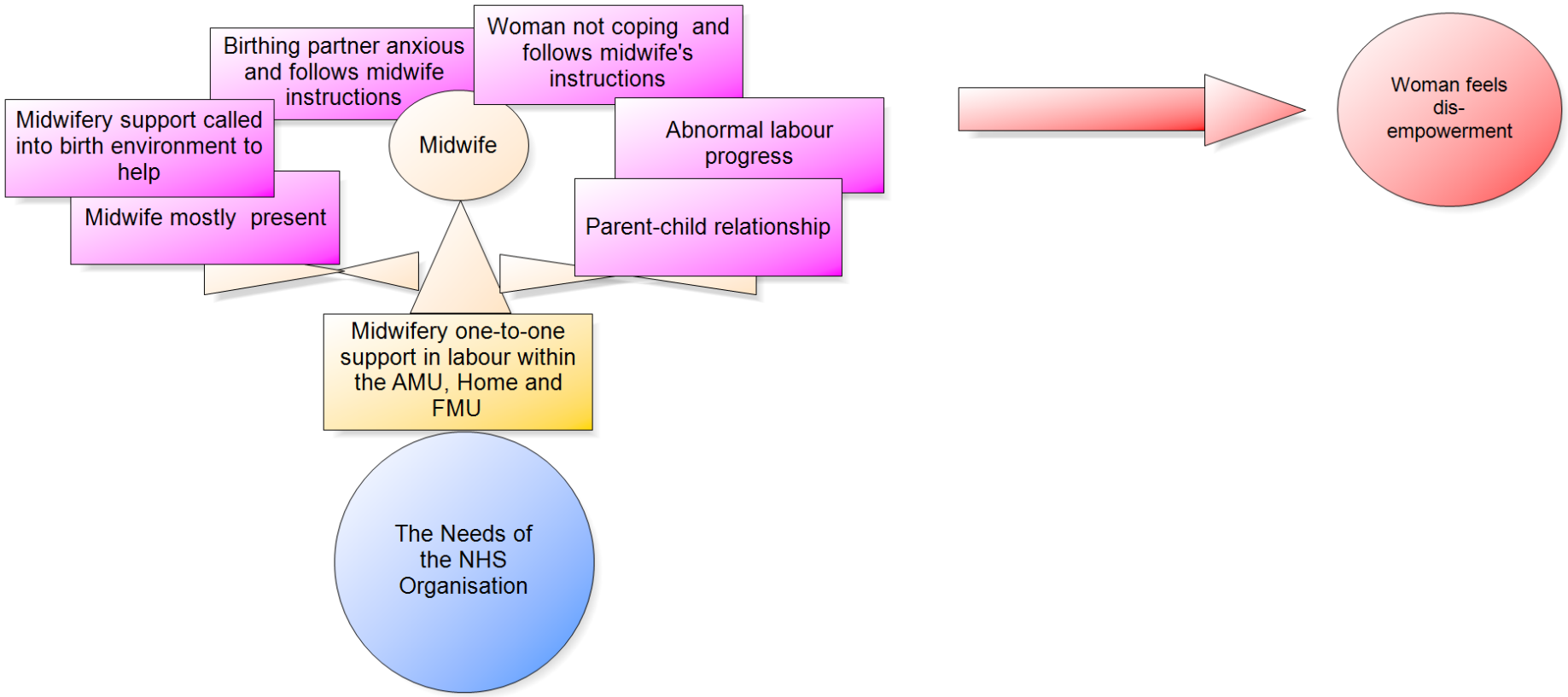
When midwives were absent from the birth environment, women found it difficult to readdress six components alone. If this situation was temporary, balance was still achievable if a one-to-one ratio was achieved providing presence of a midwife who had skills to assess and focus on the current situation. They would also need to start tuning in and synchronising the six components to reflect the needs of the woman. If the midwife remained mostly absent from the birth environment women felt anxious

7.2.3.3 Midwife using 'instructor mode'

The third situation observed in this study concerned progress in labour (Figure 24). In this situation, a ratio of one midwife to one woman was achieved from midwives with knowledge, experience, intuition and motivation to focus on a woman, tune into their needs and synchronise the balance inside the birth environment. The synchronisation was more difficult to achieve however, as the atmosphere inside the birth environment changed from listening and following the woman's body to listening to the midwife's instructions.

When midwives changed to 'instructor mode,' it was a last attempt to readdress the balance of labour progress to avoid transfer to the labour ward. Synchronisation of the six components was achieved when a woman and partner submitted and followed the midwife's instructions. In this situation, the midwife was mostly present and when not, they were consulting a colleague to seek advice. The midwife-woman relationship reflected that of a parent and child (Berne 1961, 1964). The birthing partner also took on the child role following the parental instructions of the midwife. The assessment of labour caused anxiety for the midwife, woman and birthing partner because there was an emphasis for the

Figure 24: Midwife using 'instructor mode'



birth to happen. This stemmed from a feeling of risk increasing, which then heightened the incentive to achieve a normal birth.

The balance was an ‘unsustainable exchange’ (B. Hunter 2006:316) and therefore couldn’t be maintained for a long period. This was due to the heaviness of increased midwifery responsibly, to take the lead for the six components and the feeling of risk associated with the wellbeing of the woman or/and baby. When women had a normal birth with no complications, they felt grateful for the midwifery instructions. However, when complications arose and things did not go to plan, women felt dis-empowered that they did not achieve the birth that they wanted.

7.2.4 Balancing the needs of the NHS organisation

7.2.4.1 Centralisation of maternity services

Each of the three case study sites were experiencing re-configurations which included centralisation of many maternity services. This study has contributed new knowledge about how the centralisation of maternity services impacts on midwives providing one-to-one support in labour, within midwife-led birth environments. In some situations, centralised services were observed to reduce the autonomy of midwives. Midwives in such situations relied on their managers and supervisor of midwives, to reassess and re-direct appropriate resources which in most circumstances were staff.

My findings revealed that the biggest impact of centralisation was in relation to fragmented antenatal care which reduced continuity and the probability that women knew the midwives in labour. In addition as previously discussed, the centralisation of on-call services at case study site three sometimes provided midwifery support that was delayed, unfamiliar and inexperienced in relation to working in the FMU. Lastly, FMU midwives at case study site three performed antenatal, postnatal clinics, group booking and parent craft classes in the FMU. This may have been a method to increase the viability of the FMU. Balancing other work activities ensured that if FMU midwives were not caring for women in labour, they were still contributing to the needs of the NHS organisation.

This study raised questions in relation to how maternity services can improve the amalgamation of centralised services and individualised care while also maintaining the autonomy of midwives.

7.2.4.2 Surveillance

Midwives practising one-to-one support in labour experienced a sense of being monitored that they were addressing the needs of the NHS organisation. Surveillance in this study implied that midwives were not trusted to offer their services to help other wards when free, check equipment or follow clinical guidelines.

Surveillance is not new to midwifery research because it has been recognised to occur inside and outside the birth environment (Reed 2013). This study however shows a different perspective, as it was unusual for surveillance to enter inside the birth environment at all three case study sites. My findings reinforced other studies that showed midwives protected the boundary of the birth environment. The midwives at the AMU at case study site one had growing concerns that surveillance may enter the birth environment in the future to ascertain details about the progress of labour and assessments of clinical decisions. Such concerns were instigated from an email stipulating that midwives needed to communicate what was happening inside the birth environments.

Surveillance occasionally entered the home environment by telephone in this study. Midwifery support attending as the second midwife at home births were conscious that if they took too long before returning to the labour ward, they were telephoned to attain a progress report. Overall however, this study reinforced that surveillance was less at home and within the FMU. Surveillance was increased at the AMU due to the close proximity to the labour ward and other maternity wards.

Three observations showing the transfer of women from the AMU to the labour ward revealed that surveillance entered the birth environment immediately on labour room. Initially this was required to provide the support and necessary interventions. Surveillance continued however even when the deviation from the

normal was resolved. Midwifery/medical support continued to enter inside the birth environment unannounced, often with no introductions with the intention to assess and monitor labour progress and clinical decisions. The labour ward culture did not appear to nurture privacy inside the birth environment and trust that the midwife would call for help, if needed. This study produced a new line of enquiry regarding transfers. The literature provides evidence about the feelings provoked during transfer to labour ward, but does not consider the cultural changes that are experienced by midwives and women. My findings provided an insight into the cultural differences between midwife-led environments and the labour ward.

This study builds on the work portraying anxiety about the viability of AMUs and FMUs as maternity services centralise. It was evident that midwife-led units providing one-to-one support in labour did not produce a high 'turnover.' This was partly due to women not being quickly transferred to the postnatal ward following birth. Midwives attempted to decrease their anxiety regarding statistical data about birth and transfer to the labour ward rates by using qualitative evidence. Such evidence included thank you cards, comment books and photos to show how women appreciated their services. The latter evidence I suggest was also an attempt by midwives to increase their autonomy to justify their midwife-led care services.

7.2.4.3 Territorial behaviours

Midwives providing one-to-one support in labour experienced territorial behaviours outside the birth environment. In particular, territorial behaviour was a very strong theme at case study site one within the AMU, due to the close proximity to the other maternity wards.

This study reinforced other ethnographic organisational studies showing territorial behaviours within AMUs (McCourt et al. 2011; McCourt et al. 2014) and FMUs (McCourt et al. 2011). This study also adds knowledge regarding territorial behaviours experienced by community midwives covering home births. The information about the latter was reduced however due to limited exposure to community midwives outside the birth environment.

Overall territorial behaviours created an ‘us and them’ culture. Midwives providing one-to-one support in labour felt good about themselves, with increased autonomy regarding their accomplishments inside the birth environment. Outside the birth environment, midwives felt judged by their colleagues from other maternity wards. They felt they were considered not to work as hard and less efficient, which reduced their feeling of autonomy. These fears were confirmed observing labour ward handovers. It is my suggestion that, such opinions were based on the fact that midwives in midwife-led care environments cared for one woman in labour. In contrast, midwives working on labour ward at case study site one, often discussed how they had to look after more than one woman in labour.

My findings indicated that handovers appeared to be core to communicating and reinforcing territorial behaviours. Questions are raised whether a cultural change is possible during handovers to respect midwives performing in all working areas. It could also be questioned whether such territorial behaviours are a good example for student midwives to witness when they are learning the midwifery culture, including communication.

My findings suggest that territorial behaviours included distrust. Midwives from the AMU and FMU felt that the community and hospital midwives did not promote the AMU and FMU services, which contributed to their reduced birth rate. Interestingly, community midwives still had the autonomy at case study site two to promote home births because they completed the antenatal care. Their challenges related to having adequate staff to release community midwives, particularly at night, to attend home births.

Overall territorial behaviours were experienced daily. Midwives at all three case study sites struggled to empathise with the working experiences of midwives in different wards and hospital sites. Midwives providing one-to-to one support in labour felt they not only had to justify their clinical activities, they also had to justify the midwife-led care services.

7.2.4.4 Documentation

There is little research regarding documentation practices in labour, therefore this study provides new insights into the culture of documentation within midwife-led birth environments, when midwives practise one-to-one support in labour.

Most midwives documented the events of their care inside the birth environments. As the labour progressed, midwives continued to document, while staying within the one metre space with women. Although midwives expressed concern about the quantity of documentation and writing in front of women, most women in this study were not aware of midwives documenting. Observations inside the birth environment revealed that although midwives wrote their notes in close proximity to women, they ensured that women came first. Women verified that when they needed the midwife, they had their full attention. This knowledge may reassure midwives and increase their confidence to balance documentation and support for women inside the birth environment. This may then reduce the incidence and risk of writing retrospective records following the birth.

Midwives in this study were very anxious about their documentation being scrutinised particularly when there had been a poor outcome. This appeared to be a major motivator for midwives in this study to complete comprehensive records.

Lastly, this study raised questions as to why midwives at the AMU were less likely to complete a partogram. I suggest it may reflect a wider debate within midwife-led care concerning the relevance of partograms for low-risk women in labour (Osbourne and Lavender 2005).

7.2.4.5 Transfers to labour ward

Transfers were not regarded to be connected to midwifery one-to-one support in labour when completing the literature review. During fieldwork however, I changed my stance, as I observed that transfers were on the minds of midwives when there were deviations from the normal inside the birth environment. In addition midwives as well as women appeared emotionally hurt when things did not go to plan. Lastly, the organisational systems determined whether midwives

could transfer with women and whether they could stay on labour ward and continue the care.

This study reinforced previous research that when the decision was made for transfer many midwives from all three case study sites experienced anxiety. My findings indicated that the anxiety was not only connected to the well-being of the women and babies. Midwives were also apprehensive about their clinical practices being scrutinised on labour ward. This study reinforced current research that midwives rehearsed possible lines of questioning that they would receive from labour ward staff. Sometimes the rehearsals were completed with the help of their midwifery colleagues. This preparation included justifications concerning their labour care. Questions were raised from these findings concerning how midwives can be supported so that they feel less anxious about transfers to labour ward.

The FMU midwives also had to risk assess each transfer situation as to whether they could escort a woman to labour ward. The risk assessment included whether the on-call midwife was competent to manage the FMU.

This study reinforced the disappointment and anxiety that women experienced when transfer was instigated. My findings go further however as they suggested four specific innovations that helped women cope with the transition to labour ward care. These innovations included continuity of the midwife continuing the care on labour ward, having a room to themselves on labour ward with their baby and partner, not being separated from their baby for long periods of time and that all staff introduced themselves. The separation of women from their babies had the most negative impact. Women were still grieving for the time lost with their babies at the interviews a few weeks following birth. This raises questions to the long-term effects of such experiences and whether it impacts on women's relationships with their baby and partner.

Midwives may find it helpful to know that when they stayed with women on the labour ward and continued their care, women noticed and appreciated their dedication and energy to their care. This impacted positively on women's overall

experience of transfer to the labour ward and appeared to build upon their inner resilience.

7.3 The strengths of the study

7.3.1 The methodology

This study is the first ethnographic research to explore midwifery one-to-one support in labour. The methodology and methods were the main strengths of this study. The findings provided the first insight regarding midwifery one-to-one support in labour, using observations inside and outside the birth environment, interviews and documentation analysis. The combination enabled observations of the front stage and back stage performances (Goffman 1990). The importance of completing observations and interviews was explicitly apparent in relation to transfers to the labour ward at case study site one. AMU midwives explained in the interviews, that they mostly transferred with women to the labour ward and continued the care until the end of their shift. Although the observations reinforced this situation, the off stage (Goffman 1990) observations also highlighted, that midwives didn't always want to go with the women to the labour ward. This appeared to be connected to the 'us and them' culture within the NHS organisation.

Using elements of symbolic interactionism helped me understand the importance of social interactions, when analysing culture. One example of this process was when midwives were observed rehearsing for their future performance, to justify their clinical care on the labour ward. Using the mantra I described in chapter two (Section 3.2.2.3), I analysed how midwives felt about their practices inside the birth environment. I also looked at how their perception changed when they viewed their clinical decisions through the analytical lens of the medical model, used by the labour ward staff. I subsequently obtained information about the transfer of care on the labour ward and how the labour ward perceived midwives working on the AMU. Overall, this helped me understand the territorial behaviours presented in this thesis.

Lastly, symbolic interactionism helped me identify how labour played out under different circumstances, depending on the individuals involved, place, time, other

activities occurring, and progress in labour. This helped me to understand the unfolding of events of all six components on a continuum.

7.3.2 Multiple case study sites

Using three case study sites offered a comparative analysis of three types of midwife-led care birth environments. Such comparisons provided evidence of transferability of these findings. The findings demonstrated that the atmosphere created and the activities performed by midwives inside the birth environments were similar within all three case study sites. The variations occurred outside the birth environment, due to the different organisational structures and systems.

7.4 The limitations of the study

The limitations were previously discussed in section 3.3.10, but the following presents a brief discussion in relation to interpreting the findings.

7.4.1 Transferability

It should be considered that the AMU at case study site one might not be typical of other AMU's. The AMU at case study site one never admitted high-risk women. In addition the midwifery support was mostly provided by AMU midwives. In contrast, evidence from case study site two and the research by McCourt et al. (2011) indicated that the labour rooms on midwife-led units were used for high-risk women when labour ward was at full capacity. In addition at case study site two community midwives covering the midwife-led unit often relied on labour ward staff as their midwifery support.

7.4.2 No observations outside the birth environment at case study site two

The limitations associated with no observations outside the birth environment at case study site two were previously presented in section 3.3.10.4. Having presented the findings however it is more evident when comparing the three case study sites that the data is missing. In hindsight focus groups with the community midwives at case study site two may have helped to further explore the themes that emerged from the interviews regarding organisational issues. This may have provided more comparative data.

7.4.3 Transfers to labour ward

I only observed transfers from the AMU to labour ward at case study site one. The logistics there made it more achievable. More insight and comparative analysis would have been achieved however observing transfers at case study site two and three.

7.5 Recommendations for future clinical practice

7.5.1 Midwifery presence inside the birth environment

Maternity services need to encourage a culture where midwifery presence inside the birth environment is the norm and valued. This study provided unequivocal evidence that following a one midwife to one woman ratio, midwifery presence is the most important attribute within midwifery one-to-one support in labour. Presence has the potential to allow midwives to use their midwifery skills more effectively and help women feel safe.

7.5.2 Accessible midwifery support

Access to midwifery support reduces midwives' anxieties, provided it is available within thirty minutes, familiar, and they have experience working with a midwife-led philosophy within a midwife-led birth environment.

Although one midwife is allocated to one woman, it is evident from this study that it takes more than one midwife to care for a woman in labour. Access to colleagues was very important to midwives practising one-to-one support in labour because they were the only one inside the birth environment. Midwifery support helped midwives to address uncertainties about variations of normality and deviations from the normal. In addition, they re-energised midwives. The value of these attributes were particularly evident when midwives were in the birth environment for many hours, when the second midwife was required for the birth, when midwives changed to 'instructor mode' and when transfer was required.

This study has highlighted the anxieties of midwives experiencing the consequences of centralising midwifery support. Although solutions are not offered, it is important to acknowledge nonetheless.

