

‘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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Abstract

This thesis presents the findings of an original study that explored NHS midwives practice of facilitating women's alternative physiological birthing choices - defined in this study as *'birth choices that go outside of local/national maternity guidelines or when women decline recommended treatment of care, in the pursuit of a physiological birth'*. The premise for this research relates to dominant sociocultural-political discourses of medicalisation, technocratic, risk-averse and institutionalisation that has shaped childbirth practices in the UK. For midwives working in the NHS, sociocultural-political and institutional constraints can negatively impact their ability to provide care to women making alternative birth choices. A meta-ethnography was carried out, highlighting a paucity of literature in this area. Therefore, the aim of this study was to generate practice-based knowledge to answer the broad research question: *'what are the processes, experiences, and sociocultural-political influences upon NHS midwives' who self-define as facilitative of women's alternative birthing choices'*.

Underpinned by a feminist pragmatist theoretical framework, a narrative methodology was used to conduct this study. Professional stories of practice were collected via self-written narratives and interviews to understand the processes of facilitation (the what, how, why), their experiences of carrying out facilitative actions (subjective sense-making), and what sociocultural-political factors influenced their practice. Through purposive and snowball sampling, a diverse sample of 45 NHS midwives from across the UK was recruited. A sequential, pluralistic narrative approach to data analysis was carried out, and a theoretical model was developed using the whole dataset.

The findings were subjected to three levels of analysis. First, 'Narratives of Doing' highlight how and what midwives did to facilitate women's alternative choices. The sub-themes reflect the temporal nature of a wide range of actions/activities involved when caring for women making alternative birthing decisions. The second analysis; 'Narratives of Experience' - highlighted the midwives polarised experiences captured as *'stories of distress'*, *'stories of transition'*, and *'stories of fulfilment'*. For the third level of analysis, a theoretical model of *'stigmatised to normalised practice'* was developed using notions of stigma/normal, deviance/positive deviance. A six-domain model was developed that accounted for the midwives sociocultural-political working contexts; micro, meso, and macro.

The implications of this research related to a number of identified constraints, protective factors, and enabling factors for midwifery practice. Key barriers included negative organisational cultures that restricted both midwives' and women's autonomy. Disparities between the midwives' philosophy and their workplace culture were highlighted as a key stressor and barrier to delivering woman-centred care. Protective factors related to the benefits of working in supportive, like-minded teams that mitigated against their wider stressful working environments. Facilitating factors included positive organisational cultures characterised by strong leadership where midwives were trusted and women's autonomy was supported. Therefore, this study has captured what has been achieved, and what can be achieved within NHS institutional settings. Through the identification of both challenges and facilitators, the findings can be used to provide maternity professionals and services with insights of how they too can facilitate women's alternative birthing choices.

Publications & presentations resulting from this thesis

Peer reviewed journal publications:

Feeley, C., Thomson, G., Downe S (2019). Caring for women making unconventional birth choices: A meta-synthesis exploring the views, attitudes, and experiences of midwives. *Midwifery*, (20) 50-59

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Professional publications:

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Feeley, C (2017) Guideline-centred care or woman-centred care? *The Practising Midwife*, 20(7): 8-11.

Feeley, C (2017) No means no...let's talk about consent. *The Practising Midwife*, 20 (4), 25-27.

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Contents

Abstract.....	iii
Publications & presentations resulting from this thesis	v
Acknowledgements	vii
Contents.....	viii
Tables	xi
Figures.....	xii
Acronyms	xiii
Glossary.....	xiv
Foreword- A woman's insight	xvi
Chapter 1 Introducing the Study	1
1.1 Overview	1
1.2 Context	1
1.3 Theoretical and methodological positioning.....	4
1.4 Aims and objectives	4
1.5 Situating the researcher- Narrative Beginnings.....	5
1.6 Thesis structure	9
Chapter 2 Barriers to physiological birth and its impact on alternative birth choices	11
2.1 Introduction.....	11
2.2 International context: Physiological birth and midwifery	11
2.3 UK maternity context	14
2.4 Understanding sociocultural-political drivers.....	20
2.5 The influence and role of employed midwives.....	34
2.6 Situating the study: alternative physiological birth choices.....	36
2.7 Conclusion.....	37
Chapter 3 Systematic Meta-ethnography	38
3.1 Introduction.....	38
3.2 Aims and Objectives	38
3.3 Methodology	38
3.5 Results	48
3.6 Synthesis findings.....	54
3.7 Discussion.....	64
3.8 Conclusion.....	67
Chapter 4 Theoretical positioning & Methodology	69
4.1 Introduction	69
4.2 Research aims	69

4.3 Feminist pragmatism theoretical framework	69
4.4 Specific theoretical lenses in this study	76
4.5 Methodology	78
4.6 Conclusion.....	89
Chapter 5 Methods- Conducting a narrative inquiry	90
5.1 Introduction	90
5.2 Participants, sample, recruitment	90
5.3 Data collection	97
5.4 Data analysis	104
5.5 Ethical considerations.....	117
5.6 Trustworthiness.....	119
5.7 Conclusion.....	124
Chapter 6 Situating the findings	125
6.1 Introduction	125
6.2 An overview of the participants.....	125
6.3 An overview of women’s birth decisions.....	128
6.4 The participants working context.....	132
6.5 Reading the findings	136
6.6 Conclusion.....	136
Chapter 7 Findings 1 ‘Narratives of doing’	137
7.1 Introduction	137
7.2 Women’s decision-making- the beginning of the story.....	139
7.3 Relationship building	142
7.4 Processes of support and facilitation	148
7.5 Care planning	152
7.6 Behind the scenes	158
7.7 Birth facilitation	163
7.8 Conclusion.....	166
Chapter 8 Findings 2 ‘Narratives of experience’	167
8.1 Introduction	167
8.2 Stories of distress.....	169
8.3 Stories of transition	183
8.4 Stories of fulfilment.....	187
8.5 Conclusion.....	198
Chapter 9 Interpretative Model	200
9.1 Introduction	200
9.2 An overview of the model	200

9.4 ‘ <i>Stigmatised to normalised practice</i> ’- A theoretical model	206
9.5 Conclusion.....	220
Chapter 10 Discussion & Final Conclusions	221
10.1 Introduction	221
10.2 Original Contribution.....	221
10.3 Relationship to the wider literature	224
Constraints.....	225
Protective factors.....	230
Enablers	232
10.4 Limitations	239
10.5 Recommendations	241
10.6 Final (personal) thoughts.....	247
10.7 Final Conclusion.....	249
References	252

Tables

Table 1 Examples of alternative physiological birth choices	2
Table 2 Search term development.....	41
Table 3 Inclusion exclusion criteria	42
Table 4 Study characteristics	52
Table 5 A presentation of the interpretations with study codes in brackets.....	55
Table 6 Worked example of data analysis 2	114
Table 7 Trustworthiness in this study	121
Table 8 Participant’s demographics (n=45)	126
Table 9 Participant employment data.....	127
Table 10 An overview of the women's alternative birth choices	129
Table 11 Symbols used within the text	136
Table 12 Storylines, overarching storyline and participant	168
Table 13 Typology of midwives experiences within their micro, meso, and macro workplace contexts.....	207

Figures

Figure 1 Summary of findings from the Lancet Midwifery Series (Renfrew, et al., 2014, p.5)	13
Figure 2 Noblit and Hare's (1988) Seven phases of meta-ethnography.....	39
Figure 3 Screening criteria	43
Figure 4 Phases 3-6 methods	46
Figure 5 PRISMA flowchart of findings.....	49
Figure 6 Recruitment process	93
Figure 7 Self-written narrative prompt for participants	99
Figure 8 Thematic Analysis Braun and Clarke (2006, 2015)	108
Figure 9 Example of Braun and Clarke steps 2-5 related to one deductive category	110
Figure 10 Example of an emotion-story: fear and vulnerability	112
Figure 11 Word cloud illustrating the reported alternative birth choices	131
Figure 12 Participant working context.....	133
Figure 13 Midwife-mother relationship during care episode as related to the 'big' story.....	135
Figure 14 Narratives of doing themes.....	138
Figure 15 Theoretical model- stigmatised to normalised practice	201
Figure 16 Constraints, protective factors, & enablers.....	224
Figure 17 What midwives need to facilitate alternative birth choices- key recommendations	244

Acronyms

- AMU:** Alongside maternity unit (birth centre within hospital grounds)
- BMI:** Body mass index
- CEFM:** Continuous electronic fetal monitoring
- COC:** Continuity of carer
- FMU:** Free standing maternity unit (birth centre that situated away from the hospital)
- GBS/GBS+:** Group B streptococcus
- IOL:** Induction of labour
- MDT:** Multi-disciplinary team
- OU:** Obstetric unit/hospital
- P₁/P₂/P₃ etc.:** Number of births the woman has had
- PET:** Pre-eclampsia toxemia
- PPH:** Post-partum haemorrhage
- RCM:** Royal College of Midwives
- RCOG:** Royal College of Obstetricians and Gynaecologists
- SOM:** Supervisor of Midwives
- SRM:** Spontaneous rupture of membranes
- PRM:** Prolonged rupture of membranes (definitions vary between 12-48 hours)
- VBAC:** Vaginal birth after caesarean section
- VBAC₂:** Vaginal birth after two caesarean sections
- VBAC₃:** Vaginal birth after three caesarean sections
- WVBAC:** Water vaginal birth after caesarean section
- HVBAC:** Homebirth after caesarean section
- HWVBAC:** Home waterbirth after caesarean section
- VE:** vaginal examination

Glossary

Alternative institutionalised birth settings: either type of midwifery-led birth centres; AMU: adjoined birth centred (within hospital grounds) or FMU: free standing birth centre (independent of hospital).

Augmentation of labour: artificial methods to speed up labour.

Band: the pay scale that operates within the NHS for nurses and midwives, normally ranges from Band 5 (newly qualified midwife) to Band 8 a-c (consultant midwife or Head of Midwifery or Director of Midwifery)

Breech: baby is bottom first in the womb.

Caseloading: women who are looked after by one midwife (with minor exceptions such as sick or holiday leave).

Caesarean section: surgical birth via the abdomen.

Continuous electronic fetal monitoring: a machine that is used to monitor the baby's heartrate throughout labour using a doppler positioned on the mother's abdomen which is attached to the machine (also see telemetry)

Continuity of carer: where women are looked after by the same midwife or small team of midwives throughout the childbirth continuum.

Coordinator/shift lead: a senior midwife on labour ward/delivery suite who has responsibility or is in charge of the whole ward.

Core midwife: a midwife that has a permanent job in one particular area i.e. labour ward/delivery suite or postnatal ward or antenatal clinic.

Episiotomy: a surgical cut to the perineum to aid delivery of the baby, commonly used in instrumental births, historically overused and can cause increased levels of perineal damage.

Fragmented care model: where women are seen by different (usually unknown) caregivers (midwives or doctors).

Grand-multipara: a woman who has had over 5 births (also see multiparous).

Group B streptococcus: a transient bacterial infection that can occur in approximately 20% of women.

Hypothyroidism: too little thyroid hormones/underactive thyroid.

Induction of labour: artificial method to initiate labour.

Instrumental births: the use of forceps or ventouse to deliver the baby.

Integrated models: where midwives offer continuity of care but work across homebirth and birth centre settings.

Intermittent monitoring/auscultation: listening to the baby's heart rate at recurrent times throughout the first and second stage of labour, however, this is not continuous. It is carried out using either a pinard or a handheld doppler.

Intrapartum care: caring for women during the labour period.

Meconium: the faeces of an in-utero infant (whether presence of meconium is deemed significant depends upon gestation, stage of labour, presentation of baby, and fetal heart sounds).

Multiparous: a woman who has given birth more than once (also see grand-multipara).

Multi-professional team: wider team that the midwife works with, could include obstetricians, paediatricians, specialist doctors, management, and GP's.

Pre-eclampsia toxemia: a potentially life threatening disorder of pregnancy, only resolved by birth.

Polydramnious: excessive amniotic fluid in the amniotic sac.

Post-dates/post-term: pregnancy beyond 40 weeks

Post-partum haemorrhage: excessive bleeding after birth.

Prolonged: slower than expected progress of particular stage of labour (also see stalled).

Rotational midwife: midwife who works on a rotational basis to different departments i.e. labour ward/delivery suite, postnatal ward, antenatal clinic, community.

Shoulder dystocia: During birth, the baby's shoulders get stuck and require active intervention to free them, is life threatening if not resolved.

Stalled labour: slower than expected progress of particular stage of labour (also see prolonged).

Third degree tear: laceration is a tear in the vaginal tissue, perineal skin, and perineal muscles that extends into the anal sphincter.

Traditional community settings: relates to midwives working in the community, often with their own caseload of women to manage, and work on calls for homebirths.

However, they do not offer continuity of care so are likely to provide intrapartum care for women they have not met.

Transfer: moving from homebirth or birth centre to hospital, normally associated with complications of labour or the immediate post-partum period.

Uterine rupture: An obstetric emergency where both maternal and fetal lives are at significant risk as the uterus has ruptured.

Vaginal examination: an internal examination to assess cervical changes.

Telemetry: a wireless CEFM.

Foreword- A woman's insight

Highlighting why this thesis is important from a woman's perspective, is the following poem written by Kati Edwards:

Speak My Language

Would you be so kind,
Instead of writing I've refused
Could you write that I've declined?
When terms used are so much softer
Equal relationships can prosper
And I know you are an expert in whatever that you do
But I'm encased in my own body and I'm an expert in that too!
So that makes us kind of equal
When there are choices to be made
And I'd like to know the evidence
A balanced argument conveyed

This child inside's my baby
And I'll always make decisions
That feel right for us
And are aligning with our visions
Please don't talk through the surges
Because I need to concentrate
I need to focus on my body
And relax my mental state
The surges through my body, the sensations that I'll feel
Give me time and hold my space, and the pleasure can be real
But if you meddle and you mess and bring fear into the room
My energy will be weakened and my confidence can't bloom
I need that trust to set me free, to believe that I can
So please do read my preferences written up in my birth plan
Please let me know my options, don't coerce me to decision
Because I'm an individual
With my individual vision.

(Kati Edwards, poet, birth worker, 2017)

Chapter 1 Introducing the Study

1.1 Overview

This thesis presents the findings of a feminist pragmatist narrative inquiry into NHS midwives who self-define as facilitative of woman's alternative physiological birthing choices - I have defined as '*birth choices that go outside of local/national maternity guidelines or when women decline recommended treatment of care, in the pursuit of a physiological birth*'. Such characterisation excludes birth choices that go outside of maternity guidelines where women are seeking increased medical surveillance and/or medical interventions. The distinction between both types of birth choices is important. The premise for this research relates to dominant sociocultural-political discourses of medicalisation, technocratic, risk-averse and institutionalisation that has shaped childbirth practices in the UK. These discourses have been attributed to creating a hegemonic birth practices to the detriment of national physiological birth rates (Dodwell, 2012; ONS, 2017), women's choices (Holton & de Miranda, 2016) and midwives' ability to provide evidence-based and woman-centred care (Herron, 2009; Griffith & Tengahan, 2010). Therefore, by focusing upon midwives that support women resisting hegemonic birth practices, practice-based knowledge can be generated to counter these dominant discourses, and improve women's access to meaningful choices. This chapter will present an overview of the study context, the research question, aims, and objectives, the theoretical positioning of the study, as well as situating myself in relation to the study. Finally, an overview of the organisation of the thesis is provided.

1.2 Context

The ability/opportunity for women to make 'choices' during pregnancy and childbirth is embedded within governmental policies, cultural norms, and women's expectations. Such rhetoric is also associated with the global movement for improved human rights during childbirth that includes respect for women's decision-making and autonomy, including the right to decline recommended care or treatment (The White Ribbon Alliance, 2013; World Health Organisation, 2012). However, evidence suggests that women can face opposition, conflict, reprisals and restrictive care provision when they attempt to challenge technocratic, medicalised, risk-averse, and institutionalised hegemonic birth practices (Viisainen, 2000; Shallow, 2013; Scamell, 2014; Keedle, Schmeid, Burns, & Dahlen, 2015; Roberts & Walsh, 2018). Alternative physiological birth choices, as previously defined, may include healthy women declining routine maternity care practices such as labour induction after 41 weeks' gestation, or vaginal examinations

to assess the progress of labour or fetal monitoring during labour. Other situations include women who have had medical or obstetric risk-factors seeking midwifery-led care and/or non-obstetric settings (home or birth centres). Table 1 illustrates examples of such choices but is not exhaustive. Decisions that resist these discourses can be perceived as controversial despite legislation that assures women’s bodily autonomy and rights to choose their care (White Ribbon Alliance, 2011; Birthrights, 2017a; Birthrights, 2013b).

Table 1 Examples of alternative physiological birth choices

<u>Seeking homebirth OR birth centre AND/OR waterbirth with risk factors e.g.:</u>	Examples of declining care
Breech	Declining a recommendation for induction of labour
Multiple births	
GBS+ colonisation	
BMI >35	
Previous caesarean (VBAC)	Declining vaginal examination during labour
Previous shoulder dystocia	
Previous post-partum haemorrhage	
Grand multip (>4 previous births)	Declining a recommendation for caesarean section
Previous baby >4.5kg	
Age over 35 at booking	Declining augmentation during labour
Medical factors such as epilepsy, diabetes, cardiac conditions, thyroid conditions etc.	
Freebirthing: birth without a medical professional	Declining a recommendation for fetal monitoring, either continuous electronic fetal monitoring or intermittent auscultation

Although some studies have explored women’s decision-making and experiences of alternative physiological birthing choices¹ (Dahlen, H. et al., 2011; Jackson et al., 2012; McKenna & Symon, 2014; Keedle et al., 2015; Plested & Kirkham, 2016), few have examined the views and experiences of midwives caring for them. This an important gap

¹ Studies have explored women’s experiences of alternative birth choices include: freebirthing, which is an active decision to give birth with no professionals present (Brown, 2009; Freeze, 2008; Miller, A., 2009; Jackson, Dahlen, & Schmeid, 2012; Feeley & Thomson, 2016c; Plested & Kirkham, 2016); ‘high-risk’ homebirths (Dahlen, H., Jackson, & Stevens, 2011; Jackson et al., 2012); vaginal birth after caesarean (VBAC) at home or in a birth pool (McKenna & Symon, 2014); and twin births or breech births at home or in a birth centre (Symon, Winter, Donnan, & Kirkham, 2010).

in the literature for the core characteristics of ‘full-scope’ midwifery as defined by the Lancet (Renfrew, Homer et al., 2014), include the optimisation of normal biological, psychological, social and cultural processes whilst respecting women’s individual circumstances and views. The facilitation of alternative physiological births directly falls within this remit and concurs with the international definition of midwifery (ICM, 2017) and the midwifery philosophy of woman-centred individualised care (Bradfield, Duggan, Hauck, & Kelly, 2018). This lack of attention is significant because women’s ability to exert their agency can be influenced positively or negatively by their midwife caregivers (Coxon, Chisholm, Malouf, Rowe, & Hollowell, 2017). Such influence may be related to the midwives’ personal philosophy of childbirth (Thompson, 2003), personal experiences of birth (Church, 2014), or professional experiences of birth (Daemers, van Limbeek, Wijnen, Nieuwenhuijze, & de Vries, 2017), skill-sets (McCourt, Rayment, Rance, & Sandall, 2012; Walker, Batinelli, Rocca-Ihenacho, & McCourt, 2018), perceptions of risk (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; Coxon et al., 2017) or how they value women’s autonomy (Kruske, Young, Jenkinson, & Catchlove, 2013).

In addition, midwives’ ability to practice can be influenced positively or negatively by their sociocultural and political working contexts (Davies, Nutley, & Mannion, 2000; Sheridan, 2010; Frith et al., 2014). Organisational issues such as medicalised, risk-averse, technocratic cultures, poor staffing and busy workloads can limit midwives’ ability to practice autonomously (Healthcare Commission, 2008; Herron, 2009; NHS England, 2016). As such, institutional limitations to midwifery practice can adversely affect women’s access to individualised woman-centred care. Consequently, this study sought to focus on the experiences of midwives working in the NHS. To date, no studies have explored the processes (the what, how, why of facilitation), experiences, or sociocultural-political factors that influence midwives who self-define as facilitative of women’s alternative birthing choices. Therefore, this thesis offers an original contribution to address the particular issue of limited women’s choices that are outside of guidelines or recommended care from the perspective of midwives providing such care. In addition, by focusing the recruitment to midwives employed within NHS institutions, as opposed to midwives working independently, this study provides insights into the nature of delivering woman-centred care within an institutionalised working context. Therefore, this thesis illuminates what is achievable within the NHS and how complex woman-centred care can be delivered, whilst attending to the experiences and sociocultural-political factors involved in delivering care.

1.3 Theoretical and methodological positioning

This study is situated within a feminist pragmatist theoretical framework that assumes a practical approach to problem-solving where knowledge generation is utilised to affect positive social change (Seigfried, 1996; Fischer, 2014). Feminist pragmatism inherently adopts a critical perspective to account for issues of gender, power, and structural influences in people's experiences, the meaning-making attributed with experiences as well as the production of knowledge (Seigfried, 1996; Fischer, 2014). In this study, midwives are viewed as 'situated knowers' (McHugh, 2015) with the capacity to generate practice-based knowledge. By using a narrative research methodology, where stories/narratives are viewed as knowledge devices (Bamberg, 2010), the midwives situated knowledge was captured and analysed via stories of professional practice (written accounts and/or interviews).

1.4 Aims and objectives

The broad aim of this study was to generate practice-based (Singhal & Dura, 2017) and heuristic knowledge for the benefit of other midwives to deliver 'full-scope' midwifery to meet the needs of women making alternative physiological birthing choices. This thesis addresses the broad research question:

'What are the processes, experiences, and sociocultural influences upon NHS midwives' who self-define as facilitative of women's alternative birthing decisions?'

With three specific sub-questions the thesis will answer:

1. How do NHS midwives self-defining as facilitative of women's alternative birthing choices achieve their delivery of care (what they do, how they do it, and the rationale for their chosen actions).
2. How do the midwives experience their facilitation of women's alternative birthing choices? (the sense-making the midwives attribute to their practice, actions, and experiences).
3. What and how do sociocultural-political factors influence the midwives' practice? (the micro, meso, and macro working contextual influencing factors upon their practice).

Objectives

- To carry out a qualitative systematic meta-ethnography to determine what is currently known about the views, attitudes, and experiences of midwives caring for women making alternative physiological birthing choices.
- To carry out a narrative inquiry study to elicit in-depth insights through stories of professional practice.
- To recruit midwives nationally across the UK, and where possible recruit midwives with different work demographics (years' experience, level of seniority, work setting), for greater transferability of the findings.
- To generate knowledge regarding the midwives' processes of facilitation to generate practice-based knowledge.
- To generate knowledge to facilitate a deeper understanding of the subjective and contextual experiences of facilitation.
- To identify what and how sociocultural-political factors influence the midwives' processes and experiences to determine context-related factors that enable or hinder the facilitation of women's alternative birth choices.
- To identify constraints and enabling factors of midwifery practice of facilitating alternative birth choices.
- To identify key recommendations to inform midwifery education, practice and policy.

1.5 Situating the researcher- Narrative Beginnings

'Lives can be revealed, understood and transformed in stories, and by the very act of storytelling.' (Sandelowski, 1991, P1.63)

At the start of a narrative inquiry study, some authors suggest there is a need for the researcher undertaking the study to attend to their 'narrative beginnings' (Clandinin, 2007). The purpose is to explicitly explore their justifications for doing the research and why the study is important (ibid). In addition, attending to one's narrative beginnings actualises a fundamental 'relational' principle of narrative inquiry (Clandinin, 2006). This is how the researcher situates themselves in relation to the focus of study and the potential participants of the study (ibid) and arguably starts the process of reflexivity that is essential to rigorous qualitative research (Kingdon, 2005). Malterud (2001) asserts that a researcher's background will affect what they choose to investigate, the angle, the methods adopted, as well as their interpretation of the findings. Therefore, positionality relates to the researcher explicitly identifying their subjective world-view to identify their location in relation to the subject, participants and research process (Berger, 2015). Subsequent reflexivity is an attitude of critically assessing research positioning and

attending systematically to the context of knowledge construction (Malterud, 2001), which should be an ongoing process throughout the study.

Positionality to the topic

Throughout this study, I have employed a range of techniques to explore my positionality and have kept a reflexive journal from the beginning. Using the concept of 'narrative beginnings', I wrote extensively about the different stories of my life that related to this study documented in my reflexive journal. These primarily revolved around my personal experiences of birth, midwifery education, and midwifery practice and as a researcher. Unsurprisingly, much rested within my personal experience of birth; one that was joyful and empowering despite a short transfer to hospital and a long second stage of labour. Writing my stories, re-telling them and re-constructing them, I reflected that the heart of my birth story (one that was, in my view, triumphant, a hero's tale²) was the depth of the relationship I had with my midwives. Where they practised 'outside of the box', not dictated by guidelines, and through loving support, it was due to them that I achieved the physiological, empowering, and transformative birth experience I had hoped for. Such was the transformative effects of my birth, it was the catalyst for huge life changes including embarking upon a career in midwifery.

As indicated, the birth of my son led me to midwifery, which forms the other component of my narrative beginnings; professional experiences. It is very hard to convey what my midwifery training was like. There isn't one particular story, rather a number of interweaving insights that have emerged as I look back and reflect on that experience. The highs and lows were immense notwithstanding the fact that my philosophy of midwifery seemed to run counter to that of my cohort and many of my colleagues. This was the biggest adjustment - fraught with frustration, sadness, and self-doubt. I quickly learned that in order to have any credibility I needed to know my facts, and so I became obsessively committed to researching formal evidence, and beyond that - the undocumented evidence. I went on extra study days and conferences, I learned about independent midwives in the US and the UK. I found professional stories that focussed on the art of midwifery, dealing with unexpected, the wide range of 'normal' and how deviations can be rectified without recourse to medical interventions. I learned that breech birth had previously been seen as a deviation from the norm, but had now become an obstetric emergency. I learned that malpositioned babies can be rectified or even prevented, without resorting to medical management. I learned about the art of

² A Hero's Tale conceptualisation of birth comes from Dr Gill Thomson's PhD work (Thomson, 2007)

midwifery based upon physiology. I certainly felt the odd one out throughout my training as conversing about the art of midwifery seemed limited to a few 'tall poppies'.

In many respects, the extremes of working as a qualified midwife have not changed, but my skills, competence, and confidence have grown. My philosophy of care has only changed in the sense that I have been able to reconcile my conflict between a natural birth activist and woman-centred care. I feel I operate on two levels, on the ground actively supporting women's choices whatever they are, and on the political level where choice is rhetorical and not a reality for many. I have facilitated many choices that sit outside of the 'norm' within the current context of maternity care. Arguably, a woman declining an aspect of care should be a part of the norm, as a choice is not a choice unless there is an option to say no. I have been involved in many cases of supporting and advocating for women who choose not to follow advice. I have also been involved in many cases where I have not managed to advocate or speak up, something that weighs heavily on me.

My commitment to woman-centred care has come at a cost. At many points since starting my training, I have been in a marginal position with my colleagues. Different working environments have exposed me to the beauty of teamwork and supportive managers, but also the devastating impact of 'not fitting in' due to my professional practice. I have been ignored, belittled and excluded. I have worked a caseload of three times more than I should have because of poor staffing. Managing this caseload, whilst trying to retain my sense of professional integrity came at a significant cost to my mental health. Worse, I felt myself shutting down from the women I cared for. I began to detach and morphed into someone I did not recognise. So much so, that I resigned from my substantive post where the job insecurity was a price worth paying in order to protect myself. Slowly, I recovered and found my way back to the midwife I wanted to be.

My previous research undertaken for my MSc in Midwifery and Women's Health involved interviewing women who made the decision to freebirth (Feeley & Thomson, 2016b; Feeley & Thomson, 2016c). This is the active decision to birth without a midwife present. My intrigue with the phenomenon was sparked as a disillusioned second-year midwifery student, where I felt that we (me and maternity services) did more harm than good. Having already known about the concept of freebirthing, I had read a lot of online stories where the profound sense of joy, wonder, and awe of birth was tangible. Something that simply was not occurring within the hospital environment (my

experiences at a later date altered some of my perspectives³). Freebirthing was not something I had considered during pregnancy, but working in a hospital environment, I had a vivid realisation one day, one that connected me deeply to the women's stories I had read, and I just 'got it'. I understood why they would not want to be part of the system on offer. Fast forward a few years later, conducting the research, hearing the women's stories, moved me deeply. For most of the women in my study, their decision to freebirth was directly related to previous negative interactions and/or traumatic experiences due to poor midwifery care.

The women's stories mirrored the wider literature of birth trauma caused by disrespectful dehumanised care, where women's autonomous decision-making was not respected (four women in the study experienced social service referrals). Carrying out the research had a profound impact upon me personally and professionally, but specifically, it provided me with the inspiration to turn my research questions around i.e. what about the midwives who *are* facilitating choices, supporting women's autonomy, operating a fully woman-centred approach, whilst working in the NHS? I knew they existed! By finding out what works, what is possible, whilst within the constraints of the NHS was an opportunity to highlight practices that could be of wider benefit to other midwives, student midwives, and most importantly to women's experiences of care.

Positionality statement

Reflecting upon the culmination of my experiences in relation to this research can be summarised into a statement of positionality, that required ongoing reflexivity throughout the study in order to minimise bias and to reveal potential 'blind spots' as I approached data collection. For transparency, the following is how I perceived my midwifery philosophy that guided my approach to this research:

My midwifery philosophy is based upon a woman-centred approach, in which working 'with' women in a non-paternalistic way is essential. I feel women have the right to express their autonomy and exert their agency. I feel that midwives have a duty to support and facilitate women's autonomy. Where that involves women's desire for a physiological birth, regardless of health status, I feel midwives are best placed to optimise the woman's chances of achieving a physiological birth. I perceive that the conditions for optimising physiological births continue to be marginalised, despite robust evidence that such births

³ Later on during my training and in my first year of being newly qualified, I had the fortune of working with some excellent woman-centred midwives on the delivery suite. These midwives taught me that magic can and does happen in hospital births, and women can leave feeling empowered and joyful. They taught a range of 'tricks' to create ambient environments, to bring artful midwifery into the hospital birth room. I am very grateful for their guidance.

improve outcomes in the short and longer term, and that the majority of women hope to achieve. I feel that the biomedical model is inadequate, but not redundant, for the complexities of the birthing processes. In addition, I feel the institutionalisation of birth practices are problematic by reducing women's and midwives' autonomy through super-valuation of standardised task-oriented care.

1.6 Thesis structure

This thesis consists of 10 chapters:

- Chapter 1 introduces the thesis.
- Chapter 2 provides contextual information required to situate this study where the broader argument in support of physiological birth and midwifery models of care are highlighted as facing significant sociocultural-political problems which hinder evidence-based and woman-centred care.
- Chapter 3 presents the findings of a systematic meta-ethnography that explored the views, attitudes, and experiences of midwives caring for women making alternative birthing choices to generate a broad understanding of the current literature.
- Chapter 4 presents and justifies the feminist pragmatic theoretical underpinnings of the study.
- Chapter 5 presents the chosen methodology - narrative inquiry - and the methods used for the empirical research.
- Chapter 6 sets the scene for the upcoming findings chapters by providing pertinent contextual information such as participant demographics, working contexts, and the types of clinical situations the participants were involved in.
- Chapter 7 presents the findings from the first stage of analysis, a narrative thematic analysis of the processes the midwives employed to facilitate women's choices.
- Chapter 8 presents the findings from the second stage of analysis, a narrative analysis of the midwives' experiences and meaning-making.
- Chapter 9 presents a theoretical interpretation of the whole data set whereby a theoretical model was developed. The model denotes 'stigmatised-normalised practice' that situates the midwives' practice within sociocultural-political micro, meso, and macro contexts.
- Chapter 10 provides an overview of the study's original contribution. In addition, a discussion of the findings in relation to the wider literature highlighting the

constraints, protective factors and enabling factors to the delivery of authentic woman-centred care. The chapter also includes the study strengths, limitations, implications, and the final conclusions.

Chapter 2 Barriers to physiological birth and its impact on alternative birth choices

2.1 Introduction

The previous chapter introduced the study, researcher, and outlined the organisation of this thesis. This chapter provides contextual information pertinent to the study. Drawing upon robust international evidence, I will establish the importance of physiological birth for maternal-neonatal biopsychosocial health. Additionally, I will demonstrate that midwives are ideally positioned to improve physiological birth rates and optimise women's experiences of care. Applying this information to a UK context an argument will be presented: that despite the robust policy, legislation and evidence in support of physiological births, midwifery-led and woman-centred care, these are constrained by broader discourses such as; medicalisation, risk, institutionalisation, governance, guidelines, mothering discourses, and conflicting ideologies amongst midwives. These barriers will be shown to impact both women seeking physiological birth choices and midwives trying to deliver woman-centred care. I will argue these barriers are more so for midwives concerned with supporting women who do not fit the standardised 'norms' of current birth practices i.e. those defined in Chapter 1 (section 1.1), therefore, providing the justification for this study. Whilst the emphasis here is on midwifery and midwives, I fully acknowledge that these discourses and the critiques I present permeate across the maternity multi-professional groups. However, for the purposes of retaining focus, it is justifiable to situate this chapter within the lens of midwifery.

2.2 International context: Physiological birth and midwifery

Whilst a number of definitions for normal physiological births exist, for the purposes of providing a broad international context, the World Health Organisation's (1996) definition was used:

'We define normal birth as spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery, with the infant being born spontaneously in the vertex position between 37- and 42-weeks' gestation, and after birth mother and infant are in good condition (p.3).'

A normal physiological birth has important psychosocial and biological benefits for mothers and babies, including reduced immediate and long-term morbidity and mortality through the avoidance of potential harmful interventions (Maternity Care Working Party, 2007; Romano & Lothian, 2008; Hyde, Mostyn, Modi, & Kemp, 2012;

Dodwell, 2012; The Lancet, 2018). Physiological births are associated with enhanced experiences of a positive birth (Hildingsoon, Johansson, Karlström, & Fenwick, 2013; Olza et al., 2018), greater levels of maternal-infant attachment (Romano & Lothian, 2008), less infant complications such as respiratory or other chronic illnesses (Dahlen et al., 2013), higher breastfeeding initiation and continuation rates which has significant maternal-infant health benefits (Rollins et al., 2016), and reduced complications in subsequent pregnancies (WHO, 2018a).

The benefits of physiological births are often discussed in relation to the potential harms of routine interventions including induction of labour, augmentation of labour, continuous electronic monitoring, episiotomies, instrumental births, or caesarean sections (Maternity Care Working Party, 2007; ten Hoope-Bender et al., 2014; Renfrew et al., 2014; The Lancet, 2018). These routine procedures often associated with hospital institutionalised birth practices (Johanson, Newburn, & MacFarlane, 2002). Whilst many procedures can be lifesaving (The Lancet, 2018), the exponential rise in birth interventions over the past 20-30 years have raised concerns that too much medicine (Miller et al., 2016) outweigh the benefits of their use, thus causing iatrogenic harm (Renfrew et al., 2014; Miller et al., 2016; WHO, 2018a). Recent international efforts have focused attention to reducing unnecessary and harmful interventions signalling a shift away from unwarranted medical technocratic birth practices (Renfrew et al., 2014; Miller et al., 2016; WHO, 2018a; WHO, 2018b; The Lancet, 2018).

However, despite such worrying trends, recent evidence has emphasised the contribution of a strong midwifery workforce in combatting excessive intervention rates and increasing physiological birth rates. The recent Lancet Midwifery Series (Renfrew, McFadden et al., 2014) examined 13 meta-syntheses and 173 systematic reviews that determined midwifery *'is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries (p.8)'*. The extensive reviews found that over 50 maternal and neonatal outcomes could be improved by the care that is within the scope of midwifery practice, highlighted in Figure 1.

Figure 1 Summary of findings from the Lancet Midwifery Series (Renfrew, et al., 2014, p.5)

'The analyses showed that outcomes improved by midwifery care include reduced maternal and newborn mortality, reduced stillbirth, reduced perineal trauma, reduced instrumental birth, reduced intra-partum analgesia or anaesthesia, less severe blood loss, fewer preterm births, fewer newborn infants with a low birth weight, and less hypothermia. The analyses also found increased spontaneous onset of labour, greater numbers of unassisted vaginal births, and increased rates of initiation and duration of breastfeeding. Increased referrals for pregnancy complications, fewer admissions to neonatal intensive care units, and shorter stays in neonatal units are examples of outcomes that indicate both improved care and resource use. Importantly, women reported a higher rate of satisfaction with care in general and with pain relief in labour in particular, and improved mother-baby interaction was also identified.'

The Lancet Series marked a significant change in the direction of maternity research, policy and (anticipated) practice. By framing their research questions on what women and babies (globally) needed (Renfrew et al., 2014), this work was unique as it was not a professional project of either midwifery or obstetrics. Furthermore, midwifery was conceptualised as a package of care in recognition that the full scope of midwifery is not always carried out by midwives and may include other health professionals dependent upon the local context (Renfrew et al., 2014). Full scope midwifery was defined as:

'Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families' (Renfrew et al., 2014, p.3).

The Lancet Series (Renfrew et al., 2014) identified key aspects of midwifery care that have been demonstrated to optimise women-babies' outcomes include⁴: midwife-led continuity model (Sandall, Soltani, Gates, Shennan, & Devane, 2016), continuous support during childbirth (Hodnett, Gates, Hofmeyr, & Sakala, 2013), alternative institutionalised birth settings (birth centres) (Hodnett, Downe, & Walsh, 2012), supporting upright positions in the first stage of labour (Lawrence, Lewis, Hofmeyr, Dowswell, & Styles,

⁴ This list is just a snapshot from the Lancet Midwifery Series.

2013), relaxation techniques for pain relief in labour (Smith, Levett, Collins, & Crowther, 2011), immersion in water in first and second stage of labour (Cluett & Burns, 2009). As such, the authors determined that qualified midwives were best placed to deliver cost-effective safe care globally (Renfrew et al., 2014). In addition, this body of research sits alongside recent evidence that investigated what mattered to women during childbirth (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018). A systematic review that included 35 studies from 19 countries determined that what mattered most to women was a positive birth experience within a psychologically and clinically safe environment, and the majority wanted a physiological labour and birth:

'...was a positive experience that fulfilled or exceeded their prior personal and socio-cultural beliefs and expectations. This included giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and competent, reassuring, kind clinical staff. Most wanted a physiological labour and birth, while acknowledging that birth can be unpredictable and frightening, and that they may need to 'go with the flow...' (Downe et al., 2018, p.1)

These findings thereby align with 'full scope midwifery' by highlighting the value and importance women place upon physiological birth.

2.3 UK maternity context

The previous section emphasised the importance of physiological birth for maternal-neonatal biopsychosocial outcomes and presented the evidence that midwives are ideally positioned to improve physiological birth rates and optimise women's experiences of care. Turning now to the UK context, this section will outline the current maternity care, highlighting the strengths and limitations of current care provision that relates to midwifery workforce, governmental policy, the choice agenda, physiological birth rates, and issues of alternative physiological birth rates.

UK governmental policy, midwifery, and the choice agenda

In the UK, midwives are the lead professional to care for healthy women across the childbirth continuum (antenatal, intrapartum, postnatal) (DH, 2010a). In the UK, the NHS is the leading employer of midwives with a small number of midwives working as self-employed independent practitioners, or within social enterprise working models or in private companies. Midwives are deemed responsible, accountable practitioners who practice autonomously, and who have the skills to facilitate normal physiological processes of childbirth (ICM, 2017; NMC, 2018). Midwives are also skilled in the identification, management, or escalation of complications should they arise (ICM, 2017).

They are able to practice in any setting including home, birth centres, and hospitals (ICM, 2017; NMC, 2018). For women deemed to have complicated pregnancies that require obstetric or paediatric input, midwives work alongside other health professionals within a 'coordinator role' to ensure women's needs are met (DH, 2010a). Fundamental to the definition, role, and philosophy of midwifery is the notion that care operates within a 'partnership' model with women i.e. woman-centred care (DH, 2010a; ICM, 2017; NMC, 2018). As such, there is a strong midwifery workforce and presence in the UK ideally situated to fulfil the broad policy aims and objectives. However, limitations discussed in the following sections demonstrate barriers to these policies.

Whilst midwives in the UK ideally situated to practice 'full-scope midwifery' as defined by the Lancet Midwifery Series (Renfrew et al., 2014), they face significant issues facilitating physiological births and women's choices. For example, for midwives working independently i.e. in self-employed models, they can be subjected to insurance restrictions and imposed sanctions by regulatory bodies (NMC, 2017a; NMC, 2017b). For midwives working with institutions, organisational factors such as culture, poor staffing and busy workloads limit individualised care, the facilitation of women's choice, and hinder optimising physiological birth processes (Healthcare Commission, 2008; Sheridan, 2010; McCourt, Rance, Rayment, & Sandall, 2011; NHS England, 2016). Moreover, these issues hinder midwives' ability to practice autonomously. Such issues sit alongside reports that many midwives do not feel they are able to provide meaningful care that they feel women deserve (RCM, 2016; RCM, 2017). Collectively, these issues have been shown as a key factor in midwifery workplace stress, and are a driver in midwives leaving the profession (Ball, Curtis, & Kirkham, 2003; RCM, 2017; RCM, 2016; RCM, 2018b). These issues remain despite robust UK maternity governmental policy (DH, 1993; DH, 2007; DH, 2010b), government initiatives (DH, 2010a; NHS England, 2016), and national maternity clinical guidelines (The Royal College of Midwives, 2012; RCOG, 2013; NICE, 2014) that situate midwives as the most appropriate professional to serve childbearing women.

Current English governmental maternity policy (DH, 2010a; DH, 2010b), national initiatives (NHS England, 2016), and national maternity guidelines (RCOG, 2015; NICE, 2017; RCM, 2018a) all advocate woman-centred care which emphasises that the woman's biopsychosocial needs, wishes, and wants are central to the care she receives. Moreover, since the 1990's, with the advent of the Changing Childbirth (DH, 1993) the importance of woman making their own choices regarding their maternity care has been emphasised. This was captured as broad concepts of 'choice, control, and continuity of

care' (DH, 1993) that continues to underpin maternity policy and initiatives (NHS England, 2016). The broad maternity concepts related to women having choice and control over their maternity care and to have greater autonomy (DH, 1993). These concepts included access to continuity of carer, where women were cared for by the same midwife or small team of midwives across the childbirth continuum and increased birthplace choices (DH, 1993). However, issues related to implementation mean that this policy has yet to be realised, as highlighted below.

A core component of all UK maternity policies has related to the midwifery-led relational continuity of carer⁵ model (with timely access to emergency facilities if required) which has been shown to be associated with optimal physiological and psychological outcomes (Sandall et al., 2016; Sandall et al., 2016). Optimal outcomes occur when a woman is cared for by the same midwife throughout the childbearing period, hence the 'continuity of carer' component. The relational component signifies a two-way meaningful relationship between mother-midwife that is characterised by equality, respect, mutual trust, and is mutually beneficial (Freeman et al., 2007; Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008; McAra-Couper, Crowther, Hunter, Hotchin, & Gunn, 2014; Sandall et al., 2016). Within this relationship, care by the midwife encompasses compassion, sensitive communication, empathy, presence and nurturance⁶ (Walsh & Devane, 2012; Olza et al., 2018). A metasynthesis of 13 qualitative studies investigated women's perspectives on receiving continuity of care (Perriman, Davis, & Ferguson, 2018). The authors found that women strongly valued their relationships with their midwives and was the '*vehicle through which personalised care, trust and empowerment were achieved*' (p.220) (Perriman et al., 2018). Moreover, midwives working in this way have reported greater job satisfaction, greater autonomy and wellbeing (Sandall et al., 2016). Therefore, relational continuity of care is mutually beneficial for women and midwives.

Despite the strength of evidence and policy support of continuity of carer models since the 1990's, widespread implementation has not been actualised (CQC, 2019). Historical issues that impacted the implementation of Changing Childbirth (DH, 1993) have continued to affect more recent policies and initiatives. These issues related to the rising tide of medicalisation, standardisation of maternity care, centralisation, rising insurance costs and the management of NHS maternity services (RCM, 2013) (These issues are explored at depth in section 2.4). To date, the numbers of women receiving continuity of

⁵ Also known as 'caseloading'.

⁶ Emotional and physical nourishment and care given to someone.

carer models in the NHS is unknown (Sandall, 2018). However, a recent national survey (CQC, 2019) highlighted that 61% of women did not see the same midwife for all their antenatal appointments, 72% did not see the same midwife during the postnatal period. These figures demonstrate that fragmented care models are the norm in the UK (NHS England, 2016). Fragmented models of care involve women being cared for by numerous maternity staff, often unknown to her, thus inhibiting the optimising health benefits of continuity carer models (Sandall, 2018). Whilst the recent *'Better Births Improving outcomes of maternity services in England, A Five Year Forward View for maternity care'* (NHS England, 2016) has included continuity of carer as a key recommendation, work to implement this nationally is still ongoing.

Another core component of the 'choice' agenda also relates to improving women's access to different places of birth including homebirth, alongside midwifery unit, freestanding maternity unit, and obstetric unit (DH, 1993; DH, 2007). Homebirths and maternity units differ greatly from obstetric units, for they are sites for midwifery autonomous practice and do not include medical doctors unless a complication arises and a transfer is required. Growing evidence has demonstrated the efficacy, safety, acceptability to women, and cost-effectiveness of non-OU birth settings (Brocklehurst et al., 2011; Hodnett et al., 2012). For healthy women at the onset of labour, birth outside of obstetric units is associated with greater levels of physiological births (Brocklehurst et al., 2011; Hodnett et al., 2012; Burns, Boulton, Cluett, Cornelius, & Smith, 2012), women's satisfaction with their birth experience (McCourt, Rayment, Rance, & Sandall, 2016; Olza et al., 2018), and midwives sense of wellbeing and autonomy (McCourt et al., 2016). However, despite robust evidence and national clinical guidelines promoting women's access to non-OU settings (NICE, 2017), recent research demonstrates that in 2013 only 11% of women in the UK gave birth in midwifery-led units (either AMU or FMU) and approximately 2% had homebirths (National Audit Office, 2013b; Walsh et al., 2018).

Such low levels of uptake have been associated with inequitable distribution and underutilisation of services (Walsh et al., 2018). For example, a survey carried out by the NCT (2009) found that only 4% of women had access to all four birthplace choices- home, free-standing birth centre, alongside birth centre and obstetric unit. Since 2009, a number of further investigations (McCourt et al., 2011; NHS England, 2016; RCM, 2011; Walsh et al., 2018) have demonstrated multi-factors that contribute to continued inequity of homebirth provision and birth centre availability across the UK i.e. local trust resourcing, staffing levels, organisational structures, on-call demands, lack of confidence by midwives, lack of support by their wider team (management/obstetric) and in some

cases negative attitudes by the obstetric team. In addition, underutilisation of birth centres services has been found to be problematic, whereby organisations are underperforming in the access, organisation and operation of birth centres (Walsh et al., 2018).

Physiological birth in the UK

Despite a strong midwifery workforce i.e. midwives and midwifery care are embedded within the maternity system, infrastructure that supports non-OU birth settings, robust evidence, and policy there are concerns regarding the rates of unnecessary interventions, rising caesarean section rates, and falling physiological birth rates in the UK (Maternity Care Working Party, 2007; Humphrey & Tucker, 2009; Dodwell & Newburn, 2010). In 2007, the Maternity Care Working Party, seeking to reduce rising interventions, defined normal physiological birth as '*without induction (spontaneous), without the use of instruments (including episiotomy), not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery (p.1)*' (Maternity Care Working Party, 2007)⁷. However, recent statistics related to England (NHS Digital, 2018) showed in 2017-2018, spontaneous onset of labour and delivery was at a low rate of 52% (compared to 68% ten years ago), induction rates were 32% (compared to 20% ten years ago), and caesarean section rates were 28% (compared to 25% ten years ago). Moreover, these national statistics did not account for other interventions during labour which could preclude a birth from being defined as 'normal' as per the Working Party's definition. Data from Birth Choice UK (2015) suggested that normal birth rates (as per the Maternity Working Party definition) in 2015 were only ~40%.

Highlighting the issues raised by Birth Choice UK was a survey carried out by Downe & Finlayson (2016). The authors suggested that many routine interventions were not being recorded⁷. To examine these issues, seven hospital trusts participated in the survey who had reported rates of normal births that averaged 65% (Downe & Finlayson, 2016). However, when the authors applied strict criteria to exclude all pre-specified interventions they found that the average normal birth rate fell to only 22% (Downe & Finlayson, 2016). Such disparities raise concerns regarding the reporting of normal birth rates and suggest that normal physiological birth rates across the UK are even less than the national data suggests. In addition, the authors noted that in some hospitals the rates of normal birth for women with complicated pregnancies was higher than that of

⁷ Such as labour augmentation i.e. oxytocics or artificial rupture of membranes (ARM), use of continuous electronic fetal monitoring (CEFM), use of a catheter, fetal blood sampling or antibiotics during labour.

healthy women at the onset of labour (Downe & Finlayson, 2016). Thus raising further concerns of the iatrogenic harm that appeared to be occurring for healthy women (Downe & Finlayson, 2016). Section 2.4 discusses the contributory factors to such low rates of physiological births in the UK.

Alternative physiological birth in the UK

The choice agenda and woman-centred approaches also resonate with recent drives to enhance dignified maternity care (Birthrights, 2013a; World Health Organisation, 2012; The White Ribbon Alliance, 2013; NHS England, 2016). The fundamental principles of dignified maternity care concern respectful care and respect for women's autonomy (Birthrights, 2013a). This includes robust legislation protects women's rights to full bodily autonomy including the right to decline recommended care (Birthrights, 2017a; Birthrights, 2013b). Whilst barriers can also occur for women seeking access to more medical care such as elective caesareans (Birthrights, 2018), evidence suggests that women making choices that are not culturally normative (i.e. in hospital with routine medical interventions or with pharmacological pain relief) can experience moralistic opposition and restrictive care provision (Viisainen, 2000; Birthrights, 2013a; Keedle et al., 2015). Examples of where choice becomes compromised include limited access to homebirth services (RCM, 2011; Lee, Ayers, & Holden, 2016); gatekeeping of birth centres (Scamell, 2014; AIMS, 2016) or birth pools (Russell, 2011).

Seeking lawful and ethical consent for any procedure underpins UK legislation which must be gained without coercion or undue pressure (Birthrights, 2017a). However, in reality, this does not always occur (Birthrights, 2017a; Birthrights, 2013b). Research has highlighted how some women report a lack of choice or control over their care, non-consenting procedures carried out by health professionals, and sometimes coercion towards particular decisions (Care Quality Commission, 2013; Birthrights, 2013a; Care Quality Commission, 2015; Plested & Kirkham, 2016). Coercive practices include repetitive discussions regarding the risks of the woman's decision (Kruske et al., 2013; Birthrights, 2013a; Plested & Kirkham, 2016; Birthrights, 2017a), attempting to influence family members (Feeley, Thomson 2016a), threats of referrals to social services (Plested, Kirkham 2016), actual referrals to social services (Feeley & Thomson, 2016b), and the infamous 'dead baby' card (Reed, Sharman, & Inglis, 2017)- an articulation that the baby or mother might die if the woman did not comply with recommendations (Plested & Kirkham, 2016). Simultaneously, maternity professionals have reported feeling pressure to conform to local guidelines and policies fearing disciplinary actions from their employers (Griffiths, 2009; Kotaska, 2011; Robertson & Thomson, 2016). Fear and

defensive practice are associated with concerns of being held accountable should an adverse event occur (Robertson & Thomson, 2016). Thus, broader systemic issues have a detrimental impact on professionals' woman-centred practice and women's experiences of care (explored in section 2.4).

2.4 Understanding sociocultural-political drivers

Within this context, the barriers to physiological birth and woman-centred care will be discussed through a critical examination of the multiple discourses that have influenced the socio-cultural-political landscape of childbirth in the UK. Whilst they are written separately, they should be viewed as a complex web of inter-relationships that have created hegemonic birth practices that limit physiological birth processes.

Medicalisation

Medicalisation has been defined as the process by which some aspects of human life, not previously considered pathological, come to be considered as medical problems (Maturo, 2012), that leads to incumbent medical management (Inhorn, 2006). Parry (2008) suggested that medicalisation is a social process whereby an expert-based biomedical paradigm dominates the discussion and often frames it in negative ways such as defining illnesses and pathologies that require treatment. Critics argue that the biomedical model of health offers a narrowed and limited focus upon people's life courses (Inhorn, 2006; Parry, 2008; Maturo, 2012) that marginalise the sociocultural context and individual meaning-making of what may be considered health or ill-health (Inhorn, 2006). Illich (1975) long raised concerns about '*the medicalisation of life (p.1)*'. His argument centred around how the dominance of medicine and associated technologies were super-valued over environmental factors that contributed to ill-health such as food security, food quality, working conditions, sanitation etc. (ibid). He argued that social and political changes were required to make improvements to population health rather than medicine and biotechnology (ibid). Concerned about the 'medical enterprise' dominating normal human process such as birth, death, bereavement, Illich (ibid) suggested it had caused unhealthy dependency, reduced people's self-efficacy creating passive medical consumers which in turn has compounded medical dominance.

Related to childbirth, the biomedical model depicts a cultural shift from pregnancy and birth practised within a social sphere i.e. historically birth occurred at home with a female birth attendant or midwife, to one that is practised within a medical sphere i.e. birth mostly occurring in hospitals where medical management is directed by doctors (van Teijlingen, 2005; Newnham, 2014). The medical model is underpinned by a

pathological approach to pregnancy and childbirth, whereby the major concern is to identify, reduce or treat 'risk' using surveillance, technology, and intervention (van Teijlingen, 2005). The medical model of childbearing has been historically related to the Cartesian mind-body dualism philosophical approach to medical practice and research (Wieringa, 2017). The body was the main concern of medicine, perceived as a 'machine' that could be explained and understood by its individual parts (Haslem, 2011; Martin, 1987).

Some authors have argued masculine normative perceptions viewed female bodies as 'defective' in relation to its male prototype (Oakley, 1980; Martin, 1987; Haslem, 2011). Dumit & Davis-Floyd (1998) argued that this perspective formed the philosophical foundation for modern obstetrics which has been criticised by feminists that pregnancy and birth rendered women's bodies in mechanistic terms, an object to be 'done to' (van Teijlingen, 2005). Moreover, women's pregnant bodies became a site for power and control as male barber-surgeons took an interest in childbearing women (Stacey, 1988; Cahill, 2000; Newnham, 2014). The classic example of such practices was the development of the forceps by the Chamberlen family (Sheikh, Ganesaratnam, & Jan, 2013). This not only created a technology which opened up access to male barber-surgeons to labouring women but, because the Chamberlen family did not allow midwives to use forceps, it also created a role division between competing for birth attendant cadres (*ibid*).

Some researchers argue that the biomedical model of birth was a professional project of subjugation, power and control by doctors over women's bodies/lives (Oakley, 1986; Cahill, 2000; Kitzynger, 2005; Newnham, 2014) and encroached upon female midwives'/birth attendants' role in supporting childbirth (Arney, 1982; Cahill, 2000; Newnham, 2014). However, others suggest that women were active agents in the cultural acceptability of the biomedical model (Oakley, 1980; Stacey, 1988; Beckett, 2005), and it has brought many positive benefits such as lifesaving treatments and access to pharmacological pain relief (Riessman, 1983; Beckett, 2005). First wave feminism is attributed to calls for access to pain relief and women were politically motivated to campaign for the right to relieve their suffering during childbirth (Riessman, 1983; Leavitt, 1984; Beckett, 2005). Beckett (2005) suggests that this early activism created a mixed effect; success for the right to pain relief and for obstetricians to consider pain relief methods. Yet women arguably facilitated the medicalisation process, losing control over childbirth including losing the comforts of home and support of female relatives and midwives (Leavitt, 1984; Beckett, 2005).

Conversely, later, 'natural childbirth' movements are associated with second-wave feminism. This arose during the 1960's and 1970's as a response to medicalised, institutionalised, and technocratic births (Kitzinger, 2005). Within this model, resisting medicalisation occurred via seeking homebirths, the rise of birth plans, resisting paternalism, and resisting pharmacology by means of coping with birth (Kitzinger, 2005; Beckett, 2005). However, critics argued that the natural birth movement was an essentialist paradigm, morally super-valuing 'natural' over medical care (Annandale & Clark, 1996; Beckett, 2005). Recent moves within the third wave of feminism support women's birthing choices of any kind (Beckett, 2005). Associated with neoliberal notions of individualism and choice (Thwaites, 2017), medicine or technology is not necessarily viewed as controlling and paternalistic, rather viewed as offering emancipation from the pain of childbirth (Beckett, 2005). However, critics argue that individualism and choice marginalise structural inequalities (Beckett, 2005; Thwaites, 2017), and view the social construction of choice as politically constrained and often inequitable (Kitzinger, 2005; McAra-Couper, Jones, & Smythe, 2011; Budgeon, 2015). Subsequently, in many cases women's choices in childbirth can be skewed towards medicalised approaches (Davis-Floyd, 1993; Dumit & Davis-Floyd, 1998; Newnham, McKellar, & Pincombe, 2017; Roberts & Walsh, 2018), and in other cases, structural inequalities such as race, class, socioeconomic status may limit women's access to appropriate medical care (Dillaway & Brubaker, 2006; Brubaker & Dillaway, 2009).

Overall disagreements regarding the positive and negative aspects of a medical approach to childbirth exist, with feminists on either side of the debates (Clesse, Lighezzolo-Alnot, de Lavergne, Hamlin, & Scheffler, 2018). However, an alternative view from Campbell and Porter (1997), who rather than accept dualities, conceptualised the feminist arguments as 'continua':

'...we would regard as ends of continua which stretch between the enablement and constraint of women's autonomy and the promotion and undermining of women's health... Our position contains value assumptions, namely that the enablement of autonomy is preferable to its constraint and the promotion of health is preferable to its undermining. Assuming acceptance of such values, the question then becomes one of deciding, on the basis of available evidence, toward which direction along the continua do specific modes of health care gravitate (p.356).'

A recent review regarding the medicalisation of birth (Clesse et al., 2018), supports this notion and situates it within a 'humanised birth' paradigm. They suggest a humanised

approach to birth can combine the positive effects of medicalisation whilst containing the iatrogenic harms (Clesse et al., 2018). In this model, a physiological and holistic perspective of birth is held, women's needs are at the centre of care, and judicious use of medical interventions are applied, resisting routine approaches and the excesses of medicalisation (Clesse et al., 2018; Newnham, McKellar, & Pincombe, 2018).

Institutionalisation

In combination with a medicalised approach to birth, the shift from social birth spheres to medical spheres was associated with the rapid growth in hospital provision during the early 20th Century (Johanson et al., 2002; Newnham, 2014). For example, the expansion of medical jurisdiction over birth peaked with the shift to almost universal hospital births during the 1960's and 1970's in many high-income countries (Johanson et al., 2002; Newnham, 2014). Moreover, government policies reflected and perpetuated the shift of birth to the hospital (Department of Health, 1970; Newnham, 2014). Cahill (2000) and Newnham (2014) stated that the hospital was pivotal to the rise of obstetric medicine (and arguably all medicine). However, critics argued that this move was not bound in evidence, but based upon an assumption that hospitals with access to doctors, medicine, and technology were safer than the previous alternative (Cahill, 2000; Kitzinger, 2005; Goldenberg, 2009). Drawing upon Foucault's critique (1973), the rise of hospitals was not because they were safer or better, but they became sites for information benefitting the growing medical profession (Newnham, 2014). However, sociologists recognise that such sociocultural shifts influenced the cultural acceptance of hospital births (Behruzi, Hatem, Goulet, Fraser, & Misago, 2013). For example, De Vries (1984) suggested what women want in birthing can both be constructed by the available maternity systems as well as being pivotal in the construction of maternity services. In this way, broader societal shifts towards technocracy have influenced birth practices, including a cultural conception that hospital births are safer (Klein et al., 2006; Behruzi et al., 2013).

