‘Practising outside of the box, whilst within the system’: A feminist narrative inquiry of NHS midwives supporting and facilitating women’s alternative physiological birthing choices.

by

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Appendix 1 - Caring for women making unconventional birth choices: A meta-ethnography exploring the views, attitudes, and experiences of midwives (Feeley, Thomson, & Downe, 2019).

(please note I have included the uploaded Word version that was published, rather than the pdf final proof due to formatting issues that would affect the thesis layout).

Introduction

There is a global movement towards improved human rights during childbirth (World Health Organisation, 2012). Respect for women's decision-making, autonomy, including the right to decline recommended care or treatment is central to the movement (The White Ribbon Alliance, 2013). However, in reality, women's birth choices can be bound in ethical dilemmas, moralistic opposition and restrictive care provision (Dahlen, Jackson, & Stevens, 2011; Keedle, Schmeid, Burns, & Dahlen, 2015; Viisainen, 2000); some women face opposition when attempting to exert their agency (The White Ribbon Alliance, 2013; World Health Organisation, 2012), particularly those deemed 'unconventional' (Keedle et al., 2015; Shallow, 2013; Viisainen, 2000).

Broadly, unconventional birth choices can be characterised by those that fall outside of national clinical guidelines. These can include choices for more technical care than is recommended (for instance elective cesarean section or early labour induction with no medical indication). However, in highly technical, risk-averse maternity systems that are prevalent in most high income settings, choices for *less* medical intervention than is recommended are more likely to be deemed unconventional. These may include women who have medical or obstetric risk-factors seeking midwife-led care settings (home or birth centres), or women declining recommendations for specific

treatments or interventions, such as routine ultrasound scanning, or labour induction after 41 weeks gestation. For the purposes of this review, we have chosen to focus on birth choices related to less medical intervention.

Midwives, like other maternity care professionals, work within contexts where medico-legal and medico-ethical tensions around caring for a mother-baby dyad are prevalent (Deshpande & Oxford, 2012; Dexter, Windsor, & Watkinson, 2013). These debates include conceptualizations of risk (Symon, 2006), the under or over-medicalization of childbirth (recently reframed as *'Too much, too soon, too little, too late'*) (Renfrew et al., 2014) and paternalistic cultures vs self-determination (Edwards, Murphy-Lawless, Kirkham, & Davies, 2011). These debates also sit alongside evidence-based medicine (EBM). EBM has the intended goal of applying the best available scientific evidence to healthcare practices or treatments, in the context of patient values and clinical skills and expertise (Greenhalgh, 2014). However, EBM has been criticized when it is used to justify the application of formulaic, population-based hospital policies and guidelines to specific individuals (Kotaska, 2011). From the perspective of maternity care, it has been argued that guidelines have been reified into rules, defendable in court should the situation arise, irrespective of the needs and choices of individual women and babies (Downe, 2010). In this context, conflicts have arisen between the rhetoric of women's birth choices, and the organizational obligations of professionals providing the care (Kotaska, 2011; Kotaska, 2017; Kruske, Young, Jenkinson, & Catchlove, 2013).

There is a body of research on women's experiences of unconventional birth choices, including freebirthing (Feeley & Thomson, 2016); vaginal birth after

caesarean (VBAC) at home (Keedle et al., 2015) or in a birth pool (McKenna & Symon, 2014), and twin births or breech births at home or in a birth center (Holton & de Miranda, 2016; Jackson, Dahlen, & Schmeid, 2012). However, to date, little is known about the views and experiences of midwives caring for women making such choices. The aim of this review was, therefore, to gather, quality assess, synthesize and interpret the views, attitudes, and experiences of the midwives caring for women making unconventional birth choices where those choices were associated with less medical interventions.

Methods

Research design

A systematic search and meta-ethnography informed by Noblit and Hare (1988) and Schutz (1962) was undertaken. Meta-ethnography was chosen due to its capacity to explore a range of qualitative studies focusing on a particular phenomenon and to formulate new conceptualizations of a phenomenon (Atkins et al., 2008). Noblit and Hare (1988) provide a seven-phase approach to selecting, appraising, summarising, interpreting and synthesizing qualitative studies, see Figure 1. A review protocol for this study was submitted to PROSPERO (The International Prospective Register of Systematic Reviews), registration number CRD (blinded for review). Additionally, the study has been written in adherence with Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) (Tong, Flemming, McInnes, Oliver, & Craig, 2012).

Figure 1 Noblit and Hare's Seven Phase Approach

Reflexivity

To enhance the trustworthiness of the review (Lincoln & Guba, 1985; Walsh & Downe, 2006), all authors reflexively considered their prior beliefs before commencing the study. In summary, X (blinded for review) and X are midwives and X has a background in psychology. All have a firm philosophy of woman-centered care and believe it is crucial to support and facilitate childbearing women in decision making even if these decisions fall outside of standard protocols and guidelines, or outside of the personal beliefs and values of the authors. X and X also have experience of the personal anxiety and tensions that arises when trying to support women in this situation, of the risk of over-identifying either with the organizational culture, or with the woman's particular situation.

Search strategy and selection criteria

A pre-designed comprehensive search strategy was carried out to seek all available studies. Free text search terms were developed using 'Population and their Problems, Exposure and Outcomes or Themes' (PEO) framework (Bettany-Saltikov, 2012). Additionally, the search terms were reviewed by two librarians given the complexity of the review. A pilot test was carried out to ensure the search strategy was fit for purpose. The search was carried out during August-September 2016 (updated in October 2017) using pre-developed search terms: midwi* OR nurse-midwi* AND facilita* OR attitud* OR view* OR experienc* OR belief* OR perception* OR opinion* OR perspective* OR support or car* AND birth OR delivery OR birth choice OR vaginal birth after cesarean OR VBAC OR breech OR home OR birth centre. Eight international bibliographic databases were searched: Cumulative Index of Nursing and

Allied Health Literature (CINAHL), MEDLINE, Maternity and Infant Care, MIDIRS, PsychINFO, Lilacs, African Journals Online (AJOL) and Web of Science. Additional searches were carried out using reference chasing, citation chasing, author tracking, hand searching midwifery journals, unpublished thesis database Ethos, and professional networks. The full search strategy can be found in the supplementary file 1. The inclusion/exclusion criteria were predesigned, detailed in Table 1. Studies before the publication of the 1993 UK 'Changing Childbirth' report (DH, 1993) were excluded as this period marked a change in concurrent international discourses (Sandall, Bourgeault, Meiger, & Schuecking, 2001) surrounding childbirth, where a greater emphasis was placed upon women's right to choice and control.

Table 1 inclusion/exclusion criteria

Screening and Quality appraisal

Initial screening was carried out by title and abstract by the first author. All papers that met the initial screening criteria were obtained in full. The full texts were scrutinized by two authors independently, and then inclusion was agreed by consensus. Debates regarding the value of quality assessments for qualitative syntheses, mirrors the same debate for primary qualitative research (Atkins et al., 2008; France et al., 2014). The debate largely centers around whether or not there is a philosophical rationale for undertaking quality assessments (Sandelowski, Docherty, & Emden, 1996; Campbell et al., 2011), and if so, what criteria should be used (Thomas & Harden, 2008; Campbell et al., 2011). Our view aligns with those who recognise the increasing value and contribution of qualitative studies to evidence based policy and practice,

signifying an emerging need to ensure minimal standards are met (Walsh & Downe, 2006; Thomas & Harden, 2008; Campbell et al., 2011). In this study the quality of the included papers was assessed by two authors using the same process of independent assessment followed by consensus agreement, using the Walsh & Downe (2009) integrated quality appraisal tool. The tool assesses the: scope and purpose; design, sampling strategy, analysis, interpretation, reflexivity, ethical dimensions, relevance, and transferability. Each paper was also graded on a scale of A to D to provide an overall assessment of the quality (Downe et al., 2009), with a full exposition of the grading framework provided in Supplementary File 2.

Synthesis

Initial data extraction comprised of identifying and tabulating each studies' key characteristics i.e. their assigned code, author, country, aims, theoretical perspective, sample, setting, data collection method, data analysis method, adherence to ethics, reflexivity discussion, key findings and the quality grade. The synthesis method combined the inductive meta-ethnography approach of Noblit and Hare (1988) and Schutz (1962) and included several readings of each study, translation, and synthesis.

As per Noblit and Hare (1998), meta-ethnography operates on the conceptual level, whereby, the familiarisation stage involved each paper being read individually to identify any author constructs, themes and metaphors. All key concepts were recorded, assigned a code that captured the meaning of the concept, and tabulated using a tool developed by Downe et al., (2009). Quotes from participants were used to illustrate the identified concepts.

The coded concepts from the studies formed the basis of 'first order constructs' (Campbell et al., 2011). It is noted that Noblit and Hare (1988) did not originally refer to the use of constructs, nor have they updated their seminal text. However, methodology within meta-ethnography has grown in the 29 years since its inception (France et al., 2015). The use of constructs emerged primarily from Schutz's (1962) concepts of first, second and third order constructs and have been frequently used in meta-ethnographies (France et al., 2014). Therefore, we felt it was justifiable to combine constructs with our meta-ethnographic approach.

In this study, first-order constructs were captured as the initial concepts identified in the familiarisation stage. Second order constructs were produced from the constant comparison approach as per Noblit and Hare (1988). This approach aims to identify how the studies relate to each other; similarities are known as 'reciprocal translation', dissimilarities are known as 'refutational translation'. Where the studies generate simultaneous reciprocal and refutational translations, a researcher may develop a 'line of argument' which is a new conceptualisation that encompasses both (Noblit & Hare, 1988). This study generated both reciprocal and refutational second order constructs, that were further synthesised into core themes at a higher level of interpretation, captured as 'third order constructs'. Additionally, a tentative 'line of argument' was developed to capture the similarities and dissimilarities across the data set. All key themes and interpretations were carried out over several iterations, moving back and forth from the primary data to the emerging themes. Extensive discussions and feedback with all three authors ensured the

findings adequately represented the data. The full data set is provided in Supplementary file 3.

Results

Twelve of 7,237 papers met the inclusion criteria at the abstract stage, see Figure 1. Five were excluded at the full-text stage; two were quantitative studies (Danerek et al., 2011; Jenkinson et al., 2015), one was an audit (Sellar, 2008), one a case study with little focus on midwifery care (Jankowski & Burcher, 2015) and one was a study that focused maternal request for elective caesarean (Karlström, Engström-Olofsson, Nysted, & Thomas, 2009). Three papers reported findings from the same study (Wickham, 2009; Wickham, 2010; Wickham, 2011), therefore the total number of included studies was five, across seven papers (Cobell, 2015; Jenkinson et al., 2016; Symon, Winter, Donnan, & Kirkham, 2010; Thompson, 2013; Wickham, 2009; Wickham, 2010; Wickham, 2011). One study that was included was an unpublished primary qualitative study, that met the inclusion criteria (Cobell, 2015). All were graded 'C' or above through the quality appraisal process. An updated search in October 2017 found one further paper (Jenkinson, Kruske, & Kildea, 2017). As this was a secondary analysis of a study already included in the review (Jenkinson et al., 2016), it was excluded. Study characteristics and quality grading are presented in Table 2.

The included studies were of heterogeneous research designs and were undertaken in the UK (3), Australia (1), and in multiple settings (1; UK, US, and New Zealand), and included 55 midwives in total. Notably, all studies were undertaken in high-income countries, all with state-funded health care

systems, and where midwives are the lead professionals for healthy childbearing women at low risk of complications. However, one study (Symon et al., 2010) had a different focus to the other included studies as it concerned independent midwives' experiences of poor neonatal outcomes following women's unconventional birth choices.

Figure 2 PRISMA flow chart

Table 2 Study Characteristics

Findings

The first, second and third order constructs are presented in Table 3. In the following sections, the three third order constructs are discussed, together with exemplar quotes from the included studies. Quotes include a key to identify whether the midwives were self-employed (SEM) or employed by institutions (EM).

Table 3 Constructs

1. **Perceptions of women's decision-making**

This construct conveys the midwives' perceptions of the women making unconventional birth choices, and conflicting views regarding the maternal-fetal dyad.

The 'type' of woman

Participants across three of the studies perceived women who opted for unconventional birth choices to be a certain *'type'* of person (Cobell, 2015; Symon et al., 2010; Thompson, 2013). Participants in these studies associated the desire for control with well-educated women who wanted fewer

interventions during birth (Cobell, 2015; Symon et al., 2010; Thompson, 2013). The participant's in the Cobell study (2015, p.39) reported that the women making these choices were predominantly '*Caucasian*', and *'independent'*. These characteristics concurred with the participants in the Thompson (2013, p.568) study, who reported characteristics such as women being '*well-educated'* and '*intelligent'* as associated with making unconventional birth choices. These attributes were viewed positively (Cobell, 2015; Symon et al., 2010) or negatively (Thompson, 2013). Self-employed UK independent midwives were positive about women taking responsibility for their decisions regardless of the outcome:

'And I know, working with the women I've worked with, that the vast majority of those women—with positive and negative outcomes—are very clear that they would rather have gone that route of taking that decision themselves with the best information available to them and to move forward with that.' (Participant SEM, (Symon et al., 2010), p.282).

Avoiding intervention, avoiding repeated trauma

Some participants noted that a previous traumatic experience could influence women's unconventional choices (Cobell, 2015; Symon et al., 2010). One participant (employed midwife) in the study by Cobell (Cobell, 2015) suggested that a previous birth involving multiple interventions had influenced a woman's decision to opt for a subsequent birth outside of recommended guidelines:

'I think it was more that she didn't want that medical, bright lights, legs up in the air, kind of scenario' (Beth EM, (Cobell, 2015), p.40).

Independent midwives in the UK (Symon et al., 2010), reported that women sought their services (usually homebirths) to avoid a repetition of *'traumatic NHS care' (*p.283), even when experiencing multiple and concurrent risk factors, such having had a previous cesarean, or having either twins or a breech presentation in the current pregnancy (Symon et al., 2010). Further examples in this study included women declining emergency transfers to avoid NHS care (Symon et al., 2010):

'What is really hard to balance is the women who are so frightened of NHS care or going into hospital that they put themselves into really complex situations based on fear.' (Participant SEM, (Symon et al., 2010), p. 283).

Conflicting views of maternal autonomy

Participants across the studies acknowledged that, in principle, women had the right to make their own birthing decisions, including going against clinical advice or standard guidelines. In three studies, midwives expressed an explicit commitment to women's autonomy (Jenkinson et al., 2016; Symon et al., 2010; Wickham, 2010):

'All you have to do is impart the recommended information. . .and at the end of the day . . . it's the woman's choice to make that decision. . . It's a woman's right to choose. To choose care, and to refuse care and not to be punished for that.'

(MW11 EM, (Jenkinson et al., 2016),p.5).

However, in specific situations, views about and attitudes towards maternal autonomy were conflicted. For example, some employed midwives in the UK (Thompson, 2013) expressed concern that the woman's choices might not be in the best interest of their fetus. This is a complex area, especially as, in UK law, the fetus is not recognized as having any rights independent of the mother. One midwife felt more secure once the baby was born, as it meant she could regain professional control over its wellbeing:

'The only rights we have are when the baby is actually born. You can then step in and give appropriate care. There is nothing we can do for the woman that refuses. We can, however, make sure the baby is safe.' (Participant EM,(Thompson, 2013), p.576).

The juxtaposition between maternal and fetal wellbeing was starkly illustrated in the study of self-employed midwives by Symon et al., (2010) in the context of neonatal deaths. Despite the emotional distress midwives felt when women declined transfer to hospital for fetal problems, they continued to provide supportive care, in recognition of womens right to autonomous decision making:

'It is possible that if she had had an elective section she would have had two live babies, but there is no way she would have consented to an elective cesarean'.(Participant, SEM, (38), p.284)

2. Conflicting tensions as caregivers

This third-order construct details the different sources of fears and frustrations experienced by respondents.

Fears and vulnerabilities

In three studies, employed midwives reported professional and medico-legal tensions, together with personal stress and vulnerabilities when women declined recommended care (Cobell, 2015; Jenkinson et al., 2016; Thompson, 2013). Issues related to fears of poor fetal or maternal outcomes, coupled with fears of being held accountable for care that women declined:

'I felt vulnerable (pause) I felt that I was being torn in two ways. In that, I had a duty of care to support her in her decisions but I also had a duty of care to keep her safe and she did understand all the risks. So it was difficult at the time.'

(Participant EM, (Thompson, 2013) p.568).

