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**'Woman centred care'? An exploration of professional  
care in midwifery practice**

**MARI ANNE PHILLIPS**

**A THESIS SUBMITTED TO THE UNIVERSITY OF HUDDERSFIELD  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE  
DEGREE OF DOCTOR OF PHILOSOPHY**

**UNIVERSITY OF HUDDERSFIELD**

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## **ABSTRACT**

This thesis explores what 'woman centred care' means to both women and midwives and how this care is offered by midwives and perceived by women. It is set within the context of current health care policy and the way in which this impacts on both the organisation and implementation of maternity care.

A flexible qualitative design was used to explore both women's and midwives' experiences of current maternity care over the full trajectory of maternity provision. A modified grounded theory approach was used framed within a feminist perspective. The fieldwork was undertaken in two phases. In phase one and interviews were undertaken with twelve women in early pregnancy, later pregnancy and after the birth; a total of twenty-five interviews with women were completed. Nine midwives were also interviewed in phase one. Preliminary and tentative categories were identified from both sets of interviews and were used to inform phase two of the study.

Five women participated in the second phase of data collection. This included both informal, telephone contact and in-depth interviews spanning from early pregnancy until after the birth and included observation of their care in labour. The community midwives and delivery suite midwives specifically involved in their care were also interviewed.

The data demonstrated a continued mismatch between the women's and the midwives' perspectives and it was evident that despite the policy drivers and consumerist rhetoric of 'woman centred care' and its original underpinning principles of continuity, choice and control, that this was not the overriding experience for the women who participated in the study. Data analysis highlighted some opportunities for negotiation but these were not explicitly recognised or realised by the women or midwives and there was little time or flexibility in the system to accommodate such opportunities.

The increasing bureaucracy of the maternity care system also constrains continuity of carer over the full spectrum of the childbearing trajectory and reduces the potential for women to know the midwife who provided care. Thus for many midwives being 'with the institution' was more likely than 'being 'with woman'.

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## **ACKNOWLEDGMENTS**

I did not anticipate when I started on this journey that it would take so long or form such an enormous part of my life and life-long learning.

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I could not have done any of this without my supervisors, Wendy Parkin and Professors Nigel Parton, Colin Robson and most recently Professor Mavis Kirkham, who have been wonderfully patient, supportive, challenging and encouraging and sustained me far beyond the normal duration of a PhD study; an enormous thank you to you all.

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## **GLOSSARY OF TERMS**

Antenatal care – care given during pregnancy

Antenatal period – time following confirmation of pregnancy preceding labour and birth

Birth plan – an expression of a woman's preferences or choices for labour normally included as a written record or check list in her maternity records

Cardiotocograph machine – a machine used for monitoring the fetal heart and woman's uterine contractions

CNST – Clinical Negligence Scheme for Trusts

Dynamap – an electronic device used for measuring blood pressure

Entonox - a gaseous mixture of 50% oxygen and 50% nitrous oxide administered via a face mask or mouthpiece used for pain relief in labour

Epidural – injection of a local anesthetic in to the epidural space of the spine either as one injection or via a very fine tube known as a catheter and used as a form of pain relief in labour

Episiotomy - an incision made in the woman's perineum to expedite birth of the baby

Intranatal care – care given during labour and birth

Intrapartum – the period of time of the labour and birth

Lochia/lochial loss – the vaginal discharges following childbirth

Multigravid/a – a woman who has experienced two or more pregnancies

Multiparous – a woman who has birthed two or more babies

Multip – an abbreviation of multiparous

Oxygen – applied with mask or via nasal prongs to improve maternal or neonatal condition

Pethidine – a drug used for pain relief in labour usually administered into the muscle of the leg or buttock

Pinard stethoscope - a traditional manual device for listening to the fetal heart

Postnatal care – care given to the woman following the birth up to 10 days but may be up to 28 days

Postnatal period – period of time following the birth up to 10 days but may be up to 28 days

Primigravid/a – a woman experiencing her first pregnancy

Primiparous – a woman who has birthed her first baby

Primip – an abbreviation of primiparous

Puerperium – the period of time after the birth of the baby – see also postnatal period

Resuscitaire - machine used to place the newborn baby on if requiring immediate suction, oxygen and any other treatment at birth

Sharps box - a sealed box used for the safe disposal of syringes and needles

Suction – equipment comprising plastic tubing attached to apparatus to exert pressure; used for clearing the airways

Syntometrine - a drug given intramuscularly to the woman during active management of the third stage of labour

Tocolytic drugs (for example Syntocinon) - given to the woman intravenously in labour to increase the frequency and strength of contractions

Vitamin K – given to the baby shortly after the birth to minimise the occurrence of haemorrhagic disease of the newborn

Supervisor of midwives - a suitably experienced and educated midwife who is available to offer professional support and guidance on practice issues and responsible to the Local Supervising Authority

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## **CHAPTER 1**

### **INTRODUCTION**

This research study explores what 'woman-centred care' means to both women and midwives and how this care is offered by midwives and perceived by women. It is set within the context of current health care policy and considers the way in which this influences both the organisation and implementation of midwifery and maternity care.

This chapter presents an introduction to the research by considering the emergence of 'woman centred care' in relation to the political, professional and user context of midwifery, maternity care and the service provision. It also outlines my particular interest in the notion of 'woman centred care' and rationale for this study. The aims of the research are discussed and various definitions of 'woman centred' care explored. The feminist perspectives that have influenced the theoretical framework are highlighted. This qualitative study also raises insider-outsider issues, and therefore my position in relation to the women and midwives who participated in the research is identified. Finally, the structure of the thesis is outlined.

#### **The Emergence of 'Woman Centred Care'?**

Radical changes took place in the NHS in the early 1990s, with the Conservative government's free market ideology and the growth of consumerism (Pope et al., 2001). The New Labour government continued reforming and modernising the NHS replacing

the internal market with the 'third way'. This differed from the old left and the new right, and was characterised by pragmatism and populism (Powell, 2000). The needs of patients rather than the needs of the institution were also claimed to be at the core of the new NHS (DH, 1997). These policy initiatives were also said to be underpinned by the concept of individualised care promising care that recognised individuals' needs and with the expectation that health care professionals would work in collaboration with individuals to meet these needs (Pope et al., 2001).

Within the maternity services this approach was recognised as 'woman centred' which refers to the philosophy of care that puts individual women at the centre or heart of the care that is provided, with an expectation that a woman is supported emotionally and practically throughout pregnancy, childbirth and the postnatal period (Deery and Kirkham, 2006, p.125). The origin of this concept pre-dates these policy initiatives since it can be traced back to *The Vision* (Association of Radical Midwives<sup>1</sup> (ARM) 1986). It then appeared more explicitly in the *Winterton Report*, (House of Commons, 1992), and the *Changing Childbirth* Report (Department of Health (DH), 1993) which were the main policy documents to have affected maternity care in the last decade. These two reports set an agenda for transformatory change for the maternity services (Page, 1995).

The ARM (1986) recognised that there were growing concerns about the organisation of the maternity services; that parents were concerned about the increase in the use of technology and midwives were concerned with the conveyor belt approach to maternity care. They proposed a 'vision' for the services over 10 years and developed a set of principles to underpin this 'vision'. These included stating that the woman-midwife

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<sup>1</sup> This was a group that formed in the late 1970s by midwives who were keen to challenge midwifery practice and was seeking to normalise birth.

relationship is fundamental to midwifery care, and that the woman is central in the process of care. The other principles in their 'Vision' covered issues of continuity of care, informed choice, accountability of services to the women themselves and the provision of care that does no harm to the woman and baby. It also recommended community based care and the full utilisation of midwives' skills.

This was a radical document with a great deal of detail in relation to the organisational, educational and professional changes required to support the proposed principles. It reflected the concerns of women and some midwives and indicated that the government's Maternity Services Advisory Committee was already aware of some of these concerns. The ARM contributed evidence to the Health Services Committee which announced its inquiry into maternity services in 1991. Although some of the ARM proposals later emerged in government policy, total reorganisation of the maternity services as envisaged in their 'Vision' did not happen.

Women were also dissatisfied with their care which they experienced as impersonal and fragmented with long waiting times, and lack of involvement in the decisions concerning their care (AIMS 1992) although many of these concerns had already been expressed earlier (Oakley, 1990). The National Childbirth Trust (NCT) gathered information and was able to demonstrate consistent views from women over a 30 year period; that they wanted:

“to have sufficient time with familiar, sensitive, well informed and skilled midwives who are able to provide the necessary level of information and support to meet the needs of individual women”  
(Page and Hutton, 2000, p. 3).

The NCT also provided evidence to the Health Services Committee inquiry, which may have contributed to the Committee acknowledging the “hearing of many voices saying that all was not well with the maternity services” (DH, 1992, para. 2).

Numerous recommendations resulted from the *Winterton Report* (House of Commons, 1992). Interestingly, there were many similarities with *The Vision* which had recognised that the relationship between the woman and her care givers as being of fundamental importance (ARM, 1986) and the *Winterton Report* stating that “the woman having a baby should be seen as the focus of care” (DH, 1992, para. 5 ).

The *Winterton Report* also highlighted the concepts of choice, continuity and control (House of Commons, 1992), though these are often incorrectly attributed to the *Changing Childbirth* report and these were viewed as the principles through which the aim of ‘woman centred care’ was to be achieved. The Royal College of Midwives (RCM) contributed to the developing philosophy of ‘woman-centred care’ and stated that it is the term used [for a philosophy of maternity care] that gives priority to the wishes and the needs of the user, and emphasised the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility (RCM, 2001).

These concepts and the philosophy of ‘woman centred care’ were subsequently adopted within the professional literature and for the remainder of the decade permeated the language of practice and education, including driving changes in the organisation of care and influencing the curricula for pre-registration midwifery programmes. However, as early as 1996 there was a suggestion that despite the adoption of this philosophy of care, it was a rather ethereal concept and there was a danger of it becoming a pious

platitudes (Walsh, 1996) and being perceived as rhetoric rather than reality (Henderson, 1995). Furthermore, Kirkham and Perkins (1997, p.vii) warned of the danger of trying to implement ideas that appeared as slogans rather than fully analysed concepts.

### **Had Practice Changed?**

Whilst visiting a maternity unit in my educational capacity of link teacher<sup>2</sup>, I observed what I perceived to be a midwife responding rudely towards a woman in her care. This could have been construed as not meeting the woman's individual needs. I was also concerned that a midwife, in a predominantly female occupational group, could treat another woman in this way. This may of course have been an isolated incident, but more generally, in relation to practice, I began to question the concept of 'woman centred care', what it actually meant to midwives and the women they cared for and how, four years after the publication of *Changing Childbirth* (DH, 1993), the concept was realised in midwifery practice. I began to question whether practice had changed or was this rhetoric that failed to have any impact on women or midwives on a daily basis. I was particularly concerned with how women were actually treated, the nature of the care that they received and the extent to which the concepts of choice, continuity and control (key precepts of *Changing Childbirth* (DH, 1993), were affecting practice in an enhancing or constraining way.

I struggled with these ideas for some time since I had welcomed and supported the publication of *Changing Childbirth* (DH, 1993). Prior to 1993 there had already been some developments in the organisation and provision of maternity services, but there was an increased momentum and various schemes and projects were initiated to

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<sup>2</sup> A role developed to support student midwives and their mentor midwives in the clinical area

improve choice, continuity of care and control for women and to meet the targets contained within the report (for example: McCourt and Page, 1997; Tinkler and Quinney, 1998). Several of these schemes involved strategies for community midwives to become more involved in aspects of care that had previously been the remit of hospital based midwives, but many of these schemes were struggling to continue due to funding issues and the unforeseen impact of changed ways of working on midwives' personal lives (Sandall, 1995). Indeed, one such scheme had been implemented and discontinued in the area where I undertook this research. I therefore wanted to explore how the notion of 'woman centred care' evolved and to explore what 'woman centred care' meant to both pregnant women and the midwives involved in delivering care; how this care was offered by midwives and perceived by women and how this was located within the context of maternity care policy, both nationally and locally.

### *The Language of Practice*

During this time, I was also aware of discrepancies in the use of language in practice. Some midwives, addressed the women as 'patients', 'ladies' or even 'their' ladies, implying some sort of ownership. Midwives also sometimes addressed their colleagues as 'girls' and occasionally, called the students 'their' students, again implying some sort of ownership. The use of language in midwifery has been highlighted in professional literature in recent years (Macintyre, 1982; Kirkham, 1989; Leap, 1992; Hunt and Symonds, 1995; Stapleton et al., 2002 a, b). Some of this focused on the nature of communication (Kirkham, 1987, 1989; Robertson, 1997) or patterns of language (Stapleton et al., 2002a, b), whilst others focused on how certain words and terms used by midwives were misconstrued by the women they were caring for (Bastian, 1992; Ziedenstein, 1998) rather than the way women were addressed or described by

midwives and other health care professionals. These discrepancies became increasingly apparent during the data collection and analysis component of this study (see for example page 262) and I considered that the language used, not only by the midwives, but also by me and the women, required further exploration.

I was also concerned, and have been throughout the research and writing up process, about the currency and value of this investigation; surely the notion of 'woman centred care' could only be a good thing therefore there was little need to question the theory. Furthermore, *Changing Childbirth* (DH, 1993) has been superseded by other Department of Health policies and initiatives and therefore could be considered 'old hat'. However, this still begs the question of the meaning of the term 'woman centred care'; to what extent is it evident in practice and how is maternity care offered or delivered after *Changing Childbirth* (DH, 1993) and in the light of emerging health care policy initiatives.

### **Aims of the Study**

At the beginning of this study the aims were formulated as follows:

1. To explore what is meant by 'woman centred care': what it means to women and what it means to professionals, specifically midwives.
2. To explore how care is offered by health care professionals, specifically midwives, and the extent to which care offered within the hospital setting effects and/or informs care offered in the home.

3. To consider the effect of recent health care policy on the organisation and implementation of maternity care.

It became apparent after phase one of data collection that my second and third aims were rather too broad and were not achievable within the scope of the research. Furthermore the principles of continuity, choice and control needed to be further explored in the context of 'woman centred care'.

#### *Reformulated Aims*

In the light of my concerns, and following discussion with my research supervisors, the aims were reformulated as follows:

1. To explore what is meant by 'woman centred care': what it means to women and what it means to professionals, specifically midwives.
  
2. To explore to what extent continuity, choice and control are reflected in the care offered by health care professionals, specifically midwives.
  
3. To explore how far the organisation of maternity services has changed with the notion of 'woman centred care'.

In order to achieve these aims I planned to use a qualitative methodology and to use interviews and observational methods of data collection. Since I was also concerned about midwives, a predominantly female profession, and their relationships with the women they were caring for, I decided to adopt a feminist perspective to the research.

### **Defining 'Woman Centred Care'**

Although the term 'woman centred care' is one that is predominantly recognised and used by midwives, rather than, for example, by obstetricians, it is difficult to locate precise definitions, perhaps because a general understanding of this term was assumed by midwives. The statement given in *Changing Childbirth* is as follows:

"The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved."  
(DH, 1993, p.8)

This appears a straightforward statement but does not necessarily capture the simple aspects of care such as kind, personal, sensitive and respectful care with the woman and her family getting to know and trust the professionals who are involved in their care (Page 1995, p.xv). Knowing and trusting was also part of the key message that Caroline Flint highlighted in 1992 which also included developing a relationship with the midwife. This was part of her strategy for improving continuity for women and drew on her previous 'know your midwife' scheme (Flint, et al., 1989).

Lesley Page later stated that the new midwifery<sup>3</sup> is explicitly woman and family centred (Page 1997). This statement recognises that the midwife not only offers care to the woman and her baby but that this care is offered within the context of the broader family group and may include the partner, other children and wider family members. Leap (2000) also recognises the wider remit and described 'woman centred care' as a concept that implies a focus on a woman's individual needs and expectations, social, emotional, psychological, physical, spiritual and cultural needs and expectations and recognition of the need for women to have choice, continuity and control from a known caregiver or caregivers. However Leap (2000) indicates the need for the care to follow the woman across the interface of both community and hospital settings with recognition of the woman's expertise in decision making.

### *Woman Centredness*

Guilliland and Pairman (1995, p.41) use a slightly different term, though its essence appears similar, stating that 'woman centredness' gives primacy to the woman who is the recipient of midwifery care...'. More recently Pairman expanded on this and indicated that [in 'woman centred care'] it is the woman who is the focus of all midwifery care, recognising each woman as an individual and then meeting those individual needs (Pairman, 2006). Couves (1995) also made a similar statement that it is the woman and her family who are central to excellence in midwifery. Furthermore, she clearly stated that in order to achieve this midwives must be able to get to know the women so that they can provide relevant care.

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<sup>3</sup> A reference to the implementation of team schemes some of which predated the *Winterton* and *Changing Childbirth Reports*.

Although the term 'woman centred' was primarily a term that related to maternity care and emerged when the focus on the individual was gaining greater recognition, there are similar examples elsewhere. In nursing, the accepted terminology was 'individualised' or 'patient centred' care and was achieved by using a nursing model or framework to assess, plan, implement and evaluate nursing care. In children's nursing the term 'family care' reflected a focus on the child within the family and was reflecting the policy drivers at the time (Hutchfield, 1999).

Hills and Mullett (2002) offer an interesting differentiation between 'person-centred' and 'woman centred care'. They explain that although person centred care values the person's perspectives as primary rather than the priorities of the institution and/or its staff, the term is viewed as gender neutral and they recognise that women may be affected differently. This justification of the term 'woman centred', rather than 'person centred', is helpful and raises awareness that there may be competing priorities in relation to the needs of the institution and/or the staff who provide care. It also makes explicit the gender dimensions of the work, which is of particular interest in that while a 68% of obstetricians are men<sup>4</sup> (RCOG<sup>5</sup>, 2007) 99% of midwives are women<sup>6</sup> (NMC, 2007) .

### *The Woman Midwife Relationship*

Midwives have traditionally been 'with woman' in terms of the woman midwife relationship (Kirkham, 2000) and this reflects the Anglo-Saxon derivation of the term

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<sup>4</sup> These are England and Wales statistics as at 14 May 2007

<sup>5</sup> Royal College of Obstetricians and Gynaecologists

<sup>6</sup> Only UK wide statistics indicate the gender balance

'mid-wife' or 'with woman'. The explanations offered thus far certainly indicate that the relationship between the woman and the midwife is the key component of the 'woman centred' element of 'woman centred care'; this incorporates kindness, sensitivity, respect and trust on behalf of the midwife (Page, 1995).

It also assumes that the professional relationship develops over time so that the woman is able to get to know the midwife and the midwife gets to know the woman. This may also encompass the wider members of the family group. In terms of continuity it also suggests that the midwife 'sees things through' with the woman and this indicates this individual relationship extends for the duration or through the journey (Leap, 2000) of the childbearing period.

### *Care and Caring*

The definition of care can also be problematic. The terms care and caring are used frequently and sometimes synonymously with the service provided, as in 'midwifery care' or 'maternity care'. The term 'care' may be used at the level of the organisation of the service or at the individual level between the midwife and the woman, though it has been suggested that the organisation and content of 'care' are not easily separated (Green et al., 2000).

At the level of the individual, or at the interface between the individual woman and the service (with either a midwife or doctor) the term usually refers to the individual components of 'care' and as such may be described in the context of the tasks undertaken and the frequency of visits or schedule of care. At the level of the service the term may be used to denote the overarching arrangements for the provision and

location of maternity care antenatally, intranatally and postnatally. It is at this point that tension between the 'woman centred' element and the 'care' element arises. If the term is being used to denote overarching arrangements for the provision of care then it is necessary to explore how these are organised and implemented to facilitate appropriate care at the level of the individual.

### **So Where Are We Now?**

Although getting to know women over time and developing a relationship with them appears fundamental to the relationship between women and their midwives, the development of 'woman centred care' in practice may be questioned when there are a number of other issues and competing priorities that stakeholders have to consider at the level of the operationalisation of the service. I will be exploring these other priorities and how far they support or undermine 'woman centred care' in practice. Hills and Mullett (2002) also suggested that there may be competing priorities from the institution and/or staff and this is an issue which was raised by Kirkham (1999) when she suggested that although 'woman centred care' was adopted as NHS policy it had to be achieved within institutions whose values were different.

The centralisation of maternity services, which has occurred with increasing momentum and bureaucracy since the 1970s, means that we now have some of the largest maternity units in Europe. Kirkham (2000) acknowledged that although there were benefits to centralisation, one inevitable consequence is that care becomes more impersonal and fragmented for the women. Furthermore, this has required midwives to comply with the organisational requirements of the institutions and caused tensions

between the institution and the views of individual women (Kirkham, 2000; Deery, 2003, 2005).

The fragmentation of care in conventional settings or 'standard' maternity care, may limit midwives' ability to develop relationships with women (Page and Sandal, 2000; Redshaw, 2006; see also Hunter and Deery, 2009). Offering choice also becomes increasingly difficult as women are expected to comply with the choices which are pre-defined by the service (Kirkham, 2004a) and which are already available (Page, 2006).

Maternity services continue to receive political attention (for example Lewis, 2007) and are the object of further policy and guidance documents which have been produced and have superseded the *Changing Childbirth* report. For example the *National Service Framework for Children, Young people and Maternity Services (NSF) (England and Wales)* (DH, 2004) sets out the requirements for the provision of maternity services across England and Wales. Maternity services feature primarily within one standard with 'woman focused care' highlighted as a key component together with the availability of a named midwife during pregnancy. However, the concept of the named midwife is not explicitly extended to labour and birth, though one-to-one care during labour for each woman is reiterated with reference to the desirability of this being a midwife that the woman has 'got to know' during pregnancy.

Issues of safety and risk appear to have increased the pressure for more standardised care and this has led to the development of policies, protocols, procedures and care pathways to manage care. Such 'measures' have to take account of what is the 'safest, most clinically effective and acceptable care for the majority of the population concerned'

(Agustsson, 2006, p.103). An important influence on maternity services has been the Clinical Negligence Scheme for Trusts (CNST) which was first introduced in 1996 with subsequent revisions of their standards in 2006 and 2007. This is a scheme that provides indemnity cover for those NHS Trusts who are members against clinical negligence claims made by or in relation to NHS clients treated by or on behalf of those NHS Trusts. The CNST sets and monitors risk management standards that have to be met by Trusts in order to secure their indemnity (CNST, 2006). This means for those working within the NHS, particularly midwives and obstetricians, to ensure legal protection it is essential that they adhere to the published policies and procedures. However, compliance with such policies and procedures leads to an increasingly standardised service for women.

The National Institute of Health and Clinical Excellence (NICE) was set up as a consequence of the White Paper in 2004 (DH, 2004) and replaced the National Institute of Clinical Excellence (also known as NICE) which had been in place since 1999, with a remit for providing national guidance for health and health care. Clinical guidelines for antenatal care were produced in 2003 (NICE, 2003); for postnatal care in 2006 (NICE, 2006) and most recently intrapartum guidelines were circulated (NICE, 2007):

“Women and their families should always be treated with kindness, respect and dignity. Good communication is essential, supported by evidence based information, to allow woman to reach informed decisions about their care. The views, beliefs and values of the woman, her partner and her family in relation to her care and that her baby should be sought and respected at all times”.  
(NICE, 2007, p.2).

These highlight the apparent continued importance and the currency of the concept of 'woman centred care' as part of the care of child bearing women and their babies. However, it also raises interesting questions about the situation in maternity care if these concepts continue to require such detailed attention.

Financial pressures and staff shortages also impact on the organisation and exacerbate pressure on remaining staff involved in the delivery of care to women (Curtis et al., 2006a, b). The majority of midwives clearly strive to put women at the centre of their care and women themselves want to be the focus of care and attention during this important time of their lives (Newburn, 2006). This poses a difficulty since the majority of midwives are female and this may mean that efforts to meet women's needs may result in them compromising their own well being (Sandall, 1995; Annandale and Clark, 1996).

It appears that the care women receive in the maternity system is shaped only partly by the policies that are prescribed by the government, professional groups and other institutions (Hills and Mullett, 2002). However, the extent of their impact on childbearing women and the midwives who provide the majority of care is not clear. Furthermore, the reality of implementing 'woman centred care' provides an ongoing challenge with the competing priorities of other organisational and policy demands.

### **Theoretical Framework**

In order to explore the concept of 'woman centredness' it is helpful to draw on feminist perspectives (Dykes 2006). A feminist approach views the personal as political since pregnancy and birth have become part of the mainstream of political debate (Bryson,

1999). Lorber (1988) also suggested that a feminist approach would highlight patterns, interrelationships and implications that may not be seen by non-feminists and these will be valuable as the complexities and tensions of current maternity care are explored.

Brown et al., (1994, p.5) explained that:

“in ‘woman centred’ research, women are acknowledged as active, conscious, intentional authors of their own lives. As an ideal this notion of ‘woman centred’ research is appealing. As a description of reality, however, the term ‘woman centred’ is not entirely satisfactory because it seems to suggest that women can occupy a powerful authoritative and controlling position in their lives: lives often hemmed in by social arrangements and structured inequalities not of their own making.”

This statement has some merit when considering the notion of ‘woman centred care’. In particular it poses a challenge for any research which seeks to explore the operationalisation of ‘woman centred care’ in day to day practice.

There has been a presumption that all feminist perspectives are perceived to have some common ground or common framework, but there is little agreement about the shared content of the perspectives thus allowing for different concerns and explanations (Ramazanoglu, 1989) and may signify that feminism is not a monolithic ideology (Tong, 1998). However, the main approaches are liberal feminism, radical feminism and Marxist or social feminism and these still prove useful when trying to explain women’s oppression and its likely elimination (Tong, 1998). These are explained further in Chapter 2. However, there is a danger that automatically aligning midwifery and feminism may overlook the conflict between birthing women and midwives (Beckett, 2005). Beckett suggests that emphasis on certain aspects of care, for example

continuity of carer may obscure that such provision may be difficult for, or even exploit midwives.

The history of childbirth and its changes over time have been well documented and demonstrate how it has moved from being in the hands of women and viewed as a normal process, to increased intervention first by man-midwives, and then by doctors (Donnison, 1977; Oakley, 1984; Nettleton, 1995). From a sociological perspective, childbearing may also be viewed as a continuing conflict between women, doctors and midwives (Kent, 2000, p.13). This conflict encompassed the formation of policies, the organisation of care and ultimately who had power over whom (Kent, 2000, p.13). The gradual institutionalisation of childbirth between the 1940s and 1960s and the more rapid changes in the 1970s with increased medicalisation and the consequent increased role of doctors and erosion of the role of female midwives in childbirth demonstrate the gendered nature of childbirth and how patriarchy has influenced and changed the process of childbirth, midwifery and the organisation of maternity services within the NHS.

Sex and gender are terms that have often been used interchangeably, though feminists have made a clear distinction (Bryson, 1999, p.46). The separation between sex, referring to biological differences between male and female, and gender, relating to cultural differences, was highlighted by Oakley in 1972. Bryson also points out that gender is related to the socially constructed aspects of masculinity and femininity and resulting social arrangements (1999, p.46). More recently Burr states that 'gender is the backcloth against which our daily lives are played out' (1998, p.2) and she goes on to say that when these minutiae are examined that there is no aspect that is not gendered (1998, p.2). Bryson goes on to say that since gender is a basic principle of social

organisation it is also about power and consequently about the notions of subordination, domination and resistance (1999, p.47).

Cultural codes of gender and their influence on the social institutions as well the socialisation of individuals and their relationships have also been well documented, both in relation to nursing (Davies, 1995) and midwifery (Kirkham, 1999). Kirkham (1999, p.732) traced the historical developments that underpin the current situation of midwives as an oppressed group within gendered institutions and the tensions between caring for individual women and the professionalisation of midwifery. She also suggested that female gendered skills, such as support, caring and of being with women become invisible within gendered institutions.

For the purposes of this study I have found it useful to examine the extent that gender, within an organisation such as the NHS, has been addressed. Colgan and Ledwith (1996) drew on work from Witz and Savage (1992) to highlight gender issues in organisations and challenge the suggestion from Kanter (1977) that the more women became integrated, the more structures would significantly alter.

Davies (1995) also focussed on gender and work organisations and addressed the issue of gender within the NHS and what this has meant for healthcare professionals, particularly nursing. She acknowledged that the policy changes have mainly focussed on providing equal opportunities and addressing discrimination but also highlighted that this focus has limitations (p.43). There are similar problems for nurses and midwives, in so far as both nurses and midwives are predominantly female and by virtue of changes to the education system have aspired to achieve professional recognition within a rapidly changing, though still bureaucratic and gendered organisation.

Kent suggests that despite women making an important contribution to the NHS their occupational segregation has impacted on the opportunities available to them (Kent, 2000, p. 80). This has also affected midwives who have been regarded as lower status compared to obstetricians. Again, this relates to the development of midwifery shaped by patriarchy and class interests (Kent, 2000, p.81; Witz, 1992) and is further discussed in Chapter 2.

Postmodernists however have rejected conceptions of women as a homogeneous category, they have also rejected universalised and normalising accounts of women as a group and have challenged the status of established categories like sex, class and race/ethnicity (Alvesson, 2002). Postmodernists argue that there is no unified central position but a suggestion that meaning is not eternal or impartial but constructed, through exclusion and repression. Furthermore, there is concern that making assumptions about women as a group replaces the singular authority of western 'man' as the universal standard with another feminine controlling norm against which some women are bound to be marginalised, therefore all ideas must be carefully scrutinized. A postmodern feminist approach involves a critical response to traditional theorising, challenges male supremacy and requires a much more nuanced focus on women, their diverse identities and practices.

Concerns about the bureaucracy of NHS maternity services and consideration of the way in which frontline practitioners go about their work has prompted the use of Lipsky's (1980) work. He defined public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work as

*street-level bureaucrats*<sup>7</sup> and the agencies that employ them *street-level bureaucracies*<sup>8</sup> (Lipsky, 1980, p.3). Lipsky commented that people who work in these jobs share work conditions and experiences; this fits the situation of midwives who provide care to women on a daily basis. He also suggested that they are often placed in situations where job or organisational requirements mean they are often unable to meet their personal ideals and develop strategies for coping with the work or processing clients most effectively.

### *Insider-Outsider Issues*

Although at the beginning of the research I was not aware of the need to identify my position within the research process, as the research progressed I reflected on my position as a researcher, lecturer, midwife and woman and how this affected my relationship with the women and midwives in my research. I became aware of the multiplicity of 'hats' and 'voices' that were emerging during the study, my varying status as 'insider' and 'outsider' within the study and the implications for my research and how I made sense of it (Pellat, 2003). Therefore I began to appreciate that the whole notion of being an insider and/or outsider had a substantial impact on the entire research process; at different stages in the process I was either or both 'insider' and 'outsider'.

Throughout the span of this research study I have had to acknowledge my own professional knowledge and experiences. This is not only because without them I would have been unable to undertake the study or gain access to the participants but also because the reflexivity, important to qualitative methods generally but central to a

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<sup>7</sup> Lipsky's emphasis

<sup>8</sup> Lipsky's emphasis

feminist approach (Letherby, 2002), has meant that I have had to question the origin and development of my professional beliefs and their impact on the research process. This has involved reviewing my personal biography, clarifying my professional positions as a midwife and an educationalist, my personal position as a woman and reflecting on my differing relationships with the women and midwives who participated in the study.

### *Professional background*

I trained as both a nurse and a midwife over twenty years ago and have been engaged in midwifery education for the majority of this time. When I trained as a midwife I undertook a 12 month course, of no specified academic level<sup>9</sup>, and in common with many other midwives I lacked confidence in my practice following registration. Gaining experience and acceptance with other midwives in my first post as a midwife depended on learning how to cope, particularly in the delivery suite, developing expertise in managing 'deliveries' and 'clearing' the labour ward. This also included proficiency in various tasks, for example: 'topping up' epidurals, giving intravenous drugs, 'scrubbing' for caesarean sections and teaching student midwives. There was little, if any, support from peers or more senior midwives in terms of exploring and discussing aspects of practice, other than if a 'problem' arose which could have been handled 'better'. Statutory supervision<sup>10</sup> was not visible for midwives working in a hospital environment and the concept of clinical supervision<sup>11</sup> unknown in midwifery practice. Working on the wards was usually busy and I developed an appearance of being 'brisk and efficient' and

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<sup>9</sup> This would now be viewed as certificate level

<sup>10</sup> Each practising midwife has a named supervisor of midwives covering her main area of practice and is expected to meet with their supervisor at least once a year to review her practice and to identify her training needs (NMC, 2004)

<sup>11</sup> Clinical supervision, a concept that originated in counselling settings and later adopted within nursing and is normally a one to one discussion with a nominated colleague about aspects of practice. It is not statutory but generally recognised a good practice.

trying to 'fit in' even if this did not reflect my true feelings of being somewhat isolated and inefficient and also quite anxious about practising as a midwife.

At the time there were limited opportunities for midwives in terms of career development; management or teaching were the only options and I undertook further professional development in order to become a teacher. This was the beginning of twenty years in education where there had been, mainly since 1990, the development and implementation of midwifery training programmes located within higher education and approved at undergraduate level.

At no time until the mid 1990s were my personal beliefs about midwifery either articulated or challenged. I trained at a time when teaching was mainly didactic and rote learning was important to achieve success in the midwifery examination. This was an era of about 100% hospital births [deliveries], following on from the *Peel Report* (Central Health Services Council, 1970) even though the *Short Report* (House of Commons, 1980) and the consequent *Maternity Care in Action* documents (House of Commons, 1982, 1984, 1985) sought to humanise the environment.

This type of institutionalised maternity care influenced my practice and teaching in the mid 1980s; care was often medicalised with induction of labour a frequent intervention, although in the mid 1980's the caesarean section rate was still less than 10%. There appeared to be an accepted way of doing things, custom and practice, which was not based on any research evidence with emphasis placed on the Procedure Book<sup>12</sup>, (though this was often out of date). There was quite a focus on 'getting things done' and being efficient appeared to be valued. There was little, if any, teaching of, or discussion

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<sup>12</sup> A manual provided by each hospital that documented how tasks should be undertaken

about, communication skills. Few midwives challenged the status quo in terms of clinical practice and in the hospital setting there was a hierarchy of midwifery personnel. Although it is important to state that this may only have been a feature of the practice I encountered, I worked in more than one hospital and some of the literature suggests my experience was neither unique nor isolated (Kirkham, 1987; Hunt and Symonds, 1995).

Although I completed the professional requirements to become a teacher which deepened my factual knowledge of some aspects of midwifery, I do not think that it had any particular impact on my practice. However, I later undertook an introduction to counselling course which helped me to develop my communication and facilitation skills. The first real impact on my thinking came with an Open University degree in social sciences especially issues around feminist theory which I applied to midwifery specifically in relation to medicalisation and intervention.

I worked as a midwife in practice without effectively challenging the medical model of care that was prevalent at the time, and to some extent colluded with the rhetoric of autonomy for midwives and *Changing Childbirth* (DH, 1993) without really addressing what these meant or considering the various constraining factors. These factors included the power differentials between doctors and midwives and also between senior and junior midwives; the local organisation of care, for example the acceptance of hospital care and delivery and limited opportunities for home births; midwives unwilling or unable to take full responsibility for the women in their care and/or challenge the status quo or to work with appropriate evidence underpinning their practice. I began to challenge these things in the educational setting from the mid 1990s but without necessarily helping midwives develop any real strategies for dealing with these issues.

I am not clear as to when I became more concerned about 'being with woman' and trusting women's ability to birth their babies or became aware of the nature of the language used. However, I was beginning to articulate these ideas more clearly in 1997 when I witnessed the episode described at the start of this chapter (see page 16). More generally in relation to practice, I felt that there must be more than choice, continuity and control in terms of the ideology or rhetoric of 'woman centred care'.

The difficulties and anxieties I experienced in my clinical practice and in education are some of those which had already been articulated through the Association of Radical Midwives (ARM). I was aware of this group but not involved in it until I undertook this research and realised that these midwives were engaged at a practical level in trying to improve and facilitate women's experiences of normal birth.

### **Structure of the Thesis**

Chapter 2 provides an overview of the development of the midwifery profession and the development of the NHS. It then considers the national policies that have impacted on maternity services since 1948, with a particular focus on the *Winterton Report* (House of Commons, 1992) and the *Changing Childbirth* Report (DH, 1993) and discusses how these have informed my thinking behind this research. More recent reports that have influenced maternity services are then discussed. This chapter also reviews the literature that has direct relevance to this study.

Chapter 3 describes the methodological approaches used for the study and the considerations that have informed the design and implementation of the research. The

methods that have been used for data collection, organisation and analysis are described and discussed. Particular consideration is given to the access and ethical issues within this study.

Chapter 4 describes the research setting, its organisational structure and management, the location of maternity services and also considers the wider influences on practice such as rules, policies and procedures. It uses empirical data from the women and midwives to explore some of the concepts that emerged, such as knowing, trusting and caring, to try and deepen understanding of the term 'woman centred care' and begins to address the first aim of the study.

In Chapter 5 the concept of continuity of care is explored and understanding of the relationship between continuity and knowing is deepened. Using the empirical data continuity from the women's and the midwives' perspectives is considered and the contradictions encountered when trying to ensure continuity highlighted. The differences that emerge between community and hospital midwives are also discussed. Finally I consider the implications for practice that this presents with regard to the organisation of care.

Chapter 6 addresses the concept of choice. The issues are explored from both the women's and the midwives' perspectives. I also consider how women's choices about their care and place of birth are modified/changed by the realities of midwives' practice and consider the boundary points for choice and the potential for negotiation.

In Chapter 7 the concept of control is considered. This includes consideration of the extent of personal autonomy or agency that women feel able to exert within the childbearing process and the midwives' response to them. The notion of control is also explored from the midwives' perspective. I analyse the use of language and terminologies adopted within the study and consider the ways in which midwives talk to and about the woman in their care, the ways in which they talk to each other and the ways in which the women refer to the midwives.

In Chapter 8 I revisit the women's and midwives' perspectives and consider how these facilitate or hinder 'woman centred care'. I also highlight the various factors that have impacted on the different perspectives and ultimately the concept of 'woman centred care', namely the policies affecting care, the nature of care and the notion of surveillance and the system and culture of maternity care. These are incorporated with my findings in relation to the language used in maternity care and the extent to which language contributes to the discourse of 'woman centred care' and in the light of these findings consider how far 'woman centred care' is a reality or rhetoric. Finally I consider the implications for policy, practice and midwifery education.

## **CHAPTER 2**

### **WOMEN, CHILDBEARING AND POLICY**

#### **Introduction**

This chapter sets out the policy context for current maternity services. More specifically it analyses the policy context in which the idea of 'woman centred care' has been developed and it relates to a range of other policy priorities and themes. Firstly I outline the nature of maternity services immediately before the implementation of the NHS in 1948 and then outline the policies that have been introduced since then and their effect on maternity care and midwifery practice. Secondly I consider the other influences such as those of non-departmental organisations which impact on maternity services. Thirdly, I reflect on how women's concerns have been documented and discuss the impact of both of these on midwifery practice in general and 'woman centred care' in particular. This chapter also explores the use of language in the policy and regulatory documents and considers the implications of this for midwifery practice and 'woman centred care'.

#### **Policy Background**

Traditionally, childbirth has been considered a private affair, undertaken within the domain of the family, and to a lesser extent the local community (Loudon 1992) although early birth attendants, predominantly local women with experience of childbirth, were under the jurisdiction of the church (Arney, 1982). Although the institution of midwifery

was based on the premise of birth as a normal process the 15<sup>th</sup> to 19<sup>th</sup> centuries saw a rise in man-midwifery and interventions in childbirth. However, in England it is only since the turn of the twentieth century that childbirth, and those who care for childbearing women, have become an explicit public and social concern and within the control of health care policy (Stevens, 2003). More recently, particularly in the last three decades of the twentieth century, childbirth practices and maternity services have been the centre of quite a polarised debate between the medical model of childbirth and the social or midwifery model of childbirth (Brooks, 2000).

One of the early driving factors for greater state involvement in health and particularly maternity care was the concern generated by the poor physique of many volunteers for the Boer War (1899-1901) (Leathard, 2000, p.2). As a response to public pressure from the Woman's Cooperative Guild and others, the government started to fund schemes for maternal and child welfare (House of Commons, 1992). The passing of the Notification of Births Act (1907) and the Maternity and Child Welfare Act (1918) gave powers to local authorities to provide schemes for home visiting of expectant mothers and provision of antenatal clinics in maternity homes and in existing institutions that had maternity beds. Following the Local Government Act of 1929, local authorities took over Poor Law institutions and their hospitals and were given money to provide a range of services. Although these developments, precursors to the legislation which provided the welfare state, were welcomed, such responses were mainly reactive and haphazard in nature (Leathard, 2000, p.2).

Prior to 1948 and the introduction of the NHS pregnant women were attended in pregnancy and childbirth mainly by domiciliary midwives who were locally based and, up

until 1936, charged women directly for their services. Women who could afford to pay for care often chose medical care rather than a midwife. Antenatal care was rather limited, home confinements were the norm and if complications arose the midwife sought assistance from the woman's General Practitioner who required a separate payment.

Provision of a salaried midwifery service by local authorities was achieved following the Midwives' Act of 1936; the goal was to provide a national community based maternity service with antenatal and postnatal care, home birth and General Practitioner support (Benoit et al., 2005).

Following the introduction of the NHS all women became entitled to maternity care, free at the point of delivery, and were able to utilise the services of both midwives and doctors for their maternity care. Although care was still primarily based in the community with home confinements being the norm, consultant based hospital service were also strengthened (Benoit et al., 2005) and the boundaries around the new 'profession' of obstetrics appeared to strengthen (Arney, 1982).

#### *The rise of medical dominance*

From 1948 to the beginning of the 1990s the policies related to maternity care contributed to increased hospitalisation and intervention and thus the medicalisation of childbirth (Johanson et al., 2002). Interventions which had been originally confined to forceps deliveries to facilitate complicated births, and performed in the home if necessary, and very limited analgesia, then developed further and encompassed new

forms of analgesia, safe blood transfusion and drug therapy for sepsis. Increased hospitalisation in the 1960s and 1970s also led to the use of induction and acceleration of labour, electronic fetal monitoring, epidural analgesia and an increased caesarian section rate (RCM, RCOG and NCT, 2001). Although midwives continued to be the primary attendant at the majority of hospital births their role was becoming increasingly fragmented and undermined as medical dominance over childbirth increased (Benoit et al., 2005).

Various reports advocated increased hospital confinements and the phasing out of home confinements on grounds of safety (Ministry of Health, 1959; Central Health Services Council, 1970 (*Peel Report*); House of Commons, 1980) though the justification for the conclusions drawn by these reports, have since been challenged (Tew, 1998) and revoked within more recent reports (House of Commons, 1992; DH, 1993). The focus of previous Social Services Committee Report ('*Short Report*', House of Commons, 1980) was to reduce the levels of perinatal, neonatal and infant mortality though there were also some concerns about the impersonal care offered in hospitals. This report resulted in three Maternity Care in Action documents - Parts I, II and III - (House of Commons, 1982, 1984 & 1985) and also resulted in further medicalisation of childbirth. These documents comprised guidance and checklists that professionals and health authorities used to inform their care and services. They were welcomed at the time as a way of articulating the essential components of maternity care and provided a template for the provision of maternity care for the next decade (Stevens, 2003, p.20). However, they also reinforced the fragmented components of care to women (Stevens, 2003 p.20)

The 1980s saw increased emphasis on the cost effectiveness of medical care (Sandall, 1995) and greater interest in the provision of maternity services (Bradshaw and Bradshaw, 1997). In 1989 the government stated that efforts to reduce perinatal, neonatal and infant mortality must continue and part of the initiatives included a review of the maternity services; in particular the provision of hospital facilities for childbirth and related care and a review of the implementation of good practice in relation to antenatal care and education (NAO, 1990). The review was specifically focused on the efficiency of these services and although the report acknowledged improvements in maternity services and a reduction in mortality rates it highlighted the lack of reliable data and the extent of the variations between service provision in some authorities. Also, it was unable to conclude whether or not services were being provided in the most efficient way. As a result of this report the Public Accounts Committee commissioned an inquiry into maternity services which resulted in the '*Winterton*' Report (House of Commons, 1992).

### *Maternity policy in the 90s*

The '*Winterton*' Report (House of Commons, 1992) recognised that it had been over ten years since the last major inquiry though it failed to state explicitly the driving forces of the review other than indicating that they heard 'many voices saying that all is not well with the maternity services and that women have needs which are not being met' (House of Commons, 1992). However, it seems that the prime motives were concerns about efficiency and economy, rather than women's experiences of childbearing (Rothwell, 1996), though one brief paragraph does state that an important consideration is that the resources are not only adequate but that they are being 'cost-effectively used' (para 7, p. v).

The focus of the report was the 'normal birth of healthy babies to healthy women' (para 5, p. v) and it aimed to match up the needs and wants of childbearing women and their families with the views of the professionals as to how the maternity services could be organised. Evidence was gathered from women, organisations involved in maternity services - both professional and lay - and the health care professionals themselves. It was within this report that the key concepts of choice, continuity and control (para 38, p. xiii) were first introduced together with the notion of 'woman centred care' (para 221, p. xlvi). It highlighted that choices in childbirth for women were both limited and illusory often resulting from institutional constraints and the reluctance of professionals to facilitate choice. Continuity of care was perceived as very important, through pregnancy, birth and postnatally, and particularly the need for women to know who would be with them during their labour and birth. The need for women to feel in control, both of their bodies and what happens to them during the childbearing process was also highlighted (para 53) as contributing to woman's overall satisfaction with the service.

The term 'woman centred care' (para 221, p. xlvi) was used in relation to the place of birth and explained as a 'non medical' orientation to maternity care and in opposition to the 'medical' orientation. The use of such binary opposites highlights the demarcation of obstetrics and midwifery with the notion of the medical orientation as the mainstream and non medical as 'other'. Annandale and Clark (1996) explain this split as a poorly drawn picture of alternatives.

The report was welcomed by midwives although it was recognised that the extent to which the recommendations would be implemented would depend on the response within government (RCM, 1992). The response from obstetricians was rather more muted, with references still being made to safety, urging the government to reconsider the findings before implementing any of its proposals (Anderson, 1992). Newburn (2006, p.5) later commented that this report was perceived as a seismic shift in relation to maternity services.

The Government's response, five months after the Health Committee report, was mainly supportive, though not all the recommendations were accepted. The formal report was in two parts (Department of Health, 1992). Part 1 identified governmental initiatives that had already begun or were about to begin and included the establishment of a Joint Department of Health/NHS Maternity Units Study Team and a Departmental Task Force to look at the management of maternity services, focusing on continuity, communications and access for black/ethnic minority women. Part 2 included the specific responses to the recommendations and conclusions of the report. Within this response the government also announced the establishment of an Expert Maternity Group. The remit of this group was to review the policy on care, including the arrangements for care during childbirth and to ensure that the services in place drew on the specific skills of each professional. The expectation of the government was that the outcome of this group would lead to changes in the Maternity Services Advisory Committee Report Part II 'Care during Childbirth', though not to Parts 1 and III (antenatal and postnatal care) which were still considered to be appropriate and valid.