However, concerns are raised regarding the nature of institutions i.e. they are big bureaucratic organisations where the needs of the institution are prioritised over the individual (Thompson, 2003; Walsh, 2007; Behruzi et al., 2013). The nature of schedules and routine based care can shape women's experiences of childbearing (Kitzinger, 2005; Walsh, 2006b; Newnham et al., 2017). For example, hospitals require schedules which require prioritising 'clock time' which runs counter to the natural rhythms of unpredictable labour (Martin, 1987; McCourt & Dykes, 2009; Newnham et al., 2017). Therefore, routine medical management and interventions have been attributed with the need to manage the unpredictability of labour, and the 'smooth' running of hospital

processes and procedures (Dykes, 2005; Maher, 2008; Newnham et al., 2017). In addition, evidence has demonstrated less physiological births occur within hospitals regardless of women's health status (Brocklehurst et al., 2011; Burns et al., 2012). Issues of task-based care, fragmented caregivers, routine but potentially unnecessary interventions have been attributed to institutionalised birth practices (Kirkham, 2003; Kitzinger, 2005; Walsh, 2006b). Therefore, there is an interdependent relationship between the medicalisation and institutionalisation of birth.

The emphasis upon process and procedures within hospitals has been said to mirror industrial production lines where efficiency is super-valued over individualised care delivery (Hunt & Symonds, 1995; Walsh, 2006b). Within this model, fragmented care is the norm, staff work shift patterns that suit the needs of the institution, thus not allowing for continuity of care (Sheridan, 2010; McCourt et al., 2011) nor cohesive inter-professional relationships (King's Fund, 2008; Downe, Finlayson, & Fleming, 2010). Such issues detrimentally affect the care women receive as well as the working cultural environment for midwives and their colleagues (Mccourt et al., 2011; NHS England, 2016). Poor intra and inter-professional working relationships have been related to poor outcomes for women and babies (King's Fund, 2008). In addition, poor working relationships within a hierarchal rigid institutionalised structures can manifest as a lack of trust between midwives (Newnham et al., 2018), where toxic cultures of horizontal violence and bullying have been identified (Leap, 1997; Gillen, Sinclair, & Kernohan, 2008). As mentioned earlier, these issues are a contributing factor to midwives dissatisfaction, high levels of stress and burn out (Leap, 1997; Ball et al., 2003; RCM, 2016; RCM, 2017) and are a leading reasons for midwives leaving the profession (Ball et al., 2003; RCM, 2016). Moreover, women have reported a lack of meaningful choices, dissatisfaction with their care and poor birth experiences within institutionalised settings (Birthrights, 2013a).

Risk

The medicalisation and institutionalisation of birth have also been affected by other cultural shifts such as the safety/risk discourse. Beck (1992) describes the 'risk society' as the result of modernisation generating a collection of human-generated risks born out of the attempt of science to create order and control. Risk indicates the possibility of unintended and negative consequences of decisions or actions (Alaszewski, Harrison, & Manthorpe, 1998). Therefore, risk management is concerned with regulating activities to reduce risks (Symon, 2006; Walsh, 2006a). However, issues arise when attempting to discern what constitutes 'risk' and from whose perspective (Walsh, 2006a; Edwards &

Murphy-Lawless, 2006). Moreover, the emotionally charged nature of childbirth is also associated with elevated anxiety and greater risk aversion (Healy, Humphreys, & Kennedy, 2016). Some authors argue how the unpredictable nature of childbirth and cultural discomfort with uncertainty appears to have influenced conceptualisations of risk (MacKenzie Bryers & van Teijlingen, 2010; Healy et al., 2016), where medically managing pregnancies and childbirth offer perceptions of greater control (Symon, 2006; Walsh, 2006a). Moreover, studies have demonstrated that women and their healthcare providers view risk differently (Cameron, 2012; Lee, Holden, & Ayers, 2016; Lee et al., 2016; Coxon et al., 2017) and there are differences amongst profession groups (Deshpande & Oxford, 2012; Healy et al., 2016; Bisits, 2016). Therefore, perceptions of risk can be seen as socially constructed and subjective.

Risk management strategies are often associated with institutionalised birth practices and obligations towards ensuring safe care and practices (Healy et al., 2016; Scamell, 2016). However, some argue that risk management within organisations is an attempt to control clinicians by reducing their autonomous decision-making (MacKenzie Bryers & van Teijlingen, 2010), others suggest that professional groups gain control by 'creating risk' (De Vries, 1993), and others suggest it is related to organisational governance, insurance and is a protective strategy to reduce liability (Berg, 2000) (discussed further in the next section). Conflicting messages of the purpose or goals of risk management strategies can be seen in the contradictory strategies employed in maternity care. For example, despite the known iatrogenic harms of a number of routine medical interventions or use of technology (i.e. continuous electronic fetal monitoring (CEFM), admission CEFM, augmentation of labour etc.) or those that have not demonstrated efficacy (four-hourly vaginal examinations, fetal blood sampling, prophylactic antibiotics in the absence of symptoms (Renfrew et al., 2014) they continue to be used routinely (Downe & Finlayson, 2016). Furthermore, the lack of implementation of known safe and beneficial practices (midwifery-led continuity of care, non-obstetric birthplaces, water immersion in labour etc.(Renfrew et al., 2014)) challenges the notions of a logical approach to risk management strategies.

Scamell & Alaszewski (2012) argued that the political nature of maternity services and related risk discourses are represented by the '*narrowing parameters of normal birth (p.1)*'. Whilst the WHO (1996) suggests approximately 80% of women are healthy at the onset of labour, in the UK, it has been noted as few as 50% of women are deemed 'healthy' (The Health and Social Care Information Centre, 2009). In the UK, the 'labelling' of women as low or high risk (Scamell & Alaszewski, 2012; Lee et al., 2016) is

commonplace, but concerns have been raised regarding the increased notions of pathology (Scamell & Alaszewski, 2012). Such labelling and categorising effects care pathways that women have access to and for midwives' to deliver autonomous care (Scamell & Alaszewski, 2012; Hunter & Segrott, 2014). Healthy women at low risk of complications are provided care by midwives almost exclusively, therefore, professional tensions occur as definitions of risk evolve and change, and these boundaries are altered (Scamell & Alaszewski, 2012; Hunter & Segrott, 2014). For example, women deemed at high risk often have limitations applied to choices such as place of birth, waterbirth, or midwifery-led intrapartum care (Edwards & Murphy-Lawless, 2006; Scamell & Alaszewski, 2012; Scamell, 2014; Buitendijk & Jonge, 2016; Roberts & Walsh, 2018). In addition, the pervasiveness of the risk discourse has been found in midwives' accounts of fears even when supporting healthy 'normal' women during the intrapartum period (Dahlen, H., 2010; Fenwick et al., 2012; Dahlen, Hannah Grace & Caplice, 2014). Within this context, fears are likely to be heightened when women make decisions that are counter to medical or midwifery advice.

A further concern relates to the medicalisation of 'risk' (Koerber et al., 2015). This is where the presence of risk factors for disease have been elevated to the status of having the disease itself, which is then medically managed (Koerber et al., 2015). Drawing upon Seigal's (2014) work, Koerber et al., (2015) consider how the medicalisation and institutionalisation of birth connect to wider cultural risk discourses:

'This system [institutionalised births] is based upon the assumption that the work of pregnancy is a healthy baby and that pregnant bodies are sites through which social, political and environmental risks are managed' (Koerber et al., p.4).

Litigation

Issues of risk-averse discourses are also bound in issues of *'blame, complaints, and litigation (p.204)'* (Healy et al., 2016). Litigation is associated with the costs awarded to families in the event that negligence has been proven to have caused a poor maternal or fetal outcome (Robertson & Thomson, 2016). Whilst data in the UK (2000-2009) demonstrated less than 0.1% of births have resulted in negligence claims (National Health Service Litigation Authority, 2012), obstetric claims account for the largest awards paid to families (National Health Service Litigation Authority, 2016). The insurance costs for hospital trusts are significant and accounts for approximately one-fifth of their overall maternity budget (National Audit Office, 2013a). Complexities associated with the UK litigation system have stimulated an inadvertent 'blame' culture with distress and

fear for families and professionals (Ortashi, Virdee, Hassan, Mutrynowski, & Abu-Zidan, 2013; Healy et al., 2016; Robertson & Thomson, 2016). The process of litigation has been historically slow⁸, contentious, and highly stressful (Robertson & Thomson, 2016). Whilst current recommendations have suggested moves towards a no-blame compensatory award system in the event of adverse outcomes (NHS England, 2016) this has not yet been implemented across the UK. The benefits of such a system have been demonstrated in other countries and include; an open and honest culture of learning when mistakes have been made, a non-punitive restorative approach to remedying clinician mistakes, improved safety and outcomes, and quicker financial compensation made available to the families to ensure their needs are met (NHS England, 2016).

Understanding the differences between litigation processes in different countries is important as they cultivate the cultures in which clinicians practice. Within 'blame' and litigious cultures, both midwives and doctors have reported cultures of fear and defensive practice (Symon, 2000; Healy et al., 2016; Ortashi et al., 2013; Alexander & Bogossian, 2018). Defensive practice has been defined as clinicians deviation from their usual behaviour or good practice in order to reduce complaints, and criticism by either colleagues or families (Symon, 2000; Ortashi et al., 2013). However well-intentioned, defensive practice has been demonstrated to increase the use of (unnecessary) medicines, treatments, or interventions whilst clinicians err on the side of caution (Ortashi et al., 2013; Robertson & Thomson, 2016). Of concern, is that the use of unnecessary care, treatments or interventions may have harmful side effects as previously discussed in section 2.2. Examples in maternity may include using continuous electronic fetal monitoring in the absence of indication, ordering extra and unnecessary blood tests or scans, early induction or elective caesarean section.

Shorten (2010) refers to 'litigation-based practice' as opposed to evidence-based practice. She suggested that despite public safeguarding intentions, the medical malpractice environment appears to have inadvertently created financial incentives (for lawyers, insurance schemes etc.) for defensive practice (Shorten, 2010). Ortashi (2013) suggests defensive practice is influenced by the court system who appears to rely upon data (evidence of actions being taken) as opposed to clinician judgement. Thus creating vicious cycles whereby health professionals feel safer from litigation by over treating rather than undertreating patients (Ortashi et al., 2013). Moreover, research suggests that the fear of litigation, not just the experience of litigation, can cause defensive practice

⁸ Some cases have taken >10 years to reach a conclusion.

(Ortashi et al., 2013; Pollard, 2011; Scamell & Alaszewski, 2012; Robertson & Thomson, 2016). Researchers have highlighted the detrimental effect of defensive practices on women's access to support and services for physiological births in a number of different contexts: services for vaginal birth after caesarean (Stephenson & Wright, 2002; Dahlen & Homer, 2013; Shallow, 2013), access to homebirth (Dahlen et al., 2011; Jackson et al., 2012; Lee et al., 2016), access to waterbirth (Russell, 2011; Burns et al., 2012). Therefore, a litigious culture in conjunction with issues of risk discourses and insurance policies required of institutions appear to super-value medicalised, technocratic practices, despite evidence to the contrary.

Standardisation

In relation to the previously mentioned discourses, issues of standardisation permeate healthcare and maternity services, influencing both the production and application of guidelines and evidence-based medicine (both discussed in the next two sections) and women's experiences of childbirth. In a historical examination of the emergence of guidelines, Weisz et al., (2007) situated standardisation as a pivotal and pervasive sociocultural influence on healthcare. Standardisation began in the 18th Century and concerned scientists seeking consistent methods to develop definitions, classifications, descriptions, and measures to enhance scientific understanding (ibid). Wears (2015) situates standardisation as the outcome of the Enlightenment period, to produce order, reason and reproducibility - a '*technical solution to the problem of complexity (p.1)*'. Concurrent shifts during the 20th Century to regulate medical practice and to reduce variations in practice also required monitoring, evaluation, and standardisation (Weisz et al., 2007; Upshur, 2014). Standardisation became expressed via the production of guidelines - documentation to inform clinical practice, procedures, use of medicines, use of technology and to provide measures of monitoring, evaluation and accountability (The McDonnell Group, 2006; Weisz et al., 2007; Kotaska, 2011). Additionally, the rapid rise of hospitals, biomedical science discoveries and technologies during the 20th Century saw the evolution of multiple complex systems requiring standardised procedures (Weisz et al., 2007).

The culmination of these factors contributed to healthcare becoming scientific-bureaucratic systems which attempt to reduce complexities to simple procedures (Weisz et al., 2007; Wears, 2015):

'Every effort to regulate increasingly unwieldy health care systems seems to produce complex mechanisms that require even more rules and conventions in order to function.'

Accordingly, we now have layer upon layer of guidelines and protocols.... clinical guidelines remain closely linked to the many other forms of regulatory standardisation that aim to bring order, predictability and commensurability to an increasingly vast and heterogeneous domain' (Weisz et al, p.716).

Wears (2015) suggests standardisation promotes routine-based operations to increase efficiency. However, Wears (ibid) asserts that the wholesale application of standardisation in healthcare has not been critically examined and is problematic within its universal approach to all aspects of healthcare. Rather, Wears (ibid) suggests a nuanced approach where a critical examination can identify aspects of healthcare that would benefit from standardisation and those that do not.

Wears (ibid) argument can be related to maternity care. For example, a standardised approach to antenatal care has been evidenced to benefit maternal-fetal health outcomes (NICE, 2008; WHO, 2016), and means it is offered to all women in the UK, thereby providing equitable care. Standardisation of antenatal care in the UK includes the timing and frequency of appointments, the identification of appropriate and life-saving screening tools (NICE, 2008), as well as the opportunity for meaningful relational continuity of care (Sandall et al., 2016). However, standardised care does not work well in other maternity care situations. For example, a standardised approach to the expected rate of cervical dilation during labour has resulted in a number of women being medically managed for 'failure to progress' (Abalos et al., 2018; Souza et al., 2018). A lack of attention to the 'unique normalness' (Downe & McCourt, 2004) of each woman's labour has meant that standardised expectations can create iatrogenic harms.

Guideline-centred care

A product of standardisation, clinical guidelines, play a significant role within the socio-cultural-political landscape of maternity services (and healthcare as a whole). Clinical guidelines are often understood as a product of evidence-based medicine (EBM). However, the production of guidelines predates notions of EBM (Weisz et al., 2007) and do not always correspond with the principles of EBM (Greenhalgh, 2014; Greenhalgh, 2015). Clinical practice guidelines are formalised documents that ideally combine the latest research, evaluated best medical evidence and expert consensus on the application of the research into a given area of clinical practice (Greenhalgh, 2014; Prusova, Churcher, Tyler, & Lokugamage, 2014; Johannessen, 2017). Guidelines are used as a method of translating the evidence into usable documents for rapid dissemination to clinicians. They are used to standardise clinical practice and reduce clinical variations

with the ultimate goal of improving the delivery of consistent, quality care that improves patient outcomes (Upshur, 2014; Prusova et al., 2014; Johannessen, 2017). Guidelines are discretionary and require healthcare professionals to use their clinical expertise in applying them to provide the most appropriate care (Kotaska, 2011; Greenhalgh, 2014; Greenhalgh, 2015). Any application of guidelines should be used in partnership with those receiving care, wherein their preferences must be taken into account and respected (Kotaska, 2011; Greenhalgh, 2014).

The over-reliance on guidelines has been widely critiqued across medicine (Greenhalgh, 2014; Greenhalgh, 2015; Wieringa, 2017). Guidelines have been criticised as creating a rule-based approach to healthcare where deviations from the guidelines need to be justified (McDonald, Waring, Harrison, Walshe, & Boaden, 2005; Griffith & Tengnah, 2010; Downe, 2010). Kotaska (2011) calls this 'guideline-centred care', which is in direct opposition to the woman-centred care approach espoused in UK maternity services. Downe (2010) suggests that guidelines became de facto rules for health workers to follow, and are defensible in court should the situation arise. Conflation with employee policies and protocols that do require adherence⁹ have further facilitated guidelines as 'rules' (McDonald et al., 2005; Kotaska, 2011). This has in part created a culture where guideline adherence is prioritised over an individual's autonomy for fear of litigation and/or disciplinary action against the practitioner (Griffith & Tengnah, 2010; Ortashi et al., 2013; Alexander & Bogossian, 2018). Investigations of adverse outcomes will often compare the care provided to that of the local guidelines (Kruske et al., 2013; Alexander & Bogossian, 2018). Moreover, guidelines can be used to yield authority over women's access to types of care, for example, excluding women from birth centres if they are operationalised on a 'rule' based approach (Scamell, 2014). In addition, issues of institutionalised procedures related to governance and insurance coverage also encourage wide-scale adoption of guidelines as rules to follow (Arulkumaran, 2010).

Other criticisms of guidelines include: the overwhelming number of guidelines, rendering access to them inconvenient for busy professionals (Upshur, 2014), inaccessibility (The McDonnell Group, 2006); flaws in their development i.e. based on weak evidence (Prusova et al., 2014); oversimplification of complex illnesses (The McDonnell Norms Group, 2006); do not account for co-morbidities (Greenhalgh, 2015);

⁹ Policies require mandatory compliance and are normally associated with terms of employment e.g. sickness, uniform, handwashing (NHS, 2006; Irving, 2014). Protocols, (processes or procedures), also require compliance but differ in that they are an agreed framework outlining the care that will be provided to women (or patients) in a designated area of practice (Irving, 2014). Examples include anaphylaxis management, eclampsia management, cardiac arrest, food handling on a ward etc.

lack of foresight regarding implementation procedures/efficacy (The McDonnell, 2006) lack of proven efficacy (Bazian Ltd, 2005) and the ‘moral authority’ of guidelines (Berg, 2000; Weisz et al., 2007; Goldenberg, 2009). There are inconsistencies across international and national guidelines (Glantz, 2012) and even between neighbouring hospitals that undermine ethical or moral arguments that the universal application of guidelines is best practice. Additionally, guidelines cannot account for every clinical possibility means that clinicians must rely upon their expertise to apply the information to individual situations (Greenhalgh, 2018). Therefore, an injudicious use and over-reliance on guidelines can be detrimental to individual (women’s) choice and professional autonomy.

Misapplication of evidence-based medicine

Evidence-based medicine (EBM) is a discipline that evolved from epidemiological studies and represented a move towards medical practice being informed by scientific research (evidence) to achieve safe, more consistent and cost-effective outcomes (Howick, 2011; Berg, 2000; Greenhalgh, 2014). David Sackett (1997), an early pioneer of EBM describes it as:

‘the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of the individual patients. The practice of evidence-based medicine means integrating individual expertise with the best available external clinical evidence from systematic search...Good doctors use both individual clinical expertise and the best available external evidence and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by external evidence... (p.1)’

EBM was explicitly developed in opposition to excessive standardisation based upon population norms and to develop methods to design, implement and assess scientific medical research (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sackett, 1997). Moreover, it centred upon patient preference and clinical expertise to apply judgement to individual clinical situations (Sackett et al., 1996; Sackett, 1997).

However, critics have argued that EBM has driven further standardisation, where population-based data are routinely applied to individuals (Howick, 2011; Greenhalgh, 2014; Greenhalgh, 2015; Greenhalgh, 2018). In addition, critics argue that EBM has over-emphasized experimental knowledge at the expense of the basic science, tacit clinical knowledge and expertise and patient values (Gabbay, 2004; Rogers, 2004; Mullen & Streiner, 2004; Greenhalgh, 2014; Wieringa, 2017), and having been ‘hijacked by industry (p.82)’ and those with vested interests (Ioannidis, 2016). However, other researchers

suggest that these criticisms have been misattributed to EBM (Ioannidis, 2016; Wieringa, 2017; Ioannidis, 2017). It has been argued that EBM has been conflated with standardisation, guideline production, and institutionalisation that has separated its original integrative principles to a dogmatic and limited approach to healthcare (Fernandez et al., 2015; Greenhalgh, 2014; Ioannidis, 2016). However, other criticisms appear to apply to EBM such as; limited application for comorbidities (Greenhalgh, 2015), evidence hierarchies that limit other legitimate sources of knowledge (Howick, 2011; Greenhalgh, 2015), over-inflated benefits of medicines or treatments (Fava, 2017), contribution of increased medicalisation due to its inherent focus upon pathology and disease (Fava, 2017), the misappropriation of the evidence-based quality mark by vested interests such as drug and biotechnology companies, financial, management and organisational (Greenhalgh, 2014; Ioannidis, 2016; Fava, 2017).

In relation to maternity care, evidence has shown that the majority of research has focused on the pathologies of birth (Renfrew et al., 2014). Even so, Prusova (2014) highlighted a significant lack of evidence in maternity care in comparison to other health specialities. The Royal College of Obstetricians and Gynaecologists (RCOG) obstetric maternity guideline recommendations, were analysed to assess their evidence base (Prusova et al., 2014). Of 1,682 individual recommendations, the authors found that only 9-12% of the guidelines were based on best quality evidence (Prusova et al., 2014). Thereby raising significant concerns regarding the quality and application of EBM principles to maternity care. In part, the lack of evidence has been attributed to ethical issues of conducting research with pregnant women (Blehar et al., 2013), and the acute nature of childbirth-related emergencies make trial design and implementation problematic (Vintzileos, 2009). However, issues of an over-emphasis of pathology and medically-informed research are argued as a bias against physiological, low-tech birth (Rogers, 2004). As previously reported (section 2.2/2.3) there is a strong body of evidence in favour of midwifery-led approaches to maternity care. However, there appear significant challenges to the implementation of this evidence, suggesting other political factors wield greater authority than EBM in maternity care.

Mothering discourses

The introduction of the ultrasound scan in the 1970's meant that for the first time doctors were able to 'see' the fetus, and created a shift from viewing the mother-baby dyad as one to a two-person model (Couture, Sangster, Williamson, & Lawson, 2016). Some feminists have argued that the newly discovered 'second patient' (Doyal, 1979, p.148) created a space for increased medical dominance over childbearing (Cahill, 2000;

Lyerly, Little, & Faden, 2008). Whilst women appear to have broadly embraced such technology (Garcia et al., 2002), some argue that the consequences have facilitated women's alienation from embodied knowledge of their pregnancies to reliance upon experts (Mitchell, 2001; Young, 2001; Parry, 2008). Some argue that the visibility of the fetus has created a cultural discourse in which women are viewed as 'containers' or 'vessels' or as Mitchell (2001) argues pregnant women have become 'living fetal monitors'. This can be viewed as women being a means to an end i.e. producers a healthy live baby (Parry, 2008).

Cultural expectations of the 'production' of a healthy baby appear to have reduced societal tolerance for anything less than perfect (Surtees, 2010; Healy et al., 2016). Aligned with strong discourses regarding risk aversion and what Bisits (2016) calls the 'risk information explosion', pregnancy and birth became viewed as a particularly dangerous and risky time - despite evidence that pregnancy and childbirth has never been safer (Scamell & Alaszewski, 2012; Healy et al., 2016; Bisits, 2016). Coxon, Sandall, & Fulop (2014) also suggested that contemporary parenting discourses influenced by popular media and culture emphasise the role of parents in becoming personal 'risk managers' in relation to birth, feeding and beyond (Kirstie Coxon et al., 2014). Such discourses place pressure and potential blame on individuals (in the event of poor or adverse outcomes) which ignore the structural factors¹⁰ at play (Healy et al., 2016). These discourses can marginalise women's experiences, where the emphasis on fetal safety is prioritised over the mother's wellbeing (Mitchell, 2001; Parry, 2008). Dahlen & Homer (2013) refers to philosophical differences between notions of 'childbirth' and 'motherbirth'. The former relates to the perspective that a good parent prioritises the baby and takes no risks (Dahlen & Homer, 2013). The latter relates to the perspective that giving birth matters to a woman, so mother and baby have equal priority (Dahlen & Homer, 2013). Some feminist critics would suggest that 'childbirth' philosophical frameworks dominate the discourse where women are vulnerable to strong social pressure to conform to being a 'good mother' (Cahill, 2000; Kitzinger, 2005; Parry, 2008).

Some authors argue that fear narratives have coalesced with good mothering narratives to create a method of societal control over women (Cahill, 2000; Kitzinger, 2005; Shaw, 2012; Newnham, 2014). The good mother is a sacrificial mother, forgoes her needs for her children, and in the case of pregnancy forgoes her needs for the unborn (Mitchell, 2001;

¹⁰ Structural factors include issues such as class, socio-economic status ethnicity etc. But also include the broad sociocultural-political drivers discussed earlier in this section such as medicalisation, institutionalisation, risk, litigation discourses etc.

Parry, 2008; Pederson, 2012). The good mother is one that listens and acts upon medical advice, entrusts her pregnancy, birth, and baby to medical professionals (Mitchell, 2001; Young, 2001; Bryant, Porter, Tracy, & Sullivan, 2007). Acts of 'deviance' are equated with a 'bad mother' (Maher & Sauggers, 2007; Miller, 2012; Havey, Schmied, Nicholls, & Dahlen, 2015). As the fetus became more visible via biotechnology, its status is elevated and the good versus bad mother narratives became further entrenched and is related to restrictive reproductive rights. For example, restricted accesses to abortion services (Doyal, 1979; Couture et al., 2016), increased surveillance via medics and social services such as when declining maternity care (Feeley & Thomson, 2016b; Plested & Kirkham, 2016) and moralistic opposition to women's choices such as women seeking homebirths (Viisainen, 2000; Shallow, 2013; Kruske et al., 2013).

2.5 The influence and role of employed midwives

Midwives have been determined to be ideally placed to deliver woman-centred care that promotes and optimises women's normal physiological processes across the childbearing continuum- as highlighted in sections 2.2. Section 2.3 highlighted the UK has a strong midwifery workforce, ideally situated to practice full-scope midwifery. The majority of midwives in the UK are employed by the NHS - a large scale institution. However, employed midwives are located within a conflicted position- their defined professional role to practice full-scope midwifery with legal obligations to fulfil their duties (NMC, 2018) and that of the wider discourses discussed in section 2.4. Arguably, for employed midwives, the interplay of discourses centres around, and are heightened by, the dominance of institutionalised birth. Through the institutionalisation of birth, issues of medicalisation, risk, litigation, standardisation, guideline-centred care, misapplication of EBM appears to be magnified. Therefore, tension exists between midwives' professional and employee obligations. Midwives can be viewed as the 'gatekeepers' of women's choices (Chilvers & Hosie, 2015; Skirnisdottir, Haukeland, & Dahl, 2016) who can be facilitative (Carr, 2008; Reed, 2013; Nicholls, Hauck, Bayes, & Butt, 2016) or obstructive (Plested & Kirkham, 2016). However, the gate-keeping role needs to be contextualised by the tensions highlighted in this chapter and this section.

Notwithstanding the known tensions for midwifery practice in the UK, midwives have different belief systems, values, and care philosophies, therefore, they are not a homogenous group of professionals. How midwives are aligned can influence their attitude to support women's choices and/or willingness to facilitate alternative physiological birth choices (as highlighted in Chapter 1, section 1.2). Despite the unique, specific role and definition of a midwife, research suggests that midwives align

themselves within two broadly different ideologies. Researchers have conceptualised these ideologies with nuanced differences but broadly mirror the same concepts. McFarlane & Downe (2000) identified two kinds of midwives; first, those who prioritised 'the clinical event (p.24)', chose to work in hospital settings, and perceived their work as an occupation. Second are those who prioritised 'supporting the evolving parent', preferred to work in community settings, and perceived their work as a vocation (ibid). Similarly, 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). Thompson (ibid) argued that midwifery care was informed by midwives ethical positioning. Furthermore, Hunter (2004) explored midwives' accounts of the 'emotional labour' of caring for women and established that two coexisting and conflicting ideologies of midwifery existed between midwives; 'with-woman' and 'with-institution'. Crozier, Sinclair, Kernohan, & Porter (2007) built upon Hunter's (2004) two typologies in a study to assess midwives' competence in the use of technology. They reported three typologies which related to; 'bureaucratic', where guidelines and policy govern decisions; 'classical professional', where judgements are made based on personal expertise and experience, and 'new professional', where women are involved in decision-making (Crozier et al., 2007). In addition, Cooper's (2011) study that investigated women's and midwives views of the role of a midwife within a hospital setting, identified two types of midwives; 'doing' and 'being'. The former is related to midwives who were comfortable and aligned with technocratic skills of intrapartum care (ibid). The latter is related to midwives aligned to a 'with-woman' philosophy where midwifery skills of watchful waiting were valued (ibid). However, those aligned with 'being' appeared to conform to 'doing' when working in hospital environments, reflecting the dominance of a technocratic culture (ibid). Moreover, Williams (2006) traced these divergences to midwives *a priori* frameworks when applying to undergraduate midwifery courses. Williams (ibid) found the majority of first-year student midwives aligned with the biomedical paradigm and reported 'fears' of community workplaces¹¹. Of interest, Williams (ibid) hypothesised that such divergences reflected the student midwives' upbringing. The study appeared to connect 'unconventional' or troubled childhoods with

¹¹ Community midwives do not usually work in hospitals (although some teams may have offices in hospitals). Community workplaces relate to home visits, running clinics from GP surgeries, children's centres, birth centres etc.

a greater alignment with community working (ibid), that was related to a 'with-woman' philosophy.

All of these studies broadly illustrate two extremes. One is based on a 'woman-centred' philosophy, where the holistic needs of the woman guide the care provided and autonomous decision making is actively supported (Carolan & Hodnett, 2007). This is opposed to a task-oriented approach or a 'guideline-centred' philosophy, in which the needs of the organization are prioritized over the needs of the individual woman (Griffiths, 2009; Kotaska, 2011). Midwives can be viewed as part of the problem through perpetuating hegemonic birth practices, or as embedded within the problem with structural disadvantages (medicalised, institutionalised etc. work environments) reducing their capacity to practice 'full-scope' midwifery. Midwives can also be viewed as part of the solution- midwives who resist hegemonic birth practices contribute a valuable counter-discourse that challenges the status quo.

2.6 Situating the study: alternative physiological birth choices

Women's access to appropriate maternity care and services that provide the optimal space for physiological birth can be restricted and constrained by the key discourses discussed in this chapter. For women seeking physiological births that are outside of broader discourses such as medicalisation, institutionalisation, standardisation, risk-averse, guideline-centred care, and perceptions of 'good' mothering to achieve a 'motherbirth', then it is likely they face greater challenges to get their needs met. Midwives in the UK are the primary maternity caregivers who play a significant role in the facilitation of women's choices. However, as discussed, NHS midwives are also juxtaposed within the tensions between delivering woman-centred care, being 'experts' in normal birth whilst situated within conflicting wider discourses in an NHS environment. Nor are midwives a homogenous group, some with an ideological alignment with the dominant medicalised discourses. Therefore, the aim of this study was the recruitment of midwives who self-define as facilitative of women's alternative physiological birthing choices whilst working within institutions to understand the processes, experiences, and socio-cultural-political factors that influence the midwives' delivery of such care. Through knowledge generation, practice-based evidence can facilitate improvements to midwifery practice so more women are able to get their needs met.

2.7 Conclusion

This chapter has positioned physiological birth as vitally important to the health of women and babies. The UK has strong governmental policies, legislation, clinical guidelines, and midwifery workforce that supports midwifery models of care, physiological birth, and women's autonomous decision-making. However, I have demonstrated women and midwives face key barriers in these areas. Such barriers were attributed to a complex interplay of sociocultural-political discourses that super-value medicalised, technocratic and institutionalised birth. Additionally, a recognition that midwives are not a homogenous group situated contextualised key differences that can influence midwives' practice and approach to caring for women. As such, this study is focused on midwives who are particularly concerned with supporting women who aim to achieve a physiological birth, but who do not fit standardised 'norms' of current maternity care provision. The next chapter provides the findings of a systematic qualitative review to ascertain what was known about midwives (with any ideology) caring for women making alternative physiological birth choices.

Chapter 3 Systematic Meta-ethnography

3.1 Introduction

The previous chapter positioned physiological births as important to maternal-fetal health and identified that the midwifery model was suited to improving physiological birth rates. Cultural discourses which inhibit physiological birth and the implementation of midwifery models were highlighted. In addition, the chapter highlighted that women's alternative physiological birth choices could be problematic for both women and midwives. In this chapter, I present the findings of a systematic meta-ethnography to ascertain what is currently known about midwives (of any ideology) caring for women making alternative physiological birth choices. The chapter provides an overview of the methodology, methods and synthesised findings which have informed the development of a publication (Feeley et al., 2019), which is presented in Appendix 1. Finally, this chapter identifies the research gaps that this thesis addresses.

3.2 Aims and Objectives

The aim of this review was to gather, quality assess, synthesise and interpret existing literature that explored the views, attitudes, and experiences of midwives caring for women making alternative birth choices. As identified in Chapter 1 (section 1.1), alternative births can be characterised as those that fall outside of maternity guidelines, with these guidelines providing a national framework for evidence-based care. They can include women seeking alternative care packages and/or women who decline recommendations of care. This review was carried out to ascertain the extent of existing research and to identify knowledge gaps to inform the development of the research study. The research question for the meta-synthesis was:

‘what are the views, attitudes, and experiences of midwives caring for women making alternative birth choices?’

3.3 Methodology

Meta-ethnography

Noblit & Hare's (1988) meta-ethnography approach was chosen due to its capacity to explore a range of qualitative studies focusing on a particular phenomenon and to formulate *new* conceptualisations of a phenomenon. Their approach includes a seven-phase framework illustrated in Figure 2. The findings from a meta-ethnography may provide a tentative theory that encompasses the nuances of the phenomenon, rather than seeking to provide a unified 'truth' of the phenomenon under scrutiny (Walsh & Downe, 2005). Fundamental to the meta-ethnographic approach is the 'translation of

studies', which can be carried out in three ways depending upon the insights detailed within the individual studies (Noblit & Hare, 1988; France et al., 2014). Translation can be reciprocal (i.e. when similar findings are reported across the different studies), refutational (i.e. when different, or contradictory findings are reported in the studies), and either or both may generate a 'line of argument' which is a new conceptualisation of the data (Noblit & Hare, 1988).

Figure 2 Noblit and Hare's (1988) Seven phases of meta-ethnography

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.

Taking a systematic approach

There is recognition of the growing contribution of qualitative syntheses to evidence-based practices and policies (Hannes, 2011; Tong, Flemming, McInnes, Oliver, & Craig, 2012), of which meta-ethnography is the most frequently used (Campbell et al., 2011; France et al., 2014). However, concerns relating to the quality of the conduct and reporting of meta-ethnographies are raised by a number of researchers (Thomas & Harden, 2008; Barnett-Page & Thomas, 2009; Campbell et al., 2011; France et al., 2014). For example, a systematic review carried out by France et al., (2014), found significant flaws in 66% of the 32 studies included in the review. The flaws related to inappropriate use of meta-ethnography, poor reporting upon the translation and synthesis methods, and a lack of new conceptualisations. Methodological and reporting flaws impede the use of meta-ethnographies in health research as the rigour and transparency undermine the trustworthiness of the findings (Tong et al., 2012; Campbell et al., 2011; France et al., 2015).

To circumvent these common pitfalls in the conduct and reporting of a meta-ethnography and to ensure trustworthiness of the findings, this study is informed by the systematic review of France et al., (2014, 2015) and draws upon best practices within systematic reviews (Francis, Coren, & Fisher, 2010). Systematic reviews involve adherence to an explicit, pre-specified and reproducible approach to identify, appraise and report findings from a body of literature (Centre for Reviews and Dissemination, 2008; Francis et al., 2010). To facilitate a systematic approach, I designed a research protocol prior to the review that was submitted to PROSPERO (The International Prospective Register of Systematic Reviews), registration number CRD42016045561 (Feeley & Thomson, 2016a).

3.4 Methods- A Seven Phase approach

Getting started- the search (Phase 1)

Noblit and Hare's (1988) original text did not provide guidance regarding searching for literature. However, as qualitative meta-synthesis methods have developed, searching for literature has been subject to debate. These concern the development of *a priori* search strategies or inductive approaches (Thomas & Harden, 2008; Walsh & Downe, 2005) and sampling methods employed (Atkins et al., 2008). For some meta-ethnographic researchers, an inductive purposive sampling approach is satisfactory so that 'conceptual saturation' can occur (Atkins et al., 2008; Thomas & Harden, 2008). Alternatively, some researchers recommend an exhaustive search strategy to find as many potentially relevant studies as possible (Francis et al., 2010). I adopted a pre-designed, *a priori*, systematic approach to searching- aiming to maximise the number of relevant studies to include in the review.

Search term development (Phase 1)

A framework was used to develop the research question and search terms; 'Population and their Problems, Exposure and Outcomes or Themes' (PEO) (Bettany-Saltikov, 2012). Following this, search terms were developed by identifying their related synonyms to ensure the comprehensiveness of the search strategy (Bettany-Saltikov, 2012). These were revised following a meeting with a university librarian and subsequently underwent a pilot test that ensured the search strategy was fit for purpose. A detailed description of the developmental process and the decisions made can be found in Appendix 2.1.

Table 2 details the final search terms with truncated symbols so that singular or plural variations of the words were found. Boolean operators AND/OR were applied throughout (Bettany-Saltikov, 2012). The table also indicates the order in which the terms were to be searched: population; outcome/themes; exposure 1, exposure 2. This

was advised by a hospital Trust librarian as a strategy to enhance the search; by linking the midwives to the exposures, it would enhance the number of relevant hits. The final search terms include two levels of ‘exposure’, to increase the specificity and sensitivity of the search strategy. During the pilot, it was found that either spelling (UK or US) of caesarean generated appropriate hits.

Table 2 Search term development

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

Deciding what is relevant to the initial interest (Phase 2)

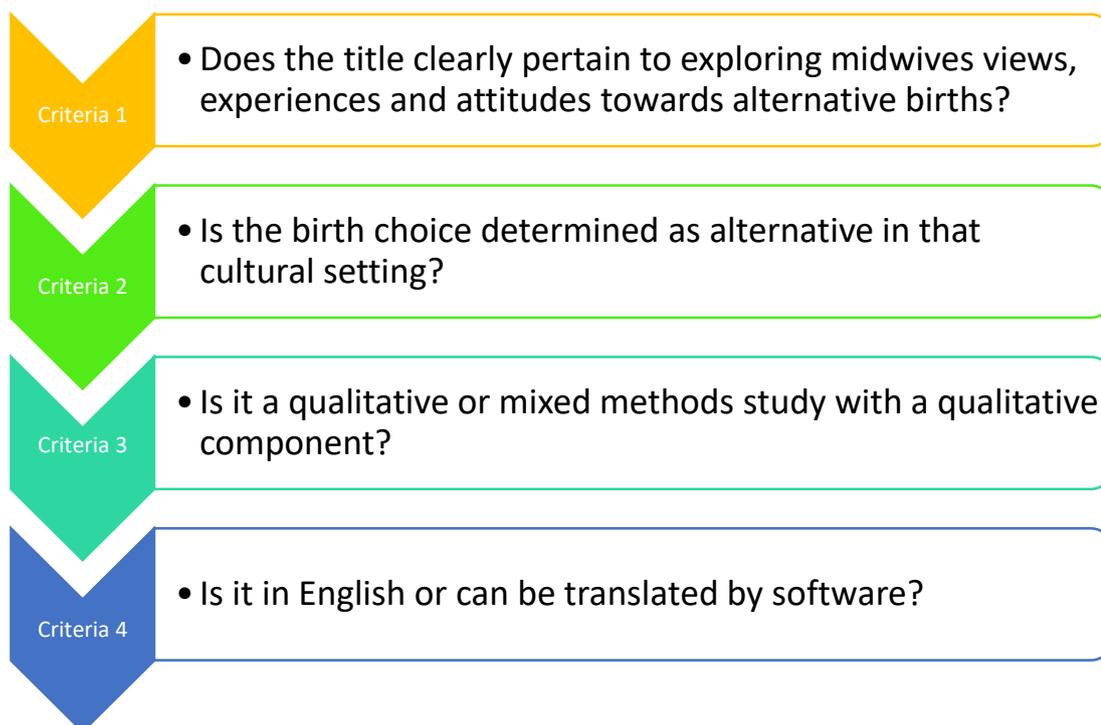
Inclusion and exclusion criteria were developed prior to the literature search to maintain a methodical and focused approach whilst searching the data sources (Francis et al., 2010). Table 3 depicts the criteria for inclusion and exclusion. The decision to include papers from 1993 onwards was due to the publication of the UK governmental policy ‘Changing Childbirth’ (DH, 1993). This marked a change in the discourse surrounding childbirth and prioritised women’s right to choice, control, and continuity of care. It also included the reversal of the official policy that the hospital is always the safest place for birth (Wilson, 2013), paving the way for new maternity rhetoric which included alternative birth choices.

Table 3 Inclusion exclusion criteria

	Inclusion	Exclusion
Timeframe	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 alternative birth choices	1. The views, attitudes, and experiences of women who choose alternative birth choices. 2. The views, attitudes, and experiences of other maternity professionals in relation to alternative 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 a qualitative component	1. RCT 2. Quasi-experiments

These criteria were used to develop questions (see Figure 3) to assess the papers. It was also taken into consideration that definitions of an alternative birth may be culturally specific, therefore any international studies were to be cross-referenced with their national maternity guidelines to assess their inclusion.

Figure 3 Screening criteria



Literature search methods (Phase 2)

A *priori* search strategy was developed (as previously outlined) and used to systematically search bibliographic databases. Additional search methods were carried out as per Bates (1989) model of ‘berry picking’ that included reference chasing, author tracking, hand searching, unpublished literature databases and reaching out to professional networks. Appendix 2.2 provides a detailed account of the search activities, below provides an overview of search methods:

- Health electronic databases: 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.
- Reference chasing involved scrutinising the reference list of all included papers that may be relevant to the search.
- Author tracking- that involved tracking the authors who were included in the review for any other potentially relevant work.
- Hand searching- the following midwifery journals were searched, focusing on the most recent publications that may not have been captured by the databases: 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. A journal alert was set up using Zetoc (2016), a

web-based platform which delivers regular update emails from pre-chosen journals.

- Unpublished literature-the same search strategy was applied to the Ethos database, a repository for theses which may or may not be published.
- The professional network 'Normal-birth' research group on Jiscmail were contacted to identify any studies relating to the research question.

Eligibility assessment methods (Phase 2)

The papers were reviewed with the inclusion/exclusion criteria and screening criteria applied (as per above). Full text of all studies that met the initial screening criteria was obtained with duplications recorded and removed (Francis et al., 2010). The full texts were scrutinised by CF and GT independently to minimise bias and maximise the reliability of the review (Francis et al., 2010). The two authors met to discuss their findings and the agreed papers were included for quality appraisal. To provide a transparent audit trail all results are provided in Appendix 2.3.

Quality assessment (Phase 2)

The aim of a quality assessment process is to distinguish between flawed or robust studies (Hannes, 2011). This is particularly important for experimental studies which seek to decipher effective treatments or interventions (Hannes, 2011). However, there is greater debate regarding the value of quality assessments for meta-syntheses, mirroring the same debate in primary qualitative research (Atkins et al., 2008; France et al., 2014). The debate centres 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). Critics raise concerns that poorly reported papers are not necessarily indicative of poorly conducted research, yet risk exclusion (Britten & Pope, 2012). Further concerns relate to limited space within journals to publish meaningful qualitative findings (Campbell et al., 2011) and the overemphasis on methodological aspects of the study, rather than the conceptual findings (Toye et al., 2013). Noblit and Hare (1988) argued that as studies that are conceptually poor will be revealed during the synthesis and less likely to contribute to the findings, that formalised quality assessments are unnecessary.

Alternatively, others recognise the increasing value and contribution of qualitative studies to evidence-based policy and practice, signifying an emerging need to ensure minimum standards are met (Walsh & Downe, 2006; Thomas & Harden, 2008; Campbell et al., 2011). My position was that quality assessments are of value, particularly within reviews that aim to contribute to practice and policy. Therefore, this review used a

quality assessment framework for all the eligible papers to review their credibility, transferability, dependability, and confirmability (Downe, Walsh, Simpson, & Steen, 2009; Walsh & Downe, 2006). However, it is also my position that for cases where little is known about a phenomenon, studies of variable quality should still be included as they may contribute valuable insights towards situating and grounding future research. Rather than excluding such papers, I felt that good transparent reporting could contextualise potentially cautious findings.

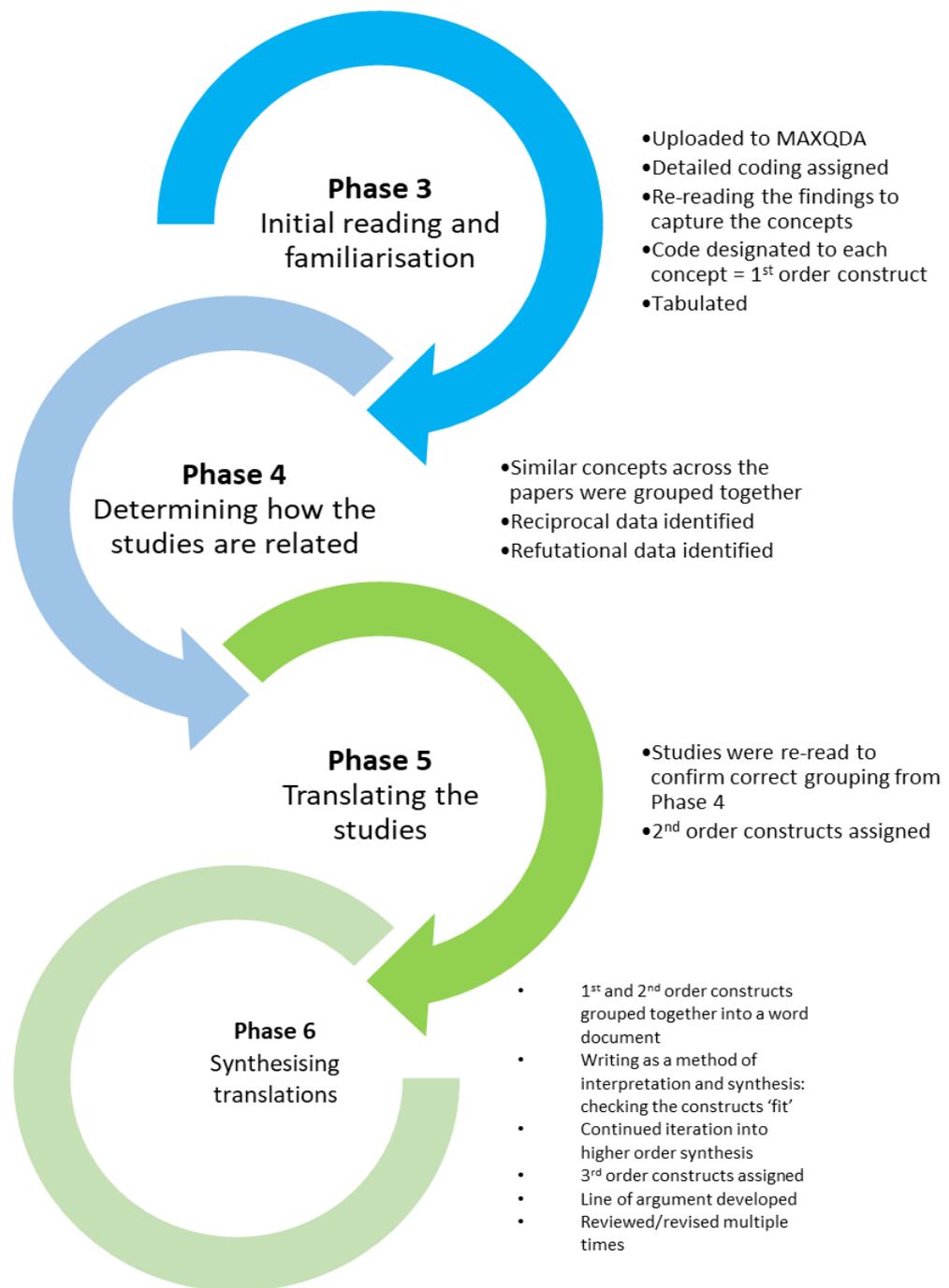
Quality assessments for all the eligible studies were carried out using the Walsh & Downe (2006; 2009) integrated quality appraisal tool (see Appendix 2.4). This was considered to be an appropriate tool as it had been developed from a meta-synthesis of a wide range of quality assessment tools and was designed to be used with flexibility, in keeping with the iterative and reflexive nature of qualitative research (Walsh & Downe, 2006). The tool (Walsh & Downe, 2006) assessed the following attributes of each paper: scope and purpose; design; sampling strategy; analysis; interpretation; reflexivity; ethical dimensions; relevance and transferability. The tool also provides a grading system in which to assess the studies, with studies graded from A-D.¹² The quality assessment was carried out by CF and GT separately. We conducted a meeting to discuss our individual findings and consensus was reached following an extensive discussion. All results are provided in Appendix 2.5.

Data extraction and synthesis methods (Phase 3)

Meta-ethnography is an inductive and iterative process, rather than linear (Noblit & Hare, 1988; Walsh & Downe, 2005; Campbell et al., 2011). This means going back and forth between the phases is appropriate and expected for the synthesis to evolve interpretative meanings, where the '*whole is greater than its sum parts*' (Walsh & Downe, 2005). Therefore, the data extraction and data synthesis methods are written together within this section. To demonstrate the process, Figure 4 illustrates my processes of phases 3-6 of the Noblit and Hare's (1988) framework.

¹² 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 (Walsh & Downe, 2006).

Figure 4 Phases 3-6 methods



Initial reading and familiarisation (Phase 3)

The first stage of exploring the data involved multiple readings of each study, building upon the familiarisation process that started during the quality assessment phase. I made notes of any initial impressions relating to the studies. Following this, each study was uploaded into MAXQDA (maxqda.com, 2015), a computer software package that offers

tools for the organisation and analysis of qualitative data. In the first instance 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 (see section 3.5).

The next stage of familiarisation involved an in-depth coding in MAXQDA. Each paper was read individually looking for metaphors that capture the paper's findings (Noblit and Hare, 1988). However, the papers largely lacked metaphorical interpretations primarily because 5/6 studies, the research design did not include interpretative analysis'. To overcome this, I was guided by Toye et al., (2013), who also found capturing metaphorical ideas problematic. Toye et al., (2013) defined a concept as a meaningful idea, therefore, a researcher can identify key concepts within a paper, even where the original authors did not. The identified concepts can then be used as per the constant comparison approach as per Noblit and Hare (1988). Therefore, working with one study at a time, I re-read each one looking for 'meaningful ideas'. As such, key concepts were identified and assigned a code (see Appendix 2.6/2.7).

Determining how studies are related (Phase 4)

Using Downe et al., (2009) meta-synthesis template, data was captured and tabulated to include: a code; summary or key concept; metaphors, phrases, ideas, concepts, relations and themes presented by the authors of the original texts. The coded concepts from the studies formed the basis of 'first order constructs'¹³ (Campbell et al., 2011). The first order constructs were organised into those that were similar, thus identifying potential reciprocal translations, and those that differed, thus identifying potential refutational translations.

Translating studies (Phase 5)

Through a process of comparing and contrasting (Noblit & Hare, 1988), going back and forth between the study findings and the coded concepts, all of the studies were re-read in relation to the first order constructs. This was an iterative process which involved going back between Phases 3 and 4 to confirm that the reciprocal and refutational findings were accurately captured. During this process, second-order constructs were

¹³ 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, I felt it was justifiable to combine constructs with the meta-ethnographic approach.

created; this involved a key phrase or metaphor that encompassed the grouped first-order constructs being assigned. For a worked example from the first iteration to the final, see Appendix 2.8. Four iterations were carried out until I felt the reciprocal and refutational insights were accurately captured.

Synthesising translations (Phase 6)

The translations were synthesised through a process of writing. Each second-order construct and the associated first-order constructs coupled with key quotes from the original papers (from Phase 3-5) were inserted into a Word document. By capturing all of this data together, I started the process of interpretive writing (van Manen, 2014); attempting to bring together the 'parts' into a new interpretation (Walsh & Downe, 2005). As the interpretations evolved, I was able to formulate third order constructs; a new level of interpretation that synthesised several second-order constructs together (Walsh & Downe, 2005). Through several iterations, the data synthesis was reviewed and revised, returning to the Phases 3-6 many times. A line of argument synthesis seeks to move beyond the translation of studies into a new interpretative concept that includes both the similarities and dissimilarities (Noblit and Hare, 1988, p.64). A line of argument was developed following several iterations of synthesising the data.

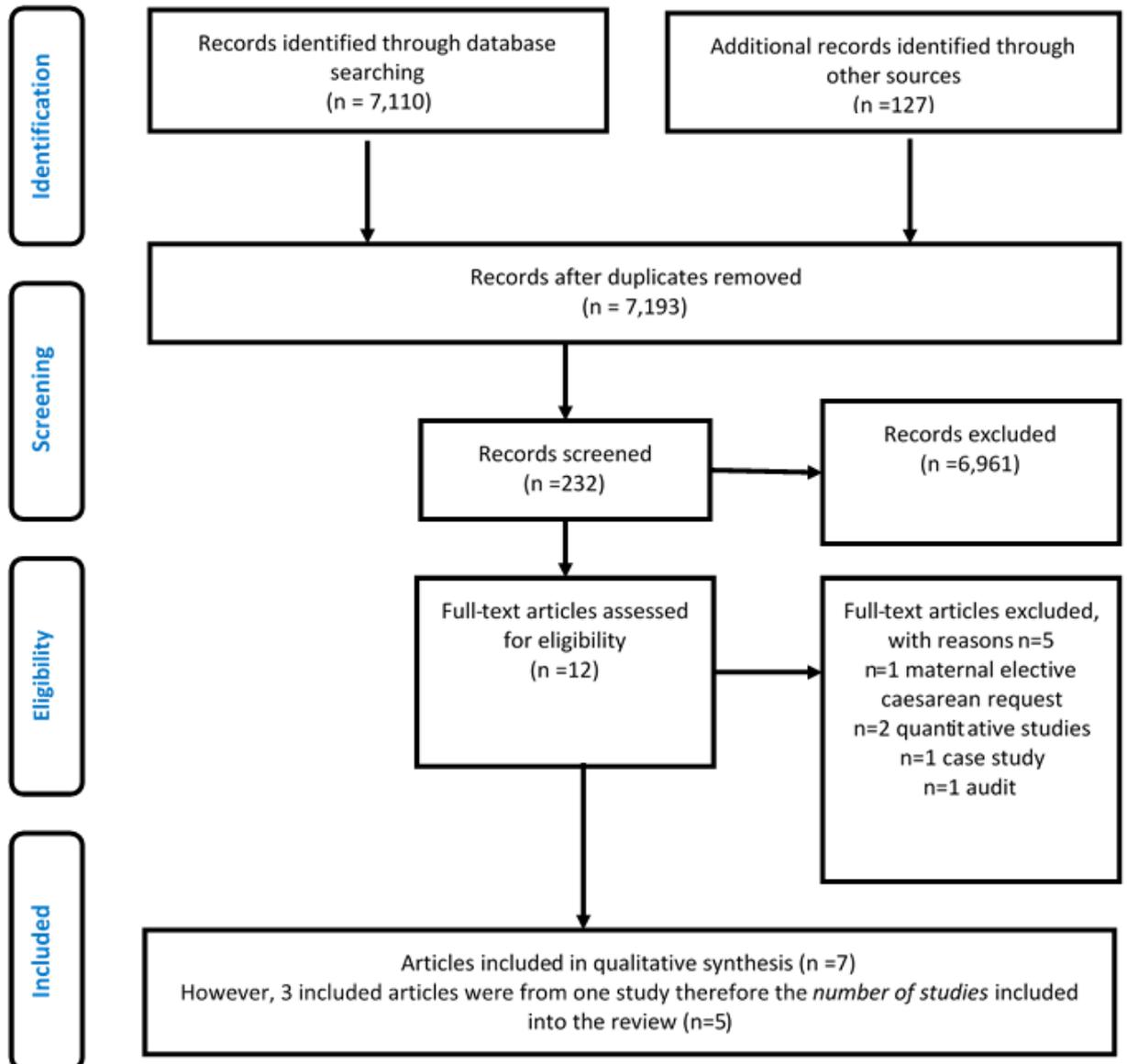
3.5 Results

Overview

The search was carried out between 2nd August and 17th September 2016 (updated October 2017¹⁴) and methods already discussed applied. This section provides a detailed account of the findings from the review process: quality assessment of eligible papers, data extraction of study characteristics and data synthesis findings. A PRISMA diagram illustrating search results is presented in Figure 5.

¹⁴ Although a systematic search was not repeated, using the Zetoc journal update function I have kept up to date with developments in the field. A recent paper did not meet the inclusion criteria but is used in the discussion in section 3.7.

Figure 5 PRISMA flowchart of findings



Searching/screening/eligibility

The exhaustive search screened 7237 papers against the predetermined inclusion and exclusion criteria. Only 12 full-text articles met all conditions of the screening criteria, and five studies were excluded during the eligibility assessment; two were quantitative studies (Danerek et al., 2011; Jenkinson et al., 2015); one was an audit (Sellar, 2008); one was a case study with little focus on the midwifery aspects of care (Jankowski & Burcher, 2015); one was a study exploring the views of midwives and obstetricians related to maternal elective caesarean request (Karlström, Engström-Olofsson, Nysted, & Thomas, 2009). Only seven papers were eligible for inclusion and three were from the same study (Wickham, 2009; Wickham, 2010; Wickham, 2011). Overall only five unique studies were included (Wickham, 2009; Symon et al., 2010; Thompson, 2013; Cobell, 2015; Jenkinson et

al., 2016) but spanned seven articles. 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.

Quality assessment

The detailed quality assessment findings can be found in Appendix 2.5. In summary, the quality of three of the studies was good and allocated a B grade (Symon et al., 2010; Wickham, 2009; Jenkinson et al., 2016). These studies demonstrated a robust methodological design, approach, and methods. Their findings were clear, and grounded in the data. These studies generated meaningful insights that were plausible and contributed to new knowledge generation for maternity services. Similar weaknesses were noted across the studies associated with a lack of reflexivity (Wickham, 2009; Symon et al., 2010; Jenkinson et al., 2016). In one study there were inconsistencies between the stated theoretical positions with that of the methods used during data analysis (Jenkinson et al., 2016) i.e. stated they were using an interpretative methodology, however, the findings demonstrated thematic analysis without higher order interpretations evident.

Two studies were given a C grade (Thompson, 2013; Cobell, 2015). Thompson (2013) had an appropriate research design and methods. However, notable weaknesses were apparent such as a lack of theoretical framework, poor justifications for study, little or no reflexivity, and no methods that included either triangulation, member checking or additional researchers involved with data analysis. These issues limited the dependability of the findings. In addition, reporting issues were noted in Thompson (2013), such as poor descriptive findings with an absence of participant quotes, thus reducing confirmability. Cobell (2015) demonstrated a methodologically sound 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, while appropriate for IPA, limits its transferability. The findings read as descriptive, rather than providing conceptually rich interpretations. Lack of a second researcher (or more) and peer-review in the analysis of the findings limited the confirmability of the findings.