Additional issues related to the impact of adverse outcomes on employed midwives' career (Jenkinson et al., 2016; Thompson, 2013). For some, this related to insurance issues when practicing outside of guidelines:

'If anything happens [poor maternal or fetal outcome] and I'm working outside of [hospital policies … then I am not covered by vicarious liability. So then, there goes my house!' (MW4 EM, (Jenkinson et al., 2016), p.5).

High levels of stress associated with these concerns affected some participants more acutely than others. Thompson (Thompson, 2013) reported that employed midwives disclosed feeling out of their comfort zones, and frustration towards some women's requests. These requests were at times considered *'silly, 'challenging and tricky'* (p.566) as well as time-consuming, to the detriment of other women's care. In contrast, employed midwives in the Cobell (Cobell, 2015) study reported vulnerabilities associated with feeling

judged by their *'fearful'* colleagues and that they '*had to prove themselves'* as highly capable midwives (p.44), rather than being supported in their practice:

'I think I get the sense that sometimes midwives think it <u>is</u> going to go wrong.' (Kate EM, (Cobell, 2015), p.44).

The constraints of arbitrary restrictions

Some midwives reported entirely different sources of frustration (Cobell, 2015) and anger (Wickham, 2010). In Cobell's study (2015), some employed midwives considered rigid adherence to guidelines to be problematic, due to creating unnecessary fears when faced with requests for alternative choices:

'what we're doing is putting people into categories and institutionalizing them via our guidelines and making people afraid if you come out of guidelines' (Ava EM, (Cobell, 2015), p.45).

These midwives challenged the concept of guidelines as rules to follow, rather than their intended use as tools to inform clinical care in conjunction with women's wishes:

'It is a guideline, it's not law, it's not gospel' (Beth EM, (Cobell, 2015), p.45).

All of the independent midwives in Wickham's (2010) study remonstrated against strict definitions of term and post-term pregnancy. They argued that the parameters set by formal guidelines were '*arbitrary*' (34, p.467), not based on robust clinical research, and counter to their experiences as midwives. They considered that the '*pervasive pressure to accept medical interventions*' (34, p.465) led to women being *'broken by the system'* (33, p.2); a metaphor

used to represent morbidities associated with routine and medicalized inductions:

> *'I just see the morbidity that's attached to that* [induction for post-term pregnancy] *and it breaks my heart. All those primips with their syntocinon drip in one arm and their sore fannies from all the prodding and they're on the monitor 'cause there's that whole package that goes with it … it breaks my heart'.* (Kate SEM, (Wickham, 2010), p.2)

Managing the tensions

For employed midwives, a primary method of managing stress associated with medico-legal concerns was scrupulous documentation (Cobell, 2015; Jenkinson et al., 2016; Thompson, 2013); to demonstrate that appropriate care was provided in accordance with the woman's wishes, thereby providing them with a *'safety net'* (36, p.567) and a source of *'protection'* (38, p.9). The focus of Jenkinson's (2016) study was the implementation of a structured maternity care plan (MCP) to ameliorate the stress and fears of midwives consequent on women seeking out of guidelines care. Midwives reported feeling less stress when a woman had an MCP in place, and especially when more senior staff held overall responsibility for the MCP:

> *'I guess practitioners, midwives particularly, just relax a little bit more if a senior doctor has spoken to her about the risks. . .That's probably the. . . advantage of them* [MCPs].*'* (MW8 EM, (Jenkinson et al., 2016), p.6).

Similarly, the employed midwives in Thompson's (36, p.568) study were more *'confident'* and '*reassured'* when a woman's birth plan had been endorsed by a senior midwife.

3. Ways of working with-woman

This third-order construct describes how midwives forged and maintained mother-midwife relationships to ensure that women remained engaged with health care services.

Relationships central to caregiving

For independent midwives in the Symon et al (Symon et al., 2010) study, the relational aspect of care was expressed by participants as *'being on their side'* (p.282); this was considered to be of fundamental importance for deeply complex and challenging cases such as fetal death. For example, one self-employed midwife expressed:

> *'Half of me feels that if I'd turned into a different sort of person and bullied her into hospital, then that might have been the right thing to do as per keeping the baby alive. However, the other side of me was—I was the only person on her side… if I had bullied her into hospital and the baby died anyway, who would she have had on her side?'* (Participant SEM, (Symon et al., 2010), p.282).

Employed midwives working within institutions (where continuity of carer was less likely) also felt that establishing rapport with women was essential in creating and maintaining positive midwife-woman relationships and for negotiating safe care plans (36, p.567). However, for some this was more difficult without an earlier relationship with the woman:

'it's harder sometimes when you've not got that relationship with the woman but speaking personally for me, it's really important that we facilitate choice and ensure that she gets the positive response that she should get when she comes into the unit. So that's why I'm happy to do it' (Grace EM, (Cobell, 2015), p.109).

Some midwives also expressed personal benefits when caring for women who opt for unconventional birth choices:

'I feel privileged to look after women that have these plans and I get an overwhelming sense of achievement for them and I feel like it does really enhance how they feel positively.' (Kate EM, (Cobell, 2015), p.41).

Keeping women engaged in care provision

Honoring women's requests was also motivated by keeping women engaged in care (Cobell, 2015; Symon et al., 2010; Thompson, 2013; Wickham, 2010). For example, one midwife reported negotiating place of birth as a compromise between women's choices and perceptions of safety:

'I think some of them are encouraged to avoid home birth if they're very risky and that's a compromise being on the MLU [Midwife led unit].*'* (Mia EM, (Cobell, 2015), p.47)

Concerns were raised that if staff were unwilling to negotiate a suitable and acceptable birth plan, then women may withdraw from the service (37, p.47) and/or opt to freebirth (without any health care assistance) (Jenkinson et al., 2016; Symon et al., 2010).

Line of argument synthesis

Whilst only five studies were found and included, the findings generated both 'reciprocal' and 'refutational' data (Noblit & Hare, 1988). Therefore, a tentative line of argument was developed to draw together salient points of similarity and differences across the data set. We acknowledge that further research is needed to strengthen the line of argument, however, it does provide important insights for further investigation:

The findings suggested that the midwives in the included studies, which encompassed both employed and independent midwives' appeared to be situated upon a spectrum of willingly facilitative or reluctantly accepting of women's unconventional birth choices. This seemed to be informed by the degree to which they value women's autonomy over institutional norms and fetal rights. However, their positioning was also influenced by vulnerabilities associated with professional accountability, subsequent litigation, and actual or potential reprisals arising from adverse events. Such vulnerabilities, and the adverse emotional consequences of them were particularly apparent for those working within institutions when compared to those working independently. However, for all midwives, the quality and nature of midwives' relationships with women were central to their response to, and management of, unconventional birth choices.

Discussion

Only five studies were located relating to the review question, indicating a paucity of research in this area. Therefore, whilst the findings need to be treated cautiously, some important insights were identified. The findings

highlight a spectrum of views, attitudes, and experiences of midwives caring for women who choose unconventional birth options. Differences in opinions regarding women's autonomy, the degree to which women can be trusted to prioritize the wellbeing of their fetus, and the acceptability of women making counter-cultural choices were identified. These differences were contextualized by fears of accountability in the event of an adverse outcome, and the potential for subsequent litigation. Such concerns were primarily expressed by participants working within institutions. In contrast, independent midwives who had direct experience of caring for women who had adverse outcomes after declining emergency care, demonstrated strong commitments to maternal autonomy, expressed as 'being on their side', with little emphasis reported regarding litigious concerns. While the findings from the self-employed midwives are unsurprising, and also reflect the relational components of continuity of carer, the divergent values demonstrated by employed midwives require closer examination.

While the transferability of the review findings should be treated with caution, the issues reflect wider literature relating maternity professionals' views and experiences of medico-legal and medico-ethical tensions (Deshpande & Oxford, 2012), perceptions of risk (Dexter et al., 2013), and perceptions of maternal autonomy (Kruske et al., 2013). This study suggests that employed midwives in high-income settings can experience difficult negotiations and institutional and social imperatives to follow population-based guidelines, whilst simultaneously working with individual women who are making alternative decisions. Fear of litigation, workplace reprisals and loss of career

consequent on working 'outside of the guidelines' is an unintended consequence of conflating guidelines with 'rules' for workers to follow (Downe, 2010). This is especially true if health workers protect themselves from negative emotional, legal, and financial sequelae by prioritizing adherence to guidelines over individually relevant care, and over women's' rights to personal autonomy. Critics suggest that the authoritative nature of guidelines has led to a shift away from an individualized care rhetoric, and towards a situation where any deviation from standard(ized) care has to be justified (Griffiths, 2009; Kotaska, 2011). Kotaska (2011) calls this 'guideline-centered care', which is in direct opposition to respecting women's autonomous decision making (Griffiths, 2009; Upshur, 2014). Inconsistencies across international and national guidelines (Weisz et al., 2007; Glantz, 2012), and even between neighboring hospitals (Hunter, 2004) also undermine ethical or moral arguments that the universal application of guidelines is best practice.

Our findings also support data from two other studies of employed midwives, that found coexistence of diverse values and perspectives within their midwifery cohorts (Thompson, 2003; Hunter, 2004). Thompson (2003) explored women's and midwives' narratives in relation to ethical components of receiving and providing care during labour and found that midwives were perceived as either *'procedure-oriented'* or *'with-woman oriented'* (p.596). She argued that midwifery care was informed by midwives ethical positioning. Hunter (2004) explored midwives' accounts of the 'emotional labor' of caring for women and established that two coexisting and conflicting ideologies of

midwifery existed between midwives; *'with-woman'* and *'with-institution'* (p.261). Both studies broadly illustrate two extremes. One is based on a 'woman-centered' philosophy, where the holistic needs of the woman guide the care provided and autonomous decision making is actively supported (The White Ribbon Alliance, 2013). This is opposed to a task-oriented approach or a 'guideline-centered' philosophy, in which the needs of the organization are prioritized over the needs of the individual woman (Griffiths, 2009; Kotaska, 2011). We suggest that midwives who are 'willingly facilitative' of women's unconventional birth choices, as our findings reveal, are closely aligned with a 'with-woman' ethical and ideological philosophy of care. In contrast, the 'reluctantly accepting' midwives appear to be more aligned with a task-oriented approach informed primarily by adherence to guidelines.

Woman-centred care is central to the protected title of the midwife, that also includes autonomous practice and advocacy (International Confederation of Midwives, 2014). As such, our findings alongside Thompson (2003) and Hunter (2004), highlighting polarized midwifery values which raises issues with the midwifery project to be 'with-woman' and challenges the constructs of midwifery practice. Notwithstanding the organizational and institutional constraints of employed midwifery practice, already discussed, the divergence of values is of concern. For example, our findings demonstrated that some midwives resisted their autonomous professional status, preferring to defer and rely upon the input of senior midwives and/or medics. Arguably, reinforcing the hierarchal status quo (Pollard, 2011) and deferring personal responsibility. The wider literature has found women can feel coerced and

steered into decision-making by maternity professionals in order to comply with local guidelines (Kruske et al., 2013; Shallow, 2013). Our findings highlight the tensions within midwifery practice which may contribute to women's experiences.

With all search strategies there is a risk of missing pertinent studies, however, we demonstrated a comprehensive systematic and rigorous strategy that included eight international bibliographic databases and seven additional search techniques to overcome search limitations. However, only five studies (7 papers) met the inclusion criteria and no studies were found in low or middle-income countries. The international scope of the review indicates that the findings may be applicable in other high-income countries where midwives are a strategic part of the workforce. Conducting a meta-ethnographic synthesis is an interpretative process, but the risk of over or under interpretation of the data was minimized through author reflexivity to ensure that personal beliefs and values did not obscure important data within the included studies, and through rigor in study selection and analysis. The paucity of literature necessitates further research into this area of midwifery practice, and into the broader question of out of guidelines health care.

Conclusion

Despite strong international rhetoric in support of women's birth autonomy, midwifery practices around facilitation or restriction of maternal rights in this area remain contested. As the 'front window' of the maternity care team, and especially where women have chosen midwife-led care, midwives' decision making is critical to ensuring the optimal wellbeing of the mother and the

baby when women make unconventional decisions. However, the findings of this review suggest that midwives' views in this area are situated along a spectrum, and are influenced by context as well as prior philosophies and values. To ensure the best quality of care and optimal outcomes when women make unconventional choices, it is essential to understand the nature and implications of different responses from midwives, and from other members of the health care team, including obstetricians and neonatologists. Future work in this area should encompass all of these perspectives.

Word count: 5269

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Figure 1 Noblit and Hare's (1988) Seven phases

1. Getting started (the search)

2. Deciding what is relevant to the initial interest

3. Reading studies and extracting data

4. Determining how studies are related (identifying common themes and concepts)

5. Translating studies (checking first and/or second order concepts and themes against each other)

6. Synthesising translations (attempting to create new third order constructs)

7. Expressing the synthesis.

Table 1 Inclusion, exclusion criteria

	Inclusion	**Exclusion**
Time frame	1993 onwards	Pre 1993
Language	English Those that can be translated with software	Those that cannot be translated with software
Publications	1. Primary studies 2. Grey literature that involves primary research	1. Secondary sources 2. Grey literature such as opinion pieces, commentaries.
Focus of paper	The views, experiences, and attitudes of qualified midwives supporting or facilitating women's unconventional birth choices.	1.The views, attitudes, and experiences of women who choose unconventional birth choices. 2.The views, attitudes, and experiences of other maternity professionals in relation to unconventional birth. 3.The views, attitudes, and experiences of maternity professionals in relation to conventional birth choices.
Methodology	1. Qualitative 2. Mixed methods (e.g. surveys) that include qualitative component	1. RCT 2. Quasi-experiments