The *Changing Childbirth Report* (DH ,1993), commonly regarded as the Government's response to the *Winterton Report* (House of Commons, 1992), was specifically the outcome of the Expert Maternity Group - including the findings of a Consensus Conference (Maternity Care: Choice, Continuity and Change) - and was subsequently adopted as policy for England. This outlined a fundamental change in terms of care - "that a 'medical model of care' should no longer drive the service". The report identified three key principles: women as the focus of care, in control and able to make decisions; that services should be accessible and that woman should be involved in monitoring and planning services (p.8). The concepts of choice, continuity and control are more accurately references to the *Winterton Report* (House of Commons, 1992) and not the *Changing Childbirth Report* (DH, 1993). The latter highlighted the need for appropriate and accessible care, together with effective and efficient services. The objectives and action points were directed at the purchasers, providers, professional and training bodies and the Department of Health. The final chapter included ten key 'Indicators of Success' and suggested that if these were achieved within five years then the majority of the recommendations would have been put in place.

The ten key indicators of success were:

1. All women should be entitled to carry their own notes.
2. Every woman should know one midwife who ensures continuity of her midwifery care – the named midwife.
3. At least 30% of women should have the midwife as the lead professional.
4. Every woman should know the lead professional who has a key role in the planning and provision of her care.

5. At least 75% of women should know the person who cares for them during their delivery.
6. Midwives should have direct access to some beds in all maternity units.
7. At least 30% of women delivered in a maternity unit should be admitted under the management of the midwife.
8. The total number of antenatal visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG guidelines.
9. All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency.
10. All women should have direct access to information about the services available in their locality.

Although the *Changing Childbirth* (DH, 1993) recommendations were seen as quite radical, to some extent these only reflected the ways in which some midwives were already working. For example community midwives who made themselves available for the labour and birth of women they knew through their antenatal care and midwives who chose to work independently (Troutt, 1994). Several key questions were raised by the document. Firstly, though the extent of the consultation was wide it could be suggested that it duplicated the detailed and comprehensive findings of the *Winterton Report* (House of Commons, 1992). Secondly, the remit of the Group constrained its ability to address socio-economic and nutritional factors that also influenced the outcome of pregnancy and childbirth; the *Winterton Report* (House of Commons, 1992) viewed both of these as important. Thirdly, it was not clear either how the indicators were formulated or what constituted the evidence base for these indicators. Since these were to be the

indicators by which the services were to be measured then further information as to how these were construed was essential.

The profession responded with various initiatives that necessitated organisational changes and created challenges for midwives. The focus of all the developments were the 'Indicators of Success', cited in the Report, and the elements of choice, continuity and control, however there was little significant exploration of the concept of 'woman centred care'. 'Team' midwifery schemes were developed and subsequently 'case load' midwifery (Page, 1995). The former involved the establishment of teams of midwives mainly in the community setting who gave the whole spectrum of care to woman in pregnancy and childbirth, including their intrapartum care. This meant that women were invited to meet all the midwives from the team in order to get to 'know' them prior to their labour. This also involved re-skilling many community midwives so that they felt competent and confident to offer intrapartum care to women and to work both in community and hospital settings. Where teams were established in hospital they involved midwives who were normally ward based being expected to give antenatal care in the clinic setting and to work on the delivery suite. The implementation of such schemes often had personal consequences for midwives in term of stress and burnout (Sandall, 1995) as they were striving to improve continuity of care. 'Case load' schemes fared slightly better as this involved midwives working in pairs with clearly defined case loads of women to whom they gave the full spectrum of care, including intrapartum care (Stevens, 2003). However, this model, though positively evaluated, has not been widely adopted due to organisational and funding issues.

Although the government stated that initiatives arising from *Changing Childbirth* (DH, 1993) should be incorporated into the priorities and planning guidance for 1994/5 and

then included in the contracts for 1995/96, no further assurances for funding were given. By 1996 it was no longer a 'purchasing priority' and many schemes were disbanded for lack of resources with a reversion to fragmented practice (Flint, 1992; Page, 1997; Rosser, 1997). One report, based on interviews with midwifery managers, stated that progress towards 'woman centred care' was not only related to the resources made available but also dependent on the number of changes and how they were made; the speed at which the changes were implemented and the involvement of the staff; the commitment of those leading and/or managing the change and the nature of the power held by the head of midwifery services (Henderson, 1996). This report also highlighted that despite opportunities arising for midwives, in some areas doctors and the medical model were valued more highly than midwives.

Another group of senior managers who were consulted about implementing *Changing Childbirth* considered that it was too idealistic and that there was a discrepancy between the rather confused goals and the realities of implementation, including a lack of resources (Bradshaw and Bradshaw, 1997).

The changes resulting from *Changing Childbirth* had resulted in a great deal of pressure on midwives (Henderson, 1996; Kirkham, 1999) and five years after *Changing Childbirth* and six years after *Winterton* concerns were being expressed by the Association of Radical Midwives (ARM) (Jowitt, 1998; Schan, 1998) that there had been little sustainable change in the maternity services and that they were in 'disarray'. Although midwives collectively, and the ARM in particular, had welcomed both of these reports and anticipated that women would get more personal treatment and midwife-led care, the reality appeared very different due a variety of factors including a lack of sustained investment by the government.

A key factor that was omitted from the *Changing Childbirth* report was any discussion of the culture of the maternity services (Newburn, 2006, p.17); this includes the ways of doing things and the practices that contribute to the way an institution works. This was highlighted by Kirkham (1999) and Kirkham and Stapleton (2001) who commented that information alone was not sufficient to change a culture.

### *Changes under New Labour*

Since 1996 and the introduction of primary led care by the Conservative government (DH, 1996) there have been a plethora of New Labour government initiated changes seeking to modernise the NHS. Few have explicitly mentioned maternity services directly, though often wherever nurses are mentioned the word midwives may be found or else is often implied. However, these initiatives and changes have impacted on the services in terms of establishing and monitoring standards, clinical governance and funding. Throughout this time there appears to have been an implicit assumption that the principles of *Changing Childbirth* (DH, 1993) were still relevant.

In 1997 the government released *The New NHS: Modern and Dependable* (DH, 1997). This White Paper began the process of reform and modernisation of the NHS, replacing the internal market with integrated care. The key features were the development of national standards, the implementation of clinical governance and changes to the organisation of the NHS, in particular the development of primary care groups, who took over the commissioning of maternity services. Although the ethos of *Changing Childbirth* was to be maintained, there was no specific mention of maternity services in it.

Recognising the difficulty which many midwifery managers were experiencing in effectively contributing to decision making which affected the nature and funding of maternity services, the Royal College of Midwives produced a guide to help them understand the process and context of purchasing maternity services and to help them better engage with purchasing authorities or GP fundholders (RCM, 1997). Whilst this provided useful information for midwives the extent to which it was used by them is not clear and it did not address the inherent cultural and power issues that midwives were facing in relation to development of maternity services.

This was followed in 1998 by a government produced consultation document, *A First Class Service* (DH, 1998), regarding the re-organisation of the NHS, focusing on a modern service delivering high quality services for all. This outlined the development and implementation of National Service Frameworks (NSF), the National Institute for Clinical Excellence (NICE), Clinical Governance, lifelong learning for NHS staff and a new system of self-regulation. It also included a new monitoring system incorporating the Commission for Health Improvement (CHI). Although this report was broadly welcomed by midwives there was criticism of the implicit assumption that clinical governance would be led by doctors and the professional response included a reminder for the government that a medical model of service delivery was not appropriate for maternity services and that NICE should not be medically dominated (Fyle, 1998).

In 1999 the government published its strategic intentions for nursing, midwifery and health visiting which included changing roles, recruitment, strengthening education and training, improving working lives, quality of care and strengthening leadership and self-regulation (DH, 1999). The expanding role of the midwife included public health, health

promotion, breast and cervical screening, contact in the postnatal period and consultant midwives.

In 2000 there were two debates in parliament on maternity services. In the Lords, Baroness Cumberlege reiterated choice, the importance of continuity and control and highlighted various issues including a midwives' crisis, inequalities, a rising caesarean section rate and stated that *Changing Childbirth* was seen by government as yesterday's policy despite reaffirmation by each successive health minister. The priority of the maternity services was questioned by Lord Hunt (Hansard 12.01.2000 column 739).

Later that year in a debate in the Commons, Nicholas Winterton suggested that in the opinion of some user organisations maternity care had not moved towards its ideals, and the likelihood of a normal birth with a known midwife was even less than previously (Hansard 19.04.2000 column 209 WH). He stated that maternity services were not just an issue of choice but of public health; furthermore there had been an increase in the centralisation of services, medicalisation and in the caesarean section rate. The need to build on *Changing Childbirth* (DH, 1993) was reiterated and it also suggested that GPs were ambivalent about midwife led care.

*The NHS Plan* was launched in 2000 and included key indicators of reform and investment for the NHS (DH, 2000). There was some recognition of midwives' contribution to the lives of mothers and babies and encouragement for midwives to develop their role in public health. This was followed by *An Action Guide for Nurses, Midwives and Health Visitors* (DH, 2001) that focused on the key themes of *The NHS Plan* together with specific action points to be used by individuals. Midwifery leadership,

fundamentals of care and not putting up with poor practice were key areas for midwives here.

*Delivering the NHS Plan* was published in 2002 and focused on funding and organisation of the NHS, incentives for Primary Care Trusts (PCT), Foundation Hospitals, staffing and training and reiterated the introduction of the National Institute for Clinical Excellence (NICE), and National Service Frameworks (NSF). It also introduced the concept of a health care regulator. Maternity services were not mentioned specifically but the implementation of NICE, development of NSFs, and PCTs all had implications for midwives and the maternity services as did the notion of foundation hospitals.

The midwives' contribution to the *NHS Plan* (DH, 2000) was identified in a further document *Delivering the Best* (DH, 2003) and highlighted five challenges for midwives: excellence in midwifery practice; dynamic leadership; partnerships with women; improving public health and working with others. However, in 2003 there were still governmental concerns regarding the degree of choice and control that women had over their maternity care and a Maternity Services Sub-committee was appointed to investigate this further. The outcome of the inquiry was several reports including the Fourth, Eighth and Ninth Reports (House of Commons, 2003a, b and c). Again oral and written evidence was taken from representatives of user, professional and pressure groups and the Department of Health and users themselves. The *Fourth Report* (House of Commons, 2003a) covered the provision of maternity services; the *Eighth*, inequalities in access to services (House of Commons, 2003b) and the *Ninth*, choices in maternity care (House of Commons, 2003c).

The *Ninth Report* (House of Commons, 2003c), published a decade after *Changing Childbirth*, highlighted that the widespread closure of smaller maternity units and birth centres, along with the shortages of midwives, limited women's choices and recognised that choice, for some women, was an illusion and that choice for some women may mean barriers for others as suggested in the *Eighth Report* (House of Commons, 2003b). It suggested that the Department needed to ensure that women were given a genuine and informed choice and not the illusion of choice as some evidence suggested. It also suggested that the usual methods the Department used to measure effectiveness of services may not be the most appropriate for the maternity services and welcomed the department commissioning more research in this area.

The following year saw the publication of the *National Service Framework for Children, Young People and Maternity Services (NSF) (England and Wales)* (DH, 2004). This was a ten year plan which aimed to demonstrate a fundamental change of thinking about children's health and set out standards for the high quality care of children, young people, pregnant women and mothers. For maternity services specific recommendations were made in relation to engaging all women early in pregnancy and particularly those socially excluded or from disadvantaged groups or; the facilitation of normal birth; provision of both routine and specialist services, including those for mental health and involving woman in planning and reviewing services.

There were some similarities with *Changing Childbirth* in the *NSF for Maternity Services*, particularly in the statements related to 'woman-focused care' and the involvement of women in the decision making about their care. It also reiterated the need for pregnant women to have clear information about care, screening tests and welfare issues, with sufficient time for reflection and making choices. This may be viewed as an opportunity

to introduce new systems of care and potentially to address the shortcomings in the existing systems, however without sufficient ring-fencing of funds the aims of the *NSF* may not be fully realised (Dimond, 2004; Newburn, 2006, p.18).

In 2007 a further policy document, *Maternity Matters*, was produced in relation to maternity care (DH, 2007). This stated that services should be woman focused and family centred and that there would be choice of how to access maternity care, choice of type of antenatal care, choice of place of birth and choice of place of postnatal care. It also states that every woman will be supported by a midwife she knows in pregnancy and after the birth. However, the reiteration of choice in this document carries some qualifiers. Safety is highlighted in relation to place of birth and it is stated that for some woman this will be what they consider to be the safest option and for those women wishing to choose maternity services outside their local area service capacity will determine the final choice. It is evident that maternity services continue to receive scrutiny from policy makers although the need for such policies and the reiteration of concepts such as 'woman centred care' or 'woman focused care' and choice suggests that earlier policies have been of limited success.

#### *Other influences on maternity services*

In addition to the explicit policy which emanates from the Department of Health, maternity services have to respond to other organisations which have responsibilities for the quality of care (Beake and Bick, 2007). These include The Healthcare Commission and the National Institute for Health and Clinical Excellence. The former is a non-departmental public body and acts as an independent regulator of health care, responsible

for assessing and reporting on the quality and safety of services provided by the NHS and independent health care sector.

As part of their role to produce national guidelines the National Institute for Health and Clinical Excellence have produced clinical guidelines for various aspects for maternity care. The first of these were the guidelines for the routine antenatal care for the healthy pregnant woman (NICE, 2003) and it was expected that these guidelines would complement the *NSF* that was in development (DH, 2004). Guidelines for postnatal care followed in 2006 (NICE, 2006) and most recently intrapartum guidelines were circulated (NICE, 2007). These were all based on the available evidence, and health professionals are expected to take them into account when exercising their clinical judgment.

As I outlined in Chapter 1 another influence on maternity services has been the introduction of the Clinical Negligence Scheme for Trusts (CNST) in 1996. This scheme pays out money when claims against an NHS Trust are won and maternity services are particularly vulnerable to litigation. Therefore compliance with the risk management standards in order to secure indemnity means adherence to the published policies and procedures within the Trust becomes a priority.

Similarly to nursing, policies and procedures have become an integral part of practice (Cheek and Gibson, 1997), though unlike nursing, midwives also have rules that govern practice. These rules have existed since the first Midwives' Act in 1902, although these have been modified and reduced in the intervening years. However, as Kirkham (2004b) noted, midwifery has been subject to other, differently labelled, rules and consequently midwives have become fearful of doing the wrong thing. One consequence of this may be that maintaining a focus on 'woman centred care' becomes more difficult.

### *Women's influences on policy*

I highlighted in Chapter 1 the concerns expressed by women about their experiences of maternity care. Mismatches between what women wanted from the service and what they experienced have been identified since the 1980s (Oakley,1980; Kirkham,1987), though consumers began to collectively voice concerns through the National Childbirth Trust (from the1950s) and the Association for the Improvement of Maternity Services and Maternity Services' Liaison Committees set up after the *Short Report* (House of Commons, 1980).

A national survey of maternity services in 1997, following the implementation of *Changing Childbirth* (DH, 2003) reported that some groups of women had less positive experiences and that women were more satisfied with the clinical than with the interpersonal and emotional aspects of care (Audit Commission, 1997a). The Audit Commission examined the phases of maternity care from three perspectives; women's view of care, the efficiency of service provision and the effectiveness in clinical practice. This report was aimed at managers and purchasers and highlighted the polarised opinions that existed about maternity care. On the one hand childbirth was viewed as inherently problematic and that medical surveillance should be promoted for all women; on the other that childbirth was seen as a normal physiological process and for most women an uncomplicated event which did not need medical involvement. The Commission found: a wide variation in care, fragmentation, that the use of resources was still quite varied and a service out of step with current thinking. A second report, focusing specifically on women's views highlighted the importance for the experience of

childbirth of the relationship between midwives and the women for whom they care (Audit Commission, 1997b).

In December 2003 the Maternity Services sub-committee also considered the findings of research carried out by the Mother and Infant Research Unit at the University of Leeds, a survey of women's expectations and experiences of intrapartum care, focusing on issues of choice and control (Renfrew et al., 2003). The sub-committee also had preliminary findings of another piece of research, an assessment of women's and midwives' views of the options for place of antenatal care and birth (House of Commons, 2003, para 13). This last project contributed to the work of the Maternity and Neonatal Workforce Group (MNWG), who reported to the Department of Health's Children's Taskforce, which concluded that the Children's NSF should seek further evidence on the views of women and their families about the different models of maternity care and the 'real life' choices which women make.

Women's views were also referred to in the Antenatal Guidelines produced in 2003 (NICE, 2003). The guidelines, referring to the collated evidence, suggested that the key aspects of care were respect, competence, communication, support and convenience (Garcia and Loftus-Hills, 2001). Other key aspects referred to in the guidelines were access to information and provision of care by the same small group of people leading to women feeling more valued and in control (Singh and Newburn, 2000).

### *The impact of policy on practice*

It is evident from the preceding sections that maternity services have been the focus of a great deal of government attention and the focus of health care policy and guidance. Brooks (2000) suggested that the debates around childbirth were meant to be concluded by the *Winterton Report* (House of Commons, 1992) but the plethora of policies and guidance since then refute this. Beake and Bick (2007) suggest that the maternity services in England have one of the most comprehensive policy agendas of any such service in the world. However, they also question the extent to which the services actually reflect such initiatives, particularly since 1997 and suggest that there continues to be a gap between policy recommendations and the realities of practice.

Clearly consumer organisations have played a more prominent role in the debates about maternity services and medical dominance has been questioned (Benoit et al., 2005). This is evident in the way in which 'woman centred care' or 'woman focused care' has featured in the policies since *Winterton* in 1992, *Changing Childbirth* in 1993 and in the latest *Maternity Matters* document in 2007 (House of Commons, 1992; DH, 1993; DH, 2007). A greater focus on normal birth together with choice, information and continuity has also consistently featured in these reports. It has been suggested that the shift in thinking that this required has allowed the integration of feminist interests into practice (Annandale and Clark, 1996). However Benoit et al., (2005) suggest it is not necessarily about professional negotiation and consumer input but more concerned with the government's modernisation agenda for the NHS (Benoit et al., 2005). Certainly the focus on inequalities, accessibility, staffing and safety would support this. However, although the need for sufficient and skilled staff is documented, the staffing issues that are particularly raised are those in relation to obstetricians and their availability for the labour ward rather than an increase in the number of midwives. This, together with the

frequent reiteration of safety, demonstrates further predominance of the medical model which is at odds with the growing emphasis of the importance of normal pregnancy and birth in a whole range of official policy and practice documents.

All of the policies relating to maternity services have to be interpreted and implemented within the wider context of health care services, the bureaucratic structures of the organisation and the local culture of the maternity services and all of these present varying challenges to midwives and senior managers. Such a complex policy agenda suggests competing priorities for the midwives aiming to provide 'woman centred care' and it is within this context that this concept is explored in this thesis.

#### *Medical model versus a midwifery model*

It has been suggested that there are blurred boundaries between midwifery and obstetrics and that within an obstetric medical model that much of midwifery has become invisible (Clarke, 1996). In 1991, Murphy-Lawless commented that there was no agreed definition as to what constituted 'natural childbirth' and suggested that shared goals between women and midwives in the model of woman controlled childbirth are difficult to achieve in reality.

The medical or obstetric model defines pregnancy as a potentially pathological condition requiring medical intervention and typically only views pregnancy as normal in retrospect (Murphy-Lawless, 1998). This model stresses physical monitoring and data collection with women being addressed as patients. Care by midwives whose beliefs and experience are embedded within the medical model will be based on the pregnancy itself

rather than the individual and be about controlling the processes of childbirth so that professional uncertainty can be reduced and women have little or not control thus becoming passive recipients of care (Bryar, 1995). Davis-Floyd has described the medical model as the technocratic model (2001) but cites three overlapping but distinct models of care vying for influence: the technocratic, humanistic and holistic and suggest that practitioners have a unique opportunity to weave together elements of each paradigm to create the most effective system of care (p.21).

A social model of childbirth was suggested by Wagner (1994) to challenge the medical model that was widely adopted. More recently, authors have tried to more clearly articulate a social or midwifery model of pregnancy and childbirth (for example Walsh and Newburn, 2002a, b). This model views pregnancy as a normal life event and places the woman at the centre of care rather than the obstetrician or the midwife (Bryar, 1995; Sinclair, 2002). However, Walsh (2007a, p.19) comments on the binary reading (either/or categories) of models as unnecessarily oppositional and mutually exclusive yet acknowledges that during his birth centre research there were other issues that dominated the landscape.

### *The challenges of bureaucracy in maternity services*

The notion of *street-level bureaucrats*<sup>13</sup> and *street-level bureaucracies*<sup>14</sup> were introduced in Chapter 1. Lipsky argues that the actions of public service workers constitute the services provided by the government and consequently that the decisions of *street-level bureaucrats* and the routines they develop and the strategies they use to cope with work

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<sup>13</sup> Lipsky's emphasis

<sup>14</sup> Lipsky's emphasis

pressures effectively *become*<sup>15</sup> the public policies they undertake; therefore the policy making and implementation is better understood in the daily encounters of front-line practitioners (Lipsky, 1980, p. xii).

One difficulty described by Lipsky is that *street-level bureaucrats*, as a result of their ideology and training, respond to the individual needs of the people they serve. However, in practice they have to deal with clients in large numbers because work requirements prohibit an individualised service. Lipsky (1980, p.xiv) also points out that the structure of *street-level bureaucracy* also poses dilemmas for the clients. This is because they normally have very little choice about the services to which they are subject and this indicates a tension between asserting their rights and accepting the limitations of the organisational structures. Lipsky's analysis and discussion of *street-level bureaucrats* and *street-level bureaucracies* is particularly relevant in relation to midwives and the maternity services described by Kirkham (2004a, p.266) and also in relation to the data presented in this thesis, since midwives talk about providing individualised or 'woman centred care' and offering women choice, yet work within structures that provide services on a large scale and are expected to provide such care within the policies and protocols of the organisation.

## **Language of Policy, Professional Regulation and Practice**

### *From 'patients' to 'women'*

Chapter 1 highlighted the language issues which appeared both prior to and during data collection and these will be discussed in some detail in Chapter 7. However, my

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<sup>15</sup> Lipsky's emphasis

concerns led me to review the terminology used in both the policy and regulatory documents relating to maternity care and midwifery practice. A review of the policies and regulations relating to maternity care highlighted the use of various terms at different times.

Early policy documents such as the *Cranbrook Report* and the *Peel Report* (Ministry of Health, 1959; Central Health Services Council, 1970) used terms such as patients and confinements, for example:

“...a more careful selection of patients for domiciliary confinements and for admission to hospital...”  
(Ministry of Health, 1959, p.91).

Although In the *Peel Report* (Central Health Services Council, 1970) ‘mothers’ was also used as an all embracing category:

“...to consider the future of the domiciliary midwifery service and the question of bed needs for maternity patients...”  
(Central Health Services Council, 1970, p.1).

Some changes were noted in the *Social Services Committee Report* of 1980; the term patients was still used but mothers continued to be used, together with the term pregnant women (House of Commons, 1980). The three policy documents which emerged from this report (Maternity Care in Action (1982; 1984; 1985) demonstrated further changes in the language used. In Part I the term woman was commonly used together with the term mother (Maternity Care In Action, 1982). In Part II the term woman or pregnant woman was used but the more commonly used term was mothers,

even relating to women before the birth (Maternity Care in Action, 1984. Where the term patient was used it qualified this by saying that "...a mother is not necessarily a "patient" and should not normally be referred to as such..." (Maternity Care In Action, 1984, p.2). In Part III, the terms mothers and babies were used, but the term consumer was also introduced (Maternity Care In Action, 1985 p.vi).

From the *Winterton Report* (House of Commons, 1992) onwards, the use of the terms woman and women predominated, together with mother and becoming a mother:

"...we conclude that there is a strong desire among women for the provision of continuity of care and carer..."  
(House of Commons, 1992, para.49).

In the government's response (DH, 1992) and the subsequent *Changing Childbirth Report* (DH, 1993) the term client(s) was also used; "...we agree with the Committee that the development of client-held records...." (DH, 1992, para. 2.1.4).

It was here that the term 'woman centred care' featured. However, in all of these reports and policy documents the term 'midwife' was used consistently. In a research project examining supervision of midwives in England, Kirkham highlighted that 'midwives saw themselves and their colleagues as women, however it was noted that within the culture of 'woman centred care' midwives were not seen as women but as the lead professional (Kirkham,1999).

### *'Patients' and midwives' rules*

The regulatory documents also demonstrated changes in the terminology used. In earlier editions of the Midwives' Rules and the parallel publication the Code of Practice, the terms pregnant woman and mother were used but the term patient predominated (Central Midwives Board Handbook (CMB), 1962, 1979; CMB, 1978). In the next edition of the Midwives' Rules, dated 1980, the terms were defined. For example, "...patient ...means a mother or baby to whom she is rendering professional services..." (CMB, 1980, p.5).

Following the Nurse, Midwives and Health Visitors Act of 1979 the CMB was replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Midwives' Rules were reissued in 1983, but with little if any change in content (UKCC, 1983a). However, the Code of Practice (CMB, 1983), reissued in 1983 (UKCC, 1983b), predominantly used the terms woman and mother, although there were occasional references to patients. The Midwives Rules and Code of Practice were both revised in 1986 and 1989 respectively (UKCC, 1986; UKCC, 1989) and the term patients was not used in either. However, the Midwives Rules offered guidance on interpretation and the term mother was used for women both before and after the birth (UKCC, 1986, p.6). These documents were combined in 1998 but the inclusive term mother was similarly used (UKCC, 1998).

In 2002 the UKCC was replaced by the Nursing and Midwifery Council (NMC) and the extant rules and standards of the UKCC were adopted. These were later revised and reissued as Midwives rules and standards (NMC, 2004) and in this most recent version the term 'woman' appears throughout and in both the antenatal and postnatal context.

### *The implications of language*

Cronk (2000, p.21) reminded us that following the first Midwives' Act in 1902 ' [middle class] 'ladies' became midwives' and that this was the start of a power shift as midwives became subservient to doctors and had to follow orders and subsequently gave orders to their own patients, the women. She also suggested that the midwife was a 'professional servant' (Cronk, 2000, p.21) and used Berne's transactional analysis (Berne, 1964) to demonstrate the need for midwives to relate to childbearing woman on more equal terms; that is as one adult to another and not as parent to child (Cronk, 2000, p.25).

Over time there has been a move from the use of the generic term patient and mother to woman, user or client (Fraser,1995) and in the professional literature the use of the term women and consumers was evident from the 1980s (Oakley, 1980; RCM, 1987). The use of language in midwifery practice has been highlighted in recent years (Macintyre, 1982; Kirkham, 1989; Leap, 1992; Stapleton et al., 2002 a, b). Some of this focused on the nature of communication (Kirkham, 1987, 1989; Robertson, 1997) and patterns of language (Stapleton et al., 2002a, b), whilst others on how certain words and terms used by midwives were misconstrued by the women they were caring for (Bastian, 1992; Ziedenstein, 1998) rather than the way woman were addressed or described by midwives and other health care professionals.

Various authors have highlighted that language is not only a central component of any interaction, but also that it reveals the power dimension of the situation (Hewison, 1995; Hunter, L. P. 2006) and that power is a very diverse phenomenon that may be wielded

consciously or unconsciously (Sinivaara et al., 2004, p.40). Spender (1998) indicated that since language is powerful those who have power to shape the symbols and their language are very privileged (p.97). Rudolfsdottir (2000, p.337) looked at how women's agency was represented in medical vocabulary and highlighted the way in which women were infantilized and patronised by the way in which they were spoken to and positioned in relation to the experts. The policy and regulatory documents indicate some shift in the language of maternity care; however the wider use of language used by midwives to and about women, to each other and in relation to 'woman centred care', is also explored further in this thesis.

### *Rhetoric*

A trawl through the literature demonstrated that the terms 'woman centred care', choice, continuity and control have been sometimes linked with 'rhetoric'. It has been suggested that rhetoric is synonymous with empty talk and deception (Herrick, 2005), though it has been closely linked with persuasion. However, rhetoric may be considered the study of how we organise and employ language effectively (p.2). As a consequence of its link with persuasion there has been debate and some conflict as to whether rhetoric is a means of gaining agreement or a more dubious activity leading to manipulation and deception. The persuasion aspect is part of professionals' skills since they are required to persuade clients on a regular basis which may not be perceived as inappropriate (p.4). Herrick suggested that there are six distinguishing characteristics of rhetorical discourse (p.7); it is planned, adapted to an audience, shaped by human motives, responsive to a situation, persuasion seeking and finally concerned with contingent issues. Not all writing and speaking that might be meaningfully be termed rhetoric clearly satisfies all criteria but may form a starting point for consideration of the issues. In

relation to 'woman centred care' I highlighted in Chapter 1 that there were concerns that it was perceived as rhetoric rather than reality (Henderson, 1995) and that there was a need to explore the underpinning attitudes and values (Walsh, 1996).

### **Feminist and Postmodern Approaches**

I highlighted in Chapter 1 that in order to analyse the dominant paradigm and to explore the concept of 'woman centredness' it would be helpful to draw on feminist perspectives. A feminist approach involves seeking out and examining women's experiences with a view to transforming society and fundamental to this is some consideration of the embodied nature of pregnancy and birth. Edwards explains this as "the need to acknowledge that women's bodies are sensitive and integral to their experiences of who they are rather than separate unfeeling attachments" (Edwards, 2005, p.45). This also includes challenging negative stereotypical images of women that exclude and oppress them and providing alternative interpretations of their lives that may be more supportive.

In Chapter 1 I introduced the main approaches to feminisms as liberal feminism, radical feminism and Marxist or social feminism (Ramazanoglu, 1989; Tong, 1998). Liberal feminism suggested that women are much the same as men and should be able to do what men do. However, their position in society is seen in terms of unequal rights; their sex is a disadvantage but men are not 'the problem'. The focus of this approach is on the public sphere and competing in the marketplace. Attainment of equality with men is seen as paramount. The sexes are not perceived to be at war and the emphasis is on reform of society not revolution and some intervention is needed to address inequality.

Radical feminism focuses on women's oppression with a rejection of male dominance as men as a group who are perceived as oppressors. There is a strong emphasis on the sisterhood of women and shared oppression. This identification with women and the rejection of male dominance involves both a critique of the existing organisation of heterosexuality as prioritising men and recognition of lesbianism as a challenge to that priority. A key concern is for women to gain control over and celebrate their own bodies, and similar to liberal feminists practical political strategies are stressed. Radical feminists often view other forms of power (for example, unequal power relations within capitalism) as derived from patriarchy. Edwards (2005) acknowledges that while more complex notions of feminism have been and continue to be developed these remain the cornerstone of all feminist research.

Patriarchy is one of the major concepts that has been used to explain woman's position in society and the exploration of gender inequalities (Colgan and Ledwith, 1996, p.6). Ramazanoglu suggested that it includes all the processes and structures that have enabled men to achieve dominance over women (1989, p.33). Colgan and Ledwith (1996, p.7) also suggested that the concept of patriarchy that has emerged in feminist writings is neither simple nor one single concept but has a range of meanings. On the one hand radical feminists used patriarchy to refer to male domination and the power relationships between men and women. On the other it has been used by socialist feminists who have attempted to explore the relationship between the subordination of women and the way in which the prevailing mode of production is organised (Colgan and Ledwith, 1996, p.7).

The patriarchal nature of the maternity care system has been well documented (Treichler, 1990; Murphy-Lawless, 1998; Kent, 2000; Davis-Floyd, 2001). More recently

the increase in female obstetricians to the already predominantly female midwifery workforce has changed the gender balance to some extent; a 10% increase over 6 years has been noted <sup>16</sup>(RCOG, 2001, 2007). However, principles of male management and domination, with the powerful assumptions about strong macho environments, may still be evident, if not directly, then at a distance. (Parkin with Hearn, 2006). This has clear implications for the NHS and specifically the maternity care system and is linked with the gendered hierarchies of occupations, such as doctors over midwives and midwives over women and may well constrain behaviour. From this perspective, any consideration of the development of the NHS and the maternity services within it may be studied using both a gender lens and feminist approaches.

Although there has been some unease between postmodernism and feminism (Tong, 1998, p.193) postmodernism offers a more helpful context for an interpretation of the issues and offers a way of viewing the culture differently (Edwards, 2005). Postmodernism claims that uncertainty and diversity are central and that “everything we know and do arises from the particularities of our lives” (Edwards, 2005, p.47).

Although still viewing woman as ‘the other’<sup>17</sup> postmodern feminists claim that the condition of otherness facilitates women to critique the norms, values and practices that the dominant culture, patriarchy, imposes on everyone (Tong, 1998, p.195) and that this is a way of thinking and being that allows for greater openness and diversity. In relation to this thesis, the objective of exploring ‘woman centred care’ together with the concepts of continuity, choice and control requires a framework that facilitates the exploration of women’s experiences in a culture that, while still tethered to the obstetric discourse, is

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<sup>16</sup> This figure is drawn from RCOG statistics for the number of female obstetricians as a percentage of the whole time equivalents of all obstetricians for England and Wales, 21% in 2001 and 32% IN 2007.

<sup>17</sup> Drawing on Simone de Beauvoir’s ‘Why is woman the *second sex*?’

trying to re-establish a midwifery discourse while dealing with contemporary issues of risk, surveillance, power and professional boundaries in increasingly bureaucratic settings.

### **What is 'Woman Centred Care'?**

In the light of the policy developments and the other influences on maternity services it is helpful to try and determine what is meant by 'woman centred care'. During the period when *Changing Childbirth* (DH, 1993) was explicit government policy a national study was commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB)<sup>18</sup> to explore the provision of 'woman centred care', that is how it was interpreted and experienced in practice (Pope et al., 2001). Data were gathered from a range of professionals including midwives, midwife supervisors, educators and doctors and also from mothers. Some positive examples of midwives working towards a more 'woman centred service' were reported though there appeared to be a considerable variation in the extent to which it was occurring and the move towards 'woman centred care' appeared to be supported although not often explicitly (Pope et al., 2001). Woodward (2000) suggested that it was important for midwives to maintain a caring, 'woman-centred identity', so that childbearing is not routinely and irreversibly reduced to medically dominated intervention. A difficulty that Kirkham pointed out is that maternity services are required to be 'woman centred' with empowered women exercising informed choice yet the reality is sometimes different with women expected to comply with the choices of care that were defined by the service (Kirkham, 2004a). A number of

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<sup>18</sup> The ENB was established in 1983 as the professional body responsible for auditing practice and approving educational programmes for training nurses, midwives and health visitors. It was dissolved in 2002, together with the UKCC (the regulatory body) and both were replaced by the Nursing and Midwifery Council (NMC)

other concepts have been identified as being closely related to 'woman centred care': knowing; trustworthiness; being 'with woman; continuity of care and carer; choice and control; care and caring and the qualities of the midwives providing care.

### *Knowing*

Other studies have used the term know or 'knowing' in relation to women 'knowing' their midwife although Stevens (2003, p.307) commented on the confusion evident in the literature by the variety of definitions and the lack of homogeneity in the use of the term.

'Knowing' may refer to whether the woman has met the midwife previously (for example Gready et al., 1995; Farquhar et al., 1996) or as described by Lee (1997, p.8), rather more explicit statements such as: 'the midwives are like friends'; 'in labour [the midwife] knows you as a patient' and 'if you have a problem they won't treat you as stupid'. Perkins and Unell (1997) explain the concept of a 'known' midwife either as a 'woman having met her midwife before' or 'a close personal relationship between mother and midwife'; however the frequency of meeting before is not given. The findings from Perkins and Unell's study suggested that women did want to be cared for in labour by a known midwife, though they were prepared to be flexible about their definition of 'known'.

Wilkins (2000), in her research on women and community midwives highlighted how mothers expressed the wish to 'know' their midwife as a person. This was described as a personal relationship similar to but not identical to friendship (p.37) which encompassed a close and trusting relationship and that over time the social dimension overlapped into the clinical encounter.

McCourt and Stevens (2009) described knowing and being known as one of the key themes that emerged from their study of one-to-one midwifery care. From this data it emerged that knowing the midwife and being known by the midwife was important and the use of the personal pronoun signified a particular relationship.

Stevens (2003) suggested that it may be more helpful to consider what it means for the midwife to 'know' the woman rather than the other way around. In this context 'knowing' [for the caseload midwives in her study] meant having clinical, social and psychological knowledge about the woman which deepened over time. However, she also stated that 'knowing' became part of the process of care and was not a feature *sui generis* (p.309).

Various authors (for example Brodie, 1996; Sandall 1997, 1998; Hunter, 2004) have shown that continuity of care and the opportunity to build relationships with women was as important to the midwives as to the women. Hunter (2004) also makes the point that for midwives, 'knowing' the women makes their work easier. This also demonstrates that for community midwives, the women form their primary reference group (Lipsky, 1980, p.47).

### *Trustworthiness*

The notion of trustworthiness, that is who can or cannot be trusted could be considered as a form of moral evaluation of the women (Hunt and Symonds, 1995, p.90). Kelly and May (1982) outlined the concepts of 'good' and 'bad' patients, based on a range of factors including their symptoms and illnesses together with characteristics of age, class and gender. Johnson and Webb (1995) developed this work further and suggested that these types of categorisations were rather more unpredictable than previously assumed

(p.466) and explored the concept of 'social judgement' in relation to the patients. They explained this as the apparent judgement of the social worth of persons by others or the notion of respect accorded to them, and was socially constructed in relation to the prevailing social influences.

### *Being with woman*

It could be argued that to be 'woman centred' in her approach the midwife needs to be 'with woman' throughout pregnancy and birth. This term has increasingly emerged in the literature. However, as Isherwood (1992) suggested this required midwives to rethink both their working practices and their relationships with women.

Flint earlier reported that in a fragmented maternity care system the difficulties that midwives faced often meant that they were with doctor or with policy rather than with woman (Flint, 1988). This dilemma has continued despite the rhetoric of 'woman centred care' in literature and policy documents.

Leap highlighted the particular nature of the 'with woman' relationship and pointed out that there is no other example of a health care worker being engaged to be alongside a woman in this way (Leap, 2000, p.4). She also suggested that as a midwife there should be a reduction in 'doing things' (p.2) to minimise disturbance. This forms part of the concept 'the less we do the more we give' and increases empowerment and is similar to Davies' notion of being available (Davies, 1995). Interestingly Cronk proposes that the midwife should be considered as a professional servant since she is providing a service, whether she is an employee or working independently (Cronk, 2000, p.21). She also indicated that this reduces issues of power and control that confound midwifery practice

since a servant role does not carry the status and power that accompanies a purely professional role.

## **Continuity**

Continuity featured as a concept in the *Winterton Report* (1992) and in *Changing Childbirth* (DH, 1993) and subsequent policy documents but was explicitly restated in the National Service Framework for Children, Young People and Maternity Services (DH 2004, p.6) which highlighted that 'women require...continuity of support during their pregnancy, childbirth and the postnatal period.' There has been some ambiguity as to whether it relates to continuity of care or continuity of carer, however, the Audit Commission Report (1997, p.15) indicated that continuity of care meant care delivered in a consistent way regardless of who provided it. It also suggested that although important to some women, continuity may not always be a top priority (Fellowes et al., 1999) and may depend how the question was asked (Garcia, 1995)

The interpretation of continuity has also varied with different organisational models of midwifery care. For example this may mean continuity for the entire span of childbearing (McCourt et al., 1998); it may also relate to pregnancy and postnatal care but not the labour and birth (Davey et al., 2005). Hodnett (2000) recognised the difficulty of definition and commented that '... [continuity is] an ambiguous term with a number of definitions including caregivers committed to a shared philosophy of care or care provided by a small group of throughout the childbearing episode'.

### *Continuity of care*

The concept of continuity of care has received some consideration in the medical literature and appeared to have multiple definitions and constructs (Pandhi and Saultz, 2006). In the UK continuity of care has traditionally meant that a patient visited the same doctor and developed an ongoing doctor – patient relationship (Guthrie and Wyke, 2000). However, this became more difficult as small GP practices became larger and other changes to health care occurred, including the reduction in single handed GP practices, patients' increasing mobility, and continuity of care has reduced (Guthrie et al., 2008). GPs have also relinquished their 24 hour services (Brown, 2000) thus potentially constraining their one-to-one relationships with patients further.

There are some parallels here between GPs and the maternity service. For example the maternity services have experienced greater centralisation and an increase in bureaucracy. For both GP services and the maternity service there is a risk that the system becomes more impersonal when clients and women in particular want personal support and trust.

Saultz (2003) suggested that continuity may be viewed as a hierarchical concept that includes three dimensions: ranging from informational at the base, longitudinal and interpersonal continuity, with interpersonal continuity of particular concern for primary care. The informational dimension relates to the medical and social information about each patient and the way in which this can be systematically accessed by any or all of those providing care. The longitudinal dimension indicates the location where a patient receives most care which should be accessible and familiar. The interpersonal dimension refers to the ongoing personal relationship between doctor and patient and

characterised by the development of trust between doctor and patient with the doctor assuming personal responsibility for the overall care of the patient and making suitable arrangements when this is not possible.

*Continuity of midwifery care*

McCourt et al., (2006) refer to Saultz's (2003) hierarchical definition of continuity of care and have adapted it to midwifery:

### HIERARCHICAL DEFINITION OF CONTINUITY OF MATERNITY CARE

LEVEL OF CONTINUITY	DESCRIPTION
<p align="center"><b>Informational</b></p>	<p>An organised collection of medical and social information about each woman is readily available to any health care professional caring for her. A systematic process also allows accessing and communicating about this information among those involved in the care.</p>
<p align="center"><b>Longitudinal</b></p>	<p>In addition to informational continuity each woman has a 'place' where she receives most care, which allows the care to occur in an accessible and familiar environment from an organised team of providers. This team assumes responsibility for coordinating the quality of care including preventive services.</p>
<p align="center"><b>Interpersonal</b></p>	<p>In addition to longitudinal continuity, an ongoing relationship exists between each woman and midwife. The midwife knows the midwife by name and has come to trust the midwife on a personal basis. The woman uses this personal midwife for basic midwifery care and depends on the midwife to assume personal responsibility for her overall care. When the personal midwife is not available, cover arrangements assure that longitudinal continuity occurs.</p>

(McCourt et al., 2006, adapted from Saultz, 2003, p.141)

They acknowledge that informational continuity may be the most important for medical staff in relation to ensuring safety of patients and preventing errors (Cooke et al., 2000)

but that this may not improve satisfaction or improve access to care. They also acknowledge that longitudinal continuity should improve access for women but question whether it allows the development of personal trust between the woman and her midwife and the extent to which the personal component of continuity is fundamental in the interpersonal dimension.

It could be argued that informational continuity has already been achieved in relation to maternity records although it is really concerned with efficiency for the professions and does not mention women giving the information they see as important.

One weakness with this hierarchy is that there is no mention of maternal choice of place of care within the longitudinal dimension. However, to some extent longitudinal continuity has been achieved antenatally by undertaking most of the care out of the hospital in the community. However though this was done primarily to reduce the size of hospital antenatal clinics ensuring that only those requiring the more limited obstetric resources accessed them, and also to improve the accessibility of care rather than to achieve continuity. This has not been achieved for labour and birth, since these primarily are undertaken within the hospital setting. The majority of postnatal care is undertaken in women's own homes but only after the immediate care which is undertaken wherever the birth has taken place and often in hospital.

The interpersonal dimension offers some helpful parallels with the maternity services but also highlights some challenges. McCourt et al.'s (2006) adaptation clearly describes the responsibilities of the midwife who becomes 'known' to the woman, however it does not consider the nature of the relationship between the midwife and woman or how this

relationship, and the inherent trust, will be developed. This the only point at which the client is likely to be aware of continuity.

### *Strategies for providing continuity of carer*

Team midwifery was one way of improving continuity of carer for women (Sandall, 1995) and the earliest model that used this and influenced subsequent practice was the 'Know Your Midwife Scheme' (Flint et al., 1989). Various other team schemes were developed to improve overall continuity of carer overall, including antenatal, intranatal and postnatal care, but were often achieved at the expense of antenatal and postnatal continuity (Farquar et al., 2000). The one-to-one project (McCourt et al., 1998) focused on continuity of caregiver where each midwife carried a caseload of pregnant women and planned and provided most of the care. In this type of care midwives staffed the women rather than staffing the hospital as in more traditional arrangements (McCourt et al., 1998, 2006).

Hodnett's (2000) systematic review demonstrated that continuity of care was beneficial though some evidence does not show sufficient discrimination between continuity of care or care provision, with continuity of *carer* favoured by some authors, for example Hildingsson and Haggstrom (1999) and Earle (2000), with others suggesting that continuity of *care* was sufficient (for example Morgan et al., 1998; Fraser, 1999) as long as the midwives were pleasant and friendly and knew what they were doing. Lavender et al., (2002) suggested that increased contact with clients would improve continuity of care.

More recent literature has not reported on overall continuity of care through the antenatal, intranatal and postnatal periods, but has identified the numbers of women who have been visited at home by midwives who have visited them previously (NPEU, 2007). An increase has been noted between 2006 and the previous survey in 1995 with more woman having three or more midwives visiting them at home (45% compared with 41%) and fewer having met all of those who visited before (26% compared with 32%). In terms of continuity of care in labour the most recent survey identified only 19% of women had one midwife caring for them during labour and during birth with no comment being made as to whether these women knew the midwife who was caring for them.

### ***Choice***

As highlighted earlier in this chapter and in Chapter 1, the *Changing Childbirth Report* (DH, 1993) emphasised the need for women to have readily available information so that they could make informed choices about their care. However, as Kirkham (2004a, p.xv) pointed out there has been great debate as to what this means in maternity care and to what extent it is possible or desirable.

### ***Consumerism***

The notion of choice is embedded within the broader concept of consumerism which has its origins in the commercial and private sector where it was recognised that producers of goods should take account of the purchasers of their goods in order to maximise profits (Gabe, 2004, p.217). Gabe then offers a definition of consumerism as follows: “consumerism, when applied to health care, suggests that users of health services should and do play an active role in making informed choices about health” (Gabe, 2004,

p.217). Consumerism emerged in policy documents and health care literature in 1990s triggered by *Working for Patients* (DH, 1989) although elements had already been seen in the NHS and Community Care Act (1990) and the *Patients' Charters* (DH, 1992, 1995). The NHS Plan (DH, 2000) focused particularly on the encouragement of citizens' involvement within decision making structuring health care. As mentioned in Chapter 1 New Labour's view of the NHS was envisioned as the 'third way' and involvement of patients or users as partners.

### *Informed choice*

There does not appear to any consistent definition of informed choice though Wiggins and Newburn (2004, p.162) suggest that the concept of informed choice depends not only on access to reliable information but also on the availability of genuine alternatives. In the context of maternity care choice and informed choice have received a great deal of attention; primarily because despite the policy prescriptions it appears that choice may be severely limited to what Trusts and the staff deem relevant (Leap and Edwards, 2006, p.99) or choose to provide (Beech, 2005, p.2). As Kirkham also suggests many choices are made by default (2004a, p.267). O'Cathain et al., (2002) reported that a large minority of women felt unable to exercise informed choice and those factors affecting their choice included the importance of maternity unit policy in women's decision making. Jomeen (2007) suggest that many choices are blocked by professionals, although there is some evidence that women prefer to leave choices and decisions to the experts (Hirst et al., 1998).