Study Characteristics

Overall the five studies included in the review captured 55 midwives' views, attitudes, and experiences. Jenkinson et al., (2016) included women's and obstetrician views in their study, however, for the purposes of this review they were excluded from the

analysis. The studies were undertaken in the UK (n=3), Australia (n=1), and one study recruited internationally, participants were from the UK, US and New Zealand. In three studies, midwives were employed by state-funded organisations (Thompson, 2013; Cobell, 2015; Jenkinson et al., 2016). Whereas, two studies midwives were self-employed, often known as independent midwives (Wickham, 2009; Symon et al., 2010). Notably, all studies were undertaken in high-income countries, all with state-funded healthcare systems, and where midwives are the lead professionals for healthy childbearing women at low risk of complications. Only one of these settings (i.e. Australia) has a strong private obstetric sector. Table 4 presents the extracted study characteristics for each study.

Table 4 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 (2009; 2010; 2011) 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., (2010) 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 (2013) UK	To explore midwives' experiences of caring for women who make choices outside of guidelines	Qualitative	n= 10 midwives Hospital setting in one Trust	Thematic analysis	Ethics approval granted	Four key themes: 1. Effects on care and concerns; 2. Coping strategies and getting on; 3. Women's	C

				Interviews		Some reflexivity	characteristics; 4. Influence of others.	
4	Cobell (2015) 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., (2016) 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

3.6 Synthesis findings

This section presents findings and the resulting line of argument synthesis. Table 5 presents the first, second and third order interpretations. Three third order interpretations were identified related to midwives' views, attitudes, and experiences of women's alternative birth choices. '*Different lenses, different views*' expresses the conflicting and contradictory perceptions and understandings of women's previous experiences and the mother-baby dyad; '*Managing multiple tensions*' conveys the different sources of fears and opposing frustrations experienced by midwifery staff; '*Ways of working with-woman*' describes the midwives' perspectives on the central role of relationships to caregiving.

Table 5 A presentation of the interpretations with study codes in brackets

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)	

Different lenses, different views

This theme describes the midwives' views and perspectives in relation to women's personal attributes, autonomy, and motivations for alternative birth choices.

Contradictory perceptions of women

In trying to understand women's alternative birth choices, participants across four of the studies perceived these women to be a certain 'type' of person (Symon et al., 2010; Thompson, 2013, Cobell, 2015, Jenkinson et al., 2016). Three studies associated women's alternative decision-making with needs for fewer interventions during birth (Symon et al., 2010; Thompson, 2013, Cobell, 2015). The participant's in the Cobell study (2015, p.39) reported that the women making these choices were predominantly 'Caucasian', 'independent'. These characteristics concurred with the participants in the Thompson (2013, p.568) study, who perceived women making alternative choices as 'well-educated' and 'intelligent'. Such attributes were viewed positively (Cobell, 2015), or negatively (Thompson, 2013). Conversely, the independent midwives in the study by Symon et al., (2010) viewed the 'type' of women who sought to take responsibility for their decisions and subsequent outcomes positively. Moreover, working with such women was fundamental to their (independent) midwifery philosophy:

'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, Symon et al., 2010, p.282).

Understanding women's motivations

Whilst perceptions about the type of woman who makes alternative birth choices were raised, some participants recognised that a previous traumatic experience could also influence this decision (Symon et al., 2010, Cobell, 2015). Some participants were sympathetic to women's previous experiences of medicalised births:

'I think it was more that she didn't want that medical, bright lights, legs up in the air, kind of scenario' (Beth, Cobell, 2015, p40).

The UK independent midwives in the study by Symon et al (2010) reported that women sought their services (and consequently sought homebirths) to avoid a

repetition of their *'traumatic NHS care'* (Symon et al., 2010, p.283). This was despite many of these women having risk factors during the pregnancy such as twin pregnancies, seeking a homebirth after a caesarean (HVBAC) or multiple risk factors e.g. breech pregnancy seeking a homebirth after a caesarean (HVBAC) or a twin pregnancy after a caesarean (Symon et al., 2010). There were also some incidences of obstetric emergencies during labour where the women declined a transfer to hospital in order to avoid NHS care and included cases where had babies died:

'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 into hospital they switch off and won't listen.'
(Participant, Symon, et al., 2010, p283).

Conflicting views of maternal autonomy

In all of the studies, participants acknowledged that women had the right to make their own birthing decisions, including going against medical advice or standard guidelines (Symon et al., 2010; Wickham, 2009; Thompson, 2013; Cobell, 2015; Jenkinson et al., 2016). However, the views and attitudes towards maternal autonomy were conflicted *between* the studies and *within* the studies. For example, Cobell (2015) found that the participants had different perspectives regarding women's autonomy, dependent upon the midwives' experiences. For example, one midwife who had experienced a woman decline a home to hospital transfer during an obstetric emergency expressed frustration at the woman's decision:

'that's the kind of mentality that I mean, she was just do or die, I want my home birth'
(Rose, Cobell, 2015, p.105)

However, in contrast, another participant felt that women should be treated as adults, not children [in relation to their decision making] and commented:

'you've taken, not a maternal or paternalistic role, you've taken a woman-centred approach and they're at the centre of the decision making' (Beth, Cobell, 2015 p.110).

Whereas other studies expressed an explicit commitment to women's autonomy (Symon et al., 2010; Wickham, 2010; Jenkinson et al., 2016). One of the midwives from the study by Jenkinson et al (2015) reported:

'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, p.5).

Women's autonomy was considered in relation to fetal wellbeing (Symon et al., 2010). Midwives in Wickham's (2010) study viewed fetal wellbeing as directly connected with its mother, viewing women's autonomy and fetal wellbeing holistically. For example:

'It's very difficult in other words to separate who the woman is from what she's going through with the pregnancy because she is the pregnant woman. It's not her body, it's her whole self... I am a midwife who would rather take each individual woman as independent and just really, just look at what's going on with this woman and this baby...' (Anna Andhra, Wickham, 2010, p.4)

Conversely, midwives in the Thompson (2013) study, expressed concern when they perceived maternal requests as conflicting with fetal well-being. Some participants expressed relief when the baby was born as it was assumed they could regain 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, Thompson, 2013, p.576).

This juxtaposition was starkly reported by the midwives in Symon et al.'s study, (2010), where women's autonomy was fully respected and supported but not without emotional difficulty due to the experience of a poor outcome:

'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, Symon et al., p.282).

Conflicting tensions

This theme explores the conflicting sources of tensions experienced by the midwives. Some expressed medico-legal fears and vulnerabilities and others were frustrated by arbitrary restrictions that defined women's choices as 'alternative'. How the midwives sought to manage their tensions is also discussed.

Fears and vulnerabilities

In four of the studies, participants reported professional, medico-legal, personal stress and vulnerabilities when women declined recommended care (Thompson, 2013; Cobell, 2015; Jenkinson et al., 2016). Issues were 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, Thompson, 2013, p.568).

Cobell (2015) found that some midwives reported women lacked an understanding of the wider impact of their decision making, should an adverse outcome occur:

'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, Cobell, 2015 p.44).

This perspective was also found in Jenkinson et al.'s study (2016), who reported some midwives had concerns about the wider implications of their livelihood should an adverse event occur. These concerns were particularly related to insurance issues and practising 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, Jenkinson, et al., 2016, p5).

High levels of stress associated with these concerns affected some participants more acutely than others. Thompson (2013) reported that midwives disclosed feeling out of their comfort zones, and frustration towards some women's requests, which they felt was at times 'silly' (p.566) and time-consuming at the detriment of other women's care:

'I think if you know they are coming ... you can arrange your day around them. They do get what they want. It's funny because their demands are usually non-demanding. They think they are being quite easy because they don't want a lot. Actually they are far

more demanding. They take up much more time and you have the worry of everyone.'

(Participant, Thompson, 2013, p.567).

Thompson (2013) also reported that some of the midwives described the women's choices as '*challenging, and tricky*' (p.566). This was associated with high levels of stress due to perceptions of increased levels of responsibility:

'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 could have gone wrong and it's probably more frightening to look back on it than actually it was at the time.' (Participant, Thompson, 2013, p.566).

Midwives who actively facilitated women's alternative birth choices in the study by Cobell (2015) reported vulnerabilities associated with feeling judged by their '*fearful*' colleagues. These midwives felt 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 is going to go wrong.' (Kate, Cobell, 2015, p.44).

Arbitrary restrictions

Some midwives reported different sources of frustration (Cobell, 2015) and anger (Wickham, 2010). In Cobell's study (2015), guidelines were conceived to be problematic as they created fears amongst midwives when faced with women making alternative choices outside of the guidelines:

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

These midwives challenged the concept of guidelines:

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

All of the midwives in Wickham's study (2009) remonstrated against the obstetric constructs and knowledge of birth in relation to defining term and post-term pregnancy. They argued that the strict parameters set by obstetrics were '*arbitrary*' (p.467), not based on robust clinical research and ran counter to their experiences as midwives (Wickham, 2009). One participant reported:

'Well, there's no real, what I would call real research done into that area of pregnancy, you know. I mean, anyway, if you do do it [research into post-term pregnancy] now who's it done by? You know, it's done in some big unit and, you know, they [the women] are not allowed to go to really post-term pregnancy... It's not even ethical anymore...'

(SilverBirch, Wickham, 2009 p.467).

Additionally, Wickham (2009) reported that all of the midwives criticised the technocratic ideology, which was seen to be a source of control over women that amounted to *'pervasive pressure to accept medical interventions'* (p.465). Within this perspective some of the midwives, considered *'women to be broken by the system'* (Wickham, 2010, p.2), a metaphor used to represent the morbidities associated with routine inductions:

'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, Wickham, 2010, p2).

Managing the tensions

Midwives employed by institutions reported that a primary method to deal with the stress associated with medico-legal concerns was scrupulous documentation of the care that they provided (Thompson, 2013; Cobell, 2015; Jenkinson et al., 2016).

Midwives reported how scrupulous documentation was seen as a *'safety net'* (Thompson, 2013, p.567) and a source of *'protection'* (Jenkinson et al., 2015, p.9) for their midwifery practice i.e. should an adverse event occur, the case would be investigated including scrutiny of all documentation associated with the case.

Therefore, the midwives perceived that thorough documentation would demonstrate they had provided appropriate care in accordance with the woman's decisions, as opposed to practising negligently (Thompson, 2013; Cobell, 2015; Jenkinson et al., 2016).

The focus of Jenkinson's (2016) study was the implementation of 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 an opportunity during the antenatal period for senior obstetricians to inform women of the possible consequences of their decisions in declining recommended care, which was

documented and shared with all maternity professionals. Midwives, as reflected by in the quote below, reported feeling less stress when a woman had an MCP in place:

'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, Jenkinson et al., 2016, p.6).

This was echoed by the midwives in Thompson's (2013, p.568) study where participants reported feeling more 'confident' and 'reassured' when a woman had a birth plan that was written by a Supervisor of Midwives¹⁵ (SOM's). When a woman did not have an existing birth plan, they reported seeking a 'sounding board' such as a SOM or senior colleague for support and advice (Thompson, 2013, p.568). Other midwives reported liaising with their SOM in relation to women's birth plans, rather than seeking the SOM to intervene (Symon et al., 2010).

Ways of working with-woman

This theme describes the essential role of forging and maintaining mother-midwife relationships and keeping women engaged in the services.

Relationships central to caregiving

In four of the studies, midwives perceived good relationships with women to be fundamental to providing good care (Symon et al., 2010; Wickham, 2010; Thompson, 2013; Cobell, 2015). Some midwives felt establishing rapport with women to be essential in creating and maintaining positive relationships with the women so that safe care plans could be better negotiated (Thompson, 2013, p.567).

Midwives in the Cobell (2015) study also valued positive communication that avoided paternalistic attitudes. Here, as reflected in the following quote, the midwives seemed to benefit from caring for women:

'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, Cobell, 2015, p41).

¹⁵ In the UK, until Spring 2017 all registered midwives had a statutory requirement to be registered with a Supervisor of Midwife who oversaw the midwife's practice. However, major reforms meant it was taken out of statute Spring 2017.

Wickham (2010, p.3) interpreted the midwives' strong emphasis on the relational aspects of care as '*journeying with women*', where the mother-midwife relationship was based on an embodied and meaningful connection. This was illustrated by one participant:

'It's really, really strongly connected to the fact that you're in a relationship. We get to know women really well, and even if you don't feel like you know the woman particularly well, because you know some people are easier to get to know deeply than others, you still have got a sense of her, you know, because the fact that you're not getting to know each other well is significant in itself ... So for me I suppose it's about that relationship... it feels like there's a sort of spiritual umbilical cord...' (SilverBirch, Wickham, 2010, p.3).

The value of relationships was echoed by other independent midwives in the Symon et al., (2010) study, who despite facing deeply complex and challenging cases such as fetal death, '*being on their side*' (p.282) was perceived to be of fundamental importance.

Keeping women engaged in care provision

In addition to the development of good relationships, honouring women's requests was also motivated by a desire to keep women engaged in care or within the service (Symon et al., 2010; Cobell, 2015; Jenkinson et al., 2016). A participant from Symon's et al.,'s (2010) study reported:

'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. And that is the hardest thing, I think, about independent midwifery: where you support women in their choices, not where you goad them into doing what you want them to do.' (Participant, p.283).

Concerns were raised that if staff were unwilling to negotiate a suitable and acceptable birth plan, then women may withdraw from the service (Cobell, 2015, p.47) and/or opt to freebirth (birth without any medical assistance) (Symon et al., 2010). This was felt to have more serious consequences than honouring the woman's requests:

'[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, Jenkinson et al., 2016, p.6).

Line of argument synthesis

Whilst only five studies were found and included, the findings generated both ‘reciprocal’ and ‘refutational’ data (Noblit & Hare, 1988). A tentative line of argument was developed to draw together salient points of similarity and differences across the data set. However, further research is needed to strengthen this line of argument:

The findings suggested that 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.

3.7 Discussion

This review found only five studies relating to the review question, indicating a paucity of research in this area. The overarching line of argument reflects the contradictory and conflicting views, attitudes and experiences of midwives caring for women who prefer alternative birth options. It demonstrates a spectrum of views related to values of maternal autonomy and the perceived acceptability of women making such choices. As independent midwives work outside of hospital protocols, it may not be surprising that they actively facilitated women in this situation. In contrast, the views of many of the employed midwives reflected wider concerns related to perceptions of medico-legal accountability and blame. Employed midwives who actively expressed tensions between supporting women’s choices and the constraints of their working environment, citing lack of support from the wider team as a particular concern. Other employed midwives only supported women’s choices reluctantly. The current literature located for this review did not identify if the variation in willingness to support women in alternative care provision may have affected the care provided or the perceptions of the women involved.

These findings reflect only two other non-qualitative studies that directly explored midwives' experiences and perspectives of women's alternative birthing choices. First, a questionnaire study carried out by Danerek et al., (2011) explored the attitudes of midwives in Sweden towards women's refusal of an emergency caesarean section (medically indicated) or a caesarean section on request (not medically indicated). The study comprised n=259 participants from n=13 maternity units and found that 89% of midwives thought that obstetricians should try to persuade women refusing a medically indicated caesarean, although 59% disagreed that a caesarean should be performed without the woman's consent. Conversely, only 23% of midwife participants agreed that obstetricians should comply with a request for a non-emergency caesarean section that was solely based on a woman's wishes. However, where there was a previous history of trauma or fetal death respondents in favour of a caesarean section at maternal request rose to 89%. The findings suggested that the midwives' perspectives of women's autonomy were related to their own values regarding autonomy and fetal rights, which altered depending upon the woman's reasons for decision-making i.e. a previous birth trauma. These findings appear to align with this meta-ethnography.

A second study by Hollander (2018), carried out a questionnaire study in the Netherlands that explored maternal requests for more care (i.e. elective induction or caesarean section), less (i.e. seeking a homebirth when usually precluded due to risk factors), or no care (freebirth) during pregnancy and/or childbirth. Participants included obstetricians, midwives and alternative midwives who were defined as holistic midwives, who were willing to care for women with risk factors at home births. Most participants reported equal requests for less or more care. However, the study found that requests for less care were more likely to be refused by maternity professionals than a request for more care. Furthermore, 'alternative' midwives had a greater frequency for requests for more care, were more likely to agree to honour such requests but did report greater fear of the legal repercussions of assisting a high-risk homebirth. Thus, mirroring the medico-legal fears and vulnerabilities highlighted in this review.

A further publication undertaken in this area was an audit undertaken by Sellar (2008) within a local alongside midwife-led unit. The focus of the audit was the outcomes of women requesting a water vaginal birth after caesarean (WVBAC), where the women opted for normal midwifery care as opposed to continuous

monitoring. From 1996-2008, of 17 women making this choice, n= 10 had a waterbirth, n=2 had a vaginal birth and n=5 had instrumental births. Importantly, no woman experienced a repeat caesarean section, and all women provided positive feedback following their births. The small number of women making this choice was attributed to women having to actively seek out the service, rather than it being routinely offered. However, the author notes that supportive consultants and management contributed to the positive outcomes for these women. Related to this review, it suggests that a supportive collaborative team is an important component of safe, effective care, particularly where women make alternative birth choices. Moreover, the audit demonstrates what is possible within an NHS setting.

Limitations

With all search strategies there is a risk of missing pertinent studies, however, a comprehensive systematic and rigorous strategy was carried out; 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. Conducting a meta-ethnographic synthesis is an interpretative process, but the risk of over or under interpretation of the data was minimised through author reflexivity, the supervision process and subsequent publication development that has involved peer review. In addition, recent methodological guidance has recently been published which was not available at the time of the review (France et al., 2019). Whilst these new guidelines may not have affected the overall findings, they may have enhanced the methods used to carry out the study.

Gaps

This review highlighted a number of significant gaps in the literature, detailed as follows:

- An overall paucity of literature pertaining to the views, attitudes, and experiences of midwives facilitating alternative birth choices, in spite of strong international rhetoric that women's choices and decision making should guide the maternity care they receive (World Health Organisation, 2012; Birthrights, 2017; The White Ribbon Alliance, 2013).
- No literature regarding this phenomenon in middle or low-income country contexts.

- No studies were carried out in alternative birth settings such as the community and/or birth centres.
- Minimal literature regarding midwives who self-define as facilitative and who are employed by institutions.
- Lack of birth outcome data.
- Only one study focused on what and how the midwives facilitated women's alternative birth choices (Jenkinson et al., 2016).

Related to a UK context, this review highlighted further gaps:

- Only two studies were situated within a UK NHS context, of which the data settings included the local delivery suite of the researcher.
- Lack of national insights from varying NHS contexts into midwives' views, experiences of women's alternative birth choices.
- No studies recruited midwives across different pay scales/bands/specialities/levels of experience.
- Lack of literature regarding *how* women's alternative birth choices can be facilitated within the NHS.
- Lack of literature regarding midwives who self-define as facilitative of women's alternative birth choices whilst working within the NHS.

3.8 Conclusion

The findings of this meta-ethnography found only five studies relating to the review question, all of which were from high-income countries. The degree to which the line of argument synthesis resulting from this review can be translated into UK practice, in general, is therefore unclear. However, the findings of this review reflect the wider critique pertaining to barriers to physiological birth and alternative care provision (highlighted in Chapter 2), whereby maternity professionals can experience restrictions upon their autonomy due to institutionalised working. These findings also add to the body of evidence that midwives hold differing ideologies and approaches to care, which has the potential to affect women's experiences of alternative birthing decisions. Accordingly, this study will address some of the gaps identified from the review; namely an investigation of UK midwives, who self-define as facilitative of alternative birth choices and who work within the NHS, to ascertain their processes, experiences, and the sociocultural-political context of facilitation.

Participants will be recruited nationally from a range of NHS settings including where possible: hospital, community and, birth centres to address the current gaps in knowledge as identified by this review. The next chapter presents the theoretical positioning of this study - feminist pragmatism.

Chapter 4 Theoretical positioning & Methodology

4.1 Introduction

The previous chapter presented the findings of a meta-ethnography that explored the views, attitudes, and experiences of midwives caring for women making alternative birthing choices. The review identified the key gap that this study will address; an investigation of NHS midwives who self-define as facilitative of women's alternative physiological birthing choices. This chapter situates the study aims and objectives through the act of story-telling within a feminist pragmatist theoretical framework. This framework explicitly assumes a practical approach to problem-solving whilst taking into account gender, power, and structural contexts which affect both an individuals' sense of experience and knowledge production. In this way, midwives are positioned as 'situated knowers' with the capacity to contribute to practical and theoretical knowledge generation or 'practice-based evidence'. The use of narrative inquiry is justified in this chapter; which assumes that stories/narratives are knowledge devices that generate rich and in-depth insights. Therefore, narrative inquiry was used to *begin* solving the problem of women who struggle to get their alternative physiological birthing needs met by generating insights from the perspectives of midwives. It was considered that eliciting knowledge from midwives who are practicing 'full-scope' midwifery whilst working within NHS institutions, would generate practice-based evidence for the benefit of others.

4.2 Research aims

As highlighted in Chapter 1 (section 1.4), the broad aim of this study was to generate practice-based (Singhal & Dura, 2017) and heuristic knowledge for the benefit of other midwives to deliver 'full-scope' midwifery to meet the needs of women making alternative physiological birthing choices. By use of professional stories of practice, this study aimed to elicit narrative accounts to understand the processes of facilitation (the what, how, why), their experiences of carrying out facilitative actions (subjective sense-making), and what sociocultural-political factors influenced their practice.

4.3 Feminist pragmatism theoretical framework

'Pragmatism and feminism both require the rejection of dualistic and hierarchical thinking. Specifically, thinking and doing should not be separate, neither should mind and body be ontologically disconnected, nor theory and practice be divided. They also

share a focus on concrete problems and the idea that people's lived experiences matter in the formation of knowledge and values (Gilman, 2015, p.239).'

Epistemology, ontology, and methodology

Ontology is concerned with the nature of reality, and epistemology relates to the theory of knowledge a way of understanding how we know what we know (Grant & Osanloo, 2015). Methodology refers to the strategies adopted to explore lines of enquiry (Crotty, 1998; Dykes, 2004). Together, epistemology, ontology and methodology function as a 'paradigm' (Scotland, 2012), a philosophical perspective that depicts a collection of shared assumptions of the researcher (Rossman & Rallis, 2016). Hence within a study, there is a direct relationship between the underpinning ontological and epistemological perspectives with that of the research aims, methods used and subsequent data analysis (Grant & Osanloo, 2015). Therefore, it is imperative that researchers identify the appropriate ontological and epistemological frameworks for their study in order to legitimise the study design and the knowledge that is generated (Walsh & Evan, 2013).

For some researchers, their perspectives are based upon pre-existing perceptions of the nature of reality and how knowledge can be known (Ormston, Spencer, Barnard, & Snape, 2013). For others, their perspectives are influenced by the nature of their research questions, thus adopt a pragmatic 'best fit' approach to their theoretical underpinnings that meets the needs of the overall study design (Ormston et al., 2013). I adopted the latter approach, a pragmatic approach that was guided by my research question and aims of the study. Whilst in the first instance, my naïve interpretation of a pragmatic approach related to the notion of 'best fit', as my understanding of pragmatism as a philosophical perspective deepened, I recognised that it articulated my implicit worldview - bringing to the fore my personal understandings.

Pragmatist ontology & epistemology

This study is underpinned by pragmatism, an ontological and epistemological perspective that is pluralist recognises both the realist and relativistic ontological¹⁶ perspectives, but holds neither one as more 'true' than the other (Rosiek, 2013). Unique to pragmatism is the rejection of arguments related to the nature of reality

¹⁶ Broadly, a realist ontology perceives reality as independent of the mind- reality is 'out there' waiting to be known and relativistic ontology perceives reality as subjective and socially constructed (Crotty, 1998).

(Cornish & Gillespie, 2009; Goldenberg, 2009; Thayer-Bacon, 2010). Attention to universal ‘Truths’ or concerns regarding reality from either realist or relativistic arguments is perceived as misplaced (Morgan, 2007). This philosophical rejection by pioneering pragmatists¹⁷ generated a new ontological and epistemological perspective; one that is rooted in human experience (Dewey, 1925a; Radin, 1990; Rooney, 1993; Rosiek, 2013). In this way, rather than issues of reality, the nature of human experiences is perceived as both an observable phenomenon and one that is constructed through sociocultural, historical, and political contexts (Clandinin & Rosiek, 2007; Cornish & Gillespie, 2009). Whilst rejecting the ontological arguments of realism or relativism, pragmatists view both of those perspectives in relation to their utility to understand human experiences (Morgan, 2007). Therefore, epistemologically, pragmatists view knowledge as a tool for action, implying that for knowledge to be meaningful, it must be useful (Cornish & Gillespie, 2009). Pragmatists are concerned with the actions of knowing as opposed to the objects of knowing (Dewey 1938). Situated within a perspective that perceives mind-body, thinking-doing, objective-subjective as interacting dyads rather than in split dualistic terms, pragmatism asserts a multiplicity of knowledge exists (Dewey, 1935; Rooney, 1993; Morgan, 2007; Cornish & Gillespie, 2009; Thayer-Bacon, 2010).

By shifting the focus of ontological metaphysical argument and debates, pragmatists’ foci are upon human life experiences, actions and the consequences of those actions (Dewey, 1931; James, 1975; Hallent, 1997). Known as ‘consequence phenomena’ (Dewey, 1931), this marked a turn from a top-down abstracted ontology to that of a bottom-up approach in which the ontological focus was on ‘real life problems’ with the goal of social action and change (Dewey, 1929; Dewey, 1935; Shields, 2017). Here, the shift in gaze was a frustrated attempt by pragmatists to re-engage philosophy with matters of social relevance (Rooney, 1993). Or as Rosiek (2013) describes, pragmatism consists of a temporal inversion where inquiries are not conducted from ‘*some transcendence remove* (p.696)’ but are conducted from within our current experience and values, as outlined by Dewey (1925b):

¹⁷ Pragmatism arose from key American philosophers- William James (1842-1910), Charles Peirce (1839-1914) and John Dewey (1859-1952) during the late 19th Century (Morgan, 2007; Strübing, 2007; Shields, 2017). Typically, they were considered the fore-founders of pragmatism, alongside George Mead (1863-1931) who later was attributed to the theoretical positioning of ‘symbolic interactionism’ (Strübing, 2007). In addition, Jane Addams (1860-1935), often neglected within the normative pragmatist texts, should be considered as a fore-founder of feminist pragmatism due to her collaboration with John Dewey on a number of practical and intellectual projects (Seigfried, 1996; Shields, 2017).

'Pragmatism, thus, presents itself as an extension of historical empiricism, but with this fundamental difference, that it does not insist upon antecedent [transcendent] phenomena but upon consequent phenomena; not upon the precedents but upon the possibilities of action. And this change in point of view is almost revolutionary in its consequences. An empiricism which is content with repeating facts already past has no place for possibility...' (p. 12)

Less concerned with universal 'Truth', pragmatists reconceptualised epistemology to one where 'truth is made' (James, 1975), not found 'out there' (Strübing, 2007). As such, knowledge is perceived as contingent, that is, what we know to be true now is likely to evolve and change (Radin, 1990; Strübing, 2007; Biesta, 2010). Central to this is the perspective:

'that knowers and the known come into being only through states, acts and practices of knowing (p.21)' (Rooney, 1993).

Consequently, pragmatism recognises an embodiment of knowing (Rooney, 1993; Radin, 1990; McHugh, 2015), where knowing and doing are not separate dualist entities, but where one informs the other (McHugh, 2015). Therefore, pragmatism is a dynamic inquiry, largely attributed to Peirce (Rooney, 1993) that reconstructed the foci to consequence phenomena and where James reconstructed the mind-body split to a non-dualistic perspective (Rooney, 1993). This reconceptualisation was expanded by Dewey who emphasised that consideration of context was essential to knowledge construction (Radin, 1990; Rooney, 1993). At the heart of pragmatism lies a radical ontological divergence in which the significance of our inquiries rests upon human experiences, injustices framed within a future-oriented ontology, where the focus of our inquiries is purposeful to make future social changes (for the better). Or as Rosiek (2013) describes:

'pragmatism locates meaning in the way our inquiries transform the relationship between present and future experiences (p.696).'

As such, pragmatism can be seen as politically motivated (Morgan, 2007). John Dewey's (1935) and Jane Addams (1902; 2017) seminal work was particularly concerned with ethical issues and social action. Such concerns facilitated a critical lens regarding issues of power (or lack of) in the generation and utilisation of knowledge (Morgan, 2007; Cornish & Gillespie, 2009; Rosiek, 2013). Therefore,

pragmatism from its conception sought to challenge the status quo of what and whose knowledge counted, what was deemed as legitimate, which at the time was dominated by white privileged males (Rooney, 1993; Deegan, Hill, & Wortmann, 2009; Thayer-Bacon, 2010; Shields, 2017). By challenging the status quo, pragmatism introduced the notions of socio-political contexts of knowledge production and utility (Dewey, 1935), thus paving the way for critical theorist approaches to notions of 'Truth', philosophy, ontology and epistemology (Radin, 1990; Ulrich, 2007; Morgan, 2014; Thayer-Bacon, 2010).

Feminist pragmatist ontology & epistemology

It is within this context that locates feminist pragmatism. Feminist pragmatists view an alignment with pragmatist perspectives with broad feminist theories - both perceive that knowledge is constructed, contingent and intrinsically political (Rooney, 1993; Seigfried, 1996; Fischer, 2014; Gilman, 2015). However, feminist pragmatists raised concerns that early pragmatism did not attend to issues related to divisions of gender (Rooney, 1993; Thayer-Bacon, 2010). Such criticisms emphasised the longstanding gender differences across social spheres as contributing to inadequacies of the metaphysical projects of philosophy (Rooney, 1993; Thayer-Bacon, 2010), knowledge production (McHugh, 2015) and issues of what constitutes knowledge (Fischer, 2014). Therefore, a feminist approach extends the arguments of pragmatism to explicitly acknowledge the oppression of women (Addams, 1902; Rooney, 1993; Seigfried, 1996) and also includes issues of intersectionality such as class, socioeconomic status, ethnicity (Addams, 1902; Seigfried, 1996; Shields, 2017).

A feminist pragmatist epistemology asserts that the standpoint or context of the knower affects the known, specifically in relation to gender differences (Seigfried, 1996; McHugh, 2015). Shuford (2010) and Fischer (2014) consider a feminist pragmatism epistemology as a relational endeavour in which knowledge is constructed from our situated standpoints. Rooney (1993) argues that the alignment between feminism and pragmatism is situated within an epistemic re-mapping that accounts for sociocultural, historical and political contexts that have constructed and limited epistemic knowing. Therefore, she (and others) argue that feminist pragmatist epistemology challenges the hegemonic gender-inscribed conceptions of knowledge and reason (Rooney, 1993; Thayer-Bacon, 2010; McHugh, 2015). Whilst much of this thinking is similar to other feminist traditions, Seigfried (2015) argued that feminist pragmatism requires '*a shift from feminist deconstructive analyses to*

practical policies of liberation (p.208)'. Seigfried (1991; 2015) reasserts the pragmatist focus upon problematic situations that end in reconstructed (improved) situations offer feminist projects the bridge between theory and the practice of change. Similarly, McHugh (2015) views a coalescence between feminist critical theorists and Dewey's pragmatism, namely, *'both seek transformative, critical dialogue and change to improve scientific practices with the goal of improving human living (p.6)*'. McHugh (2015) argues for a pluralistic approach where both experimental inquiry and situated knowledge are applied to meet the needs of marginalised communities. Within this perspective, feminist pragmatism is situated within an ontological and epistemological philosophical movement, rather than one specific feminist sociological movement (Thayer-Bacon, 2010; Seigfried, 2015; McHugh, 2015).

This distinction is important as feminist pragmatists do not reject other feminist theories (epistemological or sociological), rather they argue for more feminist theorists to adopt a pragmatist theoretical perspective. Seigfried (1991; 1996) has particularly argued in favour of pragmatism as a means to address the feminist calls for social change. By starting from 'experiences', feminist pragmatism offers an inclusive, pluralistic approach to knowledge production and social change (Seigfried, 2015). In this way, feminist pragmatism can be viewed as a means to bridge diverse feminist theoretical perspectives that can be deployed as required (Seigfried, 1996; Thayer-Bacon, 2010; Fischer, 2014). Therefore, mirroring the pragmatist arguments of a 'bottom-up' approach to problem-solving, rather than a top-down approach that, applies a theoretical lens which then shapes the nature of inquiry and knowledge production (McHugh, 2015). Moreover, concerns regarding polarised feminist perspectives have been raised (Fischer, 2014; Seigfried, 2015). For example, Fischer (2014) proposes that the analogies of 'feminist waves' as singular trajectories have served to simplify complex nuanced diversities and constrained the feminist conversation by creating divisions; inter-generationally, political orientations, and between the goals of the feminist project. Both Rooney (1993) and Fischer (2014) caution against viewing either feminist philosophies or sociological theories as single doctrines but as a set of interacting/intersecting movements which is summed up by Tong (1989):

'Women's standpoint is not an ossified truth...it is a kaleidoscope of truths... (p.193)'

With this view, I chose not to explicate the particularities of the different feminist perspectives, as this study has been generated from a 'bottom-up' approach i.e. the problem associated with hegemonic birth practices that marginalise physiological birth and in particular women's alternative choices (discussed in Chapter 2). In essence, the research problem has been generated from issues that affect women's and midwives' agency and autonomy, an explicitly feminist issue that crosses the boundaries of a range of feminist theories. Therefore, my alignment to feminist pragmatists ontological and epistemological perspectives is situated in a broad understanding that gendered inequalities exist across the social spheres, which requires rectification through an explicitly gendered epistemological perspective in the pursuit of knowledge production and social change.

I consider a feminist pragmatist theoretical underpinning to be justified for this study as the research question poses a feminist inquiry - it relates to midwives', a female-dominated profession and women's birth choices. Women's bodies as a site for power, control and regulation has long been discussed (Davis-Floyd, 2001; Kitzinger, 2005; Fahy & Parratt, 2006), with feminists arguing that structural paternalism marginalises women's ways of knowing (Belenky, Tarule, Goldberger, & McVicker Clinchy, 1986), access to equitable services (Kitzinger, 2005; Russell, 2011; AIMS, 2016) and autonomous decision making (Birthrights, 2017; Birthrights, 2013; World Health Organisation, 2014; Schiller, 2016). As outlined in Chapter 2, the midwifery profession is arguably, also a site for power, control and regulation (Ball, Curtis, & Kirkham, 2003; Edwards, Murphy-Lawless, Kirkham, & Davies, 2011; NMC, 2017). Therefore, the application of a feminist pragmatist aims to generate solutions by investigating the midwives' experiences. Where the midwives are positioned as 'situated knowers', it is assumed they have the capacity to contribute to practical and theoretical knowledge generation or 'practice-based evidence'.

Theoretical perspective

The rejection of realist/relativistic ontological and epistemological perspectives means that feminist pragmatism does not align with divided theoretical perspectives such as positivism or constructivism¹⁸ (or any other) (Morgan, 2007). Such theoretical perspectives are considered alternative and opposing paradigms commonly applied to

¹⁸ Often used interchangeably with interpretivism and sometimes constructionism or subjectivism (Crotty, 1998) indicating shared definitions. However, there appears ongoing debate regarding the sameness or differences between them that is beyond the scope of this thesis to explore.

health and social sciences that mirrors realist and relativistic debates (Morgan, 2007). Positivism is broadly associated with generating objective knowledge from observable, testable facts and is generally aligned with a realist perspective (Crotty, 1998). Constructivism is broadly associated with generating subjective knowledge as to how individuals experience the world that is generally aligned with a relativistic perspective (Crotty, 1998). For feminist pragmatists, the rejection of such ontological and epistemological arguments does not mean the rejection of such perspectives as approaches to research (Morgan, 2007). Morgan (2007) asserts that these differing research traditions are contextually situated which generate diverse experiences and knowledge. Therefore, pragmatists would consider the approaches of both positivism and constructivism and deploy a theoretical perspective that best served to meet their aims (Morgan, 2007; Biesta, 2010). Pragmatism, whilst often associated with mixed methods research, proponents continue to advocate that methodological decisions are guided by the inquiry (Morgan, 2007; Biesta, 2010; Ostland, Kidd, Wengstrom, & Rowa-Dewar, 2011; Evans, Coon, & Ume, 2011). Feminist pragmatism concurs with this but also emphasises the focus of the research should relate to problems associated with issues of gender, and methodological approaches should mirror broad feminist principles when conducting research (Rooney, 1993; Seigfried, 1996; Fischer, 2014; McHugh, 2015). Accordingly, section 4.5 outlines and justifies the use of narrative inquiry in this research.

4.4 Specific theoretical lenses in this study

The previous section highlighted that feminist pragmatism extended the ontological and epistemological arguments of pragmatism to explicitly include issues of gender oppression. Many feminist pragmatists draw upon Dewey's pragmatism to apply his theories to their philosophical arguments (Radin, 1990; Rooney, 1993; Seigfried, 1996; Shuford, 2010; Thayer-Bacon, 2010; McHugh, 2015). As such, Dewey's theories of experience and inquiry are discussed in the following sub-sections.

Dewey's theory of experience

Dewey's (1925a) theory of experience considers experience as a philosophical concept, as '*a notation of the inexpressible (p.325)*'. This is likened to Kant's 'thing-in-itself', an idea that is necessary for a coherent theory of knowledge, but that is fundamentally unrepresentable (Clandinin & Rosiek, 2007). For Dewey, experience is a changing stream that is characterised by continuous interaction of human thought with our personal, social and physical environment (Dewey, 1925a). Dewey conceptualises this

as 'continuity', wherein experiences give rise to other experiences, that give rise to more experiences that influence further experiences, thus encompassing the past and the unseen future (Clandinin & Rosiek, 2007). Therefore, he views experience as ongoing and cumulative where experience requires the active participation of person to their environment. How a person engages with their environment ultimately determines the sense-making of their experiences. Therefore, Dewey (1925a) perceives experience as interactional - the *result* of an interaction between a person and aspects of the world (s)he lives in:

'in an experience, things and events belonging to the world, physical and social, are transformed by the human context they enter, while the live creature is changed and developed through intercourse with things previously external to it' (p.251).

As such, for Dewey, meaning can only be determined through their relationship to specific situations, history's, social conditions etc. Alexander (1987) describes Dewey's assertion as the idea that an organism (person) is *already* dynamically involved with the world in which it inhabits. As such, Dewey's pragmatism treats all experience as both historically and culturally located that is open to the changing nature of circumstances (Morgan, 2014). Therefore, to inquire into 'experience' is to inquire into the relations between the person and environment; life, community, culture, world (Clandinin & Rosiek, 2007). When applied to my study, by inquiring into the experiences of the midwives (who self-define as facilitative of alternative birth choices) the nature of their 'interactions' i.e. with the women, their colleagues, wider teams, Trusts, personal histories and cultural discourses can be explored. Through such an exploration, complex and nuanced intrapersonal, interpersonal and cultural insights can be illuminated that may generate complex and multi-faceted heuristic knowledge.

Dewey's concept of inquiry

For Dewey (1925a), experiences create meaning from bringing into contact two inseparable questions; What are the sources of our beliefs? And what are the meanings of our actions? As such, experiences are asserted to always involve interpretation (Morgan, 2014). Often, our experiences require little thought, which Dewey refers to as a 'habit' (Dewey, 1882). However, when self-conscious attention

(reflection) is brought to an experience, Dewey refers to this as ‘inquiry’¹⁹ (Dewey, 1910). As such, Dewey’s concept of inquiry can be applied to research endeavours, where Morgan (2014) asserts that inquiry is a specific kind of experience, and research is a specific form of inquiry. Additionally, Dewey argues that experiences always have an emotional, embodied element whereby feelings provide an essential link between action and beliefs (Dewey, 1925a; Dewey, 1931). Both James (1975) and Dewey (1929) acknowledge that the start of any inquiry usually begins with a sense of discord, unrest or a feeling of something not being right. Rooney, a feminist pragmatist, (1993) expands upon Dewey’s notion of ‘qualitative thought’ (feelings) to argue that feelings indicate the presence of a dominating quality in a situation, one that calls for action. Arguably, the acknowledgement of the role of feelings and emotions is a strength of Dewey’s (and James’) pragmatism exemplifying the mind-body connection, embodied knowledge, thus dissolving traditional dichotomies (Radin, 1990). When applied to my study, this inquiry began as a feeling and embodied knowing of the challenges in which women and midwives face in order to access/deliver care that is deemed alternative. Where I have positioned myself in Chapter 1 (section 1.5), it follows that my ‘discord’ has given rise to the line of inquiry within this thesis.

4.5 Methodology

The previous sections situated this study in a feminist pragmatist theoretical positioning. This section will justify the use of narrative inquiry. In addition, I will outline an overview of the different epistemological positions of the three main narrative methodologies, through which, I will demonstrate how this research has overcome incompatibilities within the approaches. Finally, I will demonstrate an alignment between feminist pragmatism and narrative inquiry that collectively forms the theoretical and methodological basis for the study.

Finding a path- beginning with the research problem

As previously stated, feminist pragmatism opts for a methodology that will answer the research question(s), a ‘bottom up’ approach. My aims and objectives (see Chapter 1/1.4), were the result of a number of iterations, where I explored different angles of the possible research questions. During several early reflective sessions, I recognised that my research questions related primarily to capturing *how* midwives

¹⁹ It was Dewey’s concept of inquiry that was felt to be a significant shift from the philosophers of his time- whereby, his move away from metaphysical concerns to a starting point of human experiences was thought to be a radical act (Morgan, 2007).

facilitated women's alternative choices. As stated in Chapter 1 (section 1.5), as a practicing midwife I knew (some) midwives working in the NHS were working this way. I also knew very little published literature had captured this. Therefore, from the outset, I was looking to capture midwives' processes of facilitation to generate practical knowledge that could be used as a learning tool for other midwives. In addition, I also felt that such data could not be separated from the midwives' experience of facilitation, nor could it be separated from the sociocultural-political context of the midwives working environments. Early on I recognised that qualitative approaches were suited to meet the aims of the research, where they have the capacity to provide rich and in-depth insights.

Prior to making a final decision on my methodological approach, two other options were considered. First, a mixed methods prospective observational cohort study to follow mother-midwife dyads throughout the childbirth continuum (from antenatal decision-making to post-birth). The study would generate qualitative insights from women and the midwives caring for them, and to record obstetric outcomes. The benefit of such a study was to capture both women's and midwives' 'real time' views of the processes and experiences and to assess the impact of such on birth outcome data. Viewing the mother-midwife within a relational dyad would generate rich holistic insights, generating specific knowledge to the mechanisms of relational care/receiving. However, the scale of such a study was far beyond a single researcher within a three-year time frame, thus excluded.

Second, as I became immersed in the literature I came to consider that the midwives' juxtaposition between women and their employing institution as particularly problematic. Moreover, given the dearth of literature from the perspectives of midwives, I felt that focusing upon the midwives' perspectives would be particularly beneficial. Therefore, I decided to limit the study to midwives only. I considered a mixed method methodology using survey and interview data. I felt that a national survey (with follow up interviews) would be beneficial to capture a 'snapshot' (Denscombe, 1998) of NHS midwives' views and experiences as well as rich, in-depth data. At this point, I had not refined the subgroup of midwives to gather data from and was considering recruiting midwives who had any experience of facilitating alternative births, not just those who willingly did so. However, limitations of survey designs such as the oversimplification of social reality (Pederson, 1992), questionable validity of knowledge claims (Pederson, 1992), and poor response rates (Kelley, Clark,

Brown, & Sitzia, 2003; Cook, Dickinson, & Eccles, 2009) meant that a survey was unlikely to yield the rich data pertaining to the research questions (Kelley et al., 2003). Therefore, a mixed methods research design with surveys was excluded.

Returning to the exploratory research questions with a greater understanding of other methodologies, the study foci was decided to only include qualitative data from the midwives' perspective. At this stage, my view of answering the research questions would entail eliciting in-depth responses from midwives by exploring a particular and specific episode of care where they facilitated a woman's alternative birthing choices. My thinking related to attempting to get as close to a real clinical situation as possible to generate rich data. I wanted to avoid generic questions of attitudes, beliefs that pertained to midwives' generalised perspectives as I felt this may limit the data generated. Therefore, the use of professional stories of practice was considered to meet the overall aim of the research, the initial research questions, and would be achievable to complete within a three-year period. As such, an exploration of methodologies related to collecting stories led me to consider a narrative inquiry methodology as a suitable research design.

Narrative inquiry overview

During the early conceptualisations of the empirical study, the decision to elicit professional stories of practice guided me to a narrative inquiry methodology. However, narrative as a method and narrative as a methodology are different points to consider. Whilst many qualitative research designs include data based upon stories of personal experiences, a narrative inquiry study has unique epistemological and methodological approaches that must be considered (Squire, Andrews, & Tamboukou, 2013; Loots, Coppens, & Sermijn, 2013; Patterson, 2013). Narrative as method relates to the collection of stories during qualitative data collection, whereby the researcher may be theoretically guided by other methodologies with their associated ontological and epistemological commitments (Dykes, 2004). However, narrative as a methodology, views narratives as knowledge devices (Squire, 2005; Fraser, 2004; Squire et al., 2013), that involve particular ontological and epistemological commitments. Broadly, narrative methodologies agree that human beings use storytelling as a way of understanding ourselves, our lives, and the worlds in which we inhabit (Plummer, 2001; Bruner, 2004; Clandinin & Rosiek, 2007; Squire et al., 2013). For some, narratives are seen an essential part of being human (Ricoeur,

1991; Bruner, 2004; Clandinin & Rosiek, 2007), a way of interpreting experiences to achieve making-sense of our lives (Ricoeur, 1991; Crossley, 2002; Bruner, 2004)

Narrative methodologies encompass a broad umbrella of definitions and understandings which can be contradictory and conflicting (Squire et al., 2013; Squire, 2013; Patterson, 2013; Loots et al., 2013)²⁰. Such differences are related to ontological and epistemological issues, discussed in the next section. Stories typically have a beginning, middle and end or a resolution (Bamberg, 2010). This view of stories can be traced back to Aristotle (Ricoeur, 1991; Bruner, 2004), and is often associated with archetypal stories such as the hero's tale or quest, tragedy, romantic etc. (Bruner, 2004). Broadly, stories or narratives suggest a constitutive temporality or sequencing, which is generally how stories and narratives are perceived (Squire, 2005). However, a number of narrative turns over the last century has resulted in contemporary narrative research that has moved beyond the typical story, to a more complex and diverse view of storying (Georgakopoulou, 2006; Squire, 2013; Loots et al., 2013). Such diversity relates to whether narrators are perceived as agentic beings, where their stories offer an internal representation of their experience and are broadly seen as 'fixed' (Ricoeur, 1991; Crossley, 2002; Squire, 2013). Whereas others perceive narrators and the act of narration as socially constructed where the stories are cultural representations rather than internal representations, therefore, not fixed (Sermijn, Devlieger, & Loots, 2008; Timboukou, 2010; Loots et al., 2013). Additionally, other researchers have challenged the notion that stories require sequencing, and have worked with fragmented, unfinished or partial utterings (Schneider, 2003; Georgakopoulou, 2006). Other researchers work visually, with photos, art, sculptures which they argue can be viewed narratively (Keats, 2009; Tamboukou, 2010; Jackson, Richter, & Caine, 2013; Mattern, Jeng, He, Lyon, & Brenner, 2015). Thus, challenging the notion of the classical story structure.

Accordingly, within narrative research methodologies a number of disagreements exist that include conflicting accounts of what a story actually is, or what constitutes a story, and whether or not story and narrative mean the same thing (Andrews, Day, Squire, & Treacher, 2000; Riessman, 2002; Clandinin & Rosiek, 2007; Sermijn et al., 2008; Squire, 2013). Often, story and narrative are used interchangeably but can

²⁰ There is some disagreement whether narratives and stories are the same thing (Squire, 2005; Hyvärinen, 2008; Bamberg, 2010) however, I personally use them interchangeably.

create confusion as many researchers deploy them differently (Andrews et al., 2000; Squire, 2005). Arguably, the creative and disruptive nature of the narrative turns has diversified the field to facilitate radical new ways of thinking and doing narrative. Conversely, the lack of shared understandings between researchers is arguably a messy and confusing endeavour (Squire, 2005), particularly for the novice narrative researcher (Daiute & Lightfoot, 2002). However, many researchers perceive stories and narratives as devices that illuminate human meaning-making and so, can be captured, understood and/or interpreted to generate knowledge (Bruner, 2004; Hyvärinen, 2008; Squire, 2013; Esin, Fathi, & Squire, 2013). Regardless of perspective, narratives are broadly perceived as a means to theoretically explore human experiences, with stories seen as rich sources of data (Riessman, 2002; Greenhalgh & Wengraf, 2008; Squire, 2013; Esin et al., 2013; Patterson, 2013; Loots et al., 2013; Jackson et al., 2013).

Reconciling conflicts within narrative epistemologies

The previous section outlined an overview of the conflicts within narrative methodologies²¹. Such conflicts are broadly associated with the differing epistemological positioning of different narrative methodologies²². There are three broad narrative approaches; event, experience, and culturally-centred. Key theoretical differences between the different narrative methodologies relate to assumptions of representation, identity, agency, subjectivity, language, and the social (Squire, 2013):

‘...relating stories to events, personal identities and cultural representations are theoretically different endeavours. Analysing clauses, searching out an intertextual hermeneutics and decoding cultural meanings are epistemologically distinct programmes.’ (Squire, 2013, p.16)

Event-centred narrative is a structural approach to examining stories that assumes a direct relationship between experience, cognition and representation (Labov, 1972;

²¹ My early reading and understanding of narrative inquiry was mostly influenced by Clandinin and Connelly (Connelly & Clandinin, 1990; Clandinin & Connelly, 2004; Clandinin, 2006; Clandinin & Rosiek, 2007; Connelly & Clandinin, 2006). Those early readings did not highlight the varied epistemological perspectives within narrative inquiry, for they have pioneered their own conceptualisations, methodology and methods. It was half way through my first year that I enrolled on a postgraduate course with the University of East London with Prof Corinne Squire, Prof Molly Andrews, and Dr Cigdem Esin that I learned of these complexities. By this point, I had my research questions and was committed to them. Through successful completion of the course, I learned how to navigate the epistemological differences.

²² There are also many different epistemological perspectives *within* the three broad categories, which is beyond the scope of this thesis to fully extrapolate.

Patterson, 2013). Labov (1972), a sociolinguist and pioneer of event-centred narrative approaches, developed a method that that recapitulates past experiences through a series of clauses within a temporal order. Event-centred narrative views stories as an objective and external expression of a person's past experiences, but unlike other approaches, it assumes that this expression remains relatively constant (Squire et al., 2013). Event-centred narrative is characterised by a micro-structuralist approach to analysing stories with particular attention to language itself, not just its content or meanings (Labov, 1972; Squire, 2005; Patterson, 2013). Labov's (1972) work was viewed as seminal, for his approach demonstrated the sophistication and subtlety of African American English, at a time when language was the object of fierce and political debate. However, the rigid framework of an event-narrative provides a narrow conceptualisation of what constitutes a story - one that is linear with clear boundaries of a beginning, middle and end (Patterson, 2013). This is viewed as problematic when considering complex narratives such as when the narrator jumps from past to future, back to the present again (Georgakopoulou, 2006), or in fragmented, unfinished stories (Schneider, 2003). Moreover, critics argue that the lack of attention to subjective meaning-making or sociocultural context is also problematic (Patterson, 2013; Squire, 2013).

Experience-centred narrative relates stories to personal identities and experience, that theoretically view narratives as internal representations of life experiences (Ricoeur, 1991; Riessman, 2002; Squire, 2013). Squire (2013) situates experience-centred approaches as a 'conceptual technology' rather than the methodological technology within the event-centred approach. An experience centred approach is largely based upon the work of Ricoeur (1991) and Bruner (2004). For Ricoeur (1991), a hermeneutist, he perceived lives to have a time-based relationship with narrative. This assumes the perspective that the sequential temporal orderings of human experience into narrative, is what makes us human (Bruner, 2004; Ricoeur, 1991). Therefore, experience-centred narrative is described as a time inflected phenomenology which places creating and maintaining meaning at the centre of human activity (Andrews et al., 2000; Squire, 2013). Experience-centred narrative has four key perspectives; narrative is perceived as sequentially ordered, often in relation to temporality (past, present, future) (Ricoeur, 1991; Bruner, 2004; Squire, 2013); is a means for sense-making (Bruner, 2004); involves the re-presenting and reconstituting of experience whilst attending to the context of the narrator and/or the narrative

itself (Ricoeur, 1991; Squire, 2013); and assumes that narratives represent personal (positive) transformations (Bruner, 2004; Squire, 2013). Within this approach, narrative is viewed from the lens of 'emplotment', where heterogeneous elements (events or incidents) come together to form a synthesised and coherent whole or plot (Ricoeur, 1991). Therefore, this narrative methodology is viewed within traditional notions of a story and employs hermeneutics as a theory and methodology for analysis (Ricoeur, 1991).

The benefits of an experience-based approach are the attendance to the meaning-making and constructions of human experience, offering unique insights to a range of human experiences (Squire, 2013). This is particularly useful in social science research, as it can offer unique insights into otherwise marginalised or invisible groups of people (Riessman, 2002; Squire, 2005). For some, the flexibility of the approach to explore nuances within a phenomenon is advantageous (Squire, 2013). However, for some researchers, the lack of specific methodological guidelines as to how to undertake the analysis can be a disadvantage (Squire, 2013). Additional difficulties highlighted with this approach relate to a tendency to make strong, prescriptive assumptions, and risk over interpretations (Squire, 2013). Furthermore, Squire (2013) argues that tendencies to only search for, or examine the 'good' story can occur - wherein transformations are assumed to be present and implied to be 'good'. Therefore, value judgements can be inferred within this approach (Andrews et al., 2000; Squire, 2013). Conceivably, some human experiences do not result in positive transformations, and some stories are partial or fragmented (Radley & Billig, 1996; Sermijn et al., 2008; Proudfoot, 2014), which this approach may not account for.

Another 'conceptual technology' (Squire, 2013) of narrative inquiry is the culturally-centred approach. Its approach inspired by a postmodern, poststructuralist and linguist turn, challenges the notion that narrative offers a window to the experiential world of a single subject (Loots et al., 2013; Sermijn et al., 2008). It broadly perceives traditional story characteristics as socio-cultural constructs (Sermijn et al., 2008), that may shift over time in relation to these constructs (Plummer, 2001; Tamboukou, 2015). So rather than a representation of life as in experience-centred narrative, here, narrative may be viewed as an event told in response to life (Tamboukou, 2010). It views narrative as not completely closed and as a performance within its micro-context e.g. what was said, how it was said and the audience observing the narration (Loots et al., 2013). Here, the role of the researcher is positioned within the study as

jointly participatory, co-constructing the narration (Loots et al., 2013; Riessman, 2002). In addition, culturally-centred approaches situate narrative within a macro-context of social, cultural, political and historical discourses (Loots et al., 2013; Plummer, 2001; Tamboukou, 2015). Notably, it holds the space for fragmented stories, disruptions and multiple ambiguities (Loots et al., 2013; Sermijn et al., 2008; Squire, 2013).

The benefits of a culturally-centred approach include that it is less prescriptive and less fixated upon temporality (Squire, 2013) whereby the perspective of human subjectivity is no longer subjected to a need for coherency and recognises the selfhood as having a multiplicity of selves/voices (Loots et al., 2013). Additionally, it provides an opportunity to explore the 'unsaid', which for some researchers is of keen interest (Craib, 2004; Todorova, 2007). It addresses the intersections of the social, cultural and political discourses upon the personal, thereby making valuable contributions of the 'self' in relation to the world in which we live (Plummer, 2001). For some, it politicises the narrative (Plummer, 1995; Plummer, 2001; Tamboukou, 2015) and may influence social change (Dodge, Ospina, & Foldy, 2005; Plummer, 2001). However, some argue that this approach risks over-interpretation, overgeneralisation, or the making of no explanatory claims (Squire, 2005), which may limit its practical applications. Once again, the lack of methodological guidelines for data analysis can be problematic for researchers (Squire, 2013).

Evidently, the three key approaches to narrative have fundamental epistemological differences between them. In my study, my multiple research questions could relate to all three narrative approaches; the intent to explore the event of 'what happened' (event-centred), their experiences of facilitation (experience-centred) *and* the socio-cultural-political interplay (culturally-centred) of the event as experienced by the midwife participants. Thus, suggesting a theoretical incompatibility. To that end, can a researcher reconcile the humanist perspective of the subject as singular, unified and an agentic storyteller and listener (Loots et al., 2013) with that of the poststructuralist perspective that narrative is '*always multiple, socially constructed and constructing, reinterpreted and reinterpretable*' (Squire et al., 2013)? Arguably, at a theoretical level these perspectives cannot be reconciled, but perhaps herewith lies an opportunity for creative approaches that work with these contradictions side by side, in which pragmatism may offer a way to circumvent these incompatibilities. Additionally, Clandinin and Rosiek (2007), narrative researchers, offer the notion of

epistemological 'borders' which acknowledges the aforementioned tensions but suggest that such borders can be crossed or merged.

Given the diversity within narrative methodology, largely the onus is upon the researcher to deploy definitions, perspectives and their own personal interpretation of salient features of the narrative inquiry they have carried out (Daiute & Lightfoot, 2002). Moreover, Squire et al., (2013) suggest that for many researchers such divisions are also heuristic rather than definitive. Therefore, decisions are made dependent upon both the nature of inquiry and the researcher's interests. Through a process of elimination, I recognised that the theoretical perspective of event-centred narrative and its micro-structuralist approach did not align with my narrative perspectives. I strongly felt that attention to personal meaning-making and context were important. However, I broadly perceive narrative as *both* a representation of life experiences *and* that of sociocultural, historical, political constructions and representations. I also situate narratives as embedded within socio-cultural structures of influence-both in relation to the micro performative aspects between the researcher and interviewee and in the macro; the social and political context of the participant's life. Where meaning-making is embedded within sociocultural and political contexts (micro and macro), where performative elements of narration are likely then I perceive narratives can be perceived as personal *and* cultural representations.

Returning to my feminist pragmatist theoretical framework, alongside Dewey's theories that posit that all experience already encompasses experience as 'interaction', I felt that Dewey's theories account for both experience and culturally-centred approaches. As my study is about the experience of facilitation, then inherently it includes all components of that experience; the what, when, how, why, experiences of, and sociocultural political influential factors. This view mirrors that of Clandinin and Rosiek (2007), who situate their narrative inquiry approach within Dewey's notions of experience, interaction, and inquiry. However, their methodological approach specifically examines experience within three particular aspects; temporality, spatially, and place (location) (Clandinin & Rosiek, 2007). Their framework was not the right 'fit' for my research questions. However, their insights regarding epistemological borderlands were applied to consider ways of navigating the complex terrain.

Pluralistic approaches

I view the experience and culturally-centred approaches to be useful conceptual devices to generate the rich, in-depth insights to answer my research questions. In addition, within a feminist pragmatist framework, it bypasses the epistemological disagreements of defined bordering of what is and isn't a narrative approach by including both as valid. Stanley (2017) suggested that the varied approaches within narrative methodologies encourage the production of different interpretations, that can be seen to generate different but equally valid knowledge. In addition, once the data is collected, approaches to how narrative is perceived, analysed, and knowledge is generated are generally analytical issues²³. Moreover, with further reading and support gained during the Narrative Research Postgraduate methods course, I recognised that my research questions aligned with pluralistic approaches.