Figure 2 PRSIMA diagram of search results

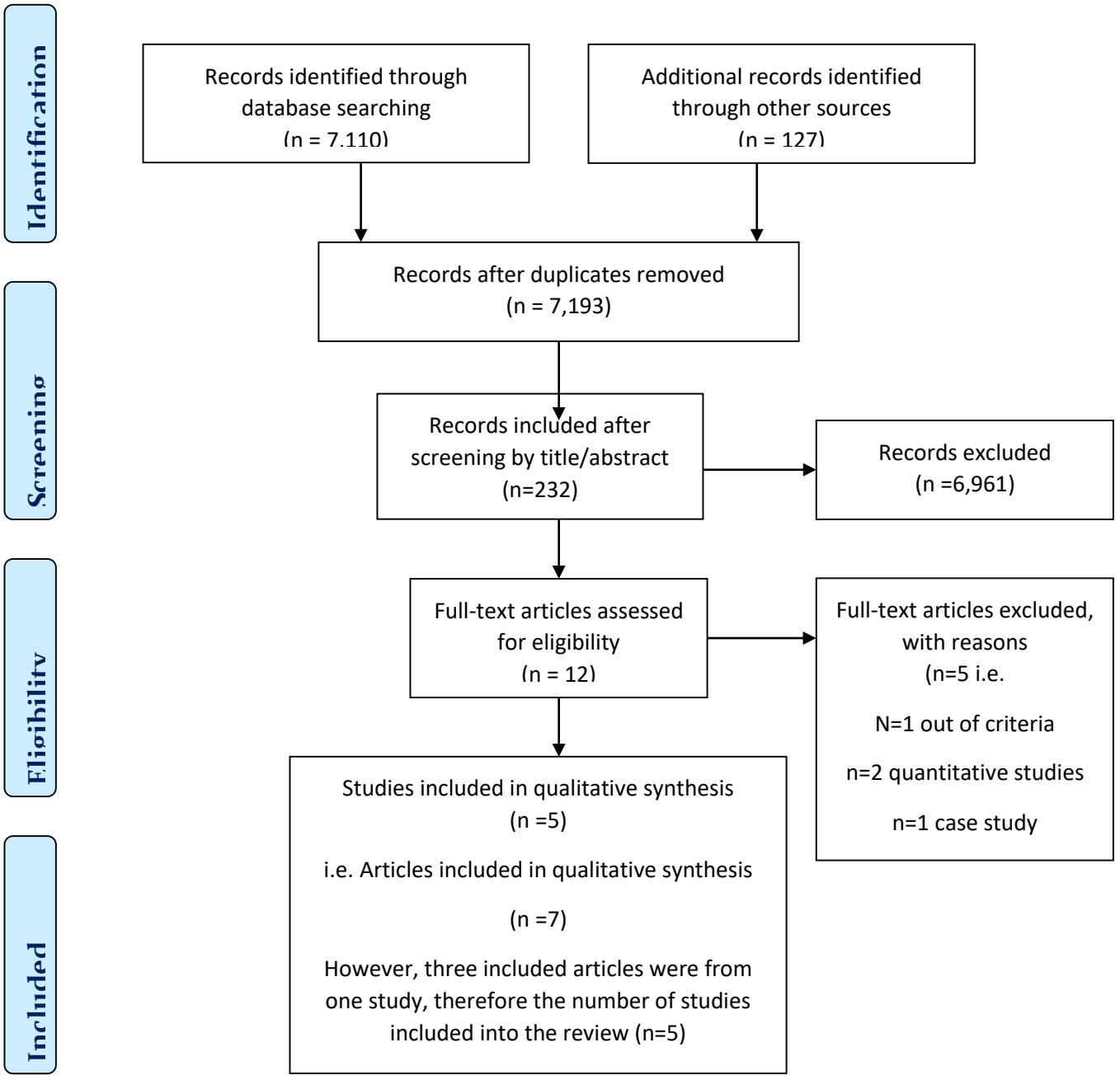

Table 2 Study characteristics

Study:			Study Design:				Findings	
Code	*Author* *Country*	*Aim*	*Theoretical perspective/ Methodology*	*Sample* *Setting* *Data collection*	*Data analysis*	*Ethics* *Reflexivity*	*Key concepts*	*Quality grade*
1	Wickham UK	To explore the views and knowledge of holistic midwives in relation to the obstetric construct of post-term pregnancy	Qualitative- Grounded theory	n= 12 'holistic' midwives International setting across 5 countries Interviews	Grounded theory, comparative analysis, theoretical sampling until saturation	Ethical approval granted No reflexivity discussed	Core concept 'obstetric spacetime' reflects the midwives perceptions of the obstetric construct of post-term pregnancy, therefore the findings across three papers: 'boundaries', 'journeying' and 'stretching the fabric' depict their practice in relation to the core concept.	B
2	Symon et al. UK	To examine independent midwives management and decision making in 15 instances of perinatal death at term	Qualitative- Descriptive	n=15 Independent Midwives Across UK Interviews, case notes and member checking	Thematic analysis/ grounded/ Voice Centred Relational Method	Ethical approval granted No reflexivity discussed	Homebirth was attempted in 13/15 cases, all of which significant (sometimes multiple) risk factors were present. Women had declined aspects of NHS care i.e. screening and/or transfer to obstetric care. Care management by the Independent Midwives was acceptable within the parameters set by the mother's choices.	B
3	Thompson UK	To explore midwives' experiences of caring for women who make choices outside of guidelines	Qualitative	n= 10 midwives Hospital setting in one Trust Interviews	Thematic analysis	Ethics approval granted Some reflexivity	Four key themes: 1. Effects on care and concerns; 2. Coping strategies and getting on; 3. Women's characteristics; 4. Influence of others.	C
4	Cobell UK	To gain an understanding of midwives' experiences of looking after women in labour outside of Trust guidelines	Qualitative- Interpretative Phenomenological Analysis (IPA)	n= 6 midwives Hospital setting in one Trust Interviews	IPA	Ethics approval granted Some reflexivity present	Four superordinate themes: 1. Women requesting alternative care; 2. Being the professional; 3. The concerns regarding care outside of guidelines; 4. Strategies to enable out with guidelines care to continue.	C
5	Jenkinson et al. Australia	To document the perspectives of women, midwives and obstetricians following the introduction of a structured process to document refusal of recommended maternity care.	Qualitative- Interpretative	N=9 women, N= 12 midwives, N= 9 obstetricians Hospital setting in one tertiary hospital Interviews	Thematic analysis	Ethics approval granted No reflexivity discussed	Four key themes: 1. Reassuring and supporting clinicians; 2. Keeping the door open; 3. Varied awareness, criteria and use of the MCP process; 4. No guarantees	B

Table 3 1st/2nd/3rd order constructs with study code numbers

First order constructs	Second order constructs	Third order (interpretative) constructs
Women taking responsibility and ownership (2) Negative perceptions of women (3) Positive perceptions of women (4)	Perceptions of women and their choices (2,3,4)	**Perceptions of women's decision-making (1,2,3,4,5)**
Previous birth needs not met (2) Perceptions of women's current needs (4)	Understanding women's motivations (2,4)	
Fetal and maternal wellbeing viewed as a whole (1) Committed to women's autonomy (2) Conflict between fetal and maternal rights (3) Acknowledging women's rights (5)	Conflicting views of maternal autonomy (1,2,3,5)	
Fear of bad outcomes/ litigation (3,5) Midwives, stress, and vulnerability (3) Being 'judged' (4)	Fear and vulnerabilities (3,5)	**Conflicting tensions as caregivers (1,3,4,5)**
Challenging obstetric constructs (1) Frustration at the 'system' (1) Perceptions of guidelines (4) Negotiating normalcy (1)	Arbitrary restrictions (1,4)	
Documentation as a safety net (3) Seeking additional support in the work environment (3) Maintaining documentation to manage fear of litigation (4,5)	Managing the tensions (3,4,5)	
Relationships, working with women and negotiating care (1) Being on their side (2) Establishing rapport (3) Positive attitudes (4) Continuity, relationships and communication (4)	Relationships central to caregiving (1,2,3,4,5)	**Ways of working 'with-woman' (1,2,3,4,5)**
Maintaining care (2) Keeping the door open (4,5)	Keeping women engaged in care provision (2, 4, 5	

Appendix 2 Literature review audit trail

2.1 Search term development

Step 1

The search terms were developed from the 'Population and their Problems, Exposure and Outcomes or Themes' (PEO) framework (Bettany-Saltikov, 2012). This framework is used to identify the key concepts within the research question and to start the process of developing appropriate search terms, inclusion and exclusion criteria (Bettany-Saltikov, 2012). This is demonstrated in Figure 16.

Figure 2 PEO framework

Population/Problem	Midwives
Exposure	Women's unconventional birth choices (as defined in X)
Outcomes/Themes	Views, attitudes, experiences

Step 2

Table 13 displays my initial search terms within the PEO framework. All possible synonyms are included (no truncations used at present).

Table 1

Population	Exposure	Outcome/Themes
Midwife Nurse-midwife Childbirth assistant Health professional Maternity professional Maternity practitioner Healthcare professional Healthcare practitioner	Unconventional Out of guidelines Not in guidelines Against advice Decline High risk At risk Refuse Autonomy Vaginal birth after caesarean Breech Twins Multiple births Elective caesarean	Facilitating Attitudes Views Experiences Beliefs Perceptions Opinions Perspectives

Step 3

Table 14 displays a revised set of search terms following a meeting with a librarian at my local Trust and a pilot test which now include truncated terms. An explanation for the changes can be found below.

Table 2 Revised search terms

Population	Exposure	Outcome/Themes
Midwi* Nurse-midwi*	Birth OR Delivery OR Birth Choice AND Vaginal birth after cesarean OR vbac OR breech OR home OR birth centre	Facilita* Attitud* View* Experienc* Belief* Perception* Opinion* Perspective* Support Car*

The following key decisions were made:

- To only include midwife and nurse-midwife in the population due to the considerable number of irrelevant hits, thus to increase specificity.
- To *not* include terms such Unconventional, Out of guidelines, Not in guidelines, Against advice, Decline, High risk, At risk, Refuse, Autonomy as they were too specific and likely to miss key results. Instead the words birth or delivery or birth choice were used to broaden the search.
- To include support or care in the outcome/theme.
- To carry out the search using the population and outcomes first as to link midwives with the outcomes/themes, then introduce the exposures into the search.
- To use two levels of 'exposure' as a search strategy: to start with use birth or delivery or birth choice, then include AND for Vaginal birth after cesarean OR vbac OR breech OR home OR birth centre.
- It was also noted that using the spelling 'ceserean' instead of caesarean yielded more results, therefore this spelling was used for the search.

- MeSH headings were problematic; due to the complexity of the search terms. MeSH terms are medical naming descriptors that are catalogued in a hierarchical structure used to search databases with various levels of specificity (US National Library of Medicine, 2016). Whilst MeSH terms can be useful for medical research questions, they can be problematic when searching qualitative literature largely due to the way terms are catalogued (Atkins et al., 2008). Therefore, the decision was made to use free text searching.

  Step 4

The final search strategy can be seen in Table 15 in the order the search categories were used. Table 16 shows how this was applied in Cumulative Index of Nursing and Allied Health Literature (CINAHL).

Table 3 Final search terms

Population	Outcome/Themes	Exposure (1)	Exposure (2)
Midwi* Nurse-midwi*	Facilita* Attitud* View* Experienc* Belief* Perception* Opinion* Perspective* Support Car*	Birth OR Delivery OR Birth Choice	Vaginal birth after cesarean OR vbac OR breech OR home OR birth centre

Table 4 Applying search terms to database

SOURCE	SEARCH STRATEGY	HITS
CINAHL	S1 midwi* or nurse-midw*	39841
	S2 Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*	1838871
	S3 (S1 AND S2)	18588
	S4 birth or delivery or birth choice	150031
	S5 vaginal birth after cesarean or vbac or breech or home or birth centre AND S3 and S4 limiters 1993 onwards	1464

2.2 Search activities

The following provides a detailed audit trail of the searching activities carried out for each data source. Table 1 provides a summary of the search activity, hits and screening.

Bibliographic databases

CINAHL: The search was carried out without any modifications - 1464 titles/abstracts were initially screened and 122 saved to Refworks. These 122 were then reviewed more closely applying the inclusion/exclusion criteria and subsequently only two were retained. Citation checking from these papers found a further three studies that met the criteria. In this first database search, I found I had initially screened a large number of papers (122) that mostly did not meet the criteria. This highlighted my concern that the research question would not yield any results and my consideration that the research question would need to change. In consultation with my supervisors, it was reiterated that I needed to retain focus on the original research question as it shall inform my overall study. Subsequently, I felt able to apply the criteria rigorously in later database searches.

PyschInfo: The search was carried out without any modifications - 1329 titles/abstracts were initially screened, and four studies were initially retained. Further checks revealed that three were duplicates of studies already identified and the final study did not fulfil the inclusion criteria during the second screening stage.

Medline: The search was able to employ MeSH terms for midwife/nurse midwife and therefore required a slight modification to the search strategy. 988 titles/abstracts were initially screened with 17 studies found to fulfil the four inclusion criteria. Five of the papers were duplicates of studies already found. On second screening only one paper was found to meet the criteria.

Maternity and Infant Care: The predesigned protocol had included the Midwives Information and Resource Service (MIDIRS) database. However, the Maternity and Infant Care database includes MIDIRS therefore a separate search in the MIDIRS database was not necessary. The Maternity and Infant Care database allows the search to include a range of other sources including books and grey literature. Therefore, this search was modified slightly to include books, dissertations as well as

journals. 36 studies were initially screened, however 20 were duplicates of previous searches. Of the remaining 16, none fulfilled the criteria once a second screening was carried out.

Web of Science: The search was carried out without any modifications. Nine studies were identified during the initial screening, but five were removed as they were duplications. Following a second screening, no studies were identified that met the inclusion criteria.

LILACS: This database is a comprehensive index of scientific and technical literature of Latin America and the Caribbean. However, its online platform has limited performance to carry out complex searches, therefore the decision was made to search just with 'midwi* or nurse-midwi*' so as not to miss pertinent papers. Sixty-four studies were identified and screened but none met all the inclusion criteria.

African Journals OnLine (AJOL): This database is a comprehensive index of peer-reviewed African-published scholarly journals. Although the platform has functions for an advanced search, its performance was limited. For example, when applying the original search strategy mainly farming literature was found. Therefore, the decision was made to search just with 'midwi* or nurse-midwi*' so as not to miss pertinent papers. All 206 papers were screened, eight were removed as they were duplications. No paper met the criteria.

Thesis repository

Electronic Theses Online System (EThOS): This database consists of the full text of any UK thesis that has been digitised from participating institutions. Whilst the search platform has an advanced search function, it was found that it did not support truncated words and that the original strategy did not yield any results. Therefore, the search was kept simple to include midwife or nurse-midwife so as not to miss any potential papers. No relevant studies were found.

Hand searching

The following midwifery journals were searched for their most recent publications that may not have been entered into a bibliographic database at the time of the first database search: Midwifery, BMC Pregnancy and Childbirth, British Journal of

Midwifery, Birth, Evidence Based Midwifery, Women and Birth, Journal of Advanced Nursing and Social Science and Medicine. The search was carried out by accessing each journal individually and reviewing the volume that related to July, August and September 2016. Each title was read in conjunction with the inclusion/exclusion criteria to ascertain its inclusion to the review. In addition, a journal alert was set up using Zetoc (2016), a web based platform which delivers regular update emails from pre-chosen journals. Only one study that was published as three papers on a midwife-researcher's professional website was identified. This was a coincidental finding, as I was using the website for other work. The study was pertinent/included in the review.

Professional networks

An email request was sent out to the professional network on the 'Normal-birth' research group on Jiscmail. I had three initial responses, which were duplicates of studies already found. Later, another response yielded a primary study carried out for a Master's thesis which fulfilled the criteria.

Citation check

The reference lists for all of the papers that met the initial criteria were checked for other relevant studies. This generated 21 further papers to be reviewed, of which five met the criteria.

Author run

For all of the papers that met the initial criteria, I carried out a check of each author to search for any other studies that would meet the criteria. This involved searching for each author via Research Gate and Google and I examined all of their previous research against the inclusion/exclusion criteria. No studies were found via this method.

Table 5 Search activity

Search Activity:

'What are the views, attitudes and experiences of midwives who facilitate women's unconventional birth choices?'

DATE	SOURCE	SEARCH STRATEGY	HITS	1st SCREEN	2nd SCREEN
	CINAHL	S1 midwi* or nurse-midw*	39841		
02/08/2016		S2 Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*	1838871		
		S3 (S1 AND S2)	18588		
		S4 birth or delivery or birth choice	150031		
		S5 vaginal birth after cesarean or vbac or breech or home or birth centre AND S3 and S4 limiters 1993 onwards	1464	122	**2**
03/08/2016	Citation checking		9	9	**3**
10/08/2016	PsychInfo	S1 midwi* or nurse-midwi* or professional	350866		
		S2 Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*	2,004,590		
		S3 birth or delivery or birth choice	111,004		
		S4 (birth or delivery or birth choice or decision) AND (S1 AND S2 AND S3)	14,490		
		S5 vaginal birth after cesarean or vbac or breech or home* or birth centre or water*	200,805		
		S6 (vaginal birth after cesarean or vbac or breech or home* or birth centre or water* or multipl*) AND (S4 AND S5) limiters 1993 onwards	1,329	4	**0**
10/08/2016	MEDLINE	S1 (MeSH terms) (MH "Midwifery") OR (MH "Nurse Midwives")			
		S2 Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*	8,129,098		

		S3 birth or delivery or birth choice	671,658		
		S4 (birth or delivery or birth choice) AND (S1 AND S2 AND S3)	4,004		
		S5 vaginal birth after cesarean or vbac or breech or home or birth centre	204,065		
		S6 (vaginal birth after cesarean or vbac or breech or home or birth centre) AND (S4 AND S5)	988	17	**1**
10/08/2016	Maternity and Infant Care	1(midwi* or nurse-midwi* or professional).af.	47216		
		2(birth or delivery or birth choice)	84573		
		3(vaginal birth after cesarean or vbac or breech or home or birth centre).af	11545		
		4 (Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*).af.	89974		
		1 and 2 and 3 and 4	2219	36	0
11/08/2016	Web of Science	1 (midwi* or nurse-midwi*)	12737		
		2(Facilita* or Attitude* or View* or Experienc* or Belief* or Perception* or Opinion* or Perspective* or support or car*)	11067995		
		3 (birth or delivery or birth choice)	701,106		
		4(vaginal birth after cesarean or vbac or breech or home or birth centre)	304,444		
		5#4 AND #3 AND #2 AND #1 limiters 1993 onwards/academic journals and dissertation	840	9	0
11/08/2016	Ethos	Midwife or nurse-midwife	99	0	0
11/08/2016	Lilacs	Midwi* or nurse-midwi*	64	0	0
11/08/2016	AJOL	Midwi* or nurse-midwi*	206	0	**0**
11/08/2016	Author run		0	0	**0**
11/08/2016	Citation checking		12	0	2