The ability to make choices is predicated on having sufficient information (Edwards, A. 2008) but as Levy (1999) identified, many women found too much information difficult to

manage whilst others ignored or avoided seeking information. One strategy developed to improve information for childbearing woman and midwives was the development and implementation of the MIDIRS Informed choice Leaflets to support women's involvement in decision making. These were subsequently evaluated and found to be useful, however the method of dissemination affected the promotion of informed choice and the prevailing culture and patterns of practice supported compliance rather than informed choice (Stapleton et al., 2001).

One difficulty in considering the concept of choice is that from a socio-cultural perspective choice may be viewed as constructed (Edwards 2004) and influenced by belief systems and resources (Davis-Floyd and Sargent, 1997; Devries et al., 2001). Furthermore, in maternity care the obstetric ideology has been particularly coercive (Edwards, 2005, p.3) and choice overlaid with concerns over safety and risk. Such concerns have influenced choices and decisions regarding maternity care, for example: type of care, place of birth (Edwards, 2004; Barber et al., 2006) and plans for birth (Too, 1996; Hollins Martin, 2008). Kirkham has concluded that informed choice is unusual in maternity care and compliance common (2004a, p.xvii) and suggests that cultural change on a large scale is required to make informed choice real.

## **Control**

Many studies have demonstrated that a sense of control is a major factor contributing to a women's perceptions of their birth experience and their subsequent well-being (for example Hodnett, 1989; Green et al., 1990, 1998; Waldenström, et al., 1996) however control is a very difficult concept to define in relation to maternity care (Green, 1999). It has also been suggested that if women are to feel 'in control' and empowered then it is

important that midwives explore the wishes of women in their care (Gibbins and Thomson, 2001)

In their original Great Expectations study Green et al., (1998) differentiated between internal control (control of your body and behaviour) and external control (control over what is done to you and involvement in decision making). They were however concerned that little distinction was made between internal and external control or how they related to each other and therefore undertook a replica study. This focused on three particular outcomes: control of behaviour, control during contractions and feeling in control of what staff did to them (Green and Baston, 2003). The study revealed that women were more likely to feel in control of their own behaviour than in control of what staff did to them and women in second or subsequent pregnancies more likely to feel in control than those in their first pregnancies.

Other studies also have attempted to explore what "control" means to women in labour and highlighted the importance of external control in relation to decision making (Morgan et al., 1998; Coyle et al., 2001) Coyle et al., (2001) also made the distinction between control being given up or taken away (Coyle et al., 2001). Coyle's study situations in which women perceived that power had been taken away were associated with a lack of control.

Other factors that impact on women's sense of control include the behaviour of care givers in labour (Halldorsdotir and Karlsdottir, 1996a) and women's perceptions of not being listened to or experiencing the negative attitudes of staff (Baker et al., 2005) Control or the lack of it has also been linked with poor information provision, poor

communication and little or no opportunity to influence decision making (Baker et al., 2005).

### *Control as surveillance*

The term surveillance has not been explicitly used in midwifery practice however Walsh suggested that 'surveillance as control' is clearly evident in the hospitalisation of birth and to some extent in the various regimes of antenatal and postnatal care (Walsh, 2002). The concept of surveillance originated with Foucault and his interests in bodily regulation and also the surveillance or monitoring of populations (Turner, 1992; Fox, 1993). The rise of surveillance medicine, involving the problematising of normality has been documented by Armstrong (1995) and has been linked to a new paradigm of health and medicine (Nettleton, 1996).

Concepts of medical power and authority have a great influence on childbirth where the well being of the fetus/baby is central (Anderson, 2004; Ehrenreich and English, 1973). This power and influence of obstetric hegemony acts to control women and disempower them rather than to facilitate their empowerment (Baker et al., 2005)

### **Care and Caring**

The Oxford Dictionary definition of care includes 'task, thing to be seen to, see to the safety, health comfort of or to do all that is required'. The Midwives rules and code of practice define a practicing midwife as 'a registered midwife... who is in attendance upon a woman during the antenatal intranatal or postnatal period...' (NMC, 2004). The term care is not defined, though the activities of a midwife, listed in accordance with the

European Union Midwives Directive 80/155/EEC Article 4, include the term 'care' in relation to care of the mother both in labour and postnatally, and care of the new born infant (NMC, 2004). According to the World Health Organisation (WHO) midwives are responsible for providing 'the necessary care' for woman during pregnancy, labour and delivery and the puerperium (WHO, 1966).

Graham (1993) suggested that caring involves the unpaid responsibility that woman have for their families and is undertaken in the community setting. This conclusion has been drawn from empirical work research mainly regarding women's experiences of looking after people with long term health and mobility problems. She also suggested that the frame of reference used is typically that of the care providers; that is what care providers give rather than of those who receive the care. Whilst these debates are focused on community care it does raise the question of the similar and potentially contradictory position that childbearing women may occupy in relation to midwives.

Celia Davies explored the nature of caring in relation to gender and professional nursing care and found it hard to define (Davies, 1995). She separated care work from care giving and professional care and suggested that there may be a range of activities encompassed by the term; sometimes it may be just being available but may also mean 'attending, physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other' (Davies, 1995, p.141).

Davies cites Waerness (1992) who suggested that caring values tend to get lost when they are professionalised and brought into the public arena and that formal training suppresses caring and promotes rigidity. Davies (1995) elaborated on this and

suggested that the professional is not 'uncaring' but is required to treat each client in a detached manner and not get overly involved or emotional. Although much of this material is written in relation to nursing, there are both parallels and differences with midwifery. In some ways midwifery could be viewed similarly to nursing in so far as there are those midwives whose work is perceived as an adjunct to a [gendered] medical profession and in some literature would be perceived as obstetric nurses rather than midwives. However, those midwives who undertake the full spectrum of midwifery activities and also become involved with the women in their care may still not match the stereotypical ideal of a professional, which is a rather gendered model. James (1992) suggested that care comprised the organisation plus physical labour plus emotional labour. However, the female gendered skills of support, caring and being with women have tended to be invisible within gendered institutions (Kirkham, 1999). Midwives in Kirkham's study also recognised the need to care for each other as women but lacked the skills within an oppressive culture (Kirkham, 1999).

Watson (2006) reflected on Law Harrison's earlier question 'can an ethic of nursing be maintained' (Law Harrison, 1990) and suggested that nursing has turned toward the technical – industrial, with time bounded, production line and institutional demands. Similarly to nursing, it could be argued that the demands of modern obstetrics have moved midwifery towards a technical, time bounded production line so that midwives have little time for the caring and relationship aspect of their work (Dykes, 2006; Deery, 2008).

### *Care, caring and midwifery practice*

Bryar (1995) suggested that there is 'conflict between the rhetoric of midwifery and the realities of practice' (p.4) and that midwives have been more concerned with midwifery practice than theorising about care. She explored the paradox that despite a close relationship between the midwife and woman being advocated, this was difficult to achieve in practice due to the pervasiveness of the medical model together with the constraints of the organisation. The overall fragmentation of care, not only between hospital and community but also between intranatal and postnatal care in hospital, is such that midwifery care continued to be undertaken as a series of tasks.

Unlike nursing, there has been little development of theories of midwifery care (Kirkham, 1987; Bryar, 1995; Woodward, 2000), though Kirkham focused particularly on care in labour and examined the roles and activities of the key participants (Kirkham, 1987). Where models or theories of care have been explored this has been mainly an attempt to adapt nursing theories with little success (Bryar, 1995). More recently there has been an attempt to develop a research based conceptual model of midwifery practice that highlights the interdependence of the midwife-client relationship though it was acknowledged by the author that further research was needed so that midwives are clearly able to articulate their practice (Fleming, 1998).

Wilkins (2000) talked about the assimilation of 'caring' as a professional objective but stated that midwifery continued to be articulated in a language appropriate to medicine. Woodward (2000), in her ethnographic study of midwives and nurses, found that there were marked differences between midwives and nurses in the ways in which they

conceptualised their practice and that caring values appeared eroded in the maternity setting and that practice was often found to be routine, task-oriented and sometimes unresponsive to women's needs. This is particularly worrying when there is emphasis on 'woman-centredness' and 'being with' woman. She highlighted the need for midwives to maintain a caring and 'woman centred' identity so that childbirth was not irreversibly subject to medical domination.

### *Midwife led care*

Leach et al., (1998) suggested that many women have not understood the scope of the role of the midwife in relation to maternity care or appreciated that they can contact a midwife directly and as previously stated there is still some confusion about the role of the midwife in relation to the obstetrician and general practitioner (Page and Sandall, 2000).

Midwife-led care usually denotes a total package of midwifery care from the first assessment in pregnancy, including all antenatal and postnatal care. It will also include intranatal care from midwives, though not necessarily midwives known to the women. This care may be offered in specific midwife-led unit (Walker et al., 1995) which may be part of or adjacent to an established maternity unit or a 'stand alone' unit at a distance from any obstetric led service<sup>19</sup>.

In some situations the use of the term midwife-led appears to have replaced 'woman-centred care' as the key driver of practice as midwives have sought to re-establish their role in relation to maternity care. The two terms are not synonymous since midwife-led

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<sup>19</sup> Some of these recent developments are known as birth centres.

care may not necessarily be 'woman-centred' and 'woman-centred care' may not be midwife-led. It could be suggested that this drive towards midwife-led care has meant that women as the focus of care may become overlooked.

#### *Care as emotional labour*

As indicated above, James (1992) suggested that care includes emotional labour and this aspect has been addressed both in relation to nursing (Smith, 1992; Staden, 1998) and more recently in relation to midwifery work (Hunter, 2001, 2005, 2006; Deery, 2003, 2005). The underpinning theory of emotion work draws from the work of Hochschild (1983) who used the term to define this component of work mainly carried out by women. Hunter showed that conflicting ideologies of midwifery practice, either with woman or with institution, created dissonance for midwives that had to be managed as emotion work (p.244). Although Hunter acknowledged limitations that had to be taken into account when interpreting the findings it was clear that the dissonance and consequent frustration affected the emotional well being of the midwives and in turn had a negative effect on the quality of care that woman received.

#### *Women's perceptions of their care*

Hutton (1994) stated that consistent messages have been received from women about the importance of the quality of their relationship with their midwife and how this can influence their childbearing experience. Some of the studies of women's perceptions of their care have been directly related to satisfaction, often investigating comparisons between different types of care schemes (Spurgeon et al., 2001; Hicks et al., 2003).

Women's perceptions of their care have been explored in relation to a team midwifery project (Tinkler and Quinney, 1998) and findings demonstrated that positive relationships facilitated conditions which influenced satisfaction with care. Similarly a small study of women cared for using a case load model of care in Leicester in 1998 found that women's perceptions and experiences were predominantly influenced by the relationships they had with their midwives who they described as 'friends' (Walsh, 1999). From an earlier study it is interesting to note that women and their partners believed that midwives 'knew best' and that although many women wanted a say in the type of care they received they did not know how to communicate that to the midwives (Bluff and Holloway, 1994).

One study exploring women's perceptions was undertaken to determine quality in midwifery (Proctor, 1998). Findings showed areas of shared understanding between midwives and women but also that key differences relating to other aspects of the service may not only affect the relationship between them but also the women's perceptions of the service.

The one-to-one project (McCourt et al., 1998) also reported on women's views, their study demonstrating that women were more satisfied with this type of care and that it should be developed and evaluated further to gain a greater understanding of women's needs of the maternity service.

A review of the literature indicated that further studies were needed to explore consumer views where different groups of women experience different types of care (Dowswell et al., 2001). I highlighted in chapter 1 a national study on woman-centred care which reported positive examples of midwives working towards a more woman-centred service,

though the meaning of 'woman centred care' appeared unclear. It also highlighted the way in which power dimensions influenced communications between professionals and women. They also indicated that continuity of care or carer was still an area for discussion (Pope et al., 2001).

### **Qualities of a Midwife**

Various studies have explored the characteristics of midwives which women value. These include respect, trust, alliance, warmth, sensitivity, kindness, care and understanding and encouragement (Hutton, 1994; Kennedy, 1995; Walker et al., 1995; Berg et al., 1996; Halldorsdotir and Karlsdottir, 1996a).

#### *Communication skills*

The attributes of a good midwife that are important for all childbearing women have been well documented as being compassionate, kind, supportive, knowledgeable and skilful; however the greatest contribution was made by good communication skills (Nicholls and Webb, 2006, p.414). Communication was previously highlighted as a key concern as part of *Changing Childbirth* (DH, 1993) and one volume of the final report was dedicated to good communication in midwifery practice.

Communication skills are reported as of primary importance and these include being a good listener and being able to explain things (Fraser, 1999). The personal qualities of midwives have been found to be equally important including being friendly, smiling and

cheerful and outgoing (Fraser, 1999). Memories of childbearing, specifically labour, include descriptions of midwives who had not only been good and caring but also supportive, giving explanations, information on progress and consulting the woman regarding her wishes (Hutton, 1994). Emotional involvement, honesty and trust were also identified as important aspects of a therapeutic relationship (McCrea and Crute, 1991).

Midwives' approaches in relation to pain relief in labour have also been explored with three types identified; the cold professional, warm professional and disorganised carer (McCrea et al., 1998). The cold professional gave information but remained detached from any personal involvement or from becoming involved in the decision making. The disorganised carer provided information on request but this was often in a haphazard way usually limited in content with inconsistent and fragmented care. The warm professional provided information and explanations but also provided emotional support and stayed with the woman throughout. This type of midwife acts as a friend as well as providing professional, holistic care.

## **Emerging Issues**

In this chapter I have considered the policy context for maternity services and shown how the plethora of Government policies has focused on maternity care. I have also demonstrated how the idea of 'woman centred care' has been developed. The range of influences of non-departmental organisations which impact on maternity services have also been identified. The underpinning principles of continuity, choice and control and the challenges and tensions that these present for practice have also been highlighted. The use of language, both in policy documents and day to day practice has been

explored. All of these issues pose challenges for 'woman centred care' and provide the context for this study. In the next chapter I consider the design and methodological considerations for this study and describe the implementation of the methods that were used.

## **CHAPTER 3**

### **METHODOLOGY AND METHODS**

#### **Introduction**

The aims of the study, set out in Chapter 1, are as follows:

1. To explore what is meant by 'woman centred care': what it means to women and what it means to professionals, specifically midwives.
2. To explore to what extent continuity, choice and control are reflected in the care offered by health care professionals, specifically midwives.
3. To explore how far the organisation of maternity services has changed with the notion of 'woman centred care'.

This chapter describes the overall methodology and design of the study. Firstly the qualitative approach is identified and the links with grounded theory highlighted. The use of a grounded theory approach is justified, the component parts of the methodology described and the interrelationship with a feminist approach discussed. The way in which narrative analysis has informed the study is also explored. The use of interviews and observation during the fieldwork is discussed together with the particular issues which have arisen during the interviewing and observation process. I consider the ethical, access and gate keeping issues that this study presented and how they were addressed. I consider what it means to be an 'insider' or an 'outsider' and the

implications of this for the study. I identify the roles that became apparent and examine the relationships that I developed with the participants and consider the work that was necessary to maintain these relationships and the impact on the research process. Finally I examine the limitations of the research.

### **Qualitative Approach**

Qualitative approaches have been increasingly used in research studies by midwives and nurses over the past thirty years (Holloway and Wheeler, 1996). They have drawn on methods initially used in anthropology and sociology but now commonly used in a range of disciplines. I was particularly interested in exploring the meanings of 'woman centred care' within the social setting of maternity care and this suggested the use of grounded theory which is both systematic and detailed (Holloway and Wheeler, 1996) and seeks to generate theory from data gathered during the study (Robson, 2002, p.190).

Whilst some authors have suggested that grounded theory has its roots in the symbolic interactionist tradition of sociology (Baker et al., 1992; Holloway and Wheeler, 1996; Alvesson and Skoldberg, 2000; Cutliffe, 2000; McCann and Clark, 2003) others, such as Robson (2002) have not made such a specific link between symbolic interactionism and grounded theory and have suggested that it has more pragmatic roots. However, Chenitz and Swanson (1986), Denzin (1989) and Charmaz (1990) have linked symbolic interactionism with qualitative research and highlighted that in order to understand individuals, researchers need to enter their world and understand behaviour as the participants understand it. They also need to learn about their interpretations and share

their definitions. Eaves (2001) goes on to suggest that as people move from one situation to another they are continually interpreting and defining events and their reality.

In the following sub sections I consider the methodological issues that I explored in relation to the design of the study. Firstly, I discuss the issues related to grounded theory; secondly I consider some of the feminist approaches in relation to the methodology; thirdly I briefly highlight the contribution of narrative and finally discuss issues of power and reflexivity in relation to the study.

### *Grounded theory*

Glaser & Strauss, in their original work (1967), stated that generating grounded theory was a way of arriving at theory that is suitable to its uses whilst Glaser argued that grounded theory allows us to discover what is going on (Glaser, 1999, p.840). He also stated that grounded theory refers to a specific methodology 'that provides a total package' that includes collecting data systematically in order to generate theory (Glaser, 1999, p.837). I anticipated that grounded theory would be suitable for this study as I wished to explore women's experiences of childbearing, their perceptions of pregnancy, birth and postnatally together with their care and how they made sense of this within the current maternity care system. By using grounded theory I hoped to develop theory from data. However, this posed certain practical and theoretical problems.

Firstly, the tensions identified between Glaser and Strauss, well documented elsewhere (Glaser, 1992; Bartlett and Payne, 1997; Babchuk, 1996), pre-occupied my thinking for a considerable time both prior to starting and during the fieldwork and initial data analysis.

Some authors have viewed these tensions as a diversification of the grounded theory methodology, that is the classic Glaser and Strauss version, expounded by Glaser and the Strauss and Corbin version (McCann and Clark, 2003) , though one not necessarily being superior to the other, but rather an indication of the developing maturity of the methodology (Annells, 1997). Although I found the structure of Strauss and Corbin's (1990) work helpful in identifying a specific process that could be followed and used, I found it constraining rather than liberating when handling the data since their development of grounded theory suggested rules and procedures for data collection and analysis which indicated a 'coding paradigm' leading to 'forcing' of the data rather than allowing the theory to 'emerge' (Eaves, 2001).

Secondly, the underlying tenets of Glaserian grounded theory indicated that theory must not be predetermined in any way (McCann and Clark, 2003b) and whilst I felt reasonably sure that I could address data collection in a disinterested way I could not ignore my past professional experience within the field. Strauss and Corbin's (1990) development of grounded theory allowed for recognition of both experience and literature and epistemologically could be labeled as having a postmodern paradigm (McCann and Clark, 2003). They suggest that there are no epistemological absolutes but that the social world is full of ambiguity and therefore not only is there is a need for a multiplicity of positions but also some recognition of the inherent contradictions.

Thirdly, although the literature is fairly clear about what constitutes grounded theory there are concerns that, as with qualitative research methods more generally and as used by nurse researchers, there are tendencies for distinctions between methodologies to become blurred and for 'method slurring' to occur (Baker et al., 1992). There are also criticisms that researchers have failed to adhere to the method (Stern, 1994; Wilson and

Hutchinson, 1996; Eaves, 2001), particularly if the explicit procedures for data collection and concurrent analysis are not followed, that is: open coding, categorizing, axial coding and theoretical coding, together with the use of field notes and memos so that ultimately a core category is inductively determined. However, Glaser was also aware that researchers may 'adopt and adapt', using other methodological strategies as the context of the research requires (Glaser, 1999, p.837).

Finally, I wished to use a feminist perspective. While grounded theory has been viewed as broadly compatible with feminism Morley has suggested that many feminist researchers have rejected grounded theory on the basis that a feminist study cannot be politically neutral as all feminist work is theoretically grounded (Morley, 1997). However, Keddy et al., (1996, p.452) state that grounded theory lends itself to a feminist approach. They suggest that the theory developing properties of grounded theory allow for complex analysis of complex questions and that the data are suitable for deconstructing the contextual discourse and taking the analysis to another level beyond a symbolic interactionist interpretation. Furthermore by drawing on non-hierarchical and participatory approaches of feminist approaches and using the resultant theory to inform social reform offers a useful combined methodology and method for feminist researchers.

### *Feminist approaches*

There has been some ongoing debate in the literature as to whether there is or is not a distinctive feminist method or methodology. This discussion originated with Roberts (1981) who suggested that feminism offered important insights into the research process. However, Harding (1987) highlighted difficulties that have arisen due to

confusion between definitions of method, methodology and epistemology; methodology referring to a theory and analysis of how research does or should proceed; methods are ways of gathering data; and epistemology is about the theory of knowledge. She then suggested that this lack of clarity makes it difficult to identify what is distinctive about a feminist method. I proposed using feminist approaches to frame this study recognising that a feminist context views the personal as political since pregnancy and birth have become part of the mainstream of political debate (Bryson, 1999).

Reinharz dealt with this complexity by suggesting that rather than defining what feminist research is, it is important to identify what such research includes (1992, p.4). Her conclusions were that feminism should be considered as a perspective rather than a research method, should be guided by feminist theory and include an ongoing critique of non feminist scholarship; and that feminists may use a range of methods. She suggested that feminist research may cross disciplines and should attempt to represent human diversity and aim to create social change. She also suggested it should include the researcher as a person and attempt to develop special relationships with the people studied and may define a special relationship with the reader (Reinharz, 1992, p.240).

Webb (1993) offered various explanations and definitions of feminist research. She suggested that the most comprehensive definition included Bernhard's (1984) eight criteria for feminist research (p.417):

1. The researcher is a woman
2. Feminist methodology is used
3. The research has the potential to help its subjects
4. The focus is on the experiences of woman

5. It is a study of woman
6. The words feminism or feminist are actually used
7. Feminist literature is cited and
8. The research is reported using non-sexist language

These criteria appear helpful but Bernhard's use of the term 'subjects' is questionable in relation to feminist research since this term suggested objectifying women rather than recognising them as participants. However, following her review of the literature Webb (1993, p.422) suggested a definition as 'research on women, by women for women' but highlighted the distinctiveness of feminist methodology as being its engagement with issues specifically related to women and using a variety of methods. Nevertheless she also highlighted several paradoxes and dilemmas facing feminist researchers and noted that it is important to acknowledge these in order to move forward.

More recently the discussions and debates about feminist research and methodology have become rather more complex (Maynard and Purvis, 1994) and have included the need to focus more on the practicalities of the research rather than the abstract principles. Kelly et al., (1994, p.46) suggested that feminists have been stern critics of 'hygienic research'; the censoring out of the mess, confusion and complexity, of doing research. This referred to the way in which the problems are hidden and emotions that may be met during the process not addressed. They have claimed that published research accounts often bear little relation to the processes undertaken which are often cyclical rather than linear and far more messy and complicated than the reports would indicate.

Thus, while drawing on grounded theory, my approach has also been informed by feminist literature. For, whilst acknowledging the tensions and difficulties, I explicitly tried to take the various women's needs, interests and experiences into account and to play some part in improving women's lives (Letherby, 2002, p.6). I have been particularly concerned about potential power inequalities between myself and the women involved in the study and the need to avoid exploitation and the 'smash and grab' approach to data collection' (Collins, 1998, p.1). I tried to overcome this by making data available to the women and to give them the option of what is included or not (see page 110).

### *Negotiated order*

Issues of power relations in health care are evident between doctors and midwives, and between midwives and the women, particularly in the hospital, and specifically in the labour ward or delivery suite environment. Strauss (1978) contended that all social orders were negotiated orders and the negotiated order approach has been used by various authors for interpreting the relationships in health care work.

Previous work in this area has been focused on doctor-nurse interactions (Svensson, 1996) and the nursing-medical boundary (Allen, 1996, 1997, 2000), and they have highlighted that continuous negotiation, a negotiated order, has replaced the more traditional doctor-nurse game as stated by Stein (1967). Stein described the relationship between doctors and nurses as characterised by the former's need for status and power which constrained open and honest communication. As a consequence strategies had to be used by the nurse to inform and advise the doctor without challenging their position, hence the 'doctor-nurse game'. Stein et al., (1990)

revisited the 'doctor nurse game' to evaluate changes to the original theory over the intervening years and in the context of some deterioration of public esteem for doctors and changes to the gender balance between doctors and nurses. They concluded overall that there were some improvements in the doctor-nurse relationship.

Svensson (1996) described the social order on wards and he saw this as the result of continuous negotiation between doctors and nurses and more appropriate than the doctor-nurse game (Stein, 1967). He argued that all social orders are negotiated orders and that one of the principle ways in which things get accomplished is by negotiation with one another. It does not mean that everything is subject to negotiation; other significant processes occur for example compulsion, persuasion and manipulation. Space for negotiating may vary and the actual negotiation at the level of the individual is always conducted within the larger social structure.

Allen (1996) used five key nursing boundaries to analyse the work of hospital based nurses and her findings demonstrated that nurse inter-occupational boundaries with medicine and support workers were accomplished with minimal negotiation and conflict. However there were tensions at the boundaries with patients and their relatives and between nurses and general management. The boundary work with nurse managers was also explored (Allen, 2000) and identified issues of control, establishing expertise and identity work.

Within the field of midwifery practice Kirkham (1987) identified examples of the doctor-midwife game and she also noted from Stein et al.'s later work (1990) that the game was changing but was unable to cite specific midwifery examples (Kirkham, 1993, p13). Although the culture of midwifery has been well documented (for example Kirkham,

1999, 2000, 2004a), and there is growing evidence of analysis of occupational identities (Sandall 1995, 1998 ;Hunter,2005) little work has explored specific interactions between doctors and midwives or midwives and women from a negotiated order perspective.

#### *Use of narrative*

Women welcomed the opportunity to talk about their birth experiences (Bluff and Holloway, 1994) and their stories which emerged during the postnatal interviews were detailed and led to some consideration of 'narrative analysis' (Riessman, 1993). Narrative has been described as a recollection of what happened, what was done and what was of interest in a temporal sequence (Tappen, 1989). Riessman (1993) stated that narrative analysis takes as its object of investigation the story itself and suggests that it is well suited to symbolic interactionism and feminist studies. Therefore the data analysis, whilst maintaining the principles of a grounded theory approach, has also been informed by 'narrative analysis', focusing on the birth stories of the women and their perceptions of care, including the nature of the language and meanings. This has been more recently highlighted in midwifery as a potent way of valuing women's experiences (Kirkham, 1997; Carolan, 2006).

#### *Issues of power and reflexivity*

It became apparent during data collection and the lengthy process of analysis in both phases of the study, though particularly in phase two, that there were various discourses of midwifery and medicine operating together with various issues of power and language at play which needed further consideration and that I needed to revisit my original methodological framework. The discourse of midwifery, focused on caring and

normalising of birth, and apparently maternalistic, competed with the scientific and paternalistic discourse of medicine, though at times the distinction appeared blurred especially in clinical practice. The power issues that emerged were not just between doctors and midwives, but also between the midwives themselves and midwives and the women to whom they gave care. The language issues appeared embedded in practice not only between midwives and the women but again between midwives themselves. It was important to pick out these issues and make them transparent.

Reflexivity as a concept permeates both qualitative and feminist approaches to research. Etherington (2004) stated that 'it is the capacity of the researcher to acknowledge how their own experiences and contexts....inform the process and outcomes of inquiry' (pp.31-32). At the beginning of the process I was aware that even though I was using a grounded theory approach my professional background as a midwife meant that I could not start the study as a 'tabula rasa', that is with an absence of preconceived ideas, but I was not always clear about the best way to handle this. However, I tried to highlight this at key points throughout the process, for example prior to analysing the data. It became clear that, reflexivity may offer a means of constructing a bridge between research and practice (Etherington, 2004, p.31) and this became evident as I acknowledged how the multiplicity of my roles impinged on the whole study (Deery, 2003).

## **Design**

An evolving flexible design (Robson, 2002, p. 163) emerged, using a broad grounded theory approach informed by a feminist perspective (Appendix 1). Fieldwork was undertaken in two phases; the focus of phase one was exploratory with a view to understanding the experiences of the women. Interviews were undertaken with twelve

women. All were interviewed in early pregnancy and, with the exception of three women (one due to miscarriage, one moved out of area and one declined to be interviewed after the birth), again postnatally. Four women were interviewed in later pregnancy with a view to observing their labour and birth, although this aspiration was not realised. Thus a total of twenty-five interviews were undertaken. Nine midwives were also interviewed; however these midwives were not specifically involved in the care of the interviewed women. The data gathered from the interviews, were initially coded and categorised in accordance with Glaser's principles (Glaser, 1992) rather than Strauss and Corbin (1990). Preliminary and tentative categories were identified from the first phase of interviews and these informed the second phase of the study.

The second phase of the fieldwork (Appendix 2) explored women's experiences of pregnancy and childbirth and the care they received and included direct observation of their care in labour. I used the tentative categories already identified from phase one in order to achieve saturation of the data. I used an in depth approach with five women. This included both interviews and informal contact spanning from early pregnancy until after the birth and included observation of their care in labour and their birth experience. The midwives specifically involved in the women's antenatal and postnatal care were all interviewed, and as far as possible the midwives involved in the intrapartum care were also interviewed. Other personnel, including one doctor, were also interviewed wherever the data suggested that further information was required.

## **Participants**

The women who took part in the study were contacted via the community midwives. I met with the community midwives collectively to inform them of the research and to ask

them if they would help me by seeking permission from women and then for me to contact them directly. Therefore a convenience sample of women was obtained. Convenience sampling involves choosing the nearest and most convenient persons to act as respondents (Robson, 2002, p.265). The first six women who agreed to be interviewed were those who had already experienced one or more pregnancies<sup>20</sup>. That these women were multigravid occurred purely by chance and I contacted the community midwives again to approach other women in their first pregnancy<sup>21</sup>. In phase one I also interviewed a convenience sample of midwives, that is those who were available and consented to being interviewed, but not necessarily those who had given care to the women already approached.

In phase two of the study, although a convenience sample of women was sought, only those women who consented to me being present for their labour and birth were included in the study. I anticipated that this would affect the number of women who finally consented to take part; therefore I tried to ensure that I contacted sufficient women to allow for the numbers of women who might decline to take part. Again, women were initially contacted through their community midwives who sought consent for me to approach them further. During informal conversations with some community midwives it became apparent that there may have been an element of 'midwives' selection' operating during this process. This could be construed as positive in so far as the community midwives had knowledge of the women in their case load and knowledge of those who were more likely or most interested in taking part. Conversely it may have affected the process in two ways. Firstly, an element of pre-judgment may have operated and thus not all women may have been given a chance of participating.

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<sup>20</sup> Multigravid is the term used for women experiencing their second or subsequent pregnancy

<sup>21</sup> Primigravid is the term used for women experiencing their first pregnancy

Secondly, I had no control over how much information the midwives gave the women before I approached them. This may have been helpful as the midwife would not have given me the name of someone whom she knew would not want me present during their labour, but also meant that the women may not have been given accurate information. The midwives who were interviewed in phase two were all involved in the women's care in some way, either giving care directly antenatally, intranatally or postnatally or giving advice about care. None of these midwives refused to take part although had they declined to be interviewed then this would have been respected.

## **Methods**

The fieldwork was carried out from January 1998 until September 2002. A number of methods were drawn on in both stages of the study; these included interviewing, observations and telephone conversations. The interviews with the women in phase one were undertaken from January 1998, followed by the interviews with the midwives in March/April 2000. Phase two interviews commenced in November 2002 with the observational component from July 2002 until September 2002. The final interviews with the women and the midwives were completed by December 2002.

In the following sub-sections I describe the types and content of the interviews that were used in both phases of the study and also the telephone contacts and observations that were used in phase two. Finally I consider the use of notes and memos throughout the fieldwork process.

## *Interviewing*

The interviews were undertaken as suggested by Kvale (1996) so that '.... the interview perceived as an inter view, an interchange of views between two persons conversing about a theme of mutual interest'(p.14) and I attempted to be both curious and sensitive to what was being said throughout. For each set of interviews I planned to address four or five main areas unless the responses indicated that these were inappropriate or had already been discussed.

Chase (1996) has claimed that qualitative researchers do not pay sufficient attention to the nature of the narrative during the interview. Being a midwife facilitated my understanding of the issues and perhaps gave the women some confidence in disclosing their thoughts and feelings. However I was aware that some of my interviews were occasionally stilted and I became concerned that they may have been telling me what they thought I wanted to hear and I may not have been sufficiently sensitive to the nuances of language and meaning. Devault (1990) suggested that researchers need to interview in ways that facilitate the exploration of aspects of women's experiences that they may not be able to articulate fully'. I reviewed my questioning style to ensure that I used open probes and to ensure that I engaged in 'skillful listening' (Devault, 1990, p.105).

### Interviews with the women in Phase One

The first six women interviewed were aged between 28 and 37 years and were experiencing their second or subsequent pregnancy (multigravid) and had one or more children. All of these women were married or in stable relationships and had current or

previous occupations spanning the spectrum of occupational groupings. Since all of the first interviews had been with multigravid women I ensured that the next six women were experiencing their first pregnancy (primigravid). These women were aged from 26 to 34 years. Four women were married or in stable relationships, one had a partner who was absent on family business and one woman was single. All of these women, with the exception of one, were currently employed in a range of occupations. For a summary table of interviews in phase one see Appendix 3.

All of the interviews, with the exception of one, were undertaken in the women's homes and with both verbal and written consent. Interviews were audiotape recorded and later fully transcribed. Brief field notes were made immediately afterwards. Copies of the typed transcripts were offered to the women for verification but no additions or deletions were requested by them.

#### Interviews with the midwives in Phase One

I interviewed one midwife from each of the five community teams in the area and also interviewed one midwife from each of the clinical areas within the hospital setting (namely: antenatal clinic, delivery suite and antenatal/postnatal ward). I also tried to ensure that the midwives interviewed represented a range of employment grades (E, F and G), thus a total of nine midwives were interviewed.

Since the actual midwives who had given care to the interviewed women were not specifically targeted, these interviews were not undertaken until all those with the women had been completed. These interviews were conducted as privately as possible, either in the hospital setting or in a community setting. All interviews were audiotape recorded

and later fully transcribed. Brief field notes were made immediately following each interview. For a summary table of interviews in phase one see Appendix 4.

### Interviews with the women in Phase Two

In-depth interviews were undertaken with a total of five women. All were contacted in early pregnancy and interviewed in mid-pregnancy and again after the birth, during the postnatal period. Thus a total of ten interviews were undertaken. These women were aged between 18 and 34 years all were married or in a stable relationship and had current or previous occupations including a child-minder and book keeper. For a summary table of interviews in phase two see Appendix 5.

All of the interviews, with the exception of one which was carried out in the woman's place of work, were undertaken in the women's homes after gaining both verbal and written consent. Of the five interviews undertaken the husbands/partners were present for three of them, with varying levels of participation. All the interviews were audiotape recorded and later fully transcribed. Brief field notes were made immediately afterwards. Copies of the typed transcripts were offered to the women for verification but they did not request any additions or deletions.

I undertook the post birth interview between the fifth and fourteenth day after the birth and in the woman's home. Prior to this interview I reviewed the transcript of the first interview and the notes of the observation of the birth. This helped to focus the areas for exploration during the interview. These included: overall perception of the labour, care given during labour, the birth and after, the birth plan, environment, the midwife and the

effect of my presence on them, the midwife and the care. I also included any particular issues that may have arisen, for example the decision to have a certain type of pain relief or nature of the intervention/type of delivery. Of the five interviews undertaken the husband/partner was only present for one and participated towards the end of the interview.

### Interviews with the midwives involved in antenatal and postnatal care in Phase Two

I interviewed the community midwife who was responsible for the majority of the antenatal and postnatal care of each woman who had agreed to participate. If another midwife was involved in contributing significantly to the care (for example on more than one occasion) then that midwife was also approached and interviewed. Four midwives were involved in giving antenatal care to the five women (one midwife was responsible for two of the women in the study) and these midwives were interviewed once during the period of antenatal care and following completion of the postnatal care. One further midwife was interviewed as she participated in the postnatal care of two of the women, thus a total of nine interviews were undertaken. For a summary table of interviews in phase two see Appendix 6.

These interviews were conducted at a mutually convenient time and usually in a community setting. Due to the nature of the community setting (usually the designated midwives' office in a health care setting) and the timing of the interviews they were not always private, as other midwives needed access to the office; however the midwives themselves appeared willing to continue the interview and on occasions consulted with colleagues prior to responding and /or actively sought their contributions. All interviews

were audiotape recorded and later fully transcribed. Brief field notes were made immediately following each interview.

#### Post birth interviews with midwives involved in intrapartum care

Although I had planned to interview the midwives who gave intrapartum care I had not prepared a specific schedule of questions. My aim was to try and explore the midwife's perception of the labour and of the care given. It was not always possible to undertake this immediately following each birth; appropriateness, opportunity and flexibility, were the key factors in determining the timing of this activity.

For the first three births this was undertaken virtually immediately afterwards, informally and often at the 'midwives' station'. These were not taped and therefore the content is based on my field notes after the event and documented at the same time as my field notes of the labour and birth. For one of these labours there had been a changeover of staff, between night and day shifts. I engaged the midwife on night duty in some informal conversation but had a longer discussion with the midwife who was present at the birth during the day shift. It was more difficult to undertake these discussions/interviews immediately after births four and five as these both spanned the day/ night and the night/ day shifts respectively and timing of the births made it impractical. The shift patterns of one of the midwives also made this more difficult and in these circumstances a date and time was mutually agreed.

### *Maintaining telephone contact*

During the first phase of the study I was unable to realise my plan to observe the labour and birth of the small number of women who had consented to me being present. This was due to various factors. From a practical point of view I had not made sufficient arrangements within my workplace to facilitate my attendance. More importantly, I had probably not developed a sufficiently strong relationship with the women to facilitate this type of access at a sensitive point in their experience and on reflection was perhaps somewhat reticent in pursuing access at this stage of the research. Therefore in order to develop an in depth analysis of the spectrum of care offered and perceived by women a different strategy was required for the second phase of the study.

I used the telephone to make initial contact with the women and arrange interview appointments both in pregnancy and after the birth in both phases of the study. However, in phase two of the study I used the telephone not only to make arrangements but also to maintain contact with the women between interviews. This proved to be a useful strategy to maintain and develop my relationship with the women and by doing this on occasion provided me with ongoing information regarding the women's pregnancies and their care. It also maintained the profile of the project and possibly ensured that the women maintained their interest sufficiently to contact me at the point of the onset of labour so that I could attend the labour and birth. I also maintained telephone contact with the women after their interviews until all the post birth interviews were completed.

### *Observations*

The observational component of the fieldwork took place in phase two of the study and in the delivery suite of the maternity unit within the NHS Trust hospital and over a twelve week period. I adopted a naturalistic approach rather than employing a specific schedule of observation (Pontin, 2000). The work of both Hunt (Hunt & Symonds, 1995) and Kirkham (1987) was particularly useful in my preparation for observation.

It was not feasible to use a notebook or tape recorder in the delivery suite; this was primarily because the rooms in the delivery suite were rather small and contributed to quite an intense atmosphere therefore I focused on the key issues arising: the nature of the environment, the care given, language used and the interplay of the various participants and made field notes as soon as possible after the labour and birth. These were mostly dictated with additional handwritten notes made as soon as practicable afterwards. For a summary table of observations in phase two see Appendix 7.

### *Notes and Memos*

These formed an integral part of the project not only during data collection and analysis but also throughout the study. During the initial preparatory work for the data collection, I documented the work undertaken to secure access and consent, not only from a practical point of view as an aide memoire to highlight the dates and times I was given to make contact with various individuals, but also as a means of reflection on these processes and the challenges or difficulties they presented. During the fieldwork preparation time I often felt anxious about the actual process and worried about the

practicalities of securing sufficient contacts to undertake the project and the preliminary work necessary to achieve this, for example seeking consent from the GPs. Reflection often highlighted the other anxieties I was experiencing and the more subtle demonstrations of power inherent within the process, for example:

*"...managed to contact 3 doctors today. It took at least 2 attempts to get through to each. Dr X was very unconcerned and agreed; Dr Y was cautious and wanted me to ring for each patient; Dr Z asked if I would be a doctor when I finished..."*  
(Memo 27.04.99)

During the data collection, when undertaking interviews in addition to audio taping the interviews I also audio taped my initial finding and reflections on each interview, immediately afterwards (often in the car prior to leaving, although out of sight of the interviewee) and transcribed these to accompany the interview record. During the period of fieldwork when I was observing labours and births it was impractical to make notes during the observation, therefore I dictated on to audiotape my observations and notes as contemporaneously as possible, transcribing them to form my observational notes.

During data analysis, I used memos to highlight codes and categories as they emerged and also theoretical memos to help make links between the various categories.

#### *Explanation of codes*

For purposes of maintaining anonymity during transcription and reporting of the interviews and observations I have used the following schema. All women's interviews

have been coded as W with an accompanying number. For example W22.1 indicates the first interview with woman number 22. Similarly, midwives' codes start with MW and follow the same pattern. In phase two observational data has been coded as WB with the number already allocated to the individual woman. These codes are also identified within the relevant appendices.

## **Ethical and Access Issues**

### *Ethical approval*

As this research included both childbearing women receiving care within one specific NHS Trust and midwives employed within the same Trust ethical approval was gained not only from the University Ethics Committee but also from the relevant NHS Ethics Committee of the specific NHS Trust. A proposal was submitted to the Trust Ethics Committee in July 1998 in accordance with their guidelines and they responded that they required further information with regard to selection of participants and the semi-structured questionnaire to be used. They also wished to see written approval from the Trust's consultant gynaecologists (sic) that: *"they are happy for their patients to be included in the trial and similar approval from the patients' GPs"*. The terminology used highlighted the predominance of the medical model and the paternalism of the medical profession towards their clients (Walsh, 2005). Clearly the use of the word 'trial' also suggests a preoccupation with more quantitative methods rather than the qualitative approach which was to be used. This fits with Holloway and Wheeler's suggestion that often the knowledge of research amongst the members of such committees is based on randomised control trials or surveys and further information required to justify a more qualitative approach (Holloway and Wheeler, 1996). Requesting to see the semi-

structured interview schedule was not a particularly unusual request from an ethics committee but does not fit well with a qualitative approach since interviews may be undertaken in a flexible manner which may not necessarily be predetermined. However, tentative schedules were devised to present to the committee (Appendix 6). The ethical approval was finalised in October 1998.

### *Practicalities of Gaining Approval, Consent and Accessing Gatekeepers*

Formal permission is important with regard to gaining access to potential participants in a research project. Robson (2002, p.380) advised that there is a distinction between what is formally necessary and what may be needed above and beyond this to gain support and acceptance. Holloway and Wheeler (1996) highlighted the power and control of access that gatekeepers have, especially those at the top of the hierarchy. They also suggested that researchers may be denied access for a variety of reasons. However, Benton and Cormack (2000) suggested that gaining access can be time-consuming but if the necessary gatekeepers are identified at an early stage and approached systematically then access is a relatively straightforward step. It was during the process of seeking ethical approval that issues of gatekeeping first emerged and at times the two processes appeared to converge and sometimes appeared inseparable. In the following sub-sections I highlight the practical issues that arose with the various gatekeepers, finally considering how I made contact with the women.

#### Obstetric consultants

The Trust Ethics Committee required written approval from the consultant gynaecologists [obstetricians]. Since I already had educational links with the senior

midwife I approached her first to explore any potential difficulties in gaining such approval and to obtain the contact details. I was then able, after several attempts, to contact the senior obstetrician by telephone to explain the nature and content of the research project, explain the requirements of the Trust Ethics Committee and seek advice regarding the best way to approach the other four obstetricians. Although it was explained to me that he perceived no particular problem he would need to seek out the opinions of his colleagues and would do so on my behalf. I offered and agreed to send multiple copies of my proposal for their perusal. Repeated telephone calls were required to ensure that the documentation had been received and to ascertain progress and thus this stage took a little time. It was finally agreed that the senior obstetrician would write, giving approval, on behalf of himself and his colleagues, directly to the committee. When I later met this obstetrician personally, at my instigation, he appeared fully supportive and again reiterated that he did not perceive any problems and implicitly, he questioned the processes of the committee. This highlights the somewhat lengthy process that ensues when seeking permission to gain access and start a specific research study.

#### General Practitioner Liaison

Gaining GP approval was rather more problematic due to the numbers of the GPs in the area and because at the beginning of the study I was not clear how many women I would need to approach or finally include in the fieldwork. The consultant obstetrician suggested contacting the liaison GP and this was achieved by a telephone contact and then forwarding a copy of the proposal. I was advised by the liaison GP to pursue all the GPs individually. The logistics of this were problematic and it was finally agreed that the

liaison GP would write a supporting letter to the Trust Ethics Committee and I would contact GPs individually when each woman had consented.

#### General Practitioner receptionists

Although I had anticipated some difficulties in gaining consent from women's GPs, an extra tier of gatekeeping was emerging in the form of the various GP receptionists. Early contacts with receptionists, when I was introducing myself as a researcher and a midwife led to comments such as *"the doctor won't speak to researchers"* or *"they don't do that [research] here"*. Clearly, the receptionists appeared to be protecting the GPs and I found this quite disconcerting. I later discovered following some of my interviews with the women that this was not an unusual finding as they too reported similar problems.

Not all receptionists were unhelpful; some were keen to suggest appropriate times to telephone and took my name and passed it on to the GP concerned. However, the difficulties were only surmounted when I found a form of words that, whilst correct, gave less focus to my role as a researcher. The introduction used became *"[I am not a patient] I am a midwife and I need to talk to Dr X about one of his/her patients"*. This usually gained access to the GP with a minimum of fuss and little challenge from the receptionists. However, this raised the issue of 'truth-telling' and posed an ethical dilemma since I was aware that the more I emphasised I was a researcher the less likely it was that I would be 'allowed' to speak to the GP.

Having negotiated the access via the receptionists, using the words indicated above, I then became concerned as to whether any GP would actually question my truthfulness

and ethics in gaining that access. However, as soon as I spoke to the GP I made it quite explicit what the purpose of my call was.

### General Practitioners

Often, it took more than one attempt to contact each GP since I had to find the appropriate time to call, usually at the beginning or end of surgery time and usually within a time slot of 5 - 10 minutes before they undertook other activities. Once the GP was contacted I outlined the research project, indicated the requirements of the Trust Ethics Committee and informed them of the consent given by their 'patient' [sic]. I offered an Information Sheet and also asked if their agreement, once given, covered any subsequent 'patients' from their practice. The discussion was brief and mostly positive but with some protective overtones. I felt there was a predominantly paternalistic attitude towards their patients. Some gave a blanket agreement to access any of their 'patients' once they were assured that the client herself had given consent. Others wished to be contacted for each of their 'patients'. Reasons given included the need to make a note on their records, or more usually, it was implied to ensure there were no problems in their history which might preclude their 'patient' taking part. Some wished to receive an information sheet on the project whilst others stated 'no', occasionally qualifying this with stating that 'they would have no time to read it'.

It also appeared that there was some variation in the relationship between the individual GP and the midwife linked to their practice. In some circumstances it appeared that the GP had a high degree of trust in the midwife and her decision making, related to the 'patient' in question, but in others, though sometimes less explicit, this trust was less evident (or perhaps lacking).