Pluralistic approaches can relate to either the use of multiple methods, data sources, theories, or researchers (Willig, 2013; Clarke et al., 2015). In relation to the analysis, pluralism recognises that '*a data set can tell us about a number of different things, depending on the questions we ask of it*' (Willing, 2013, p.80). Analytical pluralism seeks to provide richer understandings of the phenomena and to avoid reductionism (Kincheloe, 2005; Willig, 2013). Willig (2013) suggests an analytical pluralistic approach involves asking a series of questions of the same data that generates different interpretative findings, which has aligned with my study aims. A feminist pragmatist positioning offers a theoretical basis for applying different analytical foci, as the focus is based upon the utility of analyses to meet the research questions. As such, both were utilised to generate pluralistic knowledge that relates to the three research questions. As will be discussed in Chapter 5, the epistemological differences were overcome by a sequential analytical approach. Moreover, pluralistic approaches have been used successfully in other qualitative studies (Honan, Knobel, Baker, & Davies, 2000; King et al., 2008; Lyons & Cromby, 2010; Robinson & Smith, 2010), and specifically in narrative studies (Burck, 2005; Frost, 2009; Frost et al., 2011; Savage, 2000; Simons, Lathlean, & Squire, 2008; Arduser, 2014).

²³ This is a generalised claim, some narrative methodologies have very specific methods such as life history researchers (Atkinson, 1998), those who use the biographical narrative interpretive method (Wengraf, 2004) or voice-centred relational method (Gilligan, Spence, Weinberg, & Bertsch, 2003).

Alignment between feminist pragmatism and narrative research

Despite the aforementioned differences within narrative inquiry, many researchers argue central to a narrative inquiry is the ongoing attention to relational ethics that is based on negotiation, respect, mutuality and openness to multiple voices (Clandinin, 2006; Squire et al., 2014). This correlates directly with feminist research principles (Thompson, 2003; Thayer-Bacon, 2010; Hesse-Biber, 2012; Gray, Agillias, Schubert, & Boddy, 2015), that supports my theoretical positioning and research aims. Similarly, reflexivity is a key concern within both narrative research (Squire et al., 2014) and feminist pragmatism (highlighted in section 4.3). Both suggest that researchers are active within the research process and that a commitment to constant self-awareness and reflections is required (Connelly & Clandinin, 2006; Clandinin & Rosiek, 2007; Squire et al., 2014; Stanley, 2017; Fraser & MacDougall, 2017). Additionally, narrative and feminist researchers place attention to the power dynamics within the researcher-participant relationships (Connelly & Clandinin, 1990; Riessman, 2002; Clandinin, 2007; Fraser & MacDougall, 2017; Stanley, 2017). Narrative researchers also consider ongoing ethical concerns such as the wider effects of participation in a research study by asking questions such as how might the research impinge on the lives of the researched, during the research, and the dissemination processes (Squire et al., 2014). Such concerns mirror feminist ethical research principles (DeAnne, Hilfinger, & DeJoseph, 2004; Fraser & MacDougall, 2017).

Recent feminist narrative research has sought to demonstrate an alignment between narrative methodologies and feminist approaches (DeAnne et al., 2004; Woodiwiss, 2017; Miller, 2017; Woodiwiss, Smith, & Lockwood, 2017; Fraser & MacDougall, 2017). Again, whilst multiple methodologies exist, feminist narrative researchers share a commitment to feminist politics, ethics, and research agendas (Woodiwiss et al., 2017). Broadly, their focus of investigation are issues of gender, with women's accounts central to their work (Stanley, 2017; Woodiwiss et al., 2017). Moreover, recent feminist narrative research has sought to resist polarised perspectives such as women as victims/heroines, rather positioning women as agentic whilst within sociocultural-political constraints (Stanley, 2017). This has been important to further the analytical project, which seeks not to simply 'give voice' to those marginalised, but to generate robust theoretical contributions to knowledge generation (Woodiwiss et al., 2017). The use of narrative methodologies, within a feminist positioning, offer

the opportunity to generate complex and nuanced practice, theoretical knowledge that will contribute to midwifery knowledge, practice, theory, and education.

Therefore, whilst feminism, pragmatism and narrative approaches encompass diverse, complex and at times conflicting perspectives, they do have shared commitments. All three perceive experiences as situational, contextual, relational and dynamic.

Collectively the knowledge generated within the paradigm of feminist pragmatism with a narrative methodological approach is intrinsically provisional, subjective, and subject to change. Thus, applied to this study, the intention is not to generate absolute 'truths', but to open up conversations of what midwifery practices are possible within the NHS in order to stimulate change on a wider level. Moreover, a feminist pragmatist narrative inquiry offers an opportunity to make visible the unseen midwifery practices - as Chapter 2 and 3 highlighted that the dearth of literature regarding such midwifery practices is a political concern. As such this study can contribute to feminist midwifery epistemological projects.

4.6 Conclusion

This chapter has situated the research problem within a theoretical framework of feminist-pragmatism. Such a framework meant starting with the research problem, a practice-based issue that affects birthing women's and midwives' lives, to develop solutions for improvement. This chapter identified that a feminist-pragmatist framework assumes a practical approach to problem solving and knowledge generation whilst accounting for gender, power, and structural contexts. Feminist pragmatism positions the midwives as situated knowers with the capacity to generate 'practice-based evidence'. In addition, I have demonstrated that the research questions lend themselves to a qualitative investigation. Through which, I have justified the use of narrative inquiry which assumes that stories are knowledge devices to generate rich and in-depth insights. Moreover, the multiple narrative methodologies, whilst challenging, do offer a pluralistic approach to knowledge generation that will provide complex and nuanced insights relating to three levels of inquiry; the midwives' processes, experiences, and sociocultural-political influences. The next chapter presents a detailed account of the methods used to conduct the study.

Chapter 5 Methods- Conducting a narrative inquiry

5.1 Introduction

The previous chapter positioned the theoretical framework of this study within a feminist-pragmatism framework. This framework explicitly assumes a practical approach to problem-solving whilst taking into account gender, power, and structural contexts which affect both an individuals' sense of experience and knowledge production. Moreover, the chapter offered a justification for the use of a pluralistic narrative inquiry research design to generate knowledge relating to processes, experiences, and sociocultural-political influences that underpin the narrative accounts of midwives. In this chapter, I provide a detailed account of the methods used to conduct this study. It includes insights into how I deployed a pluralist narrative analytical approach congruent with my feminist pragmatist theoretical framework. Issues of ethics, reflexivity, and trustworthiness are also discussed.

5.2 Participants, sample, recruitment

Purposive and snowballing sampling methods were used for recruitment. Such methods were appropriate to collect data from specific participants with knowledge and experience related to the research questions (Coyne, 1997). The plan was to include registered midwives in the UK who facilitated women's alternative birth choices as part of their regular practice, and to exclude students, under 'supervised²⁴' practice, or those working independently, in a social or private enterprise. In reality, it was not always clear whether the participants met the inclusion/exclusion criteria. For example, in the case of one participant, it became clear that she did not have extensive experience of facilitating alternative birth choices until partway through the interview. The decision was made to use her data as it offered valuable contrasting (and potentially disconfirming data). Another participant met the inclusion criteria, but the clinical situation she narrated related to her final year of student midwifery. However, as she was a newly qualified midwife at the time of the interview, I felt she would also add a unique perspective as few newly qualified midwives answered the recruitment call. Two other participants had current employment within universities

²⁴ Supervised practice was a formal process with academic and practice learning outcomes that seeks to assist a midwife to improve her knowledge and skills so she can demonstrate that she is competent in practice and may be assessed as fit to remain on the NMC Register. This was usually overseen by a 'Supervisor of Midwives' and usually related to a concern about the midwife's practice. However, changes to midwifery statute in Spring 2017 means that this process has now changed.

but had extensive and recent NHS experience related to facilitating women's alternative birthing choices. Their NHS experience took place less than two years prior to the interview, so their data were also retained. Such decisions were made in consultation with my supervisory team to ensure the integrity of the data collection.

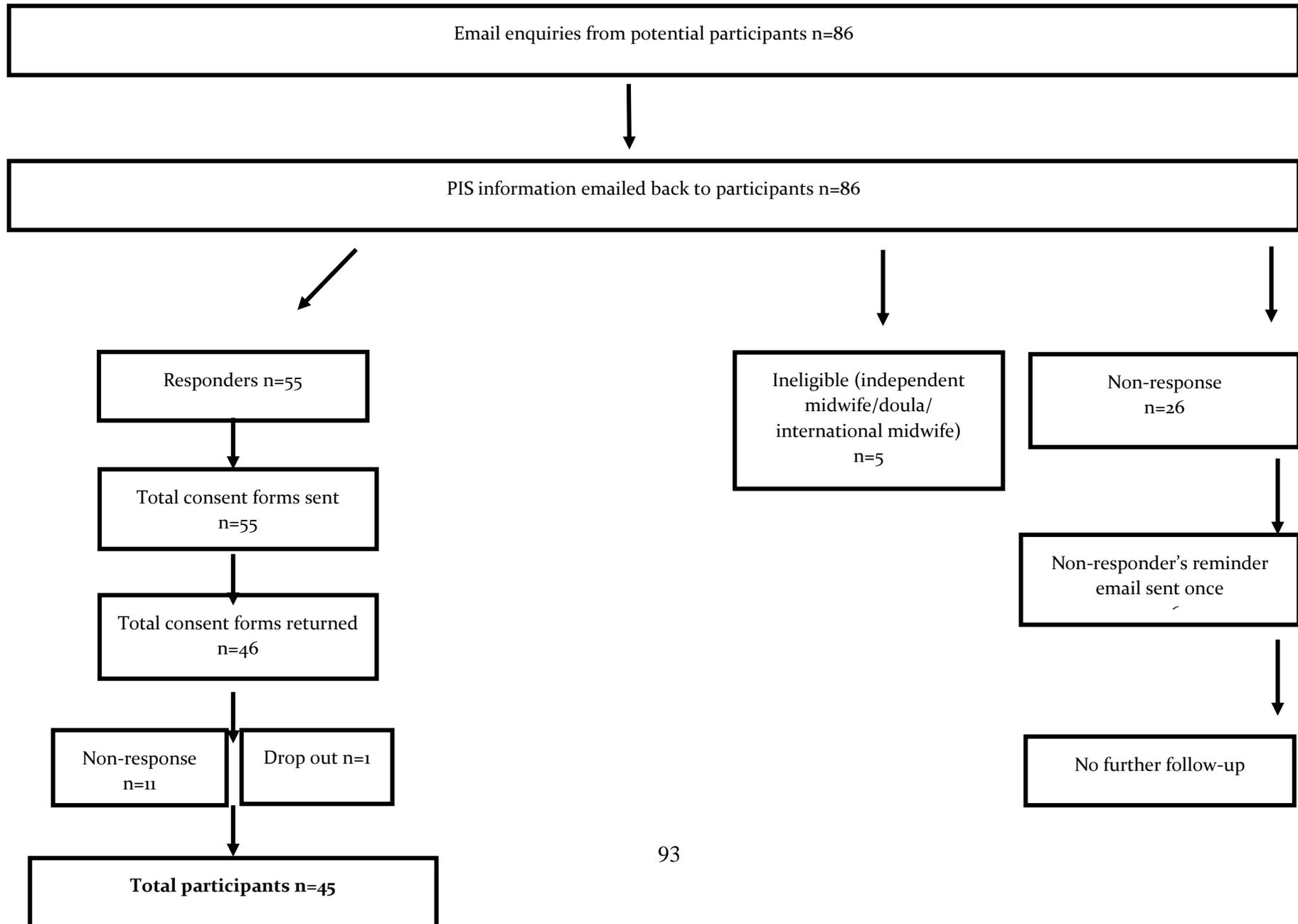
The aim was also to recruit midwives from a range of practice settings (community/birth centres/hospital), and different employment bands (between levels 5-8) to capture a range of experience or seniority or speciality. There were plans for further purposive sampling should there have been a lack of variety within the sample (in the event, this was not needed). I aimed to recruit 20-30 midwives into the study, to ensure that the planned range of participant characteristics could be included (Mason, 2010).

Recruitment was launched in January 2017 via social media, midwifery networks, and professional networks (see Appendix 3.1 for the recruitment plan, Appendix 3.2 for advertisements). The response rate was unexpectedly high. The very high response rate was considered due to several big publicised changes within midwifery at the time of recruitment. The Department of Health had confirmed changes to the statute to remove midwifery supervision and to remove the midwifery committee component of the Nursing and Midwifery Council (NMC, 2017b). In addition, independent midwives had been stopped from their practice by the NMC due to inadequacies with their indemnity provision (NMC, 2017a; Schiller, 2017; NMC, 2017b). These issues resulted in several online campaigns such as #savethemidwife and generated big debates and discussion across the profession as well as publically. Such was the profile of midwifery at the time of recruitment, with many concerned that women midwives' rights were being further eroded, I consider the success of the recruitment in this context.

Between 17th January and 25th January, I received 77 email enquiries which rose to 85 enquiries by 1st February. One additional participant was recruited following the study being advertised in the Association of Radical Midwives Spring quarterly. In total, of 86 enquiries, 55 consent forms were sent, 46 were returned, and 45 midwives participated in the study. See Figure 6 for the total participant response, non-responders, drop out, and final recruitment numbers. A minority of enquiries related to midwives who were not eligible, such as independent midwives, birth workers (doulas, antenatal teachers etc.), or international midwives. For those that appeared

eligible, an initial email response (see Appendix 3.3) was sent along with copies of the participant information sheet (see Appendix 3.4), demographic questionnaire (see Appendix 3.5), and consent forms (see Appendix 3.6) so that they could make an informed decision as to participation or not.

Figure 6 Recruitment process



The numbers of participants far exceeded anticipation. Rather than adhere to the planned number of participants I made the decision to include all willing participants for several reasons; in context of the political landscape of midwifery at the time of recruitment, previously mentioned (p.91), I felt it was an opportune time to capture as many willing participants' experiences as possible. Additionally, during the early email contact, many respondents highlighted a range of clinical situations where they facilitated women's alternative birth choices, with greater diversity than I expected. Therefore, I felt it was opportune to capture the scope of alternative physiological births that had been facilitated within the NHS. Moreover, once I realised the wide heterogeneity of the sample (see Chapter 6), I felt it important to capture the experiences of a diverse sample. Within this context, I did not feel that 'over' data saturation (Mason, 2010) would be problematic.

Participants were given two options of participation; to write a self-written narrative regarding a specific clinical situation as well as a follow-up interview, or to have an interview only (discussed further in section 5.3). Those willing to take part were asked to respond with their preferred mode of participation and to provide a postal address. They were sent hard copies of the consent and demographics forms with an SAE for return. Once a consent form had been returned, the participant was re-contacted. For those who chose to provide a written narrative, a safe emailing guide (see Appendix 3.7) was forwarded to ensure the safety of their data alongside a prompt sheet to guide their writing (discussed in section 5.3). Due to the large volume of participants, they were requested to return the self-written narrative within 4 weeks. For those who chose to participate in the interview only, arrangements were made for a telephone interview at a date/time that was convenient to them.

Positionality & reflexivity

Notions of positionality are used alongside reflexivity for researchers to consider and account for the impact of pre-existing personal values and beliefs (England, 1994; Berger, 2015) and to offer transparency to the co-constructed nature of data collection within narrative research (Bignold & Su, 2013; Carter, Lapum, Lavallée, & Martin, 2014). Berger (2015) suggested that a researcher's positioning includes; gender, race, class, age, personal experiences, theoretical and political stances, and emotional responses to the participants. Berger (2015) also argues that those attributes affect the research process in three ways; access to the 'field', shaping the researcher-participant relationship and shaping the data collection, analysis and conclusions of the research.

Therefore, reporting of positionality and reflexivity is important to trustworthy qualitative research (Horsburgh, 2003). In my study, I highlighted in Chapter 1 (section 1.5) my positioning in relation to the research topic and drew upon my personal, professional and research experiences that situated my *a priori* midwifery philosophy as a starting point for reflexivity that was maintained throughout the study (discussed in the next section). My *a priori* positioning affected my access to the field. As a midwife researching midwives I knew the midwifery conventions and 'language' to use during the recruitment phase, as well as where to recruit midwives. How I framed the study inferred my positioning to the study, namely that I was in support of midwifery practices that facilitated women's choices. According to Berger (2015) and De Tona (2010), perceptions of researcher sympathy to the topic can positively benefit the number of potential participants interested in the study, and their willingness to share their stories. This mirrored my experiences in this study and was of benefit to recruitment.

In line with a reflexive stance, an awareness of the limitations of my positioning was also required. I considered that I may confer too much agreement within interviews, thus reducing the opportunity to examine issues critically. This was addressed through prior and ongoing supervisory discussions whereby I was provided with appropriate critiques of my interview techniques. I adjusted my interview style to include more open examining questions where it was appropriate to do so. Unexpectedly, there were occasions that challenged my personal midwifery philosophy. For example, one a participant held views that contrasted to mine on what woman-centredness meant., I found this to be challenging, as I found it hard not to challenge their taken-for-granted statements. The reflective work I had carried out prior to data collection meant I was able to identify such responses in 'real-time', as they happened to me. Highlighting this is an extract from my field notes following such an interview:

'At first I could feel my biases being pushed as the language X (anonymised) was using and framing her practice was a very different perspective. More so in how it was conveyed, that at first insinuated women being steered into hospital. But as we went along, I could 'see' my bias in my inner reactions, which definitely affected the questions /interactions at first. I was aware that I was mental preparing debates and challenges to what she was saying. Once aware though, I started to listen to what she was saying and how she was saying and was able to facilitate a hugely informative interview that

provided rich nuanced data that was led by her and not me- and not me trying to steer her line of narrative (which is indeed ironic, given the subject). (13th March 2017)

Notions of positionality also relate to a researcher-participant relationship that requires awareness and reflection throughout the research process (Fine, 1994; Denzin, 1997). Such considerations can relate to potential power dynamics (England, 1994). All research comes with responsibilities and a level of power differentials related to the methods of data collection, analysis, and write up i.e. who to include, what quotes to use that relate to issues of why or why not? Or issues of using quotes that the participants may not like, or generating an interpretation in which participants may not agree with (Squire et al., 2014). Such power differentials are a risk in any research project, however, in my study, I felt these were mitigated by my position as a midwife researching on and with colleagues in relation to a shared topic of interest. So whilst I did consider the power issues in relation to the analysis and write-up, I felt that the researcher-participant relationship was relatively equal. This also related to how I conducted the data collection, where during the interviews (where appropriate) I shared my experiences. As such, I was not a passive observer within the research process but an active participant engaged in creating co-constructed knowledge.

An interesting facet of positionality in this study was that I knew several of the participants – this had not been expected or planned. As mentioned previously, I had recruited midwives via professional networks, social media etc. which included contacting my previous work colleagues to disseminate the adverts. Overall I knew seven of the participants, three I had previously worked closely with, three I knew but had no prior working relationship, and one I knew in a research capacity. Whilst I did not feel this was problematic in terms of data collection, I was mindful that I would need to try and suspend my previous knowledge as much as was realistic. It was interesting to notice that both I and they were careful not to make assumptions about our working knowledge of each other. For example, the interviews did not hold a sense of familiarity until the end, where we moved on to have a ‘chat’, there was a sense of being ‘professional’ in the research context that appeared to operate simultaneously for them and for me.

I maintained reflexivity throughout the research process. Building upon my narrative beginnings highlighted in Chapter 1 (section 1.5), reflexive journaling (Fraser, 2004;

Ortlipp, 2008) was carried out throughout the study by recording thoughts, issues, in a word document that ended up being over 280 pages long. Excerpts from my journal are presented in Appendix 3.9. My reflexivity has taken many forms, from simple observations, quotes from interesting books/articles, to extensive emotional journaling or thoughts as I grappled with philosophical concerns. It also included documenting mind maps and crude (bad) drawings that I had created when making sense of parts of the data analysis. These I photographed and inserted into the word document to keep all my thinking-working-writing together and as a method of keeping an audit trail. Journaling was also a welcome place to work through my anger that related to my feelings of injustice within maternity care.

The ongoing use of a reflective journal has been instrumental in documenting my thoughts, feelings to identify areas of bias and emotional responses during the study. Moreover, it has been a site for expressing early impressions about the nature of the study itself. Additionally, reflexive journaling creating space for contemplation which in turn enabled me to generate insights that have strengthened my study. On a number of occasions, I shared extracts from my journal with my supervisors to provide a platform for discussion, e.g. to work through an area of challenge or to support my thinking process. Conversing about my journal helped to broaden my view on particular aspects of the study, refine my thinking and where appropriate, reject a line of inquiry. As such, journaling has been instrumental in enhancing the trustworthiness of this study that is also linked to Dewey's (1938) notion of knowing/doing, that knowing comes from doing, and the doing changes the knowing.

5.3 Data collection

Participants were asked to complete demographic data that included information regarding gender, age, ethnicity, location, highest educational level attained, number of years qualified as a midwife, current employment status including department and their midwifery band. Out of 45 participants, n=2 provided a self-written narrative only, n=21 provided a self-written narrative and had a follow-up interview, n=22 had an interview only (total n=65 pieces of data). The following section describes both methods of data collection.

Self-written narratives: justification

Longitudinal completion of diaries is a standard data collection method in research (Braun, Clarke, & Gray, 2017). However, one-off self-written narrative is less common

(Handy & Ross, 2005). Narrative inquiry researchers do mention written story/narrative elicitation as an appropriate means of data collection (Polkinghorne, 2005; Squire, 2005; Savin-Baden & Niekerk, 2007; Squire, Andrews, & Tamboukou, 2013), but only a few studies appear to have used this technique (Nygren & Blom, 2001; Beck, 2004; Handy & Ross, 2005; Rawlings, Brown, Stone, & Reuber, 2017). Those that have done so, do not appear to have combined it with other data collection methods as in my study. My previous success with combining these methods (Feeley & Thomson, 2016b; Feeley & Thomson, 2016a) influenced my decision to offer the potential to provide written accounts in the current study for several reasons. The first was to find out whether this was an acceptable means of data collection to a different group of participants. Second, to use the written accounts to inform the interviews. Third, as a way of 'getting to know' the participants and experiences as told by them, unmediated by the interpersonal interactions of an interview.

Handy & Ross (2005) found that purposeful writing (termed self-written narrative in this study) was a useful method when researching families in which one member had an eating disorder. By using a purposeful writing method, they overcame participants concerns that the researchers would accidentally reveal their private reflections to other members of their family. However, the authors acknowledge that the technique was not suitable for all research questions and that it required good levels of literacy and willingness from the participants to engage with the method. The participants in my study were assumed to have good literacy level as that is a basic requirement of the midwifery profession. As such, the concerns of Hardy and Ross (2005) were unlikely to apply.

Self-written narrative: method

Participants who opted to write their accounts were provided with a written prompt sheet. This comprised of a broad prompt asking the participants to write about a particular experience that related to the research question (see Figure 7). The participants were encouraged to type their experience and send via an encrypted email as opposed to handwriting and returning it via post. Once the narrative was received, I read the participant's story to familiarise myself with it, then printed it off, making notes, reflections, early analytical interpretations and areas I felt needed to be followed up during the interview (discussed further in the next section and at depth in section 5.4).

Figure 7 Self-written narrative prompt for participants

Guide for participants: Written narrative

For this aspect of the study, I would like you to write an account of a particular time where you facilitated a woman's unconventional birth choice, this could include the situation, what actions you took, your thoughts and feelings about the situation and what the outcome was. It might include your reasons for providing the care, professional interests or philosophy that guides the care that you give. It might include your reflections about that experience-how you feel about it now. It may be as short or as long as you want.

The self-written narrative method generated 23 diverse accounts that ranged from ½ - 7 typed pages of text (368-3411 words) and was presented in a variety of ways. For example, one participant used a proforma from the Nursing and Midwifery Council that is used for reflective practice. Another participant's account began with bullet points that related to the woman's obstetric history, which mirrors documentation convention in midwifery clinical practice before she moved on to providing a discursive account. One participant wrote and forwarded an account without waiting for the consenting procedure (Chapter 5/5.3), but did so afterwards. Another participant provided a detailed account of the particular woman's pregnancy including the antenatal appointments as significant time points. In this, she reported her perspective of the woman's fears and what actions she took to support her, including her professional rationale for each clinical decision. Another participant provided an extensive account in which she clearly identified her motivation for joining the study, and perhaps for writing the account:

'I chose to share this story as an antidote to anger and resentment. I became a midwife because I wanted to protect and enhance women's health and their rights. It feels more and more that I am ensnared in a mad conspiracy which licenses obstetric butchery'
(Beatrice).

More broadly, the participants shared rich and detailed insights regarding the woman's situation they were involved in, their actions, and the outcomes. One included her experience with a poor neonatal outcome. The account was written

factually, devoid of emotion until the last paragraph which I later realised mirrored her experiences of being investigated. Most of the participant accounts included some description about how they viewed their midwifery practice, how they positioned themselves to the broad issue of 'alternative physiological birth' and often wrote of their midwifery philosophy. However, it was noticed that many of the written accounts did not convey the midwives' feelings (with a few notable exceptions).

Interviews: setting

Forty-three participants opted for an interview. Most were conducted on the telephone due to geographic distances. One was face to face as the participant worked locally to me. There are debates over the quality of data collected via different methods i.e. face to face interviews, telephone and now the use of the internet (Burke & Miller, 2001; Opdenakker, 2006). Some researchers would argue that face to face interviews allow the researcher to develop a better rapport and pick up on social cues (Opdenakker, 2006). Conversely, telephone interviews are viewed as a means to enhance inclusivity to the study by broadening the geographical area of the participants (Burke & Miller, 2001). For some participants in the current study, this was a particular advantage as they were able to fit the interview within their working day. One participant provided her interview while stuck in a traffic jam; she reported that it was a particularly enjoyable experience.

Interviews: methods

A narrative interview style was adopted which entailed asking a broad open question to elicit a storytelling response by the participant (Rapley, 2004; Elliot, 2005; Riessman, 2008; Anderson & Kirkpatrick, 2016). The aim was for the interview to not have a fixed agenda, and to create the space for the interviewee to control the direction, content, and pace (Riessman, 2008). Beyond the initial introductions and checking whether the participants had any questions, for participants who opted for an interview only, the opening question was:

'can you tell me about a time when you have facilitated a woman's choices outside of the guidelines or where she declined care?'

The contents of the self-written narratives generated the initial opening question for the follow-up interviews. In these cases, the opening question was along the lines of:

'Thank you for providing such a rich account, I see that you were involved with X (situation), can you tell me more about how you felt during that experience, or what it was like for you looking after the woman?'

Such opening questions were designed to elicit storytelling from the participant, where I avoided interrupting the participants with questions or seeking clarity, but I did use prompts such as *'then what happened'* or affirmative verbal responses such as *'uh-huh'* or *'mmm'* to encourage the participant to continue talking (Rapley, 2004; Elliot, 2005). Such affirmative responses were particularly important in the telephone interviews as I could not rely on non-verbal gestures such as nodding, facial expressions or body language.

During the participants' initial opening story, I made notes of any questions or points of follow-up I wanted to explore. Once it appeared that the participant had finished their particular story, which was normally when they relayed the outcome for the woman in the narrative, I would then take the opportunity to ask follow-up questions. The follow up questions related to seeking clarity, or going back to a part in the story and asking them to expand certain aspects of the story such as *'earlier you mentioned X, can you tell me about that'* or *'what did you mean by Y'*. Similar techniques were used for participants who opted for an interview only.

The interview then adopted a 'conversational' style (Riessman, 2008). This is a dialogical co-constructive approach which is used in both narrative and feminist methodologies (Clandinin, 2006; Hesse-Biber, 2012; Squire et al., 2014; Gray, Agillias, Schubert, & Boddy, 2015). Such an approach differs from an interrogative or passive style of interviewing. It mirrors a two-way conversation but one that is focused on a particular topic (Riessman, 2008). The participants and I co-constructed the discussion throughout the rest of the interview which generated new insights and lines of discussion. At times, using an active listening technique, where I would repeat back what the participant said, which stimulated a further response. Where appropriate, I offered my own insights i.e. *'did you mean X?'* or *'it sounds like you're saying Y'*. I was, therefore, an active agent within the interview (Riessman, 2008), although I was also mindful not to take over and talk over the participant. All interviews were digitally recorded.

For participants who opted for an interview (n=43), there was no real difference between the lengths of the interviews for those who wrote an account (25 to 92

minutes) and those who had a stand-alone interview (23 to 98 minutes). The open nature of the interview meant that the participants covered a wide range of topics, including the exploration of the participant's sense of identity, their personal experiences of birth, pivotal moments in their career, difficult relationships within their current workplace, personal illness or difficulties, and broader notions of birth, feminism or institutionalism. Mostly these directly related to the intrapersonal, interpersonal contexts of the participant's lives, which situated their original story within a broader context of their life experiences and perspectives. Therefore, I generally did not try to contain these other stories, as they appeared to be meaningfully relevant to their accounts of facilitating alternative births. Differences between the interviews were noted i.e. midwives who experienced negativity by their colleagues and/or reported conflicts in the workplace, their accounts were noted to be emotionally charged, angry, distressed and often lengthy. Conversely, where midwives worked within supportive contexts, these interviews were generally shorter, less emotive, and often produced 'matter of fact' accounts. I noticed I had to facilitate the interviews with directive questioning, which appeared to reveal that their practice was so 'normal', that it was difficult to articulate - a sense of 'that's just the way it is'.

Interviews: minor issues

Some issues related to interviewing occurred. For example, poor mobile signal affected the quality of some interviews. This was resolved by phoning the participant on their landline. Another issue related to a situation where a participant had opted to speak during her workday, but I was unaware she was in a shared office. Whilst her interview provided rich extensive data as she was exceptionally experienced in facilitating women's alternative birthing choices, she did send me a follow-up email. Within this email, she reported that she was not able to be completely frank about her experiences of practising this way. She reported that she was incredibly lonely, with little support or back up from her colleagues. She reported that she was largely left to 'get on with it' which came at a great cost. I responded with a supportive message. Some interviews flowed better than others and those that were challenging were reflected on and discussed with my supervision team. On one occasion, a participant had appeared reticent to answer questions and was guarded throughout. While she continued a 60-minute interview in this manner, at the end she revealed that she had significant concerns about confidentiality as she had a previous bad

experience with a journalist. Once I reiterated the procedures in place to preserve anonymity, she reported feeling relieved and wished she had mentioned it earlier.

'Field' notes

Field notes are a means of collecting contextual information during data collection (Creswell, 2012; Phillippi & Lauderdale, 2018). Whilst they have been historically associated with ethnographic research, there is an increased interest in field notes across the qualitative discipline (Phillippi & Lauderdale, 2018). Phillippi & Lauderdale (2018) identified several key functions of field notes; a prompt for the researcher to observe the environment and interactions of the data collection setting, document physical and environmental context of the data collection, as a reflexive tool, facilitate early analytical interpretations or lines of enquiry, provide essential context to inform data analysis. Whilst the interviews were primarily undertaken on the telephone I still took 'field notes'. I made notes throughout the interview, to capture areas to follow-up or pertinent messages that were striking. In addition, immediately after the interview, I wrote about the experience of the interview, my personal reflections/insights about the content as well as my personal feelings about the conduct of the interview. I referred back to these notes during data immersion and analysis, where they were useful prompts to interrogate my emerging analytical thoughts in relation to what I had noticed at the time of interview. In some cases, my original insights made a valuable contribution to the analysis and in others, it was discarded.

Transcription

I uploaded and transcribed all interviews in MAXQDA (2015), a qualitative data management software tool. Transcription is an integral part of the data analysis process and can be described as a translation process from the recordings into text (Davidson, 2009). However, some researchers caution against an uncritical acceptance of the validity of a transcript to fully convey the interview (Ochs, 1979; Mishler, 1991; Poland, 2002; Davidson, 2009). They argue that transcription cannot be a taken for granted process within qualitative research since it is not merely a technical task, but is one shaped by theoretical commitments or research positioning, (Ochs, 1979; Mishler, 1991; Poland, 2002; Davidson, 2009). Such a critique were deemed important for this study, as some researchers argue transcription decisions will impact the subsequent analysis and interpretation of the data (Mishler, 1991; Poland, 2002; Riessman, 2008; Davidson, 2009). In addition, the differences between

the spoken word and the translation to text can be problematic, as conversational speech is often fragmented with pauses, hesitations, stutters or digressions (Frisch, 1990; Poland, 2002). Some researchers, 'clean' up the speech, removing the fragmentations (Frisch, 1990; Mishler, 1991; Poland, 2002). Participants who have been invited to check their interview transcripts or partake in member-checking may find that reading the text can create a sense of unwelcome incoherence and/or inarticulation (Davidson, 2009). Frisch (1990) conceptualised transcription as a representative translation and not a literal reproduction. Therefore, the transcribing process involves judgements and decisions that require transparency i.e. the level of detail to transcribe, whether to transcribe *ad verbatim* as opposed to correcting grammar and speech, and whether to represent the non-verbal data (Davidson, 2009). Such selective decisions are necessary for all researchers (Mishler, 1991; Frisch, 1990; Poland, 2002).

I transcribed all of the interviews. Prior to which, I created a transcription convention sheet (see Appendix 3.10), to strike a balance between retaining important details but not so much information that the text would be difficult to follow. I included non-verbal utterances such as sighing, giggling, laughing, and I indicated where participants emphasised words or spoke louder (Fraser & MacDougall, 2017). By retaining such detail, I was able to remember and convey the meanings of their spoken words when I read the transcripts. I also chose to include pauses which were indicated as (.) for one second, (..) for two seconds etc. I felt that capturing pauses was important as to represent the reality of the interview, as cleaning up the pauses would suggest that the interview flowed 'perfectly' throughout. Moreover, for some participants, it was the pauses that strongly indicated emotional difficulty - such context would have been lost had these not been included. On a few occasions, respondents asked for certain aspects of their interviews to be removed in the transcript, due to concerns about being identified, especially where they had voiced criticisms of their organisation. The text was duly redacted.

5.4 Data analysis

During my postgraduate narrative methodology course at the University of East London (highlighted on p.82), I developed a formative analytical framework with guidance from the course leaders, prior to data collection. However, the framework was extensively revised once the data were collected, which reflected my increased understanding of narrative methodologies and greater clarity of the research

questions. The following sections provide a synopsis of the analytical methods used, - this represented a sequential pluralistic approach to data analysis (discussed in Chapter 4 /4.5) where one analysis was completed before carrying out the next (Simons, Lathlean, & Squire, 2008). However, whilst this reads like a linear process, the reality meant that as I worked with the data for one level of analysis, insights related to the others emerged. Therefore, whilst the final analytical processes were carried out sequentially, the early data immersion activities and initial stages of analysis reflect the 'messiness' and iterative nature of qualitative research (Mellor, 2001; Hunter, 2010). However, continuing through the 'mess', working with the different lenses of the research questions and experimenting with a range of narrative analytical methods all contributed to Dewey's (1938) concept of knowing/doing i.e. knowing comes from the doing, and the doing changes the knowing.

Data immersion

Formal analysis commenced after all data had been collected, primarily because I wanted to get a sense of the whole dataset (Harding & Whitehead, 2013). This approach differs from other methodologies such as grounded theory where one interview informs the other (Harding & Whitehead, 2013). As I had recruited a heterogeneous sample and aimed to include as many practice stories related to alternative physiological birth as possible, I approached each narrative like an individual 'case study' where one participant's data or my line of enquiry was not dependent upon another. In addition, as this study had not been carried out before, it was exploratory. Therefore, my initial approach was to 'cast the net wide' to see what data was produced. This was made possible as I had recruited midwives early on in the PhD process. Had time been limited, waiting to analyse until all data were collected may have been problematic. Moreover, in reality, the time-consuming nature of the administrative tasks related to liaising with a large number of participants with two methods of data collection, and the time required to personally transcribe the interviews meant that the formal analysis would have been delayed until the end of data collection anyway.

However, a degree of engagement with the data took place throughout the data collection, some of which were discussed in section 5.3. The following data immersion activities have been integral to this study and my development as a researcher. Without an 'off-the-shelf' narrative method (highlighted in Chapter 4) to readily use, these activities were essential to learning how to work with the data. The following

lists the activities carried out that reflect different attempts of working with the data, before settling on the analytical methods:

1. Self-written narratives were read line by line with early impressions and interpretations noted. Questions for the follow-up interview were documented.
2. Following the interview, reflections, initial thoughts and impressions were documented in my reflexive journal?
3. Working with the written and interview transcripts in Word, I read each one line by line, highlighting early impressions such as significant statements or particular aspects of the story that stood out. I would also ask questions about the data, seeking alternative interpretations. Using the track change function, I made notes about these early impressions in the documents.
4. The track-changed transcripts were forwarded to my supervision team for feedback on my early thoughts, impressions or interpretations. These formed the basis of several discussions where we examined the data in light of our different perspectives. This process was particularly beneficial to interrogate the data within a wider lens and to seek alternative perspectives.
5. Informed by Hollway & Jefferson (2000), pen portraits were developed for each participant to keep sight of the individual within the whole data set and to provide memory cues when undertaking data analysis. The portraits involved tabulating the participants' main clinical situation alongside key contextual information about their working context, personal contexts and significant elements of the story. As these data were potentially identifiable they were only used to support the data analysis and were not included in the thesis to protect the participants.
6. Data relating to clinical episodes were extracted and tabulated for two reasons; to increase my familiarity with the data and to generate information on the types of alternative physiological births (presented in the next chapter).
7. Once data collection was completed, the entire dataset was read line by line, deductive, inductive and 'in-vivo' codes were applied in MAXQDA.

Managing large volumes of data

To manage the large volumes of data which included hundreds of clinical encounters across the participant accounts, and to retain focus on the research questions, I had

to decide how to work with the data for each analysis. Drawing upon narrative conceptualisations of 'big' and 'small' stories, informed what to include in each analysis. Big stories generally relate to the highly structured narratives of past events (Bamberg & Georgakopoulou, 2008), which in my study related to the participant's first story written or told. As previously discussed (5.3), the self-written narrative and stand-alone interviews started with an open-ended narrative research question, eliciting an in-depth initial story- their 'big' story. These tended to provide the most detail regarding the clinical situation in relation to the woman's history, the clinical event, what happened and the midwives' processes of facilitation. Therefore, the participant's big story generated the most insights related to the first research question, so I made the decision to only include the big story data in the first analysis. 'Small' stories relate to the everyday interactional stories people tell in conversational encounters or within data sets that may be fragmented, unfinished, partial, side or short stories (Bamberg & Georgakopoulou, 2008). In my study, numerous small stories were generated during the latter part of the interview due to the dialogical, conversational interview approach that covered a wide range of topics (see 5.3). These smaller stories offered contextual insights that were meaningful to the participants. Therefore, to answer research questions two and three, both the participants big and smaller stories were considered during the subsequent analyses.

Data analysis 1- Research question 1

To answer the first research question of what, how, and why- the midwives' processes of facilitating women's alternative birthing choices, a narrative thematic analysis was used. Whilst a number of narrative researchers have used narrative thematic analysis (Riessman, 2008; Simons et al., 2008; Ross & Green, 2011; Jones & Lynn, 2017), there is no agreed approach. Riessman (2008), a narrative researcher, provides a methodological approach to narrative thematic analysis, whereby the whole transcript is used as the unit of analysis. A key aspect of Riessman's (2008) approach is to not fracture or decontextualise the data. Whereas in my study, to answer this research question, I was specifically analysing one section of the whole narrative, therefore, Riessman's (2008) approach was not suitable. My decision was also influenced by concerns raised by the participants- some feared that the detail within their accounts could be identifiable. Therefore, I purposefully sought to decontextualise the data in a way that served the needs of the participants whilst simultaneously answering the research questions. So whilst decontextualising data is

generally avoided in narrative research as context is key to understanding the participants situated experiences (Wong & Breheny, 2018), it was an appropriate ethical decision in my study.

I combined Braun and Clarke's (2006; 2015) thematic analysis method with a narrative component, where the themes were developed in relation to the temporal ordering of the story (Squire, 2013). This was justified for several reasons; first, thematic analysis is a method, not a methodology, therefore can be used flexibly (Braun et al., 2015). Second, thematic analysis is a useful method to analyse large data sets that seek to '*identify, analyse, and interpret patterned meanings or themes in qualitative data*' (Braun et al., 2015, p.95). Third, Braun and Clarke (2006; 2015) provide constructive guidance to undertake a robust thematic analysis. Finally, the nature of data collected (discussed in 5.3) purposefully elicited a traditional story structure; beginning, middle, end (Bamberg, 2010), which generated a classic temporal structure that could be 'identified, analysed, and interpreted' to produce findings that answered the first research question. As highlighted on p.106, the data used in this analysis related to the participants' initial 'big' story told, as these provided the most detail regarding their actions, processes etc.

The narrative thematic analysis was guided by Braun and Clarke's six-phase process illustrated in Figure 8. Each phase of the method described is highlighted in italics.

Figure 8 Thematic Analysis Braun and Clarke (2006, 2015)

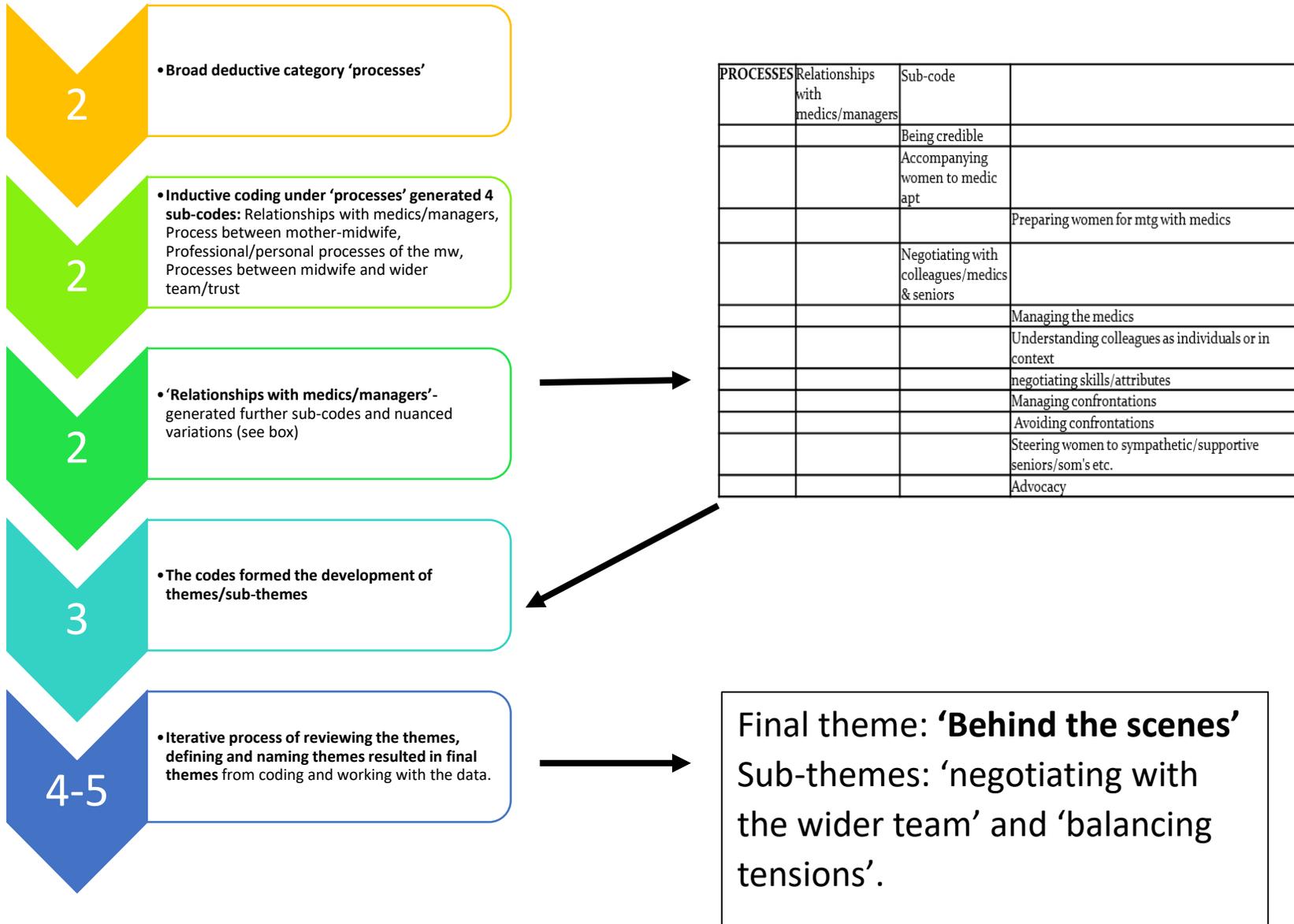
The approach to TA involves a six-phase process:

1. ***Familiarisation with the data***: This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content.
2. ***Coding***: This phase involves generating succinct labels (codes) that identify important features of the data that might be relevant to answering the research question. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.
3. ***Searching for themes***: This phase involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, so that you can work with the data and review the viability of each candidate theme.
4. ***Reviewing themes***: This phase involves checking the candidate themes against the dataset, to determine that they tell a convincing story of the data, and one that answers the research question. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded.
5. ***Defining and naming themes***: This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each. It also involves deciding on an informative name for each theme.
6. ***Writing up***: This final phase involves weaving together the analytic narrative and data extracts, and contextualising the analysis in relation to existing literature.

As per this method, *familiarisation with the data (step 1)* was carried out by a range of data immersion activities previously discussed (p.105-6). *Coding (step 2)* was carried out as a combination of deductive and inductive coding. Broad deductive coding was used to highlight the temporal structure of the accounts where I used the first few participant's big story data to develop a broad deductive coding system; situation, context, processes, experience, outcome and (participants reported) evaluation. Once developed, each source of data was read and coded within the deductive categories. Once completed, the data was read again and nuanced inductive codes/sub-codes were identified and applied to the data under the broad deductive categories. This was an iterative process whereby I would go back to adjust, refine, or reject particular codes. I worked with each individual piece of data whilst keeping in mind the whole dataset. I revisited the whole dataset three times to ensure that the coding was consistent (Braun et al., 2015).

Searching for themes (step 3) was an iterative process, using the temporal sequencing of the stories, the codes and sub-codes were grouped into initial tentative clusters of similar meanings and time points (Braun et al., 2015). This grouping formed the development of early overarching themes, in which a central organising concept was developed for each (Braun et al., 2015). At this point the original deductive category labels were removed as through interpretation the *themes were reviewed (step 4)* and new names were applied. Through an iterative process of writing, developing the themes, and sub-themes, they were *redefined and named (step 5)*. During a further iterative process of writing, working back and forth between step 4/5, the themes and sub-themes were merged, split, or rejected to ensure the analytical findings represented the data. *Writing up (step 6)* was not completed at this point as this data analysis was not an endpoint- therefore, writing up was carried out in relation to the whole research study, see Chapter 10. Figure 9 highlights a worked example and Appendix 3.11 illustrates the whole coding system, both deductive and inductive.

Figure 9 Example of Braun and Clarke steps 2-5 related to one deductive category



Data analysis 2- Research question 2

Notions of experience or sense-making is a broad concept and are open to multiple interpretations where multiple methods and approaches to data analysis exist (Andrews, Day, Squire, & Treacher, 2000; Squire, 2013; Squire et al., 2014). Therefore, to answer the second research question of 'how midwives experienced their practice of facilitating women's choices', a second analysis was carried out informed by Riessman (2008), Smith (2016), and Kleres (2011). This analysis sought to examine the midwives' broader experiences of facilitation, as opposed to just the specific experience generated from their 'big' story. Taking a broader approach offered a way to examine the midwives' sense of experience that was socially and relationally constructed (Riessman, 2008; Smith, 2016) and to examine their personal sense-making within these contexts. Therefore, attention to what was said and how it was said were key narrative methodological tools in this analysis (Riessman, 2008; Smith, 2016). Specifically, I adopted a lens of 'emotionality' informed by Kleres (2011) to analyse the data as throughout the data immersion activities (previously described, p.105-6), the presence of strong emotions prevailed across the accounts. Drawing upon Kleres (2011) who perceived emotions as intertwined with narratives where '*narratives evoke emotion and emotion shapes narrative (Rees et al., p.81)*', therefore, by attending to the emotionality of the narratives, knowledge regarding the participants sense-making and experiences were generated.

This analysis was undertaken initially by using Riessman's (2008) method of viewing the whole account as a unit of analysis. I, therefore, went back to the original transcripts and re-read them. I then drew on the methods outlined by Riessman (2008) and Smith's (2016) methods to re-examine the contents of the participant accounts, including both big and small stories to explore 'what they said' and 'how' in relation to their experiences, and with a specific focus on the presence of emotions and feelings. As per Smith (2016), I identified broad narrative themes which were explicitly *not* a coding process as in thematic analysis, to minimise the defragmentation of the data and to retain context (Riessman, 2008; Smith, 2016). As such, large chunks of data were highlighted and captured with my early tentative interpretations which I called 'emotion-story'. Figure 10 presents an extract from an interview which demonstrates an example of a fear and vulnerability emotion-story.

Figure 10 Example of an emotion-story: fear and vulnerability

‘...it's the fear of finger pointing, it's the fear of being hauled up in front of the trust and saying (.) and them saying that you didn't do all that you could, you didn't talk her out of it, I hate that, you get that a lot, 'why can't you talk her out of it' (.) they don't understand that these women are educated, they know what they want and our job is to advocate for them and provide support for their choice, whether we agree with them or not but unfortunately that's where the fear comes from, and with Supervision going you feel that much more vulnerable now, I know I do (..) and I like to think I am fairly well read, I am an experienced midwife now but with Supervision going I feel incredibly vulnerable cos it only takes for me to miss something out and I'm in front of the NMC , and I think that's going to have a huge effect on how we facilitate women's choice especially when they choose to birth outside of guidelines (..) yea’ (Edna, interview).

However, again to manage the large volumes of data, analytical decisions were made to exclude some of the data- it was not feasible to include every emotion-story for each participant. Therefore, I decided to use the most prominent emotion-story for each participant as a unit of analysis. This involved returning to the captured chunks of data and re-examining them to determine the most prominent emotion-story. The narratives were analysed structurally (Kleres, 2011; Smith, 2016) where consideration of ‘how’ the participants narrated their stories were taken into account. This was achieved by examining the participant's use of language, overall tone, reflections and evaluating comments (Kleres, 2011; Smith, 2016). Whilst this was an interpretative and subjective process, it was carried out in conjunction with referring back to my earlier field notes (I had captured mood, tone, significant emotions at the time of interview), reflexive notes during the previous analysis, and discussions during supervisory meetings.

Following this, I tabulated the corresponding chunks of data for each participant together that related to their emotion-story. This created a data document 175 pages long. Whilst not a specified method from other authors, it served as a useful tool to develop the analysis further and a way of demonstrating my interpretations were grounded in the data. A short extract is provided below in Table 6, where Laura’s interview consistently highlighted the benefits of relational team-working which I initially felt captured a meta-story of team togetherness. However, her account was

also situated within an 'us versus them' context, where she and her team were reported to face conflicts with hospital midwives, therefore evolved to a meta-story of 'protection'. For some participants, the same emotion story was threaded throughout their accounts and narrated through a variety of different examples. For example, Meg's moral distress was evident in all her clinical experience narrations. All her small stories illustrated a similar point, where she had distressing feelings that arose from the disparity between her values and that of her employer expectations. For others, they explicitly told me how their experiences had affected their emotions and vice versa. For example, Beatrice situated her emotional self at the start of her self-written narrative which continued throughout the interview where she expressed her anger in a number of ways. For other participants, the emotion-story was subtle and hard to decipher, taking a number of readings to garner their subtleties.

By using all the information within a table format, I was able to interrogate my interpretations, examine alternatives, and use the data as evidence to support my knowledge claims, to ensure a robust, rigorous approach. Keeping the participants together in one table supported a cross-checking method, where individual interpretations were examined in relation to other participants. This process also generated similarities and differences across the accounts. The grouped stories were categorised as meta-stories which were situated within overarching storylines that conveyed the similar groupings. Each meta-story highlighted a nuanced aspect of the overarching storyline. This process mirrored Smith's (2016) method of 'building a typology'- the clustering of similar narratives but which conveys differences between them. Broadly the storylines represented a polarisation between positive and negative experiences.

Table 6 Worked example of data analysis 2

Quote experience	Interpretations	Meta-story	Overarching storyline
<p>I: I noticed that throughout this you talked about 'we' a lot and I understand that you are in a case load homebirth team, can you tell me a bit more about being in that team?</p> <p>P: Yes, it is amazing, we started about five and half years ago uhm, and I think there is only a handful of us in the country about having a specific home birth team so I know we are lucky. Yes, it was just normal community care beforehand and uhm they decided to put money into a dedicated homebirth team and uhm and yea we have been going ever since. There is a team of six of us now and we caseload, ahh the thing is to try and get them at booking but that is not always the case, so we will take them from any point from booking, and we see them obviously and case load and during the birth, hopefully, uhm and then after birth until day 10. It is a real nice caseloading job which you don't really get in the normal community setting, just because there are so many other midwives etc etc etc. And doing your on calls, not many people want to do, cos it is fairly full on. But yea. But we all have the same ethos, and we all work really well together and we I think that's what helps us, cos we have got really good rates as well. And being a really tight knit team, and knowing exactly how each of us works helps us. Um, support each other.</p> <p>I: The level of care and advocacy you are giving, it sounds like you have got each other...</p> <p>P: Yes, yes we have had several incidents where things haven't gone quite (..) how we planned it to go, but uhm we all kind of get together and we have a real debrief, and we are there for each other. And we all kind of get on with it. And the fact that none of us have had really one sick day in the whole 5.5 years pretty much says how dedicated we all are in terms of the team, and we want to work and we want to support our women more than anything uhm, but I don't get that, get that in the hospital that dedication is definitely not there uhm but I think when you are with people that support you and also that are there to have your back as well, it really makes a difference in how you feel going to work</p> <p>I: Mhm (affirming) (Int: 96-123)</p>	<p>Co-constructed, slightly challenging for Laura to articulate her personal views as earlier in the interview all of her narratives related to 'we' as in the team she works in. Evidently strong bonds within the team, in which she is strongly socialised to a normalised way of practicing i.e. outside of the guidelines.</p> <p>Teasing out, Laura offers a sense of duty towards women, and a role of advocacy but she is quick to contextualise this in relation to 'having the opportunity' to work this way – again demonstrating strong links with her team rather than viewing herself as wholly separate. She situates this opportunity by comparing it with her perceptions of the disadvantages of hospital working- for both her and the women – strong metaphor of the hospital being a 'conveyor belt'. Strong values of building relationships with women, the importance of getting to know them and their needs.</p> <p>Laura reiterates her personal sense of duty 'SHOULD happen' which she relates to the midwives' role, what midwives 'should' be doing.</p> <p>Laura reiterates the opportunity she has to work in the way she prefers by being within this team, thus acknowledging that her midwifery and experience of midwifery could be very different within a different working context.</p> <p>Whilst challenged to articulate, it appeared that Laura had a strong moral compass, a sense of integrity that was easier to talk about in relation to when she was not able to practice in the way she would like to normally, i.e. in hospital.</p>	<p>Story of togetherness evolved- to</p> <p>Story of protection</p>	<p>Stories of distress</p>

Interpretative model- Research question 3

To answer the third research question, an examination of the sociocultural-political factors that influence the midwives' practice, I originally planned to do a third narrative analysis. However, this changed to the development of a theoretical model which encompassed the whole data set that accounted for the midwives' sociocultural-political contexts. Therefore, the theoretical model served a dual purpose; a means of integrating and explaining the whole data set and a means of addressing the third research question. The model was developed from a tentative hypothesis during the earlier analyses. I posited that the midwives' polarised experiences (previously mentioned p.113), related to broad notions of stigmatised and normalised practice. Stigmatised practice appeared to account for the participants who had unsupportive working relationships related to their style of midwifery practice. Whereas normalised practice appeared to account for participants who were practicing 'full-scope' midwifery within supportive environments, that was characterised by a lack of tension or conflicts with their colleagues.

It was during the concurrent 'mess' of data immersion where I recognised firstly the polarity between the accounts, and secondly, what it might mean. A number of coalescing events created a 'light-bulb' moment where notions of stigma/normal resonated with my interpretations during the data collection and subsequent data analyses. Turning to the literature, I realised that the theory (of stigma/normal) shone a light on the data, accounting for the midwives' personal context as well as their sociocultural-political context of practice. This relational component between personal experience and the midwives' 'environment' resonated with Dewey's (1925a) concept of 'interaction' where experience cannot be separated from a person's social and physical environments. Therefore, the midwives' sense of experiences could be accounted for within a wider sociocultural-political context to generate knowledge relating to the third research question.

In order to test this, first, I sketched out an initial framework of my early conceptualisations which consisted of seven key domains that was generated from my prolonged engagement with the data. These initial conceptualisations formed an initial framework, whereby, I turned to the conceptual literature pertaining to notions of stigma/normal. Adjustments were made as my reading provided further concepts of deviance/positive deviance to consider (all discussed at length in Chapter 9). I explored my initial framework in relation to the literature to ensure that my

insights did in fact account for the data. Supervisory discussions aided this process to ensure that my conceptualisations were appropriate. Whilst other theories could have been applied to the data, notions of stigma/normal, deviance/positive deviance strongly resonated and connected with the dataset. To confirm my findings, I worked with the data in a similar way, to that of my second analysis methods. Again, returning to the original manuscripts I re-read them, but with the notions of stigmatised and normalised practice in mind. For each participant, I tabulated sections of their accounts with an initial interpretation of whether their account depicted stigmatised or normalised practice with an outline of why I felt the accounts represented the broad notions. This created a data document 83 pages long, working with the data in this way, I identified nuances within those broad categories, supported by the literature relating to deviance/positive deviance. Working iteratively, I initially developed seven categories across the spectrum of stigmatised to normalised practice which was refined to six domains. Through a process of iterative writing, and discussions with my supervisors, I was able to ensure that the model adequately accounted for the dataset, generating sociocultural-political insights.

Member checking

Member-checking involves gaining participant's views and feedback upon the researcher's findings and relates to ensuring trustworthiness of the study (Lincoln & Guba, 1985; Carlson, 2010). Member checking can be carried out in different ways. For my study, I sent the participants copies of findings for data analysis 1 and 2. I did not send individual participant transcripts back for approval (Creswell & Miller, 2000; Carlson, 2010), for two reasons: I did not feel it was appropriate to ask the participants to carry out further 'work' for the study (Thomas, 2017), as such a task would be time consuming and they had already offered a substantial amount of time to the study without recompense. Second, I concur with Davidson (2009) and Carlson (2010) that reading an orally transcribed interview is problematic, particularly as my transcriptions included a lot of detail (outlined above) I recognise speech to text does not convey a fluid conversation and is difficult to read. Davidson's (2009) consideration that reading a transcript can create an unwelcome sense of incoherence was found in my study. For example, even where I only sent the findings to the participants, one asked me to amend a quote as she reported:

'I have just edited one of my quotes- I had no idea how terrible I was at stringing a sentence together.'

For the first analysis, 10/45 participants responded, all with positive feedback that suggested they felt the findings reflected their stories. Some participants provided short reflections on reading the first analytical findings, some related to other stories resonating with their own experiences or practice, some related to learning from the stories or that the findings would empower other midwives who want to support women making such choices. For the second analysis, 6/45 participants responded, mostly a brief acknowledgement that they received the document with offers of congratulations. One participant offered a further reflection that reading the stories helped with her sense of isolation. See Appendix 4 for a table of all participant responses. In either analysis, the participants' feedback did not change the research interpretative findings.

5.5 Ethical considerations

Ethical approval for the primary study was granted by the University of Central Lancashire's STEMH committee 29th November 2016 (REF 567). An amendment to change the advertisement wording was approved 12th January 2017. Copies of the approvals are found in Appendix 3.8. Any research carries a great level of responsibility towards the participants involved in that research (Social Research Association, 2003; Department of Health, 2012). The Department of Health (2012) has clear guidelines for researchers in the health sciences to ensure that high ethical standards are met. These include duties by the researcher to ensure honesty, integrity, objectivity, accountability and openness as well as the application of professional standards (Department of Health, 2012). Guidance is based upon the ethical principles of autonomy, free and informed consent, veracity, respect for vulnerable persons, privacy and confidentiality, justice and inclusiveness, harms and benefits (Social Research Association, 2003; Department of Health, 2012). The following demonstrates how I applied these principles to this study, both the broad issues and those specific to this study.