22/08/2016	Email sent to professional network		3	0	**0**
12/09/2016	Email response professional network (late response)		1	1	1
17/09/2016	Hand search	British Journal of Midwifery (July-Sep)	0	0	**0**
	Hand search	Birth Issues in Perinatal Care (Vol 43 Issue 3 Sep 2016)	0		
	Hand search	Women and Birth (Vol29, Issue 4, Aug 2016)	0		
	Hand search	Journal of Advanced Nursing (July-Sep 2016)	0		
	Hand search	Midwifery (July-Sep 2016)	0		
	Hand search	Social Science and Medicine (July-Sep 2016)	0		
	Hand search	BMC Pregnancy and Childbirth (July-Sep 2016)	0		
	Hand search	Evidence Based Midwifery (July-Sep 2016)	0		
17/09/2016	Hand search	Found on Sara Wickham's own website-coincidental finding	3	3	**1 NB this is one study, but published as 3 papers**
	Citation checking		0		0
TOTAL			***7237***	***232***	***10***

2.3 Eligibility screening

Table 6 Eligibility screen

	Paper	>1993	English	Primary research	Includes midwives views, attitudes or experiences of unconventional birth	Qualitative methodology	Included Y/N	If no: reason
1	The VBAC waterbirth experience in Fife (Sellar, 2008)	y	y	no	y	no	N	Audit
2	Examining Autonomy's Boundaries: A Follow-up Review of Perinatal Mortality Cases in UK Independent Midwifery (Symon, Winter, Donnan, & Kirkham, 2010)	Y	y	y	y	y	Y	
3	Swedish caregivers' attitudes towards casearean section on maternal request (Karlström, Engström-Olofsson, Nysted, & Thomas, 2009)	y	y	y	y	y	N	Relates to c-section
4	Attitudes of Midwives in Sweden Toward a Woman's Refusal of an Emergency Cesarean Section or a Cesarean Section on Request (Danerek et al., 2011)	y	y	y	y	no	N	Quantitative
5	Women's, midwives' and obstetricians' experiences of a structured process to document refusal of recommended maternity care (Jenkinson et al., 2016)	y	y	y	y	y	Y	

6	Midwives' experiences of caring for women whose requests are not within clinical policies and guidelines (Thompson, 2013)	y	y	y	y	y	Y	
7	Maternity Care Plans: A retrospective review of a process aiming to support women who decline standard care (Jenkinson et al., 2015)	y	y	y	y	no	N	Quantitative
8	Home Birth of Infants with Congenital Anomalies: A Case Study and Ethical Analysis of Care providers' Obligations (Jankowski & Burcher, 2015)	y	y	no	y	no	N	Case study, with little focus on midwifery aspects of care
9	What are midwives' experiences of looking after women in labour outside of Trust guidelines? (Cobell, 2015)	y	y	y	Y	y	Y	
10	Post-term pregnancy: the problem of the boundaries (Wickham, 2009)	y	y	y	y	y	Y	
11	Journeying with the woman (Wickham, 2010)	y	y	y	y	y	Y	
12	Stretching the fabric (Wickham, 2011)	y	y	y	y	y	Y	

Template for metasynthesis of qualitative research studies

Downe S[1] Walsh D[2] Simpson L[3] Steen M[4]
2009

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Initial screen (full text papers)

Reviewer:

Date of review :

Code	Author/date	(insert inclusion criteria 1	(insert inclusion criteria 2)	(insert inclusion criteria 3)	IN?	Comments

QUALITY ASSESSMENT TOOL

Reviewer: Date:

Complete the first row using Y=yes, N=no, UC= unclear

Code	Author (year) and country	Aims clear?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective?	Methods appropriate for design?	Sample size & sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study ethical?	Do the data presented justify the findings?	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Include?

Summary quality rating:
(use grading system and codes on next page)

Comments:

Grading System (Downe et al 1997)

A: *No, or few flaws. The study credibility, transferability, dependability and confirmability is high.*

B: *Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.*

C: *Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study.*

D: *Significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.*

Consider: are all studies to be included, or only those that meet or exceed one of the grades above?

CHARACTERISTICS OF INCLUDED STUDIES & FINDINGS

Reviewer: Date:

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
KEY FINDINGS (author(s)):										
OTHER FINDINGS (not identified by the author(s))										

SYNTHESIS TEMPLATE

Summary of study findings

	Author (date)	Author (date)	Author (date)	Author (date)	Author (date)
	Code	Code	Code	Code	Code
Summary or key concept					
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.					
New metaphors, phrases, ideas, concepts, relations and themes in original text (as identified by reviewers)					

Synthesis template

	First iteration	Second iteration	Third iteration	Final consensus
Reciprocal Translation *(how are the findings similar between studies)*				
Refutational translation *(how are the findings different between studies, and disconfirming data)*				
Line of argument synthesis **(***a statement that summarises all the findings succinctly, and that incorporates the refutational as well as the reciprocal data*				

Reference list

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Please reference this document as follows:

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2.5 Quality assessment findings

Table 7 Quality Assessment

Code Author (year) and country	Aims clear ?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective ?	Methods appropriate for design?	Sample size & sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study Ethical?	Do the data presented justify the findings?	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Grade	Comment
1. Wickham (Wickham, 2009; Wickham, 2010; Wickham, 2011) UK	Y	Y	Y	Y	Y	Y	No	Y	Y	Y	Y	B	This study in which the findings are reported in three papers, has methodological strength in its research design, methods and theoretical grounding, which are well reported. The conceptually rich interpretative findings offer a unique perspective and contribution to self-identified holistic midwives that challenge the obstetric discourse of post term pregnancy. The findings are grounded in the data, resonate well and the interpretations are embedded within the wider literature. In addition, the use of three papers allows the researcher to explore the themes at depth alongside a good integration of the wider literature. Whilst the participant numbers are small, that reflects the nature of the study and of the participants. However, this study is limited by the lack of discussion relating to the researcher's reflexivity and there is a lack of detail regarding some ethical practices. Its main limitation is the lack of triangulation, member checking or a second researcher thus reducing its dependability.

Code Author (year) and country	Aims clear ?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective ?	Methods appropriate for design?	Sample size & sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study Ethical?	Do the data presented justify the findings?	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Grade	Comment
2. Symon et al., (2010)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B	This study offers a unique insight into the implications of personal autonomy in conjunction with independent maternity professionals. It is methodologically appropriate, good design, methods were clear and interpretations plausible. The lack of discussion regarding the researcher's reflexivity is this study's main weakness. Given the challenging topic, this would have been beneficial. Credibility challenged by the lack of the participant's identifiers, although issue is addressed by the authors in relation to the sensitivity of the topic and to protect the anonymity of the participants.
3. Thompson (2013)	Y	Y	Y	Y	Y	Y	Some	Y	Insufficiently	Limited	Limited	C	The research design and methods were appropriate to meet the aims, however notable weaknesses were apparent: Lack of theoretical framework, justifications, reflexivity, triangulation, member checking or additional researchers reduce the dependability of the findings. Poor descriptive findings, lack of confirmability as there were no identifiers for the participants so reduces integrity as unclear of the diversity of participant voices. The findings were interpreted with the wider literature, rather than letting the findings speak for themselves. Lack of context to illuminate the findings. Themes with no quotes.

Code Author (year) and country	Aims clear ?	Participants appropriate for question?	Design appropriate for aims and theoretical perspective ?	Methods appropriate for design?	Sample size & sampling justified?	Does the data analysis fit with the chosen methodology?	Reflexivity present?	Study Ethical?	Do the data presented justify the findings?	Is the context described sufficiently?	Is there sufficient evidence of rigour?	Grade	Comment
4. Cobell (2015)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	C	Methodologically sound, good research design, methods and delivery. The analysis and interpretation were clearly grounded in the data and provided plausible and valuable insights of relevance to maternity services. However, the small sample number, whilst appropriate for IPA, weakens the overall findings. Reads as descriptive, rather than providing conceptually rich interpretations. Lack of second researcher (or more) limits the confirmability of the findings. It is unpublished, therefore may not have been peer reviewed.
5. Jenkinson et al., (2016)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	B	This study demonstrates a clear aim, with a robust methodology/ methods to support the achievement of its aims. The findings were clearly grounded in the data and it provides important and useful insights into the use of maternity care plans for women who refuse recommended maternity care. However, the study states it is interpretative design, but the analysis reveals thematic analysis and no further discussion of higher level interpretations; weakening the overall findings. This may explain the occasions of a lack of coherence between the themes and findings. Additionally, there is a lack of discussion regarding reflexivity and related issues.

2.6 Data extraction

	Wickham 2009, 2010, 2011	Wickham 2009, 2010, 2011	Wickham 2009, 2010, 2011	Wickham 2009, 2010, 2011	Wickham 2009, 2010, 2011	Wickham 2009, 2010, 2011)
Code	**Challenging obstetric constructs**	**Challenging obstetric knowledge**	**Women broken by the system**	**Negotiating normalcy**	**Relationships**	**Fetal and maternal wellbeing viewed as a whole**
Summary or key concept	The midwives challenged the obstetric definitions of term and post-term pregnancy.	The midwives challenged the basis of the recommendations to induce before 42 full weeks of pregnancy.	The midwives cite morbidities women suffer by accepting routine induction.	The participants emphasised the individuality of each women and how they resisted the obstetric constructs of post term pregnancy.	Underpinning the midwives' philosophy of care was the importance of developing trusting relationships with women.	The midwives viewed fetal and maternal wellbeing as a whole.
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.	The metaphor of 'the problem with boundaries' was used to challenge the obstetric notion that there could be a defined cut off for term and post term pregnancies. The midwives felt that the use of population statistics proved problematic when working with individual women. This was seen as an obstetric construct that did not fit in with the midwives' views and experiences of post term pregnancies. This was seen as a source of pervasive pressure and control for women to conform by accepting routine inductions.	The participants reported knowledge of the research behind the current recommendations to induce for pregnancy beyond 42 weeks. They identified flaws in the research and felt it was based upon a flawed technocratic ideology. This did not fit with their worldview or experiences of post term pregnancies (where normal	The metaphor of 'women broken by the system' demonstrates the midwives' perceptions and views of what happens to women when they accept routine induction: *'I feel so passionately because in my work I pick up a* *lot of the pieces of the broken women … you know the broken women who've been through this [experience of induction], and virtually it's a story that we could all recite by heart… (Kate)'*	They offered an alternate view that included the metaphor 'normal for her' which represented an understanding that individual variables will affect pregnancy length. 'Negotiating normalcy' was used to describe how the midwives adopted a 'no absolutes' philosophy which affected how they saw pregnancy, birth and how they delivered care i.e. not imposing guideline recommendations upon women without assessing them as individuals. This also included a 'not normal for her', wherein the midwives had identified women who needed obstetric intervention but did not meet the guidelines definitions of abnormal, but through the midwives individual assessment and knowingness of	The relationships with women which seen as fundamental to giving good care. The importance of which was emphasised in relation to the skills of developing individualised and flexible care plans *with* women. This was said in contrast to imposing care upon women. The participants also used the metaphor of 'journeying with women' to represent the lack of hierarchy within their relationships as well as to represent the	The participants perceived the baby's physical wellbeing only in relation to the multi-dimensional wellbeing of the woman and her personal and social contexts. No fetal-maternal conflict

		fetal outcomes occurred).		the woman meant they attempted to refer for consultation.	individuality of each woman they cared for.	
New metaphors, phrases, ideas, concepts, relations etc	Alternative views of childbirth.			Different ways of seeing, doing and being.		No fetal-maternal conflict

	Symon et al, 2010	Symon et al, 2010	Symon et al, 2010	Symon et al, 2010	Symon et al, 2010	Symon et al, 2010
Code	**Avoiding perceived risks of the NHS (at all costs)**	**Women taking responsibility and ownership**	**Being on their side**	**Committed to women's autonomy**	**Maintaining care**	**Challenges of hospital transfers**
Summary or key concept	The midwives reported how women accessed their independent midwifery services to avoid using the NHS.	The midwives reported that women in their care took responsibility for their decisions and the outcomes.	Refusing not to care was not an option raised, despite the complexity of some of the women's medical history and challenges to the midwives.		Refusing not to care was not an option raised, despite the complexity of some of the women's medical history and challenges to the midwives.	The difficulties midwives faced when transferring women.
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.	The participants reported that women had sought independent midwifery (and consequently sought homebirths) to avoid a repetition of 'traumatic' NHS care. This was despite many of the women having risk factors during the pregnancy e.g. twins, some with multiple risk factors e.g. breech VBAC and those where obstetric emergencies arose during labour but they declined a transfer to hospital. This included cases where babies died.	There was consensus by the midwives that the women took full responsibility for their pregnancy decisions and the subsequent outcomes, even in the event of a perinatal death. They also reported that supporting women who take responsibility is fundamental to their independent	'Being on their side' was a metaphor used to describe the extent that the independent midwives went to support the woman's decision even in the face of a fetal death.	Here, women's autonomy was fully respected but not without emotional difficulty: Half of me feels that if I'd turned into a different sort of person and bullied her into hospital, then that might have been the right thing to do as per keeping the baby alive.	The midwives described the difficulty they faced in extreme cases, however they made the decision to continue caring for the women (in 6 reported cases), citing otherwise the women would have freebirthed.	On the occasions that women permitted a (necessary) transfer to hospital, the midwives cited the difficulties they faced with the hospital maternity staff. Three cases were reported as delays being caused by the hospital staff, who did not accept the independent midwives view that the situation required urgency.

	'It is the fact that a lot of these women had substandard care in their previous pregnancies that has resulted in their distrust of the NHS. They have nowhere else to go, and even with lots of support and encouragement from their independent midwives once they hear that they need to transfer in to hospital they switch off and won't listen.'	midwifery philosophy.		However, the other side of me was—I was the only person on her side… if I had bullied her into hospital and the baby died anyway, who would she have had on her side?		This indicated the (sometimes) acrimonious relationships between independent midwives and the NHS staff.
New metaphors, phrases, ideas, concepts, relations and themes etc	Overall- overtly facilitative, women prioritised, no fetal-maternal conflict etc.	Trusting, believing and actioning women as autonomous, even in the face of perinatal death. Defending women's rights.	Refuse to abandon 'ship'- significance of relationships			

	Thompson, 2013	Thompson, 2013	Thompson, 2013	Thompson, 2013	Thompson, 2013	Thompson, 2013	Thompson, 2013
Code	**Midwives frustration, stress, and vulnerability**	**Fear of litigation**	**Conflict between fetal and maternal rights**	**Women who are well educated, intelligent, seeking control- viewed negatively**	**Establishing rapport**	**Keeping women engaged in the service**	**Seeking additional support in the work environment**
Summary or key concept	Midwives report feeling 'out of their comfort zone'.	Documentation as a 'safety net'.	Midwives were seeking to regain control over neonatal wellbeing.	The midwives reported a range of characteristics of women that they perceived as more likely to ask for out of guideline care.	The midwives reported the benefits of antenatal care planning.	Maintaining relationships to keep women engaged with the service	The midwives sought a 'sounding board' from senior colleagues.
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.	Midwives expressed frustration, stress and vulnerability when looking after women who made choices outside of the guidelines, particularly those who declined assessments or vaginal examinations. They reported feeling 'out of their comfort zones' and described the women's choices as challenging, tricky and stressful citing increased levels of responsibility. Additionally, the midwives reported that the women's requests were time consuming inferring at the detriment of others. 'We had no way of knowing it was a breech because we had been unable to do a full examination … But in retrospect you'd start to think about what potentially could have happened, what	The midwives reported a fear of litigation, feeling vulnerable and being held accountable for care that the woman declined. More scrupulous documentation was reported and was seen as a 'safety net' and defence. (assumingly from litigation? 'I felt vulnerable (pause) I felt that I was being torn in two ways. In that I had a duty of care to support her in her decisions but I also had a duty of care to keep her safe and she did understand all the risks. So it was difficult at the time.'	The midwives reported that some of the maternal requests conflicted with fetal wellbeing, expressing relief when the baby was born as they perceived they would regain control over the baby once it was born. 'The only rights we have are when the baby is actually born. You can then step in and give appropriate care. There is nothing we can do for the woman that refuses. We can, however, make sure the baby is safe.'	The midwives reported that certain personality traits of women led them to choose out of guidelines care with largely a negative connotation i.e. well educated, intelligent, those seeking to have more control over their birth. There was some acknowledgement that some women had previous traumatic birth experiences had influenced their later decisions. Additionally, the midwives perceived the women as losing sight of the risks associated with their decisions as those women who viewed pregnancy and birth as normal and 'presumed everything would be fine'.	Establishing rapport with women was reported to be essential in creating and maintaining positive relationships with the women so that safe care plans could be negotiated. The findings suggested the midwives found this easier to do if they knew the woman in pregnancy.	Additionally, this was felt to be important to keep the women engaged in the service and did not withdraw from the service.	Midwives reported seeking support from supervisors of midwives (SOM's), delivery suite co-ordinators and medics. They reported needing a 'sounding board' to discuss any challenges they faced when women wanted out of guidelines birth options. Conversely, they reported feeling more confident when a woman had a birth plan that was written by a SOM. It was 'reassuring' to have everything written down in black and white.