Even in situations where access via the receptionists had been particularly difficult the GP was usually polite, and sometimes helpful. Some were overly brisk and little concerned with the whole process whilst others appeared to listen carefully, were cautious and wished to retain their right of veto over individual patients, even though they might not be directly giving care themselves. This raised the issue of power relations between the GP and patients and the GP and me as researcher and/or midwife. It was also interesting to note that sometimes the women passed particular comments regarding their relationship with their GP and these were mostly fairly positive. However, one woman did not know her GP's first name and made a comment to this effect when I told her that I had spoken with her GP and the mode of his introduction to me. Explicit joviality might also indicate that as an individual I pose very little threat to any GP.

Accessing the GPs and to some extent the consultant obstetrician also raised the issues of my own 'game-playing' in order to both fulfill the requirements of the Trust Ethics Committee and ultimately to gain access to my target population. Buchanan et al., (1988) state that fieldwork is permeated with conflict between what is theoretically desirable and what is practically possible and argue that the researcher adopts an opportunistic approach to fieldwork in organisations. They also highlight the point that research accounts in academic journals depart considerably from the research practices of their authors, offering instead a 'reconstructed logic'(Silverman, 1985). This linked with the notion of 'hygienic research' as discussed on page 101. However, rather than just stating that ethical approval was sought and gained following the submission of some supplementary information, I have tried to demonstrate, in a transparent way, the challenges and issues that gaining access presented.

There were many gatekeepers evident at the beginning of this study, all of whom had some power to deny or facilitate access and various difficulties and issues emerged which have made the process of access complex and sometimes lengthy. Although the difficulties proved surmountable the study provided valuable experience in highlighting the complex and sometimes lengthy nature of this process and the importance of establishing and maintaining good relationships with key personnel.

The gatekeeping issues which emerged whilst seeking to negotiate research access included the tiers of gatekeepers identified, the individual nature of requests and responses and in particular the tensions and dilemmas posed by the responses of one professional group and their own gatekeepers.

#### Midwifery Managers

Seeking support was somewhat easier from the midwife managers. These were people known to me in an educational capacity and with whom I had previously developed working relationships, therefore access was slightly easier to arrange and could on occasion be rather more informal. The first contact was made with the senior midwife to identify the 'appropriate' way to gain staff co-operation regarding access to women. Discussion also took place with regard to any potential difficulties with GPs for example those who may be less helpful and/or antagonistic to research in this area. This was followed by a meeting with one of the 'team leaders' to explain the project and gain basic information regarding GPs in the area. It was also a way of arranging to meet midwives collectively to explain the project and make preliminary attempts to access women.

## Midwives

The first meeting was held with community midwives to outline the study and to raise the issues of gaining access to women. I was quite anxious but this was more to do with gaining access to women as quickly as possible in order to 'get started' rather than any particular anxiety or problem with the midwives. Most midwives appeared fairly supportive, others were quiet during the meeting and although I perceived no real hostility overall, some interesting questions were raised for example did I wish to speak to primigravidae or multigravidae or both and the possibility of accessing women directly from antenatal clinic records rather than the midwives themselves. Although I had explored the issues previously during supervision I had not prepared myself for these particular questions from the midwives. I observed that many midwives openly referred to the women as their patients and some were preoccupied with the difficulties which might ensue, possibly trying to protect their patients from me, especially in difficult situations e.g. if I inadvertently spoke to a patient who had experienced a miscarriage or had a particularly bad experience of pregnancy. I interpreted this as a personal slight on my skills as a midwife but could also construe this as being perceived as a researcher rather than a midwife.

Subsequently, I found it more useful to speak to midwives individually by sitting quietly and unobtrusively in their base room at the hospital and accessing them on a one-to-one basis when they called in. For those who did not use the hospital as their base room I telephoned and aimed to speak with the same midwife on each occasion who would then pass on information or requests to their colleagues. Initially I provided midwives with written packages to be given to women as part of their first antenatal visit (Appendices 7 and 8). The information explained the study and invited them to take part

and enclosed a consent form for completion and return in the stamped addressed envelope provided. This was not a particularly productive way to access the women since only one respondent was recruited in this way. On reflection this method relied on women actively choosing to participate by returning a form, which, given the information overload already experienced at the time of the first antenatal visit, was possibly unrealistic. Furthermore, the timing (immediately prior to the Christmas period) also constrained this process. It was also clear that women were verbally expressing interest to their midwife, but not completing the formal process, thus potential participants were being lost. The method finally used included the midwife asking the woman's permission for me (the researcher) to contact her by telephone in the first instance. When this permission was gained I was able to make telephone contact and to explain the research further and make a preliminary appointment. At this meeting I was able to gain consent and then, if appropriate, to carry out the first interview.

I accessed the midwives whenever I required more women for interview and accessed the teams equally so that the respondents would be taken from a wide geographical area within that served by the NHS Trust. Although there were occasions when this contact was by telephone for all the midwives, I found the one-to-one and face-to-face contact, by being present in their base room, more productive as it seemed to lead to a less pressurised encounter and served to remind the midwives of the research as an ongoing project.

#### Access to women

My first contact with pregnant women as potential participants was via a telephone call following verbal consent given to their own midwife that I could contact them to explain

the research study. I found the timing of this first telephone call extremely important, especially if the woman already had one or more children. Calls were best timed later in the evening after the child (ren) had been settled for the evening. It was also important to ask whether it was convenient to talk at that particular time. For those women in their first pregnancy it was important to gauge a time when they were home from work but prior to any other evening commitments. At this stage I explained the nature of the study and briefly what it would involve. If the women were still interested at this stage then I proceeded to make a mutually convenient appointment to visit. The right of refusal or withdrawal was emphasised at all stages of negotiating participation. Some women, at this stage required further time to consider this and if there were any concerns I offered to ring later, or if they preferred, I gave them my telephone number to contact me as and when they were able. A small number of women failed to return my call and I did not pursue this further. The first visit then involved explaining the study in greater detail, providing an information sheet (Appendix 9) and obtaining formal, written consent for the study. Only one woman failed to respond when I made my first home visit and again I did not pursue this. In all cases the women then consented to the first interview taking place at that time. It has been suggested that written consent may, in fact prejudice the study or interfere with the researcher-participant relationship (Holloway and Wheeler, 1996). However, in accordance with the local ethical guidelines (Guidelines for Ethical Approval undated) a consent form was included and used (Appendix 10).

## **Data Collection**

Data were gathered from various sources during the span of the project. In the following sub-sections I describe how this was done in each phase of the study.

### *Phase One*

In phase one these included interviews with women and midwives, and the use of notes and memos generated from the interviews. Although, I had developed interviewing schedules to comply with the requirements of the Trust Ethics Committee (Appendix 8), this was not in the spirit of a grounded theory approach, so I relied on these as aides-memoire and started the conversation with a 'tell me about' type question. I only used further questions or prompts as necessary to elicit further information. An example of the range of prompts and questions actually used with both the woman and the midwives is also included, having been extracted from full interview transcripts (Appendices 11 and 12).

### *Phase Two*

In phase two data included interviews with women, midwives and one doctor; notes from telephone calls, field work observation and memos. All interviews undertaken were tape recorded and fully transcribed. Observation and field work notes were dictated on to audio tape as soon as practicable after the event normally within 2 hours, and then fully transcribed.

Once field work commenced the gestation of each woman's pregnancy at the point of my initial contact with her dictated the actual timing of the first interview and the timing of telephone contact was by individual arrangement. I also made arrangements with each woman with regard to contact at the onset of labour for the observation of the episode of labour and birth. However, each taped account was reviewed and key aspects noted prior to the next interview or observation and a full transcription made as soon as possible.

Notes of telephone conversations were reviewed but not fully transcribed. Interviews with the community midwives involved in care were undertaken both during the pregnancy and after the birth whilst those midwives involved in intranatal care were interviewed at a convenient point after the woman's labour and the birth of the baby. Where time did not permit a formal taped interview then an informal discussion was undertaken as soon as practicable and these notes included as field work data, dictated as soon as possible after the event and transcribed with the field work notes.

### **Data Analysis**

In grounded theory, data collection and analysis normally occur concurrently and are based on the constant comparative method (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Baker et al., 1992). This involves open coding, categorizing, axial coding and theoretical coding together with the use of field notes and memos so that ultimately a core category is inductively determined. This means that each interview or data set is compared with each other and as theory emerges data is compared to theory. To some extent in this project this was difficult to achieve since time restrictions meant that interviews were planned and undertaken within a fairly narrow time span and each interview was not always fully transcribed prior to undertaking the next. I analysed the data manually to become fully immersed in the material and replayed the audiotapes in addition to studying the transcripts.

Open coding is the initial process which includes breaking down the data, analysing and comparing it so that it can be grouped into categories. Axial coding identifies the relationships between categories whilst selective coding highlights the process by which

the categories generated ultimately relate to the core category. The core category or process is the underlying principle which dominates the whole situation and which links the other processes in an explanatory framework (Baker et al., 1996). Memos are notes made about a code or category and particularly about relationships between categories and are used throughout the entire process. They may be identified as code notes, theoretical notes or operational notes (Bartlett and Payne, 1997).

In this study coding and categorisation have been undertaken in accordance with Glaser's principles (Glaser, 1992) rather than Strauss and Corbin (1990). Within this project transcripts were analysed in various stages. Firstly, each was studied line by line to highlight and identify initial codes which were identified on the transcripts themselves. These codes were then listed for each transcript and grouped together into potential categories. Categories were reviewed, together with notes and memos to attempt to generate a core category. This proved difficult as several categories appeared to emerge.

At the beginning of phase one the data from each transcript was compared with the others, and at the end of phase one the transcripts were also reviewed in pairs, linking up the pregnancy and post birth interviews from the individual respondents. Preliminary and tentative categories emerged from the analysis of the women's and midwives' interviews, together with some weaker categories (Appendix 13). These were then used to inform and guide the interviews in phase two of the study.

In phase two of the study, which included observational data in addition to interviews, transcripts of observations and field notes were treated similarly: an initial coding undertaken individually and then each transcript compared with pregnancy and post birth

interviews and those of the midwives involved with care. It is these findings that have been reported in this thesis.

Brief coding or operational memos were made and written on 'post it' notes during the process (Appendix 14) and then these were grouped together with the potential categories. Summarising memos were made as transcripts were analysed and reviewed. Lengthier memos of a more theoretical nature were made on separate sheets and appended to the emerging groups of categories.

### **Establishing Trustworthiness**

Establishing trustworthiness is an important component of effective evaluation of qualitative research (Lincoln and Guba, 1985; Holloway and Wheeler, 1996). The terms reliability and validity, commonly used in quantitative approaches, are not helpful in qualitative or flexible design approaches (Morse, 1999; Robson, 2002). Robson (2002, p.171) has suggested that threats to validity are a useful way of addressing this and uses Maxwell's typology (Maxwell, 1992), which contains four types: description, interpretation, theory and prolonged involvement. I have commented briefly on each of these, though the issues raised with regard to theory and involvement are further addressed in the next section on insider/outsider issues.

#### *Description*

The accuracy and completeness of the data was ensured by audio taping all scheduled interviews. These were then fully transcribed and then checked against the original audio tape. When I returned to the woman for a further interview they were offered the

opportunity to read the transcript of the previous interview but most declined. Some women took the typed transcript but did not offer further comments on it. Where interviews were not formally scheduled and not audio taped, for example some of the interview/discussions with midwives following the episode of intra partum care, then my recollections were dictated onto audio tape as soon as possible after the event and then transcribed and checked with my handwritten notes made shortly afterwards.

### *Interpretation*

The interpretation of data was an iterative process, both in coding and categorizing and in a similar way to Letherby (2002, p.7), I was aware that I 'took away their [the women's] words' and analysed them from my own perspective. However, the findings were also discussed with my supervisory team as part of the ongoing process. This was evident through the notes of supervisory meetings and regular reviews of the notes to draw out the key ideas and themes, to raise my awareness of my position (see insider/outsider issues below) and to consider other perspectives of the emerging issues.

### *Theory*

In terms of trying to find alternative explanations for my findings and avoiding researcher bias I have used reflexivity which has been a vital component of the research process and generated through the consideration of my position as an insider or outsider to the process and the fieldwork setting.

### *Prolonged involvement*

Although the fieldwork was carried out over a period of four years, this was not a continuous involvement. The longest period of involvement was when I was undertaking the observational component of the study. This was over a period of two months when I would attend the unit whenever one of the women was in labour. The particular issues that this presented are highlighted within the next section.

### **Insider/Outsider Issues**

At the beginning of the research process I was not particularly aware of the need to identify my position within the process itself, other than to give some consideration to how I would respond if women asked me questions about their pregnancy during any of the interviews. At that stage I found Oakley's work (1981) useful and was determined that if this arose I would try to ensure that the woman was referred back to the midwife giving her care. Where this was not practical, or I deemed it important that the woman received an answer promptly, I suggested that we continue with the interview and I would answer the question or explain the point at the end of the interview. During later stages of fieldwork, and as analysis started, I began reflecting on my position as a researcher, lecturer, and midwife and how this affected my relationship with the women and midwives. I also considered my personal role in the fieldwork and used the framework given by Allen (2003). This focuses on the actual practice of fieldwork and the micro-level processes through which the fieldwork role is negotiated. This involved 'identity work' or interactional work done during the fieldwork in order to develop and sustain my relationships.

As I became increasingly reflective I became aware of the multiplicity of 'hats' and 'voices' that were emerging during the study and it became increasingly important that I reviewed my position and reflected on my insider or outsider status; terms I had loosely used when negotiating access to the fieldwork site and I began to reflect more deeply on what the insider/outsider roles meant and their implications for my research and how I made sense of it (Pellat, 2003)

Bonner and Tolhurst (2002) suggested that an insider is a researcher who is part of the social group they intend to study. There are various benefits identified, although these are identified in relation to participant observation, and these include a greater understanding of the culture, not altering the flow of social interaction, having an established intimacy with participants, allowing the process rather than outcome to be explored, gaining access, establishing rapport and dealing with ethical concerns. Conversely an outsider is deemed to be a researcher who is not a regular member of the team and may be removed from immediate situations and activities (Bonner and Tolhurst, 2002). The advantages of being an outsider are considered to be the ability to be independent and non-judgemental, able to observe and seek clarification of otherwise familiar experiences and the very transitory nature of the researcher's involvement may permit staff to share sensitive information.

Allen (2004) suggested that situations are neither totally familiar nor totally strange and the researcher's insider-outsider status may change at different points in a project and is different with different groups and different individuals. Furthermore she argued that it is important to focus on the dimensions of reflexivity that are directly relevant to the research role. In relation to this particular study I was a midwife lecturer exploring the world of maternity care and an insider. However, although I was known to some of the

midwives providing maternity care I was not part of the team and technically an outsider. However, I was also an outsider to the women though sometimes viewed as an insider because they perceived that I was part of the maternity care system.

### *Identifying roles*

Initially I considered myself a midwife and a novice researcher but later reviewed this and included my lecturer role and my role as a woman. As a researcher I was an outsider to the research site but I had specific knowledge of the nature of maternity care, gates, and gatekeepers, including ethics committee and key managers because of my other roles. For example, in my capacity as a lecturer I had insider knowledge of the site and midwifery care and this gave me my particular interpretive lens. Allen (2004) talks about individual history and biography and theoretical perspective. Reviewing my own biography helped me to identify my personal values and beliefs about midwifery and when and how they changed.

Not only was I a lecturer but the site I used for fieldwork was my clinical link area and my position at the university was known to some, though not necessarily to all of the midwives with whom I came into contact. Therefore some midwives viewed me primarily as a lecturer and assumed my presence was connected with the students and others saw me as a researcher and only concerned with specific women in labour.

As a midwife my role also gave me insider knowledge of the language, jargon and some of the practices used, though I had not worked clinically in the fieldwork site. At times midwives viewed me as another midwife, for example when seeking to justify care or a decision made. I utilised my role as a midwife primarily when accessing certain

gatekeepers, for example when talking to GP receptionists in order to access GPs. Originally I planned to use my practitioner status to participate to some extent in women's care but this changed during the first phase of the fieldwork.

For some time I didn't really think about my role as a woman which was rather ironic given my espoused feminist approach adopted within the study. I was also aware however that as a woman and midwife without children this may be questioned by the women or midwives participating in the study and, similar to Bewley (2000), have some impact on my relationships with them. However, one of my foremost concerns had been the way in which midwives, as women, could treat other women, that is those in their care. I had noticed, on occasions, that some of the midwives I encountered did not really appear to like or respond positively to them and that this was contrary to my understanding of 'woman centred care'. Similarly, there were midwives who did not respond positively to me. I had presumed that as midwifery was a female dominated profession, midwives would give a more holistic and empathetic style of care (House of Commons, 1992; Page, 1993). However, as Sandall (1995) suggested, this assumption needs to be critically explored as there was little evidence to support it. This may or may not have a direct link to gender issues but also needs some consideration. Although midwifery is a predominantly female profession (there are some male midwives, though none within this study, see also page 22), it has raised questions for me as to how women treat and behave towards each other.

#### *Relationships with the women and their partners*

I made it clear to the women that I would not participate in their care in any way however I think that I was viewed by women as an insider to the system. Women appeared to

find it reassuring that I was a midwife. This may have helped them decide whether or not to participate. There were occasions during the fieldwork when the women or their partners might turn to me for further explanation and similarly when responding to a woman, I made a professional judgment as to whether responding would compromise their care or interfere with their relationship with their midwife in any way. Interactions with the women generally focused on their experience of their labour, including any comparisons they made with previous experiences and sometimes family arrangements, while conversations with their partners often focused on more general topics.

### *Relationships with midwives*

Although I presented myself primarily as a researcher this was not necessarily the perceptions of the midwives some of whom may have viewed me as a 'lecturer' and 'expert' and not only felt threatened but also felt that they needed to portray themselves in a different way to normal. Others may well have viewed me as a lecturer with a different view of the world and of no threat to them as I was not and never had been engaged in full time clinical work in that area. We shared a common language which sometimes was advantageous as it meant I understood professional jargon and was familiar with most aspects of professional practice. However, it was also a disadvantage as I could not pretend not to know things which they would assume I knew. I tried to 'downplay' my position and, similar to Allen (2003), on occasions shared self-effacing stories and experiences from my own practice. Being perceived as unobtrusive was difficult to achieve, even though I became more familiar to the staff over the time span of the observations. As I became more familiar to staff it became easier to wander out of the room and chat to staff more informally about care in general and sometimes care in particular.

Although, somewhat naively, I was initially only concerned about how I would respond to women who asked questions of me during interviews (Oakley, 1981), later I became increasingly concerned as to how my position might affect the research. When I observed episodes of care during fieldwork it was difficult to know the extent to which my presence affected care, since my background already had affected why the research was carried out and also the role I assumed in the data collection (Pellatt, 2003; Mulhall et al., 1999). Kemmis (1980) suggested that whatever is observed simply does not exist independently of the observer and that there is bound to be some distortion whereas Kite (1999) later suggested that observation notes may well be a record of [midwifery] care in the presence of an observer.

As a lecturer I developed an increased awareness of the nature of the experiences that students are exposed to and the strength of the culture of midwifery and the hierarchies involved. As a midwife I had an increased awareness of how some practices change and how many do not. As a woman I was particularly concerned about how women treat each other for example how midwives treat other midwives and how obstetricians, who may be female, treat both midwives and childbearing women. I found, similar to Pellatt (2003, p. 32), that nothing had prepared me for the effect that undertaking the fieldwork would have on myself. She talks about the impact of listening to patients. For me it was listening and observing birthing women and the midwives and also listening to the way in which women's previous experiences had affected the current pregnancy by, for example delaying a further pregnancy; or perceptions of midwives as 'matrons'. In my observations, I was aware of the separateness of the episode of labour and birth and the way in which midwives did not listen to women and were not fully aware of their expectations.

## **Limitations of the Research**

As with any research project there were some limitations. This was a study in a particular location, at a particular time and the findings may not be replicable or transferable. Furthermore, qualitative designs necessarily focus on meanings and understandings but the small numbers involved constrain the generalisability of findings.

The observational aspect of the fieldwork also involved small numbers and due to the timing of this there was little time for staff in the fieldwork site to become accustomed to my presence in the area. This may well have affected their behaviour when they were being observed, but I cannot say with confidence whether or not this happened. Kirkham (1987, p.20) suggested that the presence of an observer must have some effect on what is observed.

Although in phase one I interviewed a convenience sample of midwives and these were from community and hospital settings, in phase two the main focus was on the five women and the midwives who were involved in providing care. This mainly included a small number of community midwives and a small number of delivery suite midwives. In phase two however I did not interview ward based hospital midwives. Although the women themselves sometimes commented on this aspect of their care, and these have been captured in the data, I do not have the full range of views from all midwives involved in their care.

## **Concluding Thoughts**

In this chapter I have described the overall methodology, design and location of the study. I have used a flexible design which included a broad grounded theory approach drawing on feminist perspectives. The methods of interviewing and observation have been considered and I have also highlighted the ethical, access and gatekeeping issues that this project presented and how they were addressed. I have explored insider/outsider issues that presented and the implications of this for the study. Finally I examined the limitations of the research.

Throughout this process I have tried to ensure reflexivity and this has caused some tensions throughout as I have struggled to define and redefine the methodological approach and been increasingly aware of the emotional impact of the research. However, I have tried to highlight the transparency of the process, rather than settling for a 'hygienic version'.

The next chapter sets the scene of the research begins to address the aims of this study. The concepts generated during data analysis are explored to try and deepen understanding of the term 'woman centred care'.

## **CHAPTER 4**

### **BEING 'WITH WOMAN' OR BEING 'WITH ORGANISATION'?**

#### **Introduction**

The concept of 'woman centred care' was introduced in Chapter 1 and further explored in Chapter 2. I was particularly interested in the extent to which midwives were able to be 'woman centred' in the existing system of maternity care provision. This chapter sets the scene of the research begins to address three of the four aims of this study, as follows:

1. To explore what is meant by 'woman centred care': what it means to women and what it means to professionals, specifically midwives.
2. To consider to what extent the concept of 'woman centred care', was implicit or explicit in clinical practice.
4. To explore how far the organisation of maternity services has changed with the notion of 'woman centred care'.

The first section of the chapter describes the research setting, the organisational structure and management of the maternity services. The influence of rules, policies and procedures are considered in relation to the midwives' practice.

The study generated data in relation to the concepts of knowing, trusting and caring, and these are explored in the subsequent sections to try and deepen understanding of the

term 'woman centred care'. The chapter then considers some of the qualities or attributes of midwives that were described as important in establishing and developing the relationship between the woman and the midwife and how this may be realised as being 'with woman'. As was seen in chapter 1 the reality of attempting to implement 'woman centred care' provides an ongoing challenge which can be understood in terms of the tensions and competing priorities in relation to being 'with woman' or being 'with institution'; this is discussed in the final section of the chapter.

## **The Practice Setting – Organisation and Influences**

### *Organisation of the service*

The setting for the study was an NHS Trust in the north of England. During the initial phase of the study there was a merger of this NHS Trust with a neighbouring, Trust within the Health Authority. This involved a restructuring of managerial level personnel, and the establishment of several new posts, some with cross-site responsibilities. Service reconfiguration was also an ongoing issue during the period of the study and had a continuing negative impact on the morale of local midwives during the span of the study.

Concerns had been expressed in the midwifery literature regarding the substantial number of maternity unit closures which took place between 1980 and 1995 and those due to take place by 2005, with no apparent strategy underpinning the change (Dunlop cited in Lee, 2001). However, in the local context it was evident that there were financial drivers to this merger and to the subsequent plans for reconfiguration of services.

During the course of the study Health Authorities were replaced by Strategic Health Authorities and commissioning arrangements for maternity services changed. Primary Care Trusts<sup>22</sup> replaced the Health Authority as key stakeholders and purchasers of the service. In 2002 NHS Trusts<sup>23</sup> were invited to apply for 'Foundation'<sup>24</sup> hospital status (DH, 2002) and the merged Trust consulted gained Foundation status in 2006. This upheaval in service organisation produced considerable insecurity and low morale amongst staff.

### *Community and hospital settings*

The local NHS maternity care system comprised various pathways of care which identified the type of antenatal care provided: for example midwife-only, shared (GP and consultant) or consultant only care. Midwife only care meant that women had antenatal and postnatal care provided solely by their community midwife, unless a problem arose when they would be referred for a consultant opinion and possibly consultant care. The shared care option included antenatal care from the woman's GP, with some visits to the hospital for obstetric care. In reality, care from the GP signified care at the GP's surgery but undertaken by the community midwife. The guidelines used in relation to the pathways for care indicated the number of antenatal clinic visits or consultations that women could have reasonably expected.

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<sup>22</sup> Primary Care Trusts (PCTs) cover all parts of England and receive budgets directly from the Department of Health. Since April 2002, PCTs have taken control of local health care while strategic Health Authorities monitor performance and standards.

<sup>23</sup> NHS Trusts are the NHS organisations responsible for the provision of health care services and accountable to central government.

<sup>24</sup> Foundation Trust status gives providers freedom from Department of Health control and the health services are owned by and accountable to local people

The choice of place of birth where the research was undertaken was either the delivery suite or the woman's own home. There was no choice regarding the community midwife who provided the care. Unlike selecting a registered medical practitioner there was no composite list from which a woman could choose a midwife within the NHS. If a woman wished such a choice she had to find an independent midwife<sup>25</sup> willing to provide maternity care. Community midwives were attached to specific registered general practitioners or their practices and once notified of a woman's pregnancy attended accordingly.

The majority of the 2,500 births per year took place in the hospital. Most antenatal and postnatal care was community based, that is care was provided either in local clinics or in the women's own homes and maternity care services were managed as an integrated service. This meant that all the midwives who cared for women were employed by the Trust, and were located either within the hospital or the community setting.

During the period of the study midwives within the community setting were organised into 5 separate teams that were linked, though not physically located, in GP practices. They provided antenatal and postnatal care to the women registered with the GP practice who chose, midwife only or shared care and postnatal care to women who had received antenatal care from a consultant obstetrician. Community midwives also provided intrapartum care to those women who requested a home birth.

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<sup>25</sup> Independent midwives work outwith of the NHS and women pay them directly for their services.

Within the hospital, midwives normally worked in one area for approximately 6 months for example: antenatal clinic, ante/postnatal ward and delivery suite. However, the more senior midwives moved less frequently and commonly undertook coordinating or managerial roles within their area.

Consultant obstetricians were based entirely within the hospital setting, offering consultations within the antenatal clinic, delivery suite and antenatal/postnatal ward. The majority of their work was with women assessed as 'high risk', though they also undertook 'shared care' of women with GPs on request. During the period of the study the local arrangements for the consultant obstetricians to provide obstetric care and 'cover' for the delivery suite changed; obstetricians from either of the two newly merged Trust sites could expect to be available on either site depending on the local 'on call' rota. GPs, who were employed separately, offered care in conjunction with either or both obstetrician and midwives. GP care was predominantly to women assessed as 'low risk'. At the time of the study GPs also received additional, itemised funding for providing maternity care. Thus a considerable number of professionals could attend a childbearing woman and this was determined by service organisation rather than the woman's choice.

#### *The delivery suite environment*

Women who had previously birthed in or visited the unit had some idea of the nature of the surroundings and many found it quite intimidating. The clinical nature of the delivery suite or labour ward had been identified as early as 1980 in the '*Short Report*' (House of Commons, 1980), and efforts were made to try and reduce this. However, in this unit

the rooms still portrayed quite a medicalised atmosphere and during fieldwork observation in phase two I noted the following:

*“...the room looked fairly clinical...there was equipment on the locker, one of these was a radio but the other was a Dynamap machine for measuring blood pressure...”*  
(WB25, p.1).

One woman in phase 1 of the study had planned a home birth to avoid this clinical setting:

*“...I've got nothing against the hospital just... I've never liked staying hospital and the clinical environment I didn't with [previous baby] ... I had him, got dressed, no [!] went down had a bath got dressed and came home...”*  
(W5.1, p.2).

Despite the availability of a birthing pool this was not offered to any of the women that I observed in phase 2 of the study. One midwife, during an informal conversation suggested that some midwives avoided offering this room to women. The reason given was that the room was too far away from the central area of the delivery suite; however there was an implied reason was that this was too much work. Thus the clinical nature of the delivery suite clearly affected some woman's choice of place of birth and opportunities to use other resources were not utilised.

#### *Local policies and protocols*

In addition to the policies discussed in Chapter 2, local policies governing midwifery practice were in place; either substantive, indicating directives for action, or procedural

highlighting the processes guiding action (Prunty, 1985). These were often developed with a dominant obstetric input, to ensure standardised response to problematic clinical situations.

At the time of the fieldwork none of the midwives specified exactly what these policies, rules and regulations were, though they assumed, and implied, that I knew. They overshadowed the midwives' practice, with the greatest impact in the hospital setting. One hospital midwife reported:

*"...looking after women as individuals and negotiating with them to meet their needs as best you can...going by the hospital protocol, if you're a hospital midwife and you have to work by the rules, but it's negotiated care for the individual..."*  
(MW19, p.1).

This demonstrated some conflict between compliance with the hospital rules and offering women individualised care. The community midwives were also aware of this and one commented:

*"...they [hospital midwives] seem to think more about the rules and regulations you know than caring for women..."*  
(MW14, p.10),

There was also a suggestion of coercion of women so that they ultimately complied with the midwives' prescription of care or intervention (Kirkham, 2004a, p.272) rather than the women's true choice and the use of the rules and guidelines as the excuse for their coercive behaviour (Edwards, 2005). One hospital midwife stated that:

*“...but there again we have our rules and guidelines that we have got to abide by as well...we can't be stepping out of line with that, but trying to keep in line with the woman's needs as well...you have to discuss and get somebody [the woman] to agree with what you want really...”*  
(MW15, p.1).

As suggested by Symon (2006) it is all too easy for guidelines to be interpreted as rules and lead to care becoming systematised and constrained so that meeting woman's individual needs or being 'woman centred' becomes less of a priority. There was also some recognition by another hospital midwife that responding fully to women's needs may be problematic for midwives and may lead to restricted options for women and failure to respond sufficiently quickly to change:

*“...I think probably hospital wise because we are perhaps more focused on set policies and protocols that we don't always change enough to deal with what the women want...”*  
(M13, p.1).

One midwife suggested that the policies and procedures on the fieldwork site differed from those of their neighbouring hospital<sup>26</sup> and that there appeared to be some resistance to the idea of merging them. She also suggested that they had not been changed recently; for example:

*“...I said are we having any policy procedure changes, are we going to match up to ... and they went oh no we're not taking on any of their things, we're not doing any things that they do, they don't do this and they don't do that...the policies and procedures that are out there in the books*

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<sup>26</sup> This was the neighbouring hospital within the same and newly merged NHS Trust

*every time I come and look, nothing's changed from 1998*

..."  
(MW28.2, p.14 -15)

This implied some resistance to change on behalf of some of the midwives, (though no specific reasons are given for this), and hinted at the differing cultures between the two sites. Kirkham (1999) examined the culture of midwifery in the NHS and highlighted the ways in which change was resisted. This particular midwife was keen to improve standards but aware that this enthusiasm was not welcomed by her colleagues.

What begins to emerge is that community and hospital midwives had differing views on the use of policies and procedures, and that there was some implied criticism of hospital midwives by their community colleagues. Furthermore, in hospital adherence to policies and procedures took precedence over caring for the women. The differences between community and hospital environments were particularly highlighted by Hunter (2004) in her study of emotion work. She identified two occupational identities and ideologies and suggested that hospital based midwifery was driven by the needs of the institution.

#### *The boundaries of local maternity care*

Within the context of this study the maternity services were defined and managed by the acute Trust as an integrated service. However the reality of this organisation was that there was some separation between the community service, comprised of community midwives working in small groups, and the hospital service, comprised of midwives, obstetricians and a range of support and allied health workers. The community midwives also liaised with other health care workers such as Health Visitors and GPs though the latter were outwith the integrated organisational arrangements. The

boundaries of the local maternity service have been demarcated by the organisation itself, by adopting, or in this case reverting to a traditional model of maternity care. Within these boundaries the policies and rules governing care were evident but did not explain all the interactions and social norms that were established (Svensson, 1996).

Although all the midwives were employed by the acute Trust there was little movement between the community and hospital setting, other than prearranged times on the delivery suite for community midwives. This separation was not necessarily understood by the women who presumed that the midwife they first met would provide all their care:

*“...I didn’t realise that [the community midwife] wouldn’t be delivering the baby...I didn’t realise they had a specialist team up at the hospital...”*  
(W12.1, p.1),

However, once this was noted the differentiation between community midwives and the ‘specialists’ or ‘experts’ on delivery suite was perpetuated. The notion of ‘experts’ is further explored on page 171. Not only were there boundaries between the community and hospital settings but also separation between the nature of the maternity care work; the majority of antenatal and postnatal work undertaken in the community and the majority of intrapartum work undertaken in the hospital.

Although these boundaries appeared relatively fixed there has been some shift in the volume of antenatal work undertaken in the community. However there has been little or no shift in the way in which midwives worked across these boundaries. There has been some shift in the involvement of GPs with fewer involved in antenatal work and very few undertaking intrapartum work. Benoit et al., (2005) suggested that the expanded

jurisdiction of midwifery care in areas of care previously provided by GPs is less the result of professional negotiations and due more to the modernisation of the NHS.

The next sections of the chapter focus specifically on the data obtained during the interviews with the women and midwives in phases one and two of the study.

### **'Knowing'**

The definition and significance of 'knowing' was explored in Chapter 2, in particular the notion that this is a component of a relationship that develops over time (Page, 1998, p.731; Stevens, 2003, p.307; McCourt and Stevens, 2009, p.18). Women 'knowing' their midwife and midwives 'knowing' the women to whom they were providing care were key issues identified in the data and included 'knowing' as a pre-requisite for trusting and establishing a meaningful relationship.

#### *Women 'knowing' the midwife*

From the interview data the women's words suggested 'knowing' the midwife was an important aspect of their care and they assumed that one midwife would provide all their care, for example:

*"...whereas at least with [the midwife] she knows everything that she needs to know so I'm not going to have to repeat myself all the time..."*  
(W9.1, p.8).

Avoiding repetition of information was understandable since it had repercussions for both the nature of the relationship and care delivery. Relationships with others, particularly midwives, may be undermined if women feel that their particular issues have not been remembered. It also offers more time for discussion if previous details do not have to be revisited. Stevens (2003) highlighted the importance of this for care delivery so that information was continually built upon in subsequent visits.

However the woman's relationship with the midwife encompassed more than just 'knowing' about pregnancy and childbirth:

*"...because at the first [pregnancy] I was just getting to know her but I feel like I know her and she knows [the toddler] as well..."*  
(W25.1, p.2).

This suggested the woman needed to know the midwife in some sort of personal way (Wilkins, 2000) and be recognised as an individual by the midwife. This was also expressed in relation to successive pregnancies and 'knowing' the wider family.

There were also examples of women not 'knowing' the community midwife:

*"...so I saw another one...she was very nice but she didn't know me so I never know who I'm going to see when I get down there..."*  
(W6.1, p.9).

It was clear from the data that whilst most women stated that they 'knew' their community midwife, they did not articulate what this 'knowing' meant to them.

Furthermore, 'knowing' did not extend to the midwife who subsequently provided their care in labour and at the birth.

Many of the women expressed a preference, or assumed that their community midwife would be with them during their labour and birth (Perkins and Unell, 1997), whilst those in second and subsequent pregnancies were aware that this was unlikely:

*"...I would have preferred it if it had been [the community midwife] because obviously I had got to know her and she had got to know me ...but yes I think I did know [the midwife would be different] once I got to the hospital I thought well anybody could help me, but yes, I would have preferred my own midwife..."*  
(W25.1, p.6).

The significance of 'knowing' the midwife in relation to a planned home birth appeared unclear. One woman who started labouring at home, anticipating a home birth, commented:

*"... [the midwife] was fantastic, she was just, it was just a real shame because she was the only person in the team I hadn't met..."*  
(W1.3, p.2).

This quote not only highlighted the complexity of defining 'knowing' as it was equated with 'having met before' (Perkins and Unell, 1997) but also demonstrated one of the difficulties identified with team schemes, that 'knowing' or meeting all the midwives in the team was problematic. However, another woman who was planning a home birth stated that 'knowing' the midwife was not significant for her:

*“...it could be anybody so I might have met the midwife or I might not...I'm not bothered about that really...”*  
(W5.1, p.3).

Therefore women were unlikely to 'know' either the hospital or community midwife who provided care in labour. Interestingly when interviewed postnatally, some women related that 'knowing' the midwife during the birth was not important though some expressed the view that they wanted the midwife who was with them at the birth to be an expert. This is a minimal expectation, given that qualification is supposed to ensure expertise. This suggested that personal 'knowing' in this context was less important than the expert knowledge of the midwife and is addressed later in this chapter.

From this study, women mostly 'knew' their community midwife but did not 'know' or had never have met the midwife who provided their intrapartum care. These findings reflected the consequences of the local organisation of maternity care at the time; whether this mattered is an interesting question. Some of these women later stated that it did not but it was unclear as to why they said this. It could be surmised that if women had never experienced care from a 'known' midwife they were not in a good position to comment on it or they adjusted their expectations to fit with what was provided. Lipsky (1980, p.53) made a similar comment in relation to citizens resigning themselves to inferior levels of service. Therefore in order to make sense of what they experienced and of course providing that they were attended by a midwife who was kind and competent then this might be their only conclusion.

*Community midwives 'knowing' the women*

In this study there was some evidence to suggest that 'knowing' women and the opportunity to build relationships with woman was as important to the community midwives as to the women (for example Brodie, 1996; Sandall 1997, 1998; Hunter, 2004):

*"...you've developed a relationship with them antenatally to look after them postnatally..."*  
(MW20, p.2).

They were able to give some information about what 'knowing' entailed and they recognised that 'knowing' the women enabled them to build up a relationship for the duration of the pregnancy and postnatally and heightened their feeling of responsibility:

*"...I also think you get to know your women really well and you feel more a sense of responsibility for them when they are in your case load..."*  
(MW13, p.4)

The sense of responsibility was highlighted here though Stevens (2003) noted that the significance of responsibility has been overlooked in the literature. This same midwife was able to draw on her previous experience as a hospital midwife and compared it with her current experience in the community and commented that:

*"...I always felt that as a hospital midwife, as a delivery suite midwife, [you] got to know the woman well while they were on delivery suite, because you do, you're forced to,,,,, you're looking after them on a one-to-one basis, but I don't think I got to know them as well as I do when I see them throughout antenatal and postnatally..."*

(MW13, p.5).

This suggested some degree of continuity throughout pregnancy and after the birth and the community midwives were also clear that continuity of midwife between pregnancies was valued and that they got to 'know' the woman and she got to 'know' them:

*"...I've looked after women two, three, four times at least, some of them more...but I do think that they like to know the midwife, not necessarily the one that delivers them, but the midwife that's giving them the biggest part of the care..."*

(MW16, pp.19-20).

This explanation of 'knowing' and the link with 'continuity' focuses on the antenatal and postnatal components of care and the relationship over subsequent pregnancies but does not give any explanation for not offering intrapartum care. Expectations thus fit with the service provided.

The community midwives were very clear that this relationship must be maintained throughout and talked about the effort needed to sustain relationships with women:

*"...you've got to give a lot of yourself, it's exhausting. You come home drained not physically but mentally...we've got to see them again throughout their pregnancy and possibly the next pregnancy so you've got to make amends, so if you've had a bad meeting with them or a bad appointment you've got to get over that haven't you?..."*

(MW27.1, p.20).

The midwives here were very much aware that unless the relationship was maintained ongoing access may be denied. The "emotional work" required by midwives in

sustaining their relationships with women was described and explored by Hunter (2002) and Deery (2003). This also demonstrated that for community midwives, the women formed their primary reference group.

The paradox here was that despite the emphasis on 'knowing' the client the community midwife was not the midwife in attendance at the birth:

*"...if you ask a woman at antenatal who she would like to deliver her baby she obviously says the midwife she knows but if you ask her after she's had the her baby did it matter that you didn't know the midwife in labour she'll tell you no it didn't..."*  
(MW27.1, pp.13-14).

This may or may not have been made explicit to the women antenatally and depended on whether the woman asked the midwife directly if she would be there at the birth. Such low expectations were also highlighted by Page (1998) and she challenged this notion that women are satisfied as long as someone is 'kind to them', saying that this is not true, and that the profession needs to become more honest.

#### *'Knowing' the midwife at a home birth*

Unlike the data from the women, for the community midwives 'knowing' the midwife for a home birth appeared to be more important than 'knowing' the midwife for a hospital birth. However there was no guarantee that the community midwife who undertook the majority of antenatal care would be the midwife in attendance for the labour and the birth at home. One community midwife stated that:

*“...I find it more disappointing with women that are having home births because their expectation of having somebody they know at the birth is greater than someone having a birth in hospital...”*  
(MW28.1, p.10).

The community midwives expressed great flexibility with regard to postnatal visiting but less over the possibilities for providing intrapartum care. They clearly valued ‘knowing’ the women and were also aware of the difficulties in providing antenatal or postnatal care or visiting women, whom they did not know, on behalf of colleagues; but they made little comment about not providing intrapartum care for women and no comment about problems that midwives on the delivery suite may experience in giving care to women they did not know.

Since not all women stated retrospectively that knowing the midwife who was present at the birth was important, many midwives appeared to accept the current system, an example of “what is must be best” (Porter and Macintyre, 1984; van Teijlingen et al., 2003) (and which is addressed later in the chapter) rather than challenge it, and used the system of care to limit women’s expectations. However, those midwives who had previously experienced getting to ‘know’ women and offered the full spectrum of care had a different understanding of ‘knowing’ and some awareness of the fragmentation of the system that they worked within.

*'Knowing' women on the delivery suite*

The concept of 'knowing' in relation to the midwives working in the delivery suite was problematic as it was highly unlikely that the midwives 'knew' the woman that they cared for; for example:

*"...sometimes they've [the women] not got to know the midwife who's looking after them on the labour ward"...but sometimes you can really, you get chatting...you can build up quite a good rapport in a short time..."*  
(MW21, p.6).

Significantly the midwife's words here suggest establishing a rapport rather than 'knowing' , but this again raised the issue of time, particularly a lack of time and if a woman arrived on the delivery suite in established labour, there was sometimes little time for gaining this rapport or becoming familiar with the woman's particular situation:

*"...I mean I'm sure some people do get to know the midwife in labour if they are in there for a long time and they are in early labour then that same person may look after them but if they are in advanced labour you just look after them and they just want someone to be kind and efficient and caring. But with the time span there isn't time to build up that relationship..."*  
(MW27.1, p.17);

This comment above by a community midwife highlighted the difficulty of establishing a relationship with a woman who was already experiencing painful contractions but none of the hospital midwives interviewed made any comment about not 'knowing' the woman in her pregnancy or being able to follow the care postnatally.

If a woman was admitted and the hospital midwife recognised from the notes that she was involved in a previous labour and birth then the midwife may request that the woman was allocated to her again but some community midwives viewed this as no more than a coincidence. However, if a woman had been admitted to the delivery suite previously in the pregnancy and the same midwife was available, then efforts were made to allocate the same midwife and this was valued by the woman:

*“...that made you feel that she remembered you from Wednesday night...”*  
(W23.2, p.10).

The data suggested that being kind and sympathetic to women during labour was rated more highly than having a detailed knowledge of an individual woman's needs and preferences achieved through 'knowing' the woman in her pregnancy. This supports some of Fraser's (1999 p.103) findings that in the absence of their community midwife's care in labour, the midwife being good at her job and being nice and friendly were good enough alternatives. Arguably this was also easier for a midwife required to give standardised care. However, continuity of midwife between pregnancies appeared to be valued.

## **Trusting**

Trusting and trustworthiness emerged in the data from both women's and midwives' interviews. Women trusting midwives and midwives trusting or not trusting women are

addressed below but also linked with women's concerns about being believed which are discussed on page 245.

### *Trusting women*

So far the data has shown that for women 'knowing' the community midwife entailed some sort of personal recognition and relationship. However similar to Anderson (2000) the women also expected to trust their midwife:

*"...I trusted them you know, I thought I was in safe hands..."*  
(W4.3, p.7).

Anderson described how women needed to have sufficient trust in their midwife and that a skilled midwife provided a sense of security to facilitate the birth process (2000, p.101). However, Kirkham highlighted a continuum of trust and described a stage of predictability; when there is a lack of personal engagement between women and midwives, but that the women can expect or predict some type of uniform service and with involvement and thus some loyalty to the midwives within the NHS, similar to 'brand loyalty' (2000, p.238).

Although Hunter (2006) suggested that midwives are reluctant to criticise clients, some midwives in this study indicated they could not trust all of the women to whom they offered care and they sometimes made judgements, for example, about whom of their clients were not trustworthy in relation to attending appointments or heeding advice:

*"...you know which ladies you can trust, if you like, to ring you if they've got a problem...you would know the person you couldn't do that to. There are occasional ones that you*

*couldn't trust...she forgets her urine, she forgets notes, she forgets both, no she hasn't rung me back...this woman is not very organised, she's not really listening so I wouldn't trust her..."*

(MW27.2, p. 13, 15).

Thus rather than reciprocating a relationship of trust some midwives expected women to obey their instructions:

*"...listen to everything that you've said and they turn up with their notes with a specimen [of urine]..."*

(MW27.2, p.14).

Notions of untrustworthiness were considered in Chapter 2 but this example could also be compared with Parsons (1951) doctor - patient relationship which described the hierarchical roles and obligations of the patient and doctor rather than an equal reciprocal relationship.

Lipsky (1980) did not identify untrustworthiness but suggested that if clients refuse to interact the professionals will see the fault as lying with the client; *"If clients refuse to continue interacting the fault may always be attributed to the client"* (p.56) and he offers a list of stereotyping *"labels that imply the exit of the client are attributable to a defect of the client"* (p56).

The notion of stereotyping of childbearing women can also be used to explore notions of trustworthiness. Although some form of categorisation may be considered inevitable when meeting people for the first time (Green et al., 1990) and seeking to apply professional knowledge (Kirkham et al., 2002a), this may well cause difficulty if the midwife has labelled women negatively and made decisions based on such stereotypes

without understanding the reasons for apparently untrustworthy behaviour. Kirkham et al., (2002a) suggested that midwives do this for various reasons but this may include the women posing a threat to the smooth running of the service or using more time or resources than normal.

### Time to trust

Midwives also identified the need for time for women to establish trust in them so that they could 'open' up to the midwife and disclose information. However, this was sometimes variable since there were instances where a midwife thought she 'knew' the woman but had missed significant information:

*"...no she didn't tell me that... [the woman had experienced bereavement and had attended a family funeral the day prior to the induction of her labour]..."*  
(MW29.2, p.11)

However, this midwife had previously indicated that *"...you can't sort of force the issues; you're relying sometimes on people disclosing things to you..."* (MW29.1, p.9).