Broad ethical principles

Autonomy, informed consent, privacy, and confidentiality: The rights of individuals to participate willingly and/or withdraw from the study were respected throughout the study. Specifically, the participants were provided with a written participant information sheet (PIS) that outlined who was carrying out the study, researcher and supervisory contact details, the purpose of the research, what participation involved, its voluntary nature, possible benefits and harms (including escalation procedures),

issues of confidentiality and anonymity and how the data was to be used. Moreover, the PIS included the right to withdraw from the study up until final analysis had been undertaken. All participants were asked to sign a consent form prior to data collection²⁵. As the PIS and consent form (and SAE) was posted to willing participants, it provided an opportunity for a 'cooling off' period, in which the participants had further time to consider participation. Confidentiality was assured in terms of data protection where personal information was not shared with third parties, where printed copies were kept in a locked cabinet and online information was stored in encrypted and password protected folders on the University computer system, and the self-written narratives were emailed with password protection. Recordings were uploaded and then deleted from the recording device as soon as the interviews finished. Only anonymised data was shared with the research team during supervision. In addition, as stated previously, where participants requested parts of the interview to be redacted, this was carried out at their request.

Harms and Benefits: The participants were informed in the PIS:

'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.'

However, during data collection and member checking, many participants voiced that their participation would benefit theirs and other colleagues clinical practice, as they anticipated the publications arising from the study would support and/or legitimise the work they carry out. Moreover, several participants reported benefiting from 'telling their story' and feeling heard. Others reported enjoying reading the findings, and some reported that they had learned from reading the integrated findings, and others reported seeing the benefit of the research to take into practice. A few participants reported a sense of community knowing that others were practicing similarly to themselves.

Specifically related to this study, I addressed the following ethical considerations:

²⁵ As mentioned earlier, one participant sent her self-written narrative as soon as she had seen the advert- however, she did retrospectively sign and return a consent form.

- In relation to harms, there was a potential for participants to become distressed due to a work experience that had adverse outcomes for the mother or baby. There was also the potential for participants to become distressed in the event they had experienced workplace reprimands, sanctions or workplace stress, or bullying. In the event of the above, and where a participant was distressed, I had planned to offer to terminate the interview and to signpost for further support such as their Supervisor of Midwives, occupational health, counselling services, or union representation. During the interviews, several participants discussed distressing accounts and reported significant mental and emotional consequences of adverse situations. I did offer to terminate the interviews and offer to signpost, but all of the participants stated their preference to continue with the interview.
- Ensuring that all hospital or employer information, colleague identifiers were removed prior to the final data analysis. This was to safeguard the participants professional and employee obligations, that was deemed particularly relevant in the event of the participant offering criticism. Had the participant been identifiable, there was concern that an employer could behave punitively to the participant.
- Ensuring that the women at the heart of the midwives' story were also protected from identifying information and remained anonymous. The woman's consent was not obtained so careful consideration was made during transcription and prior to data analysis that the women's stories were not identifiable.
- In the unlikely event that a participant revealed unsafe midwifery practice, I knew I had a duty as a registered midwife to escalate any concerns raised. This would have involved terminating the interview, seeking support from my supervisors and possibly informing the participant's employer and/or the Nursing and Midwifery Council (NMC). This was made clear in the PIS, so participants were aware of this possibility. There were no cases of unsafe practices reported.

5.6 Trustworthiness

The trustworthiness of a study relates to the extent to which the claims of the research are credible i.e. can the findings be trusted? (Lincoln & Guba, 1985; Loh, 2013; Greenhalgh, 2016). Related to my study, Loh (2013) identified that narrative

research appears to have neglected issues of trustworthiness or rigour citing arguments against applying quality markers to narrative methods have related to interpretative, contingent, contextual nature of a narrative inquiry (Garratt & Hodgkinson, 1998). Loh (2013) and Greenhalgh (2016) counter this argument by advocating quality markers are necessary so judgements about the plausibility of knowledge claims can be made. Loh (2013) argued that the rigour of narrative research is what '*permits it to be acceptable, and therefore gain the necessary weight to affect changes (p.12)*'. Where narrative research is seeking to make practice, evidence, or policy-based changes, it is important that the procedures and methods used are reliable in order to trust the findings (Loh, 2013; Greenhalgh, 2016). In line with these standards, in Table 7 I demonstrate how my study meets the trustworthiness criteria informed by Lincoln & Guba's (1985); credibility, transferability, dependability, and confirmability along with Loh's (2013) suggested criteria for narrative research; verisimilitude and utility.

Table 7 Trustworthiness in this study

Broad criteria	Specific criteria	Overview	Evidence in this study
Credibility (Lincoln & Guba, 1985) 'Confidence in the 'truth' of the findings'	Prolonged engagement	Normally associated with ethnographic studies, but does also include spending sufficient time with the data.	This was undertaken via the in-depth nature of data collection and my time spent during the analysis period where two analyses were carried out and the development of a theoretical model derived from the data analysis (see section 5.3 & 5.4).
	Triangulation	Triangulation involves using multiple data sources in an investigation to produce understanding because a single method can never adequately shed light on a phenomenon. Could include: methods, sources, analyst, theoretical triangulation.	This study applied two methods of data collection and data analysis. In addition, analytical interpretations were discussed with the supervision team which created new ways of seeing the data (see section 5.2/5.3/5.4).
	Peer debriefing	Peer debriefing involves conferring with peers in order to illuminate pitfalls, areas of bias and areas that need clarification enhancing the researchers' attentiveness and focus on the question.	Ongoing and regular supervision provided peer debriefing.
	Member-checking	Member-checking involves gaining the participant's views and feedback upon the researcher's findings (whilst contentious in qualitative research many researchers do use some form of member-checking).	This was achieved by sending the participants the final interpretative findings from both analyses (see section 5.4).
Transferability		Transferability relates to how meaningful the findings are, and the	This was achieved by the large data set that included a diverse sample. In addition, I

<p>(Lincoln & Guba, 1985)</p> <p>‘Showing that the findings have applicability in other contexts.’</p>		<p>extent to which they can be applied to a wider context. Whilst this may be difficult in qualitative research, it is accepted to achieve this that the researcher has to provide ‘thick descriptions’ of the phenomenon and the methods used.</p>	<p>have provided a detailed account of the methods used and used thick descriptions within the analytical write up of the findings. Whilst this study relates to midwives’ who self-define as facilitative, the findings are transferrable to similar contexts where midwives are a key part of the maternity system, and who also self-defined as facilitative of women’s choices.</p>
<p>Dependability (Lincoln & Guba, 1985)</p> <p>‘Showing that the findings are consistent and could be repeated.’</p>		<p>External audits involve having a researcher not involved in the research process to examine both the process and product of the research study. The purpose is to evaluate the accuracy and evaluate whether or not the findings, interpretations and conclusions are supported by the data.</p>	<p>Whilst this study has not undergone an external audit, an audit trail has been provided throughout this chapter and appendices.</p>
<p>Confirmability (Lincoln & Guba, 1985)</p> <p>‘A degree of neutrality or the extent to which the findings of a study are shaped by the respondents</p>	<p>Reflexivity</p>	<p>Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process.</p>	<p>Lincoln & Guba’s (1985) assertion of ‘neutrality’ is less applicable in this study due to the relational, co-constructed nature of narrative and feminist research. However, reflexivity was a key activity throughout this study and presented as ‘narrative beginnings’ in Chapter 1, discussed in this chapter regarding ongoing reflexivity, journaling etc. (section 5.2), and in Chapter 10 with an account of my final reflections (section 10.6).</p>

and not researcher bias, motivation, or interest.'			
Verisimilitude (Loh, 2013)		The study must 'resonate' and seem plausible to the consumers of the study. Hence, the trustworthiness technique of member checking, specifically peer validation and audience validation, are essential.	This was achieved through member checking and peer review via presentations at multiple peer review conferences (highlighted on p.v).
Utility (Loh, 2013)		Three measures of utility: 1.Comprehension: can help us understand a situation that would otherwise be enigmatic or confusing 2.Anticipation: provides descriptions and interpretations that go beyond the information given about them 3.Guide/map: highlights, explains, provides directions the reader can take into account; deepens and broadens our experience and helps us understand what we are looking at.	This was achieved in Chapters 7 and 8 as well as the development of the theoretical model in Chapter 9.

5.7 Conclusion

This chapter has presented the methods used to conduct this pluralistic narrative inquiry. It has highlighted the participants, sample and recruitment processes alongside my positionality and ongoing reflexivity that was carried out throughout the study. A detailed exposition of the data collection methods was provided with my justifications. In addition, the analytical pathway was detailed, and an audit trail provided in the appendices. Ethical and trustworthiness considerations were highlighted. The next chapter situates the findings chapters by providing demographic and contextual data for the participants.

Chapter 6 Situating the findings

6.1 Introduction

The previous chapter provided a detailed exposition of the study methods. The purpose of this chapter is to contextualise the subsequent findings chapters. Firstly, I present an overview of the participant personal and work demographical data, with a rationale for not introducing the participants individually. Secondly, I present results related to data collection methods. Following this, I present an overview of the range of the women's alternative birth decisions to provide a snapshot of the data that was generated by the participant professional stories of practice. Finally, I provide a brief overview of both the working context of the midwife participants and its influence on the provision of care as reported by participants that contextualised the findings.

6.2 An overview of the participants

This section presents an overview of the 45 midwife participants recruited to the study. The decision to not to provide individual demographic data was to preserve participant anonymity. Participants were offered the opportunity to choose their own pseudonym or to have one assigned. Table 8 displays the summarised demographic data. The majority of the participants were female (n=44) and White British (n=39) and were within the age bracket 25-34 (n=11) and 35-44 (n=19). The majority lived in England with distribution across all English regions. Two participants lived in Wales, one in Northern Ireland. None were recruited from Scotland. Just over half held degrees as the highest level of educational achievement (n=24), with 17 holding additional postgraduate qualifications.

Table 8 Participant's demographics (n=45)

Sex	
Female	44
Male	1
	45
Age	
18-24	1
25-34	11
35-44	19
46-54	8
>55	5
	44 ²⁶
Ethnicity	
British African-Caribbean	1
White British	39
White Welsh	2
White Irish	2
White American	1
	45
Region²⁷	
North East England	1
North West England	8
Yorkshire and Humber	4
East Midlands	3
West Midlands	2
Greater London	8
East of England	4
South East England	8
South West England	4
Wales	2
Northern Ireland	1
Scotland	0
	45
Education	
Diploma	4
Degree	24
Postgraduate certificate	3
Master's	12
PhD	2
	45

²⁶ One participant chose not to answer.

²⁷ Data collected in relation to where participants lived, not necessarily worked.

Table 9 displays the participants work related to demographic data. Two participants had been qualified for less than two years at the time of the interview. The majority of participants were divided between either 6-10 years' experience (n=14) or 11-20 years' experience (n=16). Only one participant had over thirty years' experience. Only two participants were Band 5, and n=21 were Band 6. The seven Band 7 participants were in a range of specialist roles such as perinatal mental health, team leader or supervision (i.e. Supervisor of Midwives). Of the five Band 8 participants, one was a manager and four were consultant midwives. The majority of participants were in full-time employment (n=32).

Table 9 Participant employment data

Year's qualified	
<2	2
2--5	5
6--10	14
11--20	16
>20	7
>30	1
Employment status	
Full-time	32
Part-time	12
Bank	1
	45
Current Clinical Band²⁸	
Band 5	2
Band 6	21
Band 7	14
Band 8	5
Other	3
	45
Job role	
Hospital	
Rotational midwife	4
Core midwife Labour Ward	6
Coordinator (shift leader)	2

²⁸ In the NHS midwives are assigned bands linked to the salary scale Agenda for Change related to experience or job roles i.e. Band 5 is a newly qualified midwife, Band 6 are midwives who have completed a preceptorship programme and no longer deemed 'newly qualified'. This could include midwives with 1 year to 30+ years' experience. Band 6 midwives make up the majority of the workforce. Band 7 relates to specialist roles such as mental health or team leader positions; Band 8 relates to leadership or managerial positions.

Community	
Community midwife	8
Integrated midwife (community and birth centre)	2
Birth centre	5
Homebirth Team Leader	4
Community Manager	1
Across all settings	
Specialist (i.e. mental health)	5
Supervisor	1
Consultant Midwife	4
Other	
Research	1
Education	2
	45
Those with additional roles	
Secondary	7
Tertiary	3
	10
Type of additional role	
Supervisor	4
Specialist	1
Research	1
	6

6.3 An overview of women's birth decisions

This section presents an overview of the range of women's alternative birthing choices reported by the midwives. Appendix 5 provides a collation of the participants' anonymised stories that are presented as a brief overview and in a generalised format to preserve confidentiality. Here, Table 10 presents the women's decisions that have been extracted from the whole dataset (see page xiii for the list of acronyms) and Figure 11 presents a word cloud to illustrate the alternative decisions. Some women had multiple factors that made their birth decision characterised as 'alternative' e.g. a woman may have requested a home vaginal birth after a caesarean section who was over 40 years old (two factors that would usually be classified as 'high risk' and therefore not ideal for a woman planning a homebirth). However, I decided to present the factors separately for ease of reference and to preserve confidentiality. Third, when midwives referred to providing care in a birth centre setting, it was sometimes unclear as to whether the birth centres were free-standing (FMU) or alongside (AMU). Therefore, I have not discerned between the two. Finally, it is

important to add, that information relating to the outcomes of women's unconventional birth decisions are not reported. Some women changed their minds during pregnancy regarding the place of birth and some women did not have a successful outcome based upon their planned decisions. The detail presented is to offer a snapshot of the types of decisions made by women that the midwives reported supporting and facilitating.

Table 10 An overview of the women's alternative birth choices

Women's birth decisions	Participant involved in clinical situation (code).
BROAD	
Declining vaginal examinations during labour	1, 2, 4, 5, 10, 17, 21, 28, 31
Declining postdates induction of labour (IOL)	2, 13, 15, 21, 26, 27, 34, 35, 38, 39, 44,
Declining recommended IOL for 'risk' factors i.e. IVF pregnancy, >40 years old, previous caesarean	15, 22, 31, 33
Declining antenatal screening/scans	8, 15, 22, 45
Declining all monitoring during labour	2, 17, 28, 31,
Freebirth	31, 28, 45
HOSPITAL	
Hospital: Declining antibiotics in labour for GBS+ or PRSOM	9, 10, 30
Hospital: Declining augmentation for PSROM	30
Hospital: WVBC (with telemetry)	14, 22
Hospital: WVBC- declining CEFM	23, 29, 44
Hospital: VBAC ₃	16
Hospital: declining recommended medical interventions (not emergency) ²⁹	3, 13, 30, 32
Hospital: declining medical interventions in emergency situations	16
Hospital: Twin waterbirth	44
Hospital: physiological third stage- PET	24
Hospital: breech births outside of guidelines	24
Hospital: waterbirth- gestational diabetes- no CEFM	25
HOME BIRTH	
Homebirth: >40 years old	5, 15, 18, 33, 39, 40, 41
Homebirth: VBAC	6, 7, 9, 12, 15, 19, 21, 31, 35, 36, 37, 41, 45
Homebirth: VBAC ₂	15, 39, 40, 41
Homebirth: VBAC postdates	15
Homebirth: water VBAC	36, 38
Homebirth: grand multipara P5-P10	7, 21, 8, 35, 41
Homebirth: PSROM >72 hours	9, 30, 38
Homebirth: GBS+	11
Homebirth: diabetes (Type 1 (n=1) or GDM (n=3))	12, 35, 39, 45
Homebirth: polyhydramnios	36

²⁹ Where the intervention was deemed as medically necessary/recommended as opposed to outside of guidelines.

Homebirth: hypothyroidism	36
Homebirth: mental health needs	5
Homebirth: blood clotting disorder	2, 45
Homebirth: epilepsy	6, 45
Homebirth: blood-borne virus	38
Homebirth: low iron levels	41, 45
Homebirth: raised BMI >35	12, 20
Homebirth: raised BMI>40	21
Homebirth: raised BMI >50	31
Homebirth: breech	8,15,42, 43, 45
Homebirth: twin breech	20
Homebirth: twin waterbirth	44
Homebirth: twins	45
Homebirth: previous history of PPH's	8, 12, 15, 21, 45
Homebirth: previous history of shoulder dystocia	45
Homebirth: previous history of 3rd-degree tear	21
Homebirth: unusual locations	12, 42, 44
Homebirth: declining a recommendation of transfer for meconium liquor	17
Homebirth: declining transfer for PPH	40
Homebirth: declining transfer for stalled second stage of labour	42
Homebirth: declining transfer to hospital during prolonged third stage (>3 hours)	5,31
BIRTH CENTRE	
Birth centre: outside of 'criteria' (unspecified)	6, 17
Birth centre: >40 years old	17
Birth centre: blood clotting disorder	7
Birth centre: antidepressant medication	7
Birth centre: gestational diabetes	12
Birth centre: waterbirth GBS+	1
Birth centre: raised BMI>35	12, 21
Birth centre: raised BMI>40	21
Birth centre: VBAC no CEFM	29
Birth centre: breech	38

6.4 The participants working context

This section provides specific contextual information regarding the participants working context and relationship with the women. As highlighted in Chapter 5 (section 5.4), the participant's big story provided the most detail regarding the processes of facilitation which also included the immediate context of the midwives. The subsequent stories that were generated in latter parts of the interviews included different working contexts, job roles and/or different relationship contexts with the women. Therefore, for clarity, this section relates contextual information with regards to the participants' initial story/account that directly informs the findings in Chapter 7.

Working context

This section reports the participants' working context. The ways in which midwives' work can directly impact the type of relationship they have with women. This includes, for example, whether they provided a fragmented model of care, or were able to provide a caseload model. Whilst meaningful relationships can and do occur in fragmented care models, the evidence outlined in Chapter 2 (section 2.3) strongly demonstrates increased benefits for women who received caseloading care/continuity of care. Figure 12 presents an overview of the different ways in which the midwives worked. Nine worked within a traditional community model, only in the community setting (antenatal, homebirth and postnatal care). Continuity across the childbirth continuum could not be assured where the number and type of on calls for homebirth, were normally shared amongst large teams of community midwives. This reduced the opportunities for midwives to know the woman they attended during a homebirth and was a potentially fragmented model of care. The exception to this related to three participants who worked within a traditional community setting but did offer 'informal' caseloading to women under their care. This generally related to being on call for specific women and/or seeking permission from management to do so, thereby, increasing the chance of offering a full continuity model of care. A further nine midwives worked within a defined caseload model of care, but mostly related to women seeking homebirths (as opposed to other potential models of caseloading women across all birth settings). These nine midwives had defined caseloads of self-selecting women and were able to offer full continuity with some exceptions, such as annual leave.

Three midwives worked within an integrated community model which involved working in the community providing antenatal, intrapartum (homebirth or birth centre) and postnatal care. Generally, the integrated model increases the chance of continuity of care but it was unclear as to the extent to which this was achieved. Three midwives worked in a birth centre primarily to provide intrapartum care, thus, largely working in a fragmented model.

Seven midwives were based solely in the hospital providing intrapartum care, thus, largely working within a fragmented model. The remaining 10 midwives, who were either in specialist or senior or management roles, worked across the different settings and were mostly involved in the care planning aspects of women's decision-making (discussed further below).

Figure 12 Participant working context



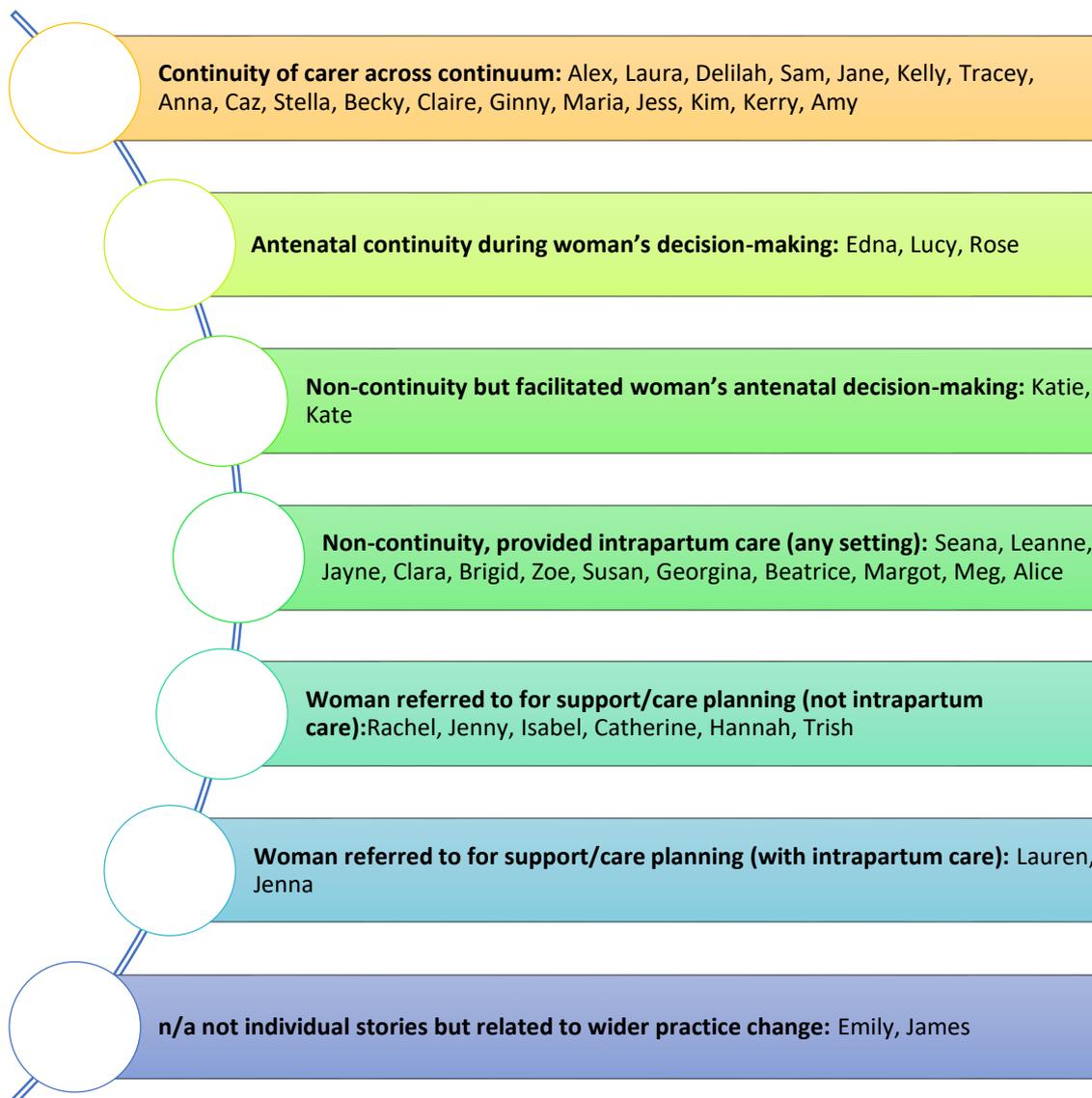
Mother-midwife relationship in the main story

Connected to and in relation to the participants working context is the nature of the relationship they had with the women. As previously stated, particular models of care offer more or less likelihood of the woman knowing their caregiver. Here, I present the context of the mother-midwife relationship as reported in the participant's initial stories (see Figure 13).

Eighteen participants provided full continuity of care across the childbirth continuum. As such, these participants were involved in both the woman's antenatal decision-making and her intrapartum care. Three midwives provided continuity of antenatal care, but they were not present at the birth due to either not being on call at the time the woman went into labour, or due to the woman's change of mind as to what kind of care she wanted. Two midwives working within the traditional community model provided antenatal care to women they did not have a prior relationship with but provided support or facilitation of the woman's alternative birth choices. Twelve midwives cared for women during the intrapartum period in a range of settings i.e. home, birth centre or hospital, whereby they either facilitated a woman's pre-existing antenatal birth plan or supported/facilitated a woman's decision-making during unfolding clinical events.

Six midwives were in clinical roles in which they received referrals from midwives to provide specific care planning for women requesting alternative birth choices. As such, they would see the woman in addition to her receiving antenatal care from the community midwife(s). Here, the participant's role was to discuss the woman's birth options and to formulate a care plan. For these particular midwives, this was a specific and expected part of their role. An additional two midwives were also within a care planning role, however, they opted to be on call for the women in their stories and were involved in intrapartum care. Two midwives offered stories of wider practice and service changes, rather than speaking of particular or specific cases but also provided clinical examples that were captured as small stories (discussed in Chapter 5, section 5.4).

Figure 13 Midwife-mother relationship during care episode as related to the 'big' story.



6.5 Reading the findings

The following table provides a key to the transcription convention, also used in the presentation of quotes in the subsequent chapters.

Table 11 Symbols used within the text

Symbol	Meaning
(N):	Sourced from self-written narrative and line numbers
(I):	Sourced from interview and line numbers
(.)	One second pause
(..)	Two-second pause
(...)	Three-second pause
Bold	Spoken loudly
<u>Underlined</u>	Spoken with emphasis
...	Part of the quote removed for brevity

6.6 Conclusion

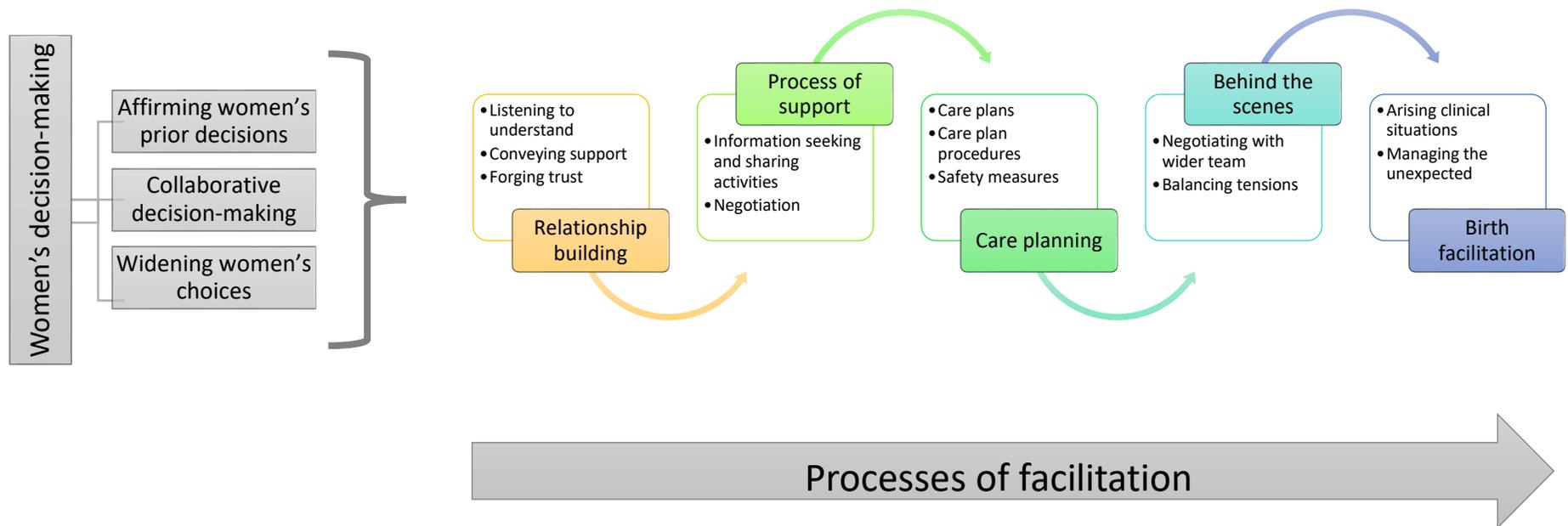
The primary purpose of this chapter was to provide an overview and introduction to the participants by providing their personal and work demographical data, and to provide an insight to the range of clinical 'alternative' birth situations the participants were involved in. The results demonstrate a diverse sample of participants involved in a wide range of women's alternative birth decisions. The chapter also presented the nature of the midwives working context, and the nature of their relationships with the women in the context of the key stories collected. The next chapter presents the findings of the first level narrative thematic analysis related to the midwives' processes of facilitation.

Chapter 7 Findings 1 ‘Narratives of doing’

7.1 Introduction

The previous chapter provided key demographic and contextual data related to the participant’s ways of working, and the types of alternative birth choices that they were involved in. The first research question related to the use of professional stories of practice to illuminate midwives’ processes of support and facilitation of women’s alternative birthing decisions. Therefore, the findings presented in this chapter represent the ‘what and how’ – the actions of the midwives. Additionally, woven through the accounts, the midwives’ provided explanations, justifications and rationales for their actions, thus, these findings also present the ‘why’ in relation to those actions. In order to capture the midwives’ processes, I have focussed on the narrative thematic findings, keeping as close to the accounts as possible. The findings are presented as six key narrative themes; the first theme provides an account of whether (or not) the midwives were a part of the woman’s decision-making process, providing key contextual information framed as ‘the beginning of the story’. The following five themes relate to the midwives’ processes of facilitation. An overview of the themes is presented in Figure 14.

Figure 14 Narratives of doing themes



7.2 Women's decision-making- the beginning of the story

The beginning of the narrated stories mostly related to the midwives' understanding of the woman's situation, needs and decision-making. The initial interaction between woman-midwife marks the beginning of most of the participants' main story.

However, the role the midwife appeared variable across the accounts. Whether this was an intentional positioning of the midwife or in response to the individual woman was not always clear, therefore, this interpretation does not suggest that this is the only way that the midwives operated. Respondents appeared to be positioned in three different ways; first, to accept and support women's pre-determined decisions: in this case, the midwives themselves contributed little to the women's decision-making. Second, some were positioned within a collaborative role wherein the women required support, information and access to services, thus creating a decision-making partnership. Finally, a third position related to midwives who reported that they actively provided additional options and choices, usually for women who did not have prior knowledge or understanding regarding their birth options or choices or women who did not make their preferences known. These three aspects are represented by the following sub-themes: '*woman-led affirmative decision-making*', '*woman-midwife collaborative decision-making*' and '*midwife-led widening women's choices*'.

Affirming women's prior decisions

Many of the midwives reported supporting women who had made specific birthing decisions independently of any discussion with health professionals, usually on the basis of previous birthing experiences. or desires to experience normal/natural labour and birth. Therefore, the midwife participants did not seem to be a factor in women's decision-making processes. For example, midwives referred to how women used language such as '*decided*', '*planning*' [a homebirth] or '*insistent*' to denote their definitive decision-making:

'...I am working with a lady who is (.) totally going against all (..) obstetric opinion whatsoever and (.) and so has clear medical risks and complications (.)...because she is quite clear in what she wants from her birth...' [Isabel (I): 6-6]

In some cases, midwives reported women asserted their decision-making regardless of whether support was offered or not, as highlighted by Jenna:

'...so I went out, sat down with her and the first thing she said was that she was going to have a breech homebirth, with or without us really (.) so I felt she would freebirth anyway no matter what we said' [Jenna (I): 5-5]

Other women were reported to be quietly assertive in their decision-making, simply resisting offers of induction (for postmaturity), or avoiding recommendations for screening, testing, scans or medical input as medical factors arose. In some intrapartum situations, the midwives referred to how women declined some or all midwifery input. For instance, Maria reported being called to a homebirth *'just in case'*:

'...When I got to her flat a doula was present and the woman was mobilising and looked to be in established labour. She declined any baseline observations and told me she didn't want me to listen in to the baby at all, she said she'd called me just in case I was needed but that I was not to call for a second midwife as she didn't want anyone else in the flat!' [Maria (N): 9-11]

Here, most of the midwives followed the woman's lead simply supporting their prior decision-making to maintain good relationships and to instil *'confidence and trust that her choices would be respected.'* [Kelly]. However, for one midwife, following the woman's lead was felt to be *'blurring the lines of consent [Leanne]'*. In this particular situation, rather than the woman making a definitive decision to decline vaginal examinations, she agreed to vaginal examinations but delayed the procedure several times.

Collaborative decision-making

In contrast to the women who had made resolute decisions before meeting the midwife, some respondents reported women required varying levels of support, information and guidance to inform their decision-making. Therefore, the midwives' role was influential in facilitating women's decision-making and navigating the system to actualise the women's wishes. In these type of situations, it appeared that women were either tentative in their decision-making or had voiced their wishes but were uncertain about available options. Sam stated:

'Yea, I was working as a community midwife, and uhm, she had a uhm a disappointing birth experience with her first baby...She said 'you know I'd really like a homebirth, what would be me options?' I said 'well, (.) leave it with me, I'll go away and have a look at

what the evidence says but at the end of the day so as long as you are aware of the pros and cons and the fact that you have got epilepsy, it's your choice.' [Sam (I): 7-7]

For some, the midwives reported women felt the decision had been made for them by previous health professionals until they had the opportunity to discuss it further with the midwife participant:

"... I offered to go round to see her at home for the 41 week, so I came around to her house, it was her first baby and at this point she'd had brief conversations about induction of labour and uhm (...) I think from her point of view it was all going to be booked in for her (.) and that was it (.) we had this conversation about it and it was at this point she said 'I don't really want to (.) get induced...' [Kate (I): 6-6]

Stella demonstrated a proactive, collaborative approach with a woman who had numerous decisions to make regarding her baby that was breech:

'We began discussing choices, not only vaginal birth versus caesarean section, but place of birth and professional to help with the birth. At my encouragement, Maisie and Callum accessed all of Jane Evans' material and read a recent (brilliant) dissertation from one of the newly qualified midwives, bringing together all recent research on breech...' [Stella (N): 7-10]

Widening women's choices

This subtheme relates to midwives 'widening women's choices', a phrase coined by Kelly. In essence, the midwives widened the women's knowledge and access to different choices, that were midwife-led but woman-driven. Kelly reported providing a woman with a number of options including homebirth. In this situation, the woman was a grand multipara³⁰, which guidelines usually precluded from homebirth.

However, Kelly noted that the woman almost experienced a BBA³¹ in her previous labour, so Kelly suggested a homebirth, an option that Kelly said the woman did not know she could access. Once the seed was sown, the woman went on to have a number of successful homebirths. Kelly believed that not all women know their options. She felt that pointing them out - *'just seems to be the right thing to do'*. She said:

³⁰ >5 births

³¹ Born before arrival i.e. birth occurs rapidly before women can access care.

'...But in the same way that she hadn't breastfed before either and she went onto breastfeed some of the other ones. It's the same thing isn't it, exactly, once you have widened somebody's choices then they make different choices.' [Kelly (I): 47-55]

Moreover, Kelly's approach captured a sense of equitable care provision, where she did not just work with women who make specific requests but practiced in a way that offered everybody the same choices:

'...It's offering, it's giving everybody the whole range of choices. Not saying to her 'no you can't have your baby at home because you are high risk', it's going 'these are your choices, you know, what do you want to do? How do you want to take this?' [Kelly (N): 47-55]

Echoing Kelly's ethos of care, those who reported widening women's choices held a strong ethos of ensuring women were provided with full information to make an informed decision. Like Kelly, other midwives observed that when women were given a wide range of options, their decisions *'very rarely correspond exactly to the guidelines'* [Clara, Georgina, Catherine, Meg], insinuating that the information that is provided (or not) is a key component of decision-making. In one example, Kerry highlighted that where meaningful conversations occurred, women may make different decisions to that of their original plans:

'...we are really lucky here as we have a specialist midwife for women who birth outside of the guidelines and I think she [the woman] was just feeling quite overwhelmed by the whole (..) process because she just wanted to have her baby but there was so much surrounding her bio status and everything (..) which was very well controlled (..) she came along wanting a pool birth in our home from home room and it ended up with her having a homebirth (..) I think that was just speaking to X [specialist midwife] that she realised 'actually I don't even want to be here, I want to be at home.' [Kerry (I): 10-10]

7.3 Relationship building

Regardless of where the midwife entered the woman's decision-making processes, a recurring issue across the participants was the prioritisation of building relationships with the women; where time, effort and the construction of relationships required continued attention/maintenance. The midwives expressed different ways to achieve good relationships with women. Getting to know them was pivotal. This was easier for midwives working in continuity models, but also possible for midwives working in fragmented models. For either model of practice, creating mutually trusting

relationships was emphasised. Trust was seen both as a representation of effective relationship development and a key component of safe care. The following subthemes reflect the various components of relationship building: *'listening to understand'*, *'conveying attitudes of support'* and *'forging trusting relationships.'*

Listening to understand

A primary component of relationship building was communication, specifically to understand the woman's *'viewpoint, her history and her ethos around birth'* [Jenny]. This was referred to as *'listening to their story and seeing how they have got to the point they are at'* [Rachel, Claire]-illustrated by Becky:

'...I think is important is being able to get alongside the woman essentially and to be able to start to understand where she is coming from. And I think there are so many cases where women want to make choices it is really important to understand why they want to make those choices, and why it is they feel that is the best choice for them...'

[Becky (I): 7-7]

Some of the midwives emphasised the importance of active listening, using phrases such as *'really listening to her'* [Rachel] to depict the importance of listening and the woman actually feeling heard, a subtle nuance articulated by Edna:

'...it really boils down to women feeling listened to, I really believe that (.) you know, listen to them, listen but don't just listen, hear what they're saying you know?' [Edna

(I): 18-18]

Authentic listening was considered to convey understanding to the women, who in turn *'opened up'* [Lucy] – revealing more intimate information regarding their decision-making. Authentic listening was perceived as feasible within fragmented care models:

'Yes I can, I have experienced it many times when I have met people on a one-off occasion, and I think it is about the skill set you use and really listening what they are saying to you and hearing what they are saying to you and people pick that up really really quickly in my experience... actually as human beings when they do have somebody hears their story and hears their voice, they align to it very very quickly. (..)'

[Becky (I): 20-21]

Factoring in enough time to foster a '*relaxed*' [Rachel] meeting and '*not rushing*' [Lauren] the women were also emphasised as a relationship building tool. For example:

'... we put her at the end of the clinic, and we were happy with that so we knew she could take her time and we would have the time to talk to her, whichever one of us it was. So we got to build quite a good relationship with her, and I think, (.) well I like to think that she felt supported by us.' [Delilah (I): 37-37]

These insights appeared to create a sense of connection from the woman to the midwife, fostering a personal connection or '*intimacy*' [Brigid]. Moreover, through listening to the women's stories many midwives reported an empathic emotional response which appeared to create a personal investment in the woman that for some, '*compelled*' [Jenny] them to act. For example, where women revealed stories of previous birth traumas, the midwives demonstrated understanding regarding the women's decision-making, recognising a previous '*bad experience*' meant that women would '*not want to do that again*' [Kim]. These women were often cited as having '*a very clear idea of what they wanted*' [Jenny] in their current pregnancy, exerting agency and control in their decision-making in attempts to avoid repeated traumas such as seeking caseloading care, homebirths, birth centres and/or declining inductions of labours. Claire described:

'I was caring for a lady, Carly, who had had a previous double instrumental birth following a long induction with her first baby and in this, her second pregnancy, she wanted to have a homebirth... During this [debrief] it became clear that she had felt that she had no choice previously, had been railroaded into the induction process without knowing that she could make decisions.' [Claire (N): 14-15]

Issues of powerlessness during women's first births and the subsequent negative sequela echoed across several accounts and were considered a contributing factor for women's decision-making. Trish described the impact of a negative birth on a woman's early mothering experiences and how she sought to avoid a repeat incident by opting for a homebirth in spite of having medical factors that recommended hospital birth:

...After this difficult birth, she had suffered severe postnatal depression. This pregnancy she had firm plans that she would have a homebirth and the positive birth experience

she had missed out on the first time. She was convinced that feeling powerless at the first birth had been a significant cause of the postnatal depression. [Trish (N): 6-9]

Some of the midwives attuned vividly to women's stories of past birth trauma, demonstrating empathic understanding. For example, Lucy used powerful language to convey the connection between the woman's previous experience and current decision-making:

'She was haunted by the words spoken by the obstetric team, the alarm bells that echoed through the hospital corridors and couldn't think of anywhere more frightening to birth her second child. Joanna told me she that was wishing to have a homebirth, as she felt most in control, comfortable and safe in her own home, which would therefore mean that she would have the best chance possible to labour naturally.' [Lucy (N): 7-8]

Some midwives suggested that women's confidence in their capabilities, framed by Jenna as '*belief in their bodies*', guided their decision-making that was often related to a previous (positive) experience of a homebirth and/or normal vaginal birth in hospital and the subsequent desire to have a homebirth. However, when pre-existing risk factors such as a '*previous caesarean*' or '*maternal age*' (or a combination of factors) and/or those that emerged during the current pregnancy such as '*Group B Strep*' or '*diabetes*' or a '*breech*' presentation, some women were keen to continue with their homebirth plans. Some of the midwives reflected their understanding through strong affirmations of the women's wishes:

'...she knew she could have a homebirth, she knew that she could birth babies and she wanted to have a homebirth...' [Jane (I): 8-8]

Conveying attitudes of support

For some midwives conveying and directly '*communicating their support to women in a non-bullying way*' [Rachel] was an important part of building relationships. Some of the midwives expressed this as a sense of '*responsibility*' [Alex] and '*duty*' [Caz]:

'...Our job is to support her in whatever informed decisions she makes, as it's her body and her birth.' [Jess (N): 8-8]

Across several accounts, the midwives reported a '*personal policy of not saying no*' [Stella] and the importance of saying '*yes*' [Lauren, Anna] to women as a means to '*clearly*' [Lauren, Kelly] convey their support for the woman's decisions. This was carried out in the early stages of meeting the women to break down potential barriers

and foster early stages of relationship building. Jenny highlighted her rationale for her policy of 'not saying no':

'...Being told 'you can't', 'I won't allow' 'no' can often create a communication problem that may encourage decisions based on fear of not being supported rather than a true assessment of risks and benefits.' [Jenny (N): 14-15]

Some midwives recognised the potential harm of not listening to or supporting women's decision-making. Concerns were raised of women disengaging with the services- *'running away kicking and screaming'* [Lauren] and/or freebirthing should their needs not be met:

'...as a group of supervisors we have always been supportive of that [women's alternative birthing decisions] because we are mindful that you know (.) if we don't give these women options and don't put a support plan in place then either they won't choose to have a midwife with them or they'll just completely disengage with the care we provide, then it causes more problems than if we just listen to them...' [James (I): 7-8]

Moreover, some reported a particular attitude of approaching women's decisions with a *'how can we help you to achieve that'* [Trish] approach. Through emphasising 'how', this demonstrated support of the woman's decision and to convey the midwife's investment in her experience:

'...I just think that makes a big difference to them (.) that feeling that you want them to have the experience that they want, and trying to see how much you can put in place to make it happen.' [Trish (N & I): 58-62]

Moreover, communicating their support, saying yes with a 'how-to' attitude appeared to be some midwives' way of approaching women on a psychological level and a means to disarm women who presented as defensive, *'prepared to fight to get the birth they want'* [Jane]:

'You have to go with what people want (laughs), you've got to pick your battles and fights and you will get more out of people if you say 'yes I'll support you in that but here you are, here are the risks', rather than saying 'no you can't, that doesn't really help anybody does it?' [Jane (I): 18-18]

During intrapartum situations, some midwives had less time to convey their support but managed to create time to discuss the women's decisions whilst offering women

'reassurance' [Margot] that they were being listened to. It was considered 'trickier' [Alice] to build a relationship in fragmented care models. To convey their support, midwives reported a range of methods; verbal support, reading and respecting birth plans, conveying agreement and understanding in a non-judgemental way.

Forging trusting relationships

A primary purpose of the midwives' approach to listening, understanding and conveying support was to foster mutual and reciprocal trust with the women:

'You know, we wanted to be there and we wanted to support her and we wanted it to be ok but I think the real pull, was knowing that she trusted us.' [Delilah (I): 39-39]

Trust was perceived to be a reflection of the 'bond' between mother-midwife. In one example, Stella reported that one couple explicitly demonstrated their trust in her by leaving the place of birth decision-making to wherever Stella felt 'happiest'. Therefore, their explicit trust in Stella superseded other decisions that could have been made:

*'We had formed quite a bond at this point, and Maisie and Callum [pseudonym] **said openly they had trust in me.** They were not set on a homebirth at this point, but **said they would go wherever I was happiest** – my managers had agreed I could be on call for the birth.'* (my bold) [Stella (N): 13-14]

Trust was viewed as the 'glue' that holds the mother-midwife relationship together. Midwives perceived gaining a woman's trust meant they would be more likely to accept recommendations to act, intervene and/or transfer in an emergency:

'...I just think it's about for those women who have the more unconventional birth plans it's about making clear we're working with them, but that also means working with us so they do listen, as I say if we say actually we do need to go in, cos I think they're more likely to if they feel listened to and respected...' [Alice (N): 27-27]

As such, trust functioned as a method of safe practice, essential to the midwives' caregiving. In ideal situations trust was perceived as a mutual exchange whereby the midwives' responsibility was to support the woman's choices and more crucially, midwives needed to demonstrate their trustworthiness, so they were 'judged' [Zoe] as trustworthy by the women. For example:

'I think they really need to trust in the person that is there, that's not going to you know, because you and I know, that you could be at any birth and make something up that that, you can find a reason for them to be transferred'. [Stella (I): 58-58]

7.4 Processes of support and facilitation

Relationship building was the foundation component of caregiving. The next stage involved the midwife taking some kind of action that depended upon the complexity of the women's decision, the midwives' role, knowledge or level of experience. Key processes are reported in the subthemes; *'information seeking activities'*, *'information sharing- collaborative relationships'* and *'negotiating with women'*.

Information seeking and sharing activities

Many of the midwives employed a proactive stance of accessing wider information and evidence, beyond that of their local guidelines, to support women's decision-making and to inform the clinical care. This was also a method of resisting local norms where hospital policies and a medicalised culture were perceived as lacking up to date evidence and limiting women's informed choices. For example:

'...I don't just accept what the doctors are telling me, are the doctors doing evidence-based practice, what are they doing? Are they just going off their opinions or are they, cos they do, like other midwives, are they going on what they know etc etc etc? I have been able to sit back and go actually no, I am not just going to with what the norm is, I am going to go with, well I go with my gut feeling also I go with, with the evidence that sits around, not just the hospital policy, I go to the RCOG, I go to with everything like that, rather than just go with our hospital policy...' [Laura (I): 45-45]

A number of methods were reported such as extensive reading [around the particular clinical situation], joining research or professional online groups to keep abreast of new research, accessing national guidelines such as NICE/RCOG, liaising with medical professionals, seeking out other hospital guidelines and accessing primary research papers. Some midwives reported that information seeking is a *'skilled'* [Edna, Rachel] activity, that requires *'competence'* [Rachel, Laura] and was imperative to good quality care. The skills included accessing appropriate and quality information, the ability to understand it and apply it to an individual woman's situation. Edna illustrated:

'... I think you have to be a particular type of person to be able to firstly, be able to do it [read and understand research papers] and secondly have the will to do, the number of people that have said to me they don't know how I can sit there and read a paper and then apply it...' [Edna (I): 45-45]

Primarily, information seeking strategies were used to provide women with evidence-based information to inform their decision-making. The information informed discussions regarding the potential benefits and harms of particular decisions was also viewed as a professional obligation, a *'duty of care'* [Caz, Beatrice, Maria, Alice, Lucy] and central to providing *'informed choice'* [Lucy, Edna, Alice, Jenna, Jess, Catherine]. In one example, Anna reported that it was important to provide women with information as unbiased as possible. Her approach to information seeking included an exploration of the *'medical side of things as well'* so as to consider the woman's *'individual'* risks that related to her birthing decision. The information was then used to guide her discussion with the woman, via a collaborative approach to decision-making:

'... then usually at that point, cos they usually say quite early on in the pregnancy, I would say 'right well, you need me to have a look at the evidence, the up to date to find out what the actual risks are uhm, for you, individually, and then we will have a look at that together and have a discussion about whether you would still feel like you want to carry on with that birth', place of birth you know, after we've looked at the risks together really.' [Anna (I): 18-18]

Some midwives reported the process of information seeking challenged their own knowledge, thus offered opportunities for professional development. For example:

'... I uhm, I kind of read around the evidence of twin births, it was something that although I knew how we clinically manage it, but I hadn't really looked at the evidence and I think that was really interesting it made me realise, and actually a lot of the things we do are based upon clinical guidance wasn't really evidence-based like the ARM for the second baby, like that increases your risk of cord prolapse but yet we were still making this woman sign a document to say that's what she would allow us to do on the day (..)' [Katie (I): 19-19]

Additionally, accessing wider information *'empowered'* some of the midwives and enhanced their confidence to care for women, highlighted by Sam:

...And I felt empowered by that fact that I had read around epilepsy, not just took it on a whim of 'yea yea everything is going to be fine' I had to read...' [Sam (I): 13-14]

Some midwives also reported that information seeking strategies were used to maintain clinical credibility with the women and the wider multi-disciplinary team (MDT):

'...it is absolutely paramount (.) uhm (.) that you are up to date on current research because a lot of the women asking for out of guidelines have already done their research so they come at you often very, very well informed and they will eat you alive, you lose all clinical credibility if you (..) make one wrong move so to speak, they are very forgiving but if you don't know your stuff and you're trying to convince them of something else or trying to explain why you know (.) option a is the safer option and this is why (.) if you don't know they are not going to continue with you (..)' [Isabel (I): 24-24]

Negotiating with women

Information seeking and sharing activities were often an iterative process occurring over a period of time and sometimes used as a means of negotiating with women. For some participants, negotiation was only appropriate once trusting relationships had been forged.

Negotiating care was also sometimes a method used to facilitate deeper discussions with women- a way of determining the women's '*non-negotiable*' [Trish] decisions and those wishes that were negotiable. Trish highlighted the benefits of such an approach when facilitating a woman's decision to have a twin waterbirth where she had additional medical complications, Trish asked the woman to '*make a list of her non-negotiable points, important points and icing on the cake wishes*'. This process revealed that the woman's non-negotiable decisions were not actually related to clinical care, but to respectful care, demonstrating the value of discerning women's core needs:

'...The things that were non-negotiable though were not to do with clinical care. She wanted everyone who came in her room to introduce themselves, no one to touch her without asking permission and all changes to the plan to be explained to her first...' [Trish (N): 12-15]

Following this, and in conjunction with extensive conversations with the woman, Trish felt able to negotiate some clinical elements of the woman's care that were a variation of the woman's original decisions. For example, negotiating to use the pool for labour but not for the birth, so to facilitate clinical procedures to support the birth of the second twin. Trish perceived the negotiated care to be a sign of mutual respect and trust.

For some midwives, negotiating acceptable care with the women was to seek a compromise between trust guidelines and the woman's decisions. For example, Jenny supported a woman to plan for HVBAC, but through discussion, negotiated an agreed time to transfer to hospital i.e. if pushing took longer than one hour. In other situations, participants sought to propose alternative options that may meet the woman's needs. Rachel employed a 'tool bag of ideas' [Rachel] to establish what options may be acceptable to the woman, to ascertain whether a compromise could be reached. For example, Hannah worked with a woman who wanted a homebirth but had multiple and complex risk factors. During the process of information sharing, a compromise was reached whereby the community midwives would attend the woman in hospital to facilitate a waterbirth without continuous electronic monitoring (CEFM) to simulate the home environment- a compromise that was deemed acceptable to the woman, who was reported to have an 'amazing delivery':

'...that was something that was acceptable to her... what she has described as an amazing delivery, waterbirth lots of brilliant pictures... I think how you mitigate some of these things is working towards a degree of compromise for women but I don't think it makes a difference what they ask for.' [Hannah (I): 26-26]

In other situations, the midwives were negotiating with women within certain restrictions such as trust insurance or policy. However, such restrictions were not consistent across the participant accounts, even where the situations were similar. Thereby highlighting disparities in service provision across the NHS. One example related to women over a certain body mass index (BMI) not being able to use the birth pool due to insurance and policy restrictions. Emily explained her approach to negotiating with women in these situations:

"... And explain to her just because she can't use the pool doesn't mean she can't be mobile in labour, and I would present options (.) ... So rather than saying 'you can't have this' (.) 'you can't have this but you can have this X, Y, Z' and quite often the reasons for

the pool are to be more mobile and be more comfortable and to have that more low risk pain relief (.) uhm I would talk about mobility and telemetry CTG monitoring because a lot of the reasons people want to be in the pool in my experience is that they don't want to be stuck on the monitors, they don't want to be lying on the bed, so I would encourage them to (.) labour in a way like being in the pool but not being in the pool if you know what I mean?' [Emily (I): 15-15]

Some midwives were unable to negotiate care that was acceptable to women due to organisational restrictions. In one case, where a woman with multiple health complications had requested midwifery presence but not midwifery care, Isabel, was unable to meet her needs. Isabel adopted a different approach by signposting the woman to external services such as independent midwifery and doula services as a method of 'empowering the woman to find alternatives that she might not have known about before.'

7.5 Care planning

Drawing upon the participant's previous activities of information seeking, sharing and negotiating with women, care plans were often the next activity the midwives reported. Plans involved either informal or formalised procedures and putting safety measures in place. This was particularly evident for women who made their decisions known during the antenatal period. Whilst many of the midwives used the words care plans interchangeably with birth plans, the two differed – birth plans often denote women's self-written birth plans, and care plans are those written by a health professional. Therefore, for consistency, I use 'care plans' that relate to those written by the midwives. The following subthemes are: 'care plans as tools', 'care plan procedures' and 'safety measures'.

Care plans as tools

Care plans were developed following discussions with women of risks, benefits, alternatives as well as an individualised risk assessment. Care plans were a documented reflection of the discussion with women, often written in the woman's handheld notes and/or as a letter. The care plans were perceived to facilitate a clear commitment of the woman's decisions, a tool for advocacy and to fulfil the midwives' employee obligations.

Lucy highlighted care plans as an advocacy tool:

'... Ok, so it tends to be like women declining postdates induction or anyone who wants something outside of the guidance, it's probably better to have a plan I'd say even if it's something small to ensure that what they want will be honoured, I think it's easier for them to go into a situation with a doctor or a midwife and all this is going on and all of a sudden they feel like they don't have a voice anymore and they can't say what they want or need (.)' [Lucy (I): 76-76]

For some, the care plan operated as a communication tool to remind women of all the discussions had. For example,

'...so she had a copy I would hope as it acts for something to her to remember, because sometimes we might have a conversation that they might forget something, so it's there for the world to see isn't it? ...' [Lauren (I): 77-77]

In other cases, the care plans were directly communicated to the women for their approval, perceived as a sign of *'mutual trust and respect'* [Jenny]. This was illustrated by Rachel:

'... we send them their plan and we say 'look, if this isn't what you think we discussed or you want to re-think it and you know come back to me and we'll keep working on it until we get it right', and uhm and predominantly women are fine with it, occasionally you get it back from somebody who uses track changes (laughs) (..) but that's fine, that's important to them and it helps them to feel confident so I'll happily sit with the track changes, and send it out again (.)...' [Rachel (I): 33-33]

On another occasion the care plan was used to delineate and communicate clear boundaries of individual roles within a birth. For example, Jenna was involved in planning a woman's home breech birth, and used the care plan to *'clearly emphasise what everyone's role would be during the birth'* i.e.:

'...the mother is the decision maker that the doula is a support, non-professional support, the community midwife is the professional advice and support and the Supervisor of Midwife is there to support both the woman and the community midwife...' [Jenna (I): 7-7]

For some midwives, the process of documenting care plans was a method to protect the woman's decisions. For example, where midwives were unable to offer continuity of carer, care plans were a tool to assure all midwives involved of the woman's informed decision-making. Thus, reducing potential repetitive risk conversations that

could be perceived as *'bullying'* [Rachel] or *'coercive'* [Lucy] tactics to steer the woman away from her decision-making. Lucy highlighted that her writing an extensive birth plan for a woman having an HVBAC was devised to *'make it easier'* for caregiving midwives *'to focus on making her feel supported and build a trusting relationship'*.

This was corroborated by Trish who viewed care plans in fragmented care models as a *'bridge'* between midwives and unfamiliar women. In another fragmented model situation, Jayne reported relying on the antenatal care plan when caring for an unknown woman that was declining prophylactic antibiotics for Group B Strep (GBS+). For Jayne, the care plan was a tool that provided reassurance:

'... Yes, yea I think definitely uhm, you can just get on with care with your woman in labour that needs you, without frantically worrying whether everything has been written down and uh maybe the I's dotted and things like that...' [Jayne (I): 79-83]

Care plans were also used as tools to support caregiving midwives who were reported as anxious when caring for women out of guidelines. Therefore, the midwife participants viewed their role as a combination of supporting the women and the caregiving midwives, as highlighted by Hannah:

'...part of the role is about mitigating against what the women want and how the midwives will manage and cope...' [Hannah (I): 24-24]

Moreover, for some participants, care plans were a document that *'contributed to the Trust's ability to provide vicarious liability when caring for women outside of the conventional NHS menu'* [Jenny]. As such, care plans were viewed as multi-functional, serving the needs of the Trust, health professionals and women. Overall, the care plans appeared to represent a form of legitimising the woman's decisions, that was perceived as acceptable to other maternity professionals. Conversely, data from Katie revealed a care plan used in a coercive manner. In this situation, it was reported that management insisted the woman sign it, inferring a disclaimer.

Care plan procedures and obligations

The procedures for care planning varied across the accounts. There were differences in whose responsibility it was to write one and whether care planning was seen as an informal or formal process. I identified that formalised processes involved structured pathways, guidelines and referral systems for women who opt outside of guidelines.

Informal processes usually related to care plans being the responsibility of the midwife caregiver and only required documentation in the woman's handheld notes.

For some midwives, care plans were the responsibility of the caregiving midwife and involved simple documentation of the discussion. For Laura, a casual approach was taken, perhaps indicative of working in a caseloading model of care:

'...we have had someone who declined all monitoring in labour at all. But we had discussed this beforehand, and we know she didn't want us in the room and and, we kind of just go 'this is what you want, that is absolutely fine' and we just discuss so that she is fully aware but on the day she's not freaked out, we're not freaked out and and it's fine.' [Laura (I): 34-34]

Where care plans were a formalised procedure, many of the participants reported referring the women to senior members of staff to write the care plan, as per their organisational procedures. Who the woman might be referred to depending on the particular organisation, for example, specialist/senior/consultant midwife/obstetric consultant or manager midwife. In some cases, women were referred to both obstetric and midwifery senior colleagues. Kelly provided a succinct overview of what occurs in her Trust:

'So first of all, whenever anybody goes outside of guidelines you offer them a consultant appointment, so they go see a consultant or they don't. Uhm, and then before 36 weeks you offer them an appointment with a Supervisor of Midwife, which most of mine have taken up uhm, and then write a detailed birth plan for that, a supervisor writes a detailed plan for that individual so then everybody knows. So then that goes in our folder where we keep all of our homebirths and one in her notes as well'. [Kelly (I): 57-57]

Where women did accept the referral, referrals to consultant midwives or supervisors were deemed beneficial by the participants due to the perception that care plans written by senior midwives were authoritative and carried more weight than their own:

'... sometimes it is like when we are referring women to the Consultant Midwife it's not because I couldn't counsel her but I want to have it written down so I don't have to have an argument at two am that's what she is doing, we do sell the appointment to the women that way because if they really don't want to discuss it with anyone, I say 'if you

go and see X [Consultant midwife] actually she can write it down then it won't be questioned when we come in and we won't need to talk about it when you're in labour and that's going to be good'...' (my bold) [Rose (I) : 90-90]

Safety measures

Care planning also included additional safety measures where necessary. During episodes of care, all midwives demonstrated ongoing risk assessments as an integral part of clinical practice. However, what specific activities they employed was influenced by the nature of the woman's decision, the perception of the specific risks involved, the clinical experience of the midwife (i.e. some were very experienced in facilitating breech or HVBAC's) and employee expectations. Whilst all women's decisions in this study related to those outside of guidelines, guidelines across Trusts varied and did not always correspond to national recommendations such as NICE (2017). As such, the midwife participants had varying experiences and conceptualisations of the risk associated with a particular decision and which in turn informed their subsequent actions.