	could have gone wrong and it's probably more frightening to look back on it than actually it was at the time.'						
New metaphors, phrases, ideas, concepts, relations and themes in original text	Overall 'reluctantly' accepting- little tolerance for women making such decisions	Fear based caregiving	Fetal-maternal conflict, need to protect fetus from mother/mothering decisions	Type of woman (viewed negatively)	**Yet, relationships still essential**		Needed reassurance, care plans seen as authoritative and protective

	Cobell, 2015	Cobell, 2015	Cobell, 2015	Cobell, 2015	Cobell, 2015	Cobell, 2015	Cobell, 2015	Cobell, 2015
Code	**Women who are Caucasian, well educated, middle class, independent, need control- viewed positively**	**Perceptions of women's needs**	**Positive attitudes**	**Continuity, relationships and communication**	**Concerns raised by the midwives**	**Managing judgements and fear in the work environment**	**Maintaining documentation to manage fear of litigation**	**Perceptions of guidelines**
Summary or key concept	The midwives reported a range of characteristics of women that they perceived as more likely to ask for out of guideline care.	The midwives perceived certain needs that contribute to women choosing out of guidelines care.	Midwives reported positive attitudes when caring for women who opted for out of guidelines care.	The midwives reported the importance of continuity of carer in developing a relationship with the women**.**	Some midwives reported some concerns regarding caring for women outside of guidelines.	The midwives report their experiences in relation to colleagues.		The guidelines are part of the problem.
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.	Midwives perceived women who requested out of guidelines care to be Caucasian, well educate, middle class and able to challenge practitioners. There were described as independent and were used to having control in their lives.	Midwives acknowledge that previous birth traumas could influence women's decisions in order to regain control over their experience. 'it's not cos they've been reading for 9 months but because of a bad experience previously' (Ava) The midwives recognised that	Midwives reported understanding women's reasons for their choices and was viewed positively. Some felt privileged and a sense of achievement when looking after the women: 'I feel privileged to look after women that	The midwives described the importance of having developed a relationship with the women during pregnancy to improve the care that the women received. They reported how positive communication that avoided paternalistic attitudes was essential in creating positive	Two midwives reported particularly challenging situations where a woman declined transfer to hospital in life threatening situations. The midwives reported feeling angry and frustrated at the women, highlighting the impact a poor outcome	The midwives reported feeling judged by their colleagues and like they 'had to prove themselves' as highly capable midwives. They reported fear from their colleagues of things going wrong which needed to managed. 'I think people are fearful, even	They recognised that the fear of litigation is rife within the NHS. To manage their own fears and still support women they refer to maintaining high standards of documentation	Some midwives reported frustration with the guidelines being 'ingrained into practice' which was perceived as part of the problem in women accessing their choices. 'what we're doing is putting people into categories and institutionalising them via

	'these women have … looked into birth in more detail and can see the different options available' (Kate)	the women wanted an alternative care package, largely to reduce medical interventions. 'I think it was more that she didn't want that medical, bright lights, legs up in the air, kind of scenario' (Beth) It was reported that women had positive satisfaction when they were listened to, even when the birth did not go according to the plan.	have these plans and I get an overwhelming sense of achievement for them and I feel like it does really enhance how they feel positively' (Kate).	relationships with women. 'I actually think she had better understanding and then trusted who she was being looked after by' (Rose)	could have on them as professionals: 'They don't understand the consequences on the health professionals … in that if something catastrophic happens … the impact that can have on the midwife looking after them, it could be career ending' (Rose)	if there is a plan in place, people are fearful of the consequences' (Ava)		our guidelines and making people afraid if you come out of guidelines' (Ava) it is a guideline, it's not law, it's not gospel' (Beth)
New metaphors, phrases, ideas, concepts, relations and themes in original text (as identified by reviewers)	Type of woman viewed positively	Understanding women's decision making	Personal & professional satisfaction from working with women making these choices	Trusting relationships essential	Red lines, limitations to providing such care	Fear based working in relation to colleagues etc. Having to justify women's decision and practice	Managing tensions and fears of litigation	Guidelines as problematic

	Jenkinson, 2016	Jenkinson, 2016	Jenkinson, 2016	Jenkinson, 2016)	Jenkinson, 2016	Jenkinson, 2016
Code	**Acknowledging women's rights**	**Fears of bad outcomes, fear of litigation**	**Ameliorating fears with documentation and care plan**	**Keeping the door open**	**Inequity of access**	**No guarantees (that care plan will be implemented)**
Summary or key concept	The maternity professionals recognised that women had the right to refuse recommended care.	Maternity professionals reported fears associated with women declining recommended care.	The participants describe the implementation of a process to support clinicians to support women.	The participants viewed negotiating care plans as a means of keeping women engaged in the service.	Inequitable access to the MCP appointment.	No guarantee that the MCP will be implemented.
Metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts.	The maternity professionals recognised that women had the right to refuse recommended care and expressed a commitment to women's autonomy. All you have to do is impart the recommended information. . . and at the end of the day . . . it's the woman's choice to make that decision. . . It's a woman's right to choose. To choose care, and to refuse care and not to be	In spite of a commitment to women's autonomy, clinicians reported professional, medico-legal, personal stress and vulnerabilities when women declined recommended care. If anything happens [poor maternal or fetal outcome] and I'm working outside of [hospital policies]. . . then I am not covered by vicarious liability. So then, there goes my house! (MW4)	The hospital adopted a structured maternity care plan (MCP) process to ameliorate the stress and fears associated with women seeking out of guidelines care. It was designed to provide a structured opportunity during the antenatal period to inform women of the consequences of their decisions in declining recommended care. The agreed plan was documented and shared with all maternity professionals. Midwives reported feeling less stress when a woman had an MCP in place: I guess practitioners, midwives particularly, just relax a little bit	Participants regarded the MCP process as a way of keeping women engaged in the service. They feared that women would freebirth if the staff were unwilling to negotiate a suitable and acceptable birth plan: [The woman's preference] might be outside of the recommendations, but the worst thing you can do is flick a woman [refuse to provide care] and say "Sorry, we can't do that". . . She's likely to freebirth at home and that could be even worse. (MW11)	Participants recognised that there was inequity in women accessing the MCP process. They described a lack of staff awareness, poor promotion as limiting women's access and subsequent uptake. They were keen to address this. I think we should let women know that they [MCPs] exist! . . . I think that big group of women [who] are running the gauntlet of "let's hope for the best on the day" would benefit greatly from the opportunity to voice their needs and wants prior to [labour]. But they don't know it [MCP process] exists. . .	Another issue raised regarding the MCP, was that even for women who had an MCP, its implementation was dependent upon who was on duty at the time of the woman going into labour. It was found that the experience of the staff had an impact with those with less experience reluctant to support women with their out of guidelines birth plan. Even if the plans are in place, it's still heavily dependent on who's on shift that day. . . Whether you've got the right

	punished for that. (MW11)		more if a senior doctor has spoken to her about the risks. . . That's probably the. . . advantage of them [MCPs]. (MW8). The process involved clear communication and thorough documentation that reassured professionals and was seen to be a source of 'protection'. Additionally, practitioners were reassured by women agreeing to be		That's actually a real disservice for everybody . . . because we've stopped other women saying "it's ok", and we've then stopped other women bringing that information to us and. . . making an informed decision, not when they are in labour. (MW6)	combination of midwives and doctors or not. If you don't. . . that plan. . . is not worth the piece of paper that it's written on. (MW8)
New metaphors, phrases, ideas, concepts, relations…	Women's rights framework/ recognition- broadly accepting and understanding	Personal & professional fears related to poor outcomes, litigation, knock on effect	Reassured by care plans- seen as a protection	Keeping the door open	Inequitable care planning	Limitations to care planning/delivery

2.7 Initial codes (taken from above)

Avoiding perceived risks of the NHS (at all costs) (3)
Perceptions of women's needs (5)
Acknowledging women's rights (6)
Relationships, working with women and negotiating care (2)
Relationships, being on their side, facilitating autonomy (3)
Establishing rapport (4)
Positive attitudes (4)
Continuity, relationships and communication (5)
Maintaining care (3)
Keeping women engaged in the service (5)
Keeping the door open (6)
Fear of litigation (4)
Midwives frustration, stress, and vulnerability (4)
Concerns raised by the midwives (5)
Fears of bad outcomes, fear of litigation (6)
Documentation as a safety net (4)
Maintaining documentation to manage fear of litigation (5)
Ameliorating fears with documentation and care plan (6)
Challenging obstetric constructs (2)
Challenging obstetric knowledge (2)
Negotiating normalcy (2)
Perceptions of guidelines (5)
Challenges of hospital transfers (3)
No guarantees (that care plan will be implemented) (6)
Inequity of access (6)
Fetal and maternal wellbeing viewed as a whole (2)
Conflict between fetal and maternal rights (4)
Seeking additional support in the work environment (4)
Managing judgements and fear in the work environment (5)
Women broken by the system (2)
Women taking responsibility and ownership (3)
Women who are well educated, intelligent, seeking control- viewed negatively (4)
Women who are Caucasian, well educated, middle class, independent, need control- viewed positively (5)

2.8 Iteration of synthesis example

1st	First iteration	Second iteration	Third iteration	Final consensus
Reciprocal Translation (how are the findings similar between studies**)**	Relationships, working with women and negotiating care (2) Being on their side (3) Establishing rapport (4) Positive attitudes (5) Continuity, relationships and communication (5)	Relationships central to care giving (2, 3, 4, 5)	Ways of working with-woman (?) Working with-woman (contradicts perceptions of women) (1, 2, 3, 4, 5, 6)	
	Maintaining care (3) Keeping women engaged in the service (5) Keeping the door open (6)	Keeping women engaged in care provision (3, 5, 6)		
	Reluctant acceptance [of ELCS]- fear of litigation (1) Fear of litigation (4) Midwives frustration, stress, and vulnerability (4) Concerns raised by the midwives (5) Fears of bad outcomes, fear of litigation (6)	Differing levels of fear, stress and anxiety associated with women's decisions (1, 4, 5, 6,) In contrast to:below	Managing the tensions between women's choices and professional perspectives (1,2,3,4,5,6) (here it is both reciprocal and refutational	
	Challenging obstetric constructs (2) Challenging obstetric knowledge (2) Women broken by the system (2) Negotiating normalcy (2) Perceptions of guidelines (5) Resisting first time mother requests [for ELCS] (1) Making a stand against ELCS (1)	Challenging the construct and concept of guidelines (2, 5) Challenging women's choice for medicalisation (1) Differing beliefs?		
	Challenges of hospital transfers (3) Managing judgements and fear in the work environment (5) Inequity of access (6) No guarantees (that care plan will be implemented) (6)	Challenges within the work environment (3, 5, 6)		
	Documentation as a safety net (4) Seeking additional support in the work environment (4) Maintaining documentation to manage fear of litigation (5) Ameliorating fears with documentation and care plan (6)	Overcoming fear, stress and anxiety associated with women's decisions (4, 5, 6)		

Refutational translation (how are the findings different between studies, and disconfirming data)	Women who are older and need control- viewed neutrally (1) Resisting first time mother requests [for ELCS] (1) Women taking responsibility and ownership (3) Women who are well educated, intelligent, seeking control- viewed negatively (4) Women who are Caucasian, well educated, middle class, independent, need control-viewed positively (5)	Perceptions of 'type of women' (1, 3, 4, 5)	Conflicting perceptions and attitudes towards the 'type of women' who request unconventional births (1, 2, 3, 4, 5, 6)	
	Previous history as influencing factor (1) Birth needs not met (1) Avoiding perceived risks of the NHS (at all costs) (3) Perceptions of women's needs (5)	Differing perspectives on the mother-baby dyad (2, 3, 4, 6)		
	Fetal and maternal wellbeing viewed as a whole (2) Committed to women's autonomy (3) Conflict between fetal and maternal rights (4) Acknowledging women's rights (6)	Differing perspectives on the mother-baby dyad (2, 3, 4, 6)		
Line of argument synthesis				

Table 8 Developing the synthesis subsequent iteration

2nd	First iteration	Second iteration (subthemes)	Third iteration (overarching themes)
Reciprocal Translation *(how are the findings similar between studies)*	Avoiding perceived risks of the NHS (at all costs) Perceptions of women's needs	Understanding women's motivations (1, 3, 5,)	Ways of working with-woman (?) Working with-woman (contradicts perceptions of women) (1, 2, 3, 4, 5,)
	Relationships, working with women and negotiating care Being on their side Establishing rapport Positive attitudes Continuity, relationships and communication	Relationships central to care giving (2, 3, 4, 5)	
	Maintaining care Keeping women engaged in the service Keeping the door open	Keeping women engaged in care provision (3, 5,)	
	Fear of litigation Midwives frustration, stress, and vulnerability Concerns raised by the midwives Fears of bad outcomes, fear of litigation	Differing levels of fear, stress and anxiety associated with women's decisions (1, 4, 5,)	Managing the tensions between women's choices and professional perspectives (here it is both reciprocal and refutational)
	Challenges of hospital transfers Managing judgements and fear in the work environment Inequity of access No guarantees (that care plan will be implemented)	Challenges within the work environment (3, 5)	
	Documentation as a safety net Seeking additional support in the work environment Maintaining documentation to manage fear of litigation Ameliorating fears with documentation and care plan	Overcoming fear, stress and anxiety associated with women's decisions (4, 5,)	

	Challenging obstetric constructs Challenging obstetric knowledge Women broken by the system Negotiating normalcy Perceptions of guidelines	Challenging the construct and concept of guidelines (2, 5)	
Refutational translation *(how are the findings different between studies, and disconfirming data)*	Women taking responsibility and ownership Women who are well educated, intelligent, seeking control- viewed negatively Women who are Caucasian, well educated, middle class, independent, need control-viewed positively	Perceptions of 'type of women' (1, 3, 4, 5)	Conflicting perceptions and attitudes towards the 'type of women' who request unconventional births (1, 2, 3, 4, 5)
	Fetal and maternal wellbeing viewed as a whole Committed to women's autonomy Conflict between fetal and maternal rights Acknowledging women's rights	Differing perspectives on the mother-baby dyad (2, 3, 4,)	
Line of argument synthesis (*a statement that summarises all the findings succinctly, and that incorporates the refutational as well as the reciprocal data*	*The overall findings suggest that midwives have conflicting/contradictory views and attitudes towards women who make unconventional choices. Whilst developing positive relationships was at the heart of most of the studies, the relationship between midwife and woman confronted many challenges. Fear of litigation was a dominant theme* *The findings demonstrate that midwives hold contradictory attitudes, fears and judgements regarding the facilitation of unconventional birth choices. Where those fears lay seemed to be dependent upon the midwives' personal philosophy of woman autonomy; for those who held this at the heart of their care their fears were associated with maintaining good relationships with the women in the care. And judgements were perceived to stem from colleagues. Here, the women were viewed positively and perceived personality characteristics were seen as a benefit for the women. For some midwives, women exerting full autonomy was challenging and a source of frustration and stress. Here, the women were viewed negatively and judged to be a 'type of woman'. The primary fear associated with this perspective was one of litigation and fear of potential reprisal. The differing attitudes were not necessarily associated with the midwives working environment, rather it was a part of their professional philosophy of care. Localised culture (working environment) seemed to affect the ease or difficulty of which midwives were able to facilitate women's unconventional birth choices.*		

