‘Stories of distress versus fulfilment’: A narrative inquiry of midwives’ experiences supporting alternative birth choices in the UK National Health Service.

Abstract

Background

Some childbearing women/birthing people prioritize out of maternity care organizational guidelines’ approaches to childbirth as a way of optimizing their chances of a normal physiological birth. Currently, there is little known about the experiences of midwives who support their choices.

Aim

To explore the experiences of UK midwives employed by the NHS, who self-defined as supportive of women’s alternative physiological birthing choices.

Methods

A narrative inquiry was used to collect and analyse professional stories of practice via self-written narratives and interviews. Forty-five midwives from across the UK were recruited.

Findings

Three overarching storylines were developed with nine sub-themes. ‘Stories of distress’ highlights challenging experiences due to poor supportive working environments, ranging from small persistent challenges to extreme situations. Conversely, ‘Stories of fulfilment’ offers a positive counter-narrative where midwives worked in supportive working environments enabling woman-centred care unencumbered by organisational constraints. ‘Stories of transition’ abridge these two polarized themes.

Conclusion

The midwives' experiences were mediated by their socio-cultural working contexts. Negative experiences were characterised by a misalignment between the midwives' philosophy and organisational cultures, with significant consequences for the midwives. Conversely, examples of good organisational culture and practice reveal that it is possible for organisations to fulfil their obligations for safe and positive maternity care for both childbearing women who make alternative birthing choices, and for attending staff. This highlights what is feasible and achievable within maternity organisations and offers transferable insights for organisational support of out-of-guideline care that can be adapted across the UK and beyond.

Keywords

Midwife, midwifery, choice, childbirth, human rights, respectful care

Statement of significance

Problem

Supporting normal birth choices outside of guidelines can be problematic for midwives.

What is already known

Employed midwives working in institutions show varying attitudes towards supporting normal birth choices outside of guidelines. Some voice reluctance and others are proactively supportive.

What this paper adds

Evidence that the experiences for those midwives proactively supporting of these birth choices are largely mediated by their working environments; sociocultural drivers negatively or positively influence their ability to deliver the care.

1.0 Introduction

The notion of women/birthing people making individualised choices during pregnancy and childbirth is embedded within global movements for improved human rights [1,2]; with emphasis on respecting women's bodily autonomy and decision-making which includes the right to decline recommended care or treatment. [1,2] Recent debates in high-income countries have centred on maternal choice *for* medical interventions outside of medical advice such as maternal choice for caesarean section. [3,4] Despite calls to reduce the rising global caesarean rates due to maternal-neonatal health concerns,[5] it has also been argued to be a legitimate birth choice and such autonomous decisions should be supported.[3,4] Multiple systematic reviews have been carried out exploring maternal choice for caesarean sections- suggesting an extensive field of inquiry. [6-9] However, an area that has received less attention are birth choices involving *less* medical intervention in spite of sociocultural-political norms to the contrary, against medical advice, and particularly those that fall outside of maternity organisational guidelines.[10] Such 'alternative' birth choices are 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 normal physiological birth (p.2)'.*[11] Examples 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. Or those with medical or obstetric risk-factors seeking midwifery-led care and/or non-obstetric settings (home or birth centres).

Evidence suggests that women/birthing people can face opposition, conflict, reprisals and restrictive care provision making alternative birthing choices[12-15]; which is associated with technocratic, medicalised, risk-averse, and institutionalised hegemonic birth practices.[16-18] While studies included into a scoping review[18] have explored women's decision-making and experiences of alternative physiological birthing choices, few have examined the views and experiences of midwives caring for them. This is an important gap as midwives work within