Some safety measures included educational activities regarding potential obstetric emergencies. These activities were instigated either by the woman's caregiving midwife or those involved with her care planning. The activities were designed to provide an opportunity for any on-call midwife to practice clinical skills associated with the woman's decision. In three situations reported the skills training related to breech home births, and one related to a twin breech homebirth. The majority of midwives (with one notable exception) had limited or no experience with facilitating breech births. As such, the educational activities involved practicing and rehearsing the mechanism of breech births, using mannequins. For example:

'... we had several training sessions with a doll, pelvis and Jane Evans [independent midwife specialising in breech birth] notes, discussing a whole range of scenarios – what if's, reasons for transfer...' [Stella (N & I): 16-17]

Additionally, 'refresher' training in neonatal resuscitation was also emphasised as babies born breech are more likely to require some level of resuscitation. However, the midwives also emphasised that skills and drills on a mannequin do not equate to competence in facilitating breech births, a point they had made with the women during their negotiating conversations:

'...secondly we offered them [midwives?] a refresher in breech, I made this absolutely clear she'll probably get a midwife who'd never delivered a breech baby before...but my worry about doing anything to do with breech training, that just because they'd done training that they would be deemed competent because you can't be competent after a couple of sessions on a mannequin (..)...' [Jenna (I): 7-7]

In other situations, some of the midwives reported self-directed learning and practicing a range of emergency scenarios as preparation for women's births. This is where the midwives applied their existing 'skill-set' [Amy] to new possible situations. This was a process that was attributed to 'being organised' [Lucy] and 'being a forward thinker' [Catherine], as highlighted by Lucy:

'I think I am quite an organised person and knowing that we'd been through every scenario very clearly (.) helped me, knowing we had covered all bases and planning (.) uhm I always set myself up for the worst case scenario, which some people don't really agree with (laughs)...' [Lucy (I): 55-55]

In addition to individual midwives going on-call for women, some reported setting up an on-call team for the specific woman. This usually involved negotiations with fellow community midwives to ascertain who would be 'happy' and 'comfortable' [Amy] and those 'who felt they had the skills' [James] to provide intrapartum care for the woman. Whereas, midwives who felt 'uncomfortable' or 'unsafe' [Amy] were seen as counterproductive to safe and effective care:

'And there are those midwives who are not comfortable coming out as my second [midwife] and we've got a particularly difficult case like a breech, we made sure there was a team around me that were happy to come out, you know, it wasn't a midwife stuck in the headlights that was frightened to be there, we didn't need that, I needed someone who wanted to be there. So in those cases we will ask if the 2nd wants to come out. otherwise it is any 2nd [midwife] really.' [Stella (I): 115-115]

On-call teams involved community midwives designing their own rota to provide 24-hour cover until the woman went into labour. In some teams, setting up a rota was relatively easy to coordinate. For example, Amy explained, she was 'very lucky to work within a team that was supportive of women's choices and who were confident in their skill-set' - when she needed to set up an on-call team for a woman seeking an HVBAC₂ who had gestational diabetes, she was 'inundated with volunteers':

'...so when I said 'is anyone interested in coming on board to put up an on-call rota' uhm I had, I was inundated with volunteers, you know I wasn't begging people and everyone was happy like 'yea I'll do that night, or I'll do that night'... [Amy (I): 20-20]

7.6 Behind the scenes

So far, the majority of the findings have focused upon the midwives' relationships with the women. However, the women's birthing decisions and the midwives' context of practice do not exist within silos. Maternity care in the NHS includes midwifery, obstetrics, paediatrics anaesthetists, primary care, maternity care assistants, and doulas. Some of the midwives reported negotiation strategies with the wider team. For some, negotiation with the wider multi-disciplinary team (MDT) was viewed positively and was a source of seeking specialist support and help. Conversely, other midwives appeared to position themselves as a mediator between the women and medical staff. These midwives reported a proactive stance of advocacy to facilitate women's alternative birthing decisions. These issues are discussed in the subthemes '*negotiating with the wider team*' and '*balancing tensions*'.

Negotiating with the wider team

In a number of circumstances, the midwives reported the involvement of the wider MDT such as the obstetric, paediatric or GP clinicians. In some situations, this was related to seeking permission to discharge women from consultant care back to midwifery-led care. For some midwives, they reported a straightforward procedure where the obstetric consultant worked alongside the midwives in a '*flexible*' manner to support the women's decisions:

'...The consultants that we have working alongside us to tend to be fairly flexible as well and if a woman doesn't want something (..) that's outside of the thing (..) they do tend to be fairly good at signing them back over to midwifery led. And we'll just write you know, 'understands that the risks are X, Y, Z and is happy to accept these risks' (..)' [Claire (I): 49-49]

Other midwives perceived that ease or difficulty negotiating midwifery-led care with the MDT was dependent on the individual team member. Some obstetric doctors were viewed as more '*supportive*' of women's alternative decision-making than others. This is highlighted by Ginny below:

'... the Reg[istrar] she had the first conversation with was supportive... but this particular Reg I literally breathed a big sigh of relief, I never said to her that it was a game changer...' [Ginny (I): 10-10]

In other situations, midwives sought specialist support and advice from the medical teams due to the nature of the women's health conditions such as 'epilepsy', 'cardiac conditions', 'diabetes'. Recognising the limitations of their expertise, some of the midwives reported collaborative working to ensure the safe planning and care of the women. In other situations, the women's health status could potentially cause health complications in the baby following birth i.e. 'GBS+³²', 'blood-borne virus', 'medications'. In these circumstances, the midwife liaised with appropriate medical staff to coordinate a complex care plan that included expertise from all relevant professionals.

In one situation, Tracey cared for a woman wanting a homebirth but had GBS+. This is a potentially life-threatening situation for the baby, and intravenous antibiotics given within a hospital environment are normally recommended³³. Tracey reported extensive collaboration with the MDT, including the GP and neonatologists, to explore a number of options that met the woman's decision to homebirth. Whilst legally the woman could have declined any antibiotics, she was reported to accept an alternative solution of taking oral antibiotics prescribed by the GP. The care plan also included postnatal considerations to ensure the wellbeing of the baby:

'so (.) what we did was, then (..) talk to the consultant uhm, (.) talk to the manager, talk to the uhm, the neonatal doctors and the GP and agreed that she could have a homebirth if she started oral penicillin a week before she was due (.) if she hadn't delivered. We had explored coming in to delivery suite and having her IV's and going home, we explored giving her IV's at home, and then the neonatal doctor said actually, uhm, if she was willing to do the baby's temperature and was aware and watch for signs for infection then she could have a homebirth...' [Tracey (I): 7-7]

In another more complex situation, Kerry reported the extensive collaboration between herself, obstetricians, neonatologists and specialist doctors to support a woman with a blood born virus requesting a homebirth. In this circumstance, Kerry

³² Group B Strep explained in the glossary.

³³ However, the evidence on the efficacy of intrapartum antibiotics balanced with potential harms is currently is disputed.

emphasised the value of working alongside the MDT, recognising both her areas of expertise and her limitations. She described:

'Uhm (..) I think it is always the same thing, just the communication being really honest (.) and listening to them as well and making sure, cos (.) I'm not an expert in the follow-up care ... (.) but reassuring them that I am an expert in normal birth, our homebirth rate was 35% so I was very confident that if things weren't going to happen we would transfer in (..) and definitely listening to them, and knowing I wasn't that expert because although we were happy to support her but there may have been specialist genuine reasons why we'd have to think of alternatives and stuff.' [Kerry (1): 28-28]

James raised concerns that medical consultants may be inclined to step back from women who opt outside of guidelines. To mitigate this, he reported continued engagement activities with the doctors:

'I think there is a little bit of risk sometimes that when the women come in to the clinic and say no, they [consultants] do step back and say 'well, you're under the professional midwifery advocate (PMA) now' but we do do a lot of communication and engagement with them and say 'actually we appreciate they are choosing this care pathway and we have put a plan in place for them, but actually we still value your opinion and we still need that input to ensure we are providing safe care' (.)...' [James (1) : 23-25]

Balancing tensions

Conversely, other participants reported that negotiating with the wider MDT was problematic. Some midwives reported that other members of staff (supervisors, managers, and medics) raised concerns regarding 'accountability' and 'responsibility' should an adverse outcome occur [Margot, Catherine, Susan, Ginny, Kelly]. For example, Kelly reported a negative response by the supervisor of midwives who had been called to write a care plan for a woman having a homebirth, but who had multiple obstetric complicating factors. The supervisor was reported to be anxious, inferring she would be held responsible if anything went 'wrong' during the birth. In these circumstances, some sought to provide 'reassurance' to staff members to alleviate their concerns as a means to continue facilitating women's alternative birthing decisions. This was highlighted by Margot who had been supporting a woman who had experienced ruptured membranes (SROM) at term with no labour. The woman had declined a recommended course of antibiotics and augmentation of

her labour, making the decision to 'await events³⁴' to continue her homebirth plans. Here, Margot is mutually supportive of the woman and the doctor who had voiced concerns regarding accountability:

'...the doctor was worried that it would be her fault (.) if something happened with the baby (.) and couldn't understand why the woman wouldn't accept it and it would come back on her, so I tried to explain to her this was the woman's choice and as long as we had documented the conversation we'd had and that she (.) had explained to her the pros and cons of both, it was up to her, the responsibility was with the woman, it wasn't with the doctor, she couldn't force, she'd done her best and any court in the land could see that (.) so I think she felt reassured by that, it wasn't on her (.) uhm it wasn't going to come back on her (.)...' [Margot (I): 60-60]

In other circumstances, the midwife participants reported that dealing with concerned managers was more stressful than caring for the woman, for example:

'...I didn't want her to hear everyone phoning and asking for updates, every half an hour 'what's going on?' (..) so that was more stressful than just looking after her, if I'd been left alone to look after her that would have been fine, it was more the stress of people going 'why isn't she in? why isn't she in? when would she have been induced?...' [Alice (I): 17-17]

In some situations, the midwife participants experienced direct confrontations with medical colleagues who disagreed with either the woman's decision-making or the midwife supporting her. On occasion, this was reported to lead to 'arguments' [Seana] or reports of comments that suggested the midwives were putting women in danger. For example, Beatrice described the conflict she encountered when she advised a doctor that she was looking after a woman with gestational diabetes in the birthing pool:

'... this time [when handing over the woman's information to the medical consultant] I got a look like I was something on the bottom of his shoe (.) and practically saying I was leading her down the path to obstetric disaster (.) and you and I know that obstetric disaster is more often iatrogenic than not (.) and uhm he said 'when she is pushing her luck in the second stage' and I thought 'she'll just be pushing sweetie' (.)

³⁴ A phrase used in midwifery that means, wait to see if labour starts/progresses.

and of course this exchange is taking place in front of at least another four people with the door of the office open...' [Beatrice (I): 21-22]

For Alex, she was enabled to support a woman's alternative choice, *only* if she was on call for the woman. She reported that her manager considered it unacceptable for other midwives to provide intrapartum care for the woman:

'...I have had a discussion with my manager and she kind of bluntly said 'if you'd like this lady to birth on the birth centre you need to come in and deliver her'...'' [Alex (I): 20-20]

As a pre-emptive measure, some midwives reported accompanying women to their consultant or maternity assessment (scans/antenatal checks with perceived problems like postmaturity) appointments. In some situations, the women had made the request, in others midwives offered it as part of routine care. In either circumstance, accompanying women appeared to serve as a method of support, advocacy and where necessary an opportunity to directly challenge medical opinion. For example, Jess adopted a challenging approach when faced with a consultant she felt was likely to be less supportive of the woman's decision to decline a recommended induction of labour:

'...when we asked about the options she [consultant] was saying 'this is the option, being induced in the option' (...)I was able to challenge (...) a consultant or just be quite firm and say 'what are the options? She is not keen to do that, what are the options? Can we try this? Can try that? Can we leave it until 41 weeks? Or yep we make an appointment with the consultant midwife and make a plan with her'...'' [Jess (I): 32-32]

In other situations, a few midwives reported preparing women for their obstetric appointments. These midwives described adopting a diplomatic approach to subtly forewarn women of what the medical team might say. The midwives appeared to be careful to not undermine their medical colleagues but set up cues of what the discussions with the medics would entail as a way of preparing them. For example:

'...with this lady I did warn her really that actually the obstetricians might have a different view, she was happy to go see them and uhm but your kind of feel that you have to prepare them for that as well as the actual (...) discussing all the risks and benefits and things cos otherwise they go to their consultant appointment and they're just completely and utterly (...) knocked back aren't they? ...' [Catherine (N & I): 14-14]

7.7 Birth facilitation

The majority of participants were involved with caring for women during the intrapartum period, most of whom had a pre-existing care plan. The majority of women were reported to have their birth plans fulfilled, with a small number of women reported to have changed their mind in the antenatal period. This theme reflects the different experiences where some midwives reported unanticipated clinical situations within planned births and other midwives reported managing unexpected situations where the women's decisions were not known to them; '*arising clinical situations during planned births*' and '*managing the unexpected*'.

Arising clinical situations during planned births

In some situations, unexpected clinical events occurred during the intrapartum period which required action. In these situations, the midwives reported being aligned with women's original decisions, however, the changing clinical situation required further information sharing and collaborative decision-making. This appeared to occur in both continuity and non-continuity of care situations. In one situation, Stella reported that in spite of meticulous planning for a breech birth at the alongside birth centre, the woman went into spontaneous labour and progressed rapidly at home. Stella was called to carry out a home assessment and on arrival, found the woman in advanced labour, leaving little time for transfer. A quick decision to remain at home was made in collaboration with the woman and her partner. During the extensive antenatal planning, homebirth had been a prior consideration, therefore, Stella reported being '*happy to stay at home*' with her. This changing event was actioned by calling for a second midwife to assist and to carry out other necessary duties:

'... The second midwife went into another room to make calls to CDU [consultant delivery unit] and the SoM on call, to relay plans, and to call for an ambulance to be on standby (part of the original agreed home plan) ...' [Stella (N): 22-28].

The outcome resulted in the safe home breech birth, that required some minor midwifery input to facilitate the birth.

In another situation, Susan was supporting a woman to have a VBAC without CEFM. However, during intermittent auscultation, a fetal heart abnormality was noticed, that required further investigation. In keeping with the woman's decision-making, Susan offered to carry out CEFM for a short time of 15 minutes to '*ensure fetal*

wellbeing' before reverting back to intermittent auscultation. Therefore, working with the woman's needs and the changing clinical situation, Susan appeared to demonstrate a collaborative working relationship:

'There was no resistance to this suggestion, the trace was reassuring and IA recommenced accordingly. The woman birthed her baby beautifully, without incident, and a physiological third stage....and no VE!!' [Susan (N): 16-17]

In another situation, Delilah described her anxieties when waiting for a woman's placenta to birth (three hours). In this situation, the clinical observations were reassuring, but the delay caused Delilah some anxiety. She reported self-awareness that her anxieties were unfounded, therefore to manage these anxieties, Delilah sought moral support from another midwife:

'...I rang up labour ward about another half hour and I said 'look this is what's happening, I'm not concerned but I'm a bit impatient I'm still waiting for the placenta'. And the midwife on the other end, who is also a supervisor she was great, she said 'don't worry, it's fine, just let us know if there is any problems' and left it at that. So I thought 'well she's not worried, so I am not worried'. And then after 4 hours it appeared. We all cheered (laughing). It was really funny, and it was fine the placenta was fine...' [Delilah (I): 89-90]

Managing the unexpected

In some situations, care planning was not carried out due to the nature of quickly unfolding events. In other situations, women that had not disclosed their birthing intentions such as declining induction for postmaturity or declining some or all intrapartum clinical observations. In these instances, some midwives perceived the lack of an antenatal care plan to be problematic and indicative of a woman's lack of trust that she would be supported. One example involved Zoe who was called out to a homebirth to a woman in advanced labour. However, on arrival, the couple and doula expressed that they did not want any midwifery care including conversations with Zoe. Zoe reported tensions between the woman and her employee expectations:

'...So when I arrived I ascertained that the woman didn't actually want any intervention at all, she didn't want me to palpate, do her blood pressure, pulse, auscultation, nothing. Uhm, but what she really wanted to do was to freebirth but with me sitting in the corner just in case. Uhm, and I found that really difficult, cos I didn't want to go kind of all gung-ho saying that was completely ridiculous and why hadn't she told

*anybody? Because obviously that isn't at all helpful in that point in time for the lady (.)
uhm so I had to be very careful what I said, what I did and what I documented... Uhm
(..) but I did find it difficult to follow policies and protocols and be the voice for the
woman as well (...)' [Zoe (I): 20-20]*

In contrast, Maria was in a similar situation, called to a homebirth where the woman did not want any midwifery care. However, Maria had a prior relationship with the woman during the antenatal period. The woman had decided to freebirth, so Maria was 'surprised' to be called, but less surprised at the woman's requests where she declined clinical observations or midwifery input. Maria did not raise concerns about the woman's decision-making, and reported that she '*just sat on the sofa and watched [the woman] really*'. Whilst Maria continued to demonstrate professional obligations through the writing of '*contemporaneous notes*', she did not report feeling challenged by trust policy or procedures. Maria was invited into the birth space that was pitch dark, an unusual situation. The woman birthed her baby and, during the time waiting for the birth of the placenta, Maria reported using her other senses to ascertain the wellbeing of the woman and baby:

'The baby had cried and was skin to skin so I presumed all was well. I asked her if I could use the torch to check on the baby and to see what her blood loss was like but she declined and asked me to be quiet so I tried to be mindful of her breathing to ensure she wasn't becoming breathless which might have suggested excessive blood loss. The baby was making snuffly little sounds that reassured me that he was near the breast.' [Maria (N & I): 36-37]

Other midwives also appeared to 'go with the flow' in unplanned situations, drawing upon their knowledge, skills and assessment of maternal and fetal wellbeing. Where observations were within normal and reassuring parameters, the midwives used this information to facilitate the woman's decision-making. For example, Alice attended a homebirth where the woman was unknown to the team, who had declined induction of labour for postmaturity. Alice reported supporting the woman's decision-making, but also referred to the (reassuring) clinical observations to support the woman and shield phone calls from concerned managers:

'...At no point was there indication of any problems, the liquor was clear, the fetal heart remained active and normal and labour was progressing at a steady and normal pace... I felt it was very important she have no knowledge of the panic her decision had caused

the managers on call, as she had already met a high degree of obstetric resistance to her birth plan.' [Alice (N): 5-6]

However, in a minority of situations, the midwives reported that women experienced obstetric emergencies that required swift action. Mostly, women were reported to consent to the proposed interventions, such as the management of a postpartum haemorrhage. However, Brigid reported a situation where a woman who had opted for a VBAC₃ had clinical signs suggestive of scar dehiscence³⁵. In this situation, the woman was reported to have declined a recommended emergency caesarean to continue with her vaginal birth plan. Brigid reported working with the woman and '*kept going*' with her plans. Over the course of the labour, the woman appeared to consent to the caesarean and experienced a major obstetric haemorrhage. While reported to be a challenging situation, Brigid reported the need to '*meet women halfway*' and to '*keep your personal views out of it and be very professional*'.

7.8 Conclusion

This first level of analysis aimed to identify and explore the midwives' reported actions in relation to supporting and facilitating women's alternative birthing decisions. Whilst the accounts were diverse in several details, they could all be captured in terms of the positioning of the women's decision-making, the nature of the midwife-woman relationship and the working context of the midwife. These findings illustrate the 'what, how and why' of midwives carrying out the processes of support and facilitation. Central to the midwives were relationships with women through dynamically listening, understanding and forging mutual trust. A key finding was the extensive seeking and sharing of information, which both enhanced the personal knowledge of the midwives, and enabled them to negotiate care packages with the women. The findings also strongly suggest that care plans and care planning form a key activity when supporting and facilitating women's alternative birthing decisions. Moreover, the findings also revealed extensive work 'behind the scenes' that related to the mediation of women's needs with the wider maternity teams. Overall, these findings illustrated the wide range of actions/activities involved when caring for women making alternative birthing decisions. The findings formed the foundation for further analysis of how the midwives experienced their practice - presented in the next chapter.

³⁵ Scar tissue separates and can lead to a uterine rupture.

Chapter 8 Findings 2 ‘Narratives of experience’

8.1 Introduction

The previous chapter presented the findings of ‘the what, how and why’ participants facilitated women’s alternative birthing decisions. However, those findings only briefly accounted for the midwives’ experiences. In this chapter, I present the findings of a second narrative analysis to answer the second research question. Specifically, an examination of the midwives’ feelings, emotional responses i.e. their ‘emotion-story’ that related to their midwifery practice. The notion of co-construction is particularly applied to these findings, whereby I, the researcher played an active role in the production of the participant accounts. For example, follow up questions were generated from the participants as opposed to following an interview schedule. Additionally, I shared my interpretative insights with the participants and together we deconstructed and co-constructed meanings or interpretations. The findings are presented under three overarching storylines: ‘*Stories of distress*’, ‘*Stories of transition*’, ‘*Stories of fulfilment*’. The following findings were selected to highlight the nuances within the meta-stories. Where similarities occurred, a salient example is presented. Table 12 provides an overview of the grouped meta-stories, the corresponding overarching storyline and which participant it relates to.

Table 12 Storylines, overarching storyline and participant

Meta-story	Overarching storyline	Participant
	Stories of distress	
Feeling torn		Jayne, Zoe, Katie, Kate, Ginny, Catherine, Margot, Meg
Battle		Alex, Seana, Clara, Stella, Jess, Edna
Protection		Laura, Rose
Reproach/recrimination or vilification		Leanne, Georgina, Beatrice
Overcoming fears	Stories of transition	Lucy
Driving change		Tracey, Emily, Isabel, Jenna
Normalised practice	Stories of fulfilment	Sam, Rachel, Anna, Caz, Brigid Jenny, Claire, Alice, Hannah, James
Togetherness (mother-midwife or midwife-team)		Becky, Kim, Kerry, Amy, Lauren, Trish
The sublime		Delilah, Jane (reverence), Kelly (tenderness), Susan (attunement) Maria

8.2 Stories of distress

The 'stories of distress' storyline was present in the accounts of 20 participants and illustrated multiple experiences of adversity differentiated by three meta-stories; '*Stories of being torn*', '*Stories of battle*', '*Stories of protection*', '*Stories of reproach, recrimination or vilification*'. The vast majority of the stories involved conflict, difficulties and challenges for the midwife in their working context; intra-professionally, inter-professionally, and/or institutionally (as opposed to distress and adversity within mother-midwife relationships).

Stories of feeling torn

A sense of feeling torn prevailed across eight participant accounts. Six constructed this in relation to conflicts between the woman's decision-making and institutional constraints, limiting their agency to deliver woman-centred care. Conversely, one participant raised internal conflict that related to her '*love-hate*' relationship with midwifery. Conversely, data revealed for one midwife, her fears of '*doing the wrong thing*' related to going against the guidelines. Therefore, she felt torn between the woman's decision-making and institutional norms.

Kate's feelings arose due to the challenges of moving from a continuity of care to a fragmented care model, where she found her ability to support the woman's alternative birthing decision was restricted by the constraints of traditional community working. Kate was torn between wanting to provide continuity of care and that of an imposed shift pattern, which meant others were involved with the woman's care. Kate alluded to disruptions in her relationship with the woman due to multiple caregivers, which she perceived to be a limitation of her care:

'...from the point of the view of supporting the woman (..) uhm (..) probably that was fine I felt quite comfortable doing that (..) from the point of view of (..) actually facilitating a plan, following it through (..) that was quite challenging because the care can be (..) uhm (..) fragmented I guess (..) because you can't have 24/7 contact (..) so you build that relationship then somebody comes in (..) and (..) we all kind of know a bit of the puzzle but nobody kind of overseeing everything (..) that's frustrating (..)' (Int: 56-60)

Limited agency and disrupted relationships were also highlighted by Katie, where she shared a story in which she felt that she and the system had failed a woman:

'...It was a really difficult situation, and I've been involved in lots of positive stories, but I think that one, I couldn't give the care I wanted, I kind of failed her, me and the rest of us (.) you know we ruined it for her really. It just wasn't necessary.' (Int: 53-55)

In Katie's detailed account, she highlighted significant tensions between trying to fully support the woman, and that of her reported manager's perspective that the woman's decision-making was unsafe. These tensions were also compounded by the historical context of the woman's care, whereby she had '*moved midwives*' several times due to being unable to get her needs met. Katie, positioned as *another* midwife involved with the woman's care, considered this problematic from the woman's perspective, revealing issues of fragmented care. While Katie reported attempts to build a relationship with the woman, she faced conflicts with her manager. The tensions appeared to relate to Katie's marginalised position of power, as she was a '*new member*' of the trust, community team and that she was relatively junior, meant that she was perceived by the manager to be incapable '*to change the woman's mind*'. As such Katie was torn between the woman's decision-making and her manager. Both Katie's agency and that of the woman's agency were undermined, and this led to a complete breakdown in her relationship with the woman, as she describes below:

'...so I went to my manager who was already up in arms that this woman was going to have this homebirth with a BMI of 40 and also that she wouldn't speak to anybody else apart from me (.) uhm, my manager was really unsupportive because she made out, because I was a junior member of the team, I hadn't managed to change this woman's mind (..) you know that I wasn't doing my job correctly, that I wasn't counselling her enough, you know I wasn't telling her about the risks enough (.) which I don't think was the case I think you know at the end of the day the woman had reached the end of her pregnancy, she knew what the risks were (.) you can't really bully anyone into doing, you can't frighten someone with all these things uhm (..) my manager insisted I took another member of the community team to one of our appointments, which I did, but that really was the nail in the coffin for the woman's relationship with community midwives, and uhm (.) she then after that she text me saying that she didn't trust me, that she wanted to freebirth (..) and it was really stressful because all I wanted to do is support her, that really upset me because she obviously felt really (.) cornered by everyone, uhm (.)...' (Int: 34-46)

For Meg, her feelings of being torn permeated across her interview through a variety of examples. All had the same thread where Meg voiced deep concerns and experienced significant challenges as she felt strongly that the relevant unit guidelines were not based on good evidence and were detrimental to women's experiences of care. Torn between her personal knowledge and her employer expectations of working within guidelines, Meg expressed deep moral conflict. Drawing upon one particular experience of caring for someone during labour when it was discovered that the baby was breech, Meg relayed her feelings of standing beside the woman in theatre during the emergency caesarean:

'...but basically uhm being in a theatre with this woman holding her hand as things were happening, and I just thought 'this shouldn't be happening' and I feel that as a (..) I feel that as a terrible moral dilemma, it feels deeply immoral of me to uhm (..) in a way, yes I feel it's a real dilemma (..)...' (Int: 106-109)

Here Meg showed signs of moral distress due to her disagreement with the decision to perform an emergency caesarean (just) for a baby being breech. Rather than a tone of injustice, Meg's account was told with sadness and expression of the internal conflict associated with feelings of complicity with the expectations of her employer, even though she did not share them. Her sense of immorality, a lack of agency and her loss of voice in speaking up situated Meg's narrative as one of self-blame, rather than towards the structurally imposed limitations of institutional working. Her personal struggle was also revealed below with long pauses between words, words trailing off and unfinished sentences:

'... but also it does sound (..) my uhh (..) my responsibility as uhm (..) and my (..) uhh (..) my personal opinion as well especially what I feel to be right is conflicted to what my employer is expecting of me, that contractual, yea (..) that I find (..) really (...) that's difficult to live with that's (..) I feel I've (..) yea (..) I sometimes I have acted immoral, I feel powerless but (..) because I don't feel agency (..) within the situation (..) and then (..) then, and then in that dialogue with myself' that's ridiculous' you know I am an experienced quite old person (laughs) I have a voice in my head (laughs) but my family were astonished that I wasn't quite able to speak up and those feelings were not (..) yea (..) of being difficult to speak (...) quite strong (..) and it's interesting that my family find that difficult to recognise (..) yea I've a lot (line muffles/goes quiet)' (Int: 115-123)

Issues of incongruence between the guidelines, evidence and professional knowledge, were also found in Catherine's meta-story. In her role where she counselled women regarding their decision-making, Catherine was torn between her employee expectations and her own beliefs and knowledge. When I asked how she managed such incongruence, Catherine placed emphasis on the language she used to counsel women. Using language as a subtle tool to subvert the guidelines, Catherine emphasised using words such as 'suggestion' to instil messages of autonomy:

'...(laughing) that is an interesting one isn't it? I suppose I often say in the (.) 'our guidelines suggest ' as opposed to 'I believe this' (.) does that make sense? ...I do make sure that uhm that any woman I talk to whether I am talking to them as a co-ordinator, as a midwife, as a supervisor you know, this is what our guidelines suggest, it is a suggestion and not a (..) 'this is protocol and we have to do it' (..) sense to it (..) allowance, I hate that word, but it allows them to say 'I don't want to do that' (..)...' (Int: 139-149)

A different perspective on feeling torn relates to Margot's account, where she specifically stated that she had a 'love-hate' relationship with midwifery. She revealed that she experienced feelings of love towards pregnant women and birth, emphasising the privilege she still felt: 'still crying at a birth of a baby after 17 years'. Margot also reported she 'likes her status', which she saw as a consequence of the hard work it had taken to become a midwife coordinator. Margot's construction of what she hates about midwifery was relayed as:

'...uhm (.) the hate side (.) (sighs) politics (.) working with women (.) [i.e. female colleagues] (giggles) the bitchiness, the bullying (.) the hours, the ridiculous expectation now of how much administrative stuff we have to do on top of our work (.) how exhausting it is, how much it disrupts family life, how (..) the fact that effectively I have taken a pay cut year on year for the last 9 years, so I feel completely undervalued' (Int: 235-239)

Whilst Margot largely associated her 'hate' to institutional working conditions and the impact upon her personal life, her brief mention of 'the bitchiness' revealed her bigger emotion-story in the interview. There were significant issues with her immediate colleagues, where personal conflicts had directly affected her in the workplace. Having 'been put in her place' (by colleagues), Margot's account was one of isolation due to being ostracised:

'... I know my place and I will manage (.) so I am very polite and friendly but I strongly feel that nobody there has got my back and that's a very lonely place (.) a very lonely place...' (Int: 447-448)

When I asked Margot how she coped, she offered an uplifting account of leaning on her supportive and loving husband and family, as well as looking to the future with new life plans. However, this was also coupled with a sense of defensiveness:

'...I'm not there to make friends, I'm not there to be popular, I'm there to do a job and earn my money and pay off my debts...' (Int: 464-465)

Stories of battle

Building upon the stories of feeling torn, the following meta-stories refer to a 'battle'. Whilst there are similarities within the two meta-stories, the differences for these seven participants was the language they used as they constructed their accounts. Combative language and metaphors such as *'fight'*, *'challenge'*, *'battle'*, *'conflict'* were used. Compelled by a sense of duty towards women, and women's rights to make their own decisions, as well as their personal alignment towards physiological birth and evidence-based care, they revealed passionate accounts of vocation and the pursuit of justice. This was constructed through their accounts of advocacy whereby the metaphor *'battle'* was indicative of the numerous obstacles the midwives faced when trying to support the woman's birthing decisions. The midwives positioned themselves as being in allegiance with the women, but against the 'system', that was perceived as uncondusive to delivering woman-centred and/or evidence-based care. For all of these participants, wider knowledge practices were constructed as a *'weapon'* to combat what they perceived to be inadequate care provision. Being *'knowledgeable'* beyond that of the guidelines through understanding both birth physiology and evidence was repeatedly narrated. Being knowledgeable was situated as both a source of frustration when knowledge clashed with their local culture/guidelines, and as a source of liberation when they used their wider knowledge to 'win' the battles.

Some experienced a *'daily battle'* with personal costs to their emotional and mental wellbeing alongside negative impacts upon their family life. Some felt they had to *'pick their battles'* in order to maintain collegial relationships with their colleagues. Moreover, some felt stigmatised as a *'troublemaker'*, which manifested itself in two ways. One of these entailed feeling 'othered': *'not being part of the gang'*; resulting in

social isolation. A second manifestation is related to fears that they were perceived to be *'seen to be encouraging'* women's decision-making. To be perceived as influencing women's decisions appeared to put the midwives in a professionally vulnerable position. However, others positioned themselves with a *'reputation as a boat rocker'* that was reported with pride but also suggestive of ongoing battles. The battles ranged from; intra-professional disputes such as conflicts and social isolation from midwifery colleagues, to inter-professional disputes such as disagreements (even arguments) with medical colleagues, to broader institutional disputes where the guidelines appeared to impose authority over the midwives' practice and women's decision-making; or a combination of all three.

The frustration that Jess revealed related to her sense of injustice that women's choices were frequently not respected unless Jess advocated for them. Frustration at a *'conveyor belt system'* of care denoted her position regarding the importance of individualised care but where it is not regularly actualised, despite wider rhetoric in maternity services. Moreover, Jess challenged the perception that women going *'off-guideline'* are making riskier choices and putting their babies at risk. She asserted that the continuity model she worked in is *'safe and actually improves outcomes'* and *'we have excellent stats and outcomes that are better than the local and national averages.'* Through Jess's narrative constructions and countering of risk discourses, she alluded to broader notions of 'good' and 'bad' mothering and how this sociocultural construction plays out during women's birthing choices. Conceivably, here lies Jess' sense of injustice and frustration that motivated her to fight for women:

'I felt so frustrated that this woman I cared for felt let down by the maternity services she initially engaged with. That she felt she was not being respected or listened to. She was just on a conveyor belt. A one size fits all approach doesn't work. It was sad that without having me as her advocate, she wouldn't have known that she could have made a plan with the SoM [Supervisor of Midwife] and consultant midwife. She probably wouldn't have had a positive, natural birth. I feel frustrated that it feels like a constant daily battle to support women who choose to go 'off guideline'. It is expected that women will do what they are told as the guidelines and health professionals know best. I know that we have to constantly risk assess every decision and that we want a healthy mum and a healthy baby, and that safety is paramount. But, we forget that it's that pregnant woman and her partner's decision to make, not ours. Women don't tend to

choose to put themselves or their babies at risk. But risk is relative and individual.' (Nar: 83-93)

Moreover, Jess' battles appeared to have culminated in a feeling of 'us and them' due to being labelled as a 'troublemaker' by her labour ward midwifery colleagues. Jess challenged the perception of her 'brainwashing' women and situated her midwifery practice as offering women informed choices. Jess' account revealed a disparity between the broader rhetoric of maternity services and the realities of practice:

'I often feel like I am labelled as a 'troublemaker' midwife when I walk on labour ward. That people think I am brainwashing my women to decline induction or decline prophylactic antibiotics etc. when in reality I am just supporting them to make their own informed decisions. Once women realise that they have choice and a voice, they feel more confident to do what feels right for them in their own unique circumstances.'

(Nar: 94-98)

In another account, Alex also shared an 'us and them' narrative, where she worked differently to that of her locale care culture. Alex voiced frustration at others' resistance to doing things outside of the norm:

'Uhm, (...) I think I didn't like the fact that (...) not just only I was getting told she [who had GBS] can't birth there [birth centre], I knew there was no reason for her not to which then becomes the bugbear because there is no reason, you're just following 'we've always done it this way we don't like to go outside, you know what we class as normal in our situation so no you are going to follow the guideline because we don't like to try anything different' (Int: 89-95)

Moreover, despite Alex seeking out the wider evidence that was asked of her (by her manager), she felt her professional autonomy had been undermined by strict adherence to the Group B Strep (GBS) guidelines and her manager's insistence that the obstetric consultant's decision should be upheld. Alex reported frustration about the disparity between evidence, guidelines and the claim of the Trust to support individualised woman-centred care. She believed it should be common sense that, once it was agreed that guidelines were not providing up-to-date evidence, then it did not make sense to restrict access to the birth centre for the woman she was supporting:

'To me it was more of a like, more of a given you know I got the knowledge here so there is no reason not to, so I am just going to go to my manager and say you know this lady is Group B strep... And if anything I was a bit shocked when I approached my manager who is in the birth centre... for her to say 'but no the consultant said she had to birth on the obstetric unit'. I felt at that point, hang on you know, it felt like she herself (..) but this is just my interpretation of it (.) but she is not educating herself and well you know actually we can facilitate this because of the, the (.) evidence shows us no reason not to.' (Int: 113-122)

Alex's insights illuminated power struggles between several layers of the maternity system whereby population level evidence is used as a method of persuasion for individual women. In the case she described, the woman's decision appeared to be systemically marginalised. Although Alex did 'eventually' manage to negotiate the woman's entry to the birth centre (where the woman did have a successful normal birth), it was only because she was advised to go on call for the woman personally, as it was felt to be unfair for other midwives to take the (perceived) risk of caring for the woman concerned. Since this entailed being on call for some weeks there is a concern about work-life balance and sustainability for individual midwives who try to support women's choices against such systemic opposition.

Power struggles were also evident in Seana's account where she disagreed with an obstetric doctor's 'insistence' to intervene with syntocinon³⁶ for what Seana felt was a woman progressing normally in labour. Seana's broader narrative of ongoing battles related to the perception that she was a 'radical' midwife, going against local norms that she reported as particularly medicalised and institutionalised. Situated as a 'lone ranger', Seana worked to engineer changes towards physiological evidence-based birth practices. Whilst still an ongoing 'battle', Seana reported some change was occurring:

'... its (.) having an impact. Rather than me being a lone ranger, which I was for a long time, I can see subtle change, even simple things like delayed cord clamping. Some midwives were like 'why would you bother?' and I'm like 'oh my god' so I would go and print out an article and leave it on the kitchen table or whatever. And to hear people talking, rather than me being the mouthpiece all the time...' (Int: 103-106)

³⁶ Artificial hormone drip used to speed up labour.

In contrast to Alex's account, it appeared that Seana had some level of support from her colleagues, even though she experienced this as variable depending on whether her colleagues 'got her'. Those who understood Seana appeared to 'let her get on with it' thus suggestive that to have autonomy, she needed to be understood and respected. Similarly, Stella reported being supported by her direct managers but did report confrontations and conflict with other colleagues. In particular, she described 'loathing' transfers from homebirths to the obstetric unit due to poor working relationships between her team and the hospital colleagues. Stella reported she had a 'reputation' for speaking out which she felt contributed to the negativity.

The toll of continued battles was particularly evident in Edna's broader narrative. Bearing the responsibility for women's birth experiences, Edna constructed the emotional toll of supporting women's choices in two ways. First, Edna revealed an emotional responsibility for women's birth outcomes:

'...a walk in the woman's journey and you do (.) and you take a little bit of every woman's journey and you feel so responsible when it doesn't go right (..) uhm and if they don't get the choices facilitated that they want, you take that (.) on the chin and you shoulder that and you blame yourself (.)...' (Int: 232-235)

Second, and more prominently, Edna constructed her accounts of stress not in relation to the particular alternative birthing decision, but the professional vulnerability it appeared to expose her to. Voicing fears of 'finger pointing' and the NHS 'blame culture' was suggestive of an insecure and unsupportive working environment:

'...uhm if I'm honest I don't think it's the fear that anything is going to go wrong (.) brutally (.) because actually I am not going to put a woman in that position, I am not going to put myself in that position, it's the fear of finger pointing, it's the fear of being hauled up in front of the trust and saying (.) and them saying that you didn't do all that you could, you didn't talk her out of it, I hate that, you get that a lot, 'why can't you talk her out of it' (.)...' (Int: 75-80)

The combination of the emotional burden of women's outcomes and fear of reprisals placed a significant mental and emotional toll on Edna. When I asked how she managed, she reported:

'...but I don't think I do (..) manage it if I'm honest, my mental health suffers because of it, my family life suffers because of it (..) uhm and everyone is the same, I'm not in isolation from that point of view, but I do, I lose sleep at night because of these women (..) I do (..) we all suffer with anxiety, I'd say 50% of the midwives that (..) practice in the same way as I do (..) suffer because of the effort and the strain it puts on everything...'

(Int: 206-209)

Stories of protection

Mirroring the previous meta-story, the two midwives in this storyline also experienced ongoing battles. However, a key difference related to the protective nature of working within 'like-minded' teams. Strong and positive team relationships appeared to offer protection against ongoing systemic conflict. The close-knit teams provided a source of resilience and ongoing mutual support that provided her with the strength to continue.

Laura revealed an 'us and them' situation where she reported that she and her team are *'always given the stick that we are not going along with hospital policies'*. It was not asked who exactly gave them 'stick', but it was inferred that simultaneous intra-professional, inter-professional and institutional conflicts occurred. Laura highlighted that the nature of her supportive team offered a coping mechanism to manage such difficulties:

'Yes, yes we have had several incidents where things haven't gone quite (..) how we planned it to go, but uhm we all kind of get together and we have a real debrief, and we are there for each other...but I don't get that, get that in the hospital that dedication is definitely not there uhm but I think when you are with people that support you and also that are there to have your back as well, it really makes a difference in how you feel going to work' (Int: 114-121)

The importance of working in a like-minded team was also highlighted by Rose, where she talked about continuing to support women's choices through the lens of relational team working:

'yea most definitely and I think the whole of the team feel like their job wouldn't be possible if it wasn't for everybody else (..) uhm so yea I think that's really important...'

(Int: 431-432)

The value of such working was expressed in relation to Rose's times of anxiety when she had worked on labour ward. Where she felt an 'us and them' division (community

midwives versus labour ward midwives), she found herself 'questioning' her actions, concerned about how she was perceived by the labour ward midwives. To manage self-doubt and anxiety, Rose referred to seeking support and reassurance via her team members and positive feedback from women. Gaining reassurance appeared to be a way to regain her composure to continue 'speaking up' for women:

'... when you go and you've had a birth on labour ward and I come home questioning myself' was I too bolshy? did I come across like this? could I have phrased that a bit better?' when I'm anxious to speak up I probably come across quite angry because I am a little bit, talking a bit fast am a bit flushed, and you go back to your team and they go 'no come on that sounds like you did the right thing, you had to say something, well done you for speaking up, it takes a lot to speak up' so you think ok I did the right thing which is exactly what you need because I think you probably wouldn't let go of those feelings (...) and also we get to see the women afterwards that makes a difference for us as well, we get to the speak to them and get their feedback and maybe they say 'thank you for speaking up about that' or whatever, or maybe they don't (laughs)' (Int: 432-

441)

Stories of reproach, recrimination or vilification

Building on the stories of battle, the narratives of three participants could be viewed as examples of the battle almost lost. All three participants experienced a formal investigation of their midwifery practice. In two situations, this was due to poor fetal outcomes. The other case was due to concerns that continuous electronic monitoring had not been used (but where there was no adverse fetal outcome). In all three situations, the midwives reported supporting and facilitating the woman's decision-making, guided by their midwifery philosophy of woman-centred care and wider professional knowledge. However, the nature of the investigations and/or referral to the Nursing and Midwifery Council³⁷ was perceived as punitive, and two of the midwives reported feeling 'scapegoated'. The accounts were constructed through stories of isolation and marginalisation contextualised by a blame culture within their particular working environments.

³⁷ Investigations are often carried out by the in-house Trust teams, but where concerns are raised about a midwife's fitness to practice, they can be referred to the NMC for further investigation, with the potential to be struck off the register.

For Leanne, whilst she was vindicated of any wrongdoing, the investigation process left a significant mark on her mental and emotional wellbeing, detrimentally affected her midwifery practice, and caused disillusionment in the notion of woman-centred care. So much so, she was making plans to leave the profession at the time of the interview. During the immense level of scrutiny that is associated with investigations, Leanne revealed that the process had undermined her confidence in her skills where she *'questions all that I do and how'*. Moreover, it appeared to have completely undermined her confidence with midwifery in the broader sense. She reported being reprimanded for not coercing the woman to accept an intervention. This was in direct opposition to her midwifery philosophy, in which she viewed notions of advocacy and respecting informed consent as an inherent role of the midwife, and to deny such could be construed as abuse:

'...My colleagues and supervisor of midwives have advised me that I should be 'more forceful', or get another midwife into the room to 'help convince the woman'. However, I strongly believe that consent is a choice and, if you have thoroughly explained what you want to do and the rationale behind why you want to do it, if the woman does not want you to do whatever it is, you do not do it otherwise it is not consent and could be classed as abuse.' (Nar: 37-41)

The conflict between her sense of midwifery, morality and her experiences of the investigation exposed a wider incongruence in the rhetoric of a midwives' role and the reality of what happens (in some areas) when things go wrong. Such incongruence was demonstrated in Leanne's narrative as a strong sense of loss, of midwifery not being what she had been taught it to be:

'Yes, it just completely undermined, (.) it showed that midwifery is more about protecting your back than it is advocating for women. And that in itself is just very very sad (..) Because as a student going into midwifery, you expect it to be(e) (emphasis) to be all about women and advocating for women and fighting their corner. But actually when it comes to the grindstone, when it comes to the crunch, it is not about advocating for women, it is about protecting your back...' (Int: 93-96)

Moreover, Leanne constructed the investigation as one of personal attack for her midwifery practice. The inference was, had she been aligned with intuitional norms rather than the woman, then she would have escaped blame:

'... when things go wrong, it is the midwife who they look to destroy. It does not seem to matter if you were advocating for that family or supporting their choices at the time, even though all things seemed normal then. It seems to matter if you covered your back with vigilant documentation, if the woman 'did as she was told', and how well you, as a midwife, can stand up and fight for yourself and your practice.' (Nar: 49-52)

A strong sense of disillusionment was also apparent in Beatrice's emotion-story. However, for Beatrice, rather than sadness, she voiced a *'burning with rage'* at several points during the interview. Her rage was largely influenced by her perceptions that institutionalised maternity practices have increasingly *'infantilised the role of the midwife and that of pregnant women'*. Such infantilisation appeared to play out in her experience of supervised practice³⁸ where there was disparity between a midwives' autonomous practice and the evidence-base, and the institutionalised routine use of guidelines, toxic organisational norms, and a subservient culture. Beatrice was clear in her reasons for joining the study, and voiced strong political concerns about the nature of midwifery and maternity services:

'I chose to share this story as an antidote to anger and resentment. I became a midwife because I wanted to protect and enhance women's health and their rights. It feels more and more that I am ensnared in a mad conspiracy which licenses obstetric butchery. Failure to comply with the legislation or the requisite guidelines results in professional vilification. The joke of the matter is that in terms of evidence-based practice, CEFM [continuous electronic fetal monitoring] has little to recommend it and certainly not for a healthy primip with a normal Body Mass Index and blood glucose levels.' (Nar: 45-51)

Beatrice's anger and frustration, represented by sarcasm, exposed power and authority struggles between both herself as a midwife and obstetrics but also the marginalisation of women making their own decisions. With similarities with 'good' and 'bad' mother sociocultural constructions, Beatrice's narrative suggested a notion of the 'good' and 'bad' midwife- where the bad midwife is one that is responsible for women making *'bad'* choices:

³⁸ When a midwife has been referred to the NMC they can put restrictions on their practice, including having 'supervised practice' akin to being a student where your practice is continually monitored and assessed by other midwives. If the midwife fails to meet the core competencies it would result in being struck off. Otherwise, at the end of supervised practice, the midwife can then remain on the professional register.

'Like Don Quixote de la Mancha, I tilt at the windmills that declare women are weak, midwives are subservient to obstetricians and need to be stripped of the vestiges of professional autonomy ... Perhaps I have fallen down a rabbit hole where every pregnant woman is too stupid and weak to make her own choices, form her own birth plan and see it through. Perhaps it is right that a consultant obstetrician should hector an experienced midwife who is – after all – responsible for a woman making a 'bad' choice.'

(Nar: 52-60)

Behind Beatrice's anger and indignation, was also a deeply distressing account of her experiences of supervised practice. During the interview, I tentatively asked whether she would like to talk about that experience, and within her responses, she revealed a devastating account of its impact. Central to this was being removed from the clinical area in which the complaint arose, and the subsequent social isolation this caused. Such a punitive approach caused a strong sense of '*shame*' that she has not '*got over*' indicating the extent of her psychological distress. As such, Beatrice constructed her experience as a '*watershed moment*' which had far-reaching consequences across her whole life; her sense of identity, loss of friends and work colleagues, damage to her career, poor mental and emotional wellbeing, and a detrimental financial impact³⁹. However, fortunately for Beatrice, she reported finding solace in family and friends. Additionally, through the kindness of other colleagues, she was helped through the process of completing her required hours, enabling her to stay in the profession.

In a similar experience, Georgina's narrative had several accounts of direct confrontations with midwifery and obstetric colleagues disagreeing with her midwifery practice of supporting women's decision. Georgina reported feeling '*attacked with ferocity*' during an altercation where it was suggested that she was '*brainwashing women*'. Georgina reported several challenging situations where she received little support from midwifery and obstetric colleagues, giving rise to a toxic working environment. She reported being '*scapegoated*' for a poor outcome during a breech birth. A number of intra-professional conflicts that occurred whilst the investigation were carried out were felt to be catalytic for a referral to the NMC.

³⁹ Whilst on supervised practice, Beatrice could not work extra shifts, work for agencies etc.

Whilst the outcome was ‘no case to answer’⁴⁰, it was a ‘threatening and traumatic’ time. Like Beatrice, Georgina found support in midwifery colleagues, but only in those who were external to her hospital Trust. This support was crucial to Georgina remaining a midwife:

‘...yea, I mean I probably would not be a midwife Claire, if it wasn't for them...’ (Int: 496)

Despite numerous conflicts, Georgina’s broader self-reflective narrative revealed her beliefs that her midwifery practice had a higher purpose. As a midwife with international expertise and a unique skill set, Georgina referred to how she could ‘weather the storms’ through a mixture of acceptance that poor outcomes will occur, and recognition that she is likely to be targeted in future, as well as a belief that the storms were reflections of what is wrong with the system. Constructing social deviance as a positive appeared to give her strength to continue as a midwife:

‘I have to a certain extent just accept that it will happen (.) uhm (.) and that (..) that is, like I said that is part of the work I do I just get back up again, and someone somewhere will attempt to knock me down (.) to a certain extent sometimes I don't even take it personally (.) you know I just think it's (..) it is just a manifestation of all that is wrong with the system and me taking the moral high ground and just carrying on just doing what I do is part of challenging that system (...)’ (Int: 290-295)

8.3 Stories of transition

This overarching storyline traverses the ‘Stories of distress’ and ‘Stories of fulfilment’ where five participants revealed some issues of battling the system, but where change was in the making. For one participant, this related to personal changes of overcoming her fears within her midwifery practice following a distressing experience. For the other participants, their stories of change related to their experiences of influencing systemic and cultural changes within their institutions. These experiences were not without challenge and difficulty, but the prevailing narratives indicated that change was moving in a positive direction towards woman-centred care, where women’s decision-making was respected, honoured and facilitated.

⁴⁰ An NMC finding which means that no further actions are required and the midwife can just remain on the register.

Story of overcoming fears

Lucy's narrative account was distinguished from the other participants as she openly discussed her fears associated with supporting women opting for vaginal birth after caesarean (VBAC) in a community setting. Lucy's fears were based on her previous experiences of caring for two women who had uterine ruptures in one year. Lucy constructed her fears by framing the small risk of uterine rupture i.e. 'less than 1%', as a 'very real risk' due to these experiences. During one of the cases, there was a poor fetal outcome. Lucy viewed the poor outcome as emblematic of poor relationships between the woman and herself, and between the woman and the wider maternity services. Viewed in this way, Lucy makes sense of the poor outcome through an empathic position with the woman, where she posits that the lack of a trusting relationship meant that the woman was unable to accept her advice to intervene:

'...On reflection, I felt that if there had been better support antenatally and more of a relationship between the maternity professionals and the patient, she may have been more trusting and, in turn, listened to the advice given to her at the time of the incident. There was no trust, and I felt unable to build a relationship with the woman, which I feel is key during labour care.' (Nar: 31-34)

When faced with a different woman wanting a home VBAC, whilst Lucy reporting feeling 'frightened', she used her previous experience as a motivating factor to 'ensure that it didn't happen again.' Constructing relational care as safe care, Lucy committed her support to this woman. Methods to manage her fears appeared to be a process of Lucy returning to and reiterating her personal values, a form of inner ethical guidance in how to proceed in her midwifery practice, as highlighted below:

'...It would not be fair of me to let my past experiences taint her birth plan, as it's not about me, or my fears: it's about the woman at the centre of my care...As midwives working within the NHS, there are always going to be challenges, in every aspect of our role. But we are able to support women's choices, we may feel bound by guidelines but women are not. The outcome of not following best practice or Trust recommendations is not always going to be perfect, and we may perceive this as being dangerous or unnecessary, but it's not our choice to make. We must ensure that the woman is fully informed, and provide woman-centred care, choice and advocacy.' (Nar: 77-83)

Stories of driving change

The prevailing emotion-story across four participants accounts was one of driving change, contextualised by their positions of seniority with their Trusts. Seeking out and enacting such roles appeared to be motivated by the desire to implement wider scale changes. For three of the participants, this appeared to relate to a midwifery philosophy that was aligned with woman's rights to choose. However, for one participant, her midwifery philosophy appeared to be aligned with safety concerns of women birthing out of hospital with risk factors and with independent midwives, rather than an emphasis on women's choices. Such data, aligned with a different perspective and constructs of safety and women's choice, provided an alternate insight to the drivers of change.

All four participants were mediators between women, midwife caregivers, obstetrics, and their organisations. Largely, the narratives consisted of the participants overcoming resistance to improving access to women's alternative choices. Resistance regarding concerns of 'safety' and/or liability stemmed from both midwife caregivers, obstetrics and the organisations. However, often it was reported that the midwife caregivers were particularly fearful of '*widening the criteria*' of women who can be supported in low-risk settings. Such fears were recounted in relation to fears of '*losing their PIN*'⁴¹, echoing earlier storylines that related to fears of being scapegoated in the event of a poor outcome.

As such, the accounts revealed the extensive nature of such work to bring about the 'buy-in' required to foster systemic changes. In order to facilitate changes, the work involved extensive negotiations across all professional groups and often? within challenging hierarchal structures. However, the participants were in leadership roles, contributing to levelling power imbalances within such structures. Developing and asserting professional '*clout*' appeared to be a valuable asset to enhance perceptions of authority. Professional clout appeared to require '*proving*' to women and all professional groups as it was not a given by virtue of their job role. Collectively, the nature of such work indicated an extensive mental load. Some participants felt this was '*unseen*' work that was difficult to '*measure*', and therefore, sometimes devalued.

⁴¹ NMC registration.

However, highlighting that change was *'moving on'*, Tracey revealed that change appeared to have reached a tipping point following extensive work carried out by the Supervisor of Midwife (SoM) team with support from the Head of Midwifery (HoM). Tracey reported changes were made to the delivery suite guidelines where women's choices were significantly broadened. The widened criteria were perceived as *'unreal'* denoting a sense of surprisingly progressive change, in direct comparison to the previous restrictive guidelines. Thus, changing social norms was occurring:

'...so now they've changed, just recently they have just put out a draft guideline and the criteria for women on delivery suite who can go on now is unreal, I mean the midwives are now like 'oh what?' cos they've said that IUD⁴² ladies can use the pool, and the midwives are like 'why would you let them?' and I'm like 'well why not?' ... but they've [obstetricians/risk and governance teams] gone (..) like the other way.' (Int: 138-145)

From a different perspective, Jenna's account also provided a vivid insight into the speed in which systemic changes could occur. Jenna talked at great length about all of the changes that had occurred within the maternity services during the time she had been in a leadership position- *only '18 months'*. Exploring how this occurred so quickly, she attributed a combination of dogged determination, the importance of creating a *'safe'* non-punitive environment for the midwife caregivers, and wider cultural changes that occurred simultaneously at the Trust. Coalescence of these features appeared to create the tipping point required to make positive changes, but central to which was creating trusting relationships with her colleagues:

'Claire: So that knock-on effect, and that change is actually pretty quick, really quick

Jenna: It is quick, and it's about you, I can't say it enough Claire, it's about you uhm people have to see you doing what you say you're going to do number one, number two they have to feel safe, I call it professional safety, people have to feel safe in the role in they're doing, they have to know if they follow their role and what's expected of them, they can't be touched in a negative way (..) they need to know that otherwise they won't do what you're asking them to do because they're too frightened' (Int: 308-314)

Moreover, Jenna drew upon her previous experience within the same Trust, recognising that previous issues of a punitive working culture had been detrimental to women getting their needs met and the midwives feeling supported. She identified

⁴² Women who have experienced stillbirth.

her own sense of accountability, recognising her role within a punitive working environment. These experiences appeared to have facilitated personal growth, that coincided with new conceptual understandings of human factors⁴³ as highlighted below:

'they've got to be safe, the woman has got to be safe but the midwife has got to be safe, the worst thing you can see if a midwife has a poor outcome...that's why we've moved on in this trust, there was a lot of punitive action I feel, it was the system, I was a part of that system, I was definitely a part of that system because I came in as a matron, this is what you do, everybody is doing it, this is what you're supposed to do (.) then over the years I thought 'no, there is something not right here, something not quite right' and that's where the human factors came in, human factors and complex birth is beautiful together...' (Int: 318-331)

Jenna perceived the changes as an 'evolution' where she anticipated (and had evidence of) midwife caregivers becoming more receptive to supporting women's alternative birthing decisions. A key element of her success appeared to be her willingness to collaborate with her teams. For example, Jenna valued the community midwives as 'experts' in their respective field, and as such, the care plans were devised collaboratively. Meaningful collaboration appeared to have instilled more confidence in the midwife caregivers, demonstrated by their less 'reliance' on Jenna:

'...so I will say to the community midwives 'this is the plan, do you think it will work, is it feasible? and if not, what do you think will work?' And gradually, I get emails all the time now like 'this lady wants a homebirth and I think we can do a, b, c, d but I'm not sure about' and I'm thinking 'yes' (.) before I would just get emails 'this woman wants a homebirth, can you go see her?' it's starting now to synthesise some of the stuff that I am feeding them (..) so they're not so reliant I think...' (Int: 290-294)

8.4 Stories of fulfilment

This overarching storyline conveys 21 participants' diverse experiences of fulfilment. For some this was related to a sense of the 'ordinary', where their midwifery practices were marked by a lack of conflict, animosity or distress. Rather, a feeling of being able

⁴³ Human factors is a concept frequently associated with the aviation industry, which saw radical safety improvements as they worked with this conceptual approach. Primarily, it removes a blame culture and fosters an open learning culture, where mistakes/poor outcomes are a collective responsibility rather than just an individual.

to 'get on' with the job of facilitating women's choices was identified. This was generally associated with the midwives being situated within supportive working environments where women's alternative choices were mostly accepted. For others, their narratives related to a sense of camaraderie either between themselves and the woman or themselves and their team. Finally, the other participants expressed a feeling of the sublime, through accounts of love, awe, tenderness, attunement and reverence. Their accounts are differentiated by three storylines; '*Stories of normalised practice*', '*Stories of togetherness*', '*Stories of the sublime*'.