First order construct	Second order construct	Third order construct
Women taking responsibility and ownership (2) Negative perceptions of women (3) Positive perceptions of women (4)	Contradictory perceptions of women (2,3,4)	**Different lenses, different views (1-5)**
Previous birth needs not met (2) Perceptions of women's current needs (4)	Understanding women's motivations (2,4)	
Fetal and maternal wellbeing viewed as a whole (1) Committed to women's autonomy (2) Conflict between fetal and maternal rights (3) Acknowledging women's rights (5)	Conflicting views of maternal autonomy (1,2,3,5)	
Fear of bad outcomes/ litigation (3,5) Midwives, stress, and vulnerability (3) Being 'judged' (5,4)	Fear and vulnerabilities (3,4,5)	**Conflicting tensions (1-5)**
Challenging obstetric constructs (1) Frustration at the 'system' (1) Perceptions of guidelines (4) Negotiating normalcy (1)	Arbitrary restrictions (1,4)	
Documentation as a safety net (3) Seeking additional support in the work environment (3) Maintaining documentation to manage fear of litigation (4,5)	Managing the tensions (3, 4, 5)	
Relationships, working with women and negotiating care (1) Being on their side (2) Establishing rapport (3) Positive attitudes (4) Continuity, relationships, and communication (4)	Relationships central to caregiving (1-4)	**Ways of working 'with-woman' (1-5)**
Maintaining care (2) Keeping the door open (4,5)	Keeping women engaged in care provision (2,4,5)	
Line of argument: *Midwives appeared to be either overtly facilitative or reluctantly accepting of women's alternative birth choices. Their positioning appears to be informed by their perspectives associated with women's autonomy, constructs of 'normal' birth, and the perceived acceptability (or not) of women making alternative birth choices. For some, their positioning is also influenced by concerns regarding litigation and associated reprisals. The quality and nature of their relationships with specific women are central to midwives' response to and management of alternative birth choices for those particular individuals.*		

Appendix 3 Empirical study methods

3.1 Recruitment sources

Table 9 Recruitment sources

Recruitment Plan			
Source	Method	Permission	Comment
RCM Midwives magazine	Advert in the magazine	Yes, Emma Godfrey-Edwards, Editor	Permission was granted following an article submission-pending ethical approval.
Birthrights.org	Advert via their social media pages: Twitter, Facebook, and possible inclusion to their newsletter	Yes, Elizabeth Prochaska and Carolyn Johnston, Trustees	Permission was granted following attendance to a Birthrights seminar-pending ethical approval. They advertised widely on social media
Association of Radical Midwives (ARM)	Advert via their social media pages: Twitter, Facebook, Yahoo discussion group & magazine (Midwifery Matters)	Yes, permission given.	A full page discussion piece and recruitment ad was submitted/published.
The Practising Midwife magazine	Paid advert or write up in the magazine	Yes, permission was given.	Advert was published.
Professional networks: Normal-birth research group-Jiscmail Known contacts with Supervisors of Midwives & Consultant Midwives, researchers involved with reproduction, Midwifery Societies	Advert via email and/or their associated social media accounts	Permission not required.	Emails with advert sent out.
Personal social media accounts	Advert via my Twitter, Facebook, and Research Gate accounts	n/a	Adverts were posted and shared across social media.

3.2 Recruitment adverts

Figure 3 General advert

uclan
University of Central Lancashire

'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'

Are you a qualified midwife working in the NHS?

Have you helped, facilitated or supported a woman's unconventional birth choice? Examples may include a woman with risk factors that chose to birth at home, or at a birth centre or in water.

OR

Have you helped, facilitated or supported a woman who had declined a recommended aspect of care? Examples include a woman that declined induction of labour, continuous electronic monitoring, vaginal examinations.

Would you like to take part in a research study that is exploring this aspect of your care as a midwife?

This study will involve you either a) writing a story and taking part in a follow-up interview OR b) taking part in an interview only.

If you are a qualified midwife working in the NHS (any band) and have direct experience of caring for women who have actively chosen a birth option that is not normally recommended (i.e. outside of NICE guidelines) or who has declined a significant aspect of care, that is part of your regular midwifery practice/philosophy and want to take part in a research study, please get in touch confidentially for more information:

Claire Feeley, clfeeley@uclan.ac.uk or 07581 295401.

If you know anyone who might be interested, please feel free to pass on this information.

This study is being undertaken by a midwife-researcher as part of a PhD Studentship at the University of Central Lancashire.

Figure 4 Advert for the Practicing Midwife

Calling NHS midwives!

Do you care for women who request out of guidelines care or who have declined recommended care?

Is it part of your regular midwifery practice or philosophy of care?

Would you like to take part in a research study to discuss your experiences?

Claire Feeley, a PhD Student with the University of Central Lancashire is looking for NHS midwives: any band, any department who would be willing to either a) write about your experience and take part in a follow up interview or b) take part in an interview only.

The focus of the research study is to explore why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?

For more information email: clfeeley@uclan.ac.uk

Figure 5 Advert for Association of Radical Midwives

over to you

Whilst we often receive articles from members, we are always keen to hear from you. Whether you have a burning question, a comment on an article, a request to reach other members or a creative contribution. This is your section...over to you! Email: lisamarie.midwife@gmail.com

Unconventional Birth: researching NHS midwives

Claire Feeley

Claire qualified as a midwife in 2011 at Oxford Brookes University, graduating with a Master's degree at the University of Central Lancashire in 2015. During this time, she has worked clinically in all areas of midwifery as well as establishing a research career. She is currently enrolled on a PhD Studentship with the University of Central Lancashire. To get involved in Claire's research email clfeeley@uclan.ac.uk

I qualified as a midwife in 2011 and during my training I went through some heavy lows and incredible highs. The low points will be familiar to many of you; over-intervention, depersonalised care and a lack of meaningful choice for women, often leaving me disheartened and disillusioned. To practice midwifery within the constraints of a medicalised and risk averse environment, I learnt that it was essential to understand and apply evidence from a range of sources. By attempting to know more than the local guideline, I was able (not always successfully) to advocate for the women in my care so they achieved the birth they desired. My passion for research grew throughout my training, so much so that I commenced my MSc in Midwifery and Women's Health soon after my degree.

During this time, I carried out a qualitative study that explored the motivations of women who chose to freebirth in the UK (Feeley & Thomson, 2016a; Feeley & Thomson, 2016b). Amongst a number of fascinating findings, this research also highlighted examples of poor midwifery practices. This included a lack of knowledge surrounding women's rights during childbirth, and a lack of respect associated with women's autonomous decision making. A key recommendation for all midwives was described: *"It is important to recognise that ethical and legal issues - such as autonomy, bodily integrity and the right to choose - are central to the care that midwives provide, and not solely concerned with women who freebirth."* (Feeley & Thomson, 2016a)

This research stimulated a different train of thought and approach for my PhD, whereby I wanted to turn my inquiries around to explore midwives who are facilitating women's autonomous decision-making. I knew that they existed, for I had worked with a number of them! To retain a clear focus, my study is specifically looking at why and how NHS midwives have facilitated women's birth choices that fall outside of NICE (2014) guidelines, described as an 'unconventional birth'. Whilst I recognise that the term 'unconventional' may be problematic, it was used as a catchall concise term for the study. We know the evidence suggests that women's decision making is often steered and sometimes coerced by midwives and doctors in order to comply with local guidelines and policies (Brass, 2012; Kruske, Young, Jenkinson, & Catchlove, 2013; Shallow, 2013). We also know that midwives are viewed as the 'gatekeepers' of women's choices (Skirnisdottir, Haukeland, & Dahl, 2016); this can be facilitative or obstructive (Feeley & Thomson, 2016a; Feeley & Thomson, 2016b; Plested & Kirkham, 2016). Therefore, my aims are to focus upon midwives who are self-defined as facilitators of women's choices, including those that sit outside of guidelines, whilst working within the constraints of the NHS. I hope to understand: what the midwives do, why they do it, how they do it, what processes they may (or may not) employ to manage the tensions in practice, their coping strategies as well as any meaning they may attribute to their caregiving. The study will generate unique knowledge in relation to midwifery practices which, at present, are largely invisible.

Recruitment started in January and within the first week I had over 70 enquiries and 50 midwives agreeing to participate. This was astounding! Whilst the current climate of midwifery is incredibly challenging, particularly for our Independent Midwife colleagues, this level of engagement has been hugely inspiring. I look forward to sharing with you the progress of the study. If you are an NHS midwife and want to be involved, please contact me: clfeeley@uclan.ac.uk.

References

Brass, R. (2012). Caring for the woman who goes against conventional medical advice. British Journal of Midwifery, 20(12), 898-901.

3.3 Recruitment email response to enquiries

Title of Project: *'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'*

Name of Researcher: Claire Feeley **Institution:** University of Central Lancashire

Contact Details: clfeeley@uclan.ac.uk/ 07581 295401

Email Inquiry Response

Dear ,

Thank you for your interest in the above study. I have attached an information sheet for you to read through in order for you to make an informed decision as to whether you wish to take part in this study.

If you decide that you would like to continue, could you please reply to this email within the next week indicating whether you will like to part in a) providing a written narrative and a follow up interview or b) an interview only. Please also include your home address as I will post you a consent form and a demographic questionnaire for you to sign and return to me. A stamped address envelope will be included for your convenience.

Please note that you are free to change your mind at a later date. If you have any questions, feel free to contact me.

Once again, I thank you for your time and interest in this study.

Best wishes

Claire Feeley

Midwife/Student researcher

Attachments:
Participant Information Sheet
Consent From
Demographic questionnaire

3.4 Recruitment- Information sheet for participants

Title of Project: 'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'

Name of Researcher: Claire Feeley **Institution:** University of Central Lancashire

Date: 21st November 2016 (Version 2)

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything that is not clear or if you would like more information, please contact us on the contact details provided at the end of this form.

Who is carrying out the study?

This study is being undertaken by Claire Feeley, a midwife and researcher as part of a Doctor of Philosophy degree in Midwifery at the University of Central Lancashire. The research is funded by a UCLan Studentship.

What is the purpose of the study?

This study aims to gather the views and experiences of qualified midwives currently working in the NHS who have enabled or facilitated a woman's unconventional birth choice. An unconventional birth choice would be those that are outside of current NICE guidelines or decisions to decline recommended care plans or treatment. This table sets out a range of 'unconventional birth choices' but may include others. Currently little is known about why and how some NHS midwives are able to facilitate women's birth options that fall outside of guidelines or women who decline a recommended plan of care. It is intended that the findings from this study will enable further understanding about midwifery practices that enable woman-centred care that may inform maternity care provision, education and guideline development.

Examples of unconventional birth choices	**Examples of declining care**
<u>Seeking homebirth OR birth centre AND/OR waterbirth with risk factors e.g.:</u> Breech Multiple births	Declining a recommendation for induction of labour

GBS+ colonisation BMI >35 Previous caesarean (VBAC) Previous shoulder dystocia Previous post-partum haemorrhage Grand multip (>4 previous births) Previous baby >4.5kg Age over 35 at booking	Declining vaginal examination during labour Declining a recommendation for caesarean section Declining augmentation during labour
Freebirthing: birth without a medical professional	Declining a recommendation for continuous electronic fetal monitoring

What is meant by enable or facilitate?

This study is specifically exploring midwives who have openly and actively supported a woman's unconventional birth choice. You may work in any department or ward of midwifery (and be of any band) but have been directly involved in caring for a woman who wanted to make a choice that currently sits either outside of NICE guidance or has declined recommended care. You may have advocated for the woman or liaised with other professionals to help the woman achieve her birth choice, or been present for the birth choice or fulfilled her choice in another way.

Why have I been invited to participate?

You have been asked to participate because you are a qualified midwife currently practising in the NHS (any department), and have facilitated at least one 'unconventional' birth choice, live in the UK and speak fluent English.

What will I be asked to do?

You are being asked to take part in the following activities:

EITHER: To write an account of a time that you facilitated a woman's unconventional birth choice, this would include the situation, what actions you took, your thoughts and feelings about the situation and what the outcome was. Ideally this would be emailed to the researcher within two weeks of agreeing to participate in the study. Information about sending this via an encrypted email will be provided for you. **AND**: to take part in a follow

up (recorded) interview (either over the telephone or face to face) which should take no longer than one hour to complete.

OR

To take part in an (recorded) interview (either over the telephone or face to face) which should take no longer than one hour to complete.

Additionally, you will be asked to fill in a demographic questionnaire requesting details such as age, gender, ethnicity, location, educational background, length of time qualified, current work role and band. This can be completed at the start of the interview. At a later date, you may be contacted to discuss the researcher's findings- however this decision does not need to be taken during this phase of the study.

Do I have to take part?

No it is entirely up to you to decide whether to take part or not. If you decide to take part, you will be asked to sign a consent form either via the post (I will send out a form with a stamped address envelope for you to return). If you do agree to take part in the interview, you may stop the interview at any point. You will also be able to withdraw all your data from the study up until data analysis (April 2017) and without giving a reason.

What are the possible benefits of taking part?

While there are no direct benefits to taking part, you will help to increase the knowledge base about woman-centred practice within the NHS. These findings may help to inform midwifery practice, education and guideline development. Telling your story may also be beneficial, by enabling your views and choices to be acknowledged.

What are the possible risks of taking part?

Occasionally interviews can bring up emotional responses. Be assured that the researcher will be sensitive to your needs and should you wish to stop the interview, the researcher will be happy to do so. If you become distressed, the researcher will be able to signpost to outside agencies to provide further assistance. These could include your Supervisor of Midwives, Occupational Health or Counselling services. In the unlikely event that unsafe midwifery practices are disclosed, the researcher has a duty as a registered midwife to escalate any concerns raised to your Supervisor of Midwives- you would be informed immediately should this occur.

Will what I say in this study be kept confidential?

Your contact details, narrative, and interviews will all be kept safely and securely, which can only be accessed by the research team. Once the interview has been downloaded, it will be deleted from the recording device, and after the interview has been transcribed, the audio file will be deleted. Any correspondence that contains personal information will be transferred by encrypted/password protected files, and all information will be stored on the University's server which is encrypted/password protected. All hard copies of any information (e.g. consent forms) will be coded and stored separately in a locked cabinet.

What will happen to the results of the research study?

Direct anonymous quotes from the interviews will be used in the research report, publications and/or presentations from this study.

Who has reviewed the study?

This study has received ethical approval from the Science, Technology, Engineering, Medicine and Health (STEMH), University of Central Lancashire's research ethics sub-committee (project no: XXXX).

Contact for Further Information

If you wish to take part or have any questions please contact Claire Feeley directly at clfeeley@uclan.ac.uk Tel: 07581 295401

Supervisory team:

Dr Gill Thomson, FHEA, PhD, MSc, BSc, Senior research fellow, Maternal and infant Nutrition and Nurture Unit (MAINN) School of health, University of Central Lancashire. Lancashire, PR1 2HE GThomson@uclan.ac.uk

Tel: 01772894578

Professor Soo Downe, BA (Hons) RM, MSc, PhD, OBE, Professor of Midwifery Studies. University of Central Lancashire. School of Health & Midwifery, Preston, Lancashire, PR1 2HE SDowne@uclan.ac.uk

Tel: 01772893815

If you have any concerns or complaints about this study, please contact the University Officer for Ethics at 01772 892735/UCLan at OfficerForEthics@uclan.ac.uk.

Thank you for considering taking part in this research study.

3.5 Recruitment- Demographic Questionnaire

Title of Project: *'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'*

Name of Researcher: Claire Feeley Institution: University of Central Lancashire

Date: 20th October 2016

Name:	
Preferred pseudo name:	
Age:	
Gender:	
Ethnicity:	
Town:	
Educational background (highest level qualification that you have gained):	Diploma Degree Postgraduate Certificate Master's PhD Other
Employment status:	Full time Part time Bank Agency Other
Current department/ward:	
Current role/job title:	
Number of years qualified:	

3.6 Recruitment- Consent Forms

CONSENT FORM: Narrative and Interview

Title of Project: *'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'*

Please read the following statements and initial the boxes to indicate your agreement, and sign to return to the researcher prior to the interview.

	Initials:
1. I confirm that I have read and understand the information sheet, dated 21st November 2016 (Version 2) for the above study and 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 my data up until final analysis (April 2017).	
3. I agree to provide a written narrative	
4. I agree to take part in an interview to discuss the narrative in more depth	
5. I understand that I am free to not answer any questions and may stop the interview at any point, without giving reason.	
6. I agree to being contacted about taking part in a further interview to discuss the findings	
7. I agree to the interviews being audio recorded	
8. I agree to complete a demographic questionnaire	
9. I understand that I will receive a copy of the findings and will have two weeks to provide any further feedback to the researcher if I want to	
10. I agree that my anonymised data may be used in publications, presentations and teaching arising from the study.	
11. I agree to take part in the study	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

CONSENT FORM: Interview only

Title of Project: *'Why and how do NHS midwives enable or facilitate women's unconventional birth choices in the UK?'*

Please read the following statements and initial the boxes to indicate your agreement, and sign to return to the researcher prior to the interview.