7.5.3 Improving the experience of transfer to labour ward

The experience of women in relation to transfer to the labour ward, have been extensively explored in this chapter, but to summarise, there are four recommendations for practice:

1. Midwives providing one-to-one support in labour should accompany women to the labour ward
2. Women should not be separated from their babies. If separation is required, the time interval should be as short as possible.
3. Privacy should be provided within the labour rooms for women, their babies and partners to bond and readjust to their new situations in-between treatments required
4. All staff should introduce themselves

In relation to the first recommendation, women valued their midwives staying with them and continuing their care on the labour ward. It is important to note that the latter three recommendations could be completed without incurring additional financial costs. Overall, when all four recommendations were completed, this study suggests that women experienced a more positive experience. Their reflections revolved around the time with their baby and the relationship with their midwife, rather than procedures and/or surgery performed. I suggest that such an experience increases women's resilience.

This study also brought up a clinical practice question about why babies and partners could not accompany women into the maternity theatre, when surgical repairs were completed. When a caesarean section or instrumental birth is completed, the partner and baby are often next to the woman. Why is it different for women transferred specifically for perineal repair, when a general anaesthetic is not used? This is an important issue to consider because women in this study who were separated from their babies for long periods of time, felt a sense of loss for a time they will never be able to get back with their babies. The long-term consequences of this sense of loss could not be identified in this study but warrants further exploration.

7.5.4 The 'labouring couple'

Birthing partners were included as one of the six components in this study as their contribution had an impact on the other five components inside the birth environment. Although this study did not specifically aim to interview birthing partners, some did contribute to interviews with women and this helped contextualise some of the observations completed inside the birth environments, at all three case study sites.

Midwives providing one-to-one support should collaborate with partners if possible, so that their knowledge about women can be used to help synchronise the six components. When partners have previous labour supporting experience, this too should be utilised. In addition, my findings suggest that more than one birthing partner is beneficial for women in labour and it takes the onus from partners. Partners are then freer to be available to women in early labour, rather than continually present. This appeared to re-energise partners. In addition, midwives and women should assess if birthing partners, particularly partners, would prefer to complete practical tasks as part of their supportive role. Practical tasks helped some partners experience a sense of achievement in their supporting role.

My findings also revealed that women think 'outside the box' prior to labour, by priming their birthing partners to provide support that is sensitive to their needs. Due to the success of this method, I suggest that pregnant women should be supported to have such conversations with their birthing partners. The knowledge of such priming also helps midwives synchronise the six components.

7.5.5 Documentation

Midwives should be reassured to complete their documentation in the birthing environment, even when sharing the one metre space with women. Women are not aware of midwives documenting, unless it takes their attention away from women.

7.6 Recommendations for future research

7.6.1 Comparative studies

Now having completed my research, I would like to replicate my study including women who cannot speak English. It would be informative to explore the activities inside the birth environment. It would be relevant to clinical practice, to learn if there would be any additional components for midwives to synchronise, such as including an interpreter.

7.6.2 Exploration of midwifery support

This study has shown how important accessible midwifery support is to midwives and warrants further exploration due to the benefits. Midwives at case study site one utilised their midwifery colleagues to re-energise, seek advice, reflect and plan for transfer. Questions are raised as to whether the attributes of the midwifery support could be replicated using action research in another site, where they are planning to start a midwifery one-to-one support in labour service. This may have the potential to create a supportive culture from day one.

7.6.3 'Instructor mode'

This study revealed how midwives changed to 'instructor mode' as a last attempt to readdress the balance to achieve a normal birth and avoid transfer to the labour ward. More information is needed about the progression of events that lead midwives to become instructors when caring for low-risk women. Most of the instructions observed in this study reflected that of the medical model of care. Questions are raised as to why midwives revert to using medicalised practices as part of their instructions. It would be helpful to investigate whether there are any other options available to midwives when they reach a point that they feel they need to readdress the balance to achieve a normal birth and avoid transfer to the hospital. I suggest, from my findings utilising midwifery colleagues for a second opinion to reassess the situation.

7.6.4 Investigating surveillance and territorial behaviours

More knowledge is required regarding surveillance and territorial behaviours, to help find out if there are ways that maternity health professionals can work as an integrated team within NHS organisations. Surveillance and territorial behaviours

were observed as part of the working culture at all three case study sites, but they were more prevalent at the AMU due to the close proximity to the other maternity wards. There has been a significant increase in the opening of new alongside midwife-led units (McCourt et al. 2011) so the timing would be relevant for the present day maternity services. Such research should include women, maternity health professionals and management. The inclusion of women is important as this study showed that they sensed tensions between health professionals within different maternity wards.

7.6.5 Investigate how women build resilience

This study has shown that some women found an inner resilience when they found themselves in a stressful situation in terms of coping in labour, emergency treatments and/or transfer to labour ward. Women reported giving themselves a talking to when events had not gone to plan. More understanding about how women build resilience could help support this process and whether it incorporated positive long-term and short-term effects. In addition this study raised questions about how women coped long-term, when they felt initially that they did not get the birth that they wanted.

7.6.6 Alone in labour

None of the women in this study felt that they needed more presence. I observed women being alone for short periods at the FMU until the midwifery support arrived, allowing a one-to-one ratio. Even in these incidences, midwives synchronised the six components and if they felt the women in labour needed them, midwives delayed the antenatal clinics. These midwives had the autonomy to make this decision. This aspect raised questions for me, in relation to working cultures, where midwives do not have the autonomy to stop one source of work. In particular, working cultures where midwives care for more than one woman in labour. More information is needed about the consequences for women being left alone in labour. In addition, what coping strategies do these women use when they are alone?

7.6.7 One-to-many ratio

Midwives shared previous experiences of working within cultures practising the one-to-many ratio. This study didn't observe this phenomenon, but questions were raised. Not enough is known about the consequences for midwives looking after more than one woman in labour. Again, what are the coping strategies used by midwives working in such cultures?

7.6.8 The long-term consequences of the partner-woman relationship

A small number of women in this study described how their partners didn't act as an advocate in labour as planned. The observations and interviews suggest that this was due to the partners feeling anxious, which made them follow the instructions of the midwife. Questions are raised from this study about the long-term consequences for the relationship between a woman and her partner, when a partner has been identified by the woman as failing to act as her advocate in labour.

7.7 Recommendations for future midwifery education

This study reinforced that midwifery one-to-one support in labour is not instinctive; rather it is a set of skills that need to be mastered (Hodnett 1996). There needs to be a cultural change to acknowledge that the midwifery skills required to provide one-to-one support in labour, are as important as the training for emergency situations (Birthrights Dignity in Childbirth 2013) and the use of high-tech equipment such as continuous fetal monitoring (Kardong-Edgren 2001).

I suggest that the theoretical framework (Figure 21) presented in this thesis, illustrating the essential prerequisites of midwifery one-to-one support in labour, could be added to the educational curriculum for student midwives concerning normality. The six components are currently part of the curriculum, but my research offers a new theoretical framework. The theoretical framework would be a useful guide, particularly for student midwives new to the birth environment.

Student midwives need to also work within midwife-led birth environments with midwives, who have skills for caring for low-risk women in labour. As part of using the theoretical framework, student midwives need to develop confidence

developing relationships with women. The literature review previously revealed that when student midwives were exposed to supporting women one-to-one in labour, they developed supportive and relationship developing skills which gave them confidence to stay present inside the birth environment (Thorstensson et al. 2008). Qualified midwives also need such training as this study has shown that not all midwives were confident using a midwife-led philosophy of care or/and working inside midwife-led birth environments. The theoretical framework presented in this thesis may stimulate discussions within birth environments and create more awareness of the skills of midwives caring for women one-to-one, within midwife-led birth environments.

7.8 Final summary

This study is the first to specifically explore midwifery one-to-one support in labour, using an ethnographic approach. The ethnographic approach generated original knowledge in relation to the activities that occurred inside and outside the midwife-led birth environments .The knowledge ascertained identified prerequisites of midwifery one-to-one support in labour, made possible by the working culture and skills of the midwives at the AMU, FMU and home settings in this study. The information was also used to reconceptualise midwifery one-to-one support in labour. Three situations were presented which involved midwives synchronising the six components. These included when the needs of the women were met, when a one-to-many ratio was encountered and when midwives changed to instructor mode.

The knowledge described in this thesis has the potential to improve the understanding of the working culture and midwifery skills performed when caring for low-risk women, when there is a ratio of one midwife to one woman. This study found that the main tool of the midwives was in fact, themselves. Utilising the prerequisites of midwifery one-to-one support in labour, midwives formed relationships with women, while gauging their presence, how women coped in labour, the progress of labour, the contribution of the birthing partners and the requirement for midwife colleagues.

I hope the knowledge from this study can be used to help inform government policies, education and research regarding midwifery one-to-one support in labour. I also hope it allays any concerns (Scott et al. 1999; Hodnett et al. 2002; 2013) that midwives are not the most effective providers of one-to-one support in labour. This study has shown that when a ratio of one midwife to one woman is normal practice for all women and presence is valued within the working culture, a midwife inside the birth environment can provide total focus for a woman in labour.

Now that this thesis is written, I find my work is still incomplete. My next objective is to compose a two page summary, including the findings which will be shared with all participants of this study and presented at all three case study sites. Finally, I aim to write a publication regarding the prerequisites of midwifery one-to-one support in labour and a second concerning the changing discourse, commencing from following a woman's body to following the midwife's instructions.

References

Adams, E. and Bianchi A. (2008) 'A practical approach to labor support', *Journal of Obstetrics, Gynaecology, and Neonatal Nursing,* 37: 106-115.

Adler P. A and Alder P. (1987) *Membership roles in field research*. London: Sage Publications.

All Wales Clinical Pathway for Normal Labour. (2004) *Active Labour Pathway*. [Online] Available at: http://www.wales.nhs.uk/sites3/page.cfm?orgid=327andpid=5786 (Accessed: 30/04/15).

Al-Mandeel, H., Almufleh, A., et al. (2013) 'Saudi women's acceptance and attitudes towards companion support during labor: Should we implement an antenatal awareness program?' *Annals of Saudi Medicine,* 33 (1): 28-33.

Allan, K. (2007) *The social lens: An invitation to social and sociological theory*. London: Sage publications.

Allen, D. (2004) 'Feature Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings', *Nursing Inquiry,* 11 (1): 14-24.

Allen, M. and Thornton, S. (2012) 'Providing one-to-one care in labour. Analysis of 'Birthrate Plus' labour ward staffing in real and simulated labour ward environments', *BJOG: An International Journal of Obstetrics and Gynaecology,* 120 (1): 100-107.

Amram, N., Klein, M., Mok, H., Simkin, P., et al. (2013) 'How Birth Doulas Help Clients Adapt to Changes in Circumstances, Clinical Care, and Client Preferences during Labor', *The Journal of Perinatal Education*, 23 (2): 96-103.

Amorim M and Katz L. (2012) *Continuous support for women during childbirth: RHL commentary* (last revised: 1 May 2012) The WHO Reproductive Health Library; Geneva: World Health Organisation. Available at: http://apps.who.int/rhl/pregnancy_childbirth/childbirth/routine_care/cd0003766_amorimm_com/en/index.html (Accessed: 10/07/15).

Andersson, O. (2014) 'William Foote Whyte, Street Corner Society and Social Organisation', *Journal of the History of the Behavioral Sciences*, 50 (1): 79-103.

Anderson, T. (2010) 'Feeling Safe Enough to let go: The Relationship between a Woman and her Midwife during the second Stage of Labour (Chapter 7)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 116-143.

Anderson, T. (2002) 'Peeling back the layers: a new look at midwifery interventions', *MIDIRS Midwifery Digest,* June. 12 (2): 207-210.

Ashcroft, B., Elstein, M., et al. (2003) 'Prospective semi-structured observational study to identify risk attributable to staff deployment, training, and updating opportunities for midwives', *BMJ,* 327: 1-4.

Aune, I., Amundsen. H.H. and Skaget. L.C. (2013) 'Is a midwife's continuous presence during childbirth a matter of course? Midwives' experiences and thoughts about factors that may influence their continuous support of women during labour', *Midwifery, 30 (1): 89-95.* [Online] Available at: *http://www.sciencedirect.com/science/article/pii/S0266613813000545* (Accessed: 29/04/15).

Aune, I., Dahlberg, U., Ingebrigsten, O. and Art, M. (2011) 'Parents' experiences of midwifery students providing continuity of care', *Midwifery,* 28 (4):432-438 [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613811000854 (Accessed: 29/04/15).

Ayers, S., McKenzie-McHarg, K. and Slade, P. (2015) 'Post-traumatic stress disorder after birth', *Journal of Reproductive and Infant Psychology*, 33 (3): 215-218.

Bäckström, C. and Wahn, E. (2011) 'Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child', *Midwifery,* 27 (1): 67-73.

Bainbridge, J. (2010) 'Doulas: supportive, calm birth partners or obstructive to clinicians?' *British Journal of Midwifery,* 18 (2): 57.

Bailey, S., Wilson, G. and Yoong, W. (2015) 'What factors affect documentation by midwives? A prospective study assessing relationship between length of shift, workload and quality of note keeping', *Midwifery,* 31 (8): 787-792.

Bakhta, Y and Lee, R. (2010) 'A survey of Russian women regarding the presence of a companion during labour', *International Journal of Gynecology and Obstetrics,* June 109 (3): 201-203.

Ball, J. and Washbrook, M. (2010a) 'Workforce planning in midwifery: an overview of 8 years', *British Journal of Midwifery*, 18 (8) 527-532.

Ball, J. and Washbrook, M. (2010b) 'Developing a real-time assessment of staffing needs in delivery suites', *British Journal of Midwifery,* 18 (12): 780-785.

Ball, J. and Washbrook, M. (2003) *Birthrate Plus: A Framework for Workforce Planning and decision making for Maternity Services*. Edinburgh: Books for Midwives Press.

Ball, J., Bennett, B., Washbrook, M. and Webster, F. (2003a) 'Birthrate Plus programme: a basis for staffing standards?*' British Journal of Midwifery*, 11 (5), 264-266.

Ball, J., Bennett, B., Washbrook, M. and Webster, F. (2003b) 'Factors affecting staffing ratios', *British Journal of Midwifery*, 11 (7): 357-361.

Ball, J., Bennett, B., Washbrook, M. and Webster, F. (2003c) 'Further issues in deciding staffing needs', *British Journal of Midwifery,* 11 (7): 416-419

Beach, J. and Oates J. (2014) 'Maintaining best practice in record-keeping and documentation', *Nursing Standard,* 28 (36): 45-50.

Bedwell, C., McGowan, L. and Lavender, T. (2015) 'Factors affecting midwive's confidence in intrapartum care: A phenomenological study', *Midwifery,* 31 (1): 170-176.

Beech, B. (2006) At Last - An NMC Home Birth Circular. *AIMS Journal,* 18 (1): [Online] Available at: http://www.aims.org.uk/Journal/Vol18No1/NMCHomebirthCircular.htm (Accessed: 29/04/15).

Begley, C., Devane D. and Clarke, M. (2009) *An evaluation of midwifery-led care in the Health Service Executive North Eastern Area.* Dublin: University of Dublin Trinity College Dublin- School of Nursing and Midwifery.

Berg, M., Lundgren, I. and Wahlberg, V. (1996) 'Women's experience of the encounter with the midwife during childbirth', *Midwifery,* 12 (1): 11-15.

Bergstrom, L., Richards, L., Morse, J.M. and Roberts, J. (2010) 'How Caregivers Manage Pain and Distress in Second-Stage Labor', *Journal of Midwifery and Women's Health,* 55 (1): 38-45.

Berne, E. (1961) *Transactional analysis in psychotherapy*. New York: Grove Press.

Berne, E. (1964) *Games people play*. New York: Grove Press.

Bernitz, S., R. Rolland, Blix, E., Jacobsen, M. et al. (2011) 'Is the operative delivery rate in low-risk women dependent on the level of birth care? A randomised controlled trial', *BJOG: An International Journal of Obstetrics and Gynaecology,* 118 (11): 1357-1364.

Bianchi, A.L. and Adams, E. (2009) 'Labour support during second stage labor for women with epidurals', *Nursing for Women's Health*, 13 (1) February/March: 39-47.

Bick, D., Rycroft-Malone, J. and Fontenla, M. (2009) 'A case study evaluation of implementation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences', *Bio Med Central Pregnancy and Childbirth,* 9:1-12. [Online] Available at: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-9-47 (Accessed: 10/07/15).

Birth Choice UK (2014) *Graphs showing trends in caesarean rates*. Available at: http://www.birthchoiceuk.com/Professionals/BirthChoiceUKFrame.htm?http://www.birthchoiceuk.com/Professionals/CSHistory.htm (Accessed: 10/07/15).

Birthplace in England Collaborative Group. (2011a) 'Perinatal and maternal outcomes by planned place of birth for healthy women with low-risk pregnancies: the Birthplace in England national prospective cohort study', *BMJ,* 343. [Online] Available at: http://www.bmj.com/content/343/bmj.d7400?tab=full (Accessed: 06/06/15).

Birthplace in England Collaborative Group. (2011b) *The Birthplace in England Research Programme: Background Q and A*. [Online] Available at: https://www.npeu.ox.ac.uk/birthplace (Accessed: 06/06/15).

Birthrights Dignity in Childbirth Forum. (2013) Dignity in Childbirth: The Dignity Survey 2013: Women's and Midwives' experience of UK maternity services. London: Birthrights 2013. [Online] Available at:

http://www.birthrights.org.uk/wordpress/wp-content/uploads/2013/10/Birthrights-Dignity-Survey.pdf (Accessed: 06/06/15).

Blaaka, G. and Schauer Eri, T. (2008) 'Doing midwifery between different belief systems', *Midwifery,* 24: 344-352.

Blix, E., Kumle, M., Oian, P. and Lindgren, H.E. (2014) 'Transfer to hospital in planned home births: a systematic review', *BMC Pregnancy and Childbirth,* 14. [Online] Available at: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-179 (Accessed: 06/06/15).

Bloor, M. (2010) 'The Ethnography of health and medicine (Chapter 12)', in Atkinson, P., Coffey, A., Delamont, S., Lofland J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage publications: 177-187.

Bluff, R. and Holloway, I. (1994) 'They Know Best: Women Perceptions of midwifery care During Labour and Childbirth', *Midwifery,* 10 (3):157-164. [Online] Available at: http://www.sciencedirect.com/science/article/pii/0266613894900469 (Accessed: 06/06/15).

Blumer, H. (1986) *Symbolic Interactionism: Perspective and Method.* London University California press.

Bonner, A. and Tolhurst, G. (2002) 'Insider-outsider perspectives of participant observation', *Nurse Researcher,* 9 (4): 7-19.