the same sociocultural-political spaces that women experience their care; as such, midwives attitudes, experiences or philosophies can directly influence women's ability to exert their agency.[16,19-21] A metasynthesis that specifically explored midwives' views and experiences of caring for women making alternative birthing choices[22] found only five studies (UK n=3, Australia n=1, UK, US, and New Zealand n=1) and included the views of 55 midwives. Midwives employed within institutions (as opposed to those who were self-employed) reported a polarity of views, ranging from 'willingly facilitative' to 'reluctantly accepting' of women's choices. Such views related to varying attitudes towards women's autonomous decision-making but were also contextualised by fears and vulnerability associated with professional accountability for women's decisions, potential workplace reprisals and/or litigation.[22] Due to a paucity of evidence, and the negative impacts when women's choices are not supported such as birth trauma[23] or decisions to birth without any healthcare assistance,[24] it has been argued that further research was needed. Therefore, the broad aim of this study was to explore the experiences of midwives working in the UK employed by the National Health Service (NHS), who were 'willingly facilitative' of women's alternative birthing choices.

2.0 Methods

This paper presents one aspect of a programme of work that used a feminist pragmatist narrative inquiry with a pluralist approach.[25,26] For the whole programme, three research questions were asked of the same data set, using three different analytical approaches, to provide richer understandings and interpretations through alternate lenses.[27] The broad research aim was to explore midwives' experiences of supporting women's alternative choices through: 1. how they facilitated choice, 2. their experiences of their practice, and 3. the sociocultural-political influences on their practice. Answering our first research question a narrative thematic analysis was carried out that focused on the methods and processes of the midwives' caregiving to facilitate birth choices- 'what they did and how' (blinded for review).

This paper presents the findings of the second research question and narrative analytical methods to answer: '*How do the midwives experience their practice of facilitating women's alternative birthing choices?*'

2.1 Setting, recruitment, and participants

The study used purposive sampling to collect data from midwives across the UK who were employed by different NHS organisations from a range of practice settings (community/birth centres/hospital), and different employment bands (between levels 5-8) to capture a wide range of experiences. Midwives employed by the NHS who self-identified as supporting women's alternative physiological birth choices were recruited via social media websites, professional networks, and advertising in two journals. On initial inquiry, potential participants were provided with an information letter explaining the study, confidentiality/anonymity, secure data management and rights to withdraw. Written informed consent was obtained before data collection.

2. 2 Ethics

Ethics approval was granted by the (blinded for review).

2. 3 Data collection

All data collection was carried out by X [blinded] during 2017. Participants had the option to provide a self-written narrative with a follow-up interview or have a standalone interview. Either method of data collection used a narrative approach whereby an open-ended question was posed to elicit a narrative 'story' response i.e. a beginning, middle and end[28]: *'can you tell me/write about a time when you have facilitated a woman's choices outside of the guidelines or where she declined care?'* During interviews, follow-up 'conversational' questions and prompts[28] were asked. All interviews were digitally recorded and transcribed verbatim by X [blinded]. Confidentiality was assured in terms of data protection where personal information was not shared with third parties, the self-written narratives were emailed to the researcher

with password protection, printed copies were kept in a locked cabinet and online information was stored in encrypted and password protected folders on the University computer system. Anonymity was maintained by ensuring that all hospital or employer information, colleague identifiers were removed prior to the final data analysis.

2.4 Data analysis

Data analysis was informed by Riessman's[28] and Smith's[29] narrative methodological tools alongside a lens of 'emotionality' as informed by Kleres.[30] Kleres[30] perceived emotions as intertwined with narratives i.e., narratives evoke emotion and emotion shapes narrative. Therefore, by attending to the emotionality of the narratives, knowledge of the participants sense-making and experiences could be generated. Riessman's[28] method of viewing the whole account as a unit of analysis was used whereby each data source was re-examined to explore 'what was said' and 'how' in relation to their experiences, with a specific focus on the presence of emotions and feelings [30]. Then, as per Smith's approach[29], broad narrative themes were identified whereby large chunks of data were highlighted and captured within early tentative interpretations named an 'emotion-story'. This was explicitly *not* a coding process as in thematic analysis, rather this method minimises defragmentation of the data and retains context by using large chunks of data to analyse.[28,29] Through an iterative process, these initial interpretations were further interrogated and refined. Similarities and differences were noted across the accounts and grouped together. The grouped stories were categorised as meta-stories that were positioned within overarching storylines conveying similarities.