	Initials:
1. I confirm that I have read and understand the information sheet, dated 21st November 2016 (Version 2) for the above study and 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 my data up until final analysis (April 2017).	
4. I agree to take part in an interview to discuss a time I have facilitated a woman's unconventional birth choice	
5. I understand that I am free to not answer any questions and may stop the interview at any point, without giving reason.	
6. I agree to being contacted about taking part in a further interview to discuss the findings	
7. I agree to the interviews being audio recorded	
8. I agree to complete a demographic questionnaire	
9. I understand that I will receive a copy of the findings and will have two weeks to provide any further feedback to the researcher if I want to	
10. I agree that my anonymised data may be used in publications, presentations and teaching arising from the study.	
11. I agree to take part in the study	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

3.7 Recruitment- Safe emailing guide

Information for participants: How to protect your files with a password for safe emailing:

- Once you have finished your document, click on FILE.
- Click on the PROTECT DOCUMENT icon.
- Click on the ENCRYPT WITH PASSWORD and type in a password.
- It will ask you to do this twice.
- Save as normal.
- Email to me as an attachment.
- In a separate email, send me your password so I can access the document.
- Any problems, ring me 07581 295401 and I can talk you through it.

Thank you!

Claire Feeley

3.8 Ethics approvals

29 November 2016

Gill Thomson / Claire Feeley
School of Community Health and Midwifery
University of Central Lancashire

Dear Gill / Claire

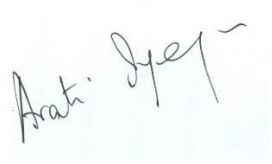
Re: STEMH Ethics Committee Application
Unique Reference Number: **STEMH**

The STEMH ethics committee has granted approval of your proposal application 'Practicing 'outside of the box' whilst within 'the system'. A narrative inquiry of NHS midwives supporting women's unconventional birth choices in the UK.'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely



Arati Iyengar
Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

12 January 2017

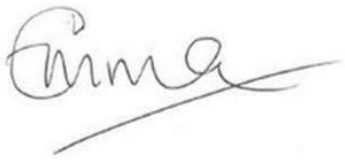
Gill Thomson / Claire Feeley
School of Community Health and Midwifery
University of Central Lancashire

Dear Gill / Claire

Re: STEMH Ethics Committee Application
Unique Reference Number: **STEMH 573_amendment**

The STEMH Ethics Committee has approved your proposed amendment to your application **'**Practicing 'outside of the box' whilst within 'the system'. A narrative inquiry of NHS midwives supporting women's unconventional birth choices in the UK'**.**

Yours sincerely



Emma Sandon-Hesketh
University Officer for Ethics
STEMH Ethics Committee

3.9 Sample reflexive journal

Figure 6 Sample extracts from my reflexivity journal

DATE	REFELCTIONS	THINGS TO DO/CHANGE IN THESIS
21.05.2016	<u>Early reflections linking past research to this study</u> One of my main and unique findings with the freebirthing were the women's 'herstories'……this builds on that! I can't believe I haven't given it enough attention, the women offered me that without my seeking that information. They contextualised their decisions from the 'story'/'herstory' of their lives up until that point. Narrative as arts-based inquiry is simply an elegant and exceptionally useful way to uncover nuance and detail about previous experiences. Linking back to this study, in a way I am asking the midwives to share a story of practice in which they enabled an unusual birth choice, but this is perhaps part of a bigger story, a story of their philosophy and approach to care practices. I wonder and hope that narrative inquiry will give me the tools to explore both, I suppose it will reveal the meaning of the experience itself, and the meaning of the midwife's identity or values in relation to the experience. 'Wounded storyteller'- 'mirrors the wounded healer, archetype Chiron, in which we seek to heal in others, belies a source of the wounded within, constantly searching and seeking wholeness through the healing of others'. (My reflections, 21st May 2016). Kim Etherington's online presentation has struck a deep resonance with me. Looking up her work, she is a counsellor practitioner/researcher specialising in childhood trauma. What strikes me that of late, I am finding and 'seeing' childhood trauma in lots of places. This of course is triggering for me, not necessarily negative, in fact it has brought about a tremendous sense of validation. There is now the language for what I went through, and this means that other people are being given a voice. What is striking about this, is when I examine the depths of my passions in terms of	

	childbirth/maternal health boils down, largely passions of choice, autonomy and human rights. I did not have a choice for many of the things that happened to me. I had no choice and nowhere to go. I was caged, impotent and frightened. Disempowered. Yet, suddenly one day I broke free of that, I created a choice where there wasn't one the day before. This choice blew up out of nowhere and slapped me in the face, that morning. The morning of my 15th birthday. And isn't this the story of my life, finding myself in confining, restricting and disempowering situations…and then POP I find a choice where there wasn't one the day before. Not only do I make a (Significant) choice, I act upon it. And largely, do not look back. So underneath, beneath? My passions, at my absolute core, my values revolve around choice and its wider implications upon my (our) sense of self.	
07.09.2016	<u>Reflecting on narrative work:</u> ''These scholars also emphasized that narrative is not merely an account of a person's illness but (often) is also a component of its treatment. In chronic illness, a good therapeutic relationship, sustained over time, can allow co-construction of a healing 51narrative that makes sense of the illness and supports the sick person in rebuilding his or her identity (10,11). Such therapeutic narratives have been depicted as healing dramas (enacted rather than told), particularly in fields such as rehabilitation (5)". (WHO, 2016) This can be applied to the therapeutic nature of the midwife-mother relationship- particularly in the event of a previous trauma. So much of the work in midwifery (when facilitating a choice including declining care) involves LISTENING and HEARING the woman's narrative. This aspect has the ability to heal or further break (compound trauma). YOU'RE NOT LISTENING- key issue for women. Makes me think about what are the actual process involved when we feel heard, supported and respected-psycho-social-physiological. IME, this is so often what women need- to offload, debrief and be HEARD, then a positive care plan that meets all of her needs (including physical safety and evidence) can be co-constructed together. I find that women who are heard, and have a relationship with you, will be receptive to advice.	
04.10.2016	<u>Reflecting on narrative and supervisory comments:</u> Am exploring the first chapter of the narrative course and reflecting upon the type of story the midwives might tell. As SD has mentioned before, it is likely to demonstrate ourselves as the hero. And indeed my research question lends itself to a hero's tale. So I need to consider how to interrogate the data, to look for the counter narratives that may go against the expected discourse. But then the expected discourse is that women don't really exert their agency, so I am actually looking for the counter narrative in the study. But I think what I am getting at, is to explore the story of the midwife's choosing but also to ask about a time when the outcome wasn't good-not necessarily disastrous but just not great-maybe the woman wasn't happy with the outcome or her decisions. Maybe the midwife wasn't. To illuminate these	**I need to consider asking for a story that doesn't go so well (if the story is one that is one that goes well) to increase the broader perspective and to not just find hero's stories.**

	stories would also be useful, a counter of a counter narrative? And I'd want to know has that changed the midwives practice/philosophy of practice too? 'Again, HIV romance seemed, for women, a genre with space enough inside it for them to narrate failures Squires in Andrews 2005' (wk1) I remember the time I looked after a woman in early labour who didn't want to go home, but also didn't want to have synto that had already been suggested. I remember how ferocious I was in support of her! I did everything to facilitate her decision. She had early labour for hours, I even got pulled away to another labourer who quickly birthed. I remember coming out of the other woman's room, and the mother (in law?) coming out very tired and cross demanding me to do something and wanting to know why nothing had happened yet. I went back to the woman, and sat with her. Naturally she was frustrated and upset as the events had unfolded, and she certainly started to blame me and take it out on me. I did feel defensive, and did remind her that I had been supporting her decision not to have synto. I was keen to point out that she was always in charge of the decisions and if she wanted something else from me I would make it happen. I can't remember if that conversation helped the woman or not. I certainly went home absolutely frazzled and disappointed for her. A mixture of defensiveness that I had followed her wishes and was then blamed for things not progressing! But it was a good insight, and made me really consider if I would/should have done something differently? I honestly don't know, but I do know it reaffirmed that I would not have been happy to have encouraged/coerced her to have the synto, as might have happened with someone else. I was quite newly qualified so I think now I'd have a few more tricks up my sleeve say with trying the spinning babies techniques etc. So, it was a good lesson that despite decisions made from good rationale/physiology, things may not go to plan, be satisfactory and that is the nature of the beast (birth). But what I had to decide, have to continue to decide whether to let these situations influence me so I would then start to become protectively 'steering'. That is another story for a different day, but I have to be brutally honest with myself- I do not/cannot always live up to my ideals and some days that wasn't poor staffing/over work.	

07.09.17	Reflecting on an interview- Georgina-transcribing A point here about the guidelines- on paper that supported breech but the reality was more problematic- another aspect to this study. Guidelines might be there but not necessarily the lived experience/reality. (also came up in Susan's, the pick and choosing of guidelines). Guidelines vs doctor's (and midwives) preferences Perceptions from wider team that the Georgina was 'brain washing women' – the sense that it is the midwives directing women's decisions comes through in other narratives, largely in units the midwives are unsupported. Will need further examining. More about the majority of women will go along with recommendations. (power/do women really want autonomy? The responsibility? Professionals undermining Georgina- multiple experiences of this. **'but you know it makes you feel like (...) sometimes it's in the woman's best interests (.) just to get them to go along with recommended treatment is because otherwise (.) either you or she or both might actually be punished by other people (.) who can't deal with it (..) that make sense?'** Prices to pay for supporting women in an unsupportive environment. - emotional cost This is a difficult interview to transcribe- my anger levels are rising at the shocking events within Georgina's narrative. Also, so much of this resonates with me yet also I keep thinking wow, I thought my old places were bad! There were positively amazing in comparison. 'Women's work'- midwifery skills undermined and undervalued. Another one where the coordinator identifies a woman that is for this particular midwife 'this has got you written all over it' (came up in Susan's and probably others- good to go back and check). If there was one interview that encapsulates the concept of Foucault's 'bio-power' – it is this one. Throughout the narrative women's bodies are being owned and her decision making being undermined, including this example of the husband twitching. Making sense of difficult situations/higher purpose/vocation. Self-reported feminist- longstanding.	**Analysis- guidelines were there but not used in reality (breech for example)** **'Brain washing'/perceptions of coercion by midwives to have unconventional births**

	Much of this has been about struggle and conflict and the interview is one of the longer ones, I wonder if it stands true again that we have more to say about conflict and struggle and less about the joys etc. I suppose the emotional landscape of struggle and conflict is perhaps more complex? Therefore, has a vaster language and requires more unpicking. {to add from initial analysis- Georgina describes 'widening' of choices/facilitation}	
22.02.18	<u>Reflections on the data:</u> A broad conceptual theme of the majority of the participants is to do with the notion of vocation, informed by their belief systems, some inferred, some explicit but related to a sense of justice and 'doing the right thing', inferred or explicit views on feminism, personal experiences (birth or other informative life experiences), professional experiences (either positive or negative) and a sense of a greater purpose related to feelings of service (?). More broadly this sense of vocation related to an inner sense of knowing, or as Belenkey describes another way of knowing. For the midwives, this sense of embodied knowing was born out of a calling to the profession. This was not consistent across all of the narratives, with some divergence with a few participants more aligned to midwifery as a job rather than a vocation. Leaving the diverging midwives for a moment, which I will return to, the midwives that conceptualised their work as a vocation also situated the sense of vocation within multiple tensions and the costs of fulfilling their purpose/vocation. This section presents the findings in relation to the multifaceted benefits and disadvantages for midwives practicing their vocation within an institutionalised system.	**<u>Considering the concept of vocation- draft writing</u>**

3.10 Data Collection-Transcription guide

10.11.2016

Transcription convention I chose informed by the UEL narrative methodology course reading materials and in collaboration with Professor Squire.

Transcribe literally

Retain sentence structure

I will retain discontinuation of words, sentences, nonverbal sounds, pauses and word doublings (I will not 'tidy up' or smooth)

I will include my words

I will not include pitches/loudness

I will include pseudonyms or general descriptions of any identifiable information i.e. people/place

I will not include emotions in the transcript, rather will use the memo function on MAXQDA to remind me later on significant emotions, phrases that need clarifying etc.

Denotations:

- Half sentences: /
- Brief pause:,
- Pauses: (.) for one second, (..) 2 seconds etc
- Mhm (affirm) or mhm (negative)
- Emphasised words will be underlined
- Very loud words in bold
- Non-verbal included as: (sigh) (laughs) etc.
- Incomprehensible words due to external factors: (phone rings) (doorbell rings)
- If muffled, or unable to make out the words: (muffles)
- Unsure of a word but think it sounds like a word (?word)
- Speech overlaps //
- If direct speech is quoted use 'speech marks'

3.11 Data analysis 1

Table 10 Coding system in MAXQDA

Overarching Temporal Code	**Major code**	**Sub-codes**	**Sub-codes 2**	
Outcome and Evaluation				
	General evaluation of unsuccessful planned births			
	Repercussions of practice/nmc referral			
		wider repercussions i.e. on service		
	Investigations			
		(positive) learning from investigations/poor outcomes		
		Defensive practice		
		Lack of support		
	Unplanned (negative?) outcomes			
	Evaluation of the study			
Experience				
	reflecting on demographic of women			
	Leadership position			

		empowering mws		
		Experience (isolating/challenging)		
		Go between		
	Self-reflection			
		Overcoming personal fears (previous prof exp)		
	Significant repercussions			
	Type of midwife			
	Positive			
		Supportive management		
			Supportive colleagues	
		Creative solutions		
		Emotional attachment		
		Mutually beneficial		
	Stress/tensions			
		two way trust issue		
		Frustration that complex care planning is specialised		
		Stress related to relationship with woman or partner		
		Managing stress/finding resilience		
		Personal costs		
	Reflecting on uncomfortable situations			

		women's regret		
		Different levels of comfort dependent on decision		
			Still supportive even if not in agreement	
		Sense-making		
			Hypothetical sense-making	
	Battle			
		Negative perceptions from wider team		
		Unsupported by mw's		
		Fragmented care		
		Perception mw has persuaded woman		
		Trying to fit in		
		Conflicts		
			wears you down	
		Unsupportive management		
			Mixed support from coordinator (depends on individual)	
		Anxiety from SOM/colleague/senior/manager/medic		
		Autonomy		
			Restricted autonomy	

				CQC external influences on practice
			Surveillance	
			Tension between subversive and overt practice	
Processes				
	Relationships with medics/managers			
		Being credible		
		Accompanying women to medic apt		
			Preparing women for mtg with medics	
		Negotiating with colleagues/medics & seniors		
			Managing the medics	
			Understanding colleagues as individuals or in context	
			negotiating skills/attributes	
			Managing confrontations	
				Avoiding confrontations

			Steering women to sympathetic/supportive seniors/som's etc.	
			Advocacy	
	Process between mother-midwife			
		Relationship building with woman		
			Mental capacity	
			Breaking down barriers	
			Being honest	
				women needing to be honest
			Reciprocity	
			Building rapport quickly (Non-COC model)	
			Understanding the woman's decision-making	
				Type of woman
				'deviant women'
			Supportive and/or facilitative	
				'Being' woman-led/not saying no

			Communication/discussion	
				Negotiating with women
				Renegotiating with women
			Making time/space for woman	
				Protecting the (birth space)
		Giving woman information/proactive information/widening choices		
			Contingency planning	
			recognising limitations of choice	
				Referring onto IM
		Clinical assessments and care planning		
			Assessing capacity	
			Individualised care in conjunction with woman's decisions	
		Consequence of trusting relationship		
			Consequence of relationship breakdown	
			Downside	

			Relationships with woman's family and supporters	
	Professional/personal processes of the mw			
		Takes responsibility		
		Being organised/planning		
		Seeking wider information and evidence		
	Processes between midwife and wider team/trust			
		Different process depending on where woman births		
		Defining boundaries		
		Supporting mws to support the women		
			empathy	
		Formal		
			Established service	
				responding to loss of supervision/setting up a service
			Wider MDT HOM/CD etc.	
				Legal involvement
			Referral to medics	
			Three way meeting	