This suggested that in relation to 'knowing' and trust time was both absolute and relative. Time is important in building relationships with women (Deery, 2008) and without this women may feel unable to disclose information; however there is no set timeframe for this to happen and the demands of the service may preclude this from happening (Dykes, 2006; Deery, 2008).

## Care and Caring

### *Women's views of care and caring*

Chapter 2 discussed the ways in which the terms care and caring were often used and some concerns that midwifery care continues to be undertaken as a series of tasks with a focus on checking rather than listening (Kirkham, 2002). When I explored the notion of care and caring I was concerned that the initial responses had little to do with caring as I noted in a memo as follows:

*“Care means the options for care – the options for care/frequency/type of care but nothing to do with caring”*  
(Memo 7.10.03 – W24.1, p.3).

In this context the word care is used to describe the service offered, there is therefore confusion when care as a concept is being discussed. However, the women were able to describe the content of caring episodes and the behaviours that they perceived as caring or uncaring.

### Caring and uncaring

Women wanted personal and individualised care and one described her hospital experience as follows:

*“...when you're on the ward you're de-individualised...I heard them refer to me a few times as number five, as in room five, has number five had her so and so tablets yet? And so that's how they refer to you...”*  
(W5.3, p.29).

In terms of caring behaviour the notion of familiarity with respect was highlighted by one woman:

*“...I expect to be treated with some kind of familiarity, not too many formalities but with respect and in a caring manner...”*  
(W5.1, p.15).

The feeling of being rushed and the need for more time was also an issue:

*“...it's like a conveyor belt isn't it. I want to be able to take my time, have a shower or a bath and just relax a bit...”*  
(W7.1, p.11).

These comments reflected the notion of assembly-line antenatal care as highlighted by Oakley (1980) that was still evident and also illustrated how time pressures confounded midwifery work (Dykes, 2006; Deery, 2008).

Sometimes descriptions of perceived caring and uncaring behaviour in the hospital postnatal ward included comparison with contemporary cases from the media; for example:

*“...and one of the other nurses [midwives] she was lovely and said to me...she put all these cushions round me and he was absolutely fine feeding...so I pressed the buzzer and eventually [another midwife] came swanning round the curtain...she just literally picked him up off me and walked off, just left me...I say it's Beverley Allitt<sup>27</sup> that...”*  
(M24.2, p.14).

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<sup>27</sup> This was a reference to a case where a qualified nurse who was given 13 life sentences for murdering and attacking children in her care.

These are quite contrasting episodes during the same shift which appeared to cause some distress to this woman.

### 'Being there'

In Chapter 2 I highlighted the notion of being with woman in pregnancy and childbirth. For one woman interviewed in phase one, 'being there' was described in relation to support, particularly in labour; for example:

*"...someone's there to support me...they will be gentler and kind...to look at me as a person and help me emotionally... be there for me..."*  
(W5.1, p.12),

This demonstrated the empathetic and emotional dimension of the 'knowing' relationship that was identified in the previous section. The notion of being supported in labour was highlighted by Lavender et al. (1999, p.42) as crucial to women's positive experience. 'Being there' for the woman was also reported by Fraser (1999, p.103) as of importance and part of the special relationship between the woman and midwife. This was further highlighted by Leap (2000) who suggested that the midwife works alongside the woman in a unique position throughout the life event of childbearing (p.4); however this requires the midwife to trust the woman, not just to obey instructions, but to birth her baby. This challenges the midwife as "expert" role which is held by many midwives and discussed later in this chapter.

### Sympathy – “I think they tried their best”

When commenting about a midwife who was not helpful or caring women sometimes attempted to offer some explanation; for example:

*“...I felt at times that they didn't seem to be bothered, but obviously there was a lot going on because there are so many people there. I think they tried their best...”*  
(W8.3, p.9).

This highlighted the way in which women excused bad behaviour or poor care, an example of how women resigned themselves to inferior levels of service (Lipsky 1980, p.53) and sometimes sympathised with the pressures of work experienced by the midwives (Kirkham and Stapleton, 2004, p.133). Kirkham and Stapleton explained that women viewed midwives as an oppressed powerless group and therefore reduced their expectations of the midwives.

### 'What is must be best'

Sometimes the women could not articulate their expectations but expressed satisfaction with what they had:

*“... when it's your first you don't want to rock the boat, you don't want to put your foot down and say you want this or that...”*  
(W22.1, p.7).

Here it appeared important to keep staff on their side and not to 'rock the boat'. In the absence of being able to say what they wanted or being offered any other choices it

appears that what they have must be best (Porter and Macintyre, 1984; van Teijlingen et al., 2003). The “package” of care carries considerable authority and is usually seen as “best” because it is designed by experts.

This notion of ‘what is must be best’ ( Porter and Macintyre, 1984) was revisited by van Teijlingen et al., (2003) and they concluded that women’s experiences were shaped by what they knew and that any responses made with regard to satisfaction with care were affected by what they had experienced or come to expect. Thus while they acknowledged that satisfaction surveys had a part to play in shaping services they recommend using them with caution. This also fits with the examples of women tailoring their expectations to fit the service, see above.

#### Checking not listening

Both antenatal and postnatal care, whether undertaken in the community setting or in hospital, appeared to be perceived as a series of necessary tasks (Methven, 1989; Leach et al., 1998 Kirkham et al., 2002b;), indeed these were sometimes referred to as checks (Kirkham et al., 2002b):

*“...she was sort of just a quick check, listen to the heart, feel at my stomach and then I was out of the door...and one particular time I was quite concerned...and I wanted a lot of questions answering but she just seemed like she didn’t want to know...so I was quite hurt...”*  
(W8.2, p.15).

Kirkham et al., (2002b) described how midwives prioritised certain activities such as checking, measuring and recording findings over addressing women’s psychological and

emotional needs. This suggests that at times women's questions may be overlooked and opportunities missed for listening to their concerns and offering support (Edwards, 2005). This has more in common with medical interventions (Al-Mufti et al., 1997) than the more discursive encounter that might be expected by women of the midwife (Kirkham et al., 2002b).

### *Midwives' Views of Care and Caring*

Although I asked all the midwives their general views of care and caring I did not get any responses that explained care in any philosophical way. One hospital midwife stated that giving good care was important because "...you want people to have a nice experience...you want to give good care..." (MW36.1, p.3) but the 'nice experience' and 'good care' were not defined further. It may have been that similar to Woodward's findings (1998, p.7-23) that they found difficulty in articulating their knowledge or it may have been closer to Bryar's (1995) findings that there is a lack of theory development in midwifery.

### Midwives' views of 'woman centred care'

When I asked the midwives in phase one about their understanding of 'woman centred care' their responses were more specific; for example:

*"... my understanding of woman centred care would be ... the woman herself being involved more in her midwifery care, antenatally and certainly delivery and postnatally... [and she has] informed choice..."*  
(MW21.1, p.1).

This signified the woman's involvement in her care and thus the potential for self-determination (Homer et. al., 2008, p.xvii) but the midwife later offered various reasons as to how women's choices and expectations may need to be modified in relation to clinical requirements such as electronic fetal monitoring or the use of an intravenous infusion which may constrain mobility.

*".. I think woman centred care is really ... where the care that is given to people is actually centred around the woman... allowing her choice, continuity with other midwives, obstetrician, the people that she meets, the GP and things like that..."*  
(W20.1, p.1)

This statement encompassed choice and continuity of care and the potential collaboration with others (Homer et.al., 2008, p. xvii) however the use of the word 'allowing' is rather worrying since it suggested that someone has the power to 'allow' or limit the woman's care (Cronk, 2000, p.21). The use of such language is further addressed in Chapter 7.

However, another midwife explained 'woman centred care' in relation to the provision of care within available resources:

*"...I mean I feel total women centred care should be having it [sic] just as they want, but I really don't think that could work for everybody because you might get such diverse ideas on what women want and a lot of them might want you to go and do visits at home for instance, I don't think that would be feasible for everybody, so I think it's doing the best for the women within the resources that we've got.."*  
(MW17.1, p.1).

In this statement there was an acknowledgement of the diversity of women's needs and the limitations and perhaps acceptance of finite resources. However there was little recognition that the system may need to change in order to accommodate such diverse needs (Homer et al, 2008, p.xviii).

### Satisfaction and complaints

Community midwives sometimes asked women about their experience of the birth and the care they received, however the woman's satisfaction was often equated with having no complaints; for example "...she was quite happy with it...she never complained..." (MW27.2, p.1).

This may of course be true but there might be other factors worth exploring in relation to this statement. It may also reflect that since the woman has nothing to compare her care with then what she has experienced must be best (Porter and Macintyre, 1984; van Teijlingen et al., 2003) or that as experts, the midwives know best (Bluff and Holloway, 1994). Not complaining may again be a mechanism whereby the women, recognising the pressures on the midwives, attempted to protect them (Kirkham et al., 2002b). However, claiming satisfaction should not preclude trying to further improve the standard of care.

If a woman had a bad experience or wanted to complain, the community midwife often addressed the issue first; for example:

*"...I mean obviously she could write a formal complaint and it would be looked into but if she feels she's told me and she asks me and I would say to her I'll go and have a look at your notes and see if there's anything I can*

*comment on...but sometimes by talking through things with us I find they don't take it any further..."*  
(MW31.2, p.8).

This type of debriefing may be viewed in two ways. Firstly, it may be helpful for the woman in understanding what has happened to her during her maternity care, and secondly it may be the means whereby the maternity care service is protected from potential litigation.

#### *Professional care - experience and competence*

Although being able to trust the midwife who attended the labour and birth was not explicitly raised by the women, midwives felt that women were concerned that delivery suite midwives were the 'experts':

*"...so in hospital the expectation is that it is somebody who is going to be an expert at delivery and as long as it's someone that's nice and somebody that you can talk to...somebody that is going to be there hopefully throughout the labour from the beginning to the end then it really doesn't matter if it's somebody they don't know..."*  
(MW28.1, p.10).

The women often used the term professional and professionalism, although they did not define the terms specifically; *"...she's [the local midwife] been very helpful and professional..."* (W4.2, p.5).

The acknowledgement of midwives' experience and competence or professional competence was also suggested by other authors (Bluff and Holloway, 1994, p.159; Halldorsdottir and Karlsdottir, 1996).

In this study the women wanted and expected the midwife to be both competent and experienced; “...I mean I’m happy that they’ve been trained that they’re competent to do it...” (W2.1, p.7) and “...the most important thing is to have an experienced midwife...” (W4.1 p11).

Not all of the women mentioned the need for midwives to be experienced but for others this may have been an implicit assumption (Fraser 1999). The expectation of professional competence assumes that as professionals, they have received appropriate education and training and as a consequence they have knowledge that the women themselves may be lacking – and leads to the belief that the professionals are the experts (Bluff and Holloway, 1994, p. 159). Cronk (2000, p.23) encapsulated some concerns of professional status and the inherent power that resided in expert knowledge: she stated that the common perception was that the midwife knew best and if not then the GP would know best but that ultimately the obstetrician knew best how pregnancy should be managed.

#### *The expert view of care*

The hospital midwives also valued the expert view of intranatal care rather than knowing gained from a relationship developed over time, as exemplified by the following observation:

*“...[the midwife said] she felt that in labour women deserved somebody who was an expert in that area rather than a community midwife who perhaps did one delivery a year...”*  
(WB25, p.6).

This emphasis on expertise, particularly in one aspect of care, reinforces the fragmentation of care rather than a more holistic approach and the use of basic skills:

*“...I think we’re certainly geared up to, we’re more technologically geared up here...we’re all into monitoring and infusions and that...community midwives, certainly relying on just their own basic skills and sometimes...they rely on their instincts...”*  
(MW21, p.15).

This also suggests that technology was preferred over more intuitive approaches. Although not raised by the women or the midwives, it could be argued that the lack of a detailed knowledge of the antenatal history and previous births makes it more difficult for the midwife to provide appropriate care in labour and meant that labour and birth was viewed by the midwife in isolation.

Graham and Oakley (1981) discussed how doctors viewed childbirth as an isolated patient episode and in viewing labour and birth separately, albeit with midwifery rather than obstetric care, imposes a more fixed medical approach to care with a divided workforce (Sandall, 1995) that may be perceived as elite.

## **Qualities of the Midwife**

### *Women’s views*

The qualities or attributes of midwives were evident throughout the data. The women’s views of midwives were unequivocal and were expressed not only in positive terms, what they should be like, but also in negative terms; that is what they should not be.

Similar to Homer et al., (2008b) the data encompassed both personal qualities and professional capacities although the sub categories within them from this study were not completely congruent with Homer et al.'s findings. The women themselves did not particularly differentiate between them.

#### Aunties, iron ladies and traffic wardens

The women's words suggested the type of midwife they preferred and terms such as nice, approachable, friendly and human were noted; for example; *"...I mean [the midwife] is really nice, very approachable..."* (W22.1, p.2).

The positive terms used by the women reflected those found in other studies, for example kind, friendly smiling and cheerful (Halldorsdottir and Karlsdottir, 1996; Pope et al., 1998; Fraser, 1999). Fraser (1999), in particular reported that it was of primary importance that midwives demonstrated these qualities (p.103).

One other comment suggested a combination of both personal and professional qualities; *"...a sort of auntie figure...somebody who...someone with lots of experience in that field..."* (W4.1, p.13). This woman viewed the 'auntie figure' in a positive manner as friendly and benevolent rather than in a negative way, but women sometimes had expectations that midwives might not be nice:

*"...I expected her to be old and grumpy...but...she was very bubbly, totally full of life, really with it, I don't know I must have expected an ogre or something. They're not like that anymore are they, not like the matrons you see in the carry on films..."*  
(W8.1, p.14).

This highlighted the power of media stereotypes that have influenced women's views and expectations. Although the term matron has seen a resurgence as the 'Modern Matron' (DH, 2001), a figurehead with responsibilities for the quality of care (Stanley, 2006), in the context of this study the meaning was derived from previous media representations which suggested a rather formidable and authoritarian character. This matches earlier ideas about the 'battleaxe' image of nurses (Salvage, 1982; Bridges, 1990). On this occasion the expectation was not realised, nevertheless another woman was concerned that certain midwives had rather different reputations:

*"...if she's nice and she makes you feel comfortable I'd be alright, cos some are a bit...some can be a bit iron ladies can't they? So I've heard..."*  
(W11.1, p.11).

This highlighted the expectation by women that they expected to feel comfortable and at ease in the presence of the midwife and this then enabled an open and trusting relationship. This mirrored to some extent the attributes of the 'warm professional' as described by McCrea et al., (1998). However, one woman was very clear that she had not liked the midwife who had undertaken her previous antenatal and postnatal care and had deferred her third pregnancy so that the midwife would have retired:

*"...the last midwife...she reminds me of a traffic warden, not a midwife, very cool...we did wait until we knew she'd retired to try for the baby because we didn't want her so much..."*  
(W5.1, pp.4-5).

This negative comment not only highlighted the woman's anxieties about one midwife in particular but also demonstrated how she altered her childbearing plans as she was reluctant to embark on pregnancy if she was likely to be cared for by this midwife. Traffic wardens are public service employees most often associated with implementing parking fines in a particularly bureaucratic way and fits particularly well with Lipsky's (1980) notion of street level bureaucrats. However, this type of behaviour was viewed by this woman as unacceptable in a midwife.

Analogies such as 'iron ladies' and 'traffic wardens' were powerful and highlighted a continuum from a friendly and aunt-type figure at one end via matron, to 'iron lady' and 'traffic warden' at the other. However, where negative comments were made, there was also some suggestion of some protection or defence of the midwife (Kirkham et al., 2002b), as women offered suggestions that the midwife may have been having a bad day or stated '*but she was a nice person*' (for example in relation to the 'traffic warden').

### Communication skills

In this study women highlighted the importance of communication skills and the ability of midwives to show concern and empathy and particularly to listen:

*"...the whole thing feels much more laid back and much more listening to what I want..."*  
(W1.1, p.2),

This woman was giving a clear message here about the importance of being listened to by the midwife. This entails giving full attention and active listening (Egan, 2008) to what is being said, and perhaps omitted acknowledging the woman's needs and preferences

regarding her care. The woman's statement about 'feeling more laid back' also suggests that time and presence is required for the listening process. Excellent communication skills were highlighted in Homer et al.'s (2008b, p.4) findings with particular emphasis on women being listened to by midwives.

An important component of communication skills included midwives' responses to telephone calls as their lack of success in getting a response from the midwife for information or guidance caused women concern:

*"...so I rang up and wanted to speak to her and left three messages and she still didn't get back in touch..."*  
(W3.1, p.5),

No reason was given by the woman for this lack of response on behalf of the midwife. Taylor (2002, p.189) reflects on similar behaviour observed in doctors and concludes that this demonstrated a lack of emotional and social skills.

Communication also encompassed the use of humour which was valued by some women in terms of putting them (and possibly their partners) at their ease, especially during admission to hospital in labour. Humour was also used in relation to highlighting woman's choice in relation to planning for the birth; for example:

*"...and [the midwife] was like well, 'I just let people get on with it you know and if she wants to deliver swinging from the light fitting then she can do that, if that's what she wants to do, you know, I'll be there to look after her', so yeah it was just great, it was a really good experience..."*  
(W1.3, p.6).

However, some literature has highlighted that the use of humour may be inappropriate and suggested that midwives may fail to respect women's choices or to have taken women's concerns seriously (Leap, 1992).

### Using personal knowledge

Sometimes there was an assumption that the midwife, had children of her own and that this personal knowledge helped in her work:

*"...she'd [the midwife] understand wouldn't she? Another woman that had given birth would understand what you were going through..."*  
(W23.1, p.11).

Although the assumption about having children was made, sometimes the fact that they did not was also recognised:

*"...you assume that they've had children and been through it themselves...so they've got that experience...I'm sure there are midwives who haven't had children..."*  
(W10.1, p.15).

One woman also asked during the interview whether I had children and assumed that I did. Although Bewley stated that at some point in a woman's relationship with the midwife the question is asked about whether the midwife herself has children (2000, p.169) she did not comment on the significance of this from the woman's point of view.

### Is gender important?

Many, though not all, of the women expressed a preference for a female midwife indicating that a female midwife knew what another woman needed; , “...*women know what woman need don't they...*” (W5.1, p.13). This was linked this to issues around privacy and intimacy and therefore they preferred their midwife to be female:

*“...it never entered my head that it might have been a man, I'd have been horrified at the thought...”*  
(W12.1, p.9).

However, for one woman, the gender of the hospital midwife appeared to be less of a concern than the community midwife; “...*I think I prefer like...I think the community one to be a lady [sic]...*” (W22.1, p.14). The assumption was that female midwives had experienced childbirth themselves and thus had personal knowledge. Similar to Wilkins (2000, p.29), some realised that they had no explicit reason for such a preference and suggested it was perhaps a ‘sisterhood’ thing:

*“...just that some sort of sisterhood thing...it comes down to gentleness...somehow you expect to be treated more gently from women...a softer approach...”*  
(W4.1, p.13 -14).

However it was assumed that even if the midwife had not experienced childbirth women expected that she knew what it was like and would dealt gently with them.

Another woman commented that she assumed the midwife would be female but acknowledged that that may be sexist. There was also a paradox in so far as some

women were happy with a male doctor but expressed concern over the possible attendance by a male midwife:

*“...I’ve been to my [male] doctor with all sorts of problems and it don’t bother me...there again if there’s a male midwife at the birth now that’s another question...”*  
(W8.1, p.11).

The importance of gender was also recognised in Fraser’s study (1999, p.103) where almost fifty percent of women expressed a preference for female caregivers. Also, in that study most women stated they would accept a male doctor if necessary but would not like a male midwife.

*Midwives’ views on the qualities of midwives*

#### Being kind and approachable

Community midwives commented on the qualities that women looked for in a midwife and similar to the women used terms such as kind, approachable, friendly and linked this with being professional:

*“...somebody who is kind, approachable, friendly and good at what they do I suppose, caring...they [the women] mention professional but they mention every time something about you, [your] personality, your kindness, your sense of humour, your cheerfulness, whatever that is, that’s the bit that they appreciate as much as you being professional...”*  
(MW27.1, pp.13,16).

This statement highlighted the importance of both the professional and personal qualities needed by the midwife and that both are valued by the women. They also commented similarly on the need for women to feel comfortable with the midwife as this was closely linked to 'knowing' and being able to establish a relationship.

One midwife commented on possible misconceptions about the midwife; for example:

*"...I think they have a lot of misconceptions...like bike pushing, lady on the community, popped in helped you have your baby and went home again...that's a lovely job, sort of like so easy working in Tesco's, I don't think they quite see it as a professional job...we're not held in the same esteem as other professionals..."*  
(MW19, p.12).

However, being a community midwife appeared to be different to being a midwife in hospital; for example:

*"...be approachable, being a community midwife you've got to be different, you're going in to people's houses and you're part of the family...and you share something of yourself, they tend to know that we've brought families up they know a bit about us so they know that you are a real person and not just a midwife..."*  
(MW27.1, p.15).

This giving of oneself was also discussed by Wilkins (2000) when she identified the type of relationship between the community midwife and the woman to whom she is providing care. This statement also raised the issue of women having some personal knowledge of the midwives, in particular whether or not they had families of their own.

### The midwife as go-between

The community midwives not only recognised the importance of communicating with the women but also that these skills were used in a variety of ways. For example, the women sometimes perceived the midwife as a 'go between' and used the midwife to clarify or explain what the doctors said:

*"...I think they see the midwife as a carer, a friend, a sort of go between, between the doctor and herself...then they ring us up and either they're not happy about something or they tell us, they don't understand what the doctors have said..."*

(MW14, p.14).

Another community midwife commented on being able to help the women:

*"...if they have any sort of problems with their social and they've no money, [I] try and sort it out and I think they appreciate that really..."*

(MW20, p.4).

This demonstrated how midwives have to communicate in a range of situations and that women viewed them as both accessible and able to do this. However, there were exceptions to this as seen earlier in this chapter (for example the iron ladies and traffic wardens), since it is often the communication problems that alienate some women from their community midwives.

### The 'Rottweillers' on delivery suite

Community midwives were also aware that women had anxieties about not being able to get on with the midwife who was allocated to them during their labour and suggested that this was something that was discussed in parenting education sessions:

*"...there is a fear that it's going to be somebody [in labour] that's not going to gel with them, somebody that they are going to have a clash with...that is discussed a lot in parentcraft, about what would you do if you have a midwife that you can't talk to..."*  
(MW28.1, p.10).

One of the delivery suite midwives confirmed this perception in the following comment:

*"...I just thought that midwives were really strange and I mean we are called Rottweillers you know...they call us Rottweillers on delivery suite..."*  
(MW36.1, p.15).

However, there was some awareness amongst the community midwives that women compared midwives and there was the possibility of a 'special relationship':

*"...the women I've talked to afterwards that haven't had that special relationship feel they have missed out on something...especially if they talk to a friend and they say oh I had a wonderful midwife..."*  
(MW28.1, p.11).

### Midwives' views of gender

Similar issues of gender emerged with midwives indicating that it was important that the midwife was female, and used their own personal knowledge:

*"...I just think there are a lot of personal things that women together can deal with better than if a man was involved as well...I don't think I would have wanted a male midwife looking after me..."*  
(MW13, p.13).

However, this midwife highlighted that there was nothing rational about this belief, but it was linked to the physical and intimate nature of the work:

*"...I think it's all about the physical thing, it's all about dealing with breast feeding, looking at stitches..."*  
(MW13, p.14).

For some midwives it was not important and they believed it was more to do with the attitude of the individual midwife. There was an assumption that the midwife, as a woman, knew what another woman needed:

*"...you're female so you can understand more of what another female is thinking or feeling...perhaps it does act as a barrier sometimes for the women you know, being looked after by a man..."*  
(MW14, p.17).

However, similar to Fraser's (1999) findings from women, discussed earlier, there was recognition that a male GP or obstetrician may be acceptable but that the role and work of the midwife was different and therefore a female midwife was preferred.

Midwives generally reflected similar qualities to those identified by the women; this included being a supporter and friend, a good listener, caring, sensitive and empathetic.

They also commented on sometimes needing to be a go-between, negotiator and interpreter. Sometimes qualities were expressed negatively, that is '*not being...*' and this included not being bossy or dictatorial or not caring.

### **The Woman – Midwife Relationship**

The midwife-woman relationship has already been documented and discussed by Kirkham (2000) and others (for example: Leap, 2000; Cronk, 2000; Wilkins, 2000; Edwards, 2000 and Pairman, 2000) who were particularly concerned with the nature of this relationship. It included the concept of 'knowing' but also involved the notion of 'cluefulness' (Leap, 2000) as midwives used their skills to respond to the various clues that women presented in their responses to midwives (Kirkham, 2000). The concept of 'skilled companionship', originally described by Campbell (1984) as 'being with' rather than 'doing to', has also been used by several others (Cooke and Bewley, 1995; Page, 1995).

The preceding sections in this chapter suggest that there are multiple components to the woman-midwife relationship. The concept of 'knowing' appeared to be key to this relationship and included the personal and professional knowledge of the midwives of their client group built up over the period of the pregnancy, after the birth, and over subsequent pregnancies, and a personal and supportive relationship (Wilkins, 2000). However, this personal relationship was not consistently developed or sustained for the duration of the childbearing experience because the main relationship was between the woman and the community midwife and this did not extend to labour and birth. Community midwives appeared to value the knowledge and relationship they had with women but did not always articulate its limitations with regard to labour and birth.

Midwives working on the delivery suite did not appear to talk about any difficulties of 'not knowing' the women for whom they provide care and the concept of rapport is used rather than 'knowing'.

The relationship between women and their community midwives also involved the establishment of a degree of trust between them. Kirkham (2000) highlighted the importance of trust between women and midwives and suggested this rested on common values even if a common viewpoint was not shared; the woman must feel sufficiently valued in order to feel safe in the relationship. However, from this data, although women appeared to trust the midwife, this was not necessarily reciprocated since midwives sometimes made stereotypical judgements about women's trustworthiness.

The community midwives described the way in which this relationship must be sustained over time and also recognised the sense of responsibility (Stevens, 2003) that was inherent within this relationship. Sustaining this relationship and its responsibility demanded emotional involvement, an important aspect of a therapeutic relationship (McCrea et al., 1998). However, it was not clear to what extent midwives or their managers recognised the importance of developing their understanding of emotion work to meet the needs of women and to improve their own working lives (Hunter, 2002; Deery, 2003).

The woman - midwife relationship also included a caring component that was both respectful and individualised and characterised for some women as the ideal of the midwife 'being there' for them, particularly in labour. The midwife was expected to have

professional knowledge and experience and sometimes there was also an assumption of the contribution of the midwife's personal knowledge (Bewley, 2000).

There were some additional factors that contributed to the woman - midwife relationship. Women commented on the positive personal qualities of midwives that can enrich this relationship and although they tried to avoid making overt criticisms their descriptions of negative qualities clearly impacted on their childbearing choices and experiences. The gender of the midwife also appeared to have some significance, since the woman - midwife relationship was perceived to be an intimate one for which a female carer was often preferred (Fraser, 1999).

Time clearly featured as a factor that may enhance the relationship and lack of time or the perception of busyness can impact on the nature of the relationships (Dykes, 2006) and the ways in which midwives go about their work (Deery, 2008). It may also affect the quality of care, as midwives, limited by time, focus on physical rather than psychological and emotional aspects of care (Kirkham et al., 2002b).

### **Midwife – Midwife Relationships**

Community midwives worked mainly in isolation but were located within small teams, comprising three, four or five members who did not always physically meet daily but who maintained contact with the hospital and each other to share the daily workload of visits and clinics. However, the relationship between community midwives appeared mainly collegial, supportive and positive though not stronger than that between the midwives and the women who formed their primary reference group (Lipsky, 1980, p.47).

The relationships between delivery suite midwives and their colleagues appeared stronger than that between them and the women they cared for, that is their colleagues formed their primary reference group (Lipsky, 1980, p.47). However, there was some evidence of tensions between hospital and community midwives. Delivery suite midwives normally only met a woman during the episode of labour and birth and, unlike community midwives there was no expectation or pressure for them to see any individual woman, or her partner, again, or to have any ongoing relationship beyond the delivery suite. Thus it was likely that the midwives who worked on the delivery suite become more familiar with each other and the co-ordinator and at times this appears to override individual relationships with the women who were cared for. However, as both Taylor (1996) and Kirkham (1999) pointed out the trust of colleagues is essential if midwives are to develop flexible responses to women.

### **Being 'With Woman' or Being 'With Institution'**

The empirical data presented in this chapter highlights both the women's and midwives' views and experiences in several areas that appear to be key to the concept of 'woman centred care', and contribute to what is described in the previous section as the woman –midwife relationship. However, this relationship was expressed and experienced at the level of the individual and tensions emerged when providing care within the differing settings and institutional norms that govern the maternity service.

The women wanted to know and trust the midwife who provided their care during pregnancy, birth and postnatal care and to establish a personal relationship but the extent to which this was realised was constrained because the organisation of care was traditional and fragmented and there were no opportunities to negotiate a different

midwife. It was more likely that some other strategy was used, for example deferring pregnancy. It was also apparent that women expressed satisfaction with what they had and may have concluded that 'what is must be best' (Porter and Macintyre, 1984; van Teijlingen et al., 2003).

Some of the midwives were able to articulate their understanding of 'woman centred care' which reflected the generally accepted rhetoric of the term and included the concepts of choice, continuity and control; however, certain qualifiers were added which suggested that choices and expectations sometimes needed modification. There was little understanding of changes to the system of care that may be required.

It was evident that policies, procedures, rules, regulations and risk management overshadowed midwives' practice and these appeared to be prioritised together with the consequent surveillance necessary to assure these. However, there was some variability as to how the policies and rules were viewed which was dependent on the midwives' sphere of work and there was also little movement of midwives between the spheres of work.

Community midwives appeared to offer a more personalised approach to women that appeared to go beyond the 'professional'. Furthermore, for community midwives, women formed their primary reference group and this will be discussed further in Chapter 8. They maintained greater awareness of the women's views and although they worked within the same policies, rules and regulations, these did not appear to cause the same pressures for them. They were, however, explicit about the exhausting nature of their work.

Delivery suite midwives appeared to work in an environment where policies, rules, regulations and surveillance were more important, however there was some belief that care was negotiated. Although they provided care to woman during labour and birth, this had limited options and was less personalised, with greater priority given to tasks associated with the process. Expertise was highly valued and the midwives perceived themselves as experts and did not comment about the emotional component of their work.

Hunter (2002) describes these as different occupational identities and ideologies but this is also suggestive of rather fundamental differences in philosophies of childbirth within the same institution. However, this is not necessarily about differing philosophies between midwives, even when apparent. Midwives working within the NHS face difficulties trying to meet the needs of women within the obstetric hegemony and are caught between women, colleagues, employers and the policies and procedures that frame their daily work (Edwards 2005). They are also working within a timeframe dominated by the organisational demands to achieve targets and rationalise services (Deery, 2008, p.3).

In this chapter I have highlighted the nature of the woman – midwife relationship and the midwife–midwife relationship and begun to outline the tensions that confounded daily practice for the midwives. In the next chapter, I revisit the concept of ‘knowing’ and explore how this impacts on the notion of continuity both from the women’s and the midwives’ perspectives. I shall also consider the contradictions encountered when trying to ensure continuity and the implications for practice that this presents with regard to the organisation of care.

## **CHAPTER 5**

### **CONTINUITY OF CARE**

#### **The Link between Knowing, Care and Continuity**

Chapter 4 focused on how women expect to 'know' the midwife who offers care and the ways in which some of the midwives talk about 'knowing' or having knowledge about the women to whom they provide care. The concept of care and how this was experienced was also discussed. Both of these concepts are inextricably linked with continuity. The main purpose of continuity of carer is that the woman gets to 'know' the midwife and that the midwife gets to 'know' the women in her care. Thus continuity, or seeing the same person over a period of time, should improve this knowing process and lead to care being more 'woman centred'. The various meanings of continuity and how this may be related to continuity of care or continuity of carer were highlighted in Chapter 2; for example continuity of carer may mean fewer caregivers or imply 'known' caregivers (Green et al., 2000) and Guthrie et al., (2008) talk about relationship continuity.

In this chapter I explore continuity both from the women's and the midwives' perspectives and consider the difficulties encountered when trying to provide continuity and the differences that emerged between community and hospital midwives. I also consider the concept of continuity in relation to the organisation of maternity care and question whether continuity can be negotiated. Finally, I review the significance of continuity for 'woman centred care'.

## Women's Views of Continuity

### *Seeing the same midwife in pregnancy*

Most of the women expressed a preference to see the same midwife throughout pregnancy and this supports the findings of Proctor (1998) and Hildingsson et al., (2002). Those women in their second or subsequent pregnancies made clear statements about this based on their previous experience; for example:

*"I'm hoping this time to see the same midwife each time I go to see a midwife ...where before I seemed to see a different one each time I think I saw about four and then completely different people for the birth and then completely different people on the hospital ward and then completely different midwife for the ten days after...it was a bit fragmented really... "*  
(W2.1, p.4).

This woman's earlier experience of fragmented care highlighted previous concerns regarding lack of continuity of carer in maternity care (for example Flint, 1989; House of Commons, 1992). The following quote demonstrated that improvement was still not being achieved for some women:

*"...I would like my midwife to follow me all the way through...I haven't seen the same one twice yet..."*  
(W6.1, p.10).

This comment articulated the woman's preference to see the same midwife on each occasion, which suggested the importance of interpersonal continuity (Saultz, 2003).

However although this woman stated that she would like the same midwife to provide her care there was no opportunity to negotiate this in any way.

One difficulty with the lack of continuity of carer is that it may have limited the nature of the discussion with the midwife; for example:

*“...the care that I have had from the midwives has been very fragmented...I think I’ve had about four, maybe five appointments with the midwifery team so I wouldn’t even consider talking about anything, my emotions to any of them and I don’t feel as if there is room in their schedule for that at all...”*  
(W5.2, p.11).

Clearly this woman felt constrained in her willingness to discuss emotional issues with any of the midwives and it is unclear whether any of the midwives raised them with her. However, this woman had earlier stated:

*“...I haven’t felt as if the midwives that I have seen have been approachable at all. I would never consider speaking to them like that at all..”*  
(W5.2 p.10).

One immediate consequence of this is that the woman did not receive sufficient emotional support, but it also questioned the nature and content of the interaction. As was seen in the previous chapter midwives spent more time checking rather than listening (Kirkham et al., 2002b) to women. However, it may also have signified midwives’ reluctance to engage with women in relation to aspects of care that they felt ill equipped to deal with in terms of time or skills (Deery, 2003), and partly because they were unlikely to see the woman again.

The expectation amongst the women studied fitted with the extant national policy that they had a named midwife (DH, 1991) who was responsible for their care on a continuous basis; there was an implied assumption here that having a 'named' midwife was sufficient to ensure such continuity of care but the span of such care was not clearly identified. Furthermore, this raised the expectations of women so that if this was not achieved may well have caused some difficulty:

*"... it's been difficult because my allotted midwife I've only seen twice...but the twice I've seen her she's been quite supportive..."*  
(W1.2, p.6).

Whether this woman was trying to defend the midwife is unclear or may be it helped to show that continuity of carer goes beyond the avoidance of repetition of information and highlighted the emotional aspects of care and the importance of the personal relational aspects of the interaction.

The concerns about continuity of care were expressed mainly by those women interviewed in phase 1 of this study. In phase 2, four of the five women who participated received the majority of their antenatal and postnatal care from one named midwife with normally one other providing care when the named midwife was not available. The fifth woman also had a named midwife, who provided some care but as she was allocated shared care she had attended appointments at the hospital so received care from hospital doctors and midwives. This reduced the episodes of care from her named midwife and consequently her care was fragmented antenatally. As the *Audit Commission* report (NPEU, 2007) suggested, effective assessment of continuity is

difficult and confounded by the different locations and numbers of health care professionals that may be involved.

*Continuity in labour and the immediate postnatal period*

Chapter 4 highlighted how the women did not normally 'know' or had met the midwife who provided care in labour; therefore there was no continuity of a 'known' carer in this context. This was confirmed during the observations in phase 2 of this study since none of the women were attended by the midwives who had provided their antenatal care.

Although the women did not 'know' the midwife who was allocated to provide care in labour they were appreciative when the midwife was able to be with her throughout the labour:

*"...I had the same midwife throughout the whole labour...so that was nice whereas [before] I was swapping, there were shift changeovers..."*  
(W6.2, p.4).

This highlighted one of the key challenges of providing continuity of carer to labouring women. Since the midwives worked shifts to staff the delivery suite their availability for individual women for the duration of labour and birth was limited to the designated shift times. In phase 2 of this study two of the women had normal labours and births which were completed within the time span of one night shift, therefore they each had one midwife who provided care and facilitated their births<sup>28</sup>. This is slightly better than the 1:5

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<sup>28</sup> A student midwife was also involved in the provision of care for one of the women

ratio indicated in the most recent Audit Commission report (NPEU, 2007, p.7) for women experiencing a normal labour<sup>29</sup>.

The other three women in this phase of the study experienced longer labours that spanned more than one shift and also resulted in interventions in the second stage of labour. Consequently there was more than one midwife involved in each woman's care and also other health care professionals (for example anaesthetist, obstetric registrar, paediatrician – see Appendix 5) involved during the labours and births. These findings also mirrored those of the Audit Commission (NPEU, 2007) which indicated that women who had longer labours, or those requiring medical induction, were more likely to have a greater number of midwives caring for them. Thus continuity of carer was extremely problematic.

Women were aware that midwives would leave at the end of the shift and commented:

*“...I know [the midwife] had to go when I was getting ready for the ventouse she had to go home and do something didn't she, and I wanted her back...”*  
(M22.2, p.21).

This suggested that this woman had been able to achieve some sort of rapport or relationship with the midwife and wanted to retain the support throughout her labour.

However, women were also aware that some midwives might stay over the end of the shift time to be with them at the birth:

*“...you know the midwife I had when [previous baby] was born was with me, she went over her shift to be with me because she had been with me from the start...”*  
(W23.1, p.7).

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<sup>29</sup> The Audit Commission stated approximately one in five women had one midwife caring for them during labour and birth

This highlighted a situation that many midwives face when working on the delivery suite, in so far that they may have established some sort of bond with a woman and wish to stay for the duration of the labour. This reflected the orientation of the midwife towards the woman and the accompanying sense of responsibility (McCourt and Stevens, 2009). It may also lead to greater personal satisfaction for the care given and, in the absence of any other continuity, may be valued.

There was no continuity of 'known' carer between labour and immediate postnatal care on the ward, though similar to Proctor's findings (1998) women appreciated being visited the next day by the midwife who had cared for them on delivery suite:

*"...I think it was really nice because the next day she [the delivery suite midwife] came in to see me..."*  
(W24.2, p.6);

The fragmentation of immediate postnatal care was also evident on the ward as seeing the same midwife appeared to occur by chance:

*"... but there was one, I can't remember her name, there was one midwife I really really liked she always came round to see how I was and then she wasn't there Thursday night and I wish she was because I was having a bit of a problem..."*  
(M26.2, p.9).

This woman was reluctant to ask for help during her stay on the ward and it was only when she returned home that she felt able to ask the questions and feel secure in the care of a midwife she had seen previously.

Although there was no continuity of carer between pregnancy and birth, women normally received postnatal care from the same community midwife who had provided antenatal care (Proctor, 1998) and the women were aware that community midwives tried to minimise the number of midwives who visited postnatally:

“...but [the midwife] said that they try and only do two different ones...”  
(W22. 2, p.13).

This was fairly well demonstrated in phase two of this study as, apart from midwives involved in antenatal preparations sessions, only those midwives who provided antenatal care for the women provided postnatal care. However, in this study women expected and preferred to see the same midwife throughout the antenatal period and often anticipated that the same midwife was in attendance when they went into labour although this was not always realised.

Fellowes et al., (1999) questioned how much of a priority it should be for women to see the same midwife throughout their care and cautioned against a literal interpretation of the performance indicators of *Changing Childbirth* (DH, 1993). However the use of the term priority may be problematic as it suggested that if continuity was viewed as a priority then something else had a lower priority and that was not helpful either.

Green et al., (2003) reported that continuity of carer was not a high priority for most women in their study but that the nature of the interactions was more important (p.24). Sandall et al., (2008, p.35) suggested that women do not want continuity improved in one aspect of care to the detriment of continuity in another. If 'knowing' the midwife and

developing a personal relationship is important to childbearing women then continuity of carer should be an integral part of the care package.

Continuity continued to be a component of the latest policy document from the Department of Health (DH, 2007). It reiterated the statement that every woman will be supported by a midwife she knows and trusts throughout pregnancy and afterwards so as to provide continuity of care (p.9). However, this commitment to continuity is embedded within the policy context that guarantees choices of maternity provision within relevant guidelines and national standards but is not explicitly expressed within the commissioning framework for providers.

### **Midwives' Views of Continuity**

#### *Community midwives' views*

Community midwives viewed continuity of carer as important but were mindful of the extent to which they are able to provide this; thus their focus was on providing antenatal and postnatal continuity:

*"...very [important] I think, or so woman tell me anyway. I mean as you know [here] we've had various schemes...and we've come down to the fact that continuity antenatally and postnatally and not doing the delivery..."*  
(MW27.1, p.13).

This was justified by reference to an earlier scheme which was undertaken and discontinued prior to this study.

However, one midwife, who had previously participated in the scheme which offered greater continuity of care, commented as follows:

*“...it would be nice in an ideal world to look after someone through the whole of the pregnancy, give good continuity of care antenatally, you know give intrapartum care and then continue...”*  
(MW29.1, p.11).

This suggested that continuity over the full spectrum of care was viewed as the ideal<sup>30</sup>, but the reality for the midwives was that it was seen as aspirational or even an alternative way of providing care (McCourt et al., 2006 p. 142).

However, another community midwife suggested that women may not want to see the midwife who supported and helped them birth their babies; for example:

*“...in fact sometimes [they are] quite pleased that they don't see that person again...they say things like oh I shouted and I was really embarrassed and I don't know what the midwife will think of me.....perhaps because they made a bit of noise or they didn't always do as they were told....”*  
(MW16, p.1-2).

This was also highlighted by Fraser (1999, p.104) who reported that one woman had said that she did not want to have care in labour from her community midwife in case she embarrassed herself. No women interviewed in this study raised embarrassment as an issue; however, an alternative interpretation of these comments might be that better preparation for labour was needed.

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<sup>30</sup> This midwife had participated in the earlier pilot scheme and experienced providing the full spectrum of care

Although immediate postnatal care in the hospital was undertaken by midwives that the women did not know, once they returned home their care was normally undertaken by the same midwife or midwives who had undertaken the antenatal care. However, it was also apparent that community midwives undertook postnatal and sometimes antenatal care, on behalf of their colleagues; for example:

*“...we cover for each other or we help each other out while somebody else is busy so we are often in other people’s, especially at weekends...”*  
(MW33.1, p.4).

This was not perceived as particularly problematic by this midwife, but it clearly impacted on overall continuity although efforts were made by the midwives to try and minimise the numbers of midwives who attended any one woman:

*“...we cover each other’s clinics, so we would try for them not to see more than two midwives, two different midwives during the pregnancy and postnatally...”*  
(MW16, p.11).

However, another midwife stated that though she managed to offer good continuity antenatally, it was different postnatally; *“...my patients antenatally have good continuity but postnatally it’s shocking...”* (MW28.1, p.8).

This appeared to be a particular problem for this midwife who worked part-time. However, this was not a new problem. These findings mirrored concerns that the implementation of greater continuity of care required greater flexibility and may therefore discriminate against those midwives who were unable to work full time (Sandall, 1995)

Midwives also appeared to use the strategy of selective visiting<sup>31</sup> to ensure that only one or two midwives visited a woman after the birth to aid continuity of postnatal care:

*“...Yes I would say, when do you want [your next visit].... or I would say if I'd got one of my own ladies and I'm not working the next day I'd say how do you feel about [not having a visit] tomorrow? I'll come and see you Friday before the weekend and if you're all right at the weekend I can leave you till next week...she might not want a visit... I said I'll see how you are on Friday...”*  
(M33.1, pp7-8).

The previous daily postnatal visiting meant that sometimes the midwives were not available, for example if they were taking days off or worked part-time, and therefore another midwife was required to visit. Thus by the use of some negotiation with individual women, not undertaking daily postnatal visits meant that postnatal work was better controlled and potentially fewer midwives become involved in the care of individual women care and greater continuity achieved. Conversely, the woman lost the possibility of midwifery care on the midwife's day off. However, the use of selective visiting reflects another mechanism highlighted by Lipsky that enables workers to control their work (1980, p.140).

#### *Delivery Suite Midwives' Views*

Delivery suite midwives viewed continuity differently. There was no mechanism for them to 'know' the women to whom they would offer care, however three strategies emerged from the interviews in relation to the provision of care or allocation of carer for the

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<sup>31</sup> Selective visiting was based on client needs and community midwives were required to use their judgement, in discussion with the woman, as to the frequency of postnatal visits, though normally this meant fewer visits.

women. Firstly, each woman was allocated a midwife who would provide care either for the duration of the labour or alternatively for the whole shift if labour spanned more than one shift.

Secondly, if a woman had been admitted to the delivery suite previously in the pregnancy and the same midwife was available, efforts were made to allocate the same midwife; this might entail some negotiation between midwives to achieve this. In phase 2 of this study one of the women attended the delivery suite on two occasions prior to her admission in active labour and seeing the same midwife was valued by the woman:

*“...that made you feel that she remembered you from Wednesday night...”*  
(W23.2, p.10).

Thirdly, if a woman was admitted and the hospital midwife recognised from the notes that she was involved in a previous labour and birth then the midwife may request that the woman was allocated to her again:

*“...but with a small unit...I’ll say I delivered her last time, I mean if that comes up we tend to say oh you had this woman last time you can have her again“...I’ve had one lady that I’ve delivered last week that it was her third baby and I’d delivered every one of them...you can’t get more continuity than that can you...”*  
(MW36.1, p.21).

The midwife viewed this as the ultimate exemplar of continuity; however some community midwives viewed this as no more than a coincidence. If allocating the woman to the same midwife was not possible then the midwife might make some contact with the woman herself:

*“...you look back into somebody’s notes and say oh I delivered her last time and just stick your head around the door and just say hello...”*  
(MW21, p.7).

No reasons were given for such a non-allocation but it does demonstrate how the demands of the institution sometimes took precedence over the provision of care. One midwife commented on this in relation to midwives having to be shared out:

*“...em, sometimes I feel it is organised for the hospital’s benefit, rather than for the woman. It’s sharing out midwives to see how many people you can look after at one time. It’s not always one hundred percent one to one care, which it would be ideal in an ideal world, everybody wants one hundred percent care from one midwife, don’t they? When they have a special time in their life they want total commitment, sometimes it’s not possible...”*  
(M19, p.2).

This midwife recognised the commitment that women wanted from midwives at this special time and also highlighted the difficulty in sometimes providing one-to-one care in labour let alone continuity of carer.

The midwives were not ‘known’ to four of the five women in phase 2 of this study and therefore none of them had any relationship upon which to base their care in labour or knowledge about the women in terms of the history of their pregnancy or any of the medical or obstetric factors or preferences for the forthcoming labour. The conventional model of maternity care, viewed by some as an industrial model or factory line approach (McCourt et al., 2006, p.143), maintained this separation of the phases of childbearing

and as a consequence midwives had to staff the service in its separated format and not the women for whom they provide care (McCourt et al., 2006, p.142).