Borbasi, S., D. Jackson, D. and Wilkes, L. (2005) 'Fieldwork in nursing research: positionality, practicalities and predicaments', *Journal of Advanced Nursing,* 51 (5): 493-501.

Braun, V., and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology, 3*:77-101. [Online] Available at:

http://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa (Accessed: 30/04/15).

Brink, P.J. (1991) Issues of reliability and validity (chapter 10), in Morse, J.M. (ed.) *Qualitative nursing research: A contemporary dialogue* (revised edition). London: SAGE publications.

Brodie, P. (2002) 'Addressing the Barriers to Midwifery: Australian Midwife Speaking Out', *The Australian Journal of Midwifery*, 15 (3): 5-14.

Brown, H. C., Paranjothy, S., Dowswell, T., Thomas, J. (2013) Package of care for active management in labour for reducing caesarean section rates in low-risk women. *Cochrane Database of Systematic Reviews Issue 9.* Art. No, CD004907. pub 3. [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004907.pub3/full (Accessed: 30/08/15).

Brown, H., Hofmeyr, G., Nikdem, V.C., Smith, H. et al. (2007) 'Promoting childbirth companions in South Africa: a randomised pilot study', *BMC Medicine,* 5: (7) 1-8. [Online] Available at: http://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-5-7 (Accessed: 30/04/15).

Bruggemann, O., Parpinelli, M., Osis, M.J., Cecatti, J.G. et al. (2007) 'Support to woman by a companion of her choice during childbirth: a randomized controlled trial', *Reproductive Health,* 4 (1): 1-7.

Buckley, A (2015) Hormonal physiology of childbearing: Evidence and implications for women, babies, and maternity care. Washington, D.C.: Childbirth Connection Programs, National Partnership for Women and Families. January. [Online] Available at: http://transform.childbirthconnection.org/reports/physiology/ (Accessed: 30/06/15).

Burns, E., Fenwick, J., Schmied, V. and Sheehan, A. (2010) 'Reflexivity in midwifery research: The insider/outsider debate', *Midwifery,* [Online] Available at: http://www.midwiferyjournal.com/article/S0266-6138%2810%2900179-8/abstract (Accessed: 30/04/15).

Burgess, A. (2014) 'An Evolutionary Concept Analysis of Labor Support', *International Journal of Childbirth Education,* 29 (2): 64-72.

Callister, L. (2004) 'Making Meaning: Women's Birth Narratives', *JOGNN,* 33 (34): 508-518.

Campbell, D. (2009) 'Men should stay away from childbirth', *The Guardian*, 18th October. [Online] Available at: http://www.theguardian.com/lifeandstyle/2009/oct/18/men-birth-labour-baby (Accessed: 30/06/15).

Capogna, G., Camornicia, M. and Stirparo, S. (2007) 'Expectant fathers' experience during labor with or without epidural analgesia', *International Journal of Obstetric Anesthesia,* 16: 110–115. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0959289X06001543 (Accessed: 30/04/15).

Care Quality Commission, (CQC) (2013) *National findings from the 2013 survey of women's experiences of maternity care*. London: CQC. [Online] Available at: http://www.cqc.org.uk/sites/default/files/documents/maternity_report_for_publication.pdf (Accessed: 06/06/15).

Chan, K. and Paterson-Brown, S. (2002) 'How do fathers feel after accompanying their partners in labour and delivery?' *Journal of Obstetrics and Gynaecology*, 22 (1): 11-15.

Chandler, S. and Field, P.A. (1997) 'Becoming a Father: First-Time Fathers' Experience of Labor and Delivery', *Journal of Nurse-Midwifery,* 42 (1): 17-24.

Chakladar, A. (2009) 'Encounter with a doula: is the system failing new mothers?' *BMJ,* 339: b5112.

Charmaz K. and Mitchell, R. (2010) 'Grounded theory in ethnography (chapter 11)', in Atkinson P., Coffrey, A., Delamont S., Lofland, J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage Publications: 160-174.
Chesney, M. (2001) 'Dilemmas of Self in the Method', *Qualitative Health Research*, 11: 127-135.

Cheung, N.F., Mander, R. Wang, X., Fu, Wei. et al. (2011) 'Clinical outcomes of the first midwife-led normal birth unit in China: a retrospective cohort study', *Midwifery,* [Online] Available at: http://www.sciencedirect.com/science/article/pii/S026661381000080X (Accessed: 30/04/15).

Cheung, N., Mander, R.; Wang, X., et al. (2010) 'Views of Chinese women and health professionals about midwife-led care in China', *Midwifery,* [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613810001440 (Accessed: 30/04/15).

Cheung, N. et al. (2009a) 'Chinese midwives' views on a proposed midwife-led normal birth unit', *Midwifery,* 25 (6): 744-755.

Cheung, N. (2009b) 'Chinese midwifery: the history and modernity', *Midwifery*, 25 (3): 228-241.

Cheung, N., Mander, R. and Cheng, L. (2005) 'The Doula-Midwives in Shaghai', *The Royal College of Midwives: Evidence Based Midwifery*, 3 (2): 73-79.

Chimwaza, A., Kabuluzi, E., Hami, M., Mbiza, C. et al. (2015) 'Experiences of men who support their partners during childbirth in low- resource settings: A descriptive review', *African Journal of Midwifery and Women's Health,* 9 (1): 29-34.

CMACE (Centre for Maternal and Child Enquiries) (2011) *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom.* BJOG (Suppl. 1), 118**:** 1-203. [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/abstract (Accessed: 30/04/15).

Coffey, A. (1999) *The ethnographic self: Fieldwork and the representation of identity*. London: Sage publications.

Collins, M. and C, Kingdon. (2014) 'One to One midwives: First-year outcomes of a midwifery-led model', *British Journal of Midwifery,* 22 (1): 15-21.

Comptroller and Auditor General. (2013) *Maternity services in England*. London. National Audit Office.

Cooper, T. (2011) *Perceptions of the Midwife's Role: A Feminist Technoscience Perspective*. PhD thesis. University of Central Lancashire. [Online] Available at: http://clok.uclan.ac.uk/2404/2/CooperTthesis-hardbound_final_collated.pdf (Accessed: 30/08/15).

Cornally P., Butler, M., Murphy, M., Rath, A., et al. (2014) 'Exploring women's experiences of care in labour', The Royal College of Midwives. *Evidence Based Midwifery*, 12 (3): 89-94.

Cronk, M. (2010) 'The midwife: A professional servant (Chapter 4)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 55-65.

Crozier, K.E., Sinclair, M., Kernohan, G. and Porter, S. (2007) 'Ethnography of technological competence in clinical midwifery practice', *Evidence Based Midwifery,* 5 (2): 59-65.

Cudmore, H. and Sondermeyer, J. (2007) 'Through the looking glass: being a critical ethnographic researcher in a familiar nursing context', *Nurse Researcher*, 14 (3): 25-35.

Curtis, P., Ball, L. and Kirkham, M. (2006) 'Why do midwives leave? (Not) being the kind of midwife you want to be', *British Journal of Midwifery,* 14 (1): 27 - 31.

Dahlen, H., M. Jackson, et al. (2010) 'Birth centres and the national maternity services review: Response to consumer demand or compromise?' *Women and Birth,* [Online] Available at: http://www.sciencedirect.com/science/article/pii/S1871519210000818 (Accessed: 06/06/15).

Dahlen, H., Barclay, L. and Homer, C. (2008) 'The novice birthing: theorising first-time mothers' experiences of birth at home and in hospital in Australia', *Midwifery*, 26 (1): 53-63. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S026661380800020X (Accessed: 06/06/15).

Davis, D. and Walker, K. (2012) 'Towards an 'optics of power': technologies of surveillance and discipline and case-loading midwifery practice in New Zealand', *Gender, Place and Culture,* 20 (5): 567-612.

Davis, D., Baddock, S., Pairman, S., Hunter, M., et al. (2011) 'Planned place of birth in New Zealand: does it affect mode of birth and intervention rates among low- risk women?' *Birth,* June: 38 (2):111-9.

Davis, J. (2010) 'Midwives and Normalcy in Childbirth: A Phenomenologic Concept Development Study', *Journal of Midwifery Women's Health,* 55, (3): 206-215.

Davis, C.A. (1999) *Reflexive Ethnography: A guide to researching selves and others*. London: Routledge.

Davis-Floyd, R., Barclay, L., Daviss, B. and Tritten, J. (eds.) (2009) *Birth Models that work*. California: University of California press.

Davis-Floyd, R. (2003) *Birth as an American Rite of Passage*. 2nd edn. California: University of California press.

De Laine, M. (2000) *Fieldwork participation and practice: Ethics and dilemmas in qualitative research*. London: SAGE publications Ltd.

de Laine, M. (1997) *Ethnography: Theory and applications in health research*. Sydney, Australia: Maclennan and Petty Pty Limited.

Deery, R. and Hunter, B. (2010) Emotion work and relationships in midwifery (Chapter 3)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 37-54.

Department of Health (DH) (2013a) *Maternity services in England.* London: National Audit Office. [Online] Available at: https://www.nao.org.uk/wp-content/uploads/2013/11/10259-001-Maternity-Services-Book-1.pdf (Accessed: 30/06/15).

Department of Health (DH) (2013b) *The Mandate: A mandate from the government to the NHS Commissioning board*: April 2013 to March 2015. London: Department of Health.

Department of Health (DH), (2004) *Maternity Standard, National service framework for children, young people and maternity services*. The Stationery Office, London. [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199957/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Maternity_Services.pdf (Accessed: 30/04/15).

Department of Health (DH). (1993) *Changing Childbirth: Report of the Expert Maternity Group*. London: The Stationery Office.

Department of Health/Partnerships for Children, Families and Maternity. (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.* London: Department of Health. April.

Department of Health, Social Services and Public Safety, Welsh Assembly Government, DH, Scottish Government (2010*) Midwifery 2020: Delivering expectations*. Cambridge: Midwifery 2020 Programme.

Department of Health and Social Security (DHSS) (1980) *The Second Report from the Social Services Committee: Session 1979-80 - Perinatal and Neonatal Mortality. Chair Short.* London: HMSO.

Devane, D., Brennan, M., Begley, C., Clarke, M. et al. (2010) *A systematic review, meta-analysis, and economic analysis of midwife-led models of care.* London: Royal College of Midwives.

Dixon, L., Skinner, J. and Foureur, M. (2014) 'The emotional journey of labour-Women's perspectives of the experience of labour moving towards birth', *Midwifery,* 30 (3): 371-377.

Dixon, L., Prileszky, G., Guilliland, K., Hendry, C. et al. (2012) 'What evidence supports the use of free-standing midwifery led units (primary units) in New Zealand/Aotearoa?' *New Zealand College of Midwives,* 46 (June): 13-20.

Doula UK (Accessed 2015) *About Doula UK*. https://doula.org.uk/about-doula-uk/ (Accessed 15/06/15).

Doula UK (2015) 'Doula UK responds to article', in *The Independent*. Press release. [Online] Available at: https://doula.org.uk/doula-uk-responds-to-article-in-the-independent/ (Accessed: 30/06/15).

Dreher, M. (1994) Qualitative research methods from the reviewer's perspective (chapter15)', in Morse, J.M. (ed) *Critical issues in qualitative research methods*. London: SAGE publications: 281-297.

Dr Foster (2014) *The leading provider of healthcare analysis*. [Online] Available at: http://www.drfoster.com/about-us/ (Accessed: 06/06/15).

Dr Foster (2007) *My hospital guide* [Online] Available (this is an up dated version) at: http://myhospitalguide.drfosterintelligence.co.uk/ (Accessed: 12/02/11).

Edwards, N. (2010. 'These's so much potential…and for whatever reason it's not being realised',-Women's relationships with midwives as a negotiation of ideology and practice (chapter 6)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship*. 2nd edn. Hampshire: Palgrave Macmillan: 37-54.

Eftekhary, S., Klein, M. and Xu, S.Y. (2010) 'The Life of a Canadian Doula: Successes, Confusion, and Conflict', *Journal of Obstetrics and Gynaecology Canada*, July. 32 (97): 642-649.

Ellis, C. (1995) 'Emotional and Ethical Quagmires in Returning to the Field', *Journal of Contemporary Ethnography*, 24 (1): 68-98.

Ellison, M., Kainz, G., Post, I. (2000) Uncaring Midwives. *MIDIRS Midwifery Digest*, 19: (1): 29-35.

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Dudley, L., Hodnett, E. and Hofmeyer, J. (2000) A guide to effective care in pregnancy and childbirth. 3rd edn. New York: Oxford University Press.

Escott, D., Slade, P. and Spiby, H. (2009) Preparation for pain management during childbirth: The psychological aspects of coping strategy development in antenatal education. *Clinical Psychology Review,* 29 (7): 617-622. [Online] Available at: http://www.ncbi.nlm.nih.gov/pubmed/19709792 (Accessed: 30/04/15).

Escott, D., Spiby, H., Slade, P. and Fraser, R. (2004) 'The range of coping strategies women use to manage pain and anxiety prior to and during first experience of labour', *Midwifery,* 20 (2): 144-156.

Fahy, K. (2002) 'Reflecting on practice to theorise empowerment for women: Using Foucault's concepts', *The Australian Journal of Midwifery,* 15 (1): 5-13.

Fahy, K., Foureur, M. and Hastie, C. (eds.) (2008) *Birth Territory and Midwifery Guardianship: Theory for practice education and research*. Philadelphia: Books for Midwives.

Fahy, K. and Parratt. J. (2006) 'Birth Territory: A theory for midwifery practice', *Women and Birth*, 19 (2): 45-50.

Falzon, M. (2009) 'Introduction: Multi-sited Ethnograpgy: Theory, Praxis and locality in contemporary research (Chapter 1)', in Falzon, M.A. (ed). *Multi-sited Ethnography: Theory, Praxis and locality in contemporary research*. Surrey: Ashgate.

Fearn, H. (2015) 'Pregnant women employ 'doulas' for support during labour as NHS cuts hit', *The Independent,* 20th April [Online] Available at: http://www.independent.co.uk/life-style/health-and-families/health-news/pregnant-women-employ-doulas-for-support-during-labour-as-nhs-cuts-hit-10190834.html (Accessed: 15/06/15)

Fetterman, D. M. (1989) *Ethnography: Step by Step.* London: Sage Publications Ltd.

Fleming A and Downe S. (2007) 'Narratives from the Blackburn West Case holding Team: Building up', *British Journal of Midwifery,* May. 15 (5): 298-302.

Foucault, M. (1980) *Power/knowledge: Selected interviews and other writings 1972–1977*. New York; London: Pantheon Books.

Foucault, M. (1973) *The birth of the clinic. An archeology of medical perception*. London: Tavistock Publications.

Foureur, M. (2008) 'Physiology and the physical space (chapter 5)', in Fahy, K., Foureur, M. and Hastie, C. (eds.) *Birth Territory and Midwifery Guardianship: Theory for practice education and research*. Philadelphia: Books for Midwives.

Fox, D., Lina, C., Kelly, E.R., Raes, A. et al. (2013) 'One-to-one midwifery care in Singapore – the first 100 births', *British Journal of Midwifery,* 21(10): 701-707.

Fraser, D.M. (1999) 'Women's Perceptions of Midwifery Care: A Longitudinal Study to Shape Curriculum Development', *Birth,* 26 (2): 99-107.

Fraser, M. and N. Puwar. (2008) 'Introduction: intimacy in research', *History of the Human Sciences,* 21 (4): 1-16.

Freeman, L. (2006) 'Continuity of carer and partnership: A review of the literature', *Women and Birth,* 19. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S1871519206000217 (Accessed: 30/04/15).

Gagnon, A., and Waghorn, K. (1999) One-to-one nurse labor support of nullipurous women stimulated with oxytocin. *Journal of Obstetrics, Gynaecology, and Neonatal Nursing*, 28: 371-376.

Gagnon, A., Waghorn, K. and Covell, C. (1997) 'A randomised trial of one to one nurse support of women in labour', *Birth,* 24 (2): 71-77.

Gagnon, A. and Waghorn, K. (1996) 'Supportive Care by Maternity Nurses: A work sampling study in an intrapartum unit', *Birth,* 23 (1): 1-6.

Gale, J., Fothergil-Bournnaiset, F. and Chamberlain, M. (2001) 'Measuring Nursing Support during Childbirth', *American Journal of Maternal Child Nursing,* 26 (5): 264-271.

Geertz, C. (1973) *The Interpretation of Cultures*. New York: Basic Books.

Gerein, N., Green, A., et al. (2006) The Implications of Shortages of Health Professionals for Maternal Health in Sub-Saharan Africa. *Reproductive Health Matters,* 14 (27): 40–50.

Gibbons, L., Belizan, J.M., Lauer, J.A., Betran, AS.P. et al. (2010) *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage*. World Health Report. [Online] Available at: http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf (Accessed: 30/07/15).

Gilliland, A.L. (2011) 'After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada', *Midwifery,* 27(4): 525-531.

Goedkoop, V. (2009) 'Side by side- A survey of Doula Care in the UK in 2008', *MIDIRS Midwifery Digest,*19 (2): 217-218.

Goffman, E. (1990) *The presentation of self in everyday life*. London: Penguin books.

Gould, D. (2000) 'Stronger leadership is needed before we can 'own' change', *British Journal of Midwifery,* 8 (8): 480- 481.

Greene, K. and Harris, M., (2003) *Silent Witness: Care and communication in the delivery room*. Royal Society of Medicine Forum: Caring for the emotions in pregnancy, birth and beyond. [Online] Available at: http://www.motherhood.org.uk/emo2.htm (Accessed: 30/04/15).

Griffith, R. (2015) 'Understanding the Code: keeping accurate records', *British Journal of Community Nursing,* 20 (10)**:** 511-514.

Gu, C., et al. (2011) 'Chinese midwives' experience of providing continuity of care to labouring women', *Midwifery,* 27: 243-249. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613809000886 (Accessed: 30/04/15).

Guba, E.G. and Lincoln, Y.S. (1994) 'Competing paradigms in qualitative research', in Denzin N.K. and Lincoln Y.S. (eds.) *Handbook of qualitative research*. Thousand Oaks, CA: Sage: 105-117.

Halldorsdottir, S. and Karlsdottir, S.I. (1996) 'Journeying through labour and delivery: perceptions of women who have given birth', *Midwifery,* 12 (2): 48-61.

