

The limits of choice: how community midwives negotiate choice in and  
of their practice.

Helen Cameron

Professional Doctorate

University of Salford

School of Health and Society

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# Table of Contents

<b>List of figures</b> .....	<b>viii</b>
<b>List of tables</b> .....	<b>ix</b>
<b>Acknowledgements</b> .....	<b>x</b>
<b>Abstract</b> .....	<b>xi</b>
<b>Chapter 1</b> .....	<b>1</b>
<b>1 Background to the study</b> .....	<b>1</b>
1.1 The study aim.....	1
1.1.1 The rationale for the study .....	2
1.1.2 Personal and professional perspective .....	4
1.1.3 Community midwifery in context .....	6
1.1.4 The history of choice within UK maternal health .....	7
1.1.5 Better births .....	10
1.1.6 Negotiating competing discourses of choice and risk in community midwifery practice.....	14
1.1.7 The rationale for adopting a Foucauldian lens .....	16
1.2 Reflexivity .....	18
1.3 Structure of the thesis .....	19
<b>Chapter 2</b> .....	<b>21</b>
<b>2 Introduction to the study</b> .....	<b>21</b>
2.1 Introduction.....	21
2.1.1 The UK Government policy on choice in healthcare .....	21

2.1.2	Drawing on psychoanalytical theories and issues of trust.....	24
2.1.3	The impact of autonomy .....	27
2.1.4	The construction of choice in maternity care.....	29
2.1.5	Personal reflections on enabling choice across different services ....	30
2.1.6	The notion of the “good mother” .....	32
2.1.7	The impact of intellectual and social capital on choice .....	33
2.1.8	Barriers to genuine choice .....	34
2.1.9	The application of policy to practice.....	35
2.1.10	Women’s response to <i>Better Births</i> .....	36
2.1.11	Information steering.....	37
2.1.12	Midwives’ myths .....	38
2.1.13	Women demanding choice .....	39
2.1.14	The ontological positioning of community midwifery.....	40
2.1.15	Conclusion.....	43
<b>Chapter 3</b>	.....	<b>45</b>
<b>3</b>	<b>Literature Review</b> .....	<b>45</b>
3.1	Introduction.....	45
3.2	The rationale for the literature review .....	45
3.3	The scoping review .....	46
3.4	The review objective.....	47
3.5	Identifying relevant studies.....	47

3.5.1	Electronic databases .....	47
3.5.1.1	Reference lists .....	49
3.5.1.2	Hand-searching of key journals.....	49
3.5.2	Study selection .....	49
3.5.3	Charting the data .....	51
3.5.3.1	The countries where the studies took place .....	51
3.5.3.2	Study setting .....	54
3.5.3.3	Participants. ....	55
3.5.3.4	Methodologies used .....	56
3.5.3.5	Summary of essential information .....	59
3.6	Narrative account of the themes.....	59
3.6.1	The limiting of women’s autonomy.....	60
3.6.2	The framing of risk in relation to choice .....	66
3.6.3	Interprofessional working .....	70
3.6.4	Organisational influences on choice .....	72
3.6.5	Informed choice and shared decision-making.....	75
3.6.6	Summary of findings .....	77
3.6.7	Consultation exercise .....	80
3.6.8	Limitations to the review .....	81
3.6.9	Conclusion.....	81
<b>Chapter 4</b>	.....	<b>83</b>

<b>4</b>	<b>Methodology</b> .....	<b>83</b>
4.1	Introduction.....	83
4.2	My epistemological and ontological stance .....	83
4.2.1	Post-structuralism .....	85
4.2.2	Feminism .....	87
4.2.3	The importance of reflexivity .....	89
4.2.4	Discourse analysis.....	91
4.2.4.1	The statement .....	94
4.2.4.2	Approaches to discourse analysis.....	96
4.2.5	Judith Butler.....	99
4.3	Methods .....	99
4.3.1	The datasets .....	100
4.3.1.1	The information leaflets and websites .....	100
4.3.1.2	Leaflet 1 Choosing where to have your baby .....	101
4.3.1.3	Leaflet 2 Planning a home birth.....	103
4.3.1.4	Isolating statements .....	104
4.3.2	Sampling strategy .....	105
4.3.3	Data collection: Interviewing .....	108
4.3.4	Reflections on power in the interview process.....	109
4.3.5	Data analysis framework.....	111
4.3.6	Issues of rigour .....	113