2.5 Reflexivity and trustworthiness

Several strategies were used to ensure trustworthiness.[31] Self-analysis of prior positioning was carried out by all researchers, with the lead author maintaining an extensive research diary which supported ongoing reflexivity throughout the research process, where potential blind spots or biases were challenged.[28] Two methods of data collection, the capturing field notes

during interviews, and three types of data analysis facilitated multiple methods of triangulation.[31] A full audit trail has been documented and available on request. Furthermore, regular peer debriefing with the research team and member checking was also carried out supporting the overall trustworthiness of the study.[31] The writing of this article was guided by the Standards for Reporting Qualitative Research (SRQR).[32]

3.0 Findings

Forty-five NHS midwives from across the UK were recruited; 2 provided a self-written narrative only, 21 provided a self-written narrative and had a follow-up interview, 22 had an interview only (65 data sources). Overall, this study included a diverse sample in terms of region, years of experience, workplace settings (hospital, community, birth centres), clinical bands (that indicate the level of seniority and or pay scales in the NHS). These demographic data have been previously reported (blinded for review) and an abridged version is found in Supplementary File 1.

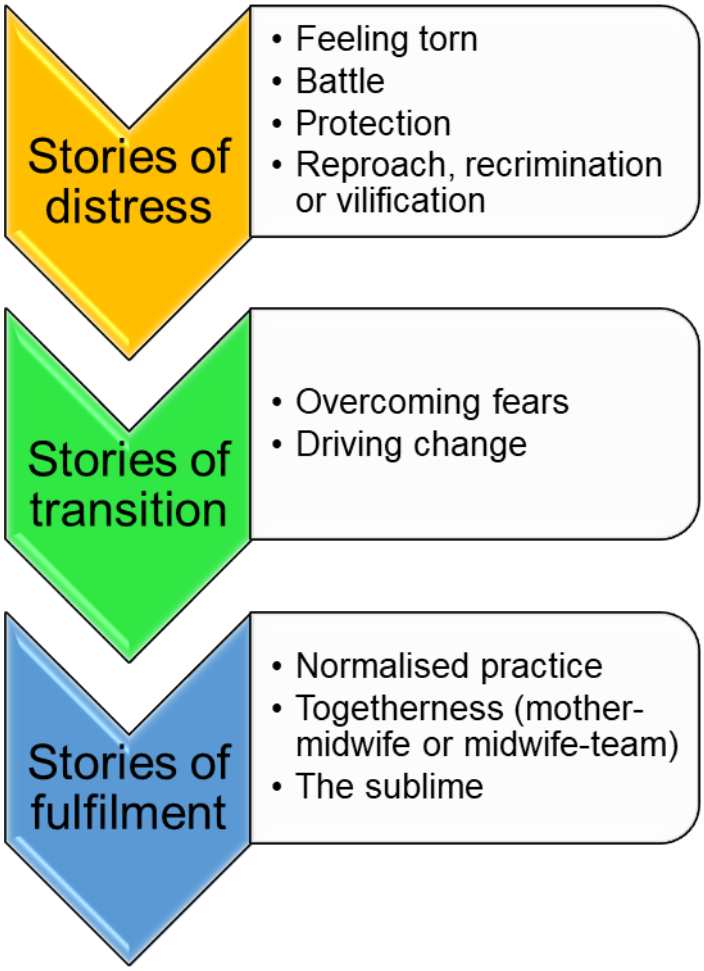
The midwives were involved in a wide range of alternative physiological birth choices. These were broadly categorised as either healthy women declining aspects (or all) of clinical care or women with complicated pregnancies requesting lower levels of surveillance or intervention than might be recommended in the guidelines, examples are found in Figure 1.