Hammersley, M. and Atkinson, P. (2007) *Ethnography: Principles in Practice* 3rd edn. Wiltshire: Routledge

Harris, F.M., van Teijlingen, E., Hundley, V., Farmer, J. et al. (2011) 'The buck stops here: Midwives and maternity care in rural Scotland', *Midwifery,* 27(3): 301-307.

Hastie, C. and. Fahy, K. (2011) 'Inter-professional collaboration in delivery suite: A qualitative study', *Women and Birth,* 24 (2): 72-79.

Hatem, M., Sandall, J., Devane, D., Soltani, H. et al. (2009) Midwife-led versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667. [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub3/abstract (Accessed: 30/10/15)

Hauck, Y., Fenwick, J., Downie, J. and Butt, J. (2007) 'The influence of childbirth expectations on Western Australian women's perceptions of their birth experience', *Midwifery,* 23 (3): 235-247.

Health and Social care information centre. (2015) *Hospital Episode Statistics: NHS Maternity Statistics - England, 2013-14*. Health and Social Care Information Centre: Part of the Government Statistical Service. [Online] Available at: http://www.hscic.gov.uk/catalogue/PUB16725 (Accessed: 30/04/15).

Helman, C. (2007) *Culture, Health and Illness*. 5th edn. New York: Oxford University Press Inc.

Heyl, S.B. (2010) 'Ethnographic Interviewing (Chapter 25)', in Atkinson, P., Coffey, A., Delamont, S., Lofland J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage publications: 369-383.

Hildingsson, I., Cederlof, L. and Widen, C. (2011) 'Fathers' birth experience in relation to midwifery care', *Women and Birth,* 24 (3): 129-136.

Hodgson, I. (2001) 'Engaging with cultures: reflections on entering the ethnographic field', Nurse Researcher, 9 (1): 41–51.

Hodnett, E.D, Gates, S, Hofmeyr, G.J, Sakala, C. (2013) *Continuous support for women during childbirth*. In: Cochrane Database of Systematic Reviews, Issue 7, Art No, CD003766. Pub 5. [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003766.pub5/abstract (Accessed: 30/04/15).

Hodnett, E. Downe, S., Walsh, D. (2012) *Alternative versus conventional institutional settings for birth*. In: Cochrane Database of Systematic Reviews. Issue 8, Art. No: CD000012. Pub. 4. [Online] Available: at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000012.pub4/abstract (Accessed: 30/04/15).

Hodnett, E. (2002) 'Pain and Women's Satisfaction with the Experience of Childbirth: A Systematic Review', *American Journal of Obstetrics and Gynecology,* 186 (5) Supplement 1: S160-S172.

Hodnett, E. (1997) 'Commentary: Are nurses effective providers of labour support? Should they be? Can they be?' *Birth,* 24: 78-80.

Hodnett, E. (1996) 'Nursing Support of the laboring woman', *Journal of Obstetric, Gynecologic and Neonatal Nursing,* 25 (3): 257-264.

Holden, T. and Lynch, P. (2004) Choosing the Appropriate Methodology: Understanding Research Philosophy. [Online] Available at: http://repository.wit.ie/1466/1/Choosing_the_Appropriate_Methodology_Understanding_Research_Philosophy_%28RIKON_Group%29.pdf (Accessed: 15/06/15).

Hollowell, J. (2011) *Birthplace programme overview: background, component studies and summary of findings. Birthplace in England research programme. Final report part 1*. NIHR Service Delivery and Organisation programme. [Online] Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR1_08-1604-140_V02.pdf (Accessed: 30/04/15).

Hollowell, J. et al. (2011) *The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth. Birthplace in England research programme. Final report* part 4. NIHR Service Delivery and Organisation programme. [Online] Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR4_08-1604-140_V03.pdf (Accessed: 30/04/15).

House of Commons Health Committee. (1992) *Second report on the maternity services (Winterton Report)*. London: HMSO.

Huber, U.S. and Sandall, J. (2009) 'A qualitative exploration of the creation of calm in a continuity of carer model of maternity care in London', *Midwifery,* 25: 613-621. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613807001386 (Accessed: 15/06/15).

Hunter, B. (2010) 'Implementing a National Policy Initiative to Support Normal Birth: Lessons from the All Wales Clinical Pathway for Normal Labour', *Journal of Midwifery and Women's Healt*h, 55 (3): 226-233.

Hunter, B. (2007) *The All Wales Clinical Pathway for Normal Labour: What are the experiences of midwives, doctors, managers and mothers?* Final project report: A Policy Ethnography to Explore the Implementation of the All Wales Clinical Pathway for Normal Labour. Swansea: Institute of Health Research, Swansea University, September. [Online] Available at: http://orca.cf.ac.uk/18745/1/NLP_final_report%5B1%5D.pdf (Accessed: 15/06/15).

Hunter, B. (2006) 'The importance of reciprocity in relationships between community-based midwives and mothers', *Midwifery,* 22 (4): 308-322.

Hunter, B. (2005a) 'Emotion work and boundary maintenance in hospital-based midwifery', *Midwifery,* 21 (3): 253-266.

Hunter, B. (2005b) 'The Need for Change: The Midwives Perspectives', *MIDIRS Midwifery Digest:* Supplement 2. 15 (4): S12-S16.

Hunter, B. (2004) 'Conflicting ideologies as a source of emotion work in midwifery', *Midwifery*, 20: (3): 261-272.

Hunter, B., Berg, M., Lundgren, I., Olafsdottir, O.A. and Kirkham, M. (2008) 'Relationships: The hidden threads in the tapestry of maternity care', *Midwifery,* May/June. 24 (2): 132-137.

Hunter, B. and Deery, R. (2010) 'Emotion work and relationships in midwifery (chapter 3)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 116-143.

Hunter, B. and Deery, R. (2005) 'Building our knowledge about emotion work in midwifery: combining and comparing findings from two different research studies', *The Royal College of Midwives, Evidence Based Midwifery,* 3 (1): 10-15.

Hunter, B. and Segrott, J. (2014) 'Renegotiating inter-professional boundaries in maternity care: implementing a clinical pathway for normal labour', Sociology of Health and Illness, 36 (5): 719-737.

Hunter, B. and Segrott, J. (2010) 'Using a Clinical Pathway to Support Normal Birth: Impact on Practitioner Roles and Working Practices', *Birth,* 37 (3): 227-236.

Hunter, B. and Segrott, J. 2008. 'Re-mapping client journeys and professional identities: a review of the literature on clinical pathways', *International Journal of Nursing Studies,* 45 (4): 608–625.

Hunter, B. and Warren, L. (2014) 'Midwives 'experiences of workplace resilience', *Midwifery,* 30 (8): 926-934.

Hunter, L.P. (2009) 'A Descriptive Study of 'Being with Woman' During Labor and Birth', *The American College of Nurse-Midwives,* 54: 111-118.

Hunter, L.P. (2006) 'Women Give Birth and Pizzas Are Delivered: Language and Western Childbirth Paradigms', *Journal of Midwifery and Women's Health,* 51 (2): 119-124.

Hunter, L.P. (2002) 'Being with Woman: A Guiding Concept for the Care of Labouring Women', *Journal of Obstetrics, Gynaecology, and Neonatal Nursing*, 31 (6): 650-657.

Hunt, P. and Bueno de Mesquita, J. (2010) *Reducing Maternal Mortality: The contribution of the right to the highest attainable standard of health*. New York: Human Rights Centre and United Nations Population Fund. [Online] Available at: http://repository.essex.ac.uk/9719/1/reducing-maternal-mortality-contribution-right-highest-attainable-standard-health.pdf (Accessed: 15/06/15)

Hunt, S. and Symonds, A. (1995) *The Social Meaning of Midwifery.* Hampshire: Palgrave Macmillan.

Iliadou, M. (2012) 'Supporting women in labour', *Health Science Journal,* 6 (3): 385-391.

Imison, C., Sonola, L., Honeyman, M. and Ross, S. (2014) *The reconfiguration of clinical services: What is the evidence*? London: The Kings Fund.

Imison, C. (2011) *Reconfiguring hospital services: Briefing.* London: The Kings Fund.

International Confederation for Midwives (ICM) (2014) *Position Statement: The Midwife is the first choice health care professional for childbearing women*. Prague Council Meeting, 2014. [Online] Available at: http://www.internationalmidwives.org/assets/uploads/documents/Position%20Statements%20-%20English/Reviewed%20PS%20in%202014/PS2008_019%20V2014%20The%20Midwife%20is%20the%20First%20Choice%20ENG.pdf (Accessed: 30/04/15).

Janssen, B., and Wiegers, T. (2006) 'Strengths and weaknesses of midwifery care from the perspective of women', *The Royal College of Midwives: Evidence Based Midwifery,* 4 (2): 53-59.

Johnston, D and Harman, J. (2007) Campaign for normal birth: Beware of institutional defences. *Midwives,* 10, (10): 476.

Johansson, M., Fenwick, J. and Premberg, A. (2015) 'A meta-synthesis of fathers ′experiences of their partner′s labour and the birth of their baby', *Midwifery,* 31(1): 9-18.

Kabakian-Khasholian, T., El-Nemer, A. and Bashour, H. (2015) 'Perceptions about labor companionship at public teaching hospitals in three Arab countries', International *Journal of Gynecology and Obstetrics,* 129 (3):223-226. [Online] Available at: http://www.ijgo.org/article/S0020-7292%2815%2900080-6/abstract (Accessed: 30/06/15).

Kardong-Edgren, S. (2001) 'Using Evidence-Based Practice to Improve Intrapartum Care', *Journal of Obstetric, Gynecologic, and Neonatal Nursing (JOGNN)*, 30 (4): 371-375.

Karkkainen O., Bondas, T. and Eriksson, K. (2005) 'Documentation of individual patient care: a qualitative metasynthesis', *Nursing Ethics,* 12 (2): 123-132.

Kashanian, M., Javadi, F. and Haghighi, M.M. (2010) 'Effect of continuous support during labor on duration of labor and rate of cesarean delivery', International *Journal of Gynecology and Obstetrics,* 109: 198-200. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0020729210000202 (Accessed: 30/06/15).

Keating, E. (2010) 'The Ethnography of communication (Chapter 20)', in Atkinson, P., Coffey, A., Delamont, S., Lofland J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage publications: 285-301.

Kennedy, H.P. (2009) 'Orchestrating normal: The conduct of midwifery in the United States (Chapter 15)', in Davis-Floyd, R., Barclay, L., Daviss, B. and Tritten. J. (eds.) *Birth model that work.* London: University of California press, Ltd.
Kennedy, H.P. (2002) 'The Midwife as an 'Instrument' of Care', *American Journal of Public Health,* 92 (11): 1759-1760.

Kennedy, H.P. (2002) 'The Midwife as an 'Instrument' of Care', *American Journal of Public Health,* 92 (11): 1759-1760.

Kennedy, H.P. (2000) ‘A model of exemplary midwifery practice: results of a Delphi study’, *Journal of Midwifery and Women's Health*, 45 (1): 4-19.

Kennedy, H.P., Grant, J., Walton, C., Shaw-Battista, J. and Sandall, J. (2010) ‘Normalizing Birth in England: A Qualitative Study’, *American College of Nurse-Midwives,* 55 (3): 262-269**.** [Online] Available at: http://www.sciencedirect.com/science/article/pii/S1526952310000425 (Accessed: 30/06/15).

Kennedy, H.P., Rousseau, A.L. and Low, L.K. (2003) ‘An exploratory metasynthesis of midwifery practice in the United States’, *Midwifery,* 19 (3): 203-214.

Kennedy, H.P. and Shannon. M. (2004) ‘Keeping Birth Normal: Research Findings on Midwifery Care During Childbirth’, *JOGNN,* 33 (5): 554-560.

Kennedy, H.P., Shannon, M.T., Chuahorn, U. and Kravetz, M.K. (2004) ‘The landscape of caring for women: a narrative study of midwifery practice’, *Journal of Midwifery and Women's Health,* 49 (1): 14-23.

Khresheh, R. (2009) ‘Support in the first stage of labour from a female relative: the first step in improving the quality of maternity services’, *Midwifery,* 26 (6): 1-4 [Online] Available: http://www.sciencedirect.com/science/article/pii/S0266613808001095 (Accessed: 06/06/15).

King, T. (2012) ‘Preventing Primary Cesarean Sections: Intrapartum Care’, *Seminars in Perinatology,* 36 (5): 357-364. [Online] Available at: http://www.seminperinat.com/article/S0146-0005%2812%2900055-9/abstract (Accessed: 06/06/15).

Kingdon, C. (2005) ‘Reflexivity: Not just a qualitative methodological research tool’, *British Journal of Midwifery,* 13 (10): 622 - 627.

Kings Fund. (2008) *Safe Births: Everybody's Business: An Independent Inquiry into the Safety of Maternity Services in England*. London: Kings Fund.

Kirkham, M. (ed) (2010) *The midwife-mother relationship.* 2nd edn. Hampshire: Palgrave Macmillan.

Kirkham, M. (2010) 'The maternity services (Chapter 1)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 116-143.

Kirkham, M. (2007) Traumatised Midwives. *AIMS Journal*, 19 (1). [Online] Available at: http://www.aims.org.uk/Journal/Vol19No1/traumatisedMidwives.htm (Accessed: on line 30/04/15).

Kirkham, M. (ed.) (2003) *Birth Centres: A Social Model for Maternity Care*. London: Books for Midwives.

Kirkham, M. (1999) 'The culture of midwifery in the National Health Service in England', *Journal of Advanced Nursing,* 30 (3): 732-739.

Kirkham, M. (1989) 'Midwives and information-giving during labour', In Robinson, S. and Thompson, A. (eds.) *Midwives, Research and Childbirth Volume 1.* London: Chapman and Hall.

Kirkham, M., Morgan, R. and Davies, C. (2006) *Why Midwives Stay.* London: Department of Health.

Kirkham, M. and Stapleton, H. (2004) 'The culture of the maternity services in Wales and England as a barrier to informed choice (Chapter 6)', in Kirkham, M. (ed.) *Informed choice in maternity care.* Hampshire: Palgrave Macmillan: 117-145

Kirkham, M., Stapleton, H., Thomas, G. Curtis, P. (2002) 'Evaluating informed choice. Checking not listening: how midwives cope', *British Journal of Midwifery,* 10 (7): 447-450.

Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation.* UK: The Stationery Office.

Klaus, M., Kennell, J., Robertson, S. and Sosa, R. (1986) 'Effects of Social support during Parturition on Maternal and infant Mortality', *British Medical Journal,* 6 Sept. 293: 585-587. [Online] Available at: http://www.bmj.com/content/293/6547/585.abstract (Accessed: 30/04/15)

Kleinman, S. and Copp, M. (1993) *Emotions and fieldwork*. London: Sage Publications.

Klunklin A, G. and Greenwood, J. (2006) 'Symbolic Interactionism in Grounded Theory Studies: Women Surviving With HIV/AIDS in Rural Northern Thailand', *Journal of the Association of nurses in AIDS care*. 17 (5): 32-41.

Knape, N., Mayer, H., et al. (2014) 'The association between attendance of midwives and workload of midwives with the mode of birth: secondary analyses in the German healthcare system', *BMC Pregnancy and Childbirth,* 14 (1). [Online] Available at: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-300 (Accessed: 06/06/15).

Knight M, Kenyon S, Brocklehurst P, Neilson J, Shakespeare J, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. (2014) Saving Lives, Improving Mothers' Care- Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12. Oxford: National Perinatal Epidemiology Unit, University of Oxford. [Online] Available at: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Full.pdf (Accessed: 06/06/15).

Kozhimannil, K., B. Laura, et al. (2014) 'Potential Benefits of Increased Access to Doula Support During Childbirth', *American Journal Management care,* 20 (6): e340-e352.

Kuo, S., Wu, C., Mu, P. (2010) 'Taiwanese women's experiences of hospital midwifery care: a phenomenological study', *Midwifery,* 26: 450-456. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613808000831 (Accessed: 06/06/15).

Lambert V., Glacken, M. and McCarron, M. (2011) 'Employing an ethnographic approach: key characteristics', *Nurse Researcher,* 19 (1): 17-23.

Leap, N. (2013) *Normalising birth: Culture and environment.* Forum on Maternity and the Newborn of the Royal Society of Medicine in association with the Royal College of Midwives on Monday 3rd June 2013. [Online] Available at: http://www.motherhood.org.uk/nb1.html (Accessed: 06/06/15).

Leap, N. (2010) 'The less we do the more we give (Chapter 2)', in Kirkham, M (ed.) *The Midwife-Mother Relationship.* 2nd edn. Hampshire: Palgrave Macmillan: 116-143.

Leinweber, J. and H.J. Rowe (2010) 'The costs of 'being with the woman': secondary traumatic stress in midwifery', *Midwifery,* 26: 76-87. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613808000442 (Accessed: 06/06/15).

Leslie, H. and McAllister, M. (2002) 'The Benefits of Being a Nurse in Critical Social Research Practice', *Qualitative Health Research,* 12: 700-712.

Lewis, G. (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom: Summary and Key Recommendations for Midwives. London: CEMACH.

Longmore, M. (1998) 'Symbolic interactionism and the study of sexuality' *The Journal of sex research,* 35 (1): 44-57.

Longworth, H.L. and Kingdon, C.K. (2011) 'Fathers in the birth room: what are they expecting and experiencing? A phenomenological study', *Midwifery,* 27:588–594. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S026661381000104X (Accessed: 06/06/15).

Longworth, H. (2006) 'Should fathers be in the labour room? Yes, for support not intervention', *British Journal of Midwifery,* 14 (5): 288

Luhrmann, T. M. (2015) Thick Description: Methodology. *International Encyclopedia of the Social and Behavioral Sciences (Second Edition)* J. D. Wright. Oxford, Elsevier**:** 291-293. [Online] Available at: http://www.sciencedirect.com/science/article/pii/B9780080970868440572 (Accessed: 06/06/15).

Lundgren, I., Karlsdottie, S.I and Bondas, T. (2009) 'Long-term memories and experiences of childbirth in a Nordic context a secondary analysis', *International Journal of Qualitative Studies on Health and Well-being.* 4: 115-128. [Online] Available at: http://www.ijqhw.net/index.php/qhw/article/view/5008 (Accessed: 06/06/15).

Lundgren, I. and Berg M. (2007) 'Central concepts in the midwife-woman relationship', *Scandinavian Journal of caring science,* 21 (2): 220-228.