As a result of her previous admission to the delivery suite one woman knew the name of the midwife who eventually provided her care in labour. Therefore the midwife had some knowledge about the woman's pregnancy. However, it is arguable whether just knowing the name of the midwife who provided care was sufficient. The delivery suite midwives appeared to accept the status quo and did not question the lack of continuity and as Edwards (2008) suggested contributes to the ubiquitous myth that women do not mind who cares for them in labour. This highlighted the challenge that such a change presented to midwives who have become used to responding to the regime of the institution rather than the needs of the women (McCourt et al., 2006).

### **Continuity and the Organisation**

Although *Changing Childbirth* (DH, 1993) was still extant during the period of data collection it is difficult to establish the extent to which the concept of continuity was reflected in the policies of the maternity services at the time. The changes in the services described in Chapter 4 focused on the overall structure and organisation of services rather than the detail of day to day care and this had some impact on the management roles in the organisation. Furthermore, similar to many others, the scheme that had been introduced to explicitly improve continuity of carer had been discontinued (Walsh, 2001).

One senior midwife, whilst commenting on her role, highlighted the Trust's policy priorities as follows:

*"...so I've got to be highly visibly and accessible to patients and staff, working the patch, being a resource for the midwives for information advice, being a resource for directorate on midwifery issues, looking at standards of care and then from the government agenda... the hospital food, working the patient liaison advisory service about patients concerns..."*  
(M32.1, p.8).

This demonstrated the change in the Trust's priorities and did not include specific reference to continuity of care or carer for women accessing the maternity services. However, as described in Chapter 4, antenatal care for women was organised using predetermined pathways of care. Although pathways of care in themselves do not ensure continuity (Haggerty et al., 2003) their implementation suggests midwife-led care pathways aid continuity of carer in pregnancy and to some extent continuity of carer postnatally. However, this does not address continuity of care on the postnatal ward and postnatal care is an area where many women are dissatisfied with the support they receive (Garcia et al., 1998). In this situation the pathway was one option within an otherwise traditional or standard system of maternity care. The midwives themselves tried to aid continuity postnatally by using the strategy of selective visiting. However, a known caregiver in labour was not ensured, either at home or in hospital and any continuity of caregiver was determined by the midwives themselves.

It was difficult to establish to what extent the midwives' workloads had increased between the two phases of the study and impacted on their ability to facilitate greater continuity of carer. Midwives themselves perceived they were busier; delivery suite

midwives with a higher turnover of women and community midwives with extra responsibilities:

*“...I’ve had a really busy spell ...and [the project leader] was concerned that perhaps my workload is increasing even more because they have a lot of other problems beside the drug addiction, lots of social problems and she’s looking at putting in a bid for some extra funding. I think if they give me some extra time for doing the drug liaison role then the rest of the team will end up taking on work that I can’t cope with... I don’t think they’ll provide any extra person to do it.  
(M30.1, p.9).*

This also highlighted how improving the continuity of care and carer for one group of women may impact on other women and the midwives who are providing the care. However, this view of an increased workload was not necessarily recognised by the senior midwife:

*“... We’ve taken on HIV and Hep B counselling and screening them antenatally which the community midwives have taken up. We’ve had the counselling after child birth, that’s still ongoing, so that’s changed, and breast milk audit that’s changed, but apart from that nothing else... Things that have happened in community that have changed, there’s the Sure Start...we’ve got a Sure Start area setting up and at ground level it involved community midwives, they might have had to go to the odd meetings, but they haven’t changed the working practices.... no they’re not busier. If you look at their figures for visiting, post natal contact, antenatal contact, if you look at the case loads per team they’re no different... well I would say they are no different from when I took over...”  
(M32.1, p5-6).*

This quote from a senior midwife indicated that she did not consider that these additional components of community midwives’ daily work meant that the midwives were

necessarily busier. Consequently this was a rather one dimensional view of the midwives' workloads, that of numbers of contacts and caseloads, which conflicted with the midwives' views. This suggested that the range of community midwives' work and the nature of the interactions required with women were not fully recognised. This type of work contributed to the increasing public health agenda of primary care but was carried out by midwives employed by an acute Trust (Walsh, 2001) whose pressures and challenges were rather different and constrained by the obstetric practices. However, it was noteworthy that this was the same senior midwife who described her role within the Trust on the previous page and it could therefore be questioned how much support that she received in order to facilitate and support community midwives' work (Brodie et al., 2008).

The conventional model of organisation of care in this setting prohibited any further continuity than was actually achieved and midwives were doing the best they could in the circumstances regardless of their personal ideals. Lipsky (1980, p.xii) commented that a large workload and busyness constrains the original ideals of street level bureaucrats. The development of these services with a medical model, centralised control and increased specialization has contributed to this organisation and Lipsky has highlighted that such specialisation permits street level bureaucrats to avoid seeing work as a whole (Lipsky, 1980, p.147).

If continuity of carer is to be achieved then clearly there have to be changes at the organisational level of the service (Guthrie and Wyke, 2000). This has been achieved elsewhere with the introduction of the One-to-One midwifery practice (Stevens, 2003) or caseload model (Sandall, 2001). However, either or both of these necessitate careful planning, organisation and appropriate and adequate support for the midwives (McCourt

et al., 2006). This means not only help and guidance with the practicalities of setting up such a service, but also with the longer term support of midwives who will be required to work in different ways.

As was seen in Chapter 2, as a result of service reconfiguration there have been more recent organisational changes to the way in which intrapartum care is organised on the site though these will not necessarily improve continuity of carer for women. Wider changes will be necessary if this is to be achieved. This raises the question of how such changes might be managed within the existing culture of midwifery (Kirkham, 1999) and dealing with resistance to change that occurs. One challenge is that the majority of midwives will not have experienced working in different ways and may find it difficult to imagine how the service could be organised differently. However, there are an increasing number of reports in the literature both nationally and internationally of different models of organisation of care, their implementation and some evaluations (Stevens and McCourt 2002; Sandall et al., 2001; Biro et al., 2000).

For midwives, and particularly their managers when large scale organisational change is needed, this means reviewing their philosophy of care for childbearing women, sharing their views and beliefs with regard to continuity (Brodie et al., 2008) and trying to negotiate the gap between the way in which they find themselves having to practice and the ways in which they might practice in order to achieve a greater congruence. One way of dealing with this is to work with local women to respond to their views and reported experiences (Lane, 2005); however if they express satisfaction with the status quo, because they have nothing else to compare it with, this adds a further challenge. However, satisfaction with the status quo (van Teijlingen, 2003) should not be a sufficient reason not to try and improve the service that is offered. Many of the women

will not have experienced a different type of service either but that should not prevent them contributing to the development of a service where greater continuity of carer could be achieved.

### **Can Continuity be Negotiated?**

At a simplistic level it could be suggested that continuity of care and carer could be negotiated; however as I have already discussed in Chapter 4 women had no choice in relation to the midwife who provides antenatal and postnatal care or intrapartum care and the frequency of consultations was prescribed by the designated pathway of care. There was no evidence of women challenging this or attempting any negotiation to improve continuity over the full spectrum of care. As Edwards (2008, p.465) has stated “women, their families and midwives tend to comply with birth policies and practices, rather than question them...challenging comes with a cost”.

There were one or two limited examples of midwives negotiating with women and their colleagues in relation to trying to improve continuity. There was evidence of midwives negotiating with women regarding the frequency of postnatal visits. Under the umbrella of selective visiting, a policy used primarily to ensure that midwife resources were used appropriately, that is only when clinically justified, midwives attempted to maximise continuity of carer and minimise the use of too many others by focusing visits on the days they were working.

On the delivery suite there were also some examples of midwives allocated to care for women who they had met during a previous admission or in a previous pregnancy. This required some negotiation between midwives, particularly with the midwife coordinator

responsible for allocating the work during the shift and ultimately depended on the prevailing institutional demands. It is evident that individuals have some small power of negotiation but in many cases they are making personal sacrifices and working around the system; the system is not adapting to them.

### **Does Continuity Matter to 'Woman centred care'?**

Continuity of carer continues to be a key aspect of discussions in relation to maternity care (Stevens, 2003; McCourt and Stevens, 2009; Sandall et al., 2008) and a key question that has emerged is whether continuity matters or not to 'woman centred care'. Conversely it may be worth considering whether 'woman centred care' can be achieved without continuity.

Green et al.'s (2000) review of the evidence suggested that women wanted consistent care from care-givers that they trusted and did not necessarily value continuity for its own sake, and their subsequent findings also suggested that it was not a high priority for women and that it should not be a major determinant for the way in which services are designed (Green et al., 2003). Hodnett's (2000) systematic review also demonstrated that continuity of care was beneficial, though suggested that the evidence does not show sufficient discrimination between continuity of carer or care provision.

Continuity has continued to feature in the policy documents that have been produced in relation to maternity services. In the NSF (2004, p. 6) continuity was mentioned twice; firstly in relation to continuity of support in pregnancy, childbirth and the postnatal period and secondly that all providers should develop community based continuity of care schemes for women of disadvantaged and minority ethnic group (p.14). The presence

of a named midwife was also mentioned twice: in relation to support in pregnancy (p.19) and recognising that women want one-to-one care from a named midwife to provide support in labour and at the birth and preferably one they have got to know and trust in pregnancy. Continuity was also highlighted in the most recent document (DH, 2007) though not explicitly mentioned in the commissioning framework and this suggests that, similar to Guthrie et al.'s (2008) findings, continuity is not necessarily rewarded.

McCourt et al., (2006) explored continuity of care and though they reflect the mixed picture of evidence to date they suggested that further research is needed on the experience of continuity and to examine whether it may be more important for some groups of women rather than others. They highlighted the various schemes that have been developed, such as one-to-one and caseload practice but also focused on the organisational changes required to provide personal continuous care to women and the inherent difficulties of achieving change in the system in order for this to happen. Although these are challenging they are not insuperable, but if continuity of carer is to be achieved then it is important that it's significance as a core value both at the level of the organisation and at the interface of care needs to be recognised and shared (Guthrie and Wyke, 2000; McCourt and Stevens, 2009) so that appropriate processes, designed to improve continuity, can be implemented (Haggerty et al., 2003).

One of the components of the concept of 'woman centred care' identified by Homer et al. (2008a), explicitly related to continuity of midwifery care:

"follows the woman across the interface between the institutions and the community, through all the phases of pregnancy, birth and the postnatal period, therefore involving collaboration with other health professionals as necessary"  
(Homer et al., 2008a, p.222)

These authors used a definition of continuity of care that explicitly meant care provided by the same midwife or by a small group of midwives who the woman gets to know throughout the pregnancy.

The findings from this study indicated that continuity of carer was not the norm over all the phases of childbirth and support Warren's (2003) statement that there were similarities to those documented elsewhere in the literature. The women expected continuity of carer through the full spectrum of childbearing but their experiences were variable with continuity of carer experienced in antenatal and postnatal care to varying degrees but not in labour. The women appeared to accept this and it could be argued that the women had low expectations and again were commenting on what they had experienced (Porter and Macintyre, 1984; Teijlingen et al., 2003).

The midwives too appeared to accept the limited interpretation of continuity within the system within which they were working and demonstrated the different emphases in pregnancy, labour and postnatally (Haggerty et al., 2003). It may be that this acceptance of the limitations of the system is necessary in order to reduce the strain and make their jobs psychologically easier to manage (Lipsky, 1980, p.141) and equated what existed with what was best to avoid confronting work failure (p.144). This strain may have come from the pace or volume of the workload or it may have arisen from peers who were unwilling or unable to deal with different ways of practice or to engage or invest in care provision that provided greater continuity and responsibility (McCourt and Stevens, 2009).

The use of pathways of care, even the midwife-led care pathway, has not contributed to the overall continuity of carer, though arguably there may have been some greater consistency of care, though as acknowledged by McCourt et al., (2006) this was still difficult to achieve in a fragmented system and the most difficult part of the childbearing continuum to facilitate continuity was the labour and birth. As McCourt et al., (2006) also suggested if this is to be achieved in the future then organisational change is required.

McCourt et al., (2006) raised concerns about continuity and the impact on childbirth outcomes and that this complex issue needed further investigation. What is not clear from this study is whether the three women in phase 2 who had longer labours and interventions in the second stage (ventouse and forceps) would have had different outcomes had they received care and support from the same midwives who had provided their antenatal care. The women themselves made no comment on this and neither did any of the midwives who were interviewed.

The women, not unsurprisingly, were pleased and grateful that their labours were over and that their babies had been born safely. Such gratitude tended to overshadow the reality of the experience and implied satisfaction even if there was none (McCourt et al., 1998). Consequently this reduced the likelihood of any consideration as to whether the outcome could have been achieved in a different way. That the midwives did not comment on the outcome is due possibly to the unrelenting pace of the task-focused work and little time or opportunity to reflect on the women's experiences overall. However, many midwives who have had the opportunity to work in schemes encompassing continuity of carer express great satisfaction with their work (Stevens, 2003; McCourt et al., 2006; Sandall et al., 2008).

In relation to 'woman centred care' it is conceivable that care might be focused on the woman without necessarily having continuity of carer throughout the full span of pregnancy, birth and postnatal period. However, for this to happen requires a clear and shared philosophy of care by all care givers; attention to detail in terms of identifying women's needs and preferences, documentation of these and ensuring that each carer address these at each episode of care. However, the increasing pressure for standardised care militates against care which is focused on the individual and sensitive to her views and needs. With continuity of carer, the likelihood of the women being 'known' to the midwife and the midwife being 'known' to the women facilitates the development of the relationship that will keep the woman's expressed needs and preferences central. However, for this to happen across the full spectrum of care requires enormous organisational changes so that midwives can be 'with women' rather than staffing the institution.

### **Emerging Issues**

Continuity of care has been a central tenet of maternity care policy and still forms part of government policy (NSF, 2004; DH, 2007); however it continues to offer an enormous challenge to providing woman centred maternity care and maternity services. At an individual level it appears relatively straightforward to expect that a woman will be able to access a particular midwife over a period of time, and get to 'know' her. However, this becomes more complicated when maternity services are provided to a number of women and the system that has evolved is centralised and more complex (McCourt et al., 2006).

Data from this study suggests that women expected to 'know' their midwife and to have continuity through pregnancy, birth and the postnatal period though this was not achieved. Fragmented care may limit women's disclosure of information. Similarly findings from the *Audit Commission* (NPEU, 2007) suggest that women who had longer labours and interventions had more care givers. Continuity means different things to community and delivery suite midwives. Community midwives recognised the importance of continuity but it was problematic for all midwives to achieve continuity within the system. Both women and midwives appeared to accept the limitations of the system of care and there was evidence of only one or two negotiation points. Similar to other findings (for example McCourt et al., 2006) the conventional organisation of care constrained the provision of continuity of carer across the full spectrum of care. Wide spread organisational changes will be required to address continuity of carer and negotiation may be required to bridge the gap between traditional ways of working and new ways to achieve greater continuity.

In the next chapter, I consider the problematic notion of choice and 'woman centred care' and consider both women's and midwives' views on choices available during childbearing. The realities of making or negotiating choices are explored and some of the factors that constrain choice are identified.

## **CHAPTER 6**

### **OFFERING CHOICE AND MAKING DECISIONS**

If 'woman centred care' is to be fully realised then women need to be encouraged to occupy a powerful, authoritative and controlling position in childbearing experience and play an active role in making informed choices about their care. Choice has been a key component of the consumer agenda within health care and continues to be a guiding principle of maternity care policy (Shribman, 2007; DH, 2007). However, as stated by Edwards (2008, p.771) choice is not straightforward and women are influenced by health care professionals, the institution and others around them. In order for women to make informed choices and decisions, for example in relation to the type of care, place of care or place of birth, they must have sufficient, timely and accurate information and the options discussed must be available. In this chapter I explore the issues from the women's perspectives as well as similar issues from the midwives' perspectives. I also consider the realities of choice within midwives' practice and outline the potential for greater negotiation between women and midwives.

#### **Women's Views of Choice and Decision Making**

##### *Choosing the type of care*

The midwife was the first point of contact within the maternity services for most of the women in the study. However, this was predicated on the women knowing how to access the community midwife. Women experiencing their first pregnancy did not

necessarily know this; therefore they contacted their GP first and then were referred to the community midwife attached to the practice. Women experiencing their second (or subsequent) pregnancy were normally aware of this aspect of the system. However, none of the women had the opportunity to choose which community midwife who attended them and one midwife stated:

*“...they don’t particularly get a choice of the midwife, because the midwives are attached to the GP...”*  
(MW20, p.1).

There was no mechanism for women to choose their community midwife. The only alternative for women wishing to exercise choice at this point was to engage an independent midwife who worked outwith of the NHS and charged directly for her services (Anderson, 2004). Thus despite the rhetoric this particular choice was limited by the way in which the maternity services within the NHS was constructed (Edwards, 2004, p.2).

Choosing the type of maternity care was the first choice that women were expected to make when they engaged with the NHS maternity services. At this stage, normally fairly early in pregnancy, this was primarily focused on the pathway of antenatal care. Women were sent information leaflets outlining the pathways of care prior to a home visit from the community midwife:

*“...I’ve read the leaflets, I read them the other day actually, you’ve three choices haven’t you and you can go to your doctors, you can go to the hospital or they can come to you. I’m happy for [the midwife] to come to me. If that’s what you mean, is that right?...”*  
(W11.1, p. 6).

However, despite the provision of such leaflets women experiencing their first pregnancy appeared less sure of the system, than those in their second or subsequent pregnancy; this included not 'knowing' the options for care or the nature of the care available:

*"...I automatically assumed you went to the hospital all the time. I didn't think you could go to your doctor's and see the midwife at the doctor's; I just thought you went to the hospital..."*  
(W9.1, p.13).

Thus women in their first pregnancy required the midwife to explain the local system of maternity care and to identify the pathways of antenatal care that were available. However, this quote also highlighted the assumption made by many women that pregnancy was automatically associated with doctors and hospitals and supported Edwards (2004, p.3) statement regarding the dominance or coerciveness of the obstetric ideology regarding pregnancy and childbirth.

Women in their second or subsequent pregnancy were generally more knowledgeable about the maternity care system, based on their previous experience, and some described the frequency and preferred location of care:

*"...I go beginning of May...they were six weeks, I went two weeks after my scan...but yes I was offered if I wanted to go up to the hospital...but seeing [the midwife] is a lot more convenient..."*  
(W22.1, pp.3-4).

Both of these quotes presumed that women had some choice about the type of care they would like, but similar to Edwards' (2004, p.3) findings, in reality their choice was

limited to the predetermined options that were available within the system and also constrained the possibility of any negotiation.

Plans for the birth were usually considered later in pregnancy, unless a woman requested a home birth. Plans for postnatal care were rarely considered at this stage and when they were discussed, normally on the woman's return home after the birth, focused mainly on the frequency of postnatal visits by the community midwife. Jomeen (2007) also highlighted that postnatal care was one aspect of maternity care in which women had little choice.

### *Information*

Green et al., (1998, p.178) suggested that information was an essential ingredient in order for women to make appropriate choices and decisions that the women needed and also that the information should be presented in a way that was understandable. One woman in this study reported:

*"...I didn't realise, because they said that...when I had the option I wasn't really sure what was meant by 'do you want the hospital'...."*  
(W24.1, p.3).

This quote highlighted the lack of information and/or understanding of the system and thus reduced opportunities to exercise choice. In both Edwards' (2004, p.5) and Jomeen's (2007) studies findings demonstrated that a lack of information contributed to the lack of choices about engaging with the maternity services and the provision of care. Kirkham (2004a, p.276) suggested that this can be remedied by the provision of information but cautions that it offers the means for health care professionals to

construct the ways in which they provide information in order that women will make the 'right' choice. In this particular situation the midwife responded that 'choosing' the hospital was restricted to women who had particular needs and she was suggested that midwife-led care was more appropriate. This is a good example of what Levy (1999) called 'protective steering', a fundamental and complex activity where the midwife made the woman aware of what options were and were not available to her.

Conversely, when women were provided with information it was very important that it was both timely and in an appropriate amount to ensure that they were not overwhelmed; for example:

*"...I think it might have been too much [information] actually...I could probably done with some of that information being sort of split up into two visits or two conversations rather than it being all at once, it was all a bit...and then it left me thinking oh my god what did they say.....I didn't realise that I had to have actually made up my mind what I was going to do by the time she came...I needed to make my decision...so when she came and said what do you want to do I thought oh she's got me on the spot because I hadn't made a decision either way...I did feel that I was a bit being pressurized into it..."*  
(W10.1, pp.9-10).

Levy (1999) also reported that many women find too much information difficult to manage and possibly avoid seeking more information or ignore it. This quote also highlighted the focus on decision making and timescale required in relation to the antenatal screening. The woman acknowledged receiving the information and had some discussions with her partner but the timescale of decision making was not clear to her and she felt pressurised to make a decision. One difficulty here is that the pressures of providing information within the prescribed and reduced schedule of antenatal visits,

together with the time pressures in an antenatal clinic so that women can make an informed choice, leaves very little time for discussion or exploration of the issues or relational decision making (Edwards, 2004; Symon, 2006). This also limits the potential for any negotiation.

### *Choosing the place of birth*

Many of the women believed that hospital was the safest place to give birth and did not challenge this view. The prevailing culture of hospital birth as the norm has been identified by others (for example: Devries, 2001; Edwards, 2004; Barber et al., 2007). The majority of women in phase one and all of the women in phase two of this study had chosen a hospital birth and the perception appeared to be that hospital was safer than home and that they would be looked after:

*“... I want to go straight to hospital definitely. Cos I'm not frightened or anything, a lot of people don't like hospitals. I'm not frightened, I'd like to be up there right from the beginning, at least you're looked after, at least you're not worrying and you're up there and they can look after... I need to be at the hospital, I'd feel safer and a lot more comfortable if I were at the hospital...”*  
(W12.1, p15)

*and*

*“...I have chosen to have this birth in hospital because for me that would be the safest option...I never thought of having it at home...”*  
(W9.1, pp.6-7).

Edwards (2004, p.6) commented on women's difficulty in choosing a homebirth because of the medicalised assumption that such a choice was unsafe and Barber et al., (2007)

highlighted how the 'philosophy of fear' continued to influence women's beliefs that hospital birth with medical presence was the safest option.

Nevertheless, two of the women in phase one of the study planned for a home birth, though they appeared to have received mixed messages. Both of these women were multiparous which supports the findings of Redshaw et al., (2006) who stated that multiparous women were more likely to choose an alternative place of birth. One woman appeared to have achieved a home birth despite encountering some unforeseen medical problems in her pregnancy. During her interview she intimated that the midwife had indicated that the final decision with regard to place of birth could be delayed:

*"...Yeah. I mean she said y'know "we won't make a decision ... obviously we can't stop you having a home birth, we can only strongly advise", but she said "we won't make a decision until the last minute, we'll give you until sort of 38 weeks." Originally she'd said 34 weeks and then 36 weeks... we'll make a decision then, but it's looking, particularly as it's going down... it's looking more unlikely..."*  
(W1.2, p.3).

This situation had some potential for negotiation around issues of safety and risk and home birth however this quote had rather more resonance with Edwards (2004, p.6) findings regarding the way in which midwives can sometimes be subtly discouraging about home birth and the way in which the risk discourse reflects a more medicalised view of birth.

Another woman commented as follows:

*“...I haven’t met with any opposition from professionals actually....but I did feel when I was talking to her [the midwife] I felt marginalised after I’d finished speaking to her...all I want to do is to try and have my baby at home and be as positive and dynamic about the whole thing...that made me think I hope she doesn’t turn up at the birth...”*  
(W5.2, p.4).

Again this concurred with Edwards’ (2004, p.6) view that even though she had planned a home birth this choice was constrained in some way by the risk discourse. Jomeen (2007) highlighted the importance of midwives believing in the model that they promoted to women and at this point in her pregnancy this woman did not feel supported by this midwife. It also raised the issue of the woman’s lack of choice or negotiation regarding her birth attendant.

Although some women felt that to ‘do’ birth properly they needed to have a home birth, from the midwives’ point of view it was only done properly in hospital:

*“...so I suppose the feeling I got was, you can try and have your baby at home but if everything doesn’t go completely sweetly, then come back into the fold and we’ll do it properly. I did feel that after the birth plan interview.....I keep putting a lot of pressure on me to get it right, you know to get the birth right...I’m seeing it as me versus the system or home birthers versus the system...”*  
(W5.2, p.17).

This message was picked up by one of the women and caused a lot of pressure for her and again highlighted the dominance of the hospital discourse.

### *Not taking risks*

The risk discourse, identified in relation to choosing the place of birth, was also evident in other ways; women were concerned about putting, or not putting, themselves at risk in any way; for example: "...I wouldn't want to take any risks..." (W4.1, p.8).

This again reinforces the 'philosophy of fear' (Barber et al., 2007) that pervades the maternity service. However, women also appeared to equate with being at risk if they misbehaved in some way: "*I don't want to put myself at risk by doing anything wrong...*" (W26.1, p.6).

Stahl and Hundley (2003) commented that pregnant women's understanding of risk is more contextual, that is embedded in their own lives rather than shared with health care professionals; however it is evident that women are more likely to be compliant if they are led to believe that either they or their baby is at risk (RCM, 2000, p.8). One consequence of this is that the choice discourse becomes confounded by the risk discourse and as highlighted by Lipman (1999) 'risk becomes the lens through which choice is filtered' and consequently for women the right choice is perceived as the one that avoids risk (Kirkham, 2004a, p.285).

### *Doing the birth plan*

Birth plans, described as a realistic plan for care in labour, (Flint, 1986; Too, 1996a; Kitzinger, 1992) featured quite prominently in the interviews about antenatal care, with antenatal visits undertaken by community midwives primarily to ensure that these were

completed. Sometimes the importance of the birth plan was not immediately apparent to all the women, but as one commented after birth:

*“... I can understand why these birth plans are done now because you don't think straight [in labour]...”*  
(W24.2, p.8).

This statement was made in relation to women's ability to think clearly when experiencing painful contractions. Although community midwives discussed birth plans with the women they were not always referred to when women were admitted to the delivery suite; as indicated by the two following quotes: “...no, not at all [discussed the birth plan]... (W24.2, p.8), and “...I think she had a quick flick over it when she took my notes but it didn't get used ...” (W25.2, p.3).

The women did not offer further information as to why it had not been used but similar to Whitford and Hillan (1998) indicated some disappointment when time had been spent considering the birth plan during pregnancy. This also suggested some difference between community midwives' priorities to ensure the birth plan had been discussed and the delivery suite midwives' varying recognition of women's expectations of labour.

However the labour and birth did not always go according to the birth plan: “...you can go in with birth plans, but they don't always... you know...” (W11.2, p.8). On this occasion it appeared there was the intention to follow the birth plan but the progress and outcome of the labour meant that the woman changed her mind about the choices that she had previously made. This reflected work by Hollins Martin (2008) who suggested that a birth plan was a way of expressing choice and not a prescription of orders. From

this perspective the possibility of negotiation emerges. However as I have suggested on page 169 XX some women found difficulty in thinking clearly during labour.

For some women the use of the birth plan appeared to create pressure:

*“...no I hadn't made a birth plan as such. The only thing I put down was that I didn't want forceps, I didn't want to put any pressure on myself so I didn't... but I thought that like I say that I wouldn't have minded using the birthing pool and I didn't want an epidural though...so it didn't go as planned, never mind...”*  
(W7.2, p.13).

Clearly the lack of clear articulation of a birth plan did not indicate lack of interest or lack of decision making on behalf of the woman (Too, 1996a); she was very clear about what she did not want but appeared to believe that documenting her wishes pressurised her to achieve labour and birth in a particular way.

Some women did not have a birth plan completed when they entered hospital; for example:

*“...I hadn't managed to write a birth plan because I was early and I wasn't very organised, but all I'd said was I definitely wanted the pool and I didn't want any drugs apart from gas and air, but I didn't even tell them that, they just didn't offer me anything to tell you the truth...”*  
(W10.2, p.5).

This quote indicated that the woman offered some excuse for not having a written birth plan, however she was very clear about the aspects of the labour that were important to her. On admission to the delivery suite the decision was made that she was not in established labour and consequently she was transferred to the antenatal ward where

she continued to labour. When she finally reached the delivery suite she was told that there was no time for the birthing pool. This demonstrated how a definition of being in labour, or not, affected the location of care. Since this woman was not officially recognised as being in labour then her preferences and choices for labour, written or unwritten, were not considered and any possibility of negotiating these unrealised. This also raises the issue of who is defining labour and controlling the woman's body. The implication from this episode is that professional knowledge, with regard to the diagnosis of labour, is valued more highly than the woman's personal knowledge and demonstrates how those who appear to have authoritative knowledge consequently hold the legitimate decision making power (Jordan, 1997).

It was evident that the birth plan appeared to focus on some aspects of the birth rather than others; for example:

*"...I don't want to have the injection of Syntometrine, I want to have a physiological third stage if I can and em I haven't decided whether or not I want the baby to have vitamin K...it was very matter of fact, we went through the plan on the back of the card...we went through it stage by stage and crossed off bits that didn't apply to home birth. Emotions never came into it..."*  
(W5.2, pp. 4, 12).

These choices appeared to be focused on the more clinical rather than the emotional aspects of labour and as Too (1996a) suggested these were a superficial checklist rather than true choices. They were also particularly focused on the midwives' priorities for the second stage of labour and care of the baby. Edwards (2004, p.8) also reported that women sometimes viewed these as the requirements of the practitioners.

There were several important issues arising here. Firstly, it was difficult for some women to make choices because they did not have the appropriate information or they were presented with options that either suggested compliance or that did not include refusal (Kirkham, 2004a, p.276). This woman was knowledgeable and articulate and had stated her preferences for labour clearly but not all women are able to do this (Kirkham and Stapleton, 2001). For others even when they had information they were reluctant to make specific choices, preferring to go along with things (Kirkham, 2004a, p.271).

### *Going along with things*

The notion of going along with things was evident from several of the women: “...I’m one of these people who go along with whatever’s offered...” (W3.1, p.8), and “...everything what they suggest is what I want...” (W26.1, p.5).

Kirkham (2004a, p.271) suggested that ‘going with the flow’ was viewed by midwives and obstetricians as a response to the pressures on them within a hierarchical service but here it was the women offering this response in response to notions of choice. Hundley and Ryan (2004) found that women tended to say they wanted what they were offered but Symon (2006) cautioned against concluding this was necessarily the case. A similar response was noted from a woman who stated that she did not know what to expect and therefore she was happy to ‘go along with things’. Again this was an example of women’s assumption that whatever arrangements were in place were the best arrangements possible (Porter and Macintyre 1984). However, one consequence of this is that women comply with normative practices and the local constraints or compromise so that they do not alienate their carers (Kirkham, 2004a, p.266).

## Midwives' Views of Choice and Decision Making

### *Choosing type and frequency of care*

As I described at the beginning of this chapter, one of the first choices that appeared to be offered to women was regarding their options or arrangements for care, known locally as the pathways for care. Whether the first contact had been made with the midwife or the GP the system for organising care meant that the hospital's maternity services triggered the community midwife's 'booking' visit. Existing information and/or notes would have been accessed and a decision, albeit tentative, would have been made as to the suitability for midwife-led or consultant care based on an assessment of low or high risk, although it was not entirely clear who made this decision or on what criteria. Symon (2006, p.9) commented that these decisions are commonly made at booking and although women may be relabelled if their level of risk increases the process rarely works in reverse. Furthermore, these labels tend to be applied by health carers rather than requested by women. One midwife commented:

*"...Yes it's been done in advance [there] is often something written on the top if they are deemed to need shared-care or midwife-led care. I do have concerns about that because I think it should be the women's choice as well..."*

(M29.1, p. 3).

This comment suggested that although community midwives gave verbal information about the options available, in reality a decision had already been made about which

pathway of care was the most suitable therefore there was little choice for the women (Kirkham, 2004a, p.267).

The introduction of protocols regarding frequency of antenatal visits has also prompted some concern amongst midwives and women about the spacing of visits as highlighted by the following:

*“...they look at you in horror if you say you are going to leave them more than four weeks, but...we don't like leaving them [the women] fortnightly from say 36 to 38 weeks, especially a primip, because on the odd times I have, you can guarantee it's the one time this one will come back with 3 plusses of protein and a diastolic of 110...it's experiences that have made us feel like that, but we are still only doing what the woman want, really...”*  
(MW27.1, p.12).

This is one example of an 'atrocious story' (Allen, 2001) related by one midwife to another; used on this occasion to support the midwife's belief in the previous norms for frequency of care. However, when describing her strategy for subverting the new protocol the reason was attributed to women's choice. This may be perceived as similar to Kirkham's example of midwives 'doing good by stealth' (Kirkham, 1999) although it could also be considered an example of the midwife negotiating the system.

### *Information*

Giving information to describe and explain tests and investigations has become a large part of the midwife's role but one midwife expressed concern that:

*“...It’s information overload at the beginning...they have so many books and leaflets now that are given out to the women. We send the pathways of care and triple testing leaflet before the community midwife goes out to book them. Then when the community midwife goes out to book them, it’s now a little box file she takes with her for each woman, full of information. Em, they get the advertising stuff like the woman and baby magazine and the bounty packs, but all primies get the pregnancy book which I think is probably adequate and they don’t need anything else, but that’s my opinion. Em leaflets on breast feeding, safety, wearing seat belts in cars, everything and everything for you to give at that first visit, I really do think that it’s information overload because then the midwife is going out to do the booking history, the women have been given the whole notes now, the national notes, so they’re going through a lot of things, discussing a lot of things and giving a lot of information at that time so I do think there’s probably too much given...”*

(MW17.1, p8)

This contrasts with one woman’s view expressed earlier, and gave some insight into the array of information that midwives need to collate and distribute. However, this also reflected the standard package of information provided by midwives which as highlighted by Kirkham (2004a, p.276) is often given without discussion or delivered in a similar way to all women.

Conversely, another midwife commented that:

*“...I think sometimes they don’t need as much information from us because they get it from other sources, so sometimes it makes your job easier...”*

(MW14, p.13).

This was some acknowledgement by the midwife that providing information or answering questions makes the job harder, or maybe threatens the smooth running of the service (Kirkham et al., 2002b).

Also the midwives appeared to discriminate in some way between the women; for example: “...*the sort of more knowledgeable group...they want to know the whys and wherefores, rightly so...*” (MW18, p.2). This implies that if there is a knowledgeable group then there is also a less knowledgeable group, who may be treated differently, and is another example of the way in which midwives may stereotype women. In this situation it may serve to limit information and as Kirkham et al., (2002a, p.549) suggested, protects the midwives from what they might consider inappropriate requests. Lipsky, (1980, p.115) highlighted how the need to simplify information for certain groups also leads to stereotyping.

### *Making decisions*

The ‘booking’ visit by the community midwife to the woman focused quite extensively on completing the records that formed the basis of the antenatal care together with giving health advice and information about screening. This often necessitated the woman making quite an early decision about screening investigations and the midwife typically expected that the woman would make a decision about these at this visit.

However, this was not always the case as many women did not want to make decisions alone:

*“...they [husbands] are very involved. I think women don't want to make decisions on their own...”*  
(MW27.1, p.10).

Midwives also reported that some women did not want to make any decisions at all and were satisfied that the professionals knew best (Bluff and Holloway, 1994); for example:

*“...some women will surrender at the door and say, do with me as you please...”*  
(MW15, p.11).

However, midwives recognised that some women chose to exercise choice; for example:

*“... will be there and say I want to do this, this and this and there's no negotiation on it...”*  
(MW15, p.11).

The midwife here perhaps recognised the potential for some negotiation even if this was not fully realised. However, Proctor (1998, p.91) commented that midwives were aware that some women wanted to defer to the advice of the professional whereas others wished to be fully involved.

### *Preferences and birth plans*

As I mentioned above birth plans appeared to be quite an important feature in the antenatal care, with visits by midwives primarily to ensure that these were completed:

*“...she's now about 37/38 weeks and I've already had her birth plan visit at home. We have discussed the birth, we have discussed her options...”*  
(MW28.1, p.1),

Sometimes the term discussed was used when in reality there was little discussion (Kirkham, 2004a, p.277) and the interaction particularly focused on the midwives' priorities for the second stage of labour and care of the baby.

If, as highlighted earlier in this chapter (page 226), the birth plan was overlooked then it was not clear how preferences for the birth or knowing and trusting were established, and one community midwife was concerned about that; for example:

*"...I think I still feel that the birth plan visits are very important, I think sometimes we do fall down and that we do the birth plan visit and em, when it gets to delivery suite it doesn't always get taken ....(unclear). I think sometimes if they just acknowledged if they've looked at the birth plan, even though it's not always possible to stick to the choices that the woman said she wants, for one reason or another, if they just acknowledge that they've looked at it and they're aware of what she would like if it's possible, that would be helpful, but sometimes it doesn't appear to be looked at all. That's a common complaint postnatally..."*  
(MW16, p.2).

However, this seemed to be at variance with the value given to them when women are admitted to the hospital in labour:

*"...they all come in [women in labour], they all want non intervention and you'd love to give it to them but there's always something that pokes its little head up and you think well I'm going to have to do this...and then it's a vicious circle, you end up doing...you tie them to the bed..."*  
(MW36.1, p.12).

This quote suggested that the birth plan was looked at by the hospital midwives however it also implies that non-intervention is something that can be given to women rather than a way of approaching care.

There appeared to be a more reductionist view of women's preferences in labour and for birth that focused primarily on pain relief, use of electronic fetal monitoring, rupture of membranes, use of Syntometrine for the third stage of labour, presentation of the newly born baby to the mother and the administration of vitamin K to the baby. One midwife commented:

*"...I think sometimes the women feel that they haven't got a choice in the matter...they think because the midwife said this is what we'd like to do, that they've got to go along with that...they're a bit under pressure to conform with what the midwives say..."*  
(MW16, pp.4-5).

Although she recognised that in part this could be due to the way things were explained to the women. However, some midwives recognised that women had quite a limited choice:

*"...their choices might be different from the options we've got available...the majority would have to fit in with what we want..."*  
(MW17, p.1)

This again highlighted the notion of a limited 'menu' of choices and the expectation that women would choose from them and comply with the local norms and practices.

### *Dealing with women's expectations*

One midwife considered that women's expectations were too high; for example:

*"...I think some women's expectations are far too high and that causes problems...I find that a lot of the reading that they see and a lot of programmes on television, it's the media – they all sort of encourage them...they just expect everything to be so straightforward, they don't seem to realise about problems that can occur..."*  
(MW31.1, p.10)

However this may not be true as many media portrayals of childbirth appear to focus on emergencies and interventions rather than normal childbirth.

Both midwives and women agreed that the safety of the unborn baby was paramount; however as I highlighted in Chapter 2 women have a broader concept of safety than midwives (Edwards 2005, p.104). One example of the differing perspectives on safety was evident in the following quote from a midwife:

*"...I think minor things to us are, they shouldn't be, but they do become things like general comfort, privacy, dealing with sort of social things, looking after them as they, part of a partnership or part of the family, we tend to very much focus on safety of mother and baby which obviously is very important, but for some of them the whole experience is very important as well and sometimes that becomes [for us] very secondary..."*  
(M13.1, p.1-2)

This midwife recognised that safety concerns sometimes dominated other aspects of the childbearing experience which were of greater concern to women themselves.

### *Risks and concerns*

Some of the tensions between risk and safety were also identified in Chapter 2 and provide further complexity for both women and midwives. One midwife commented on the extent to which women were prepared to take risks in their pregnancy; for example:

*“...some are prepared to take risks and do things they know are not healthy for them and their babies and others are so careful they’re going in almost the opposite direction and being too cautious about things...”*  
(MW15, p.4).

This comment was made in relation to lifestyle issues such as smoking and drinking alcohol; the midwife acknowledged the differences between women but did not comment further on the complexity of the issues.

The increased focus on safety and risk within maternity care has inevitably led to an increase in the protocols affecting care in pregnancy, but primarily care in labour, and consequently these impact on women’s choice and affect the way in which midwives provide care. The introduction of the Clinical Negligence Scheme for Trusts (CNST) has contributed to the risk discourse and has meant increased anxiety for some midwives regarding assessment of risk and concern about intervention and outcomes:

*“...but it’s the same old thing, she’s had an epidural so they end up being on the monitor, then you have a monitor that’s frustrating because it’s giving you a trace like that girl had, you know it’s far better if you don’t go anywhere near the...and you’re just listening in with a Pinard’s every quarter of an hour...and yet we can’t stop*

*using them, you know it wouldn't be seen in a court of law, no if you hadn't...there's some reason to use it, that you hadn't used it. You couldn't say well we didn't want to have any intervention..."*

(MW36.1, p.11)

This midwife's account uses references to potential litigation to justify the use of intervention and demonstrates the pervasiveness of the risk discourse and how it is presented in a rational way (Walsh, 2006) that ultimately limits women's choice.

There has also been an increase in the development and use of protocols within the context of intranatal care and these have been primarily for use in those women's labours identified at risk. However this has also affected something as seemingly normal as the request for a water birth, which would help with the relief of pain and facilitate normal birth:

*"...sometimes with the protocol for water births...there's a strict protocol like if they have meconium, they can't go in the pool...so I've said no to that, but once it's explained...women are usually quite accepting and understand the risks..."*

(MW18, p.2).

Again, the risk discourse is implied with deference to the implementation of the protocol and the expectation that women will accept this and comply and therefore the notion of choice is further constrained.

## **The Realities of Choice in Practice**

Despite the continued emphasis on choice the reality of women's experiences and of midwives' practice suggested that real choice remains elusive (Jomeen, 2007). Whilst all the midwives spoke of offering women choice, some of the decisions regarding the type of care or place of birth had already been made, so that the range of choices was limited. Furthermore there appeared to be greater evidence of compliance or 'going along with things' than negotiating any compromise, particularly if they were led to believe that either they or their baby is at risk (RCM, 2000, p.8).

If women felt unhappy with the community midwife then other than making a formal complaint her only strategy, as described in Chapter 4 was to defer pregnancy. Therefore there appeared to be no choice or negotiation here within the boundaries of the NHS system. Women's only recourse would be to opt out of the system completely and engage an independent midwife who would offer a totally different approach to her childbearing experience (Anderson, 2004, p.262).

The perception of the hospital as the safest place to give birth appeared to be embedded in many women's thinking. The dominance of obstetric ideology (Edwards, 2004) and proliferation of protocols regarding care and issues of safety also appeared to influence the way in which midwives responded to women's choices. One consequence of this is that the choice discourse becomes confounded by the risk discourse and as highlighted by Lipman (1999) 'risk becomes the lens through which choice is filtered' and consequently for women the right choice is perceived as the one that avoids risk (Kirkham, 2004a, p.285).

Kirkham also identified that many choices were made by default (2004a, p.267) and reiterated her previous work on informed choice that many of the topics covered in the series of leaflets (MIDIRS Informed Choice Leaflets, 1996, 1997<sup>32</sup>) were not regarded as real choices in practice (Kirkham and Stapleton, 2000). She highlighted that the service defines the occasions for choice, thus the choices offered by midwives have to fit in with clinical practice and women are unlikely to make choices if they have not been informed by staff (Kirkham, 2004a, pp.267-8).

The key boundary points for the women accessing maternity care were similar to those points when choice was apparently offered: for example the type of antenatal care; screening tests and investigations in pregnancy; place of and preferences for birth; admission to hospital in labour and postnatal care. There was little explicit evidence of negotiation in these situations, although in the example of the home birth it was apparent that the final decision regarding place of birth was deferred.

However, whilst some women were confident and articulate in expressing choices or preferences others were less so and it was unclear as to the extent of negotiation that may have taken place. Engagement in negotiation requires effective communication skills in both women and midwives, sufficient time for this to happen and support for midwives so they in turn can support the women. It was very clear from many women that time pressures, and perhaps some reluctance to alienate the midwives, precluded them engaging in effective interactions (Kirkham, 2004a, p.275).

The notion of choice and informed choice as indicated within the policy documents and the rhetoric of practice may therefore be problematic despite the policy prescriptions

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<sup>32</sup> The Midwives Information and Resource Service (MIDIRS), together with the NHS Centre for Reviews and Dissemination, produced leaflets summarising research evidence for ten discrete topics on which decisions are made in pregnancy. Leaflets 1-5 published 1996 and leaflets 6-10 in January 1997

since there is often more 'telling' than discussing of options (Kirkham, 2004a) and without all options, including refusal, being fully explored. Choice is clearly a complex concept and the implementation of choice even more so (Edwards, 2008). The provision of information and its related decision making are overlaid with concerns of risk and safety and the provision of care is governed by policies, procedure and rules which may implicitly or explicitly constrain women's choices or the way in which options or choices are presented to women by midwives and health care professionals.

The concept of negotiation may offer a different perspective that offers women a more proactive position in the interaction with midwives and greater potential for involvement in decision making. Rather than offering choices as either (a) or (b), (a) plus (b) or neither it maybe more helpful for the information to be provided and then all the available options explicitly discussed or negotiated rather than women being coerced into making the 'right' choice. Some midwives might argue that this is already done but the evidence from this study has demonstrated that there was little true choice or explicit negotiation and little flexibility or time in the system to facilitate this type of approach. Shribman recommended that services should be redesigned to facilitate choice of various services, however perhaps more importantly there was also recognition that plans will be open to change at any point during the pregnancy (2007, p.2), with a qualifier that any risks should be carefully assessed, which offers a glimmer of hope that the negotiation process might have some part to play.

### **Emerging Issues**

Choice continues to be promulgated as government policy (DH, 2007) however it is not necessarily available to all women and is constrained within a framework of policies,

procedures and rules, and the discourse of risk and safety and thus causes some difficulty.

Women had no choice of midwife and though they appeared to be offered choices with regard to their pathway of care in many cases these decisions had already been made. Many women and some midwives still believed that hospital was the safest place to give birth and this highlights the 'philosophy of fear' that permeates maternity care. Women's preferences for birth were also identified and documented but not necessarily heeded when women were admitted to hospital in labour.

Analysis of the data highlighted some opportunities for negotiation but these were not explicitly recognised or realised by the women or midwives and there was little time or flexibility in the system to accommodate such opportunities. If 'woman centred care' is to be fully realised then women need to be able to take a more active role in negotiating their childbearing choices with midwives; however this also necessitates changes to the system in order to provide more time and greater flexibility for midwives to achieve this.

In the next chapter the concept of control is explored in relation to 'woman centred care' and considered from the women's and midwives' perspective in turn. I also discuss how factors such as language, power and control combine to undermine women's agency in relation to childbearing.

## **CHAPTER 7**

### **CONTROL**

#### **Introduction**

In Chapter 2 I highlighted that having a sense of control contributed to a positive birth experience (for example, Green and Baston, 2003), however it was evident that not all studies conceptualised control in the same way. Green and Baston (2003) differentiated between external control, for example women's control over care givers, and internal control which was women's control over their own bodies and behaviour. Although control was a key principle of Changing Childbirth (DH, 1993) and subsequently mentioned in the Maternity Standard of the national Service Framework (DH, 2004) it was a notable omission in the most recent documents (Shribman, 2007; DH, 2007). Maternity care has become even more complex and, despite the centrality of control to any definition of 'woman centred care', remains a contentious issue. In this chapter I explore control from the women's and midwives' perspective in turn. I then consider how surveillance, language and professional power undermine women's control in relation to childbearing. Aspects of boundary work are identified between midwives and medical staff and finally I discuss the relationship between control and woman centred care.