Figure 1 Examples of birth decisions

Birth decisions otherwise 'healthy' pregnancy	Birth decisions 'complicated' pregnancy
Declining vaginal examinations during labour	Vaginal birth after caesarean (VBAC) homebirth, birth centre or at hospital without usual monitoring
Declining postdates induction of labour (IOL)	VBAC (after 2 or 3 caesareans) homebirth/birth centre
Declining all monitoring during labour and/or freebirth	Waterbirth – VBAC or gestational diabetes or twin pregnancy or breech presentation at home/birth centre or at hospital without usual monitoring
Declining recommended medical interventions (not emergency)	Raised BMI (>35-50) homebirth or birth centre
Declining antenatal screening/scans	Breech homebirth or birth centre or at hospital without usual monitoring
Declining antibiotics and/or augmentation for GBS+ or PRSOM	Medical conditions such as epilepsy, diabetes, blood clotting disorder, hypothyroidism, blood borne virus- homebirth or birth centre
Declining augmentation for PSROM	Previous obstetric complications such as haemorrhage, shoulder dystocia, severe perineal tear- homebirth or birth centre

Three overarching storylines were developed, *'Stories of distress', 'Stories of transition', 'Stories of fulfilment'*. Where quotes are presented, the participant pseudonym is included alongside the data source i.e. I-interview, N-self-written narrative and within quotes (.) indicates length of pauses whereas ... indicates edited texts.

Figure 1 Storyline themes



3.1 Stories of distress

This storyline arose from 19 participants who provided multiple experiences of adversity differentiated by four meta-stories: *'Stories of being torn', 'Stories of battle', 'Stories of protection', 'Stories of reproach, recrimination or vilification'.* Most 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 largely constructed in relation to conflicts between the woman's decision-making and institutional constraints, limiting the midwives' agency to deliver woman-centred care. For example, Katie was supporting a woman to have a homebirth but who had a raised body mass index (BMI) and who had reported poor relationships with other midwives. While Katie reported attempts to repair the relationship and be supportive of her birth choice, Katie experienced conflicts with her manager who felt the decision was unsafe. Her manager insisted that a further midwife was needed to try and influence the women's choice. This led to a breakdown in Katie's relationship with the woman, and, indeed, in a loss of trust by the woman in the whole community midwifery system, driving her to make an even more extreme choice for her birth:

'...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 (.)...' (Interview)

For Meg, her feelings of being torn permeated across her interview through a variety of examples. All of which related to Meg's concerns that that the relevant hospital 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 experience, Meg showed signs of moral distress due to her disagreement with the decision to perform an emergency caesarean (just) for a baby being breech:

'...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 (..)...' (Interview)

Meg's account was told with sadness. It expressed 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 being focused outwards towards the constraints of institutional boundaries:

'...what I feel to be right is conflicted to what my employer is expecting of me..., 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...' (Interview)

Stories of battle

Building upon the stories of feeling torn, the following storylines refer to a 'battle'. Whilst there are similarities within the two storylines, the differences for the six participants represented here was the language they used as they constructed their accounts. Metaphors such as *'fight', 'challenge', 'battle', 'conflict'* were used and indicated they were perceived negatively by their colleagues. 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, their accounts revealed passionate accounts of vocation and the pursuit of justice.

Jess revealed frustration regarding her perceived injustice that women's choices were frequently not respected unless she advocated for them. She expressed frustration at a *'conveyor belt system'* of care and strong views that *'one size fits all approach doesn't work'*, and lamented that individualised care was not regularly actualised, despite the political and

professional rhetoric about this requirement in maternity services. Moreover, Jess challenged the perception that women going 'off-guideline' are making riskier choices for them and their babies. She asserted that the continuity model she worked in was '*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 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.' (Narrative)

Power struggles were evident in Seana's account where she disagreed with an obstetrician's 'insistence' to intervene with syntocinon 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. Similarly, the toll of continued battles was also evident in Edna's broader narrative. Edna constructed her accounts of stress not in relation to birthing decisions, 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:

'... 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' (.)...' (Interview)

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 them with the strength to continue.