Lundgren, I and Dahlberg, K. (2002) 'Midwives' experience of the encounter with women and their pain during childbirth', *Midwifery,* March 18: 155-164. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613802903025 (Accessed: 06/06/15).

Lykkeslet, E. and Gjengedal, E. (2007) 'Methodological Problems Associated With Practice-Close Research', *Qualitative Health Research,* 17 (5): 699-704.

Macfarlane, A., Rocca-Ihenacho, L., et al. (2014) 'Survey of women's experiences of care in a new freestanding midwifery unit in an inner city area of London, England: 1. Specific aspects of care', *Midwifery,* 30 (9): 998-1008.

Machin, D. and Scamell, M. (1997) 'The experience of labour: using ethnography to explore the irresistible nature of the bio-medical metaphor during labour', *Midwifery***,** 13: 78-84. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613897900607 (Accessed: 06/06/15).

MacKinnon, K., McIntyre, M., and Quance, M. (2005) 'The meaning of the nurses' presence during childbirth', *Journal of Obstetric, Gynecologic, and Neonatal Nursing.* 34 (1): 28-36.

Madi B., Sandall, J., Bennett, R. and Macleod, C. (1999) 'Effects of Female Relative Support In Labor: A Randomized Controlled Trial', *Birth,* 26 (1): 4-8.

Magee, H. and Askham J. (2007) *Women's views about Safety in Maternity Care: A Qualitative study*. London, Kings Fund.

Maimbolwa, M.C., Sikazwe, N., Yamba, B., Diwan, V. et al. (2001) 'Views on involving a social support person during labor in Zambian maternities', *Journal of Midwifery and Women's Health,* 46 (4): 226-234.

Mander, R. (2010) 'Skills for Working with (the Woman in) Pain (chapter 8)', in Walsh, D. (ed.) *Essential Midwifery Practice: Intrapartum Care.* West Sussex: Wiley-Blackwell**:** 125-140.

Mander, R., Cheung, N., Wang, X., Fu, W., et al. (2009) 'Beginning an action research project to investigate the feasibility of a midwife-led normal birthing unit in China', *Journal of Clinical Nursing,* 19: 517-526**.** [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2009.02849.x/abstract (Accessed: 29/04/15).

Mander, R., (2001) *Supportive Care and Midwifery*. London: Blackwell Science.

Manktelow, N., Smith, L., Evans, T.A., Hyman-Taylor, P. et al. on behalf of MBRRACE-UK collaboration. (2015) MBRRACE-UK (2015) *Perinatal Mortality surveillance report: UK perinatal deaths for births from January to December 2013*. Leicester: MBRRACE-UK.

Marcus, G. (1995) 'Ethnography in/of the world system: the emergence of multi-sited ethnography', *Annual Review of Anthropology,* 24: 95–117.

Marshall, B.P. Cardon, P. Poddar, A. and Fontenot, R. (2013) 'Does sample size matter in qualitative research?: A review of qualitative interviews in IS research', *Journal of Computer Information Systems,* 54 (1): 11-22.

Marshall, M. (1996) 'Sampling for Qualitative Research', *Family Practice,* 13 (6): 522-526. [Online] Available at: http://fampra.oxfordjournals.org/content/13/6/522.short (Accessed: 30/06/15).

Martis, R. (2007) *Continuous support for women during childbirth*: RHL commentary (last revised: 8 September. Geneva: The WHO Reproductive Health Library. World Health Organisation. [Online] Available at: http://apps.who.int/rhl/archives/rmcom/en/ (Accessed: 30/06/15).

Maternity Care Working Party. (2007) *Making Birth a Reality: Consensus Statement from the Maternity Care Working Party our shared views about the need to recognize, facilitate and audit normal birth*. London: NCT/RCM/RCOG.

McCourt C., Rayment, J., Rance, S. and Sandall, J. (2014) 'An ethnographic organisational study of alongside midwifery units: a follow-on study from the Birthplace in England programme', *Health Services and Delivery Research*. 2 (7). [Online] Available at: http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0020/114563/ScientificSummary-hsdr02070.pdf (Accessed: 30/08/15).

McCourt C., Rance, S., Rayment, J. and Sandall, J. (2011) *Birthplace qualitative organisational case studies: How maternity care systems may affect the provision of care in different birth settings.* Birthplace in England research programme. Final report part 6. NIHR Service Delivery and Organisation programme [Online] Available at: https://www.npeu.ox.ac.uk/birthplace/reports (Accessed: 30/08/15).

McCourt, C. and Page, L. (1996) *Report on the evaluation of one to one midwifery*. London: Centre for Midwifery Practice.

McGrath, S. and Kennell, J. (2008) 'A Randomized Controlled Trial of Continuous labor Support for Middle class couples: Effect on Cesarean Delivery Rates' *Birth*. 35 (2): 92-97.

McIntosh, T. (2013) 'Changing childbirth: consigned to the shelf of history'?' *MIDIRS Midwifery Digest*, 23 (4): 415-420.

McLachlan, H., Forster, D., Davey, M., Lumley, J. et al. (2008) 'COSMOS: Comparing Standard Maternity care with One-to-one midwifery Support: a randomised controlled trial', *BMC Pregnancy and Childbirth,* 8 (35): 1-12.

McNiven, P., Hodnett, E., O'Brien-Pallas, L., et al. (1992) 'Supporting Women in Labor: A Work Sampling Study of the Activities of Labor and Delivery Nurses', *Birth*, 19 (1): 3-8.

Miles, M. Huberman A and Saldana (2014) *Qualitative Data Analysis: A methods sourcebook* 3rd edn. London: Sage Publications Ltd.

Miles, M.B. and Huberman, A.M. (1994) *Qualitative Data Analysis.* Beverly Hills: Sage.

Miltner, R. (2002) 'More Than Support: Nursing Interventions Provided to Women in Labor', *JOGNN*, 31 (6): 753-761.

Ministry of Health. (1970) *Peel Report: Domiciliary midwifery and maternity bed needs: the Report of the Standing Maternity and Midwifery Advisory Committee* (sub-committee chair J.Peel) London: HMSO

Ministry of Health. (1959) *Report of the Maternity Services Committee (Cranbrook Report)*. London: HMSO.

Morse, J.M. (2000) 'Determining sample size', *Qualitative Health Research*, 10 (1): 3-5.

Morse, J.M. (1994) 'Designing qualitative research', in Denzin N.K. and Lincoln Y.S. (eds.), *Handbook of qualitative inquiry*. Thousand Oaks, CA: Sage: 220-235

Morse, J. M. (1991) Strategies for sampling. In J. M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue Newbury Park, CA: Sage: 127-145.

Moyer, C., Adongo, P., Aborigo, R., Hodgson, A., et al. (2014) ''They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana', *Midwifery*, 30 (2): 262-268.

Munhall, P. (2012) Nursing research: A qualitative approach (5th edition) London: Jones and Bartlett learning.

Murphy, F. (2005) 'Preparing for the field: developing competence as ethnographic field worker', *Nurse Researcher*, 12 (3): 52-60.

Murphy, E. and Dingwall, R. (2010) 'The ethics of ethnography (Chapter 23)', in Atkinson P., Coffrey, A., Delamont S., Lofland, J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage Publications: 339-351

National Audit Office (2013) Maternity statistics in England. London: The Stationary Office. [Online] Available at: http://www.nao.org.uk/wp-content/uploads/2013/11/10259-001-Maternity-Services-Book-1.pdf (Accessed: 30/06/15)

National Childbirth Trust (NCT). (2008) *NCT Briefing: Midwife-led units, community maternity units and birth centres*. London: National Childbirth Trust (NCT).

National Federation of Women's Institutes (NFWI) and National Child birth Trust (NCT) (2013) Support overdue: Women's experiences of maternity services. London and Cardiff, The National Federation of Women's Institutes and NCT.

National Health Service Litigation Authority (NHS LA). (2012a) *Ten Years of maternity Claim: An analysis of NHS litigation authority data*. London NHSLA. [Online] Available at: http://www.nhsla.com/safety/Documents/Ten%20Years%20of%20Maternity%20Claims%20-%20An%20Analysis%20of%20the%20NHS%20LA%20Data%20-%20October%202012.pdf (Accessed: 30/04/15).

National Health Service Litigation Authority (NHS LA) (2012b) *Ten Years of Claim: New Release*. London NHSLA. [Online] [Online] Available at: at:http://www.nhsla.com/safety/Documents/Ten%20Years%20of%20Maternity%20Claims%20-%20News%20Release%20-%20October%202012.pdf (Accessed: 30/04/15).

National Health Service Litigation Authority (NHS LA) (2012c) *Archives: Standards and assessments. NHSLA*. [Online] Available at: http://www.nhsla.com/Safety/Pages/HelpfulTools.aspx (Accessed: 06/06/15).

National Institute for Clinical Excellence (NICE). (2015a) *Safe midwifery staffing for maternity settings*. London, NICE.

National Institute for Clinical Excellence (NICE). (2015b) *Intrapartum care: quality standard*. London, NICE.

National Institute for Clinical Excellence (NICE). (2014) *Intrapartum Care: Care of Healthy Women and their Babies during Childbirth* (Full text), Commissioned by the National Institute for Health and Care Excellence. London: RCOG Press

National Institute for Clinical Excellence (NICE). (2011) *Caesarean Section.* London: RCOG Press.

National Institute for Clinical Excellence (NICE). (2007) *Intrapartum Care: Care of Healthy Women and their Babies during Childbirth* (Full text). London: RCOG Press. September.

National Patient safety Agency/National Research Ethics Service (2009) *Information sheets and Consent Forms: Guidance for Researchers and Reviewers*. London: NHS

Newburn, M. (2012) 'The best of both worlds – Parents' motivations for using an alongside birth centre from an ethnographic study', *Midwifery*, 28 (1): 61-66.

Newburn, M. and Singh, D. (2005) *Are Women getting what they need? A Report of a National Survey of Women's Experiences*. London: National Childbirth Trust (NCT).

Newburn, M. and Singh, D. (2003) *Creating a better birth environment- women's views about the design and facilities in maternity units: a national survey*. London: The National Childbirth Trust.

Newbury, J. (2011) 'Reflexivity in a study of family carers in home palliative care: A personal account', *Nurse Researcher,* 19 (1): 30-36.

Newell, F. (1997) *The new rules of marketing: How to use one-to-one relationship marketing to be the leader in your industry*. London: McGraw-Hill.

Ngoma, C. and Charity, C. (2013) 'Support during pregnancy, labour and childbirth by husbands in Zambia', *African Journal of Midwifery and Women's Health*, 7 (4): 186-190.

NHS Choices (2011) *Guide rates best and worst hospital in 2011*. [Online] Available at: http://www.nhs.uk/news/2011/11November/Pages/2011-hospital-performance-data-analysed.aspx (Accessed: 06/06/15).

NHS England. (2015) *Ambulance Quality Indicators Data*. [Online] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambqi-data-2011-12/ (Accessed: 06/06/15).

Nilsson, C. (2014) 'The delivery room: Is it a safe place? A hermeneutic analysis of women's negative birth experiences', *Sexual and Reproductive Healthcare.* 5 (4):199-204.

Nilsson C, Bondas, T. and Lundgren, I. (2010) 'Previous birth experience in women with intense fear of childbirth', *Journal of Obstetric Gynecologic and Neonatal Nursing,* 39 (3):298-309.

NMC (Nursing, Midwifery Council). (2015) *The Code*. London: NMC.

NMC (Nursing, Midwifery Council). (2012) *Midwives rules and standards 2012.* London: NMC.

NMC (Nursing, Midwifery Council). (2009) *Record keeping Guidance for nurses and midwives*. London: NMC.

Nolan, M. (2010) 'NCT Birth Companions: a new training programme and a new service', *National Childbirth Trust New Digest 51.* July: 14

Oates, M., Harrper, A., Shakespeare, J. and Nelson-Percy, C. (2011) 'Back to basics in Centre for Maternal and Child Enquiries (CMACE) *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London: BJOG: *An International Journal of Obstetrics and Gynaecology*, 118**:** (suppl. 1): 16-21.

Oboro, V., Oyeniran, A., Akinola, S.E. and Isawumi, A.I. (2011) 'Attitudes of Nigerian women toward the presence of their husband or partner as a support person during labor', *International Journal of Gynecology and Obstetrics,* 112 (1): 56-58.

O'Cathain, A. (2004) 'Can leaflets deliver informed choice? (Chapter four)', in Kirkham, M. (ed.) *Informed choice in maternity care*. Hampshire: Palgrave Macmillan: 71-83.

O'Connell, R. and Downe, S. (2009) 'A metasynthesis of midwives' experience of hospital practice in publicly funded settings: compliance, resistance and authenticity', *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 13 (6): 589 -609.

Odent, M. (2008) 'Birth Territory: The besieged territory of the obstetrician (Chapter nine)', in Fahy, K., Foureur, M. and Hastie, C. (eds.) *Birth Territory and midwifery guardianship: Theory for practice education and research.* Philadelphia: BFM books for midwives: 131-148.

O'Driscoll, K., Meagher, D., Boylan, P. (1993) *Active management of labour.* London: Mosby Year Book Limited.

Office of National statistics. (2014) Live Births in England and Wales by Characteristics of Birth 2, 2013. [Online] Available at: http://www.ons.gov.uk/ons/dcp171778_384394.pdf (Accessed: 30/05/15)

Ohaja, M. (2012) 'In Deep: Contestations around motherhood and safe motherhood initiatives', *Essentially MIDIRS*, 3 (6): 32-36.

Olsen, O. and Clausen, J. (2012) Planned hospital birth versus planned home birth. *Cochrane Database of Systematic Reviews.* Issue 9. Art. No.: CD000352. doi:10.1002/14651858.CD000352.pub2.

Osbourne, A. and T. Lavender (2005) 'Debate. Partograms are not needed in birth centres', *British Journal of Midwifery,* 13 (10): 618-619

O'Sullivan, S. (2002) 'Why Do Midwives Leave?', *RCM,* 5 (7): 210.

Oxford Dictionary. (2011) *Concise Oxford dictionary*. Oxford: Oxford University press.

Page, L. (2008) 'Being a midwife to midwifery: Transforming midwifery services (Chapter 8)', in Fahy, K., Foureur, M. and Hastie, C. (eds.) *Birth Territory and midwifery guardianship: Theory for practice education and research.* Philadelphia: BFM books for midwives: 115-130.

Page, L. (2003) 'One to one midwifery: Restoring the 'with woman' relationship in Midwifery', *Journal of Midwifery and Women's Health,* 48 (2): 119-125.

Page, L., Beake, S., Vail, A. and Hewison, J. (2001) 'Clinical outcomes of one-to-one midwifery practice', *British Journal of Midwifery*, 9 (11): 700-706.

Page, M. and Mander, R. (2014) 'Intrapartum uncertainty: A feature of normal birth, as experienced by midwives in Scotland', *Midwifery,* 30 (1): 28-35.

Page L., McCourt. C., Beake, S., Vail, A. and Hewison, J. (1999) 'Clinical Interventions and Outcomes of One-to-One Midwifery Practice', *Journal of Public Health Medicine,* 21: (3) 243-248.

Pairman, S. (2010) 'Midwifery partnership: A professionalizing strategy for midwives (Chapter 12)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 208-231.

Pascali-Bonaro, D. and M. Kroeger (2004) ‘Continuous female companionship during childbirth: a crucial resource in times of stress or calm’, *Journal of Midwifery and Women's Health*. 49: 19-27.

Patterson, J., Skinner, J. and Foureur, M. (2015) ‘Midwives ‘decision making about transfers for ‘slow’ labour in rural New Zealand’, *Midwifery*. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0266613815000625 (Accessed: 30/07/15).

Payant, L., Davies, I., Graham, I.D, Peterson, E., et al. (2008) Nurses’ Intentions to Provide Continuous Labor Support to Women. *Journal of Obstetrics, Gynecologic and Neonatal Nursing,* 37 (4): 405-414.

Pembroke, N., and Pembroke, J. (2006) ‘The spirituality of presence in Midwifery’, *Midwifery,* 24 (3): 321-327.

Plumridge, G., Redwood, S., Greenfield, S., Akhter, N., et al. (2012) ‘Involving interpreters in research studies’, *Journal of Health Services Research and Policy,* 17 (3): 190-192.

Prowse, J. and Prowse, P. (2008) ‘Role redesign in the National Health Service: the effects on midwives' work and professional boundaries’, *Work, Employment and Society,* 22 (4): 695-712.

Prus, R. (1996) *Symbolic Interaction and Ethnographic Research: Intersubjectivity and the Study of Human Lived Experience*. New York: State University of New York Press Albany

Pugh, L.C. and Millgan, R.A. (1993) ‘A framework for the study of childbearing fatigue’, *Advances in Nursing Science,* 15: 60–70.

Quality Membership Group. (2010) *Midwifery 2020 Programme: Measuring Quality Workstream, Final Report*. London: NCT. [Online] Available at: http://www.nes.scot.nhs.uk/media/1891400/measuring_quality.pdf (Accessed: 30/04/15).

Ralston, R. (1998) 'Communication: create barriers or develop therapeutic relationships?' *British Journal of Midwifery,* 6 (1): 8-11

Rayment, J. (2011) *Midwives' emotion and body work in two hospital settings: Personal strategies and professional projects*, University of Warwick. [Online] Available at: http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.537758 (Accessed: 30/04/15).

Reed, R. (2013) Midwifery practice during birth: Rites of passage and rites of protection. Thesis for the degree of Doctor of Philosophy: University of Sunshine Coast (Australia)

Rees, J. (2011) 'A Consideration of Ethical Issues Fundamental to Topics: Substance use during Pregnancy', *Evidenced Based Midwifery*, 9 (1):16-22.

Reeves S, Albert, M., Kuper, A. and Hodges, D. (2008) 'Why use theories in qualitative research?' *BMJ,* 337: 631-634.

Riemer, F. (2012) 'Ethnographic research (Chapter 7)', in Lapan, S. Quartaroli, M. Riemer F. (eds) *Quantitative research: An introduction to methods and designs*. San Francisco: John Wiley and Sons Inc.

Ritchie, J, and Lewis, J. (eds) (2003) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications.