			Liaison with MDT	
			Mode of birth clinics	
				Criteria
				Referrals
				Benefit of clinic
				Feedback
			Seen cons mw	
				Liaison with cons mw
			Referral to SOM to discuss risks	
			Structured care planning	
				Skills and drills (being prepared)
				Complex care planning/dissemination
				Benefits of formalised processes
				Limitations of structured care planning
			Documentation	
			Proforma for woman to sign	

				Proforma for mw to sign
		Going on call for woman (where it's not the usual)		
			Getting an on call team together	
		Informal		
			time and place to discuss risk	
			Taking over care	
			Informal planning	
			Double checking with woman (not COC)	
			Handover	
			Chat with SOM/Senior/Medic	
				Informing or discussion shift lead/coordinator
				Conversation with woman and document
			Managing the unexpected	
				Torn between woman and seniors

				Not to be seen 'encouraging the woman'- protecting self
			Care planning	
Context				
	Wider context of trust/guidelines/institution/work env/societal			
		Wider context of experience of different units		
	Personal context of the midwife			
	Immediate context of the situation			
		Previous relationship with woman		
Situation				
	Broad situation			
	Midwife widening choices			
	Woman-led decision making			
	Unanticipated situation			
	Anticipated situation			
		Unanticipated event within the planned event		

Appendix 4 Member checking

Table 11 Member feedback- Findings 1

	Participant pseudonym	Comments
1	Rachel	Thanks Claire I had a quick skim read – really pleased its coming together for you
2	Jess	This looks great! Such an important piece of research. Well done for all your hard work. Thanks,
3	Claire	Looks good, there were a few points though where I read them and thought 'why didn't I mention that - we've had that one happen, but didn't realise that was outside of criteria in other places' (birth centre or homebirth over 40), or 'why didn't I talk about X, she'd have been a fantastic example' (declined all scans, has had a term baby with anencephaly and since had two more babies - and declined scans and doppler auscultation with all of them) and with her first - who she had at home - I even had mentioned the possibility of the baby being born with a fatal condition) or ones I've had since we spoke (standalone birth centre and lady on metformin due to GDDM) But looks really interesting and good
4	Emily	Thanks for the update. I have read through and it all looks great to me. Good work! I look forward to hearing more in the next stage. Thanks,
5	Jenna	WOW! Impressive, looks great. You must be almost done now
6	Lucy	This is Amazing! I am so looking forward to reading your final piece. I have just edited one of my quotes- I had no idea how terrible I was at stringing a sentence together. ‘ So (.) you have to build a relationship with them cos they don't know us and it's all about them and their experience and what they want to gain from it, and I think when people go in guns blazing making it sound like the woman's wrong, their guard goes up, and once that happens that's it, they're not going to listen to what you're saying in an emergency situation, they're not going to trust that it is an emergency because they think that you're you know, coercing them to do what you think is right (.) and that's where I found the issues arose (.) in my previous experience (.) the woman has to feel as though they can trust you, otherwise it's not going to work.’ [37 Lucy (I): 43-43] I am now the team leader of our stand alone birthing unit and the girls are all so passionate about personalised care planning and supporting choice, I can't wait to show them what you produce.
7	Kelly	Many congratulations on completing this first stage of your thesis. What a lot of hard work! I really enjoyed reading the two documents and found them fascinating and mostly very positive although some of the clashes with the obstetric team are disappointing. I particularly relate to the account of the midwife attending a high risk home birth who said she was far more bothered by the constant phone calls for updates and comments like ‘why isn’t she coming in’, than the actual birth itself. I had a very similar experience supporting my own daughter who birthed her second baby at home at 36+2. Good luck with the rest of your work and many thanks for sending this.
8	Susan	WOW! Well done you! Unpicking and presenting that amount of information is very impressive!

		I love the idea of getting the woman to list the things that are non-negotiable and those that are more flexible….definitely nicking that one ;) Reading it gives me a warm fuzzy feeling that there are so many midwives out there that are willing to facilitate women's choices, and not just scaring them into making the choices the establishment would prefer. I think reading this may make those practitioners, that are scared of women who challenge the guidelines, feel empowered to rethink this stance. Congratulations Hon.
9	Delilah	I'm really sorry but I'd completely forgotten about this, it's been so busy. It's probably too late to provide feedback but I'll make a determined effort to read it later. Many thanks,
10	Georgina	Hi Claire, Thanks so much for this & I'm sorry it has taken me so long to read it. I've been swamped with my own work lately. What you've done is fascinating! I can't wait to see the final project. Some things I've noticed … In the participant working contexts model, Georgina is listed as 25 — but I think I'm 24, right? Also, although when I was interviewed I was working as a bank midwife in Intrapartum care, at the time of the breech episode, I was working as a Band 7 specialist across all settings. Not sure whether this matters! So looking forward to where you take this.
11	Delilah	Dear Claire, I've finally got round to reading this! Sorry it's taken so long. It's very interesting and I'm really looking forward to reading more. I'm happy with the quotes I made. Keep going! Best wishes,

Table 12 Member checking data analysis 2

	Participant	Comments
1	Catherine	Thanks for this Claire - I'll read it later!
2	Hannah	Thanks for your email. This is an excellent read which captures so much valuable information, including that sense of treading a tightrope when facilitating women's birth choices in certain circumstances. It was useful to read that others have similar feelings as you can feel quite alone at times. For me personally I found this quite helpful as I've been doing a bit of reflection on my experiences over the last few years and beating myself up a bit.
3	Claire	No issues with it.
4	Georgina	Thank you Claire, well done
5	Tracey	Love the stories. Well done.
6	Jenna	Looks amazing Claire! You've nearly done, well done.

Appendix 5 Situating the findings- an overview of the participants' stories

Name	Key clinical situations
Alex	Big story- supporting a woman with Group B Strep (GBS+) to have a waterbirth at the birth centre. Small-stories included- multiple situations of women declining vaginal examinations (VE) and supporting other staff to facilitate women's unconventional decisions.
Laura	Rather than one big story, Laura had many small stories as it is a regular part of her practice that included: multiple situations of women declining postdates induction of labour (IOL) to continue with homebirth plans; a woman declining all monitoring in labour, a woman with a blood disorder supported to have a homebirth.
Seana	Big story- supporting a woman to have a vaginal birth after caesarean (VBAC) against the doctor's care plan. Small-stories related to supporting staff to support normality within a medicalised setting.
Leanne	Big story- a woman declining a vaginal examination during labour.
Delilah	Big story- a woman wanting a homebirth, who was a first time with several additional needs that local guidelines advised hospital as the place of birth. Small stories included her past extensive experience facilitating physiological births and/or women's unconventional birth decisions.
Sam	Big story- supporting a woman with epilepsy to have a homebirth and another of supporting a woman to access the birth centre against local guidelines. Small stories included multiple situations of supporting women to have a home vaginal birth after caesarean (HVBAC) and her extensive experience of facilitating unconventional birth decisions. VBAC at home and is experienced in a wide range of women's unconventional birth decisions.
Jane	Big story- of supporting a woman wanting a homebirth in rural location who was a grand-multipara (p6), with a complicated obstetric history. Small-stories included: caring for different women with medical risk factors at a birth centre, and Jane's extensive experience of facilitating women's unconventional birth decisions..
Kelly	Big story related to supporting a woman to have a homebirth who was a grand-multipara and had declined all antenatal screening. Small stories included: Kelly's extensive experience of facilitating women's unconventional birth decisions i.e. home breech birth, grand-multipara's to have homebirths, women with complicated obstetric histories to have homebirths. An additional Small story related to Kelly's approach of 'widening women's choices'.
Rachel	Big story related to supporting a woman during the antenatal period to plan for a HVBAC. The woman went onto have some minor complications prior to the start of labour in which Rachel was positioned to support the woman's decision-making and the midwives delivering the care. Small-stories included supporting women who make a wide range of unconventional birth decisions. However, Rachel's overarching story relates to being in a leadership position that simultaneously supports/facilitates women's unconventional birth decisions as well as providing the support to the midwives caring for the women.
Jayne	Big story related to caring for a woman in labour at hospital who declined recommended antibiotics for GBS and VE's.

Tracey	Big story related to facilitating a woman's decision to have a homebirth but had GBS. However, Tracey's overarching story is about how she stimulated changes into a new Trust that she joined to create a formalised and structured approach in collaboration with the wider multi-disciplinary team(MDT), to widening women's unconventional birth decisions in the area.
Anna	Big story related to supporting a woman to have a HVBAC. She had many Small stories as this is a part of her everyday practice mainly around women wanting access to homebirth/birth centre with risk factors i.e.: history of PPH, gestational diabetes, >BMI and birth in unusual places.
Clara	Two big stories related to: supporting a woman to hold her baby skin to skin after birth against medical recommendations, and supporting a woman to continue with the IOL process rather than a recommendation for caesarean. Small stories related to Clara's extensive experience of facilitating women who decide to decline postdate IOL.
Caz	Big story related to supporting a woman to have a water VBAC (WVBAC) using telemetry.
Stella	Big story related to supporting a woman in her first pregnancy to have a breech homebirth. Small stories related to Stella's extensive experience of facilitating women's unconventional birth decisions i.e.; women who have declined antenatal scans and/or antenatal testing who want homebirths, women who want home VBAC after one or more caesarean sections, women declining IOL to continue with homebirth plans, women with health risk factors who wish to continue with homebirth plans.
Brigid	Big story related to two episodes which involved caring for women declining interventions during an emergency situation. Brigid's overarching story relates to Brigid's leadership role and how she supports the midwives to care for the women.
Zoe	Big story related to caring for a woman in labour at home, who declined all routine observations, VE's and recommendation of transfer due to the clinical situation. Small stories included supporting women to access the birth centre who did not fit the criteria.
Becky	Big story related to supporting a woman wanting a home waterbirth who had age risk factors. b. Small stories included extensive experience of experience working with women outside of guidelines.
Jenny	Big story related to supporting a woman to have a HVBAC which Jenny states is a recurring request in her role of facilitating women's unconventional births. However, Jenny's overarching story related to facilitating wider trust systemic changes to improve the access and care delivery of women's unconventional birth decisions via introducing formalised processes with the support of the wider MDT.
Katie	Big story related to a woman who wanted a homebirth but had a raised BMI, but where relationships had broken down with the woman. Katie's other big story involved supporting a woman to have a twin home breech birth.
Claire	Big story related to supporting a woman declining induction of labour (IOL) for postdates to have a homebirth. Small stories included Claire's extensive experience working with women making unconventional birth decisions that included: women wanting a homebirth/birth centre who have a significantly raised BMI, woman wanting HVBAC, women who are grand-multipara requesting homebirths, women wanting homebirths who have declined postdates IOL, women declining VE's during labour, women wanting homebirths but have experienced obstetric complications previously.

Emily	Big story about facilitating wider changes into her unit to encourage women to return to hospital care rather than birthing at home. In collaboration with the wider MDT, birthing pools and new guidelines were introduced as well as structured processes in which to support women wanting unconventional birth decisions e.g. WVBAC using telemetry.
Susan	Big story related to facilitating a woman wanting a WVBAC in hospital but who declined (recommended) continuous electronic fetal monitoring (CEFM). However, Susan's overarching story was *how* she cares for labouring women, regardless of their decisions.
Georgina	Big story related to facilitating a woman to have a physiological third stage of labour, where the woman had some risk factors for haemorrhage. Small stories included the facilitation of breech births; some outside of guidelines and some outside of doctor's recommendations. An additional Small story related to Georgina's approach of approach of 'widening women's choices'.
Beatrice	Big story related to supporting a woman with gestational diabetes (GDM) to labour in water without CEFM.
Kate	Big related to supporting a woman who wanted to decline IOL for postdates and to have a homebirth.
Ginny	Big story related to supporting a woman who declined IOL postdates to continue her homebirth plans. Small stories largely involved Ginny's midwifery philosophy and the experience of being newly qualified.
Isabel	Rather than one big story, Isabel's interview incorporated a number of general situations of supporting women with unconventional birth decisions as it is within her leadership role, including a woman with multiple risk factors declining all interventions during labour and seeking a homebirth. Her overarching story related to embedding the facilitation of women's decisions across the maternity service that has created a cultural change.
Catherine	Big story related to supporting a woman to have a VBAC on the birth centre no CEFM. Whilst in this situation, Catherine was positioned as a supervisor to create a care plan for the woman, Catherine's Small stories reported her extensive experience in caring for women wanting VBAC's without CEFM and experienced in facilitating women's unconventional birth decisions generally.
Margot	Two big stories, firstly related to supporting a woman and the midwife caregivers in a situation where the woman declined a recommendation of caesarean section by the consultant in a non-emergency situation. Her second big story related to supporting a woman and the midwife caregiver where a woman declined augmentation and antibiotics where her waters had ruptured to continue with her homebirth plans.
Maria	Big story related to supporting a woman at home who declined all observations including fetal heart (FH) and declined Maria's presence in the room until the final stages of birth. Maria's smaller stories related to her extensive experience in facilitating women's unconventional birth choices i.e. supporting women wanting homebirths but with risk factors i.e.; raised BMI, HVBAC, declining IOL, IVF pregnancy.
Meg	Big story related to supporting a woman who declined an artificial rupture of membranes (ARM) during a slow (but normal) labour.
Jess	Big story related to supporting a woman wanting a homebirth who declined IOL where she had an hypertensive disorder
Kim	Big story related to supporting a woman who declined a recommended IOL for postdates, which she reported happens regularly.
Alice	Big story related to caring for a woman at home who was >42 weeks pregnant. Alice's small stories included extensive experience regarding the facilitation of women's unconventional homebirth decisions including: women who are grand-multipara, women who have gestational diabetes, and women who have had previous caesareans. Her wider story relates to the setting up of a homebirth team to improve women's access to continuity of carer as well as her leadership role whereby she supports midwives to facilitate women's unconventional birth decisions.

Edna	Big story related to supporting a woman who wanted a HWVBAC alongside multiple obstetric factors. Other small-stories included supporting women to have a HVBAC and supporting women with endocrine disorders to have a homebirth.
Lucy	Big story related to supporting a woman planning a HVBAC- Lucy wrote the care plan for her but a different midwife attended to her in labour. Lucy regularly works with women making unconventional birth decisions and will co-create the women's birth plans.
Kerry	Big story related to supporting a woman to have a homebirth who had a blood born virus (BBV). Kerry's micro stories included her extensive experience of facilitating women's unconventional birth decisions i.e.: WVBAC at home, women who have PSROM wanting a homebirth, breech births at the birth centre, and frequent occurrences of women declining recommended induction of labours.
Amy	Big story related to supporting a woman to have a HVBAC2 who also had other obstetric risk factors. Amy's small stories related to her extensive experience of supporting women with unconventional birth choices i.e. women declining postdates IOL.
Hannah	Rather than one big story, Hannah's interview incorporated a number of small storied situations of supporting women with unconventional birth decisions as it is within her primary role that included: women who wanted homebirths with significant risk factors e.g. HVBAC2, a woman that declined a transfer to hospital whilst during an obstetric emergency. However, alongside care planning with the women, Hannah's role and small stories related to supporting the midwives who will be delivering care to the women.
Rose	Big story related to supporting a woman to have a HVBAC2, who had an additional obstetric risk factor. stories included regularly supporting women with HVBAC, women with iron disorders to have a homebirth, and women who were grand-multiparas.
Lauren	Big story related to facilitating a woman's decision making regarding a home breech birth. Lauren's smaller stories related to her extensive experience in care delivery and complex care planning for women making unconventional birth decisions.
Jenna	Facilitating women's unconventional birth decisions is key component of Jenna's role. Her Big story related to facilitating a woman to have home breech birth. Jenna's overarching story is the facilitation of a wider trust systemic changes to improve the access and care delivery of women's unconventional birth decisions.
Trish	Big story related to facilitating a woman who wanted a home twin water birth with a complicated previous obstetric history. Small stories related to Trish's extensive experience of facilitating women's unconventional birth choices in care delivery and complex care planning i.e. water twin births, women having WVBAC, women who birth in unusual locations. supporting women who decline IOL, supporting women who want home births in rural locations.
James	Big story related to setting up a specific service with a colleague to support/facilitate women who want out of guideline homebirths. As a team and personally, James has extensive experience of facilitating women's unconventional birth decisions including: supporting women at home with epilepsy or Type 1 diabetes, previous obstetric histories that include caesarean, PPH, shoulder dystocia, platelet or iron disorders, women who have declined antenatal care, scans/screening, or who have freebirthed. Additional examples include supporting women with a planned breech home birth and planned twin home births. James other small stories related to supporting the community midwives to care for the women making unconventional decisions.