Laura revealed an 'us and them' situation where she reported that she and her team were *'always given the stick that we are not going along with hospital policies'.* It was not asked who exactly gave them 'stick' (slang for negative feedback), but it was inferred that simultaneous intra-professional, inter-professional and institutional conflicts occurred. Laura highlighted how 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' (Interview)

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...' (Interview)

The value of such working was expressed in relation to Rose's times of anxiety when she found herself '*questioning*' her actions, about how she was perceived by the labour ward midwives. To manage self-doubt and anxiety, Rose sought 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.

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 Council was perceived as punitive, and two of the midwives reported feeling *'scapegoated'*. Their accounts were constructed through stories of isolation and marginalisation contextualised by a blame culture within their working environment.

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. Being reprimanded for not coercing the woman to accept an intervention was in direct opposition to her midwifery philosophy:

'...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.' (Narrative)

The conflict between her sense of midwifery, morality and her experiences of the investigation exposed a wider incongruence in the rhetoric of a midwifes' 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...' (Interview)

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 practice where the disparity was 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.' (Narrative)

Beatrice's anger and frustration exposed feelings of power struggles between midwifery/women's choices and obstetrics. Beatrice drew parallels between 'good' and 'bad' mother sociocultural constructions and that of a 'bad' midwife:

'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.' (Narrative)

3.2 Stories of transition

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.' (Narrative)

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...' (Narrative)

Stories of driving change

The prevailing emotion-story across five participants accounts was one of driving change, contextualised by their positions of seniority with their NHS organisations. Seeking out and enacting such roles appeared to be motivated by the desire to implement wider scale changes. All five 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'* (registration), 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. To facilitate changes, the work involved extensive negotiations across all professional groups 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 an 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.

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 IUD [stillbirth] 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.'* (Interview)

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 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:

'*Researcher: 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 [X] researcher, 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' (Interview)

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 unsupported. She identified 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 factors 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…,' (Interview)

3.3 Stories of fulfilment

This overarching storyline conveys 20 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 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

Nine midwives' emotion-stories, characterised as 'normalised practice', were underpinned by supportive environments where they could facilitate alternative birth choices with relative ease, mostly free from conflict or constraint. 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.' (Narrative)

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 statutory changes in supervision. Their achievements were highlighted as James jokingly referred to them 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 organisational hierarchy was inverted i.e., woman led. James highlighted the *'shock'* of new members of staff regarding the 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:

'... 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' (Interview)

Claire also conveyed non-hierarchal 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' (Interview)

However, her account also revealed a mutually beneficial arrangement that fostered positive interactions. Claire reported that women deemed to be at moderate risk of adverse outcomes remained with midwifery care as opposed to being seen by the obstetric doctors, which had two benefits. First, the midwives were enabled to support the women to meet their needs;

second, the doctors were reported to value their time being freed up to focus on '*women that really needed their input'*.

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 came from the mother-midwife relationship, reflecting an emotional attunement as they '*walked alongside*' the women. They reported a strong emotional investment with positive emotional gains suggestive of 'reciprocity'. For others, togetherness was highlighted within the midwives' team relationships where 'relational team-working' was a source of support and resilience and an enabling feature of woman-centred care.

Trish 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 gained from women '*pushing the boundaries'*. Her alignment with women's choices centred on the personal relationships with women, through which Trish resisted her colleagues' assertions that such birth choices are '*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 ...' (Interview)

From a different perspective, Kerry articulated a sense of togetherness in relation to her immediate team. Kerry narrated a strong woman-centred focus and 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...' (Interview)

Similarly, Amy 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 ' (.)' (Interview)

The sense of togetherness and camaraderie 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 (..)' (Interview)

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. Moreover, for one midwife, these exchanges occurred in a non-continuity model of care, thus offering an understanding of the mutual benefits of relational care within a fragmented model.