Roberts, J.M., González, C.B. and Sampselle, C. (2007) 'Why Do Supportive Birth Attendants Become Directive of Maternal Bearing-Down Efforts in Second-Stage Labor?' *American College of Nurse-Midwives,* 52 (2): 134-141

Robertson, A. (2000) *The Midwife Companion: The Art of Support during Labour*. 2nd edn. Australia: ACE Graphics.

Rock, P. (2010) 'Symbolic Interactionism and Ethnography (Chapter 2)', in Atkinson P., Coffrey, A., Delamont S., Lofland, J. and Lofland L. (eds.) *Handbook of Ethnography*. London: Sage Publications: 26-38.

Rooks, S. (1999) 'The Midwifery Model of Care', Jo*urnal of Nurse-Midwifery,* July/August 44 (4): 370-374.

Roper, J.M. and Shapira, J. (2000) *Ethnography in Nursing Research*. London: Sage Publications.

Rosen, P. (2004) 'Supporting Women in Labor: Analysis of Different Types of Caregivers', *American College of Nurse-Midwives,* 49 (1): 24-31.

Ross-Davie, M. (2012) *Measuring the quantity and quality of midwifery support of women during labour and childbirth: The development and testing of the 'supportive midwifery in labour instrument'*, Thesis for the degree of Doctor of Philosophy: University of Stirling. [Online] Available at: http://dspace.stir.ac.uk/handle/1893/9796#.VrCxTFKnE7s (Accessed: 29/04/15).

Ross-Davie M. and Cheyne, H. (2014a) 'Intrapartum support: what do women want? A literature review', *The Royal College of Midwives. Evidence Based Midwifery,* 12 (2): 52-58.

Ross-Davie M. and Cheyne, H. (2014b) 'Understanding support in labour: the potential of systematic observation', *The Royal College of Midwives. Evidence Based Midwifery,* 12 (4):121-126.

Ross-Davie, M., Cheyne, H. and Niven, C. (2013) 'Measuring the quality and quantity of professional intrapartum support: testing a computerised systematic observation tool in the clinical setting', *BMC Pregnancy and Childbirth,* 13 (163): 1-12.

Rowe, R., Kurinczuk, J,. Locock, L. and Fitzpatrick, R. (2012) 'Women's experience of transfer from midwifery unit to hospital obstetric unit during labour: a qualitative interview study', *BMC Pregnancy and Childbirth,* 12 (129):1-15. [Online] Available at: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-12-129 (Accessed: 06/06/15).

Rowe, R. (2011) *Birthplace terms and definitions: consensus process. Birthplace in England research programme. Final report part 2*. Oxford: NIHR Service Delivery and Organisation programme. [Online] Available at: https://www.npeu.ox.ac.uk/birthplace/reports (Accessed: 06/06/15).

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2008) *Standards of Maternity Care: Report of a Working Party.* London: RCOG press. June.

Royal College of Midwives (RCM). (2012) *Evidence Based Guidelines for Midwifery Led Care in labour: Supporting Women in Labour.* London: RCM

Royal College of Midwives (RCM). (2010a) *One to one midwifery care in labour: A Briefing Paper*. London: RCM

Royal College of Midwives (RCM). (2010b) *The Royal College of Midwives' Survey of positions used in labour and birth*. London, RCM.

Royal College of Midwives (RCM). (2010c) *Maternity Support Workers: Position Statement.* London: RCM.

Royal College of Midwives (RCM). (2010d) *Responding to a proposal for merger or reconfiguration of Maternity Services Provision in England: A Good Practice Guide*. London: RCM.

Royal College of Midwives (RCM) (2009). *Guidance Paper: Staffing Standard in Midwifery Services*. London: RCM.

Royal College of Midwives. (2008) *Towards better births: A review of maternity services in England*. London: RCM. July

Royal College of Midwives and Netmums, (2009) The RCM and Netmum's survey: Alone and lost in labour; Shortage of midwives, lack of postnatal and antenatal care concerns for new mums. RCM. [Online] Available at: at:http://www.rcm.org.uk/college/media-centre/press-releases/the-rcm-netmums-survey-alone-lost-in-labour-shortage-of-midwives-and-lack-of-postnatal-antenatal-care-concerns-for-new-mums/ (Accessed: 02/09/11 No longer accessible)

Royal College of Obstetricians and Gynaecologists (RCOG). (2011) *High Quality Women's Health Care: A proposal for change.* London: RCOG. July 2011.

Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCOA), Royal College of Paediatrics and Child Health (RCPCH) (2008) *Standards for Maternity Care: Report of a working Party.* London: RCOG.

Royal college of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCOA), Royal College of Paediatrics and Child Health (RCPCH) (2007) *Safer Childbirth: Organisation and Delivery of Care in Labour: Report of a Working Party.* London: RCOG.

Russell, K. (2007) 'Mad, bad or different? Midwives and normal birth in obstetric led units', *British Journal of Midwifery*, 15 (3): 128 - 131.

Ryan, K., Brown, S., Wilkins, C., Taylor, A., et al. (2010) 'Which hat am I wearing today? Practising midwives doing research', *Practising midwives doing research,* 9 (1): 4-8.

Sandall, J., Soltani, H., Gate, S., Shennan, A. and Devane, D. (2013) Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* Issue 8. Art No: CD004667. pub 3. [Online] Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub3/abstract (Accessed: 29/04/15).

Sandall, J., Homer, C., Sadler, E., Bourgeault, I., et al. (2011) *Staffing in Maternity Unit: Getting the right people in the right place at the right time*. London: King's Fund.

Sandall, J., Manthorpe, J., Mansfield, A. and Spencer, L. (2007) *Support Workers in Maternity Services: A national scoping study of NHS trusts providing maternity care in England 2006*. London: King's College.

Sandall J. (1998) 'Occupational burnout in midwives: new ways of working and the relationship between organisational factors and psychological health and well-being. Risk', *Decision and Policy*, 3 (3):213–32.

Sapkota, S., Kobayashi, T. and Takase, M. (2013) 'Impact on perceived postnatal support, maternal anxiety and symptoms of depression in new mothers in Nepal when their husbands provide continuous support during labour', *Midwifery,* 29 (11): 1264-1271.

Sapkota, S., Kobayashi, T., Takase, M. (2011) 'Women's experience of giving birth with their husband's support in Nepal', British Journal of Midwifery, 19 (7): 426 – 432.

Sauls, D. (2006) 'Dimensions of Professional Labor Support for Intrapartum Practice', *Journal of nursing scholarship,* 38 (1): 36-41.

Save the Children. (2011) *Missing Midwives.* London: Save the Children UK.

Schroeder, E., Petrou, S., Patel, N., Hollowell, J., et al. (2012) 'Cost effectiveness of alternative planned places of birth in woman at low-risk of

complications: evidence from the Birthplace in England national prospective cohort study', *BMJ* 344. [Online] Available at: http://www.bmj.com/content/344/bmj.e2292 (Accessed: 06/06/15).

Schroeder L., Petrou, S., Patel, N., Hollowell, J., et al. (2011) *Birthplace cost-effectiveness analysis of planned place of birth: individual level analysis. Birthplace in England research programme. Final report part 5*. Oxford NIHR Service Delivery and Organisation programme. [Online] Available at: https://www.npeu.ox.ac.uk/birthplace/reports (Accessed: 06/06/15).

Scott, K. D., Berkowitz, G. and Klaus, M. (1999) 'A comparison of intermittent and continuous support during labor: A meta-analysis', *American Journal of Obstetrics and Gynecology,* 180 (5): 1054-1059.

Sengane, M. (2012) 'The expectations of fathers concerning care provided by midwives to the mothers during labour', *Health SA Gesondheid* 17(1):1-10 [Online] Available at: http://www.hsag.co.za/index.php/HSAG/article/view/527 (Accessed: 06/06/15).

Sherratt, D. and Odberg-Pettersson. K. (2006) *Investing in Midwives and Others with Midwifery Skills to save the Lives of Mothers and Newborns and improve their Health.* Sweden: UNFPA and ICM

Shribman, S. (2007) *Making It Better: For Mother and Baby*. London: Department of Health.

Silverton, L. (2009*) Doulas have their role but should not interfere in clinical decision say midwives* [Press Release]. 2 December London: Royal College of Midwives. http://www.rcm.org.uk/college/media-centre/press-releases/copy-of-doulas-have-a-role-but-should-not-interfere-in-clinical-decision-making-say-midwives [Accessed 14/03/10 No longer accessible]

Simkin, P. (2002) 'Supportive Care during labor: A Guide for Busy Nurses', *JOGNN,* 31 (6): 721-732.

Singh, D. and Newburn, M. (2006) 'Feathering the nest: What women want from the birth environment', *Midwives,* 9 (7): 266-269.

Sjöblom, I., Lundgren, I., Idvall, E. and Lindgren, H. (2015) 'Being a homebirth midwife in the Nordic countries–a phenomenological study', *Sexual and Reproductive Healthcare*, 6 (3): 126-131.

Smith, A., Dixon, A. and Page, L. (2009) *Health-Care professional' view about safety in maternity services.* London: The King's Fund.

Smith, A., Dixon, A., et al. (2008) 'Health-Care professional' view about safety in maternity services: A qualitative study', *Midwifery,* 25: 21-31.

Snow, S. (2010) 'Mutual newness': mothers' experiences of student midwives', *British Journal of Midwifery,* 18 (1): 38-41.

Spradley, J.P. (1979). *The ethnographic Interview.* Florida: Harcourt Brace Jovanovich, inc.

Speziale, H.J. and Carpenter, D.R. (2003) *Qualitative Research in Nursing: Advancing the Humanistic Imperative* 3rd edn. Philadelphia: Lippincott.

Stapleton, H. (2004) 'Is there a difference between free gift and a planned purchase? The use of evidence-based leaflets in maternity care (Chapter five)', in Kirkham, M. (ed.) *Informed choice in maternity care.* Hampshire: Palgrave Macmillan: 87-112.

Steen, M., Downe, S., Bamford, N. and Edozien, L. (2012) 'Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care', *Midwifery,* 28 (4): 422-431.

Stephens, L. (2010) ‘Improvement of maternity services will require investment’, *British Journal of Midwifery,* 18 (3): 142.

Stevens, J., Dahlen, H., Jackson, D. (2011) ‘Midwives’ and doulas’ perspectives of the role of the doula in Australia: A qualitative study’, *Midwifery,* 27 (4): 509-516.

Stevens, T. and McCourt, C. (2002a) ‘One-to-one midwifery practice part 2: the transition period’, *British Journal of Midwifery,* 10 (1): 45-50.

Stevens, T. and McCourt, C. (2002b) ‘One-to-one midwifery practice part 3: meaning for midwives’, *British Journal of Midwifery,* 10 (2):111-115.

Stevens, T. and McCourt, C. (2002c) ‘One-to-one midwifery practice part 4: sustaining the model’, *British Journal of Midwifery,* 10 (3): 174 -179.

Stevens, T. and McCourt, C. (2001) ‘One-to-one midwifery practice part 1: setting the scene’, *British Journal of Midwifery,* 9 (12): 736-740.

Stockton, A. (2010) Mother’s mouthpiece or clinician’s curse: the doula debate continues. *MIDIRS Midwifery Digest,* 20 (1):57-58.

Strauss, A. and Corbin, J. (1990) *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.

Strøm, A. and Fagermoen, M. (2012) ‘Systematic Data Integration-A Method for Combined Analyses of Fieldnotes and Interview Texts’, *International Journal of Qualitative Methods*, 11 (5):534-546.

Surtees, R. (2010) ‘‘Everybody expects the perfect baby... and perfect labour ... and so yTanou have to protect yourself ’: discourses of defence in midwifery practice in Aotearoa / New Zealand’, *Nursing Inquiry,* 17 (1): 81-91.

Tarlazzi, E., Chiari, P., Naldi, E., et al. (2015) ‘Italian fathers’ experiences of labour pain’, *British Journal of Midwifery,* 23 (3): 188-194.

Teshome, M., Abdulla, A. Kumbi, S. (2007) 'Parturients' need of continuous labor support in labor wards', *Ethiopian Journal of Health Development,* 21 (1): 35-39.

Tew, M. (1985) 'Place of birth and perinatal mortality', *The Journal of the Royal College of General Practitioners,* 35 (277): 390-394.

Thorstensson, S., Anette, E., Lundgren, I. and Wahn E.H (2012) 'Exploring Professional Support Offered by Midwives during Labour: An Observation and Interview Study', *Nursing Research and Practice.* [Online] Available at: http://www.hindawi.com/journals/nrp/2012/648405/ (Accessed: 29/04/15).

Thorstensson, S., Anette, E., Lundgren, I. and Wahn E.H (2008) An exploration and description of student midwives' experiences in offering continuous labour support to women/couples. *Midwifery*, 24 (4) : 451–459.

Tully, G. (2015) *Spinning babies: Easier birth with feta positioning*. [Online] Available at: http://spinningbabies.com/learn-more/maternal-positioning/ (Accessed: 29/08/15).

Tzeng, Y., Teng, Y., Chou, F. and Tu, H. (2009) 'Identifying trajectories of birth-related fatigue of expectant fathers', *Journal of Clinical Nursing.* 18 (12): 1674-1683.

UNFPA. (2009) *The Annual Report 2009: The Maternal Health Thematic Fund Accelerating Progress towards Millennium Development Goal 5*. New York. The United Nations Population Fund.

UNICEF and World Health Organisation. (2014) *Fulfilling the Health Agenda for Women and Children: The 2014 Report*. Geneva. WHO Press

United Nations. (2015) *The Millennium Development Goals Report 2015*. New York. United Nations.

Van Zandt, S., Edwards, L. and Jordan, E. (2005) 'Lower epidural anesthesia use associated with labor support by student nurse doulas: Implications for intrapartal nursing practice', *Complementary Therapies in Clinical Practice.* 11 (3):153-160.

Waldenström, U. (1999) 'Experience of labor and birth in 1111 women', *Journal of Psychosomatic Research,* 47 (5): 471-482.

Walker, K. (1997) 'Cutting edge: deconstructive inquiry and the mission of the border ethnographer', *Nursing Inquiry,* 4 (1): 3-13.

Warren, L. and Hunter, B. (2014) 'Reflecting on resilience in midwifery', *The practising Midwife*, 17 (11):21-23.

Warwick, C. (2011) *Midwife numbers do matter says RCM on King's Fund report*, RCM, Sunday 6th March, [Online] Was available, but has been removed: http://www.rcm.org.uk/college/about/media-centre/press-releases/midwife-numbers-do-matter-says-rcm-on-kings-fund-report-06-03-11/ (Accessed: 01/06/11).

Walsh, D. (2010a) 'Birth Environment (Chapter 4)', in Walsh, D. (ed.). *Essential Midwifery Practice: Intrapartum Care*. West Sussex: Wiley-Blackwell**:** 45-61.

Walsh, D. (2010b) 'Evolution of Current Systems of Intrapartum Care (chapter 1)', in Walsh, D. (ed.). *Essential Midwifery Practice: Intrapartum Care*. West Sussex: Wiley-Blackwell**:** 1-11.

Walsh, D. (2010c) 'Childbirth embodiment: problematic aspects of current understandings', *Sociology of Health and Illness,* 32 (3): 486-501.

Walsh, D. (2007) 'A birth centre's encounters with discourses of childbirth: how resistance led to innovation', *Sociology of Health and Illness,* 29 (2): 216–232.

Walsh, D. (2006a) ‘Nesting’ and ‘Matrescence’ as distinctive features of a free-standing birth centre in the UK’, *Midwifery*, 22: 228-239.

Walsh, D. (2006b) ‘Subverting the assembly-line: Childbirth in a free-standing birth centre’, *Social Science and Medicine,* 62: 1330-1340. [Online] Available at: http://www.sciencedirect.com/science/article/pii/S0277953605004302 (Accessed: 29/06/15).

Walsh, D. (1999) ‘An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend’, *Midwifery,* 15 (3): 165-176.

Walton, I. (2009) ‘Power, places and spaces: issues for women in labour’, *Midwifery matters*, Autumn. (122): 3-6.

Walton, C., Yiannousiz, K. and Gatsby, H. (2005) ‘Promoting midwifery-led care within an obstetric-led unit’, *British Journal of Midwifery,* 13 (12): 752-755.

Washbrook M, and Ball J. (2015) Birthrate plus work force planning for midwifery services: Acuity Assessment. [Online] Available at: http://birthrateplus.co.uk/index.php?option=com_contentandtask=viewandid=18andItemid=26 (Accessed: 30/04/15).

Welsh Government. (2014) Maternity Statistics, Wales Method of Delivery, 2004-2014. Cardiff: Welsh Government. [Online] Available at: http://gov.wales/docs/statistics/2014/141202-maternity-method-delivery-2014-en.pdf (Accessed: 30/06/15).

Whitehead, T. L. (2004) What is ethnography? Methodological, ontological, and epistemological attributes. Cultural Ecology of Health and Change*. (CEHC)*. [Online] Available at: http://www.cusag.umd.edu/documents/WorkingPapers/EpiOntAttrib.pdf (Accessed: 06/06/15).

Which??Birth Choice. (2015) *Birth environments*. [Online] Available at: http://www.which.co.uk/birth-choice/understand-your-choices (Accessed: 06/06/15).

Wilkins. R. (2010) 'Poor relationships: The paucity of the professional paradigm (chapter 5)', in Kirkham, M. (ed.) *The Midwife-Mother Relationship* 2nd edn. Hampshire: Palgrave Macmillan: 66-90.

Williams, K., Lago, L., Lainchbury, A., Eagar, K. (2010) 'Mothers' views of caseload midwifery and the value of continuity of care at an Australian regional hospital', *Midwifery,* 26 (6): 615-621.

Wiysonge, C. (2009) *Midwife-led versus other models of care for childbearing women: RHL commentary* (last revised: 1 September 2009). The WHO Reproductive Health Library; Geneva: World Health Organisation. [Online] Available at: http://apps.who.int/rhl/pregnancy_childbirth/antenatal_care/general/cd004667_Wiysongecs_com/en/index.html (Accessed: 16/05/15)

WHO. (2015) *WHO Statement on Caesarean Section Rates*. Geneva: Department of Reproductive Health and Research World Health Organisation. [Online] Available at: http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1 (Accessed: 16/05/15).

WHO (2010) Countdown to 2015 *Taking stock of Maternal, Newborn and Child Survival 2000–2010 decade report*. Geneva: WHO.