Stories of normalised practice

Building on the '*stories of driving change*', these narratives conveyed the other side of that process, where sufficient cultural shift had occurred and change was embedded. Whilst they may have experienced resistance from some colleagues, the ten midwives in this storyline had enough support to facilitate women's alternative birth choices with relative ease. The enabling factors were related to an interplay between the midwives' personal motivations, and obstetric, managerial, institutional and effective leadership support. The alignment fostered a culture in which women's alternative decisions were 'normalised', as Caz stated:

'This [supporting alternative birth choices] happens on a daily basis – it is not an unusual occurrence.' (Nar: 27-28)

James highlighted this interplay when he described the creation of a new birth choices clinic to support women's alternative choices. Whilst supporting women's choices was already embedded within the Trust culture, the new clinic was a proactive response to the statutory changes in supervision⁴⁴. The overall achievements within James' trust were highlighted as he jokingly referred to as '*being victims of our own success*'. Attributed to their success, was the contribution of local women to the normalisation of alternative birthing decisions. James narrated a story of a power transposition, where the hierarchy within the trust was inverted i.e. woman-led. James highlighted the '*shock*' of new members of staff regarding the

⁴⁴ In 2017, legislative changes removed statutory supervision for midwives. Supervision had historically been used in many areas as a mechanism of support for women and midwives who make alternative birthing decisions. A new model has since been introduced but Trusts are not legally obliged to implement it, therefore, some areas are now lacking an equivalent service.

nature of the women's decisions, but how quickly they 'fall into line' constructing the power dynamic as one that is in women's favour:

'yes they are [supportive], I think partly because they are used to our women, new ones get a bit of a shock (laughs) when they come here (.) because our women will say 'no I'm not doing it', they are quite vocal and our MSLC⁴⁵, the consultants are really involved with, are extremely vocal and extremely passionate about tailoring the care to what women want, to what our population of women want and they've had to, for want of a better word, they've had to fall in line because you know it just causes them more stress than it does the women because the women are quite formidable when they want to be, they'll just say 'no I'm not doing it' and we are quite lucky that a lot of our new consultants are quite young and dynamic and will just you know, they appreciate the women do have a choice' (Int: 140-150)

Claire also conveyed non-hierarchical working relationships between midwives, doctors and management, that was supportive of women's choices. In part, Claire characterised this by the doctors knowing the midwives will support the women 'regardless', so a sense of positive defeatism fostered a supportive dynamic:

'...the two consultants who come out to our area to cover it have been there for quite a while and they kind of know that we will support the women regardless so they may as well go along with us' (Int: 346-348)

However, her account also revealed a mutually beneficial arrangement that also fostered positive interactions. Claire reported that women deemed to be at moderate risk of adverse outcome remained with midwifery care as opposed to being seen by the obstetric doctors, which had two benefits. Firstly, the midwives were able to support women with risk factors making alternative birthing decisions in a supportive environment. Secondly, the doctors were reported to value their time being freed up to focus on 'women that really needed their input'. The inference was that the notion of low-high risk categories was applied judiciously, to the satisfaction of both professional groups:

'...quite often some are technically high risk but not that high risk, they don't even see them, they just sign them off, you know if we've got a lady with a slightly high BMI

⁴⁵ Maternity Services Liaison Committee which comprises of lay members, multi-professionals coming together to improve local maternity services.

they'll just say 'a GTT [glucose tolerance test] at 28 weeks if ok MLC [midwife-led care]'... and they've got the time to use with the women who actually need their input (..) so it works both ways (.)' (Int: 355-358)

Claire's account was contextualised by working in an isolated rural area, and through discussion, it appeared that this was a contributing factor of cohesive relationships between midwives and doctors, and the acceptance of women's choices. I suggest their way of working to be a 'pragmatic' response to the realities of rural working, to which she agreed. The concept of a pragmatic approach to care that normalised women's choices were also highlighted in Anna's account. Anna also worked rurally, where travelling time was factored into women's decision-making and contributed to a wider acceptance (doctors, management, organisation) of women having homebirths but with risk factors. That the community midwives lived locally to the women, carried small caseloads (30-35 women p.a.) meant they were able to consistently offer intrapartum care. Attending the women was viewed as a safer alternative to the women travelling long distances, despite their risk factors. As such, a pragmatic approach to delivering maternity services contributed to the normalisation of women's choices:

'Well, I work in X (place) it is very rural, it is sparsely populated, we don't have a district hospital at all, we only have birth centres... obviously we probably get more women uhm (..) say they would like to stay with us than you might get somewhere there is a hospital, just because they don't want to do that travel, actually a lot of them live well over an hour away from the hospital, and quite a long journey and if it's their third or fourth baby then it's a long way for them to go. For us, it is quite easy and that is probably just because we have small caseloads and geographically how we are placed, and the population we look after, yea, it makes it quite easy for us to do that sort of care really.' (Int: 107-120)

A key aspect of gaining and maintaining a normalised culture was highlighted by Jenny. Jenny had previously experienced situations where women's decisions were undermined which '*pushed a red button*' in her. These experiences were narrated as a catalyst for change, whereby Jenny sought the support of the HoM to facilitated wider organisational changes. This resulted in the appointment of a consultant midwife whose primary role was to coordinate the changes. Jenny reported the introduction of

care pathways, structured referrals and care plans, created collaboratively with the MDT and legal teams, has resulted in the normalisation of women's choices:

'Yea, so the supervisors used to do the care plan but they were uhm (..) they, they probably weren't written as well as they could have been, they probably didn't include the discussion around the actual evidence...it's definitely bringing a consultant midwife in with her training (.) uhm that formalised those care plans and made them a lot more professional and acceptable to the medical team uhm and the learning that (.) and I also think it is something that is quite easily taught so (..) uhm (.) ... We've run it past our legal department now as well to say how does this affect our insurance, does this look like a robust enough letter? And they're really really happy with it (..)' (Int: 240-252)

Stories of togetherness

This storyline denotes narratives from six participants that concern a strong sense of closeness, friendship and understanding. For two midwives, a sense of togetherness was particularly highlighted in the mother-midwife relationship. Here, togetherness reflected an emotional attunement where midwives 'walked alongside' the women to facilitate their birth choices. The emotional investment was also viewed as an emotional gain for the midwife, suggesting 'reciprocity'. For others, togetherness was highlighted within the midwives' team relationships. A relational team-working relationship was constructed as an enabling feature of providing woman-centred care and as a source of resilience.

Trish's worked in a care planning role where she frequently met women who wanted alternative births. Trish's sense of 'togetherness' with women making such choices was attributed to the personal joy and satisfaction she gains from women '*pushing the boundaries*'. Trish's alignment with women's choices was characterised by an account that resisted her local cultural narrative of women making such choices as '*crazy*' or '*reckless*':

'...a big thing is that sometimes people talk about these women but they haven't met them (.) so (..) what you will get is somebody saying 'oh my god' and they haven't actually met the woman so it all gets blown out of proportion when they're talking to each other and panicking about it (.) so partly it is they haven't met the woman uhm (...) I don't know really (.) I don't really understand why when some people who talk to people who want something different I don't know why they get so worked up, it's really

hard to see it from their shoes, there is probably fear isn't there? A fear that you're going to get blamed if something goes wrong, whereas I feel as long as you have explained all the things that might happen then the woman takes the responsibility herself, and really when someone wants something outside of guidelines, are pushing the boundaries that makes me excited (laughs) I don't know if that makes me dangerous (laughs) but I am always, I will always tell them the things that could possibly happen and will say we advise you to go to the hospital but we will support you (..) (Int: 132-146)

Given the conflicting opinions about the women she cared for, I asked her how she managed the tensions in practice. Trish revealed a strong sense of togetherness with the women, which resisted the burden of negativity from colleagues via '*focussing upon the woman*'. As such it appeared that Trish's alignment with women was a protective factor against tensions:

'uhm (..) I think it is easy in a way because you're completely focussing upon what the woman wants and what's right for that woman so (.) then all the other stuff about hierarchies and other things you can make that irrelevant because you are fighting for what's right for that woman (..)...' (Int: 180-182)

Echoing Trish's account, was Lauren who also felt excited by '*women pushing the boundaries*', a term used several times throughout the interview. Lauren appeared to enjoy supporting women making alternative birthing decisions and '*being there*' for women and reported confidence in doing so. Lauren constructed her confidence in such birth choices through her extensive experience where she'd '*seen most things*', her willingness to stay '*up to date*' with the latest evidence and from personality traits of not being someone '*who will fall to bits if something goes wrong*'. However, Lauren was mindful that her enthusiasm for alternative births should not unduly influence women's decision-making, thus situating her focus as primarily woman-centred:

'that's why I say I love it when people push the boundaries, the ones that don't want to be induced or don't want this that and the other, in our situation we can't ask people to ask for out of the ordinary, but it's lovely when they do (.) and you have to kind of, I was well aware because I was so excited that this mum wanted to do [breech homebirth], that's why I said I'll be there, I'll be there (.) and I did say to her, 'my concern is that I don't want you to pick up on my enthusiasm (laughs) you need to realise I am able to be enthusiastic because you're taking responsibility for this' so I was aware of that, because you don't want that to be any part of her thinking either (.)' (Int: 252-261)

From a different perspective, Kerry articulated a sense of togetherness in relation to her immediate team. Kerry strongly narrated a woman-centred focus and also highlighted reciprocal gains from working with women as a caseloading midwife. However, the joy of working within a team was described as '*amazing*' both within her self-written narrative and interview:

'... and I worked with this team of midwives who are now like my sisters (laughs) they're just like (.) yea (.) I get emotional just thinking about it, they're just really really supportive and caring and I was able to ask questions, I wasn't afraid to ask questions...' (Int: 135-150)

The positivity of working within a like-minded team was perceived to be conducive to positive woman-centred care. This was represented by Kerry's account of their standing in the local community:

'...I think that we had a good reputation in our area like, I remember one of the church's invited our team to come for a special evening or something, it was just like (laughs) we had a lovely community aspect, we would picnic every year with the women, they'd come back with their 4, 5, 6-year-old children that we'd you know been at their birth (.) I definitely feel that it was yea, a really special (..) I was so lucky, really really lucky' (Int: 159-163)

Also passionate about working with women and her particular team was Amy who reported a '*privilege to work with really incredible midwives*'. Amy was a team leader, managed staff and had a caseload of women. When discussing the cohesiveness of the team, Amy attributed this to the open, respectful communication and ongoing learning within the team:

'...like I said we run these skills sessions, we listen to each other, we learn from each other and I'm really privileged to work with really incredible midwives, so that kind of information sharing, 'what would you do if?' (..) but just respecting the knowledge of our elders (laughing) as they have had these situations, and so we can learn from it so I'm like 'ok if I am ever in that situation, that's what I would do ' (.)' (Int: 299-304)

Moreover, Amy highlighted a sense of togetherness through an example of being '*inundated with volunteers*' when seeking midwives to set up a rota for a woman wanting a homebirth with multiple risk factors. This appeared indicative of the team's similarities in terms of skill sets and values:

'...we are really lucky to have a lot of community midwives who a. are confident in their skill set and b. very much believe in women's right to choose, so when I said 'is anyone interested in coming on board to put up an on-call rota' uhm I had, I was inundated with volunteers, you know I wasn't begging people and everyone was happy like 'yea I'll do that night, or I'll do that night' (.) ...' (Int: 84-88)

The sense of togetherness and comradery echoed throughout Amy's narrative accounts where she cited many different small stories of the positive 'top-down' support her team received from senior members of staff. For example, she described the consultant midwife as the '*most amazing one going*', the supervisors as '*powerful*' and management as '*supportive*'. Importantly, the support was not lip-service, in Amy's example below she demonstrated that the senior managers were also 'hands-on':

'...our deputy head when we've had two homebirths going on at the same time, he on multiple occasion gone out to a homebirth himself you know? You know homebirth is very protected, it's very sacred (..)' (Int: 149-151)

The team's 'togetherness' was shared with new or nervous midwives, where direct and indirect support was provided. Amy also reflected that some midwives preferred not to work with women making alternative birthing choices. However, within her working context, there were enough like-minded members of staff, that women and midwives were able to get their needs met.

Stories of the sublime

'*Stories of the sublime*' captures and expresses the feelings of warmth, love and compassion that permeated across five of the participant accounts. During data collection, the participants revealed moving accounts of love, awe, reverence, attunement, and tenderness - both towards the women in their care, and about birth itself. Embedded within the accounts was the notion of reciprocity, where the midwives received many emotional gains from their relationships with the women. Moreover, for one midwife, these exchanges occurred in a non-community model of care, thus offering an understanding of the mutual benefits of relational care within a fragmented model.

Jane provided a moving account in which she expressed reverence for the longstanding relationship she had with a couple throughout a number of pregnancies and births. During her account of the woman's last birth, the depth of detail Jane

remembered was striking. Through re-telling her story, Jane re-lived the moment; 'choking up' which she reported it as the 'pinnacle of her career'. Throughout the interview, Jane voiced a strong sense of 'emotional attachment' towards this family, which was conveyed in a heartfelt compulsion to do everything she could to make this birth the 'most positive experience that they could'. She spoke of all the possibilities that could have occurred during the birth and finished each statement with 'I'll make it the best I can'. My lasting impression was the profound impact that this family had on Jane, walking alongside them throughout joyful and sad times, they left a significant mark in Jane's heart. The following extract reveals the scope of the impact and the power of connection between Jane and the couple. Moreover, coincidentally Jane bumped into the parents during the recruitment phase, whereby she had the opportunity to discuss the study with them and re-live together the specialness of the birth:

'one very frosty March morning I was called X [woman's name] husband and uh m, we, a nice wood burning stove, ice cold marmalade on toast and she had a waterbirth and prior to her going into the pool, her little son had been in the pool so we made it quite jolly, and uhm then she birthed and she had little girl called X [name], it was one of the most (..) privileged times that I have ever had in my career (choking up), it makes me want to cry when I think about it (.), because I felt privileged to be there, and to be part uh of their experience and you know I had been part of their life, and, for such a long time, you know because I had been through a lot with them. And when I had seen your flyer the other day, I actually met this couple shopping and I haven't seen them for several years and I said funny thing is, I was thinking about X [baby name] and how old she was now and I was saying to them how privileged I felt about being there, and they said uhm to me 'no, it was privilege that you were there with us, because you had been through so much with us', but like I said, it sounds silly, but it does make me want to cry because I do feel it was so, was one of the pinnacles of my career, it is something I will always think about, that that, that moment she came up in the water and it wouldn't have mattered if it had been another boy but I just thought the fact that it was a little girl (choking up) after that time, that was fantastic as well.' (Int: 55-69)

Kelly also highlighted a longstanding connection between her and a couple when they requested her personally during two subsequent pregnancies. Kelly felt that this signalled 'trust' between them, which was particularly relevant in light of the woman's history. The woman was reported to have considerable fears of hospitals and

clinical procedures which meant that throughout several pregnancies she had declined all screening/blood/urine tests and scans. Throughout Kelly's lengthy self-written narrative, she detailed many aspects of her care which I interpreted as a loving tenderness. Her words and actions denoted kindness and gentleness towards the woman, demonstrating respect for her choices throughout the narrative. Kelly re-told the story constructed through a lens of purposefully seeking the woman's trust through deliberate actions; seeking permission to personally care for the woman (who was out of her usual catchment), responsive care when the woman became distressed to demonstrate respect for her choices, visiting the family every two weeks⁴⁶ and taking an interest in the other children as a way to 'encourage her to talk and be confident in trusting that her choices would be respected' and 'going on call' for the birth. As the pregnancy progressed, Kelly appeared to foster a sense of protectiveness towards the woman, symbolising the connection she felt. The following extract highlights a combination of Kelly's protectiveness, connection and responsive care:

'I arranged a meeting at their home with myself and the supervisor. I felt it was really important for me to be there to support X [couple]. The supervisor explained the risks of having a baby at home and asked whether she would consent to a presentation scan. X [name] became tearful at this suggestion and the supervisor did not press the issue. It was agreed at this meeting that I would be on-call for her which I was very happy to do. I felt it was much more likely that she would call me to attend the birth this time rather than leave it too late as she did last time.' (Nar: 66-71)

Kelly's actions and experiences of providing compassionate care can be contextualised by her midwifery philosophy that is underpinned by two significant beliefs. Firstly, she believed birth and the mother-midwife relationship to have 'massively long-lasting effects' throughout a woman's life, so the relationship is 'hugely important'. Secondly, she believed that the core components of safe and satisfying care were 'appropriate antenatal care and a trusting relationship'. Most striking was the reciprocal nature of the trusting relationship, in which Kelly reported that a 'relationship of trust enables me to feel safe when supporting women who make choices outside the normal'. Therefore, highlighting how feelings of safety work both ways within the mother-midwife relationship.

⁴⁶ 2 weekly visits throughout a pregnancy is not the usual pattern of care.

Susan also conveyed the value of connection and trust in a midwife-woman relationship. However, her account was characterised by a sense of attunement, where she employed deliberate actions to harmonise with a woman in labour. Whilst Susan worked in a fragmented model of care, she explained how she worked to achieve a space in which the women felt they were the centre of their experience, and that they mattered. When I asked her how she achieved that, she responded with vivid language suggestive that simple acts of kindness foster mother-midwife attunement:

'You just, you just (.) talk nicely to people and you go to that place where they are rather than expecting them to somehow meet you (.) on your plane, it's theirs, it's their space it's their experience and you go to where they are (..) or or and if they're not in a place that is conducive for (..) for labour cos they're in a heightened state of anxiety or feeling they have to be very talky to make me feel comfortable cos they're meeting a new person or they're in a strange environment (..) you go in and you put yourself in that space, you talk softer and and you respond less, you respond to make them feel (...) comfortable so if they are very talky you might be slightly more talky at the beginning but consciously talking less and less to uh (.) and being ok with silence so they get that feeling without you saying 'it's ok not to talk now' [loud] (laughs) that they get that sense that this is ok, this is about them, you make it all about them and because the place where labour happens best.' (Int: 58-78)

However, Susan also reflected in order to 'hold the space for women' in labour, she had to learn to hold space for her own 'big feelings to be felt', specifically learning to recognise, acknowledge and let go of her 'fears and attachments'. Using language of mindfulness, Susan deconstructed how this has positively affected her midwifery practice, bringing greater authenticity to her work:

'I now attend to these feelings with compassionate awareness. This manifests as giving myself time, when I feel a need to do something I bring my attention to my breath to become truly present and then assess if there is an actual need or was it just my need. I find that this helps me to act more appropriately and with more authenticity.' (Nar: 37-40)

Moreover, during the interview, Susan reflected upon the evolution of her (longstanding) midwifery practice. It was during a massage research study, she witnessed a different style of midwifery that 'triggered a change' both within her

professional practice but also personally. Susan constructed this pivotal moment as a time for 'personal growth' kindling a spiritual self. Moreover, Susan perceived a mutual benefit in her new style of caregiving, where she gained 'more':

'So that you know triggered a change and then I think personal (..) personal growth away from being a midwife kind of finding mindfulness and meditations (..) getting to know myself more deeply, more spiritually and (.) things and then how that influenced recognising, you know it is a real toing and froing and with that a quite organic way of developing of learning... being present with women is (...) uhm is I guess is a two straight street (..) whatever (..) me being present for them, it has brought (..) more for me (.) being able to watch that whole energetic dance (..) you know (.) the whole fear thing and seeing, you get to see (..) uh life, the microcosm of life itself the entirety of your existence played out in (.) in a myriad of ways by different people in this dance of labour... (Int: 282-296)

8.5 Conclusion

This second narrative analysis aimed to explore the midwives' sense of feelings, emotions and embodied experiences that related to supporting and facilitating women's alternative birthing choices. The findings presented relate specifically to the dominant meta-story I identified within the participant's accounts. Three overarching storylines are presented that reveal a wide range of experiences that were mediated by social and cultural contexts. The midwives' ability to practice woman-centred care were influenced by their working environments. Negative experiences were characterised by a misalignment between the midwives' philosophy and that of their colleagues and/or organisational cultures. Positive experiences were characterised by an alignment. Moreover, these findings suggest that where midwives had enough like-minded colleagues (intra and inter-professional), challenges to delivering women-centred care were minimised.

The findings suggest that both virtuous and vicious cycles (Downe, 2010) affect the midwives' wellbeing and their ability to care for women. Furthermore, these findings highlight the amount of work – emotional labour and the mental load – that is involved in caring for women making alternative birthing decisions and/or creating institutional changes to deliver improved woman-centred care. Thus, the findings revealed the 'invisible' work required to deliver such care. Consideration of the work involved highlighted important issues of sustainability. Where midwives are working

in physical or emotional isolation, their approach is unlikely to be sustainable. Conversely, the findings also illuminated the positive benefits of relational based care to the midwives. Where such midwifery practice was normalised, the midwives' wellbeing was positively enhanced. Moreover, the personal benefits of reciprocity were also highlighted in accounts of love, awe and emotional gains. These findings offer valuable insights into the positive experiences that are possible, despite institutional constraints. Overall, they offer a 'window' into the experiences of midwifery practice, whilst acknowledging that the subjective and contingent nature of knowledge generation. The findings of the analyses in both chapters seven and eight have been used to develop a theoretical model, presented in the next chapter.

Chapter 9 Interpretative Model

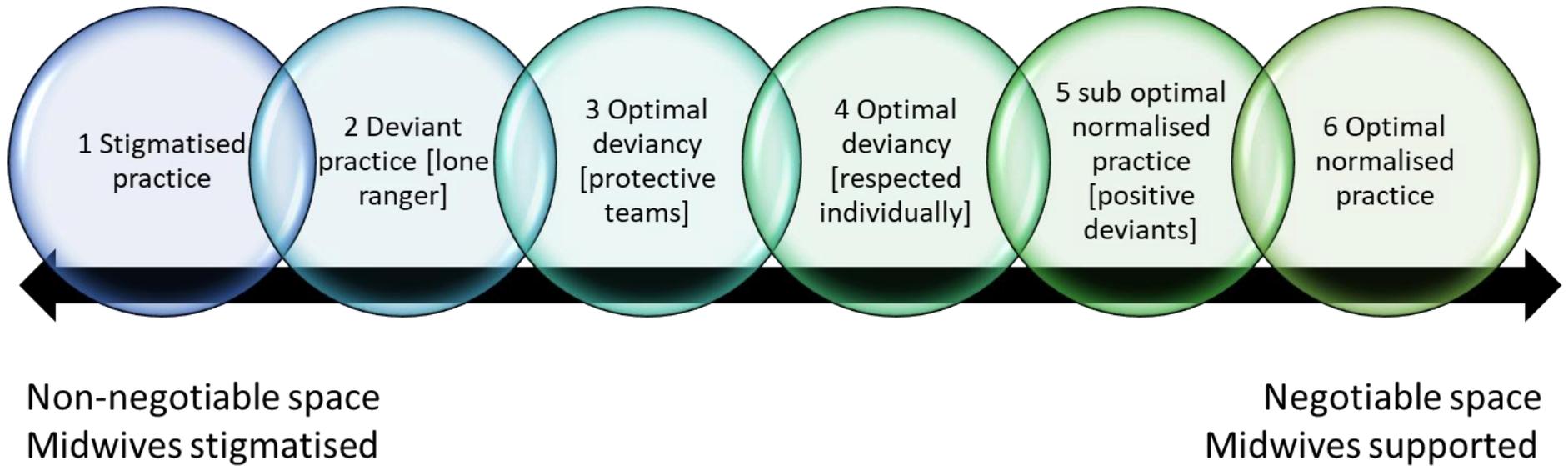
9.1 Introduction

The previous chapter presented the midwives' experiences of facilitating women's alternative birthing decisions. The findings revealed dominant storylines across a spectrum between negative to positive experiences, mediated by their working environments. In this chapter, I draw on data from the previous two chapters and the wider data set to present findings that related to the third research question. As previously discussed (Chapter 5, section 5.4), rather than a third analysis, an interpretative model was developed to account for the midwives' sociocultural-political context of practice. Notions of stigma/normal, deviance/positive deviance arose inductively from the data analysis which was explored at length with the theoretical literature to confirm their applicability to the data (discussed p.115). As such, this chapter is presented as the following; the first section presents an overview of the model. The second section provides the theoretical literature used to explain the data. The final section integrates the midwives' micro, meso, and macro working contexts data with the theoretical literature to present the six-domain interpretative model encompassing '*stigmatised to normalised practice*'.

9.2 An overview of the model

The theoretical model situates the midwives across a spectrum of stigmatised to normalised practice, illustrated in Figure 15 as six domains. It is important to note that one midwife did not fit in any of the domains. Whilst she participated in the study, she reported that she did not care for women making alternative birthing decisions often, therefore, could not be situated within the model.

Figure 15 Theoretical model- stigmatised to normalised practice



9.3 An overview of the theories

Central to the theoretical model are notions of normal/stigma, deviance/positive deviance. These concepts were used to develop the findings into broader meanings. An overview of the theories is presented below. The synthesis of the findings and theories to produce the model is presented in section 9.4.

Normal/stigma, deviance/positive deviance

Stigma can only be understood in relation to constructs of 'normalcy' and vice versa. To be stigmatised correlates with perceptions of being abnormal (Misztal, 2001). 'Normalcy' is a social construct located within particular social, cultural and historical meanings (Frost, 2011). Misztal (2001) argued that notions of 'normal' manifest as the 'taken-for-granted' value of everyday life. A sense of normality makes the world predictable, reliable, legible - fostering a sense of 'things as usual' (ibid). Goffman (1963) viewed normality as a collective representation (of a given group/society) sustained by interactional rituals. Thus, notions of normalcy are based on implicit and explicit social interactions where people gradually acquire practical and tacit knowledge that enables them to understand how to act within a particular environment (Goffman, 1963). Therefore, normalcy operates within relational contexts, contributing to social order (Goffman, 1963; Misztal, 2001). This can have both positive and negative consequences (Goffman 1963).

Misztal (1996) argued that shared senses of normality fosters feelings of predictability and reliability, that in turn, generates social trust; *'trust is an outcome of situational normality (p.314)'*. Trust can be defined as *'the mutual confidence that no party to an exchange will exploit another's vulnerability (p.1133)'* (Sabel, 1993). This definition indicates acceptance of risk and uncertainty is required for mutual trust to occur (Sheppard & Sherman, 1998; Luhmann, 2000). Therefore, for Misztal (1996), social trust is an outcome of shared senses of normality, that generate cooperation through reinforced expectations of reciprocity. Conversely, Garfinkel (1963), considered that judgements of normality, and by consequence social order, *are a consequence of* evidence of trust between two parties. Thus for Garfinkel (ibid), trust was integral to the construction of normality rather than being a product of shared notions of what is normal. Conceivably, trust may be involved in both the production and consequence of normality. If trust is required *for* cooperation to retain a sense of normality (ibid), and where both parties keep their social contract (do not exploit the other through mistrustful activities), then trust and cooperation are mutually reinforced. Therefore,

trust can be seen also as an outcome of situational normality (Miształ, 1996). Regardless of whether trust is a component or a product of retaining a sense of normality, social trust can be seen as a *'stabilizer of social order (p.313)'* (Miształ, 2001). In this context, notions of normalcy are tied into notions of trust (Luhmann, 2000), cooperation and reciprocity (Scott, 1999).

Goffman (1971) provided a theoretical lens to examine social interactions to discern how normal order is constructed, including 'normal appearances'. Goffman (ibid) asserted that the appearance of normality⁴⁷ counted more than actually *being* normal. Such appearances of normality limit the perceptions of threat to those around us, enhancing peaceful, safe environments (Miształ, 2001). The preservation of daily routines, ordinary living, means that the reality of unpredictability is concealed (Miształ, 2001). For individuals whose beliefs, attitudes, etc. are not aligned with the social order, this can require effort for them to 'pass as normal' (Miształ, 2001; Frost, 2011). Moreover, 'passing as normal' contributes to Garfinkel's (1963) other argument that notions of normality are bound in conceptualisations of morality. Therefore, being perceived as abnormal, or causing disruptive events to other's perceptions of normalcy can lead to moral judgements about that person (ibid).

To be perceived as 'abnormal' or 'deviant' gives rise to stigma (Link & Phelan, 2001). Deviancy relates to attributes, attitudes, behaviour or actions that are perceived to violate local norms (Dodge, 1985; Adler & Adler, 2015). Stigma was defined by Goffman (1963) as:

'an attribute that can be deeply discrediting, which reduces the whole persons to tainted and discounted others (p.3)'.

Whereas Herek (2009) later defined stigma as:

'the negative regard, inferior status and relative powerlessness that society collectively accords to people who possess a particular characteristic or belong to a particular group or category (p.441)'.

Frost (2011) argued that the shift of definitions moved the origin of stigma from an individual identity (perceived defect) to the societal level. Therefore, meanings attributed to deviancy behaviours and stigma are socially, culturally and historically located, and can change over time (Frost, 2011; Herek, 2009). Link and Phelan (2001)

⁴⁷ Normal appearances relate to behavioural attributes not facial/body features, although facial/body features can also be a component.

highlighted components of stigma as; labelling, stereotyping, separation, status loss and discrimination. Their model argues that labelled/stereotyped people are placed in distinct categories, thus 'separated'- accounting for divisions of 'us and them' (ibid). Notions of us and them can be traced back to Émile Durkheim's [1912](1995) seminal work that identified the power of shared group identification. Durkheim claimed that shared experiences, values, norms and beliefs contribute to feelings of belonging and solidarity, and reinforce group identification (Durkheim, 1995). Danger occurs when a group perceives a threat to their stability by 'others' (Beyer, von Scheve, & Sven, 2014), which creates the conditions for labelling and stigmatisation to mitigate against the threat (Phelan, Link, & Dovidio, 2008; Beyer et al., 2014). Moreover, the process of stigmatising 'others' may strengthen the social bonds for those who are in the 'in' group (Durkheim, 1995).

Power imbalances are also a characteristic of stigmatisation (Foucault, 1975; Link & Phelan, 2001). Foucault (1975) argued that institutional hierarchies enforce 'normalisation' via disciplinary tactics to both create and retain power, and to maintain social norms. Hierarchies play a significant role in power differentials, arising in both small informal social groups and macro groups i.e. institutions (Link & Phelan, 2001). Where a person is situated within a hierarchy is largely dependent upon their perceived status (ibid). Link & Phelan (ibid) suggested that some stigmatised people may experience low status from the outset of joining an organisation, often related to discrimination (i.e. gender, ethnicity, class, job role etc.) Others may experience a loss of status that occurs by a process of devaluation, discrimination and prejudice (ibid). Low status and/or a lowering of status can have negative consequences for the individual; mentally, emotionally, physically and financially (Phelan et al., 2008).

Recent research has identified that experiences of stigma operate as a 'social stressor' which leads to individuals trying to adapt intrapersonally and/or interpersonally often with negative consequences (Meyer, 2003b; Frost, 2011; Thoits & Link, 2015; Doyle & Molix, 2018). The onus may be placed upon the stigmatised person to manage others perceptions of them, known as 'stigma management' (Frost, 2011). This form of 'management' mirrors Goffman's (1963) 'passing as normal' whereby a stigmatised person has to decide whether to conceal or make visible their stigma⁴⁸.

⁴⁸ For those with visible 'stigmas', this can be a particularly difficult and a significant source of stress (Frost, 2011).

Whilst concealing one's stigma can be a protective mechanism, it is also a cognitive burden (Frost, 2011). In addition, internalising stigma can impact on one's self-identity resulting in self-devaluation (Meyer, 2003a). An integrative review carried out by Frost (2011) identified a number of impacts regarding the cognitive burden of stigma; negative impacts upon a person's mental health, physical health including biomarkers such as cardiovascular disease, poorer health outcomes, increased risk behaviours, poor job performance and satisfaction.

Frost (2011) also identified coping mechanisms that stigmatised people employ. Individual coping mechanisms may include positive strategies such as meditation, expressive writing or attempting to change the circumstances (Thoits, 1995; Swim & Thomas, 2006; Thoits & Link, 2015). Conversely, maladaptive coping strategies such as increased alcohol, drug, smoking, or food consumption may be used at a cost to their physical health (Hayward, Vartanian, & Pinkus, 2018; Pollard, Nadarzynski, & Llewellyn, 2018; Wardell, Shuper, Rourke, & Hendershot, 2018). Group-level coping processes include the reliance on others in a stigmatised group to provide physical and psychologically safe environments, with some evidence to suggest that it can reduce the negative ill-effects of being stigmatised (Meyer, 2003a; Frost & Meyer, 2012; Kumar, Mohanraj, Rao, Murray, & Manhart, 2015). However, other researchers have highlighted how some employ meaning-making processes and narrative strategies to overcome the delimiting effects of stigmatisation (Crocker & Major, 1989; Shih, 2004). Unger (1998) a critical feminist, argued that notions of 'positive marginality' may foster agency and resilience, highlighting alternative responses that individuals may have to such stressors. Active resistance and the exertion of agency to reclaim experiences of being marginalised (Campbell & Deacon, 2006; Farrugia, 2009; Savio, 2016) can manifest as activism and attempts at social change (Hall & Fine, 2005; Riggle, Whitman, Olson, Rostosky, & Strong, 2008).

Positive marginality can also be viewed within the lens of positive deviance. Spreitzer and Sonenshein (2003) defined positive deviancy as the intentional behaviours that depart from the norms of a referent group in honourable ways. Moreover, they emphasised that the focus should be on intentions not outcomes, for positive outcomes do not always follow positive intentions (Spreitzer & Sonenshein, 2004). In a conceptual review of positive deviancy, Herington & van de Fliert (2018) consider positive deviancy to be a theoretical concept or a practical strategy. From a theoretical perspective, positive deviancy can aid understanding of how and why

positive deviancy occurs, the circumstances it occurs, thereby contributing knowledge regarding human social processes (Herington & van de Fliert, 2018). From a practical perspective, studying positive deviancy offers the development of frameworks to facilitate the improvements of social problems (Lawton, Taylor, Clay-Williams, & Braithwaite, 2014; Shoenberger, Heckert, & Heckert, 2015; Herington & van de Fliert, 2018). Singhal and Dura (2017) argued that attention to positive deviancy signalled a 'practice turn' in social science studies- moving away from an evidence-based practice approach where problems are researched and disseminated that are decontextualised from everyday practice, to 'practice-based evidence' which is a practical problem-solving, bottom-up approach.

9.4 '*Stigmatised to normalised practice*'- A theoretical model

By drawing upon normal/stigma, deviance/positive deviance theories, I now present a theoretical model that describes different levels of facilitation of women's alternative birth decisions. Table 13 presents the attributes of each domain, highlighting the interaction between the participant and her/his organisational environment, accounting for the micro, meso, and macro sociocultural-political context. The domains are discussed in relation to the theoretical literature below.

Table 13 Typology of midwives experiences within their micro, meso, and macro workplace contexts.

Model	Personal level	Immediate team	Wider team; management, obstetrics, MDT	Broader organisational context	Participants
1. Stigmatised practice	Normal practice for the individual, but is isolated, marginalised and stigmatised. Experienced negative reprisals and punitive action.	Unsupported by immediate team generally (might have one/two good relationships). Frequent conflicts and arguments.	Little support from MDT, or senior staff or management. Frequent conflict/battle when facilitating women's choices. Fears/experiences reprisals/punitive actions.	Little or no pathways or processes, poor or no leadership for women's choices. Hierarchal and patriarchal working culture and structure. Toxic culture for the midwife.	Leanne, Georgina, Beatrice
2. Deviant practice [lone ranger]	Normal practice for the individual, but is isolated, a 'lone ranger'.	Unusual practice within the immediate team, frequent conflicts, but the midwife is generally able to deliver women's choices- but at a cost to his/her wellbeing.	Mixed support from MDT, senior staff or management. Frequent disagreements when facilitating women's choices. Although does maintain some level of relationships with wider team.	Little or no pathways or processes. Poor or no leadership for women's choices. Hierarchal and patriarchal working culture and structures. Challenging culture for the midwife.	Alex, Seana, Clara, Ginny, Katie, Margot, Maria, Meg
3. Optimal deviancy [protective teams]	Normal practice for the individual.	Normal practice for the immediate team, supportive relational team working. Collectively, they are mostly able to deliver women's choices.	Mixed support from MDT, or senior staff or management. Frequent conflict/battle when facilitating women's choices. Divisions between community midwives and hospital midwives.	Pathways and process may be present but are not acknowledged by the wider team/trust. Inconsistent leadership. Challenging wider culture for the midwife but has team as a protective factor.	Laura, Kelly, Stella, Zoe, Kate, Jess, Edna, Rose

4. Optimal deviance [respected individually]	Normal practice for the individual.	May or may not work in teams fully supportive of women's alternative choices, but as an individual midwife, s/he is respected and enabled to facilitate women's choices.	Whilst some conflicts may occur, negotiation with MDT, or senior staff or management is feasible. Facilitation of choices may not be culturally embedded, inconsistency present, but as an individual practitioner, s/he is supported to support women's choices.	Pathways and processes are present but inconsistently used across the organisation. Facilitation appears to be dependent upon individual practitioners. Positive leadership. Minimally challenging for the midwife to deliver woman's choices.	Delilah, Jane, Catherine, Susan
5. Sub-optimal normalised practice	Normalised practice for the midwife- is in a leadership role.	Faces fears and resistance from midwife caregivers.	May have support from obstetrics and MDT, but may also experience conflicts. Challenges of embedding change across the service.	Role has introduced pathways, processes, liaison with MDT and legal teams. Has supportive leadership. Challenging culture for the midwife, but change is occurring.	Kelly, Rachel, Tracey, Stella, Jenny, Isabel, Hannah, Lauren, Jenna, Trish
6. Optimal normalised practice	Normal practice for the individual.	Normal practice for the immediate team.	Supportive management, senior staff, MDT and leadership. Collaborative working relationships with MDT which are mostly consistent – has 'critical mass'.	Supportive pathways within the Trust, embedded across the maternity service. Processes accessible by women and midwife. Proactive leadership. Wider culture supports woman-centred decision-making, and midwives delivering their care.	Sam, Anna, Caz, Brigid, Becky, Claire, Emily, Kim, Alice, Lucy, Kerry, Amy, James

1 Stigmatised practice

This domain represents three midwives whose normal midwifery practice was to facilitate women's choices but who were isolated, marginalised and experienced negative reprisals including investigations and referrals to the NMC for unsafe practice. In this situation, the midwives appeared to sit outside of their sociocultural working norms and were perceived as negative 'deviants' (Dodge, 1985). This resulted in varying degrees of stigmatisation. In two instances, poor birth outcomes appeared to 'make visible' the midwives' 'deviant practice'. In the other, it appeared the facilitation of a woman's birth without the use of continuous electronic fetal monitoring positioned the midwife within a deviant role in the eyes of their colleagues. Normalised practice for the organisation could be characterised by hierarchal and patriarchal cultures where women and midwives' autonomy appeared to be devalued. Guidelines were perceived as authoritative and super-valued over women and midwives' autonomy. Arguably, guidelines were a cultural representation of patriarchal and hierarchal dominance (Berg, 2000; Rogers, 2004; Goldenberg, 2009) and a tool of '*disciplinary power*' (Foucault, 1975). Therefore, in these situations where the midwives did not sustain 'the interactional rituals' (Goffman, 1963) of their working environments they were 'othered'.

Drawing on Misztal's (1996) notions of normality which fosters predictability, reliability and a 'sense of things as usual' then these midwives appeared to cause tension and threatened the 'social order' of stability. The disruption of social order was particularly profound in situations where a poor outcome occurred. The public nature of the reprisals or investigations subsequent to an adverse event meant that they were no longer able to 'pass as normal' (Goffman, 1963). Separation occurred via either removing the midwife from her clinical area, stopping a service the midwife was heading up or through prolonged investigations (highlighted in Chapter 8). Such separation and the stigma associated with being investigated resulted in 'status loss and discrimination' (Link & Phelan, 2001) rendering the midwives powerless until the investigations had been completed. These midwives became 'othered', situated into marginalised position, where 'separation' (Link & Phelan, 2001) of midwives from their clinical area suggested '*disciplinary tactics*' (Foucault, 1975) to retain social norms.

Moreover, these midwives felt that they were judged to be immoral in their violation of local social norms (Garfinkel's (1963). Applying Link and Phelan's (2001)

components of stigmatisation, the midwives felt that their colleagues believed they were *'brainwashing women'*, and that women would not make 'bad' choices if they were attended by different midwives that were more aligned to local norms. Such *'discrediting'* (Goffman, 1963) by their wider teams resulted in their stigmatised position and greater scrutiny, resulting in the belief amongst the *'deviant'* midwives that others thought they were dangerous practitioners (highlighted in Chapter 8). Moreover, constructs of *'bad choices'* or *'bad midwives'* belie a patriarchal social norm of assumed compliance of midwives and women, as highlighted by Georgina:

'...but again the underlying doubt is always is this 'is it actually her choice? or has the midwife convinced her to have a physiological third stage because the midwife would always choose what is natural' (.) and that is disturbing to me because uhm (.) it belies the notion that (.) actually women choose what you need them to choose and that's the way perhaps other health professionals operate, whereas (.) you know whereas people don't notice when women under my care choose to have an epidural or choose an active third stage they just always notice when they choose not to (..)' (Int: 207-213)

Negative consequences of being stigmatised were found across all three accounts including the deterioration of the midwives mental, emotional, and physical wellbeing (Phelan et al., 2008; Frost, 2011). Moreover, the deleterious effects also impacted the midwives' financial wellbeing as limitations placed on their practice restricted their income capacity⁴⁹. Thus, the midwives experienced a significant *'social stressor'* (Frost, 2011) where they adapted in different ways. All midwives appeared to *'manage their environment'* (Frost, 2011), one by leaving the Trust and seeking support for her midwifery practice elsewhere. Another midwife reported making significant changes to her midwifery practice that resulted in *'defensive practice'* (Symon, 2000; Ortashi, Virdee, Hassan, Mutrynowski, & Abu-Zidan, 2013) and avoidance of working alone during intrapartum clinical care:

'...I was also very defensive and I was always getting colleagues in to check ... I am on call for homebirth, but that is a bit different because if you need to, you just go straight into hospital and hand over (...)... I am happy to go out, I am happy go and do that but you always have a 2nd midwife you always go in pairs. But I will always be the one

⁴⁹ Depending upon the nature of the investigation and/or outcome midwives' practice could lawfully be restricted. In some cases, this would be suspension from midwifery practice until the investigation has been finalised. In other cases, where a midwife is on *'supervised'* practice finding work elsewhere (another Trust, agency etc.) can be restricted.

standing back, and happily doing the documenting and let the other midwife take over.'

[Leanne Int: 344-362]

Whilst practicing this way ran counter to Leanne's beliefs about midwifery, such was the trauma of investigation, she adapted her midwifery practice to protect herself. She was also making plans to leave the profession. Another participant, Beatrice, sought a research role by way of 'active resistance' (Campbell & Deacon, 2006), as highlighted below:

'Could I leave midwifery? ... It is better to build bridges than walls. Or more prosaically, 'it is better to be inside pissing out, than outside pissing in'. So I am researching to a standard that might even attract the approbation of Don Quixote by achieving a marriage of facts and truth. And preparing for my next joust with a windmill.' [Beatrice

Nar: 70-74]

2 Deviant practice [lone ranger]

This domain represented the midwives whose personal practice of facilitating women's choices was not within local norms of practice, where s/he worked in relative isolation with little support- a 'lone ranger'. The midwives differed from those in the previous domain as they appeared to practice their preferred midwifery whilst retaining some 'membership' of their teams. However, those relationships were characterised with frequent conflicts and a lack of support. The midwives appeared to be identified as social 'deviants' which they managed by a combination of 'fighting' back, subversive tactics to deliver woman-centred care and attempts to 'pass as normal' (Goffman, 1963). The misalignment between the midwives' notions of 'normalcy' and their colleagues left the midwives vulnerable to consequences of stigmatisation. There are similarities for midwives in this domain and the first domain of stigmatised practice i.e. the misalignment between the midwives' moral values predisposed them to experience 'moral distress' (Rushton et al., 2013; Borhani, Abbaszadeh, Nakhaee, & Roshanzadeh, 2014), with detrimental effects upon their wellbeing. Similar to the midwives in domain 1, the midwives financial position was also negatively impacted as they adapted by reducing their working hours. Whereas others required sick leave due to the adverse impact on their wellbeing.

Salient differences between these two groups of midwives related to fears rather than actual experiences of investigations. In addition, through a process of 'stigma management' (Goffman, 1963) the midwives' '*picked their battles*' (highlighted in

Chapter 8) in order to maintain social working relationships, that suggested that midwives were unable to practice the full scope of midwifery all of the time. Whilst this was a source of distress, it meant that the midwives attempted to manage the tensions arising from their practice to limit the perception of 'threats to the social order' (Misztal, 1996). Such practices were arguably employed to garner trust, cooperation and reciprocity (Misztal, 2001) from their colleagues and to retain membership of their 'groups' i.e. wider teams. One participant referred to it as '*playing the long game*'- picking her battles, keeping up appearances long enough to be in a job role with more power (i.e. senior midwife) in which she could actualise her midwifery ideal.

Such acts of stigma management are suggestive of the power imbalances within the participant's workplace. In these situations, the onus appeared to be on the midwife to manage the tensions arising from others' perceptions of their midwifery practice whilst continuing to deliver what they felt to be authentic midwifery. As such, these midwives were in somewhat powerless positions, where fears of '*penalties*' for their midwifery practice created tensions:

'...the way that the maternity services are, where I work there is a fear that is very large (..) it's a fear, yea (..) it's something I am very (..) very conscious of (..) there are things that I'd be thinking about, like documentation, how am I expressing what's happening, how do you justify yourself? To a a (..) probably negative critic...' [Meg Int: 44-49]

Such tensions related to the feeling of constant scrutiny, and fears of negative consequences that could threaten their job status and/or financial security. In these situations, the midwives were managing the tensions in practice to prevent escalation of their perceived 'deviancy' to the full extent of stigmatisation. Perceptions or experiences of 'surveillance' (Foucault, 1975) could be attributed to the midwives' awareness they needed to 'manage stigma' (Goffman, 1963). Foucault (1975) argued that hierarchised, continuous and functional surveillance contributed to an integration of systemic power that is both explicit as it is everywhere, yet insidious as it is largely silenced. This was highlighted by Alex:

'...but whereas you go onto an obstetric unit you do find that the doctors, although you are supposedly autonomous they are watching over your care. The way the birth suite is set up where they have all the monitors and the computer IT systems when you are in

the room with a lady and you write down everything but they are being watched by the doctors at the same time... [Alex Int: 165-169].

3 Optimal deviancy [protective teams]

This domain represented the midwives whose personal practice of facilitating women's choices was normal within the local midwifery team but deemed 'deviant' in the wider organisational context. Midwives in this domain worked within teams that were *'like-minded'* deviants. Operating within a 'relational model of working', the midwives' immediate co-workers were friends or *'like sisters'* (highlighted in Chapter 8) indicating closeness, mutual respect and reciprocity. Being able to rely on each other, to bounce ideas, to provide support when work was challenging characterised the midwives' experiences. As such, the teams operated as a source of resilience, providing mutual protective factors against individual vulnerability and the threat of full stigmatisation. This domain could be viewed with a positive deviancy lens (Herington & van de Fliert, 2018). However, the accounts of midwives working within this domain were characterised by numerous difficulties, conflicts and challenges between the midwives' team and wider organisation (either management or the multi-disciplinary team), with inconsistent support from leadership. Unique to this domain is that all of the midwives were community-based. This may have accounted for a particular sense of 'us and them' (Link & Phelan, 2001). I have used the term 'optimal deviancy' to describe the way in which behaviours are seen as deviant to the wider organisation operated to create positive team environments, as reported by the study respondents.

Respondents in this domain worked within teams where a woman-centred philosophy of care was mostly deliverable and was 'normalised practice'. The midwives who worked in this context shared the values and beliefs of the team, thereby mutually reinforcing their team's social norms; such practices illustrating the notion of normality as a collective representation sustained by interactional rituals (Goffman 1963). The alignment between the midwives personal values and that of the teams they were working in - their *'ethos to care'* - created space for the midwives to acquire the practice and tacit knowledge (Goffman, 1963) to enact their preferred midwifery philosophy (highlighted in Chapter 8). Their ability to enact their midwifery was socially contingent on mutual values, exemplified by Rose:

'I think I just liked the way they worked I just knew that's what I definitely wanted to do...I think probably just working with the right people in the right team... I know very much that I don't work well in the hospital, I really like being at home so by virtue of that, you start working with people that feel the same and you start with women who feel really strongly about that as well so it becomes a little bit more normal and it snowballs from there (.)' [Int: 165-170]

Midwives in this domain reported that trust was an outcome of the alignment of values and beliefs among team members. This resonates with trust as producing normality (Garfinkel, 1963), and with the concept of situational normality (Misztal, 2001). The alignment between the midwife and the team's midwifery values communicated feelings of safety for the midwife to practice her preferred midwifery (highlighted in Chapter 8). Thus, trust constructed and perpetuated the normalcy of delivering/practicing woman-centred care as highlighted by Laura:

'It is a real nice caseloading job which you don't really get in the normal community setting...But we all have the same ethos, and we all work really well together and I think that's what helps us, cos we have got really good rates as well (.) and being a really tight knit team, and knowing exactly how each of us works helps us. Um, support each other...but I think when you are with people that support you and also that are there to have your back as well, it really makes a difference' [Int: 105-121]

Midwives reported that trust between each other was represented by reciprocal feelings of safety, in which they were enabled to ask questions and not to fear ridicule (highlighted in Chapter 8). Whilst trust was central to the immediate team relationships, this did not transfer across to wider hospital teams. Divisions of 'us and them' (Link & Phelan, 2001) were similarly identified in this domain where the midwives' (and their teams) were labelled with a 'reputation', 'troublemakers' or 'brainwashing women'- so far a consistent finding across perceptions of deviant midwifery. Contributing to the divisions between community and hospital midwives, are likely the different working practices or structures, roles and physical locations. By virtue of their role, community midwives often have greater independence than hospital midwives and are less visible on the wards. A lack of personal relationships between midwives working in the community and those working in the hospital resulted from reduced opportunities to build intra-professional relationships. This is highlighted by Rose:

'...and also being community midwives they don't know very much we probably get more suspicion than other people (.) which is slightly off topic but they think 'who is this person in their own clothes who I have never met before, who has waltzed into labour ward in her sandals' or something (laughs)' [Int: 391-394]

4 Optimal deviancy [respected individually]

This domain represented the midwives who normally facilitated alternative women's choices but where such practices were not fully embedded across their immediate teams or wider organisational cultures. In contrast to the previous domain, where the midwives operated within 'protective teams', these midwives, were largely able to deliver woman-centred care without 'protective teams' and despite an incongruence within the localised culture. These midwives reported that their colleagues typified their practice as 'different', but did not label or stereotype it as (morally) 'deviant'. Where conflicts or challenges arose, these did not appear to be perceived to threaten their colleagues' notions of 'normalcy' (Misztal, 2001). In turn, the midwives in this domain did not appear to feel threatened by their colleagues. Overall, the midwives reported that they were respected in their working environments, on an individual level, and were largely able to deliver woman-centred care unencumbered. This is exemplified by Susan:

'The birth plan for this lady was quite extensive and had been discussed at length with the Consultant Midwife prior to coming in. At handover she was proclaimed as 'one for me', with rolled eyes at the birth plan.' (Nar: 12-14)

The midwives in this domain appeared to have developed (largely) positive working relationships with their midwifery and MDT colleagues, despite their different midwifery style. Although all the midwives in this domain reported several frustrations regarding their organisational cultures, these did not appear to detrimentally affect their personal midwifery practice. All of these midwives seemed to have garnered the respect of their colleagues. In essence, they were trusted to '*get on with it*'. This might be explained by their extensive clinical experience- all of them had over 20 year's clinical experience and/or had been employed within the organisation for many years. Conceivably, these factors contributed to the development of mutually respectful and trusting working relationships. Highlighting this, Catherine described conversations with obstetric colleagues who were supportive of women's alternative decision-making, *if Catherine was the midwife*

caregiver. Other midwives were reportedly identified as a '*type of midwife*' particularly suited to women requesting out of guidelines care. In these situations, the women were labelled (Link & Phelan, 2001) and the willingness of the participant to care for the woman appeared beneficial to the team as they did not want to look after the woman. Therefore, what could be deemed deviant behaviour in other contexts, was viewed favourably in these specific situations.

5 Sub-optimal normalised practice [positive deviants]

This domain represented the midwives who facilitating women's choice as part of their usual practice. In addition, they were 'change agents' (Herington & van de Fliert, 2018) as they worked to improve women's access to choices and embed woman-centred care within their organisations. From a positive deviancy perspective, the focus on improving access to choice for all women can be deemed as '*honourable and intentional behaviours that depart from the norms of the [organisation] referent group (p.842)*' (Spreitzer & Sonenshein, 2003). Unique to this domain, all midwives were in leadership (senior) positions and were 'positive deviants' by virtue of their role. They were enabled as positive deviants by supportive leaders (usually the Head of Midwifery) as some midwives were employed specifically to develop, manage, oversee this component of midwifery practice. Other midwives used their senior position to collaborate with colleagues and senior leaders to drive the change. Either way, as leaders and senior midwives, their roles involved ongoing collaboration, negotiation with the wider MDT (obstetrics, paediatrics, legal departments) and the midwives who would be expected to deliver the care. This domain represented the 'in-flux' nature of change as highlighted in Chapter 8.

The midwives' roles situated them in a unique position in the organisation. For example, they were a senior member of staff, yet not a manager. They had extensive clinical experience, yet not deemed a front line worker as much of their work was 'behind the scenes'. Most of the midwives were consultants, yet not part of the collective obstetric consultant teams. They were midwives, but worked across the settings (hospital, community, specialist midwives, research) and often not in a hands-on clinical way. As these midwives often worked alone, some reported feeling lonely and isolated. As such, there were multiple sources of 'us and them' (Link & Phelan, 2001) as they could be viewed as 'deviant' from different professional groups, and this required proactive engagement to overcome such labelling. Their seniority

and/or role, alongside the support of their leaders, may have offered some protection against the negative effects of being labelled or stereotyped. Highlighted by Isabel:

'...I would say that it has taken me a long time to forge those relationships with them (.) it really is been (.) I've found me being clinically visible and constantly supporting women (.) for example I am constantly in the antenatal clinic supporting women, going to meetings with the consultants, bringing cases to the consultants, talking with the cases with the consultants, it's taken a lot of leg work to get there... that's really just part and parcel of culture change, isn't it? and no it's not always been like that (.) I think (..) there has been inroads I suppose you know I didn't forge the way completely, there were inroads but uhm (.) yea it has taken a lot of time and its onerous when it does end up coming down to one individual and I know the wider Supervisory team (..) does support but often we have different opinions (..) so uh yea (.) makes it a little bit more challenging (.) can be very isolating too' [Int: 42-61]

Whilst most of the midwives reported the occurrence of positive cultural changes across obstetric, paediatric, legal and management teams, they also reported that front line clinical midwives delivering the care to women were a major source of resistance. Such resistance was reported to be attributed to fears of accountability, or of being blamed or scapegoated in the event of a poor outcome as highlighted in Chapter 8. Most of the midwives in this domain empathised with the front line staff and commented that all staff needed a sense of '*professional safety*' and trust in a non-punitive culture to overcome their resistance to change:

'...the sense of anger amongst the community team was actually quite palpable, and now it is something that is accepted and it's something as normal' [Hannah Int: 253-254]

Therefore, change involved extensive work that included the formalisation of care pathways, systems of referrals and care plans. These processes were viewed as a method of 'legitimising' women's choices and provided a physical indicator of a cultural shift occurring. Moreover, the formalisation processes were also viewed as supportive mechanisms for clinical staff delivering the care. Visual artefacts such as new guidelines, pathways and referral processes symbolised the new 'social contracts' (Misztal, 1996) that were being put in place, meaning that the clinical staff could rely on organisational support for delivering such care:

'... I think it [care plan] empowers midwives to support women whereas maybe they, some midwives are more nervous about it, but if they have this robust plan, it empowers them to do the stuff that they really want to do...' [Jenny Int: 385-398]

6 Optimal Normalised practice

This domain represented midwives whose normal midwifery practice facilitated women's alternative choices; practices that reflected the cultural norm of their teams and across their organisations. Being a change agent was less important for those working within this domain because in their local situation, women's choices were already authentically embedded within the organisation. These midwives appeared to work in organisations that had reached critical mass (Oliver & Marwell, 1985) across the professional groups and organisational structures. Some tensions or conflicts may have arisen, but these appeared to be the exception rather than the norm. The midwives seemed able to work around resistant colleagues with minimal effort:

'...so I think yes we do, we might have uhm, you could say a bit of conflict maybe if the medics are like 'why is this woman having her baby at home in the first place' sort of thing, but... usually we don't come across too many problems really...' [Anna Int: 176-185]

Of note, this domain was populated by midwives from a range of settings (community/hospital), varying years' experience and levels of seniority. Therefore, the notion of 'normalised practice' was not ascribed to an individual or a team - it was characterised across the organisation. Optimal normalised practice reflected an alignment of values between the midwives preferred woman-centred practice and their immediate and wider multi-disciplinary teams. The everyday normality of respecting women's choices was represented by effective collaborative and multi-disciplinary working, supportive and accessible care pathways, referral or care planning processes that were embedded across the maternity services. Strong, supportive leadership that valued both women's choices and midwives' autonomy was present in all of the midwives accounts- highlighted by Sam:

'Our matron and our trust is very pro-homebirth and is very pro woman's choice, so you kind of have her support for these women who don't fit the guidelines, you know they're not textbook women kind of thing. Her attitude is 'as long as they know the risks and you've had the conversation'...' [Int: 74-86]

Midwives in this domain characterised 'normalcy' (Misztal, 2001) within 'good team dynamics' across intra and inter-professional groups marked by non-hierarchical working structures. Non-hierarchical workplaces manifested as a lack of professional territorialism, and approachable doctors and/or senior members of staff who were respectful of women's decisions and the midwives' professional autonomy. This furthered open and constructive communication and positive collaborative working across the professional groups. Mutual respect, cooperation and reciprocity appeared to be a product (Garfinkel, 1963) and an outcome (Misztal, 2001) of women's choices being 'normalised'. Kerry's account exemplified positive intra and inter-professional collaborative working:

'...when I first joined the trust when I had the time I used to go these weekly meetings with the doctors, registrars and midwives who would go through the cases of women on the ward and would go through the plan and say like 'is there any other options? has anybody heard of this before?' and that really blew me away (..) it's not all wonderful (laughing) there are definitely a few that are (...) and midwives that aren't perfect but there are some really good aspects of encouraging communication' (Int: 236-244)

Mutually reinforced 'collective representations [of the organisation] sustained by interactional rituals' (Goffman, 1963) appeared to strengthen the normalised culture. So much so, that some participants referred to new members of staff 'being shocked' to the apparent 'permissive' culture (highlighted in Chapter 8). In those situations, new members of staff were reported to be socialised quickly into adopting the organisational values with a reframed sense of 'normalcy'. The socialisation process also included the midwives' knowledge and skill sets. For example, the midwives in this domain often cited confidence and competence in their own skill set when caring for women with complex needs. The midwives then promoted a normalised culture by providing new midwives with ongoing support and enhanced learning opportunities to gain the skills necessary to deliver such care. By not limiting new midwives' exposure to women's alternative birthing choices, arguably the midwives created 'virtuous circles' (Downe, 2010)- furthering a woman-centred agenda:

'Yes we do a lot of work outside, so when the preceptor midwives come out we do our own home emergency skills and drills training with them uhm so just to try and give them that boost before they get out there and do it, so we do try to do a lot of homebirth based assessments, like we do assessments together with them and we do a lot of

additional support training outside of the actual labour environment and then it all comes down to making sure no one is ever on their own... So yea I think it's as much supporting the midwives as it is the women uhm because the last thing we want is a midwife to end up that they're not happy with and it ruins their career for them (..) uhm it doesn't take much to push midwives out of midwifery because the nature of the work we do (..) uhm so I think it's really important that we try and look after the newer people and make sure they're being supported...' [Alice Int: 320-332]

9.5 Conclusion

In this chapter, I have presented an integration of the empirical data with concepts of normal/stigma, deviance/positive deviance to generate understandings and provide an explanation of the findings. An inductive theoretical 'stigmatised-normalised practice' model has been presented that situates the midwives' actions and experiences in their local micro, meso and macro working contexts. The model also accounts for and explains the influence of the midwives' sociocultural- political working contexts. The next chapter presents an extensive discussion regarding the study original contributions, the findings in relation to the wider literature and the final conclusions of this thesis.