## Women's Views of Control

### *Being believed*

Other elements of control identified in the literature such as support, continuity, choice and information provision are dealt with elsewhere in this thesis (Chapters 4 and 5). For the women in this study the concept of control encompassed three components; being believed, retaining control and giving up control. The importance of being believed is captured in the following quote from one woman:

*"...what I hope I will get during the labour is someone who will help me fulfill what I want by empowering me to believe in myself, in my body, in the process and in them..."*  
(W5.2, p.12).

This quote highlighted the woman's wish that the midwife must trust her ability to birth her baby. However this expectation was not necessarily always realised and some women were concerned that when they sought admission to the delivery suite they would not be believed and consequently sent home, on one, or more than one, occasion; for example:

*"...I'm just worried I'm going to keep going up and they say oh no you're not in labour, go home..."*  
(W9.1, p.11).

I knew that this had been a complaint of women highlighted by previous research (for example, Oakley, 1979, 1980) and had hoped that this type of behaviour, namely

midwives not believing women, was no longer an issue. However, being believed with regard to the progress of labour was also an issue; for example:

*“...but they [the contractions] were getting more and more regular...and they were starting to come on top of each other, but every time the midwife came to check me out they'd stop...and they said oh you're not in labour love...well it got a bit ridiculous when they were really coming fast and I actually thought this is getting painful now, I can't keep on top of it and then to be told that they weren't...because I knew they were...it's almost like they didn't believe me...”*  
(W10.2 pp.2, 6),

This woman's anxiety about not being believed about her labour supports other findings in relation to women being believed (Mander, 1992; Edwards, 2005). Hunt gave examples of how midwives failed to trust mothers and disregarded or disbelieved what women said (Hunt and Symonds, 1995, p.92). The importance of trust and midwives trusting women in this study was discussed on pages 159-162.

Even before raising the issue of being believed about the onset of labour one woman was very concerned about 'knowing' whether she was in labour or not. This was a different aspect of 'knowing' to that discussed in Chapter 4:

*“...I think they assumed because it was my fourth that I would naturally know everything“...and then when she said I was only 3 or 4 cm dilated no further forward than I was Wednesday night I was a bit...the pain was different...”*  
(W23.2, p.1).

This raises several issues; firstly the recognition of the signs of labour and the woman's anxiety that she would recognise these when her previous labours had been induced.

This woman was very concerned that the midwife would think her 'silly' for not recognising this. Secondly, it was apparent that the woman had recognised that the nature of her pain was qualitatively different, but in the absence of significant physiological changes the midwife indicated that there was no change.

Later this woman was concerned about her progress in labour as the midwife providing care concluded that she was not in labour. Using data from both interview and observation in phase two I was able to follow up this issue from different perspectives.

During the observational phase of the study I noted that:

*"... [the midwife] was fairly convinced she was not in labour...she had palpated that [one] contraction, and said it wasn't particularly strong..."*  
(Field note WB23, p.4).

The midwife communicated her conclusions to the coordinator and also made a comment to me:

*"...coordinator had returned from theatre and asked what was happening and [the midwife] was fairly clear that she wasn't in labour... [the midwife] said to me "M you might as well go home..."*  
(WB23, p.3-4)

However, shortly afterwards this was proved incorrect and the woman proceeded to birth her baby. The woman herself was already anxious in relation to her own ability to birth her baby and told me during her interview after the birth of her concern:

*“...when I knew I wanted to push I thought is she going to come and say no you’re not ready yet... thought I’m not going to do it all myself...”*  
(W23.2 pp. 2, 4).

It was also evident during the interview after the birth that the woman did not explicitly criticise the midwife, conversely she praised her for her friendliness and ‘for taking control’ and claimed satisfaction with the care and support she received. Since having a normal labour and birth was different to the woman’s previous experience she had nothing to compare this type of labour. However, this further reinforces the notion of “what is must be best” (Porter and Macintyre, 1984; van Teijlingen et al., 2003).

#### *Being in and retaining control*

Although my data was not as refined as that of Green et al., (2003) some women were able to articulate being in control in labour, though they acknowledged that this was easier in their second pregnancy: *“...this time I felt a lot more in control... but maybe that’s because it’s your second...”* (W22.2, p.8). This is not surprising since they have the experience of their first labour to draw on even though no two labours are the same:

*“...No. With my previous I had an older midwife, I think one her comments was, you sound like a train puffing, calm your breathing down. Now I know as daft as it sounds I breathe how I know I can control the pains at the end of the day... It’s how I feel that I can control it and I knew [this time] there wouldn’t be any comments like that, yes they’d tell me to take a bit deeper breaths and I knew exactly what I was doing was ...”*  
(W23.2, p.9)

The use of breathing to allay panic and maintain control supports the findings of Slade et al., (1993). However, for some women the only way they believed they could retain control was by choosing a home birth:

*“...I suppose because women who chose to have their babies at home are less likely to want intervention anyway em, so they’re more hands off and it’s that kind of losing the control by going into hospital, I feel like I’m more in control of what’s going on if I’m at home .. em but I think it’s a thing of just being very clear in the first instance and just saying “you know this is how I want my birth to happen” and making sure that whoever is with me, whether it’s [my partner] or whether it’s a friend or my mum, knows that’s how I feel and is able to convey that. But there is the worry that sort of lack of control, having said that, that might be completely unfounded... I don’t know ...and certainly ... but then again because I chose to labour in the water, I’ve chosen a non-interventional sort of pathway anyway. So there’s that fear of just kind of becoming another y’know production line... and sort of losing control...”*

(W1.2, p.13)

### *Giving up control*

Coyle (1999) reported a difference in women’s perception of control depending on whether they gave up control themselves or whether they had it taken from them; although using Green and Baston’s terms (2003) could be considered a mixture of giving up of internal control and lack of control of attendants, that is external control. For some women in this study this meant that they would comply with whatever needed to be done:

*“...Yes, safety’s the main priority but obviously I’d like to have a nice birth... whatever needs to be done...”*  
(W4.1, p.9).

The need for authoritative knowledge was also reflected by some women in their interviews this was in the context that they wanted to be told what to do by the midwife and their need to follow instructions: “...I'll need someone there to tell me what to do...” (W26.1, p.8).

Both of these statements imply that the women wants some else to be 'in charge' and is relinquishing control and assuming that the midwife 'knows best' (Bluff and Holloway, 1994). Hirst et al. (1998) also reported that women preferred to leave decisions to the experts. Dykes (2006, p.85) explained that a lack of culturally acquired knowledge creates an opening for authoritative biomedical knowledge to predominate. One woman also commented on the midwife's bossiness, but she attempted to explain this by suggesting that this was something the midwife had to do; for example: “... [the midwife] may be quite bossy but I suppose they have to be don't they...” (W22.1, p.10).

This reflects previous negative stereotypes about midwives and the woman hesitates to criticise the midwife and appears to accept the behaviour. This may be because she has trust in the midwife or again assumes that the midwife knows best (Bluff and Holloway, 1994).

Another woman was aware of how her involvement in decision making changed when the circumstances of the birth changed [from a planned home birth to hospital for an emergency caesarean section]:

*“...when I was at home it felt like a joint decision but once we got to [the hospital] ...I was not in control, then, for example when I said that three people examined me vaginally...he was going to do it anyway...I felt as if my fate was in their hands as to whether or not it would be a spinal block or I would be put to sleep about whether [my husband] would be allowed to be there so I felt as if they were in control of care and they were weren't they?...I don't think I felt fully in control then until I got back home. I think the hospital felt quite intimidating, the whole atmosphere felt quite intimidating to me when I was there. I just felt better and more in control when I got home...”*  
(W5.3, pp. 19, 21).

She commented on the nature of the hospital environment and she experienced this both in the context of her labour and her stay on the postnatal ward. She recognised that she was normally quite assertive about her needs occasionally demonstrated this behaviour; for example:

*“...it just seems crazy and the point is that I wasn't assertive enough to say 'go away' or 'this is what I'm doing' so I didn't feel in proper control, I just took the tablet...”*  
(W5.3, p.22).

This demonstrated how the influence of the delivery suite and the postnatal ward setting changed her normal feelings of control and autonomy (Machin and Scamell, 1997).

It appeared that some women were willing to accept that the midwife should be in control. Clearly for some women this would be viewed as reassuring whilst others would not. These findings are similar to those of Lavender et al. (1999, p.42), who also found some women for whom maintaining personal control was important, whilst for others knowing that midwives and doctors were in control, because there were risk factors, was reassuring.

Clearly if women are to have control over their bodies and their experience it is vital that they are listened to and that midwives trust in the women and their ability to birth their babies and affirm this with the women. Not listening to women has potentially damaging consequences for both women and midwives; not only does it undermine women's confidence in their own bodies and their ability to birth their babies but also failure to recognise signs of labour may mean for example that midwives are not in a position to prepare the women or themselves for the birth. Leap (2000) talks about the need for midwives to respond to the clues women give and to believe in women's own ability to understand their bodies. Not being listened to is also raised by Baker et al., (2005) who go on to state that this negation of women's experience is very disempowering of women and their bodies (Baker, et al., 2005) and is also typical of paternalistic models of childbirth (Anderson, 2004; Edwards, 2004).

### **Midwives' Views of Control**

#### *Safety and control*

The increased focus on safety and risk within maternity care has already been addressed in Chapter 6 in relation to how this impacts on women's choices and the provision of care by midwives. The concept of safety was also linked to control as some midwives acknowledged the need for woman to feel in control of their care; "... *I think choice and continuity [are important] and that they've got some control over what's happening as well...*" (MW16.1, p.2), and were also very clear on the safety of the woman and baby as the core of their work:

*“...we tend to very very much focus on safety of mother and baby which obviously is very important, but for some of them the whole experience is very important as well and sometimes that becomes very secondary...”*

(MW13.1, p.1).

Some midwives' views of what was meant by 'woman centred care' were included in Chapter 4 but one midwife explicitly mentioned control in relation to 'woman centred care':

*“...Woman centred care should be, the care we offer should be given to what the women particularly require with what the professional feels she needs to lead the woman into for the safety of the pregnancy, the child and then the delivery. So the outcome is a good one. So we have to guide the woman and offer the care, but offer the right care that she needs...”*

(MW15.1, p.1)

Despite the reference to 'woman centred care' the implication in this statement was that the midwife assumed control in order to guide the woman to the correct choices. Levy, (1999, p.106) also highlighted how midwives retained control over information when engaged in 'protective steering', which was seen as necessary in both protecting the women and themselves from undesirable outcomes. One midwife commented that it was necessary for the midwife to retain control; *“...I think patients like to feel secure...you can still give them the idea that you're still in control...”* (MW36.1, p.3).

It is not clear whether either of these midwives recognised the significance of their statements, however both of these midwives worked in the hospital setting and reflected the typical attitudes and behaviours that fit with traditional models of medical power and authority (Hunt and Symonds, 1995; Kirkham and Stapleton, 2004, p.118) and

demonstrated ways in which they interacted with woman to symbolise and limit their relationship (Lipsky, 1980).

### **Controlling the Birth**

In Chapter 4 it was shown how care was often described by women as checks and though midwives talked about providing care, they appeared to undertake checks and tasks. The data from women describing midwives' tendencies to focus on tasks supported the findings of other authors that women were more likely to define the midwife's role in relation to the tasks undertaken (Leach et al., 1998; Kirkham et al., 2002b). Kirkham et al. further commented that there was a contradiction between the rhetoric of 'woman centred care' and how women viewed midwives (p.449).

Some of the tasks observed on the delivery suite were generated from the policies and procedures in place; for example the preparations prior to an epidural. However, it also appeared that these appeared to have a ceremonial or ritualistic element of their own; for example preparations for a birth were undertaken as follows:

*"...so with great sort of ceremony the preparations were made around the cot, those must have included labels, putting various things out on the side, the rescusitaire was switched on, babygro was retrieved, the delivery pack was opened, instruments laid out, gloves opened and then the pack was folded over in preparation with a tray on the top just to keep the edges together..."*  
(WB23, p.23).

More worryingly it appeared that preparation of equipment took precedence over the woman's needs or her care; for example:

*"...I thought at that point that [the midwife] would have palpated a contraction and gone up and asked [the woman] exactly how she felt but she came in and she went straight to the trolley and proceeded to open it and move it around..."*  
(WB23, p. 6).

Hunt and Symonds (1995, p.63) described some of the everyday rituals that were observed as part of the every day culture of the labour ward and Dykes (2006, p.130) reported ritualistic performance of procedures on the postnatal ward. From my data it is evident that these rituals not only were still perpetuated but also that they encroached into the delivery room and appeared to acquire greater significance and attention than the women themselves.

It has been suggested that;

*"behaviour in hospitals is not always as rational and scientific as it would seem. Much that occurs in obstetrics is heavily ritualised... We do not regard the practices surrounding childbirth in our society as ceremonial or ritualistic, but may the ritual be hidden from us only because we are so hypnotised by the apparently rational assumptions behind them that we do not even begin to seek a further explanation?"*  
(Lomas, 1978, p.174).

Machin and Scamell (1997, p.81) referred to this, and to Davis-Floyd (1990) who also tried to explain hospitalised childbirth practices, and suggested that hospital confinement can be considered as ritualistic behaviour. Since much of childbirth, particularly labour and birth, is dealing with uncertainty, then midwives adopting such rituals and ceremonies could be dealing with this uncertainty or attempting to protect themselves from it and thus controlling their work (Lipsky, 1980). Furthermore, it could be perceived that these activities become more valued than being 'with the woman' in labour and

supporting them physically or emotionally. However, the difficulty is that these rituals become so embedded in the daily practices that they may become self serving and reinforce the behaviour of the particular group.

Since no community midwives were involved in the intrapartum care of the women who participated in phase two of the study and I had not specifically planned to observe postnatal care in women's homes, I was not able to explore whether, or to what extent, community midwives' practice differed with regard to particular tasks and rituals.

### **Surveillance and control**

The changes in local policies and procedures with increased emphasis on safety and risk have led to the increased surveillance of child bearing women. It has been suggested that surveillance is a form of control, particularly in relation to the hospitalisation of birth, but this also related to antenatal care (Walsh, 2002), for example monitoring and screening activities taking up a great deal of the midwives' time. For those midwives working in the community this primarily impacted on the nature of antenatal consultations undertaken with the women:

*"...I feel our role has changed to more of an antenatal role than a postnatal role because we do quite selective postnatal visiting whereas with all the screening tests now available we do all the blood tests and do all the clinics, I feel our role has definitely turned, whereas before the booking was like a whizz through and then up to hospital wasn't it and that was it..."*  
(MW27.2, p.12).

It has raised issues of the problematisation of normality, since all the women are targeted and monitored and the 'clinical gaze' is broadened.

Women, especially those experiencing their first pregnancy did not always know about or understand the extent of the surveillance undertaken, whilst those in their second pregnancy commented on the increased number of screening tests and investigations with more information and depth of detail provided:

*"...the HIV test ...that's a new thing...before it was just like they did your blood test and told you it was for anaemia, rubella, the normal, but this triple test is for spina bifida and Downs', that lot. So that is gone into in more depth...lots of leaflets about that...and that new scan..."*  
(W23.1, pp.9-10).

This comment demonstrated acceptance by the woman of the various investigations that comprised the antenatal surveillance. However, another woman had a rather different view:

*"...last time didn't bother having any of the screening ...because I knew I'd looked after myself I'd been taking the folic acid and thought if there is anything wrong I'm having this baby anyway. So didn't have any of the tests, screening tests. I had the rubella this time because I felt more responsible for him....."*  
(W3.1, p.11).

She was clearly happy to refuse the majority of these investigations and was satisfied that her lifestyle was sufficiently healthy not to warrant such intervention. However other women sometimes perceived that they should not only comply with the screening activities but also monitor themselves.

For those midwives working in hospital, and particularly the delivery suite, the reality of day to day practice was somewhat unchanged as observation and monitoring of woman in labour has been their core work. The effect has been rather more insidious since despite the rhetoric of 'woman centred care' there appeared to be fewer options offered and continued recourse to electronic fetal monitoring:

*"...because everyone was coming in and looking at the paper that was coming out [of the machine] and monitoring it's heartbeat, and saying that he just needs to keep moving about more because he wasn't really moving much. The case was coming up as abnormal and so she had to like ... the doctor had to cut into his head like to get the blood but then it was coming out normal and they couldn't understand why... I didn't know what was going on ..."*  
(W26.2, p.8).

It can be noted from the above quote that several people became involved and a conflicting picture of the status of the fetus emerged. This young woman had expressly stated that she did not want this type of monitoring but ultimately conformed to the local prescription for care as she did not want to put her baby at risk.

I observed electronic fetal monitoring used on one woman in her apparently 'normal' labour but since I was not present during the admission process was not aware of the reason for this. I later asked the midwife about this:

*"...[I was ] very curious to ask about the monitoring but I left that to the very last question and asked does every body get monitored and she said no only if there is a problem but she had asked [the woman] and she had asked to be put on the monitor."*  
(WB25 p.5).

This was an example of the midwife apparently responding to the woman's choice, even though there was no clinical indication. In a later interview with the same midwife I again addressed the question of electronic monitoring:

*"...It's not easy is it?...we have now got a policy where we don't have to, if everything's gone alright you don't have to monitor them you can individualise it which... but it's hard, it's hard for midwives and it's hard for me actually because we've now been indoctrinated that you've got to do this half hour trace and to stop yourself from putting them on that monitor is very hard indeed, I mean we've all said it, we've all found it hard but I mean we are doing it but it's not easy is it?..."*  
(MW36.1, p.11).

This highlighted the difficulty the midwife experienced in relinquishing a means of surveillance and reflects the challenge that changing practice presents to midwives who have worked for a long time within the medical model. Furthermore, although the policy may have changed the risk discourse has increased which provides a further source of tension when attempting to address the practice issues.

### **The Influence of Language on Control**

During the data collection I noted a discrepancy between the written language of official reports, policy and regulatory documents, explored in Chapter 2, and the verbal language used by the midwives in their daily practice. Although this discrepancy was not common to all midwives, the midwives did not always recognise this characteristic of their language and the concomitant issues of power and control. However, if they did recognise it as inappropriate, they did so without understanding the underpinning reasons.

### *Midwives to and about women*

It appeared from the data that several midwives talked to and about women in quite characteristic ways and these were reflected in their use of greetings and jargon, how they described the women to whom they were providing care and also the varying use of terms of endearment.

#### Greetings and jargon

Cameron (1992, p.105) commented that languages have normally developed a way or system of address that reflect or accommodate the distinctions of the culture. In this situation there has been a notable change from the more formal use of titles. However, where the midwife has introduced herself with reference to her own title highlighted the difference in the relationship and status; for example; “...*she even said what she was called, was it Sister X...*” (W25.2, p.14). Tannen (1998, p.262) also commented on relationships where one speaker addresses the other using a first name but is addressed by title is subordinate to another. She described this as an asymmetrical relationship which is governed by power.

When talking about women, midwives used terminology such as ‘primip’<sup>33</sup> meaning primiparous, ‘multip’ meaning multiparous, or ‘primigravida’ as these are part of the professional jargon normally understood by all midwives and doctors. Since the midwives knew that I was a midwife they expected that I would know and understand their use of such terminology, for example:

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<sup>33</sup> See glossary

*"...I also think in that early pregnancy period they are quite vulnerable, especially the primips..."*  
(M27.1, p.3),

I chose not to ask midwives to explain the terminology because I could not deny my knowledge of it, and it was further evidence of my insider role, and asking for an explanation may well have hindered the interviews. Furthermore this was an example of me demonstrating some solidarity with the midwives; Tannen (1998, p.262) also described how solidarity governs symmetrical relationships that feature equality and similarity.

#### Women or patients?

The term patients was, and is, commonly used by doctors and nurses and widely understood by those seeking health care. The use of this term inevitably leads to assumptions of illness or sickness and the notion of the sick role which identifies the obligations incumbent on the person who adopts the sick role (Parsons, 1951). This term has also been widely used in maternity care and both Kirkham and Hunt described how admission into hospital marked the adoption of the role of patient and subsequent manifestation of the sick role (Kirkham, 1989, p.121; Hunt & Symonds, 1995, p.75). I noted in my study that of the term 'patient' was still used by some midwives; for example; *"...I get the feedback from my patients..."* (M27.1, p.4).

Some midwives appeared to use the term woman comfortably perhaps recognising that 'patient' was not an appropriate term for childbearing women who were not necessarily patients in the accepted usage of the term in so far as they were not unwell or sick, but

others used the term woman or women occasionally and in and amongst using the terms ladies and patients; “...*the numbers of women I see...it's quite nice when another colleague will see a patient...*” (M28.1, p.6-7). Midwives sometimes referred to women as ‘mums’ and sometimes in quite a derogatory way, for example; “...*this bloody mum is coming to this clinic again...*” (M18, p.22).

Although a colloquial term, ‘mum’ was only technically correct after the birth; however it was not appropriate for all women in their pregnancy and the term ‘mum to be’ was then substituted. To some extent this was encapsulated in the term ‘mother’ and used as a ‘catch all’ term and this is the term Kirkham used when focusing on the midwife-mother relationship (Kirkham, 2000).

### Ladies and girls

The use of the term ‘ladies’ was very common, for example ‘my ladies’, ‘your ladies’ or ‘our ladies’; “...*whereas your own ladies, you know, because you see them every time...*” (M31.1, p.11).

Although not all midwives used this term, those that did deemed it acceptable and did not appear to appreciate that there were other connotations in the use of such language. Some midwives appeared to use terms women, ladies and patients interchangeably and the notion of ownership of the women by the midwives was rarely questioned or challenged. For younger women it was not uncommon for the term ‘girls’ to be used; “...*the younger girls are generally happy to...*” (M19, p.10). But on occasion the term ‘lasses’ was also heard; “...*yeah, there's one or two lasses who would have said...*” (M21, p.21 p13).

This use of the term ladies was noted by Oakley (1990) and Murphy-Black (1995) questioned why there was no comment made about it (p.290). Cronk used Berne's transactional analysis (1961;1964) to demonstrate the need for midwives to relate to childbearing woman on more equal terms; that is as one adult to another and not as parent to child (Cronk, 2000, p.25). Speer (2005, p. 35) cited Lakoff (1973) and suggested that women are more often referred to as 'girls', regardless of age than men as boys. Cameron (1992, p.106) has suggested that this is not just about friendliness, but rather it is a way of denying adulthood and removing the dignity of a subordinate group.

#### Terms of endearment

I was not accustomed to using terms of endearment, either as a midwife or in my educational capacity. I was however, aware of their use to some extent in the maternity care environment. Terms of endearment were rarely heard during the interviews with midwives about the women in their care although there was one exception to this; *".....but you always tell the lady, right luvvie... you've been doing all right but...."* (M21, p.10).

However, during the observations of labours and births various terms of endearment were heard used, for example 'darling', sweetheart' and sometimes praise given or behaviours reinforced by the use of the term 'a good girl':

*"...she had addressed [...] with a lot of endearments; 'darling' being the commonest, also 'sweetheart' and sometimes she called her a 'good girl'..."*  
(Fieldnote WB25, p.2)

This last did not appear to be perceived negatively by the woman as her overall perception of the situation was one of warmth and being welcomed:

*"...I remember thinking when we got onto the [labour] ward and we saw her and she said oh come in love..."*  
(W25.2, p.14).

Hunt mentioned terms of endearment in her ethnographic work (Hunt and Symonds, 1995, pp.81-82), particularly focusing on those used in the labour ward setting and also commented on women's negative responses to such terms of endearment. She also used Berne's transactional analysis (Berne, 1968) to liken these to the parent/child relationship but also cites Garmonikow's (1984) classification of social relations and suggested that this was indicative of the power and dominance of midwives over women. Cronk (2000, p.26).suggested that the tone of voice used by midwives should be similar to that we would expect our solicitor or others providing us with a service and that we would not expect to be addressed as 'dear', 'honey bunch', 'lovey' or 'duckey'.

Cameron (1992, p.105) commented that women tend to be the recipients of terms of endearment, and classified these as small insults within the sexism of everyday encounters. However, she also questioned their meaning and suggested that they denote intimacy, but if used by strangers would be construed as disrespectful (p.106). This presents a challenge and paradox for midwives since labour is an extremely private time for women, but has arguably become a very public process. Midwives undertake quite intimate procedures but whether they would be considered as 'intimates' is debatable. Furthermore some, though not all, women find such terms of endearment offensive.

Whilst a few of the midwives may have been exposed to the literature and discussions about the use of language during their pre-registration education, all of the midwives would have had some exposure to professional literature. Clearly some midwives have made attempts to change their language but others have not necessarily recognised the significance of changes in the language or adapted their own language as a result of this.

Some midwives used terms of endearments together with words such as ladies, girls or lasses without any apparent awareness of the connotations of such language; that is, that these terms may be offensive (Robson, 1993, p.478). However, these terms may also be considered at best patronising and at worst derogatory not only to the woman in their care but also to their midwifery colleagues.

It is not clear whether this language is considered sexist or not, as it is being used by women, to and about women. Other terms of endearment, such as 'love', appear to be a formative component of the local dialect and also used by men and women in a wider context. This usage may be more akin to Tannen's suggestion that "a strategy that is intended to dominate may in the words of another be one seeking to establish a connection" (Tannen, 1998, p.262).

However, guidance on the use of anti-sexist language suggests that men are rarely referred to as boys or gentlemen yet women may be referred to as ladies or girls as if they had not become adults (Robson, 1993, pp.477-478). Spender states that whilst the use of 'lord' still maintains its original meaning the term 'lady' is no longer only used for women of high rank and has undergone a process of 'democratic levelling' (1998, p.17).

However, Spender also cites Schulz (1975) and suggested that any words marked as female contribute to the 'semantic derogation of women' (Spender, 1998, p.16).

Spender has suggested that wherever there is sexist language and theories then the reality observed may well be sexist (Spender, 1998, p.96). Cameron also put forward the view that language could be viewed as a reflection of a sexist culture (1990, p.14), and that it is the business of language to represent reality (1992, p.103), although her preferred viewpoint is that language is a carrier of ideas and assumptions which become, over time, so familiar that their significance is missed and then not only reflected but demonstrated repeatedly in day to day encounters. However, Cameron also pointed out that sexist language cannot merely be labelled as such but recognised as a multi faceted phenomenon with many complex ways of representation.

Doyle (1998, p.150) suggested that the use of non-sexist language may well be paying lip service rather than addressing the fundamental issues of sexism in society. However, Cameron (1998) has also proposed that non-sexist language may be a concession made to feminism without ruining the dominant ideology (p.155) and that it is not sufficient to change words but to change the meanings associated with the words (p.161).

#### *The language of 'woman centred care'*

Concerns about the effect of language on 'woman centred care' has been expressed by Leap (2009, p.15); she indicated that there are many implications for the way in which 'woman centred care' is articulated, not least the use of the terms 'ladies' and 'girls' instead of women. I indicated in Chapter 4 that several midwives described to me their

understanding of 'woman centred care', however from the data above it was clear that their daily use of language did not always reflect this. It may be that as Stapleton et al., suggested (2002a) midwives have adopted the rhetoric of 'woman centred care' but have yet to change their professional practice. On the other hand it may be that as Woodward (2000), who draws upon Usher et al. (1997), considers, there is a reliance upon personal theory as a basis for practice and that formal theory is 'remote, irrelevant and useless'. Ziedenstein (1998, p.75) claimed that the language used by birth attendants reflects their attitudes and influences their beliefs and Hunter, L.P. (2006, p.123) considered that woman centred language should emphasise caring and respect.

In Chapter 2 it was shown how women were infantilised and patronised by the way in which they were spoken to and positioned in relation to the experts (Rudolfsdottir, 2000, p.337). Rudolfsdottir (2000, p.344) draws on a Foucauldian approach and suggested that this infantilisation was one strategy for 'downplaying the agency of pregnant women'. When women become pregnant they become part of the ideological and discursive practices of motherhood (p.338). Certain images and truths are preferred over others and may serve as norms and this may well extend to the way in which language is used.

It is difficult to identify exactly what is happening with the use of language in this context. Many midwives remain unaware of the implications of their language use even though I became increasingly sensitive to the use of language throughout the period of the study. I was not sure to what extent midwives were aware of the way in which they used these various terms, however since the midwives knew that my day job was in education, this may have contributed to this struggle to use 'correct language'.

Similar to Speer (2005, p.1), who described examples of comments where she knew that there was a 'gender thing' happening, but highlighted the difficulty of unpacking the patriarchal understandings of her claims, I was concerned as to whether this was sexist language representing the power dimensions of the cultural context or acceptable language towards and between women. Speer commented that a feminist interpretation of statements may rest less on the specific meanings attached to the words, but more to the knowledge and context of the words (p.2). The majority of women with whom I spoke during the study did not comment on the language used, or recognise the implications of the language used by the midwives. However, in relation to 'woman centred care'; it is reasonable to expect that 'woman centred' language should be both caring and respectful and be consistently used by midwives towards the women in their care.

## **Power and Control**

### *The hierarchy on delivery suite*

Hospital midwives on the delivery suite had more contact with hospital obstetric staff, namely consultants, registrars and senior house officers, rather than GPs. Their relationship with the hospital doctors was normally mediated through the midwife co-ordinator and highlighted a form of negotiated order between the midwives and the obstetric staff. For example if complications arose when a woman was in labour this meant that the senior midwife, acting as co-ordinator, became involved in advising about the care and management and whether or not a doctor should be called for example:

*“...it’s usually the co-ordinator [who calls the doctor] or the midwife that’s looking after her but it’s usually with the full knowledge of the co-ordinator...”*  
(MW36.1, p.4).

This appeared to be done firstly to ensure that the request was appropriate and thus legitimised and secondly to ensure that the co-ordinator was fully aware of the situation under consideration and the guidelines were being followed. From a negotiated order perspective this suggested some implications for the role boundaries (Allen, 1997, p.505) as it appeared that the co-ordinator was not only protecting the boundary between midwives and the obstetric staff but ensuring that she was the person discussing the situation and/or negotiating the likely intervention. It also highlighted potential for some boundary blurring (Allen, 1997, p.511) since the co-ordinator not only summarised the situation but often made suggestions for the potential intervention needed.

The issue of trusting obstetric colleagues appeared to be particularly important for the co-ordinator and was based on relationships with doctors being built over considerable time. In one situation, the importance of developing trust over time was clearly demonstrated when the obstetrician ‘on call’ was less well known to the coordinator;

*“...had it been one of our own consultants I would have rung them to discuss it with them.....I haven’t got the confidence in the registrar...and I don’t trust them...”*  
(MW36.1, p.5, 7).

The importance of trust in relation to boundary work was also reported by Allen (1997, p.512) though she reported this in relation to the potential for rule breaking. In this instance the co-ordinator chose not to contact the obstetrician to discuss the situation

because she did not know or trust him. Having confidence in one's obstetric colleagues is fundamental to sound working relationships within maternity care. However, in a maternity care setting this can have several consequences. The trust and confidence may be reciprocated and result in obstetricians not intervening unless requested to attend by the co-ordinator. Here the obstetricians are dependent on the co-ordinator to provide the necessary surveillance and both professional groups respect their role boundaries. Conversely, it may mean that when there is a close working relationship the obstetricians' presence may be welcomed and manifest as a 'watching brief' over all the women whether or not it is necessary. In this situation the boundary is rather more blurred. Both types of surveillance reflect the prevailing power of obstetrics in the current system (Arney, 1982). Interestingly Hunter (2005, p.256) found that unlike previous studies (for example Kitinger et al., 1990; Curtis, 1991; Murphy-Lawless, 1991) conflicts with medical staff were not reported and that a 'workable truce' had been achieved.

#### *Trust or compliance*

In order to achieve the necessary surveillance it was also important to the co-ordinator that the individual midwives kept her informed of the progress of the labour, or lack of it, of the women in their care. This also included discussing with and/or advising the midwife about the interpretation of any observations. This presented another area of boundary work between co-ordinator, overseeing the work and those midwives providing the immediate care to women. This was similar to the nurses providing direct care to patients in Allen's (1997) study.

Trust was again mentioned as one coordinator expected that the midwives trusted her; for example:

*“...when the staff midwives come up [to me] I’m hoping they’re trusting me...and if I say something is right that they trust me...”*  
(MW36.1, p.7).

This comment appeared to be linked with the concept of trustworthiness but alternatively could be interpreted as compliance or obedience; keeping the coordinator informed could be viewed as one of the unwritten rules of the culture. Hollins Martin and Bull (2005) reported the success of a senior midwife in influencing a more junior midwife and Hunter (2005) suggested that non compliance by the staff midwives could be construed negatively. Following these unwritten rules was a source of conflict for more junior staff and reported by Hunter as a source of emotion work.

#### *Lack of trust between delivery suite midwives and community midwives*

Conflict not only arose between senior and junior midwifery staff but also between delivery suite and community midwives. I was unprepared for the level of anxiety and apprehension expressed by some community midwives related to the hospital setting and their hospital colleagues. One community midwife stated:

*“...it’s hospital/community difference wherever you work...it’s different work and different stresses and it’s a lack of appreciation and respect for the different roles...not knowing where things are the routines, policies, procedures...and those that are there [hospital] all the time they don’t seem to be very understanding of that...it’s a barrier, it’s always been there, it’s quite hard.....I think the urgency and the situations that can arise, people are clinically good and know what to do and the support in those situations can be quite dire because you’ve just got to get on with it and how they [hospital midwives] handle you in that situation is appalling...”*  
(MW28.2, p.7, 8).

This midwife highlighted the importance of the policies and procedures of the hospital staff, mentioned in the first section of this chapter, and also acknowledged the expertise of her delivery suite colleagues when dealing with urgent clinical situations. However, she commented on her own negative feelings regarding the way she was treated by the same midwives. Kirkham (1999) identified a similar example in her work of a community midwife’s view of her routine updating. However, she did not specifically suggest this as a cultural difference between the two locations but went on to explain that the way in which midwives treated each other maintained the midwifery culture (p.736). Whilst my data did not demonstrate such a strength of animosity as displayed in Kirkham’s work, the anxiety and apprehension in some of the midwives’ accounts of their experiences showed clear similarities.

Although Maines and Charlton (1985, p.278) stated that negotiations occur when rules and policies are not inclusive, there appeared to be little negotiation evident between delivery suite and community midwives. I had no opportunity to observe such interactions therefore I am unable to report on this, however on the basis of the interviews with several community midwives a general comment indicates that the role boundaries were rather fixed.

Begley (2002, p.310) suggested that midwifery is a female hierarchy exercising power over women within a male-based power structure. Begley also cited Witz (1992) who suggests that an oppressed group such as midwives use dual closure to exclude others from their group (p.315). It could also be suggested that hospital midwives in this setting used this process to exclude community midwives from their group.

The notion of horizontal violence in midwifery encompasses a range of behaviours and was described by Leap (1997, p.689) as non-physical hostility, including a range of behaviours such as sabotage, scape-goating, negative criticism, failure to respect privacy or keeping confidences. It was also highlighted by Kirkham (1999, p.733) in relation to midwives generally. Such horizontal violence was evident in the interviews with community midwives. They described their experiences in the hospital setting and similar to Kirkham's findings (1999), some of the community midwives in this study expressed anxieties about working on the delivery suite. This was not reported by all community midwives but the extract above was not an isolated description. However, the midwives had not expressed their views publicly and demonstrated similar helplessness and muting when in the hospital setting (Kirkham, 1999).

#### *Community midwives and doctors*

Midwives' daily working relationships included other midwives and medical staff. For community midwives these included contact with GPs and to a lesser extent with obstetric consultants. The variable relationships and working practices of midwives and GPs has been highlighted by Battersby and Thomson (1997), and this is shown in the following examples:

*“...he’s often asking me for my opinion and he tells me things that I need that he thinks I need to know...you feel as if you’re on an equal level there, rather than the GP being more powerful...”*

(MW29.1, p.8);

*“...some of them [GPs] don’t want midwives in the surgery or some won’t let you do...and some of them are quite happy for you to do the whole antenatal and just refer them if they’ve got problems, so they all work different...”*

(MW18, p.7).

In the first example the midwife described a relationship which was characterised by the GP providing information for the midwife. However, this fails to acknowledge whether information that she provided to the GP was welcomed, although she implied an equal relationship and considered that her skills and experience were being used appropriately, which reflected the view presented in the *Changing Childbirth Report* (DH, 1993). This also suggested that there was little formal division of the midwife – medical boundary (Allen, 1997, p.511) and that some negotiation was possible between the midwife and the GP and that the midwife was not passive in the relationship.

In the second example the midwife related two differing modes of working. In one the GP excluded the midwife totally and in the second, a more common example, the GP’s involvement was limited to referral when problems are encountered. It was not clear whether the exclusion of the midwife in maternity care was also the woman’s choice but this is contrary to the recommendations of the *Changing Childbirth Report*, which indicated that GPs should work in partnership with midwives (Young, 1998). This also indicated a more formal division of labour between the GP and the midwife, though I had no evidence of how the boundary was negotiated when a formal referral was made.

Sometimes the midwives had to respond to women's choice with regard to not involving the GP:

*"...the patients said they didn't want to see him [the GP], they wanted to see me all the time and he's gone along with that but he's not right happy, in fact he was very cagey about midwife/GP led care and said that he would ideally like all his patients to have shared care and come to the hospital and see the consultants as well..."*  
(MW16, p.11).

In this situation the midwife had to negotiate the boundary both with the woman and subsequently the GP in order to maintain her relationship with the GP to assure future working relationships.

#### *Language on delivery suite*

Midwives commonly addressed each other on first name terms though when talking about others within their team or even to each other collectively also used the term 'girls'; *"...most of the girls do, yes...[call the co-ordinator]"* (M36.1, p.2). This suggested a degree of infantilisation not only of women by the midwives, as highlighted on page 262, but sometimes of midwives by their colleagues. This was also demonstrated occasionally by midwives talking about medical colleagues; although they commonly referred to doctors by their title for example the registrar or consultant, there were some examples where a midwife referred to a doctor as 'this girl'; *"...you know this girl has got problems..."* (M36.1, p.7).

Kirkham (2000, p.233) stated that since working as employees within institutions midwives have received orders from their employers and then given orders to their

patients and highlights that references to midwives by senior obstetricians as 'my midwives' or 'my girls' have often gone uncorrected. She cited Leap (1997) and Stapleton et al., (1998) and suggested that oppressive values have been internalised and then acted out on colleagues and clients. Stapleton et al., (2002a) also suggested that the use of language reflected the differences in power between midwives and others within the institutions. It is not yet clear whether this is a sufficient or the only explanation for the use of such terms in the daily practice of midwives.

### **Control and 'Woman Centred Care'**

The notion of control appeared to present a conflicting picture in midwifery practice and although my data was not as detailed as that of Green and Baston (2003) there were some similarities with other aspects of the literature. For some women it was very important, for others it was less so as they appeared willing to give this up to the healthcare professionals (Bluff and Holloway, 1994). Midwives consistently reported the need for women to be in control but the reality was rather different with some explicitly stating that women preferred them to be in control. One difficulty here is that women have been socialised into believing that the health care professionals 'know best' (Bluff and Holloway, 1994) and will act in their best interests (Baker et al., 2005) and this was deeply embedded.

For many women being believed and being listened to was very important. Not believing and trusting the women's understanding of their own bodies may have significant implications for midwives in relation to observing and understanding the progress of their labours, particularly if combined with not 'knowing' or having developed a trusting relationship. This highlights a significant gap between the reality of midwives' practice

and some of the available literature about recognising women's ways of knowing and recognising woman's private knowledge (Belenky et al., 1986) rather than prioritising authoritative knowledge (Jordan, 1997) as highlighted in Chapter 6.

Women and many midwives have come to rely on the surveillance and technology that has become commonplace in pregnancy and childbirth. Since surveillance strategies are often presented as essential within the risk discourse and without consideration of all the options, including refusal, it is more likely that women will comply with the prevailing norms. This further contributes to women's perceived lack of control and supports the arguments of some feminists that the 'medical gaze' has undermined women's sense of control (Rich, 1976; Shildrick, 1997). Midwives also experienced tension when existing practices, adopted to comply with the risk and surveillance discourse, were no longer required and therefore they needed to amend their clinical practice accordingly.

It was evident that increased the increasing use of procedures has contributed to the medical control of childbirth. Some of this has arisen from the risk discourse but also from the nature of working within such a bureaucratic institution which is dealing with large numbers of women, rather than individuals where the development of routines serves as an important coping mechanism for staff confronted by the problems of dealing with work stresses (Lipsky, 1980, pp.85-6). Routines may be described as the way in which every day activities are given form and structure and may be viewed as integral to both the individual and the institution (Giddens, 1984). Taking this a stage further routinisation is the way in which these routines are continually reproduced.

"Routinisation operates on two levels. At the level of the individual, it provides for ontological security in the predictability of events. At a collective level, routinisation is critical to the workings of institutions which exist by virtue of the continued reproduction of routines"  
(Frohlich et al., 2001, p.788).

Thus routines become embedded in the day today work of clinical practice and serve as ways to both limit scarce resources and manage the unpredictability of the work (Kirkham, 2004a, p.280). Kirkham (2004b) also commented on the ubiquity of rules or near rules and cautioned that although policies, procedures and guidelines may be derived from randomised control trials and applicable to the average childbearing woman, the reality is that all women are individuals. Furthermore guidelines often become adopted as standard practice and rules. Kirkham used the term 'proceduralisation' (2004a, p.273) to describe the circumstances where written procedures exist for all eventualities. Further issues around control emerged from some midwives desire to limit the uncertainty associated with their work and hence their reliance on tasks and rituals which further serve to control birth.

The term 'proceduralisation' had been used by Lawton and Parker (1998) reporting on the introduction of procedures to guide medical practice in the British National Health Service. They suggested that the use of procedures is useful way of managing risk, standardising practice and ensuring that research evidence is incorporated into client care. However, they cautioned that the development and introduction of procedures does not ensure that they are actually followed. They also outlined the potential effects of 'proceduralisation' on professional autonomy and on the working relationships between professional groups. They concluded that successful implementation depended on striking the right balance between standardising practices and allowing professionals to exercise clinical judgement.

In this study there was some evidence that language, not only in the use of medical or technical vocabulary, but also the wider use of language, by midwives to and about women, may tacitly undermine women's sense of control. This challenges women's

agency in relation to childbearing and reinforces the message that midwives retain control both over the women in their care and maintain a subtle hierarchy between midwives.

There was also evidence of hierarchical relationships within the hospital delivery suite which highlighted the lack of trust between colleagues and contributed to a lack of trust in the workplace. Without trust and positive working relationships it was difficult for midwives to support women or colleagues (Kirkham, 1999) and consequently the likelihood of empowering women was reduced.

### **Emerging Issues**

The nature of the data from this study has suggested that women's perceptions of control are variable. In Chapter 1 I suggested that Brown et al.'s (1994) explanation of 'woman centred' research could be adapted for 'woman centred care' with women occupying a powerful authoritative and controlling position in their childbearing. However, the challenges posed by this in relation to control appear to have been realised in so far as women's experiences of childbearing were constrained by issues of proceduralisation (Lawton and Parker, 1998; Kirkham, 2004a) safety and risk and surveillance.

Midwife-doctor interactions were not the main focus of the study though there is some limited data which highlights some of the tensions between midwives and doctors. Furthermore, the continuing evidence of hierarchical relationships between staff members on the delivery suite and boundary tensions suggested that much control still resided with midwives and other healthcare professionals rather than the women in their

care which suggests that women are at the bottom of the hierarchy. The language issues identified in relation to care also demonstrate how women are undermined and contribute to their place at the bottom of the hierarchy.

In the next and final chapter of this thesis I revisit the reformulated aims of the study and reflect on the notions of knowing and trusting, continuity, choice and control in the context of the data presented in this thesis. I also discuss how the various factors that have emerged from the data such as the policies affecting care, the notion of risk, surveillance and proceduralisation have impacted on maternity care and affect the extent to which 'woman centred care' is 'reality or rhetoric'.

## CHAPTER 8

### 'WOMAN CENTRED CARE': REALITY OR RHETORIC?

#### Introduction

In this final chapter I revisit my reformulated aims and outline the extent to which they have been addressed by the data. Secondly, I revisit and discuss how various factors such as the policies affecting care, the notion of risk, surveillance and proceduralisation have impacted on maternity care. I reflect on the notion of 'what is must be best' and consider how this operates in limiting women's choices and midwives' thinking. Thirdly, the extent and limits of negotiation in relation to the maternity care trajectory are discussed. In the light of these findings I consider the extent to which 'woman centred care' is 'reality or rhetoric' and highlight the tensions between the provision of care at the level of the individual and the demands of the institution and how midwives deal with this. Finally, I shall consider the limitations of the study and the implications for policy, practice, education and research.

In Chapter 1 of this thesis I stated the original description of 'woman centred care' as used in *Changing Childbirth* as follows:

*"The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved."*  
(DH, 1993, p.8)

This places women at the centre of care, implies that she has control over those who provide care and is able to make decisions based on sufficient information. The

description also assumes that women will have the opportunity for discussion with the midwives and/or doctors who may be involved. The concept of 'woman centred care' was underpinned by the principles of choice, continuity and control (House of Commons, 1992).

I adapted Brown et al.'s (1994) definition of 'woman centred' research, for 'woman centred care':

*"women are acknowledged as active, conscious, intentional authors of their own lives and can occupy a powerful authoritative and controlling position in their childbearing experience".*

(Adapted from Brown et al., 1994, p.5).

This statement had some merit when considering the notion of 'woman centred care', but that it also posed a similar challenge in interpretation in so far as social arrangements for childbearing and inequalities may constrain continuity, choice and control (see Chapter 1). Leap's (2000) definition of 'woman-centred care' also highlighted in Chapter 1, offers a comprehensive description of what might be included and features continuity, choice and control. It was then further developed in the philosophy statement for midwifery of the Australian College of Midwives (2004) and also highlighted the political dimension of the discipline.

From the preceding chapters I have identified a continued mismatch between the women's and the midwives' perspectives and also that the concepts of continuity, choice and control have not been fully realised. Whilst these terms were not always explicitly used by the women, they were familiar to the midwives and still had currency during the period of the study.

## **Aims of the Study**

My overall purpose in undertaking the research was to explore what was meant by 'woman centred care'; my findings in relation to women's experiences of their care and the views of midwives involved in the provision of care within a maternity service have been reported and explored within the concepts of continuity, choice and control. I will consider each of my research aims in turn.

The first aim was:

*To explore what was meant by woman-centred-care: what it meant to women and what it meant to professionals, specifically midwives.*

Chapter 4 demonstrated that women expected to know and trust their midwife and would be able to discuss with her what was best for them during their pregnancy. Knowing emerged as a key component of the woman-midwife relationship and which was also characterised by trust, previously documented by Kirkham (2000) and responsibility, described by Stevens (2003). Knowing and being known were also highlighted in Stevens' (2003) study. However, in this study differences appeared between community and delivery suite midwives in relation to their understanding of knowing.