WHO (2006) *Factsheet: Skilled attendant at birth 2006 updates*: Geneva. World Health Organisation. [Online] Available at: http://apps.who.int/iris/bitstream/10665/69951/1/WHO_RHR_06.15_eng.pdf (Accessed: 16/05/15).

WHO, ICM and FIGO. (2004) *Making pregnancy safer: the critical role of skilled attendant*. Geneva, World Health Organisation. [Online] Available at: http://apps.who.int/iris/bitstream/10665/42955/1/9241591692.pdf (Accessed: 16/05/15)

WHO. (1996) *Safe Motherhood. Care in Normal Birth: a Practical Guide. Department of Reproductive Health and Research*. Geneva: World Health Organisation.

WHO, UNICEF, UNFPA, and the World Bank. (2007) *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva: World Health Organisation.

Whyte, W.F. (1981) *Street Corner Society: The Social Structure of an Italian Slum* 3rd edn. London: University of Chicago Press, Ltd.

Wöckel, A., Schäfer, E., Beggel, A. and Abou-Dakn, M. (2007) 'Getting ready for birth: Impending Fatherhood'*, British Journal of Midwifery*, 15 (6): 344-348.

Wolcott, H.F. (1995) *The Art of Fieldwork*. London: Altamira (A division of Sage publications).

Wolcott, H.F. (1990) 'Making a study 'more ethnographic'. *Journal of Contemporary ethnography*, 19 (1): 44-72.

Women Deliver. (2009) *Focus on 5: Women's Health and the MDGs*. New York. Women Deliver. [Online] Available at: http://www.womendeliver.org/assets/Focus-on-5.pdf (Accessed: 16/05/15).

Yin, K.Y. (2003) *Applications of Case Study Research* 2nd edn. London: Sage Publications.

Zhang, J., Bernasko, J., Leyhovich, E., Fahs, M., et al. (1996) 'Continuous Labor Support from Labor Attendant for Primiparous Women: A Meta-Analysis', *Obstetrics and Gynecology,* 88 (4): 739-744.

Appendix I: Invitation letter to midwives

Georgina Sosa
PhD student at University of East Anglia
Email: [redacted]
Mobile: [redacted]
[redacted]

Dear Midwife

My name is Georgina and I am a practicing midwife who is also doing a research study about midwifery one-to-one support in labour. Starting from the beginning of [redacted] I will be at the [redacted] for 12 weeks, completing the study. In that time I hope to observe approximately 10 labour cases. This is part of a study that will take approximately one year to complete, as it is based at three different hospital organisations [redacted] is therefore one of the three maternity organisations.

I would like to invite you to take part in my study where I will be working in the capacity of a researcher. Before you consider this however, I have attached an information sheet for you to read, describing the aims of the study and what you can expect when considering whether to give consent or not to participate in the study. I have also attached a consent form. Please read carefully. It is your choice to say yes or no to any of the statements.

At any point in the study if you require any further information please do not hesitate to contact me.

Many thanks for taking the time to read the information about the study

I look forward to the meeting you

Yours sincerely

Georgina Sosa

PhD Student at the University of East Anglia

Appendix II: Information leaflet for midwives

[redacted]

Research regarding Midwifery One-to-One Support in Labour

Participant Information Sheet

For Midwives working at the [redacted]

Introduction

My name is Georgina and I am a midwife who is doing a research study about midwifery one-to-one support in labour. I would like to invite you to take part in my study where I will be working in the capacity of a researcher only. This means that while I am conducting the research at the [insert site], I will not be practising as a midwife. Before you decide I would like you to understand why the study is being done and what it would involve for you. Please read through the information sheet.

I suggest this should take about 10 minutes. Please talk to others about the study if you wish.

For further information please contact Georgina using:

Email: [redacted]

Mobile: [redacted]

What is the purpose of the study?

The aim of the study is to understand the training needs of midwives when providing one to one support in labour. To achieve this there needs to be an understanding of how midwives provide their support in different birth environments including the Home, Midwifery Unit and Hospital and how that care is perceived by women.

The [redacted] will be representing midwifery one-to-one support provided in a midwifery stand alone environment to women who are receiving midwifery led care.

What will the study involve?

If you give consent, you will be asked if I can observe you providing support to a woman in labour. The observation will not be longer than 8 hours. I will when appropriate ask opportunistic questions so that I understand why and how you do activities. If you also consent to an interview, I will aim to clarify descriptions and meanings of the labour observations.

Why have I been invited?

All midwives who have at least one year labour care experience, are a band 6 or over and work at the [redacted] in the months of [insert date] to the end of [insert date] are being invited to take part.

Do I have to take part?

It is up to you to decide whether you join the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. There are no repercussions for this decision.

What do I have to do?

If you wish to take part in the study you will be asked to sign a consent form. The consent form is in two parts:

1. Consent for observation in labour
2. Consent for a interview following the labour

You can either place your consent form into my research consent box so that I am pre warned if you want to give consent or when you start your shift on labour ward you will need to inform the labour ward coordinator of your decision regarding consent.

What Will Happen to Me if I Take Part?

If you do give consent, you will support a woman in labour as you would normally, but I will be in the background observing and asking you opportunistic questions. If you also consent for an interview you can clarify descriptions and meanings observed. The interview transcript will be offered for you to read so that you can step back and assess the accuracy of what you wanted to articulate.

What are the Possible Disadvantages and Risks of Taking Part?

There is a potential psychological risk associated to you participating in this study as you may feel anxious that I am watching your practice. My aim however is not to assess your practice, but to understand it. You may also find it inconvenient having a researcher observing you in the labour room and asking you questions.

What are the possible benefits of taking part?

You may benefit from knowing that someone observing your care in labour has a genuine interest for your perspective. The knowledge gained will also contribute to the overall analysis and interpretation about how midwives practise in various environments and how women respond to it. This understanding will help the training of current and future midwives in relation to midwifery one-to-one support in labour.

What happens when the study stops?

Once the 3 months has ended at your hospital, the study may not have ended for me, as I have to study two other NHS Trusts. When all three NHS Trusts have been visited it will take approximately a year to analyse all the data collected and write it up. I will send you a two page summary of the overall findings when the research is complete.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. This means that management will not have access to the information concerning you and I will not discuss any of your details with them. The information will only be used for research purposes. Any direct quotes used will be anonymised. If I witness that a mother or baby is at risk however I will summon for help.

What will happen if I don't want to carry on with the study?

Once you have given consent, you can withdraw your consent from the study at any point without giving a reason. If you do withdraw all data collected will not be used. There are no repercussions for this which means that it would not be reported to your manager.

What if there is a problem?

If there are any problems concerning the observations or/and the interview, you can page the [redacted] at the [redacted]

What will happen to the results of the study?

The results will be written up as a PhD thesis and then published through midwifery journals and conferences. The aim will be to publicise the results of the whole study which will include recommendations regarding midwives' educational needs and suggestions how one-to-one support in labour should be described in government policies and research.

Who is organizing and funding the research?

The research is part of a PhD at the University of East Anglia. The PhD is being funded by the East of England Strategic Health Authority

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Committee-London: Brent

Please contact me (Georgina) if anything is unclear

Email: [redacted]

Mobile: [redacted]

Appendix III: Consent form for midwives

[redacted]

CONSENT FORM

For Midwives working at the [redacted]

Title of Project: Midwifery One-to-One Support in Labour

Name of Researcher: Georgina Sosa ***Participant Identification Number:***

	Please initial appropriate box	
	YES	**NO**
1. I confirm that I have read and understand the information sheet dated September 2011 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without repercussions.	☐	☐
3. I agree for my labour care to be observed by the researcher Georgina Sosa.	☐	☐
4. I agree to be interviewed by the researcher Georgina Sosa to clarify descriptions and meanings of the labour observation	☐	☐
5. I agree for a audio device to be used to record the interview	☐	☐
6. I understand that the data produced will be analyzed by Georgina Sosa and supervised by two University of East Anglia Lecturers. The supervisors will not have access to my identifiable details	☐	☐
7. I understand that quotes by me will be anonymised and may be used when the research is published	☐	☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed one copy for participant, one copy for researcher site file and one copy (original) to be kept in maternity records.

Appendix IV: Invitation letter to women

Georgina Sosa
PhD student at University of East Anglia
Email: [redacted]
Mobile: [redacted]
[redacted]

To women accessing the maternity services,

My name is Georgina and I am a practicing midwife who is also doing a study about midwifery one-to-one support in labour. Starting from the beginning of [redacted] I will be at the [redacted] for 12 weeks, completing the study. In that time I hope to observe approximately 10 labour cases. This is part of a study that will take approximately one year to complete, as it is based at three different hospital organisations. [redacted] is therefore one of the three maternity organisations.

I would like to invite you to take part in my study where I will be working in the capacity of a researcher. Before you consider this however, I have attached an information sheet for you to read and discuss with a midwife or myself, describing the aims of the study and what you can expect when considering whether to give consent or not to participate in the study. I have also attached a consent form. Please read carefully as there are different levels of consent. It is your choice to say yes or no to any of the statements. The midwife assessing you in labour will look at the consent form and will only discuss it further if you have said yes to give consent.

At any point in the study if you require any further information please do not hesitate to contact me. If you would prefer to speak to a hospital representative for [insert site] please refer to the information leaflet for the contact details of the Patient Advice and Liaison (PALS).

Many thanks for taking the time to read the information about my study

I look forward to the meeting you

Yours sincerely

Georgina Sosa. PhD Student at the University of East Anglia

Appendix V: Information leaflet for women

[redacted]

Research regarding Midwifery One-to-One Support in Labour

Participant Information Sheet

For Women Accessing Maternity care at the [redacted]

Introduction

My name is Georgina and I am a midwife who is doing a research study about midwifery one-to-one support in labour. I would like to invite you to take part in my study where I will be working in the capacity of a researcher only. This means that while I am conducting the research at the [insert site], I will not be practising as a midwife. Before you decide I would like you to understand why the study is being done and what it would involve for you. Please read through the information sheet.

I suggest this should take about 10 minutes. Please talk to others about the study if you wish.

For further information please contact Georgina using:

Email: [redacted]

Mobile: [redacted]

What is the purpose of the study?

The aim of the study is to understand the training needs of midwives when providing one-to-one support in labour. To achieve this there needs to be an understanding of how midwives provide their support in different birth environments. This will include the Home, Midwifery Unit and Hospital and how that care is perceived by you.

The [redacted] will be representing midwifery one-to-one support provided in a Midwifery stand alone environment to women who are receiving midwifery led care.

What will the study involve?

If you give consent, you will be asked by a midwife when you are admitted into the birth centre in established labour, if I can observe you in labour. The observation will not be longer than 8 hours. If you have also consented to an interview, I will visit you once at home, 2-4 weeks following the birth of your baby. This should not take longer than an hour.

Why have I been invited?

All women that are under midwifery led care, deemed low risk and are having their baby in the months of [redacted] to the end of [insert date] at the [insert site] are being invited to take part.

Do I have to take part?

It is up to you to decide whether you join the study. The midwives and I will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This will not affect the standard of care you receive.

What do I have to do?

If you wish to take part in the study you will be asked to sign a consent form. The consent form is in two parts:

1. Consent for observation in labour
2. Consent for a postnatal interview

When you are admitted in labour, you will need to inform the midwife of your decision regarding consent. You will also need to give a contact number if you give consent for the postnatal interview. I can then text or telephone you 2-4 weeks following the birth of your baby to arrange an interview.

What Will Happen to Me if I Take Part?

Your care in labour will not change whether you are part of the study or not. The only difference is that if you do give consent, I will be present as a researcher observing your labour. I will also interview you once at home, 2-4 weeks after you have given birth to your baby.

What are the Possible Disadvantages and Risks of Taking Part?

There are no risks associated to you participating in this study. You may find it inconvenient however having a researcher observing you in the labour room and visiting you at home for a postnatal interview.

What are the possible benefits of taking part?

You may benefit from knowing that someone observing your labour has a genuine interest in your labour and perspective. The knowledge gained will also help to understand how and why midwives work as they do when providing one to one support in labour and how women respond to it. This understanding will help the training of current and future midwives relating to midwifery one-to-one support in labour.

What happens when the study stops?

Once the 3 months has ended at your hospital, the study may have not ended for me, as I have to study two other NHS Trusts. When all three NHS Trusts have been visited it will take approximately a year to analyse all the data collected and write it up. I will send you a two page summary of the overall findings when the research is complete.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. This means that none of the hospital midwives or management will have access to the information concerning you and I will not discuss any of your details with them. If I witness that you or your baby is at risk however I will summon for help.

What will happen if I don't want to carry on with the study?

Once you have given consent, you can withdraw your consent from the study at any point without giving a reason. There are no repercussions for this which means that it would not affect the standard of care you receive as a result of the withdrawal. If you do withdraw all data collected will not be used.

What if there is a problem?

If there are any problems concerning the observations or/and the interview, you can contact the Patient Advice and Liaison (PALS) at [redacted] :

Email: Telephone: [redacted]

What will happen to the results of the study?

The results will be written up as a PhD thesis and then published through midwifery journals and conferences. The aim will be to publicise the results of the whole study. I aim to make recommendations about midwives' educational needs and how one to one support in labour should be described in government policies and research.

Who is organizing and funding the research?

The research is part of a PhD at the University of East Anglia. The PhD is being funded by the East of England Strategic Health Authority

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee. Their role is to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Committee-London: Brent.

Please ask your midwife or contact me (Georgina) if anything is unclear

Email: [redacted]

Mobile: [redacted]

Appendix VI: Consent form for women

[redacted]

CONSENT FORM

For Women Accessing Maternity Care at the [redacted]

Title of Project: Midwifery One-to-One Support in Labour

Name of Researcher: Georgina Sosa ***Participant Identification Number:***

	Please initial appropriate box	
	YES	**NO**
1. I confirm that I have read and understand the information sheet dated September 2011, (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without repercussions to the standard of my care	☐	☐
3. I understand and give permission for Georgina Sosa to read and analyse my maternity records for the research purposes.	☐	☐
4. I agree to be observed in labour by the researcher Georgina Sosa.	☐	☐
5. I agree to be interviewed 2-4 weeks after giving birth to my baby by the researcher Georgina Sosa	☐	☐
6. I agree for a audio device to be used to record the interview	☐	☐
7. I understand that the data produced will be analyzed by Georgina Sosa and supervised by two University of East Anglia Lecturers. The supervisors will not have access to my identifiable details	☐	☐
8. I understand that quotes by me will be anonymised and may be used when the research is published	☐	☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed one copy for participant, one copy for researcher site file and one copy (original) to be kept in maternity records.

Appendix VII: Maternity Services Liaison Committee peer review

Discussion with the Maternity Services Liaison Committee (MSLC) covering Case one: 14/06/11 at 1000-1100 am

Venue: MSLC member's house.

I described research to group. Points raised by the MSLC group included:

- My presence will affect mums in the labour environment. Example given by a mother present who is a multip. The mother expressed that she mostly had the midwife present, doing nothing. She felt better that even though the midwife did nothing, she was there. It was felt that me being in the room may provide the same reassurance when the midwife leaves the room.
- Birthing rooms are small. It is going to be difficult for me to blend into the background
- Women will not be themselves when being observed. Could I not use cameras as less obtrusive? Discussed implications from cost and ethics putting camera's in homes and hospitals, but good idea. (I am also thinking that I would not be able to ask opportunistic questions).
- My presence will influence the midwives practise. They may feel they can leave as you are in there
- Midwives are going though changes concerning midwifery led care (MLC). Having extra teaching on MLC. This may have implications on results. I will explain the situation as part of the write up
- A mother who is a multip said that at times she did not notice/aware if someone was present or not. She questioned whether this affects the response of mothers when asked if they received one to one care?
- If a woman starts talking to me will I respond? Discussed how I will make it clear at the beginning that I will only be observing.
- Will I meet the women prior to observing them? It was discussed in many circumstances' the woman does not know her midwife now she will have someone else present who she does not know. Some present felt it would be better if I introduced myself in the pregnancy.
- Two weeks postpartum is a good time to interview women. A mother who is a multip and 5 weeks postpartum explained how at present she cannot recall events

of her labour. She explained how at this time you have to get involved with other things other than baby. At 2 weeks she would have recalled her labour. Closer to 2 weeks as possible others reinforced.

- Face to face interviews were recommended rather than telephone calls. You can multi task while speaking face to face. A mother gave an example how difficult it is to communicate using the phone at present. She cannot have a complete conversation.
- Liked it that women can chose to opt out of interview if they want even if they chose to be observed in labour.
- Liked it that women can sign the consent form prior to admission to make it clear regarding consent, so women are not asked about the research if the consent says no.
- Asked if they could use NCT women as pre sampled then you could follow them through. Discussed how this population maybe more motivated than general population regarding normality etc that could have implications on the findings.
- Asked what I would be writing when I am observing. Explained activities of the midwife and woman, equipment used and descriptions of environment.
- Asked what would happen if she turns high-risk. I advised I will stay.