Jane expressed reverence for a longstanding relationship she had with a couple throughout several pregnancies and births, that included trauma and loss, but where the most recent birth was a home waterbirth (out of guidelines) and described as the *'pinnacle of her career'*. Jane voiced a strong sense of '*emotional attachment'* towards this family, conveyed as a heartfelt compulsion to make the birth *'the most positive experience that she could'*. Following a successful home waterbirth Jane reported the longstanding positive impact of this experience:

'...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.'
(Interview)

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 considering 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 revealing a loving tenderness. Kindness and gentleness were demonstrated throughout the narrative as 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 weeks 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:

Susan also conveyed the value of connection and trust in a midwife-woman relationship characterised by *'attunement'* where she employed deliberate actions to harmonise with a woman in labour. While 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; simple acts of kindness to 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.' (Interview)

4.0 Discussion

In this study, we present the midwives' experiences of supporting women's alternative birthing choices primarily through their feelings and emotions. Building on our previous work, that identified the midwives micro-interactions with the women/people in their care, their processes and acts of clinical care when facilitating alternative birth choices i.e. what they did and how, including the safety aspects of relational caregiving. Here, through a second research question and analysis, our findings provide a deeper understanding of their experiences of their care highlighting the influence and impact of their broader working contexts. The overarching storylines revealed polarised experiences mediated by social and cultural contexts; the midwives' ability to practice woman-centred care was strongly influenced by their working environments. Positive experiences were characterised by an alignment between the midwives' philosophy and that of their colleagues and/or organisational cultures and supportive, trusting working environments. In this way, midwives were trusted to 'get on with' their jobs to support women's birthing choices.

However, negative experiences were characterised by a misalignment between the midwives' desire to deliver care that women wanted, in line with their philosophy and/or values, verses organisational resistance to these birth choices. Where midwives worked in unsupportive environments, their accounts revealed high levels of emotional labour and/or mental load; for some high levels of stress and distress were of concern. This raises issues of sustainability in delivering woman-centred care (as within the core definition and expectation of a midwife) and/or staff retention. However, negative organisational contexts were mitigated if midwives had immediate supportive colleagues. Conversely, where such midwifery practice was normalised throughout the organisation, the midwives' job satisfaction and wellbeing were positively enhanced, suggestive of sustainability. The findings also illuminated the positive benefits of relational based care to the midwives, with personal benefits of reciprocity highlighted in accounts of love, awe and reverence- highlighting the emotional gains when

midwives can enact relationship-based care. These findings offer valuable insights into the varied experiences of midwives, primarily mediated by their institutional environments. As such, the findings will be interpreted through issues of organisational culture.

Negative organisational culture

A key finding of this study indicated that where organisational cultures did not value or support women's or midwives' autonomy, this constrained midwives who wished to deliver woman-centred care. Organisational culture can be defined as:

> *'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 (*[33p.112]*)'*

Viewed in this way, organisational culture offers a lens to understand 'the way things are done around here' and what or how things are understood, judged or valued.[33] In this study, negative organisational cultures appeared to be distinguished by a patriarchal culture that permeated all levels of the organisation characterised by; poor leadership, unsupportive middle management, unsupportive obstetric staff, lack of peer support, and where guidelines superseded women's and midwives' autonomy. Moreover, the study findings specifically highlight issues of the organisational *culture* as problematic, rather than those of the organisational environment, such as staffing, resources, workload or busyness, that has been highlighted in other studies.[34-36]

Such cultures arise from multiple complex factors. However, a common facet, as found in this study related to a 'blame' culture,[37] 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[38] and seek to determine negligence in response to potential litigation.[37] It has been suggested that such cultures reduce practitioner's openness and transparency in the event of possible mistakes[38] and is believed to generate systemic fear of failure or transgression in practitioners, with detrimental impacts upon their emotional

wellbeing.[39] These include a loss of confidence,[37,40] and increased dependence on defensive clinical practice where 'doing' or performing tests interventions is deemed more justifiable over not carrying out medical intervention.[37,39,40] Arguably, a blame culture contributed to the negative organisational cultures identified in this study, in which fears of accountability, negligence, and litigation coalesced, creating restrictions or challenges or direct repercussions for midwives delivering the care women wanted. Some midwives resisted the influence of the negative organisational culture they worked within, and, as a result, risked or experienced persistent stigmatisation and reprisals for their practice, even where poor outcomes did not occur. Despite this, most of the midwives affected continued to practice in line with 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. However, does call into question the sustainability for midwives working in this way.