Women appeared clear about the qualities they expected from midwives and the data supports the findings from other studies including wanting the midwife to 'be there' (Fraser, 1999) for them and to be supported (Lavender et al, 1999). However, sometimes women had previous negative experiences of midwives and on occasions

this had a serious impact on their childbearing plans, for example the woman who delayed a pregnancy to ensure that the midwife assigned to the area would have retired from her post before she needed antenatal care.

Midwives also were clear about the positive qualities of midwives that women wanted. These were similar to those expressed by the women, and community midwives stated it was important to be a 'real person'. Interestingly some midwives were also aware that they may themselves be perceived negatively though no explanation or suggestions were offered as to how this may be perceived by the women or the impact on the reputation of midwives.

Midwives were able to describe what their understanding of 'woman centred care' was and that care should be focused on the woman, with some recognition of the provision of care within finite resources. Of more interest was the suggestion that women's expectations may need some modification and that choice and continuity were 'allowed'. This may have been a slip of language but, as seen in Chapter 7, is an example of the way in which language may reflect health professionals' attitudes and beliefs (Ziedenstein (1998) and that power differentials may be reinforced by the use of language (Cronk, 2000).

The second aim was:

*To explore to what extent continuity, choice and control are reflected in the care offered by health care professionals, specifically midwives.*

## Continuity

In the literature, continuity of care appeared to be confounded by lack of agreement as to whether it related to continuity of carer or continuity of care and some lack of agreement as to its relative importance to women. However continuity still forms part of government policy (DH, 2004, 2007) and the challenges of continuity are well documented in the literature (Stevens, 2003; McCourt and Stevens, 2009; Sandall et al., 2008). From the participants' data, it was evident that women, especially those pregnant for the first time, expected that their community midwife, would care for them throughout their pregnancy, labour and birth and although the use of pathways of care offered some continuity of carer in pregnancy and postnatally there was no continuity over the full span of childbearing. This demonstrated no discernible difference between the provision of care during the period of study and traditionally organised care. Also evident in Chapter 5 was that continuity sometimes meant different things to community and delivery suite midwives. All the midwives identified the need for women to have continuity of care and of carer but some believed that this was unachievable or idealistic and that women were satisfied with the status quo.

It seems that this approach to continuity has changed very little over time and it is organisational factors that influence the extent of continuity. Although community midwives described difficulties in providing antenatal or postnatal care to women they did not know they did not extrapolate this to delivery suite midwives providing care to women they did not know. The midwives on delivery suite perceived themselves as experts in this aspect of care and suggested that delivery suite midwives were realigning themselves in the professional paradigm rather than 'knowing' and 'being with' women as suggested earlier in this chapter.

The complexity of the centralised services and the drive to standardise care appeared to constrain continuity of carer; however there was some limited evidence of community midwives negotiating with women to improve continuity. These are issues I will return to later in the chapter.

### Choice

The data demonstrated that choice for women was at best limited and at worst illusory. Since choice was limited then opportunities for negotiation were similarly limited. Community midwives told me about the importance of women's choice but some recognised that the choices were limited.

The type and frequency of care was mainly determined by the local policies and guidelines with limited opportunities for negotiation. With regard to place and type of birth there was evidence that some community midwives offered home birth as an option though it was not consistently offered. The community midwives viewed the birth plan as important and made a special effort to visit women at home to undertake this discussion. However, the interviews with women and the observations of labours and births demonstrated that preferences that may have been expressed by women either verbally or documented within their birth plans were not always acknowledged.

Constraints on women's choices were again constraints of organisational factors; with the prioritisation of the discourses of risk and surveillance affecting the way in which choices were offered and temporal factors often compromising the decision making

process. Some choices were made by default (Kirkham, 2004a) and there also appeared to be reliance on the experts knowing best (Bluff and Holloway, 1994).

### Control

The concept of women having or retaining control over their bodies and their pregnancy was also rather variable. Women were anxious that they would not be listened to or would be unable to trust their own bodies in the birthing process yet there were few, if any, strategies observed to support or facilitate women in this way.

Some women, for whom it was important, managed to retain involvement in decision making but others wished to relinquish control to others, often the midwife. It could be argued that retaining control and making decisions was easier for women in a community setting than in the hospital setting; however the potential for women to feel marginalised was sometimes evident in the community as well. Midwives collectively spoke about women having control and the importance for women of being in control; however, it was difficult for women to retain control within a system that they did not know and which at times appeared more controlling in terms of the policies, procedures, rules and regulations.

The maternity service also appeared to demonstrate hierarchical relationships, particularly evident in the delivery suite and, as discussed Chapter 7, there was a lack of trust between colleagues. Kirkham (1999) has documented the way in which midwives who are not able to trust and support each other will be unable to support women.

The nature of the language used by midwives towards the women in their care, between midwives when talking about the women and by midwives towards and about each other check was described in Chapter 7. The midwives did not always recognise this characteristic of their language and the concomitant issues of power and control. The majority of women with whom I spoke during the study did not comment on the language used or recognise the implications of the language used by the midwives.

I reflected on these findings and also noted the shift in the language used in policy documents and literature. Various authors have previously commented on the use of language by midwives (Kirkham, 1987; Murphy-Black, 1995; Hunt and Symonds, 1995; Leap, 2009) and in the context of this study, I felt that there was some link between 'gender talk' and the realisation of 'woman centred care'. The subtle use of words and terms that infantilises women limits their agency and reinforces power differentials between women and midwives and undermines women's ability to retain control of their childbearing experience.

Arguably, words used by midwives about women and to and about each other, are only words, a neutral means of expression (see Speer 2005, p.7), and may have no direct bearing on care given. Conversely, the use of oppressive and infantilising language may be viewed as a way of midwives keeping women and each other 'in their place' within the hierarchy and within the patriarchal system. Challenging this use of language may be perceived either as unnecessary or requiring too much effort to attempt to change the norms and practices of the entire system that perpetuates the status quo. Although, to some extent this has been addressed through the more recent pre-registration educational curricula, students continue to be exposed to the daily language of the midwives, and become socialised in order to 'fit in' more easily.

The third aim was:

*To explore how far the organisation of maternity services has changed with the notion of 'woman centred care'.*

Since the inception of the NHS childbirth has been subject to increased hospitalisation and medicalisation. This was recommended by a range of reports and policies, documented earlier in this thesis, which have both encouraged and sanctioned these trends on the basis of safety and improvements in mortality outcomes. However, concerns were raised by both women and professionals about the consistency of provision and the extent to which women's needs were being met. The *Winterton Report* (House of Commons, 1992) and the *Changing Childbirth Report* (DH, 1993) appeared to offer women a greater chance of having their needs met and giving midwives opportunities to use their skills fully. It has also been clearly stated in the most recent policies related to maternity care and in the professional literature that woman should be at the heart of care and thus their care be 'woman centred' (DH, 2004, 2007; NICE, 2006; NICE, 2007).

Despite policy documents that indicated a shift to primary care, the organisation of maternity care was, and still is, primarily within acute hospital Trusts (Walsh, 2001). This has meant that although hospital and community midwifery were organised under the same umbrella, care was fragmented between the community and hospital and ultimately the hospital based service appeared to take priority. The working practices of each group of midwives were governed by the type of care they were engaged in and it became apparent that not only were their working practices different but that their beliefs

and attitudes varied. Safety and risk issues, appeared to have greater prominence in the hospital setting, not least because of the need of the Trust to comply with CNST requirements. Whilst these issues also had implications for the community midwives, some felt they either had greater flexibility to interpret the policies and procedures or slightly less pressure to comply since they worked at some metaphorical, if not geographical, distance from the centre.

It was evident from the data that the issues that were important to women were not new and some of the difficulties that women experienced and reported had not been satisfactorily addressed. Initially it appeared from the data that there were two separate perspectives: one from the women and a different one from the midwives. However, subsequent analysis demonstrated there were multiple perspectives. Firstly, the women's experiences were identified; secondly, it became apparent that there were views or perspectives from the midwives, reflecting their sphere or context of work; thus one for the community midwives and another for the delivery suite midwives. Finally a further perspective emerged at the macro-level of the system which prioritised policies, rules, safety and risk management and the consequent importance of surveillance necessary to assure these.

### **Policy, Procedures, Risk and Surveillance**

Immediately prior to this study the most important policy document was *Changing Childbirth* (DH, 1993). The one local scheme set up in response to this had already been discontinued when data collection for this study started and the organisation of care reverted to the traditional model of practice. However, following on from *Changing Childbirth*, and during the period of the study there have been a plethora of other policies

directed at the maternity care services (DH, 2004; Shribman, 2007; DH, 2007), though Beake and Bick (2007, p.89) have suggested that despite such a comprehensive policy agenda in England the effectiveness of implementation has yet to be demonstrated. The concepts of continuity and choice have been restated in all the recent documents. However control was mentioned in relation to the Maternity Standard within the *National Service Framework* (DH, 2004), it is not mentioned in the most recent *Maternity Matters* (DH, 2007). 'Woman centred care' was included as 'woman focused' care in the *National Service Framework* (DH, 2004) but not mentioned in *Maternity Matters* (DH, 2007).

The difficulties faced by midwives trying to provide care to woman within the constraints of the NHS have been increasingly documented (Kirkham, 1999, 2000, 2004a; Kirkham and Stapleton, 2001; Sandall, 1995, 1998; Deery, 2003, 2005, 2008; Sandall et al., 2008; Stevens, 2003; Page, 1995, 1998; Page and McCandlish, 2006). Although some improvements to the maternity services have been noted there are still concerns about women's access to the service and safety and midwifery staffing levels (Anon, 2009).

The day to day practice agenda of the midwives in the study was governed by local guidelines and procedures and midwives described how these affected the care they gave, often making little differentiation between policies, guidance and professional rules. Modern forms of governance, demonstrating a close relationship between power and knowledge can be seen in this context. The idea of 'governmentality', according to Foucault (1979) is characterized by diffuse power which includes surveillance of individuals and populations, though at a distance (Cheek, 2000). Drawing on

Foucauldian perspectives and the use of the 'panopticon'<sup>34</sup> as a metaphor (Cheek and Rudge, 1994) it can then be seen how the pressure of the acute hospital at the centre exerts a tremendous force on those key points within its span. The closer the midwives and the women get to the centre, as they do when admitted in labour, in an obstetrically driven traditional system of maternity care, then the greater the pressure to comply with the policies and procedures of the institution. Although care is deemed to be 'woman centred' in practice the service is very much a bureaucratic and system centred, where concerns about risk, surveillance and compliance are key factors in driving the service. Abbott and Wallace (1990) questioned the extent that nurses and social workers were able to deliver personalised care to clients because both worked in bureaucratic organisations and the rules and regulations of the organisation conflicted with the needs of the client. Edwards (2008) reiterated the tensions highlighted by other writers including (for example Murphy-Lawless, 1991; Kirkham and Stapleton, 2004, and Deery, 2007) that midwives face when trying to balance the needs of the institution with those of the woman. It was noted that rather than 'being with' women, midwives all too often were 'with institution' as the constraints of the bureaucratic system characterised by obstetric dominance, detailed policies and insufficient time hindered an individualised approach.

Lipsky's (1980) notion of 'street level bureaucrats' also offers helpful insights into the ways in which midwives manage their work. Firstly organisational pressures, framed within the safety/risk discourse and implemented through policies, procedures and clinical standards and guidelines, constrain midwives' responses to individual women, since it is easier and quicker for time-pressed midwives to comply with policies and

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<sup>34</sup> Foucault used the metaphor of the 'panopticon' which was a circular prison with all cells facing an inward tower thus allowing for continuous scrutiny by the guards and prisoners did not know whether or not they were being observed – but was originally described by Jeremy Bentham.

encourage women to comply with available choices, rather than engage with them in exploring or negotiating concerns and preferences which are considered outwith of the accepted norms. Secondly, increased specialisation hinders midwives viewing their work or engagement with women as a whole. Although midwives have not experienced the degree of specialisation seen in other disciplines (for example medicine and nursing), midwives working in hospital, especially those working on the delivery suite were not able to gain a view of the full spectrum of childbearing and neither did the community midwives who provided antenatal and postnatal care only. Furthermore, the view expressed by some midwives and women in this study suggested that the midwives, particularly those in the hospital delivery suite were viewed as the 'experts' who 'knew best' (Bluff and Holloway, 1994) an issue that is addressed later in the chapter. However, the concept of being with or supporting women, as described by Leap (2000) challenges the reliance on 'expert' knowledge.

#### *Dealing with the safety/risk discourse*

Although recent documents have focused on service redesign (Shribman, 2007; DH, 2007) and the consumerist imperative of choice for women, the safety/risk discourse continues to dominate many decisions about service provision with an increase in centralisation and standardisation of maternity services. Furthermore, the settings in which midwives practice are dominated by concerns about risk, risk factors and risk avoidance (Edwards and Murphy-Lawless, 2006, p.35). It was evident from the data that the majority of woman in this study perceived hospital births as safest and they were reluctant to take any risks with regard to their pregnancy and birth. Similarly many midwives commented on prioritising safety. These findings support Edwards' (2008)

statement that ultimately women and midwives comply with birth policies and procedures.

Edwards (2008) has highlighted the difficulties of defining safety in relation to risk and draws on science, rationalism and neoliberalism for explanation. The scientific and rational approach to birth underpins the medical approach to birth and highlights the technological developments and expertise required for their implementation. However, Beck (1992) suggested that each new development brings a new set of possible disruptions and risks and these complexities have led to the notion of the 'risk society'. This has been particularly noticeable in relation to childbirth practices (Edwards and Murphy-Lawless, 2006, p.37). Furthermore, the scientific rational view of the body is as an inanimate mechanical object that can be repaired when faulty. Women's bodies are viewed as faulty especially in relation to reproductive activities (Shildrick, 1997), and, as mentioned in Chapter 7, this can undermine women's sense of control in relation to childbirth. The neoliberalist view suggests that pregnant women are treated like consumers and having a baby is considered in a similar way to visiting the supermarket, where woman can choose, but only from the available and affordable choices and there is no possibility of creating a personal view of safety rather than accepting the medically dominated one. As a consequence women become fearful and avoiding risks becomes a moral imperative.

It was not clear as to what extent midwives discussed the minutiae of safety and risk issues with women during their interactions. Furthermore such detailed discussions take time and are dependent on several factors. Firstly, there must be a relationship of trust between the woman and midwife to enable such discussion. As was seen in Chapters 4 and 5 whilst women spoke about wanting to trust their midwife, the lack of continuity of

carer over the full span of childbearing undermined the potential for a trusting relationship. Secondly, the midwife requires a thorough and accurate understanding of the safety/risk issues; however as suggested by Murphy Lawless (1998) the construct of risk can often depend on flawed statistics and may not be applicable to individual women. Furthermore, the culture of the environment means that it is sometimes difficult for midwives to 'let go' of strongly held and sometimes outdated beliefs (see Chapter 7). Thirdly, there must be sufficient time for such a discussion that should not be confined to the midwife giving information to the woman. This is particularly difficult when there is sometimes more telling of information than discussion (Kirkham, 2004a). Finally, the midwife requires confidence in her practice to challenge the status quo if required. This may prove difficult for midwives and as Edwards (2008, p.465) described how midwives might find themselves bullied or reported to the Nursing and Midwifery Council Conduct and Competence Committee. The culture of the service has also developed in such away that if a woman experiences a poor outcome to her pregnancy and birth the system demands that those involved have to account for their actions and protect themselves from being sued - which any of the women or their partners could do. This provides difficult terrain for midwives and women to negotiate so it is understandable that midwives continue to work within standardised regimes of care and maintain the status quo rather than challenge the policy directives and seek alternatives ways of facilitating women to positively experience pregnancy and childbirth.

### *Proceduralisation*

Procedures and tasks appeared to have become increasingly important during the span of this study. In Chapter 2 the way in which policy feeds into protocols, procedures and guidelines was highlighted and revisited in relation to the control of childbirth seen in

Chapter 7. The way in which midwives prioritise checking tasks over listening to women and meeting their emotional needs was seen in see Chapter 4 whilst in Chapter 7 the ritualistic nature of various tasks, particularly in relation to the birth, were also highlighted.

Many midwives commented on the influence of policies and procedures over their practice and this has also been noted by Symon (2001) who commented that practitioners can feel constrained by protocols. He acknowledges that although NICE have stated that guidelines and protocols are recommendations for action rather than instructions this is often not the case yet the unthinking application of a protocol would not be accepted as sufficient defence in the case of an error or incident (Symon, 2006, p.8). Symon suggest that it would be more helpful to use the term decision aid rather than policy, procedure or guideline. The introduction of the clinical risk negligence scheme has also driven the development of standards and procedures that govern clinical practice. Kirkham's use of the term 'proceduralisation' (Kirkham, 2004a, p.273) to describe the circumstances where written procedures exist for all eventualities, was highlighted in Chapter 7. Not only does this have an affect on professional autonomy and judgement but, as suggested by Lipsky (1980, p.121), such high degree of routinisation may dampen the tendency to differentiate among clients as people. It then ultimately contributes to making choice less likely for women.

As discussed on page 239 the risk/safety discourse underpins such development, and this includes Trust concerns over the potential costs of litigation in obstetrics. However, the uncritical adoption of this discourse and its sequelae has the potential to constrain midwives' skills in the recognition and support of normal childbirth and to further increase the philosophy of fear in women.

### **'What Is Must Be Best'**

One concept that recurred in Chapters 4, 6 and 7 was 'what is must be best'. This was originally used by Porter and Macintyre (1984) who stated that:

"Women tend to assume that whatever system of care is provided has been well thought out and is therefore likely to be the best one. Where they express a preference, it is generally for whatever arrangements they have experienced rather than for other possible arrangements. (Porter and Macintyre, 1984, p.1197).

The authors were describing findings from a study of innovation in maternity care in Scotland and reported that those who experienced the innovation were more positive than those who had not. They concluded that users' views will be limited by their experience and that there are complex links between expectations, preferences and satisfaction. This concept was revisited by van Teijlingen et al., (2003) who reported on women's overwhelming satisfaction with their antenatal, intrapartum and postnatal care. They described that one reason for such positive responses was that women were reluctant to criticise their care givers, although they cautioned that this may have been compounded by the study design and that satisfaction surveys should be used with care.

Similar to van Teijlingen et al., (2003) it was evident in this study that there was a tendency for women to say they preferred the care they had received. As seen in Chapter 4 this was related to the notion of knowing or not knowing the person who cared for them in labour. Although women expressed a preference to have a midwife known to them to care for them in labour, when asked after the birth some stated that it did not matter. Midwives also reiterated that this did not matter to the women. However, if the

woman had not experienced having a known midwife then she was unable to comment. As van Teijlingen et al., (2003, p.80) stated it is important to recognise that peoples' experiences and preferences are shaped by what they know. Lipsky (1980, p.94) also recognised that clients sometimes judge services positively if they are treated with respect regardless of the quality of the service. This has the potential to further confound perceptions of maternity care, since women might be reluctant to criticise their care or even put up with sub standard care if the midwife is 'nice ' to them.

In chapter 4 it was also shown that women were concerned about 'not rocking the boat' (page 166); this was associated with women's reluctance to articulate their preferences and to keep the midwives 'on their side' and not alienate their carers (Kirkham, 2004a, p.266). A similar aspect to not 'rocking the boat' was 'going along with things' which was seen in chapters 6 and 7. Hundley and Ryan (2004) found that women tended to say they wanted what they were offered rather than making alternative choices. If this is the case then this can be used to limit women's choices and ultimately women will tailor their expectations to fit the service norms.

Although my data demonstrated specific examples in relation to knowing or not knowing the midwife and making or not making choices there may be wider consequences of this concept in relation to the concept of 'woman centred care'. If women are to have an active and controlling position in their own childbearing experience it is important that midwives offer genuine choices with sufficient information that women feel able to enter into meaningful discussion and negotiation prior to making decisions. Midwives also need to be aware of how women's views may be limited by their experience and impact on the choices made or not made.

In this study women's views were gained via interview or during discussion during the observational component of the fieldwork, which may also necessitate the use of caution when interpreting the findings, since women may also have been reluctant to criticise their care to me. However, other interview findings from my data suggest that many of the women spoke freely and made comments knowing that I was not part of their maternity care.

### **Negotiating the Trajectory of Maternity Care**

There has been little explicit exploration of specific interactions between doctors and midwives or midwives and women from a negotiated order perspective (see Chapter 2). One of the few studies to draw on the idea was Benoit et al., (2005) who explored the social organisation of maternity care systems across developed welfare states, including the United Kingdom. They suggested that a re-negotiated order was possible between midwifery and obstetrics. As seen in Chapter 2 the concept of social order as negotiated was proposed by Strauss et al., in 1963 based on their observations of the complex division of labour in health care. They suggested that studying the formal institutional rules of a hospital was insufficient to explain how a social order was possible. Furthermore the notion of social order as relatively fluid and constituted through social interaction offered a challenge to the view of organisations as stable, formally organised bureaucracies where rule following was the norm (Gabe, 2004). However Strauss et al., (1963, p.162-3) had pointed out that not all aspects of activity were equally negotiable as they were dependent on a range of influencing factors.

I have used the term the 'trajectory of maternity care' drawing from Strauss et al.'s(1985) illness trajectory concept, which was underpinned by theories of social interaction.

Strauss et al., used the term 'illness trajectory' to reflect not only the way in which a disease unfolds but also the total organisation of work (1985, p.8) within increasingly fragmented bureaucratic structures. However, Allen et al., (2004) have suggested that the term 'trajectory of care' is more appropriate since Strauss' framework was based on a medical model which was not relevant to their study of chronic illness. For the purpose of this thesis, I have used the term 'trajectory of maternity care' to reflect the full spectrum of care.

In Chapter 7 reference was made to Maines and Charlton (1985) who stated that:

"Negotiations occur when rules and policies are not inclusive, when there are disagreements, when there is uncertainty, and when changes are introduced."  
(Maines and Charlton, 1985, p.278).

Within the bureaucratic structures of the increasingly policy and rule driven NHS, and where there is greater proceduralisation, it could be argued that there is less scope for choice and negotiation. However, exploring maternity care from this perspective was not a primary aim of the design of this study; I sought to explore women's experiences of their care and was sensitised to general tensions regarding the nature of the maternity services and the implementation of the most recent policies in the process of the fieldwork.

### *Negotiating the system*

Negotiating the system appeared to be a key process identified within the data, both for the women and the midwives, and operated at various levels. This suggested that the

system was not a tight coherent machine but something a little more amorphous and fluid but not at all transparent. Women had to access and negotiate the maternity care system and become familiar with the local arrangements for obtaining care. For women with a second or subsequent pregnancy this entailed identifying and negotiating any changes to the system which had occurred since their previous experience. This raised key issues for me about what was negotiable or non-negotiable within the system and if there was negotiation when it happened, with whom, and who held the power during the process of negotiation.

It appeared that there were many potential negotiation points during pregnancy and birth but at the outset of pregnancy many of the women were not aware of how to access care, what comprised the care and what was negotiable or non-negotiable. However what became apparent was that there were very few examples of negotiation.

Negotiating the system also merged as a process experienced by both community and delivery suite midwives. For the community midwives this was in relation to negotiating the maternity care system for, and with, the women in their care; and providing care to women within the constraints of the relevant policies and pathways. For delivery suite midwives it was about negotiating the plethora of policies within the hospital system and those policies and procedures directly relevant to providing care for labouring and birthing women. Sometimes, if a community midwife had previously worked on the delivery suite, accessing and negotiating the hospital based system appeared easier.

### *Negotiation and continuity*

In Chapters 4 and 5 it was shown that women had no choice of community midwife in relation to the provision of antenatal or postnatal care. Since there was no choice there was also little opportunity for negotiation. However, midwives made some efforts to try and provide antenatal care at convenient times and place for women; they also tried to minimise the number of midwives involved in postnatal care. These were examples of the midwives working around the system to try and provide improved continuity for the women because the system itself was not flexible enough to ensure this.

It was evident that the temporal organisation of midwives' work on the delivery suite, particularly the specified and allocated shifts, constrained continuity of carer. Whether this influenced the differing view of continuity by midwives on the delivery suite was not clear, however they demonstrated some negotiation between themselves so that a midwife might provide care to a woman she had met or cared for previously. Potentially the midwife could also stay with the woman over her allotted shift hours to maintain such continuity, but this would mean possibly working hours that either she would not receive financial remuneration for or time off in lieu or possibly making personal sacrifices. Again one possible reason for this was the inflexibility of the organisational model which required midwives to staff the delivery suite rather than being available for individual women on a more flexible basis.

### *Negotiation and choice*

The key boundary points for negotiation of choice were the same as those where choice was promulgated. However, in practice choices were limited and consequently there

was little evidence of negotiation. In relation to choosing the type of care, described in Chapter 6, there was little or no negotiation because the system which provided predetermined pathways of antenatal care. If women did not 'choose' the most appropriate pathway (as defined by the system) then they were persuaded to make a different choice. Svensson (1996) acknowledged that compulsion, persuasion and manipulation are all methods used in health care to make people behave in appropriate ways.

In relation to choosing their place of birth (see Chapter 6) most women chose the hospital as their place of birth based on the medicalised assumption that hospital birth with a medical presence was the safest option (Barber et al., 2007). However, if women were not consistently offered a genuine choice of place of birth then it was likely that a hospital birth was chosen supporting the notion of 'what is must be best', as discussed earlier in this chapter. Those women who chose a home birth also accepted the prescriptions of staff to transfer to hospital if required, although the extent of negotiation or persuasion that was involved in the encounter was not clear.

### *Negotiation and control*

There was some evidence that the recognition of labour was sometimes a contested area between the personal knowledge of the woman and the professional knowledge of the midwife. This emerged in relation to women telling me during their interviews about the importance of being believed, especially in relation to the onset and progress of labour. Being believed was a key aspect of control for these women because of gaining access to care and there was little evidence of negotiation; the professional knowledge of the midwife appeared to be privileged. Other potential negotiation points during

intrapartum care were not realised with women tending to accept the prescriptions of the midwife or doctor in the belief that 'they know best' (Bluff and Holloway, 1994).

### *Negotiating role boundaries*

Although this was not an anticipated part of the fieldwork there was some limited evidence of the negotiation of role boundaries (Allen, 1997) between midwives and obstetric staff and between the midwives. This primarily involved the midwife coordinator protecting the boundary between midwives and the obstetric staff but also highlighted some role blurring when suggestions were made to medical staff regarding potential interventions. Allen (1997) describes this as *de facto* boundary blurring which reflects the difficulty in sustaining a formal division of labour. This is applicable in the delivery suite situation since even after consulting obstetric staff midwives maintain ongoing responsibility for the woman in their care. Allen (1997) also described the way in which doctors had higher status within the organisational hierarchy. However, there was some limited evidence of hierarchical relationships between personnel within the delivery suite (see Chapter 7).

Trust appeared key to the maintenance of relationships between midwives and women and between midwives and their colleagues though there appeared to be several occasions when this was not realised. As was seen earlier in this chapter in the absence of trust between women and their midwives the development of the woman – midwife relationship becomes compromised and the absence of trust between colleagues undermines supportive, collegial relationships which underpin 'woman centred care'.

Reflecting on the possibilities and limits of negotiation within the maternity care trajectory has provided some glimpses into the complexity of care and the sites of the tensions and struggles. In the context of continuous government focus on maternity services and the ongoing consumerist perspective these findings reflect a service entrenched in a traditional model of care and midwives struggling with the rhetoric of 'woman centred care'. It could be argued that maternity care is a 'contested sphere of practice' (Lane, 2006) since traditional professional boundaries of knowledge and practice have been and continue to be challenged.

### **Midwives and their Primary Reference Groups**

Chapter 2 has highlighted how maternity services might relate to Lipsky's definition of a street-level bureaucracy (1980, p.3) and included the notion of midwives having to deal with women on a mass basis since their work pressures prohibit giving an individualised service. However, I also suggested in Chapter 4 that for the community midwives, the women formed their primary reference group, which is uncommon for street-level bureaucrats since clients are not perceived to be the primary reference group or to determine street-level bureaucrats' roles (Lipsky, 1980, p.47). For midwives working in hospital, particularly on the delivery suite their colleagues formed their primary reference group and as described by Lipsky, work related peer groups are much more significant in determining role behaviour.

It could be argued that the women do not directly determine community midwives roles since these are normally formally prescribed by the employer and the various professional requirements. However, the relatively isolated nature of community midwives work often means that on a daily basis community midwives possibly spend

more continuous time with individual women with potentially less opportunity during the working day to interact with colleagues, since when not attending women either at home or in another community setting, time is spent travelling and completing paperwork. Comparison with midwives based in hospital who when not directly involved in providing care to women may be observed interacting with colleagues on a more frequent basis.

This has a number of consequences. The time that community midwives spend with the women contributes to the development of woman-midwife relationships that are often maintained over time and contribute to the 'knowing' concept that is valued by the women. The community thus provides a context within which midwives can be 'with woman' and part of the wider family and social network and oriented to it in a way the hospital context prevents (Wilkins, 2000, p.48). Most community midwives also value this aspect of their work though acknowledge its exhausting nature. However this may also contribute to community midwives experiencing greater tension in meeting the needs of the women to whom they provide care; midwives run the risk of experiencing stress and burnout if they fail to apportion appropriate work and personal time, as evidenced in many of the earlier schemes introduced to improve continuity of care in the *Changing Childbirth* era (see Sandall, 1997).

Many midwives who choose to work in hospital, particularly on the delivery suite, do so because they prefer the hospital environment and value the more continuous support of colleagues. However, as noted in Chapters 4 and 7 this may provide a different set of relational challenges with colleagues in a more hierarchical setting. Midwives in hospital may feel more drawn to interact with colleagues, seeking professional approbation and socialisation. This may hinder the development of any type of rapport or relationship

with the women whose length of stay is relatively short and further compromises the likelihood of the woman's needs being heard and met.

### **'Woman Centred Care': Reality or Rhetoric?**

On the basis of the data from this study none of these descriptions of 'woman centred care' discussed at the beginning of this chapter could be seen as being easily fulfilled. Similar to findings of Baker et al., (2005) it was clear from the women who participated in this study that continuity, choice and control was not their overriding experience. However it is overly simplistic to state that the notion of 'woman centred care' is rhetoric rather than reality. The situation is far more complex.

In terms of what was meant by 'woman centred care', women wanted care that was focused on them and the opportunity to 'know' and develop trust in the midwife who provided their care. This 'knowing' is ideally developed over time, thus linked with continuity, and within the context of a trusting woman-midwife relationship. The notion of 'knowing' the midwife and being known by the midwife (Stevens, 2003) encompasses both professional and personal knowledge. Women also wanted to have their voices heard and to be believed (Baker et al., 2005). This gives primacy to the childbearing woman and her family and this will enable women to feel a greater sense of internal control and confidence in their own bodies and ultimately their ability to birth their babies. A greater sense of internal control also leads to women being more able to articulate their choices and preferences rather than being satisfied with the existing situation and dependence on the notion of 'what is must be best' (Porter and Macintyre, 1984; van Teijlingen et al., 2003).

Many midwives have acknowledged that getting to know the women they work with as one of the most rewarding aspects of their job (Deery and Kirkham, 2006, p.125) and midwives in this study believed that women were at the centre of their care; however the day to day reality of this was rather variable. Many of the community midwives commented on 'knowing' the women for whom they provided care and at the point of the initial contact between the midwife and the woman it was relatively easy for the woman to engage with the midwife and to be the focus of her care. However, the nature of this relationship appears to have changed, with increased information giving and surveillance and some reduction in frequency of contact.

It appeared that somewhere within the childbearing experience, often in relation to labour and the early postnatal period, care became increasingly fragmented, with a lack of continuity and midwives sometimes failed to listen to women or to believe and trust in women's bodies in relation to the birthing process. Furthermore, women, more often than not, were *controlled* rather than being *in control*. Midwives sometimes lost sight of the women and the women became rendered virtually invisible despite being at the centre of the surveillance system. Wilkins (2000) also described a greater priority given to tasks over caring and how women become overlooked as they become the object of professional practice with their insights dismissed and bodies taken over (p.49).

The lack of continuity of carer cannot be attributed to the midwives themselves; the nature of the organisational model of maternity care meant that continuity over the full spectrum of childbearing was not achievable. Deery and Kirkham (2006, p.126) have highlighted how services may be described as 'woman centred' when they are run according to an industrial conveyor belt model with no continuity of relationship between the woman and midwife and with midwives viewed as interchangeable workers who

have to keep the system running. McCourt et al., (2006, p.142) imply that it is the strong influence of such industrial systems of care that have constrained the development of systems of care with which have a greater emphasis upon continuity of carer. They suggest that a change in the pattern of practice is necessary but may not be sufficient and that new patterns of practice are needed; however they point out that the development of alternatives requires a huge change in attitudes.

Deery and Kirkham (2006, p.126) also comment on how the policy initiatives have failed to acknowledge the level of support that midwives require in order to develop and sustain meaningful relationships with women. They also describe how organisational support given to getting through the work has led to the development of strategies that undermine the primary task of caring for women. It was very clear that being a midwife was, and is, a complex job with numerous overlapping and sometimes conflicting pressures. Midwives do their best under difficult circumstances working within the obstetric hegemony (Edwards, 2004) and NHS bureaucracy, as street level bureaucrats (Lipsky, 1980), but the overriding policy and risk agendas mean that there were minimal opportunities for choices for the women and that women had little control. Leap and Edwards (2006, p.99) recognise that choice and control are problematic and complex and that women are likely to have little control or understanding about the values upon which the various regimens or choices are based upon. Whilst the principles of the policies highlight consumer choice, implementation at a local level presents challenges for midwives. If women are to have choice then they must have adequate information and genuine options, at an appropriate time. The pressures on community midwives to give all this information does not necessarily facilitate this process since many women feel rushed and pressurised. Furthermore, if women are to have choice then it seems this should include not only the choice of midwife, but also to the type of care and place

of birth, and their choices respected. This becomes difficult when midwives again feel pressurised by Trust policies and the 'stick' of safety and litigation and the culture of blame is ever present.

Baker et al., (2005) described the rule governed nature of maternity care where women are expected to behave in certain ways with little opportunity for negotiation and reluctance to speak out. This resembles the Foucauldian notion of disciplinary power (Foucault, 1979) and the regulation of women's bodies (Rich, 1976; Edwards, 2004). This view highlights the way in which childbirth has been constructed as a risky situation requiring the expert skills and knowledge of specialist staff and thereby undermining women's autonomy and self determination (Baker et al., p.334). As a consequence technology and intervention are prioritised and choice becomes either coercive or rendered meaningless (Anderson, 2004; Edwards, 2004).

#### *Feminist perspectives on 'woman centred care'*

The challenge to the midwifery profession is to find a way of providing genuine 'woman centred care' within the current structure of the health care system (Klima, 2001, p.288). Drawing on feminist perspectives it is important that if 'woman centred care' is to be realised then power and information must be shared between the woman and the midwife or other health care professionals (Klima, 2001, p.289). Leap and Edwards (2006, p.99) note that power imbalances ensure that in most situations the person who does the informing 'influences' the decisions that individual women make. This means that there needs to be a shared understanding, between women and midwives and between midwives themselves, of what 'woman centred care' means and how this care will be experienced by the woman.

If power and information are to be shared then the language of 'woman centred care' must also be considered (Leap, 2009) and forms of address and terms of endearment that may undermine the woman-midwife encounter should be discarded. The encounters should also facilitate a supportive and trusting relationship and ensure that women are active participants with informed choice rather than a rhetoric of choice (Baker et al., 2005).

If women are to be supported by midwives then, as I have already indicated, it is imperative that midwives themselves are supported (Deery, 2003; Deery and Kirkham, 2006) since feminist perspectives cannot concern the women without also focusing on the midwives who are expected to provide 'woman centred care'. Deery and Kirkham (2006, p.137) also suggest that factors that provide support for midwives also enhance support for their clients and include a small scale organisational model of care; challenging the industrial conveyor belt care and enhancing continuity and professional autonomy.

#### *Alternatives to traditional maternity care*

In order to facilitate 'woman centred care' it is important that midwives are able to articulate and agree their shared understanding of the meaning of the term and how it might be implemented in clinical practice. They also require sufficient time to establish a meaningful relationship based on trust and to provide sufficient and appropriate information so that women feel more confident in their ability to make or negotiate choices. Midwives have to negotiate between what the women expect and want and what the policy driven agenda demands; evidence from this study indicates that such

negotiation is more likely from the community midwives' perspective, than the hospital midwives' perspective. However this requires flexibility and goes beyond the view of childbirth as either within a medical or social paradigm.

Wilkins (2000) suggested that the only way for midwives to be 'with woman' is to do this outside of the professional paradigm although she also implies that midwives' views do not have to be identical or completely subjective but that to be a 'caring professional' is not enough. This would be difficult to achieve as the majority of midwives practise within NHS employment within a heavily regulated environment and working outside of the professional paradigm is not an option. Davis-Floyd (2005) suggests the notion of a 'post-modern' midwife who needs to work fluidly between the various paradigms, namely the biomedical system, traditional midwifery methods and professional midwifery - recognising their strengths and limitations but also incorporating the unique 'woman centred' dimensions (p.33). In some ways this offers a far less polarised option of midwifery practice for the future, but none the less, a challenge for midwives since it is still a long way from many midwives current practice. Although the notion of a 'post-modern' midwife is appealing this proposal fails to acknowledge that perhaps the whole system or organisation of maternity care needs to change in order to facilitate true 'woman centred care'. If the fundamental tension is between offering care at the level of the individual when the organisation is orientated towards standardised care reflecting institutional norms then changes to the organisational model are required, with features that promote continuity of carer, autonomy and responsibility (Stevens, 2003, p.312).

These changes require an approach to maternity care that offers women genuine options. Such occasions for choice might include the opportunity for each woman to choose the midwife who attends her and to negotiate the level of continuity and type of

care and place of birth required to fulfill her birth aspirations (Leap and Edwards, 2007). This type of care would not privilege normal birth over interventionist or surgical interventions as Leap (2009) cautions but focus on 'woman centred care' within a collaborative framework.

This also accommodates a greater range of maternity service models rather than polarised medical/social or obstetric/midwifery led arrangements. Models of care that have proved more effective in providing 'woman centred care' include those which have adopted a 'one-to-one' approach to care (McCourt et al., 1998) and 'case load' practice (Sandall et al., 2001; Stevens, 2003). In both of these approaches midwives worked within the NHS but outwith of the traditional type of service. These involve midwives either working in pairs or small groups with smaller case-loads offering greater continuity of carer and the opportunity to develop meaningful and trusting relationships with women. They also experience greater autonomy in their working practices. The development of free standing birth centres (for example Walsh, 2007b) demonstrates a contrasting way of being 'with woman' and offering 'woman centred care'. Walsh (2007b, p.52) describes how childbirth can be taken off the 'assembly line' and challenges the bureaucracy and institutionalisation that has influenced childbirth. This is a very positive and postmodernist approach to childbearing and offers smaller scale option for maternity care.

### *Summary*

Unfortunately the policy documents that have driven the aim of 'woman centred care' fail to take into account the number of issues and competing priorities that stakeholders have to consider at the level of the operationalisation of the service. These include the

nature of the system itself, the drive towards the management of risk, the centralisation of maternity services, the financial pressures that are inherent within the NHS and the tensions between offering individualised care within an institutional framework.

The organisational focus is on the system itself rather than the day to day dealings with individual women requiring care. The system assumes that being well organised will serve the interests of all women equally well. However, the very nature of a bureaucratic system means that those who work within it are torn between providing an efficient and effective service and improving their responses to those in receipt of the service (Lipsky, 1990, p.4). Furthermore those working within the system have been trained to offer individualised care, whereas the reality in practice means that the numbers of clients prohibit an individualised service (Lipsky, 1980, p.xii).

These findings pose a challenge for policy, practice and education. This is not least because the policies already set an agenda for 'woman centred care' that midwives on occasions struggle to address. Also, for many midwives complying with the policies, procedures and guidelines may make their daily job easier (Lipsky, 1980). Although many of the midwives in this study recognised the constraints within which they worked, few sought to challenge them or risk stepping out of line to do so. Likewise, few of the women challenged the status quo of the care on offer, not least perhaps because they viewed the health and safety of their baby as paramount, and they possibly assumed that compliance would ensure this.

## **Limitations of the Research**

As with any research study there were some limitations. Qualitative designs focus on meanings and understandings but the small sample numbers involved can constrain the generalisability of findings. Nevertheless, these findings do add to the body of knowledge around the nature of midwifery care and 'woman centred care' in particular.

Due to this study being undertaken on a part time basis that is in addition to my main full time job the fieldwork had to be arranged around my normal working commitments. This was less of a problem for the interviews which were arranged at mutually convenient times; however arranging the observational aspect of the study was more problematic. In phase two I negotiated specific time for this aspect of the work. However this was so specific to the five women who were participating that there was little other time for staff in the fieldwork site to become accustomed to my presence in the area. This may well have affected their behaviour when they were being observed, but I cannot say with confidence in what way.

In phase two the main focus was on the five women and the midwives who were involved in providing care. However, this mainly included the community and delivery suite midwives. All of these women spent some time in the postnatal ward environment prior to their transfer home, however I was unable interview these ward based hospital midwives. Although the women themselves sometimes commented on this aspect of their care, and these have been captured in the data, I do not have the full range of views from all midwives' involved in their care.

## **Insider Outsider Issues and the Emotion Work of Research**

Although I was a novice researcher I recognised that my years of clinical and educational experience could not be ignored. Hence it was necessary for me to both explore my underpinning beliefs and philosophy of midwifery and then try to set these aside so that I would not prejudice the study. As I progressed with the research, I became more aware of the complexity of my various positions and beliefs and also recognised that I had both inside and outsider status in relation to the study.

I highlighted in Chapter 3 that, similar to others for (example Pellatt, 2003; Deery, 2003), I was unprepared for the emotional impact of the research on myself. She also referred to the work of Coffey (1999) in relation to the emotions generated by the fieldwork and the personal journey of self-discovery that may be undertaken. For me, the journey has been lengthy and on occasions made longer by the emotional impact firstly of the fieldwork and secondly of the analysis and writing up.

As an insider, negotiating access and seeking consent to the various areas and personnel was made slightly easier. However, as an insider I was also a part and a product of the system I was seeking to enter, albeit in a different role. Thus my own socialisation within a patriarchal system generated anxieties for me in dealing with the various medical personnel who appeared to have the power to 'allow' me, or not, to undertake this study. Had I been an outsider seeking access to the system without such a personal history, this may have been easier.

Undertaking the fieldwork, listening to the women's stories and observing their births were powerful and emotional experiences. I acknowledged this in my personal

reflections at the time and was able to share some of this with my supervisors, but on reflection it may have been easier had I arranged and used some formal support for this element of the work. However, it was not only listening to, or observing the women, some of the interviews with the midwives also generated strong emotional responses in me. Some of these feelings and emotions reappeared during the data analysis and the period of writing up, this made these parts of the work even more difficult as I tried to maintain objectivity whilst recognising the issues for the women, the midwives and for midwifery practice and trying to find a meaningful way of taking these forward.

With hindsight it should have come as no surprise that these emotions emerged, however the literature on emotion work in midwifery was only just emerging and links between that and fieldwork in midwifery were not yet clear to me. The personal journey in this type of study goes far beyond the fieldwork and the analysis. This has been about recognising more clearly the issues women face when seeking care and the enormous pressure that midwives face, on a daily basis, in providing it in the current climate.

## **Recommendations**

### *Recommendations for practice*

- There is a need to ensure that midwives have a shared understanding of 'woman centred care', that they are able to articulate and demonstrate in their day to day practice and to be 'with woman'.

- Ensuring that midwives have a shared understanding of knowing, trusting and listening in a midwifery context, beyond the tasks currently undertaken, so that these elements of the role are more clearly recognised. However, this may well have further consequences as the emotional aspects of midwifery work (Deery, 2003) are exposed.

#### *Recommendations for service development*

- Develop, implement and evaluate alternative organisational models to facilitate 'woman centred care' and to provide continuity of carer for those women who desire it.
- Address the organisational factors that constrain women's choices so that genuine choices with sufficient and appropriate information are made available and women are able to feel in control of their childbearing experience.

#### *Recommendations for education*

- Address the concept of 'woman centred care' within pre-registration midwifery curricula and explore how it can be best achieved within various organisational models of maternity care provision.

- Prepare students effectively for the multiple pressures that midwives have to negotiate in their daily work and facilitate the development of strategies for students to manage these effectively in clinical practice.

#### *Recommendations for further research*

- Further research at the site following the implementation of the reconfigured service.
- Collaborative and interprofessional research is needed to explore alternative organisational models of care to improve continuity of carer and
- Further exploration of the impact of language on implementing and sustaining 'woman centred care'
- Exploration and evaluation of telephone support for women by their 'known' midwife.

#### **Concluding Thoughts**

When I first began this study I was preoccupied with the notion of what 'woman centred care' really meant because I felt sure that it was a notion that went beyond reorganising midwifery care into various schemes and teams. I too had used the term 'woman centred care' without really exploring it or challenging what it might mean for women and midwives. The research question seemed simultaneously superfluous and vague and

this continued to preoccupy me for the duration of the study. At intervals I felt anxious, confused but sometimes vindicated as I talked to woman, midwives and observed midwifery practice. Clearly 'woman centred care' has continued to be used by policy makers as documents published after my data collection, but before completion of the thesis, demonstrate. Visits to other universities in my capacity of educationalist also highlight that the concept of 'woman centred care' has many meanings. Thus this study has posed as many questions as it has answered about the nature of midwifery care and how this is organised and offered.

It was evident that despite the consumerist rhetoric of 'woman centred care' and its original underpinning principles of continuity, choice and control, that this was not the overriding experience for the women who participated in the study. There still appears to be some discrepancy between what women want and what is provided, as my data have demonstrated. What was also evident is that practices and language, in relation to labour and birth that were observed by researchers in the 1980s and 1990s were still evident during my fieldwork. It appeared that although midwives described 'woman centred care', the reality of care was overshadowed and confounded by the increasing safety/risk discourse and the plethora of policies, procedures and rules that governed midwives' clinical practice and constrained women's choices and the likelihood of them retaining control over the experience. The increasing bureaucracy of the maternity care system also constrains continuity of carer over the full spectrum of the childbearing trajectory and reduces the potential for women to know the midwife who provided care. Thus for many midwives being 'with the institution' was more likely than 'being 'with woman'.

I was clearly unprepared for the emotional impact of the research, and in particular undertaking the observational aspect of the fieldwork, despite Coffey (1999) stating that fieldwork is about emotions. The majority of the women appeared 'grateful' for their care, regardless of its content, and women appeared to accept that they did not know the midwife who cared for them in labour and that she did not know them. Despite the references to women's choice and the need for women to be in control it was evident that this was not realised. However, being able to stand back and observe a labour and birth and not giving care was a privilege as this is a rarity for most midwives and for those women who allowed me to follow them through labour and birth I was the one person who achieved continuity and 'knew something', though not all, about their history and their care.

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