Appendix VIII: Ethics committee approval notice

NHS
National Research Ethics Service

NRES Committee London - Brent
Room 019, Level 7 Maternity Block
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ
Telephone: 020 88693805
Facsimile: 020 88695222

19 September 2011

Mrs Georgina Sosa
Governance Midwife
James Paget University Hospitals NHS Foundation Trust
Lowestoft Road
Gorleston
Great Yarmouth
NR31 6LA

Dear Mrs Sosa

Study title: **Midwifery One to One Support in Labour: Ethnographic Study of different Birth Environments**
REC reference: **11/LO/1283**

Thank you for your letter of 01 September 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/LO/1283	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Maurice Hoffman
Chair

Email: junsakuma@nhs.net

Enclosures: *List of names and professions of members who submitted written comments*

"After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Mrs Susan Steel*
University of East Anglia
Research, Enterprise & Engagement Office,
The Registry, University of East Anglia,
NR4 7TJ

Karen Reavell
ion: James Paget University Hospitals NHS Foundation Trust
R&D Office
Training & Education Centre
Lowestoft Road, Gorleston, Great Yarmouth
NR31 6LA

NRES Committee London - Brent

Attendance at Sub-Committee of the REC meeting on 16 September 2011

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Suresh Akula	Retired Civil Servant	Yes	
Mr Maurice Hoffman	Work Placement Advisor	Yes	

Appendix IX: Ethics committee review

NHS

National Research Ethics Service

NRES Committee London - Brent
Room 019, Level 7 Maternity Block
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Telephone: 020 88693805
Facsimile: 020 88695222

24 August 2011

Mrs Georgina Sosa
Governance Midwife
James Paget University Hospitals NHS Foundation Trust
Lowestoft Road
Gorleston
Great Yarmouth
NR31 6LA

Dear Mrs Sosa,

Study Title: **Midwifery One to One Support in Labour: Ethnographic Study of different Birth Environments**

REC reference number: **11/LO/1283**

The Research Ethics Committee reviewed the above application at the meeting held on 22 August 2011. Thank you for attending with Dr Crozier to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Covering Letter	Letter from Georgina Sosa	26 July 2011
Letter of invitation to participant	1 - For the Midwives - June 2011	
Letter of invitation to participant	1 - For the Women - June 2011	
Other: CV - Georgine Sosa	1	17 June 2011
Other: CV - Kenda Crozier	1	06 June 2011
Other: CV - ANDREA STÖCKL	1	19 July 2011
Other: To Whom It May Concern from Nicola Pilsbury		28 June 2011
Other: To Whom It May Concern from Sue Steel		19 July 2011
Other: MSLC covering th		14 June 2011
Other: MSLC covering		14 June 2011
Other: Poster for Midwives	1 - June 2011	
Other: Poster for Women	1 - June 2011	
Other: The Research Plan : A 3 month time table of the field work at each geographical site	1 - June 2011	
Other: The Research Plan : Research Plan from Sept	1 - June 2011	

2011 to Jan 2014		
Participant Consent Form: For Midwives	1 - June 2011	
Participant Consent Form: For Women Accessing Maternity care	1 - June 2011	
Participant Consent Form: For Midwives : Appendix : VII	1 - June 2011	
Participant Consent Form: For Women Accessing Maternity care : Appendix X	1 - June 2011	
Participant Information Sheet: For Midwives	1 - June 2011	
Participant Information Sheet: For Women Accessing Maternity care	1 - June 2011	
Participant Information Sheet: For Women Accessing Maternity care : Appendix : IX	1 - June 2011	
Participant Information Sheet: For Midwives : Appendix VI	1 - June 2011	
Protocol	1 - June 2011	
REC application		19 July 2011

Provisional opinion

1. The Committee asked you what the objectives of the study were. You responded that the main objective is to establish what the educational requirements of midwives are as Trusts are striving to reach one to one care. You confirmed that some hospitals are already providing this care and she aims to discover what this looks like and whether the midwives are ready. You added that the second objective is to examine how policy translates into the clinical arena.

2. The Committee requested clarification regarding the methodology of the study. You stated that fundamentally it is based on observations and interviews with midwives. You confirmed that it is essential that you observe births as you aim to study a model of care in the home and at hospital and whether the labour environment causes the model to change in any way. You informed the Committee that you wish to discover what the midwives do and how they interact with the mothers; once you establish this you can determine whether or not they require further training based on how prepared they seem for one to one care.

3. You informed the Committee that you will only be sending information out to midwives and that this will be done via Senior Midwives on the wards. You stated that you propose to approach these Senior Midwives at the beginning of a shift to ask if they are willing to give consent to the study and that if no one gives their consent you will request permission to stay in the ward environment and look into policies etc. You added that the mothers to be will be given the information regarding the study at their antenatal or Parent Craft appointments and will be asked to sign a Consent Form before going into labour.

4. The Committee asked whether you had thought about giving the midwives Consent Forms in advance. You stated that you had and that you will be leaving a box on the ward for them to post their completed Consent Forms in advance of the observations.

5. The Committee asked whether the mother to be confirms her consent to the study when she is admitted to hospital to give birth. You confirmed that this was correct and that the midwife that takes on her notes would take her consent.

6. The Committee asked you whether it was likely that there would be any disruption of

normal service and you confirmed that this would not occur. You stated that the interviews with midwives would only take place at a time suitable to them and could be scheduled on a study day or day off. You added that the interview does not have to be completed in one session and that you would be available five days a week so that the midwives could choose the most suitable day and time.

7. The Committee asked who your 'agreed contact' was. You informed them that it would be the Head of Midwifery and that this would have to be confirmed by each Research and Development Department. You added that two of the sites have confirmed so far.

8. The Committee asked what would happen if the participants do not agree to you observing the labour but you do get permission to remain outside of the labour room. You stated that you would observe the happenings outside of the room and on the ward itself. You assured the Committee that in this case you would not observe any of the labour.

9. The Committee queried why a questionnaire or interview guide had not been submitted and you stated that the interviews will be based on activities during the observations and that they would be completely unstructured. You confirmed that you would also interview the mothers as you wish to record their point of view however there is no schedule for these interviews either.

10. The Committee asked what would happen if any untoward information was disclosed regarding the mothers' medical care. You informed them that confidentiality is your highest priority however if the mother or baby is at risk then you would always inform the Head of Midwifery.

11. The Committee asked you whether the data has to be stored at your home. You responded that the Consent Forms will be stored in a locked cabinet in your workplace however as you will be working at home all other details need to be stored there. You added that it is difficult for part time students as they do not have an assigned computer at the university and do not attend very often. It was confirmed that in order to safeguard confidentiality you will delete addresses as you go along and that all data will be anonymised.

12. You agreed to add a statement for the participants to agree to an audio recording being taken on the two Consent Forms.

13. The Committee asked at what point it is decided that one to one care will be administered. You stated that the hospitals make this decision when labour begins.

14. The Committee asked whether the points raised by other review groups have been addressed. You informed them that the issues listed in the submission were from one person out of 20 and that you bore these points in mind whilst designing the study. It was agreed that it must be made explicit that you would be present at the labour as a researcher and not a midwife.

'ou left the meeting and the following discussion ensued:

15. The Committee agreed that you are clearly competent and confident with all aspects of the study.

16. It was agreed that the main concern is that you must make it explicit that a research project is being carried out and that you are not present as a midwife.

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

The Committee delegated authority to confirm its final opinion on the application to a meeting of the sub-committee of the REC formed of the Lead and Second Reviewers.

Further information or clarification required

1. Written confirmation should be provided that you will make it explicit to all involved that a research project is being carried out and that you are present at the labours as a researcher rather than a midwife. This should also be made clear in the Participant Information Sheets.

2. The following amendments should be made to the Consent Forms:

   a) A statement for the participants to agree to an audio recording being taken should be inserted.

   b) Point one should be updated to refer to the new version number and date of the Participant Information Sheet.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 22 December 2011.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

11/LO/1283	**Please quote this number on all correspondence**

Yours sincerely,

Dr John Keen
Chair

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Mrs Susan Steel, University of East Anglia*

Karen Reavell, James Paget University Hospitals NHS Foundation Trust

NRES Committee London - Brent

Attendance at Committee meeting on 22 August 2011

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Suresh Akula	Retired Civil Servant	Yes	
Mrs Sunder Chita	Manager	Yes	
Dr Graham Davison	Pharmaceutical Consultant	No	
Dr Neeta Ghosh-Chowdhury	General Practitioner	No	
Ms Homa Syeda Hasan	Genetic Counsellor	No	
Mr Maurice Hoffman	Work Placement Advisor	Yes	
Dr John Keen	General Practitioner	Yes	
Dr Ina Lisa Lauinger	Research assistant/associate	No	
Mr Adeyemi Olagbegi	Clinical Pharmacology Study Data Manager	No	
Mr Lawrence L. Penez	REC Coordinator (Temporary)	No	
Miss Vashti Ragoonanan	Specialist Nurse - Haematology	No	
Dr Manish Saxena	Doctor	No	
Mr Alan Smith	Retired Barrister's Clerk	Yes	
Miss Ourania Xeniou	Clinical Trial Site Manager	Yes	
Miss Zainab Yate	Bioethics Researcher	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Susie Cornick-Willis	Senior Coordinator

Appendix X: Posters for midwives regarding study

[redacted]

To All Midwives at the [redacted]

In [redacted] to [redacted] a study is taking place concerning
Midwifery One-to-One Support in Labour.

If you are a midwife who is band 6 and over, have over one year experience providing labour care and are providing one-to-one support in labour to women having their babies
in [redacted] *to* [redacted]
you may be approached to take part
in the study.

This means that a midwife researcher will be asking to observe the activities of midwives and labouring women when midwifery one-to-one support in labour is provided.

Georgina (midwife researcher) will be providing information about the study and then you can decide whether you would consider consenting to take part

Thank You
If you would like further information please do not hesitate to contact
Georgina Sosa

Mobile: [redacted] or email [redacted]

[redacted]

Appendix XI: Posters for women regarding study

[redacted]

For Women having their baby at the

In [redacted] to [redacted] a study is taking place about *Midwifery One-to-One Support in Labour.*

If you are under midwifery led care and due to have your baby in

[redacted] *to* [redacted]

at the [redacted]

you may be approached to take part in the study

This means that a midwife researcher will be observing the activities of midwives and labouring women when midwifery one-to-one support in labour is provided.

Your midwife or Georgina (midwife researcher) will provide information about the study and then you can decide whether you would consider consenting to take part

Thank You

If you would like further information please do not hesitate to contact

Georgina Sosa

Mobile: [redacted] or email [redacted]

Appendix XII: Laminated guidance cards for midwives regarding study

[redacted]

To All Midwives at the [redacted]
Midwifery One-to-one Support in Labour Research
[redacted] to [redacted]

Guidance summary for Midwives caring for women in labour:

To help recruit low-risk women to the research please can you perform the following when assessing women in labour:

1. Check to see if a consent form is present in the maternity notes for all low-risk women

2. If the woman has written "no" on the consent form, please do not discuss the research. If the woman has written "yes" on the consent form please check with the woman that she is still happy to be observed in labour.

3. If the woman is happy to be observed in labour and you as the midwife are also happy to be observed please inform Georgina.

4. Following the birth, please check whether consent has been given for a postnatal interview. If the woman has written "no" on the consent form, please do not discuss the postnatal interview. If the woman has written "yes" on the consent form please check with the woman that she is still happy to provide a contact number for Georgina to call her in two weeks time.

Thank You
Gina (Georgina Sosa)

[redacted]

To All Community Midwives at the [redacted]
Midwifery One-to-one Support in Labour Research
[redacted] to [redacted]

Guidance summary for Midwives contemplating participation in the research:

Please consider the following:

1. Read the research literature including the invitation letter, information leaflet and consent form.

2. If you know that you would like to participant contact Georgina by email or mobile. Alternatively place your consent form in Georgina's research box so that Georgina can approach you

3. At the beginning of each shift the senior midwife coordinator will ask if there are any midwives who are happy for Georgina to observe them supporting a woman in labour. Georgina will only be informed when a midwife and woman have both agreed for Georgina to observe them in the labour.

4. If you are happy to be observed while providing support in labour, you will need to inform Georgina if you would also be happy for a follow up interview at a time that is convenient for you to clarify what Georgina has seen

Please remember that all women and midwives involved in the research with be anonymised to protect identity locally and nationally

Thank You
Gina (Georgina Sosa)

Appendix XIIIa: Interview questions for midwives

How long have you been a midwife?

What areas of midwifery have you mostly worked in your career?

What does one-to-one support in labour mean to you?

Did you know the woman you cared for in labour?

What informs you to start midwifery one-to-one support in labour?

Are there any differences caring for a primigraviida or a multigravida, when you are providing one-to-one support in labour?

What informs you to call the second midwife?

I observed you telling the woman that she was doing really well, why did you do that?

I observed you encouraging fluid, why did you do that?

What do you feel the role of the birthing partners were?

When you was providing one-to-one support, could you share the reasons that you would need to leave the birth environment?

What reasons would people knock on the door of the labour room?

When do you think one-to-one support in labour should finish?

When you are unsure of something, who do you get that support from?

If you were caring for [named woman] in the hospital, what do you think the differences would be?

If were caring for [named woman] in a homebirth, what do you think the differences would be?

If were caring for [named woman] in a midwife-led unit, what do you think the differences would be?

Is one-to-one support in labour about presence of the midwife, or is it about availability and when I say availability I mean call me when you need me?

Is there anything about midwifery one-to-one support in labour that we haven't discussed, that you think would be an important contribution?

Appendix XIIIb: Interview questions for women

Why did you choose to give birth at the …?

What did you think of the rooms?

What does one-to-one support in labour mean to you?

Do you feel that you experienced one-to-one support in labour? Why?

When do you think the one-to-one support should start?

When do you think the one-to-one support should finish?

How did the midwife's presence make you feel?

Was there any time you wished that the midwife was out of the room when she was present?

Was there any time that you wished the midwife was present when she was not?

Did the midwife's presence effect your behaviour?

The midwife was saying you are doing well. How did the midwife's words make you feel?

How did you feel emotionally in labour and did this change as it progressed?

The midwife asked you many questions about how you felt the labour was progressing, how did that make you feel?

How important is it for midwives to talk to you about your progress?

What do you think the role of your birthing partners were?

Do you feel they were supported?

How important is it to see and feel that your partner is looked after through the labour?

The midwife kept offering water and food how did that make you feel?

Was you aware when the midwife was documenting?

How did it make you feel to see the midwife documenting?

If you was going to give advice to a first time mum who was going to have her baby at … What would you advise her, after having your experience?

What advice would you give to a junior midwife that is just starting out giving one-to-one support?

Midwifery one-to-one support to you, is it about presence of the midwife, or is it about availability and when I say availability I mean call me when you need me or both?

Is there anything about midwifery one-to-one support in labour that we haven't discussed, that you think would be an important contribution?

Appendix XIV: The meaning of abbreviations used for drawings

Abbreviation	Meaning
W	Woman in labour
BP	Birthing partner (mostly the partner but sometimes the mother, sister and friend)
P, part	Partner
MW	Midwife
MW1	The first midwife
MW2	The second midwife
MW3 and above	Showed the number of the midwife/midwives due to shift changes
ST MW	Student midwife
CTG	Continuous fetal monitor
Lith	Lithotomy

Appendix XV: One-to-one audit tool

Hospital number : **Women's 1:1 Care in labour Audit Tool** **Date of Delivery:**

Information for women: We are very keen to find out your views on whether you feel you had 1:1 care in established labour. We would be very grateful if you would take the time to complete this questionnaire as fully as you can. The information you provide will help us to improve services for women during labour and will remain confidential. Thank you very much for your help .

Definition of 1:1 care in labour: A woman in established labour receives care from a designated midwife for the whole of that labour, or the midwife's whole shift, whichever is shorter. The midwife will be available to care for the woman 100% of the time.

No:	Question	Yes / No	Comment
1	Did you feel that you had a specific named midwife that was looking after you?	Name?	
2	Did the midwife/ midwives introduce themselves to you?		
3	Did the doctor/doctors introduce themselves to you?		
4	Did you receive 1:1 care by a midwife while in established labour		Comments if No
5	Did your midwife leave you alone for long periods of time while you were in labour		If yes – was the reason explained yes/no
6	Did the midwife explain to you how to get help if you needed it?		
7	Would you have liked more time without the midwife being present while you were in labour?		
8	Do you feel your midwife / doctor explained things to you in a way you could understand?		
9	What is your overall view of the care you received while on the labour ward?		

Appendix XVI: Pain relief used at all three case study sites

Women	TENS	Entonox	Injection
1			
2		x	
3			
4		x	
5		x	
6	x	x	
7			
8		x	
9		x	
10			
11		x	
12		x	
13		x	
14		x	X
15	x	x	
16		x	
17		x	
18		x	
19			
20	x	x	
21		x	
22		x	
23		x	
24		x	
25		x	
26		x	
27		x	
28		x	
29			
30		x	

Appendix XVII: ‘Take charge routine’ (Simkin 2002)

The ‘Take charge routine’
The Take Charge Routine is reserved for any time that the laboring woman (a) hits an emotional low; (b) is in despair, weeps or cries out; (c) wants to give up and feels she cannot go on; (d) is tense, cannot relax, and has lost any rhythm in her responses to contractions; and (e) is in a great deal of pain. The nurse can model the Take Charge Routine for the partner, watch him do it, and give feedback. With the Take Charge Routine, the nurse or support person moves in close and helps her intensively until she regains her ability to cope with the contractions. Usually her despair is temporary; with appropriate help, she can pass through it and her spirits will rise. The nurse or other support person should: 1. Remain calm, using firm and confident touch, and a calm and encouraging tone of voice. 2. Make eye contact. If the woman’s eyes are clenched shut in an expression of pain or anguish, tell her to open her eyes and look at the nurse or partner’s hand, face, or at some other person or object. Without eye contact, there is little to be done to help the distraught woman. Instructions must be given in a voice loud enough to be heard, but calm and kind in tone. Whenever she reverts to clenching her eyes shut, she needs to be reminded to “Look at my hand (face, partner’s face, etc.).” .Help her find a ritual, a different position or movement, a different breathing or moaning rhythm. 4. Pace her rhythmic breathing/moaning or movement by “conducting” (having her follow the rhythm of the support person’s hand movements, stroking, or speaking). 5. Encourage her every breath with words in a calm confident tone of voice, in the rhythm of her breathing: “Look right at

me . . . Breathe with me . . . That's the way . . .Just like that . . . Good . . . Stay with it . . . Just like that. . . (If she closes her eyes) LOOK AT ME (or MY HAND) . . . Stay with me . . . Good for you . . . It's going away . . . Good . . . Good . . . Now just rest . . . That was so good."

6. Talk to her between contractions. Ask her if what the nurse or partner is doing is helping and/or make suggestions, for example: "With the next one, let me help you more. I want you to look at me the moment it starts. We'll breathe together so it won't get ahead of us. Okay? Good. You're doing so well. Not too much longer."

7. Repeat the instructions. The woman may not be able to continue doing what she has been instructed to do for more than a few seconds. This should not be interpreted as a lack of success. To continue, she may require frequent or constant encouragement.

8. Hold the woman close or ask her partner to do so.

9. Between contractions, help the woman release tension with each exhalation. "Now get your rest. Take a big sigh and let all your tension go as you breathe it out. That's the way."

10. Directly address discouragement if she expresses it. Unfortunately, when a woman says, "I can't do it," she is often told, "You are doing it." She feels unheard. It is better to validate her feelings: "This is rough right now. Let me help you more." Consider pain medication if the end is not near and she cannot cope, or if she has planned to use it.

11. Reassure the woman's partner, pointing out that as long as the woman can maintain a rhythm, even though she needs constant guidance to do so, she is okay, and that this is what is expected at this stage in labor. Note. From The Birth Partner, by Penny Simkin. Copyright 2001 by the author. Adapted with permission.