Protective factors

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'. The findings suggest that these midwives had a source of social capital [41] that was generated by 'horizontal trust (employee to employee) and reciprocity'.[42] Hunter[42] undertook a review in this area and noted that positive collegial relationships, typified by trust and reciprocity, were rarely found in maternity care. However, Walsh[43] observed positive collegial relationships akin to being in a family in his ethnographic study of a free-standing birth centre; with the identified issues of flexible working, mutual support and the value of friendships were reflected in our findings. Similar findings have also been established in other

contexts. A survey investigating why midwives stay in the profession in Australia[44] determined that interactions with colleagues and a sense of belonging ranked third in midwives' motivation to stay. Another qualitative study in Australia[45] found that supportive team relationships were key to mitigate difficult workplace cultures. Furthermore, findings from the New Zealand study[46] demonstrated that working with like-minded colleagues who shared the same midwifery ethos was essential for sustainable practice.

Positive organisational culture

In stark contrast to the previous issues of constraints and related protective factors, this study also found midwives who experienced positive workplaces. Woman-centred organisational values and culture created the optimal environment for midwives to deliver woman-centred care where women's (alternative) choices were made acceptable and part of 'what is done around here'[33] – therefore, deemed normalised practice. Midwives reported ongoing and accessible support across the maternity continuum; antenatal care planning, intrapartum care and/or postnatal. Another important strategy was colleague debriefing; where midwives had access to supportive, non-judgemental peers or senior staff they reported greater confidence in delivering woman-centred care. As such, our findings mirrors Braithwaite's[47] characterisation of positive hospitals organisations: *'a cohesive, supportive, collaborative, inclusive culture p.2.'* Moreover, these cultural attributes are also associated with improved safety in maternity care.[48] Beyond structural requirements such as staffing levels, access to appropriate equipment etc, it is the staff, their relationships with each other and across the organisation that creates safety.[48] Rather than a punitive, blame culture previously described some of the midwives worked in organisations that enabled an open, trusting and restorative culture.[37] These findings highlight a shift of focus, 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- intra and inter-professionally. As

such, 'alternative' birth choices could be the norm, rather than unconventional, enabling more birthing people to get their needs met without risk to an individual care provider.

4.1 Strengths and limitations

This study 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. The large number of participants and dual forms of data collection strengthens the potential for transferability to other similar settings for employed midwives. 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 team debriefing to ensure that personal beliefs and values did not obscure important interpretations. A key limitation was that the women within the midwives' stories did not provide their point of view, and therefore claims of woman-centeredness may not wholly reflect their experience. Further research to recruit and compare women's and midwifery accounts of how out of guidelines care is managed and experienced would be beneficial.

5.0 Conclusion

This study is the first to explore NHS employed midwives, who self-defined as facilitative of out of guidelines physiological birth choices, from across the UK, across practice settings and with a large diverse sample. The findings highlight emotion-based experiences mediated by the midwives' working contexts. Negative experiences were characterised by a misalignment between the midwives' philosophy and their colleagues and/or organisational cultures. These issues raise concerns regarding midwives' wellbeing and the sustainability of their practice and contribute to the existing literature of why midwives leave the profession. These findings expose rich insights related to the influence of negative organisational cultures that created

undue burdens on individual midwives trying to deliver woman-centred care. Positive organisational cultures were also identified, where midwives and women's autonomy were respected and supported, indicating feasibility and achievability within large-scale organisations. Collectively, these findings illuminate the need for meso and macrostructural changes to ensure women are receiving individualised and respectful care within a human rights framework to facilitate what matters to them in their maternity episode, even if this is not in line with organisational guidelines. Further work is needed to apply what works well, and to drive positive change throughout all maternity services.

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