Chapter 10 Discussion & Final Conclusions

10.1 Introduction

This study set out to explore the processes, experiences and sociocultural-political influencing factors of NHS midwives who self-defined as facilitative of women's alternative birthing decisions. Through a sequential analysis, the findings have revealed the 'what, how, and why' – the actions of their midwifery practice (Chapter 7), that revealed nuanced insights into the nature of such work. Central to the midwives' processes were the relationships they forged with the women, highlighting that relational care is safe care. The findings generated new insights that trust operated both ways. When the midwives felt both trusted by and trusted in the women, they were confident to fulfil women's requests even in situations where women were radically 'outside of the guidelines'. However, the findings from the second analysis revealed polarised experiences in the enactment of such midwifery care (Chapter 8). The midwives' accounts exposed key micro, meso and macro working influences that affected their ability to practice woman-centred care. Where midwives were isolated and unsupported, they generated distressing accounts highlighting the negative impact upon their mental, emotional, physical and financial wellbeing. Conversely, where midwives were supported within relational teams and/or broader working contexts, the midwives' accounts highlighted positive effects of delivering authentic woman-centred care. Collectively, the findings were interpreted through a stigma/normal, deviant/positive deviant lens to develop a theoretical model to explain the findings within a broader sociocultural-political context (Chapter 9) to meet the final aim of this study.

The purpose of this chapter is to demonstrate this study's original contribution and to explore the findings in relation to the wider literature. In addition, limitations are presented alongside recommendations for practice, research and policy-making. Finally, this chapter will provide my closing reflective thoughts and draw this thesis to its overall conclusions.

10.2 Original Contribution

Women's autonomy during childbirth has been strongly advocated in the UK for decades (Kitzinger, 2005) and the role of midwives to support and facilitate women's physiological birth choices has been a fundamental component for midwifery philosophy, practice, and theory since the 1990s (DH, 1993). Recent and strong

evidence in support of the midwives' role in delivering safe, effective, and desired care situates midwives as the ideal professional to deliver 'full-scope midwifery' to fulfil what has been termed 'woman-centred' care (Renfrew et al., 2014). In Chapter 2, I argued that there was an alignment between 'full-scope' midwifery and women's physiological birth choices that are outside of the guidelines since facilitation of women's choices is a key part of the midwives' role. However, this was contextualised by known constraints, including medicalisation, institutionalisation, risk, governance, poor application of guidelines and evidence-based medicine, feminist issues, and even the disparities between 'types' of midwives⁵⁰. Moreover, Chapter 3 identified that, despite extensive policy rhetoric, legislation, birthrights movements, research and midwifery philosophy, there is a dearth of literature pertaining to midwives' experiences of caring for women who make decisions that contravene current guidelines for care. Fundamentally, Chapters 1-3 problematised physiological birth choices especially those outside of the current 'norms' for both women making those decisions and for midwives caring for them- I argued to be an inherently feminist issue.

Within this context, the empirical study was underpinned by feminist-pragmatism with ontological and epistemological commitments that assumes a practical approach to problem-solving and knowledge generation that implicitly accounts for gender, power, and structural contexts (Seigfried, 1996; Fischer, 2014; McHugh, 2015). Therefore, starting with the problem outlined above, an inherently feminist issue, a bottom-up approach to problem-solving was taken. Moreover, the feminist-pragmatism positioning of midwives as 'situated knowers' (McHugh, 2015) with the capacity to generate 'practice-based knowledge' (Singhal & Dura, 2017) was central to the study design and theoretical commitments. Such knowledge was collected via professional stories of practice, where narratives were considered knowledge devices (highlighted in Chapter 5). This study's original contribution relates to the pluralistic research questions, research design, and subsequent knowledge production that addressed the research gap regarding the midwives' processes (Chapter 7), their experiences captured as their emotion-stories (Chapter 8), and the impact of sociocultural-political contexts of practice upon the midwives' personally and professionally (Chapter 9). These are discussed further below, section 10.3. This study

⁵⁰ Discussed at length in Chapter's 1 & 2.

was the first to design, recruit, and collect national data from NHS midwives who self-defined as facilitative of women's alternative birth choices, and who worked across different practice settings (community/hospital), different models of care (continuity and fragmented) across different pay bands, specialities and levels of experience. Moreover, the large number of participants (n=45) strengthens the potential for transferability to other similar settings for employed midwives.

Narrative inquiry was a knowledge device in which to capture, explore, analyse and theorise the nature of experience for midwives facilitating women's alternative birthing choices. Using professional stories of practice, the narrative elicitation and analytical techniques applied to this study offered a critical window to explore the complexities of practice-based situations. Told from the midwives' perspectives, the stories were shaped by historical, sociocultural and political context, that operated on micro, meso, and macro levels. Because narrative inquiry (largely) resists seeking absolute truths and acknowledges the contingency of knowledge generation, it was an appropriate qualitative methodology for this study that broadly aligns with the epistemology of pragmatism. It also provided a way to generate useful practice-based knowledge. Moreover, the relational components of narrative research methods align with feminist methodological approaches, thus, congruency between the theoretical and methodological approaches was achieved. As such, the combination of a feminist pragmatist with a narrative inquiry methodology offers an original contribution to this study, as to date, no studies using this combination in midwifery research have been found.

Narrative inquiry independent of a feminist methodology has been used in other midwifery research projects (Williams, 2006; Weston, 2012; Marsh, Shawe, Robinson, & Leamon, 2016; Gould, 2017), but the use of self-written narratives along with interviews was a novel approach used in this study. There were several benefits to this approach. For example, where participants provided a self-written narrative, the accounts sometimes lacked feelings or emotional responses, or contextual information. Follow-up interviews provided this contextual experience-centred data. Conversely, stand-alone interviews sometimes lacked details regarding the processes of facilitation; the what, how, why. Therefore, the combined data collection methods mitigated against the limitations of a single method. The findings from this study demonstrated that self-written narratives were an acceptable means of data collection to the participants, provided rich insights even if used alone and provided a means of

triangulation where they were used in conjunction with interviewing techniques and data analysis. Additionally, this served as a useful (pragmatic) method where prolonged engagement with the participants via several interviews was not possible.

10.3 Relationship to the wider literature

This study has focussed upon the professional stories generated from individual midwives, however, the three analyses generated a shift in focus; from individual actions to that of broader sociocultural and political contexts. This wider perspective facilitated a new framing of the whole dataset in relation to the wider literature- namely, generating insights regarding the constraints, protective factors, and enablers of authentic midwifery practice. Therefore, this discussion advances what was already known, whilst synthesising new insights from the study in relation to the wider literature. Figure 16 presents an overview of the discussion and its salient points.

Figure 16 Constraints, protective factors, & enablers



Constraints

My study found midwives who experienced constraints or negative reprisals when facilitating women's choices, much of their experiences mirrored the issues set out in Chapter 2. Issues of medicalised, risk-averse, standardised and institutionalised birth practices played out across the narratives. First, it was highlighted in Chapter 7, where the midwives reported '*balancing tensions*' whilst negotiating with their wider teams. The midwives resisted a 'guideline-centred' culture (Kotaska, 2011) but had to draw upon a number of extra resources as they battled to provide care that the women wanted, highlighted in the '*Stories of distress*' in Chapter 8. The culmination of such challenges was interpreted through a deviant/stigma lens in Chapter 9, highlighting the personal toll of such labour. The personal cost of providing authentically relational midwifery care was profound. Yet despite the personal costs, the majority of the midwives remained in practice indicating strongly held values and beliefs that largely surmounted those difficulties. Whilst this raises significant concerns regarding the sustainability of their midwifery practice it does highlight a strong vocational commitment that starkly contrasts the scientific-bureaucratic professional norms of their structural working environments. Therefore, an original contribution of this study is the impact of these structures on the action, feelings, emotions, and mental health of midwives who challenge the dominant discourses in the name of authentic relational care. These issues are explored below in relation to negative organisational cultures and disparities of philosophies.

Negative organisational culture

A key finding of this study indicated that where organisational cultures did not value or support women's or midwives' autonomy, it constrained midwives who wished to deliver woman-centred care. Using the definition of organisational culture by Davies, Nutley, & Mannion (2000):

'a pattern of shared beliefs and values that gives members of an institution meaning, and provides them with the rules for behaviour in their organisation (p.112)'

Viewed in this way, organisational culture is thought to be a common way of making sense of the organisation in which its distinctive features may be identified as 'the way things are done around here' and how things are understood, judged or valued (Davies et al., 2000). In this study, negative organisational cultures appeared to be distinguished by a patriarchal culture that permeated all levels of the organisation

that was characterised by; poor leadership, lack of embedded (tacit or documented) pathways that supported women's choices, unsupportive middle management, unsupportive obstetric staff, lack of peer support, and where guidelines superseded women's and midwives' autonomy. Moreover, the study findings related specifically related to issues of organisational *culture* as problematic, rather than organisational issues such as staffing, resources, workload or busyness that has been highlighted in a number of other studies (Ball, Curtis, & Kirkham, 2003; Curtis, Ball, & Kirkham, 2006; RCM, 2016b; RCM, 2016a; RCM, 2018).

A consequence of negative organisational cultures appeared to be restrictive autonomy for midwives to practice full-scope midwifery. Beyond obvious restrictions such as discriminatory or punitive actions, restrictive autonomy could occur more subtly, such as situations where the midwife faced numerous obstacles or 'hoops' to jump through. In the context of midwives supporting out of guidelines physiological births, restrictive autonomy related to organisational cultures that super-value medicalised births and guidelines over women's and midwifery autonomy. This finding mirrors broader criticisms of over-medicalisation (Johanson, Newburn, & MacFarlane, 2002; Greenhalgh, 2014; Greenhalgh, 2015) and guideline-centric healthcare (Griffiths, 2009; Kotaska, 2011; Anjum & Mumford, 2017). Arguably, an over-medicalised and 'guideline-centred' (Kotaska, 2011) approach to care contradicts the values of evidence-based medicine (Greenhalgh, 2014; Greenhalgh, 2015; Wieringa, 2017), legal standing of women's autonomy (Birthrights, 2015; Birthrights, 2017), midwifery philosophy of individualised care (DH, 2010a; ICM, 2011; NMC, 2018a), national maternity guidelines (The Royal College of Midwives, 2012; RCOG, 2013; NICE, 2014), and government maternity policies (DH, 1993; DH, 2007; DH, 2010b; NHS England, 2016). Such contradictions appeared prevalent in some cases, despite the known limitations of guidelines (Gabbay, 2004; Kotaska, 2011; Wieringa, 2017; Greenhalgh, 2018), and the iatrogenic harms caused by an over-medicalised approach to birth (Renfrew et al., 2014; Miller et al., 2016). However, a negative organisational culture appeared to prioritise the operational processes within medicalised and guideline-centric discourses, over evidence-based medicine, client and midwifery autonomy.

As noted above, there are many studies of contextual and organisational factors in health care in general and maternity care in particular. The unique contribution of this study is the impact of these structures on the action, feelings, emotions, and

mental health of midwives who challenge them in the name of authentic relational care. Patriarchal organisational cultures appeared to be expressed by the deviant label of 'bad midwife'- highlighted in Chapter 8 '*Stories of distress*' and in Chapter 9 '*Stigmatised or deviant practice*'. Midwives experienced or feared such labelling that set them apart from their colleagues and outside of organisational cultures. A bad midwife appeared to be perceived as one who actively encouraged the women to make 'dangerous choices'. 'Bad' midwifery inferred dangerous practice and was a detrimental stigmatising label (Goffman, 1963). The stigmatising label applied within a working context supports Bos, Pryorb, Reeder, & Stutterheim's (2013) notion of 'structural stigmatisation'. Structural stigmatisation relates to the way institutions perpetuate stigmatisation through hegemonic practices exercising power and control towards conformity to the institution (Bos et al., 2013). In this study, power over the stigmatised midwives appeared perpetuated by colleagues who arguably reinforced organisational cultures. Bad midwifery mirrors the patriarchal binary 'good/bad' mother discourses (Goodwin & Huppertz, 2010), which situates 'good mothers' as women who are '*docile bodies, that will not resist or question the 'experts' (p.21)*' (Rock, 2007). Applied to the midwives, a 'good midwife' could be perceived as the efficient (docile) worker that values the institutional needs over women's, one that does not resist or question organisational structures (experts). Thus the midwives were 'othered' (Rock, 2007; Goodwin & Huppertz, 2010), that served to discredit the midwife and fostered feelings of fear and vulnerability - a method of control to reinforce hierarchies. Therefore, organisational cultures that stigmatise midwives who work within an authentically woman-centred philosophy can catalyse severe adverse consequences for those midwives. This is a significant barrier for those midwives to deliver the kind of care that is embedded in their professional rules and codes of practice.

Issues of negative organisational cultures also related to notions of a 'blame' culture (Robertson & Thomson, 2016), where punitive rather than restorative action was the norm. A 'blame' culture is characterised by investigations that focus upon individual fault, rather than system failures (DH, 2000) and seek to determine negligence in response to potential litigation (Robertson & Thomson, 2016). A blame culture is suggested to reduce practitioner's openness and transparency in the event of possible mistakes (DH, 2000), and is cited as a cause of fear in practitioners with detrimental impacts upon their emotional wellbeing (Alexander & Bogossian, 2018), causing a loss

of confidence (Robertson & Thomson, 2016; Wier, 2017) and can increase defensive clinical practice (Robertson & Thomson, 2016; Wier, 2017; Alexander & Bogossian, 2018). Arguably, a blame culture contributed to the negative organisational cultures identified in this study. Fears of accountability, negligence, and litigation coalesce creating restrictions for women and midwives facilitating alternative birthing choices. However, a key finding in this study were the midwives who resisted negative organisational culture, and, as a result, risked or experienced persistent stigmatisation and reprisals for their practice, even where poor outcomes did not occur. However, as previously highlighted (p.225) most of the midwives affected continued to exercise their sense of moral vocation, despite the barriers, and despite the negative impact upon their health. Their values and alignment with supporting women's access to skilled midwifery care served as a resistance to the dominant culture of fear and blame.

Disparities of philosophies

Disparities between the midwives' philosophy of care and their colleagues' philosophy created significant tensions and constrained the midwives practice. My findings build upon Hunter's (2004) notion of 'emotion work' that related to conflicting midwifery ideologies as a source of difficulty and challenge for some midwives. Hunter's (ibid) study identified key differences between community and hospital midwives. Community midwifery was associated with a 'with-woman' ideology that was characterised by values of individualised care and natural birth models (ibid). In contrast, hospital midwifery was associated with a 'with-institution' ideology that was characterised by values of a universalistic medicalised approach to care where institutional demands were prioritised (ibid). Hunter (ibid) found a key source of emotion work occurred when midwives aligned with a 'with-woman' ideology were unable to deliver such care, for example, midwives working as 'integrated' worked across community and hospital settings. Likewise, in my study, I found that for some midwives the disparity between ideologies was problematised between community versus hospital midwifery, and for midwives with a 'with-woman' philosophy but who worked primarily in hospitals. The dominance of a 'with-institutional' culture was a source of tension and distress for these midwives.

My study also identified where there was a strong misalignment between the midwives' practice and their colleagues, the midwives' practice could be labelled and stereotyped as 'deviant' resulting in social isolation, vulnerability and stress. This can

be viewed as bullying in the workplace, mirroring the wider literature that has explored bullying and horizontal violence in midwifery (Leap, 1997; Ball et al., 2003; Curtis et al., 2006; Kirkham, 2009; Hunter, 2010; RCM, 2016b). In my study, social isolation, a form of bullying, was specifically related to clashes between midwifery values, contextualised by organisational cultures that did not support women's or midwives' autonomy. Moreover, my study participants highlighted that fears of being labelled and stigmatised created stress, hence, tensions between colleagues arguably created another source of emotion work for the midwives (Hunter, 2010), in addition to clashes between ideologies (Hunter, 2004). Strained collegial relationships have been identified in other studies as a source of distress and challenge (Hunter, 2005; Deery & Kirkham, 2007; RCM, 2016b). Moreover, my findings reflected the existing literature regarding the subsequent ill effects of poor working relationships and/or bullying; stress, burn out, health problems, mental-emotional distress, taking time off sick, leaving jobs and leaving the profession (Hunter, 2005; Curtis et al., 2006; Gillen, Sinclair, & Kernohan, 2008; Hunter & Warren, 2013; RCM, 2016b; Hunter, Henley, Fenwick, Sidebotham, & Pallant, 2018).

The misalignment between the midwives', their colleagues' and/or organisational philosophies contributed to situations experienced as 'battles' to deliver woman-centred care. Even where midwives did not report bullying, ongoing conflict is a serious cause of stress that raises concerns of its impact upon the midwives mental, emotional and physical wellbeing. This finding mirrors the study by Geraghty, Speelman, & Baves (2018) who investigated midwives' workplace stress. The author's core theme was 'fighting a losing battle' echoes some of my study findings. Midwives working in isolation were particularly at risk of the negative consequences. These findings are reflected in other studies which have found midwives suffer when they are unable to deliver appropriate good care (Ball et al., 2003; Curtis et al., 2006; Hunter & Warren, 2013; RCM, 2016b; Hunter et al., 2018). However, unique to this study, was the finding that the majority of the midwives experiencing such stress maintained their vocational commitment to keep providing their ideal care. Whilst for some this meant leaving a particular workplace, they remained in the midwifery profession (bar one who was planning to leave). For others, this meant findings ways to manage the tensions. For example, some midwives managed the tensions of ideological differences by sacrificing some of their midwifery values to retain collegial working relationships with their colleagues. In these situations, the midwives juggled

ethical dilemmas of which battles to fight, with the view that adopting a discerning approach would provide some sense of protection and so they could continue to practice their preferred midwifery most of the time.

The midwives displayed simultaneous challenge to and reinforcement of the status quo, akin to the ethnographic findings by Pollard (2011) who investigated midwives discursive practices on a labour ward. Pollard (ibid) demonstrated that midwives revealed inconsistent identities that sometimes challenged medicalised and professional hierarchies but at others reinforced the status quo. However, my study revealed new insights regarding these midwives' rationale and mechanisms for managing their identities and midwifery practice. Largely, the midwives in this study were distressed by the ongoing ethical dilemmas of which battle to fight which can be viewed within notions of 'moral distress' - knowing the ethically correct thing to do but feeling unable to act (Jameton, 1984). In this light, the current study raises concerns regarding the long-term impact upon midwives managing persistent ethical sacrifices and moral dilemmas with future sustainability of staying in the profession. Moreover, it raises ethical issues and dilemmas for the midwives of who to offer 'extras' to, as the midwife is unlikely to be able to offer the same level of care to all women. Thus, potentially leading to inequitable care provision and divisions between women.

Protective factors

Situated against the constraining factors identified above, my study found that some midwives had protection against the negative effects of poor and unsupportive work environments. For some, their broader working environment mirrored the issues highlighted in Chapter 2 and related to the findings in Chapter 7 '*balancing tensions*'. However, different to those midwives experiencing extensive constraints, the findings in Chapter 8 '*Stories of fulfilment*' specifically related to '*Stories of togetherness*' whereby the midwives' teams were a source of joy, support, and mutual trust. These were reflected in Chapter 9 as '*Optimal deviancy-protective teams*'. Conversely, for a minority of midwives, a protective factor related to the lack of deviance labelling by their work colleagues that was reflected in Chapter 9 '*Optimal deviancy-respected individually*'. So whilst there were challenges for these midwives, an original contribution of this study highlights the nuanced resources that were available to some midwives to manage the tensions in practice. These are discussed below in relation to supportive like-minded teams and 'different, not deviant'.

Supportive like-minded teams

A key protective factor and source of resilience were working in like-minded and supportive teams. Feeling supported and understood created a shared identity and a sense of belonging - protecting the midwives from the ill-effects of negative labelling or stereotyping. Working with those with a similar ethos, midwives were enabled and empowered to practice woman-centred care. Whilst negative situations did occur, the teams dealt with them together, thus sharing the 'burden'. Consequently, my study identified that the midwives source of social capital⁵¹ was generated by 'horizontal trust (employee to employee) and reciprocity' Hunter (2010). Hunter (ibid) noted that positive collegial relationships, typified by trust and reciprocity, were rarely found in a review of this area. However, Walsh's (2007) observed positive collegial relationships akin to being in a family in his ethnographic study of a free-standing birth centre. Flexible working, mutual support and friendships were identified (ibid), similar to my findings. These findings have since been established in other contexts; a survey investigating why midwives stay in the profession in Australia (Sullivan, Lock, & Homer, 2011) determined that interactions with colleagues and a sense of belonging ranked third in midwives motivation to stay. Another qualitative study in Australia (Catling, Reid, & Hunter, 2017) found that supportive team relationships were key to mitigate difficult workplace cultures. Furthermore, findings from the New Zealand study (McAra-Couper, Crowther, Hunter, Hotchin, & Gunn, 2014) demonstrated that working with like-minded colleagues who shared the same midwifery ethos was essential for sustainable practice.

Different, not deviant

Conversely, protective factors appeared to exist for individual midwives who were practising woman-centred care but where it was not the cultural norm. In these situations, the midwives appeared to be perceived as 'different' rather than 'deviant', a protective factor against negative labelling or stereotyping. Moreover, they were perceived to be beneficial to their team or organisation. Situated as a midwife suited to a 'type of woman' these midwives appeared to lessen the workload for their colleagues who preferred not to care for women making alternative birthing choices. Therefore, the midwives had a valued position within their working social groups. Being accepted by their teams, despite their different midwifery philosophy, could be

⁵¹ the networks of relationships among people who live and work in a particular society, enabling that society to function effectively.

explained by the midwives' extensive clinical experience. They were trusted and respected- largely left to 'get on with it'. Additionally, they had built working relationships with their colleagues over extended periods of time suggesting that 'being known', protected them from negative stereotyping. This finding is supported by the literature pertaining to the benefits of positive working relationships discussed in the previous section. However, it does offer a unique insight into the nature of midwifery practice where philosophies amongst colleagues differ, demonstrating that it may not always be disadvantageous.

Enablers

In stark contrast to the previous issues of constraints and related protective factors, my study also found midwives who experienced positive workplaces that did not conform to the issues highlighted in Chapter 2. Offering a positive counter-discourse, this original finding was important as it traversed particular practice settings such as community or birth centres and reflected a wider organisational culture. Such cultures were reported to be supportive of both women's choices and midwives' to deliver such care. These findings were highlighted in Chapter 7 where some midwives reported '*negotiating with the wider team*' was a straightforward and constructive process. Additionally, notions of normalised practice were captured in Chapter 8, '*Stories of fulfilment*' which was the catalyst for the interpretative domain in Chapter 9, '*Normalised practice*'. Overall, these findings shifted from an individual 'burden' of fulfilling women's choices to that of a collective responsibility that was characterised by mutual respect, trust, and open communication across the organisation.

Moreover, Chapter 7 sub-theme '*conveying attitudes of support*' highlighted personal attributes of the midwives - a 'how to' [help/facilitate] attitude framed their responses to women's decision-making, reflecting a sincere partnership model of care, as opposed to an expert or authoritative gatekeeper role (Chilvers & Hosie, 2015). Moreover, this original finding reflects the practical application of the human rights in childbirth legislative framework (Prochaska, 2015), where the midwives demonstrated meaningful attempts to fulfil the women's wishes. Whilst in some situations, some compromises were made, these were contextualised by vivid accounts of an authentic 'with-woman' approach to negotiate packages of care. However, caution must be applied as it cannot be assumed that the women experienced all/some of the compromises as positive. Notwithstanding such caution, the findings in Chapter 7 did demonstrate the range of activities the midwives

undertook to fulfil women's choices, that indicated their vocational commitment that I have called 'skilled heartfelt practice'.

Traversing between negative organisational cultures and established normalised positive organisational cultures, an original finding relates to the role of change agents. Here, the midwives demonstrated their personal attributes that were aligned with women's autonomy which coalesced with their specific senior roles they used to influence positive changes in their organisations. In these situations, the findings demonstrated they were required to create an enabling environment for other midwives to deliver care in line with women's alternative choices. These findings were highlighted across and through Chapter 7's themes, specifically related to '*Stories of driving change*' in Chapter 8, and informed the interpretative theme '*Sub-optimal normalised practice [positive deviants]*' in Chapter 9. Overall, these findings are explored below in relation to positive organisational cultures, skilled heartfelt practice, and leadership roles.

Positive organisational culture

Woman-centred organisational values and culture created the optimal environment for midwives to deliver woman-centred care where women's (alternative) choices were 'normalised'. These positive cultures went beyond individual midwives, teams, or areas of midwifery practice. As such, the burden of delivering woman-centred care was not placed upon one individual or team, rather, it was a shared vision and a collective responsibility across the organisation. Central to this was the valuing of women's autonomy over organisational needs, and trust in the midwives to deliver such care. Midwives reported ongoing and accessible support when caring for women making alternative choices across the continuum; antenatal care planning, intrapartum care and/or postnatal. Additionally, colleague debriefing was valued and appeared to facilitate the delivery of woman-centred care. Where midwives had access to supportive, non-judgemental peers or senior staff they reported greater confidence in delivering woman-centred care. In keeping with definitions of 'organisational cultures' outlined earlier in this study, positive organisational cultures appeared to be characterised by; valuing women's autonomy, valuing and trusting medical colleagues, strong and supportive leadership, positive and trusting intra and inter-professional relationships, and embedded pathways or processes that were accessible and utilised.

Skilled heartfelt practice

Skilled heartfelt practice denotes the interrelationship between the midwives' attitudes and beliefs in support of women's choices, their values of cultivating meaningful relationships with women along with their practical clinical skills. Arguably, it is these qualities combined which give rise to the practice of 'full-scope midwifery' (Renfrew et al., 2014), and are an essential enabling factor to support women's alternative choices. As previously discussed above (p.232), the midwives' 'how to' attitude was a key component of conveying their support to the women. Through conveying their support, the midwives affirmed their commitment to the women, thus, formed the foundation of building positive, trusting relationships. Relationships are a key component of quality maternity care as is evident in many studies and extensively discussed in the wider literature. These studies have identified that positive, trusting relationships with midwives enhance women's experiences and outcomes of care (Hodnett, 2002; Freeman et al., 2007; Walsh & Devane, 2012; Sandall et al., 2016). Other studies have identified that midwives value the development of positive relationships with women, and are a key source of satisfaction (Sandall, 1997; Walsh, 1999), meaning in their work (Reed, 2013; McAra-Couper et al., 2014), and a source of resilience (Hunter, 2004; McAra-Couper et al., 2014). However, a key original finding in this study, demonstrated how the midwives achieved meaningful relationships.

Building upon the existing literature, my study identified new findings regarding the qualities and attributes that the midwives seemed to possess. Such attributes included a sense of 'emotional openness' where the midwives sought to understand the women - who they were as individuals and how their experiences shaped their decision-making. Emotional openness also denoted emotional vulnerability; as meaningful relationships occur within a space of intimacy where both parties risk their emotional selves (Brown, 2012). A guarded professional disposition is unlikely to generate feelings of emotional safety that are required for women to 'open up', but can guard against perceived professional vulnerabilities (Patterson & Begley, 2011). However, in my study, the midwives retained an emotional openness by creating the space to listen and hear the women's stories and potentially be moved by them. Flemmer, Dekker, & Doutrich (2014) argue for Brown's (2002) *Acompañar* (accompany) theory where mutual vulnerability between professional/client is essential to the development of an empathetic partnership. Additionally, they argue

where mutual vulnerability occurs, it creates a shift in power in favour of the client (woman) (Flemmer et al., 2014), and provides the space to forge meaningful connections (Brown, 2012). Additionally, emotional openness and vulnerability can be likened to Crowther and Hall's (2015) notions of relationship building as a spiritual act. Such emotional connection expressed via empathic concern (Ménage, Bailey, Lees, & Coad, 2017) appeared in this study as a key facilitatory factor that enhanced the midwives' willingness and ability to deliver woman-centred care in a wide range of clinical situations.

In my study, empathic concern was expressed by midwives who were moved by the women's accounts, usually distressing, which '*compelled them to act*' (highlighted in Chapter 7). Such compulsion seemed to create a mother-midwife allegiance that mitigated against potential obstacles such as workplace cultures or constraints. This important finding sheds light on what mechanisms occur within the mother-midwife relationship from the midwives' perspective. Arguably, an emotional attunement occurred resulting in empathic responses to serve the women's needs that can be viewed as 'compassionate midwifery care' (Ménage et al., 2017). Compassion has emotional and behavioural elements where the recognition of another's suffering creates a motivating behaviour aimed at alleviating that suffering (Gilbert, 2013). A recent conceptual analysis (Ménage et al., 2017) was conducted that included 73 published studies and discussion papers to construct notions of compassionate care in midwifery. A key component of the conceptual analysis related to 'motivation' for compassionate care. However, the author's found that there was limited information regarding midwives' motivating factors, rather, the authors were more easily able to identify barriers (ibid). My study builds on such work, in that midwives' motivation for compassionate midwifery care related to an emotional attunement to the woman and a personal connection to the women's stories of experience. This appeared to induce empathy (emotional response) and a compulsion to act (behavioural response), even where that meant an increased workload and challenging constraints. As such, this required a degree of self-sacrifice as the midwives were emotionally and mentally putting themselves on the line which in some cases was risky. However, broadly this was not a position of victimhood as the midwives reported reciprocal joy through visceral accounts of the sublime. Through close relationships with the women, many of the midwives appeared willing to take on difficulties for the eventual gain of joy and elation that was felt both vicariously and personally.

Practical skill sets were also identified in this study. Midwives had the knowledge and experience of delivering alternative birthing choices, was crucially underpinned by competence and confidence in their 'normal birth' skills. Where out of guidelines birth choices may suggest or assume it is women at high risk of complications during labour, that may require specialist knowledge, this was not always the case. This broad scope of this study (as defined in Chapter 1) meant that many midwives cared for healthy women with low risk of complications during labour but who simply declined routine clinical observations or interventions i.e. healthy women declining vaginal examinations, prophylactic antibiotics (asymptomatic), fetal monitoring etc. Supporting these decisions, arguably reflect core midwifery skills (ICM, 2018; NMC, 2018b) as opposed to the requirement of specialist knowledge. However, despite the fact that supporting, facilitating and promoting physiological birth is what constitutes the role and definition of a midwife (ICM, 2017), studies have found that many midwives report a lack of skills and confidence working within midwifery-led non-technical settings, with an emphasis on non-invasive care (Russell, 2011; McCourt, Rayment, Rance, & Sandall, 2014; Darling, 2016).

In contrast, midwives in this study demonstrated high levels of experience, skill, competence and confidence in their physiological birth skills which they were able to apply to out of guideline birth choices. This was partly explained by their personal motivations or philosophy, actively seeking to develop their skills and competence, and extensive exposure to non-obstetric environments. Repeated exposure within supportive environments has been found as a key facilitator for midwives to develop confidence and competence in their skill sets (Nicholls & Webb, 2006; Jordan & Farley, 2008; Thompson, Nieuwenhuijze, Low, & de Vries, 2016; Nicholls, Hauck, Bayes, & Butt, 2016). The midwives' demonstrable skills in physiological labour were also explained by the availability and accessibility of continuing professional development, refresher days, and supportive structures in which an ongoing learning environment continued to enhance the midwives' skill-sets. Such environments combined with self-motivation enabled many of the midwives to move from 'novice-expert' practitioners (Benner, 1984). Expertise relates to the shift from the reliance upon rules and analytical thinking (novice) to inform decision-making, towards greater independence where knowledge, experience, and intuition is synthesised quickly to guide actions or decision-making (expert) (Benner, 1984). Downe, Simpson, & Trafford (2006) investigated notions of expertise specifically related to

midwifery via qualitative meta-synthesis methods. While a dearth of literature was identified the authors drew upon pre-existing theories of novice-expert to theorise that expert non-physician (midwives or nurse-midwives) maternity care related to concepts of wisdom, skilled practice and enacted vocation. The progression to expertise was reported as follows, that concurs with the findings in this study:

'expressions of qualities such as trust, belief, and courage, to be more willing to act on intuitive gestalt insights, and to prioritize connected relationships over displays of technical brilliance' (Downe et al., 2006, p.136).

In contrast, other clinical situations highlighted in this study did require specialist input or advanced knowledge e.g. caring for women with multiple morbidities, significant illness such as blood-borne viruses, epilepsy or insulin controlled diabetes. In these situations, the midwives' had to apply their midwifery knowledge of healthy women in labour to those with complicated pregnancies, mirroring 'expertise' (ibid) as previously discussed. However, additional skills involved seeking wider knowledge pertaining to particular illnesses and/or seeking collaboration with obstetric or specialist doctors to develop appropriate care plans. Again, repeated exposure to women with complicated pregnancies appeared to broaden their experience and enhanced their skill-sets (Nicholls & Webb, 2006; Jordan & Farley, 2008; Nicholls et al., 2016). Exposure, competence in physiological labour skills, competence, confidence and positive multi-disciplinary relationships were facilitatory factors in the provision of woman-centred care.

Leadership Roles

For respondents who were situated as change agents, being in or securing a leadership role facilitated improvements to the services. The change appeared to be facilitated by working in collaboration with the multi-disciplinary team and midwifery caregivers. However, the change agents had to provide meaningful structures, tacit and practical, to overcome resistance from midwife caregivers. Where caregivers were particularly resistant, visual artefacts such as care pathways endorsed by the organisation combined with direct support from the change agents facilitated positive cultural changes. A scoping review carried out by Frith (2014) identified a number of studies that have sought to improve a midwifery model of maternity practice within organisational cultures with various service changes (Collin, Blais, White, Demers, & Desbiens, 2000; Hughes, Deery, & Lovatt, 2002;

Deery, & Hughes, 2004; McKellar, Pincombe, & Henderson, 2009). However, none of the included studies related to changes stimulated by midwives specifically in leadership roles (specialist, supervisory or consultant midwife) as was found in this study. My study suggests that midwives in senior leadership positions who were philosophically orientated towards authentic relational care were able to change organisational cultures in this direction.

Consultant midwives were introduced in 1999 to retain and develop clinician leaders to transform improvements to maternity services for better outcomes for women and babies (DHSC, 1999; Wilson, Hall, & Chilvers, 2018). Underpinning the role are four key functions as defined by the Department of Health and Social Care (1999) that include: expert clinical practice, clinical and professional leadership, research and education, practice and service development. Therefore, the consultant midwives were seen to be positioned to facilitate changes in maternity services (Robinson, 2012). Whilst a number of service evaluations have been published that have demonstrated positive impact (Guest et al., 2004; Gould, Hogarth, & Stephens, 2005; Rogers & Cunningham, 2007; Robinson, 2012) few external studies have investigated or demonstrated the effectiveness of consultant midwives (Robinson, 2012), with concerns raised regarding their role being subsumed by medical hierarchies (Stephens, 2006; Robinson, 2012). A notable exception was a recent study by White, Le May, & Cluett (2016) who found that the implementation of consultant midwifery-led VBAC services improved the intended and actual rates of vaginal births. However, the lack of research regarding the effectiveness of consultant midwives may signal 'invisibility' of the role, where limited attention or funds have been made available to carry out such research. Moreover, with only 84 consultant midwives in post in the UK (Wilson et al., 2018), they are in a marginalised and disadvantaged position, limiting our understanding of the effectiveness of the role.

In my study a driver for effecting change occurred where leaders created an 'emotionally and professionally safe' environment for the midwife caregivers that included: access to support and help, a learning not blame culture, and demonstration of leadership. Such a relational approach to leadership can be viewed within transformational leadership theory (Kouzes & Posner, 2011). One model by Kouzes & Posner (ibid) suggests there are five domains of transformational leadership; 1. 'Model the way' relates to leaders developing their own values and setting an example for others. 2. 'Inspire a shared vision' that relates to leaders

developing an exciting vision that inspires others. 3. 'Challenge the process' that relates to innovations, experiments and risk-taking. 4. 'Enable others to act' relates to fostering collaborations and empowering others to act. 5. 'Encourage the heart' relates to recognition and acknowledgement for others' achievements. Viewed within a transformational leadership model, the findings of the current study add qualitative insights regarding the positive benefits of consultant midwives and other specialist roles in the facilitation of change towards greater woman-centred services.

Currently, there is less known regarding the role of consultant midwives or professional maternity advocates (previously SoM's) in relation to care planning for women with complex needs. This aspect of the role reported across hospital websites (Royal Berkshire NHS Foundation Trust, 2014; Royal Free London NHS Foundation Trust, 2016; Trust, Guy's and St Thomas' NHS Foundation, 2018; Luton & Dunstable University Hospital, 2018), and has been the subject of discussion papers (Carr, 2008; Brass, 2012; Sonmezer, 2017) suggestive that complex care planning is a key part of such specialist roles. However, apart from the White et al., (2016) study (previously mentioned), no other published studies appear to have examined the role of consultant or specialist midwives in complex care planning. One unpublished study by Hattan, Frohlich, & Sandall (2014), involved a mixed methods design investigating the outcomes of women seeking out of guidelines physiological birth where structured care planning was carried out by a consultant midwife. Outcome data of the 156 included women found that there was a lower rate of caesarean section, instrumental deliveries and post-partum haemorrhage compared to the national averages (ibid). The authors strongly advise against drawing conclusions due to the retrospective design and lack of matched cases (ibid), and suggested further research is needed. However, the qualitative data generated insights regarding the high-value women placed upon the process of shared decision-making which appeared regardless of transfer, mode, or actual place of birth (ibid). This concurs with the findings in the current study, albeit from the midwives' perspective.

10.4 Limitations

Whilst this study has generated a number of new contributions to midwifery practice, theory, and methodology, there are some limitations to the findings. All qualitative research is an interpretative process, but the risk of over or under interpretation of the data was minimised through explicit author positionality, reflexivity, and supervision to ensure that personal beliefs and values did not obscure important data

during the analysis. Moreover, all data analyses had a firm grounding in the data, therefore, whilst other judgements could have been made particularly in relation to data analysis 2 or 3, the ones presented offer credible interpretations.

Specific issues related to midwives recruited as 'self-defined' facilitators of women's alternative birthing choices. Therefore, this study does not relate to midwives with differing philosophies. In addition, the notion of 'self-defined as facilitative' was not 'verified' in any way. As such, it was found one participant appeared more aligned with the notion of 'reluctantly accepting' of women's choices as highlighted in Chapter 3. Another participant appeared more aligned with institutional discourses or risk, safety, and governance. In both situations, this was not clear until halfway through the interview. However, both participants did generate important insights and contributed alternative perspectives. Additionally, it is unclear whether the demographics of the midwives (i.e. educational attainment) in the study are representative of the wider workforce. Future research could examine this further.

Another limitation was that the women within the midwives' stories did not provide their point of view. The research design did not allow for the recruitment of mother-midwife dyads, largely due to the focus upon midwives' experiences as well as limited time factors. To manage women's lack of consent I carefully removed identifying particulars about their cases. Although this was an appropriate and ethical step to take, it did mean that specific features that could have contributed to midwifery education, practice and theory were unable to be used. Similarly, during several interviews, some midwives asked me to remove portions of the interviews as they feared identification. This largely related to criticisms of their trust so feared reprisals should they be identified. Unfortunately, the redacted parts of the interview offered further insights into the constraints placed upon midwives but could not be used.

Another limitation was identified towards the end of data collection, and this related to a lack of knowledge generation regarding alternative birth choices by women who were in disadvantaged positions. During recruitment, I did receive several emails from midwives working specifically with disadvantaged populations, but unfortunately, they did not participate in the study. Whilst a few participants did explicitly report such situations, it appeared that the stories were generated from the choices of well-educated middle-class women. However, I was unable to verify this. It is conceivable that this reflects systemic issues of structural disadvantages racism,

classism etc. where women from minority groups are less likely to know their options, or access extra services (Ebert, Bellchambers, Ferguson, & Browne, 2014). Therefore, is a limitation of this study and future research must examine issues of (in)equitable access to alternative birthing choices.

10.5 Recommendations

The findings of this study have a number of important implications for midwifery practice, organisations, policy, and research. First and foremost, this study has highlighted what is possible in relation to the successful facilitation of women's physiological alternative birthing decisions. Therefore, a key recommendation is for all maternity practitioners to know what has been achieved which can be applied to other situations they may face. The following sections highlight key recommendations:

Midwifery practice

On an individual practitioner level, this study supports the wider literature regarding relational care, whereby a key recommendation is for midwives to endeavour to forge understanding to convey their support for women's autonomous decision-making. This creates the foundation for *mutually* trusting relationships, a key component of safe and effective care. Keeping ethical and legal frameworks of women's autonomy at the forefront can help guide midwives to deliver respectful and dignified care, even where they may not agree with the woman's decision. In addition, this study has identified that positive relationships *are* possible within fragmented care models, so whilst time can be a barrier, a key message emphasises that relational care can be fostered quickly in most circumstances. Additionally, this study has demonstrated the importance of midwives being proactive and forward thinking in keeping abreast of the wider evidence, literature, as well as knowledge of what is occurring in other trusts. Therefore, continuing professional development is vital to full-scope midwifery. Where midwives may face constraints within their workplaces, seeking out external information can be used to advocate and negotiate care for women. Moreover, this study highlights the essential nature of midwives' competence and confidence in physiological birth. Responsibility for developing such skills need to be shared between the individual midwife and that of his/her employers. As this study found, midwives exposed to high rates of physiological births were able to apply those skill-sets to 'out of guidelines' births. Moreover, it is essential that student midwives have continued exposure to physiological birth throughout their education. Of

particular importance, is for student midwives to be equipped to facilitate birth in community settings (home, birth centres) to secure confidence and competence required of the professional autonomous practitioner.

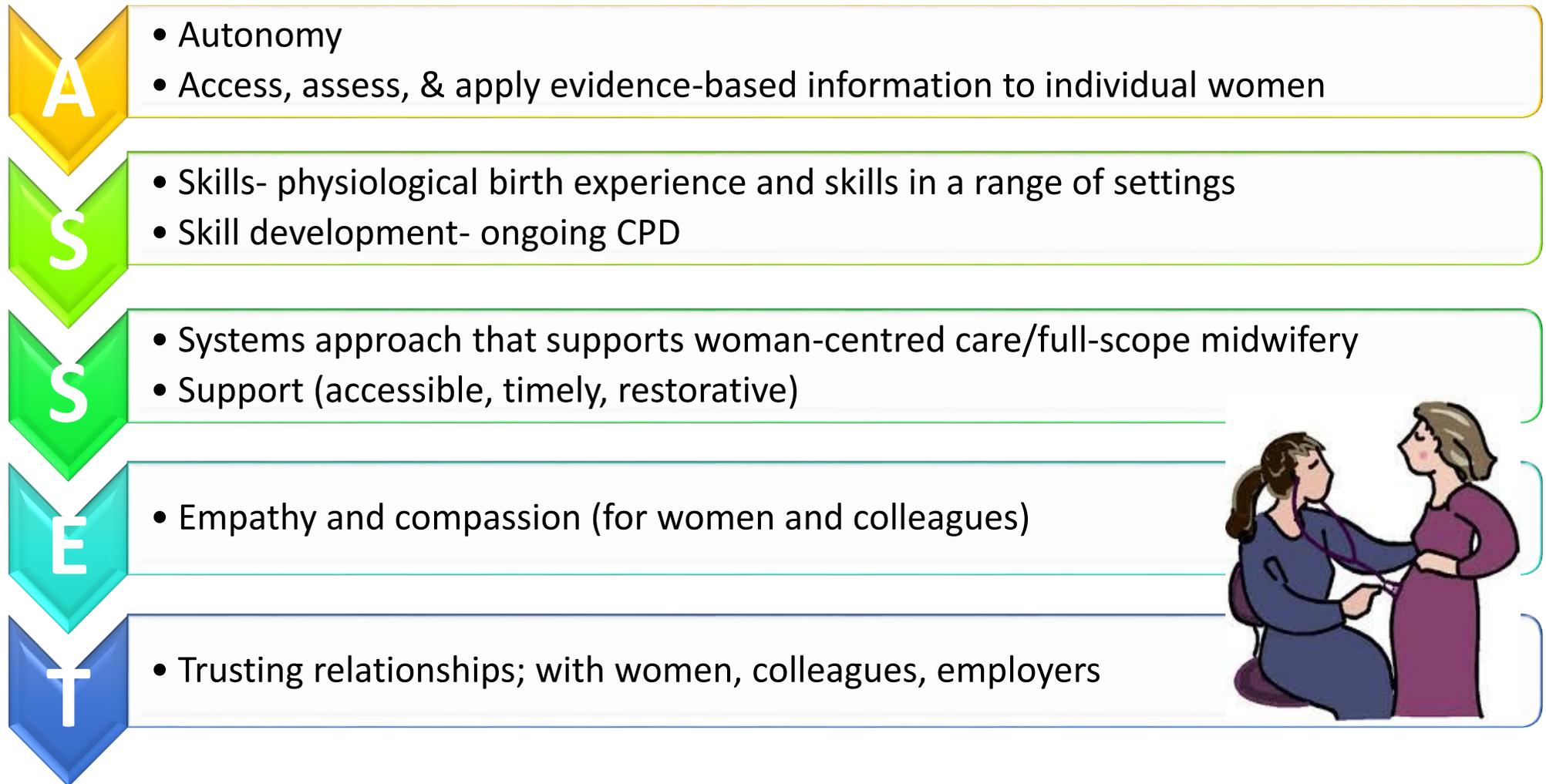
Front line midwives need to be supported within non-punitive, open and learning cultures where their autonomy is respected. A supportive work environment is an enabling factor for providing true woman-centred care and creating the space for 'full-scope' midwifery. The benefits to women are well documented, therefore, could be used to enhance women's psychological and physiological birth outcomes. Ideas for implementation are provided below aimed at senior midwives, managers, and trust boards:

- Organisation-wide education regarding women's childbirth legal rights (to include senior medics, midwives, trust board directors, legal department etc.)
- Formalised documentation that reflects women's human rights in childbirth, with the responsibilities of all maternity staff to ensure dignity and respect for women's autonomy clearly identified. Such documentation could include guidance with common scenarios, to ensure that staff are reminded that, whatever their views about the decisions made, if the woman is properly informed (and not pressured with biased or repeated information) her decision should always override that of her attendants unless she has, in a legal sense, lost competence, which is very rare indeed.
- To stimulate positive change that enhances women's access to meaningful choices could include the development of a co-created tool-kit (informed by all maternity staff, representation from all practice settings, and women) that has the support of senior management. And/or an 'Alternative birth choice bundle' could be developed, a toolkit designed to help support women, midwives and trusts to provide safe, woman-centred care where choices are outside of guidelines.
- Identify a lead midwife (in the absence of a consultant midwife) who could be the liaison between maternity staff, the multi-disciplinary team, legal and managerial teams.
- Set up supportive learning sessions for multi-disciplinary teams to discuss what has worked well when supporting/facilitating women's alternative birthing choices.

- Establish 'open door' sessions for junior/inexperienced staff to discuss ongoing cases with senior/experienced midwives. These can be used to provide support, and/or identify gaps in knowledge or skill-sets. This could generate a co-created action plan for staff skill development, where both the individual midwife and the trust are obligated to fulfil training needs.
- Offer debriefing sessions to all/any staff automatically after challenging experiences – not just related to adverse outcomes, but issues of relationships with women or their families breaking down, issues of poor communication between staff, inappropriate care etc.
- Provide ongoing feedback from women who have requested alternative birth choices. Inviting women in after their birth to share their stories with staff could provide beneficial learning opportunities and validation of the service provision.

These collective recommendations can be captured as 'what midwives need to facilitate women's alternative birthing choices', illustrated in Figure 17. The mnemonic 'ASSET' was developed to highlight a) that midwives are the 'asset' for women getting their needs met and b) situates what midwives need from an individual level across to the organisational level.

Figure 17 What midwives need to facilitate alternative birth choices- key recommendations



Organisational

This study has reiterated previous research that recognises the influential nature of organisations upon professionals' autonomy and practice, women's experiences and outcomes. Whilst this study has been limited to individual midwives' perspectives, it has provided insights into the nature of their experiences within their working environments. The midwives' highlighted a vast disparity in their employing organisation's approach and delivery of woman-centred care, with extreme consequences for the midwifery participants. Such polarity occurred within the same broader backdrop of recent governmental changes, ongoing budgetary cuts, restricted pay rises etc. Moreover, the polarities also coexist within the same broader discourses or risk, litigation, governance, medicalisation etc. Conceivably, political will has influenced such disparities. Therefore, this thesis is a call to individual NHS trusts, to consider their role and responsibility in their structural processes which enhance or impede the midwives' and women's autonomy. With the knowledge of how some Trusts are managing to deliver woman-centred care in light of difficult times in the NHS, can serve to enhance others. Moreover, at a time of continued midwife shortages, where a leading factor for midwives to leave the profession is the inability to practice 'full-scope' midwifery, Trusts who operate within 'normalised' women's autonomy cultures could use these findings to recruit and retain midwives with a 'with-woman' philosophy.

A practical solution could involve Trusts carrying out a simple questionnaire to identify whether midwives feel that their organisation supports a woman-centred culture. These could be distributed anonymously across the maternity workforce so Trusts could identify where the majority of the staff feel situated on the theoretical model spectrum. Having identified a broad overview, where overall the feedback supports woman-centred care, trusts could use this feedback to recruit staff/upsell their organisation. Where trust has mixed or negative feedback, they could use the findings to implement proactive changes as outlined in this study.

Policy

As set out in Chapter 2, the UK has robust policy, legislation, and national maternity guidelines that advocate and support women's autonomous decision-making. Therefore, this recommendation relates to the need for *implementation* of woman-centred care. In conjunction with the recommendations in the previous sections, a

broader approach of implementation could include setting up a national level 'Community of Practice' for Trusts to share what works and how.

Research

Future research should consider:

- A follow-up participatory discussion with participants from this study to generate potential ways in which these study findings could be operationalised for practicing midwives. Using the study findings and their experiences of participation, an online discussion could generate practical implementation knowledge so that the findings could benefit midwives in clinical practice (ethical approval has been gained for this).
- A qualitative investigation that involves the purposeful recruitment of midwives working with women from disadvantaged groups to explore their views, attitudes, and experiences of facilitating out of guidelines physiological births. How would these findings compare to those of this study? What can be learned from such a comparison, if anything?
- A qualitative investigation that involves gathering and exploring the views, attitudes, and experiences of women who have made physiological alternative birth decisions, and where they have co-created 'complex care plans'. Were they acceptable to the women? If so, what contributed to the acceptability? Were there any perceived advantages or disadvantages of having a care plan?
- A prospective longitudinal observational mixed-methods study investigating the experiences and outcomes of mother-midwife dyads, where women seek physiological alternative births. What was the experience like for the midwife? What did s/he do? What actions did they take? What was the experience like for the woman? What things did the woman value or dislike? What were the perinatal outcomes?
- A case study approach to investigate the qualities, processes, and cultural context of organisations that appear to have 'normalised' women's choices. Interviews with all key stakeholders including obstetricians, paediatricians, managers, board members and the legal teams. What can be learned and applied elsewhere?

10.6 Final (personal) thoughts

Reflecting throughout this study has been a big part of the process, with over 300 pages typed in a word document and 10 notebooks generated. One of the biggest challenges during this research was the immersion in the feminist literature that reignited old hurts. Having grown up in a strict patriarchal household, and having experienced stigmatisation for my own midwifery practice, such immersion in feminist theory pushed many buttons. To work through such strong emotions is still an ongoing process, not yet completed. However, through the process of this research, I have learnt to channel it, make it productive, and even see (some) things in a more balanced way. Where I was angry at (some) midwives for perpetuating patriarchal norms, a key paper by Beckett (2005) stood out and radically altered my perspective. Amongst many arguments within her paper, Beckett suggested that the nature of midwifery work is exploitative of women i.e. the physical, emotional, and mental demands for usually poor pay and insecure working conditions. Whilst this was not a new insight, how she framed it startled me and made me question whether we can ask midwives to practice 'full-scope' midwifery when so many systemic issues stack against it. Whilst I still feel conflicted about this, my feelings of anger towards midwives who do perpetuate patriarchal norms have greatly reduced. This coupled with other feminist literature⁵² where patriarchal structures can cause women to act against each other, made me recognise that whilst we do hold personal responsibility for our actions, such negative behaviour is often a symptom of pervasive structural inequalities.

The data collection was at times challenging. To hold the space for midwives who had suffered terribly within their work was heart-breaking. Having a natural tendency to try and 'fix' things for people, hearing such accounts was another opportunity for me to learn and relearn holding the space and bearing witness to another's pain. This I hope, was conveyed to the participants and was of benefit to them. In other accounts, the participant stories were triggers for my own workplace experiences. Where there were stories of social isolation it brought up buried pain and shame that I still carried from those experiences. Where there were stories of great team-working and joy, it reminded me of my loss of leaving a wonderful team to work elsewhere. Yet simultaneously, those stories brought back wonderful memories and gave me hope

⁵² I was particularly influenced by Kate Manne's (2018) 'Logic of Misogyny'.

for midwifery. Listening to beautiful stories of the births the midwives were involved with was a joy. Some of the participants were wonderful story-tellers that to listen to them retell their stories, I felt like I was there with them. They reminded me of the beauty and awe of positive birth experiences and reconnected me to my love of midwifery. Listening to all of the participant stories was a privilege, whether it was sadness or despair, anger or rage, or beauty and love, or a straightforward matter of fact 'this is how we do things'. Additionally, I learned so much for my own midwifery practice, so many 'tricks' and 'tools of the trade', that had I not carried this research I would not have known. I was also deeply inspired to find out that the normalisation of women's choices exists in many organisations.

Engaging with the narrative inquiry literature brought immense amounts of simultaneous frustration and joy. Just as I grasped an argument, it would slip away by a different researcher's perspective. Having come to narrative inquiry from what appeared to be a fluke, I felt a strong resonance with it. I have a personal affinity with people's stories, so narrative inquiry was personally fitting as well as meeting the aims of the research. However, my initial and naïve understandings of narrative gave way to a messy, complicated world of narrative research. I was bemused and frustrated to find that what a story *is*, was in dispute. Part of my frustrations stemmed from lack of experience and fear of doing the research incorrectly. Attending the postgraduate course in narrative research at the University of East London was meant to bring clarity and develop my skills. However, it appeared that the messiness of narrative research was even messier than I had thought. The process of the course meant that I had to live with ambiguity, complexity, and conflicting perspectives. Fundamentally, I had to make my own decisions about how I viewed narrative to guide my subsequent approaches. Such freedom was daunting and caused paralysis at times. I found myself avoiding such decisions through more reading, which in turn created more arguments to choose from. Eventually, I managed to move forward, to develop enough confidence to begin the deep work of analysis. This was also facilitated by my engagement with feminist pragmatism, which rather than being an approach that I 'adopted' for this research, it appeared to articulate many of my views.

The ending of this research actually marks the ending of a bigger cycle in my life. The labour and birth of my son was the beginning, where I experienced the immense power of a trusting and meaningful relationship with my midwives. No words can

convey my gratitude to them, but as I reflected upon the hidden meanings of choosing such a PhD topic, I realised that is where this started. They practised ‘full-scope’ midwifery; loving, compassionate, skilled in the art and science of midwifery practice. It is because of them ‘practising outside of the box, whilst within the system’ that I achieved the physiological birth that I so wanted. Having an embodied experience of the transformative power of birth changed how I viewed the world and was the catalyst for massive life changes. I left an abusive partner, started an OU course, applied for midwifery undergrad, got accepted, and so forth. Getting this far, having been immersed in a topic that is so deeply personal has been a blessing and privilege. With privilege comes great responsibility; self-doubt and fear of not doing justice to my midwives and the midwife participants has been problematic at times. However, I have learned to accept that uncertainty and doubt is not only an important part of being a researcher but to be human. So, the beginning began with the birth of my son with two wonderful midwives, I fought my way through single-parenthood to gain meaningful work and my ending has culminated in the longest thank you letter I have written. For doing this work is my way of ‘giving back’ to my midwives and all those who continue to enact ‘full-scope’ midwifery against such great odds. As such, this ending has greater significance for me, beyond just completing this research, it signifies a greater sense of completion, paving the way for a new beginning.

10.7 Final Conclusion

Through a feminist pragmatist narrative inquiry, this thesis has generated practice-based knowledge answering the broad research question: ‘what are the processes, experiences, and sociocultural-political influences upon NHS midwives’ who self-define as facilitative of women’s alternative birthing choices’. Through collecting data from a diverse sample of 45 midwives from across the UK, using two data collection methods and pluralistic narrative analytical methods, this study provides an original contribution to midwifery practice, research, policy, and education.

Through the collation of a vast number of alternative birth choices unique insights into the nature of how midwives facilitate women’s choices have been generated. Central to the midwives’ activities were their relationships with the women; through authentic listening, understanding and forging trust that operated both ways. Additionally, the majority of midwives reported extensive information seeking and

sharing activities, beyond that of their local guidelines. This information was used to enhance the personal knowledge of the midwives, enabled them to negotiate care packages with the women, and deal with unexpected situations. Moreover, findings suggested care plans and care planning formed a key activity when supporting and facilitating women's alternative birthing decisions. The findings also revealed extensive work 'behind the scenes' that related to the mediation of women's needs with the wider maternity teams. These findings contribute practical knowledge for the benefit of other maternity professionals, students, women and families. Knowing what has been achieved in the NHS, and importantly *how* it has been achieved can drive improvements across the service as a whole.

The midwives reported polarised emotion-based experiences that were mediated by their working contexts; negative experiences were characterised by a misalignment between the midwives' philosophy and that of their colleagues and/or organisational cultures. Positive experiences were characterised by an alignment. Furthermore, these findings highlighted the amount of work – emotional labour and the mental load – that is involved in caring for women making alternative birthing decisions and/or creating institutional changes to deliver improved woman-centred care. Thus, the findings revealed the 'invisible' work required to deliver such care. Consideration of the work involved highlighted important issues of sustainability- where midwives are working in isolation, it is unlikely to be sustainable.

The midwives' processes and polarised experiences were theorised within notions of stigma/normal, deviance/positive deviance. For midwives working in organisations where women's and midwives' autonomy was *not* respected, the midwives' were burdened with the responsibility for women's alternative decision-making which put them in a vulnerable position. In these situations, some midwives experienced significant repercussions with long-lasting detrimental effects. Conversely, other midwives working within cultures that normalised women's alternative choices did not experience such burdens, rather the care for women making alternative decisions was a collective responsibility and a shared vision. Whilst this study was limited to the views from individual midwives working within an organisation, it has offered important insights; by moving the focus to the sociocultural-political working contexts, the theoretical model provides a broader picture, where the onus of

delivering woman-centred care shifts from individual responsibility to one of a collective.

The broader picture was also highlighted through the identification of constraints, protective factors, and enabling factors. Whilst mostly these mirror other research, nuanced insights were also highlighted the impact of negative labelling and stereotypes, the importance of working within like-minded teams as a protective factor, that positive organisational cultures generate virtuous cycles that benefit both midwives and women. New insights regarding midwives' attunement to women's emotional needs which compelled them to act, demonstrated that a mother-midwife allegiance could mitigate against potential obstacles such as workplace cultures or constraints. Moreover, throughout the study findings, facilitators for change were identified. Where midwives were in senior positions, supported by good leadership, they, in turn, were able to provide support to midwives delivering the care to women. This study adds to the dearth of knowledge regarding the positive impact of consultant and specialist midwives in creating woman-centred care cultures. Fundamentally, this study has captured what has been achieved, and what is achievable within NHS institutional settings. Thus, can be used to provide midwives, managers, and wider teams, insights how they too can facilitate women's alternative physiological birthing choices.

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