4.4	Ethical issues in research.....	114
<b>Chapter 5.....</b>		<b>117</b>
<b>5</b>	<b>Analysis of the datasets .....</b>	<b>117</b>
5.1	Introduction.....	117
5.2	Locating statements .....	117
5.2.1	Analysis of Leaflet 1 and the host website .....	117
5.2.1.1	Defining and locating statements .....	117
5.2.1.2	The pregnant patient .....	118
5.2.1.3	Reinforcing the medical discourse .....	119
5.2.1.4	The risky pregnancy and birth.....	121
5.2.1.5	Intertextuality and the discourse of choice .....	122
5.2.1.6	Hidden discourses.....	124
5.2.2	Data analysis of website 1 .....	126
5.2.2.1	The disembodied pregnant woman .....	127
5.2.2.2	The threshold of epistemologization.....	129
5.2.3	Data analysis of the leaflet 2 <i>Planning a Home Birth</i> .....	130
5.2.3.1	Birth as an embodied experience .....	130
5.2.3.2	Community midwifery knowledge .....	133
5.2.3.3	“Holding” the woman .....	134
5.2.3.4	Being with women .....	135
5.2.4	Data analysis of website 2 .....	137

5.2.4.1	Community .....	137
5.2.5	Summary of analysis .....	139
5.2.6	Data analysis of the community midwife transcripts .....	141
5.2.6.1	Locating the women in the community .....	141
5.2.6.2	Locating community midwifery in relation to hospital midwifery .....	143
5.2.6.3	Responding to risk .....	145
5.2.6.4	Disciplinary power .....	147
5.2.6.5	Midwives exercising power.....	148
5.2.6.6	Institutional power .....	149
5.2.6.7	A community midwifery risk discourse.....	154
5.2.7	Summary .....	155
<b>Chapter 6</b>	.....	<b>157</b>
<b>6</b>	<b>Discussion of findings</b> .....	<b>157</b>
	Introduction .....	157
6.1.1	Community as a disciplinary space.....	158
6.1.1.1	Utopia and Heterotopia .....	162
6.1.2	The document and issues of power .....	164
6.1.3	Technocracy and the contextualisation of risk .....	171
6.1.4	Docile bodies and midwifery abdication .....	175
6.1.5	Community midwifery risk discourse.....	181
<b>Chapter 7</b>	.....	<b>183</b>

<b>7</b>	<b>Conclusions and Recommendations .....</b>	<b>183</b>
7.1	Introduction.....	183
7.2	Conclusions.....	184
7.3	Implications for policy and practice.....	186
7.4	Limitations of the study.....	188
7.5	Recommendations .....	188
7.5.1	For practice:.....	188
7.5.2	Research Dissemination .....	189
<b>8</b>	<b>Appendices.....</b>	<b>190</b>
8.1	Data charting form.....	191
8.2	Leaflet 1:Choosing where to have your baby .....	209
8.3	Website for leaflet 1.....	214
8.4	Leaflet 2: Planning a home birth.....	215
8.5	Website for Leaflet 2 .....	223
8.6	Confirmation of ethical approval .....	224
<b>9</b>	<b>References.....</b>	<b>225</b>



## List of figures

Figure 3.1 themes arising from the studies.....	60
Figure 4.1 Statement 1, Leaflet 1 .....	118
Figure 4.2: example of medical terminology Leaflet 1 .....	120
Figure 4.3 Statement 2, Leaflet 1 .....	121
Figure 4.4 Statement 3, Leaflet 1 .....	124
Figure 4.5 Leaflet 1: website .....	127
Figure 4.6 Leaflet 2: statement 1 .....	130
Figure 4.7 Leaflet 2: statement 2.....	132
Figure 4.8 Leaflet 2: statement 3.....	134
Figure 4.9 leaflet 2: statement 4 .....	135
Figure 4.10 Leaflet 2: website .....	137

## List of tables

Table 3-1 inclusion criteria.....	48
Table 3-2 inclusion and exclusion criteria.....	50
Table 3-3 Country of origin.....	51
Table 3-4 Study location.....	54
Table 3-5 participants.....	55
Table 3-6 Methodology.....	56
Table 4-1 Representation of research process.....	85
Table 4-2 Characteristics of the midwives.....	111
Table 4-3 Analytical framework.....	113

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## **Abstract**

### **The limits of choice: how community midwives negotiate choice in and of their practice**

This study explored the ways in which community midwives negotiate competing discourses when supporting choice in pregnancy and birth. The ways in which choice was presented to pregnant women by NHS Trusts providing maternity services, via their information leaflets and the websites that host them, offered an indication of how such organisations conceptualised pregnancy and birth, providing the context in which the community midwives practised. Foucauldian discourse analysis was undertaken of the leaflets and websites, illustrating the discursive structures in which community midwives worked. Interviews with community midwives explored the ways in which they negotiated competing discourses when supporting women to make choices in their pregnancy and birth.

In *Leaflet 1* and its host website, a dominant medical discourse was identified. The power/knowledge of this discourse could be traced to a medical philosophy that believed that pregnancy and birth are risk laden activities, that women's bodies are likely to fail and therefore require medical input to manage. In this discourse women are discursively constructed as patients, which repeats and renews medical dominance.

*Leaflet 2* and the associated website demonstrated a midwifery discourse, which recognised pregnancy and birth as a social as well as a biological construct. In this discourse, the community midwife is discursively constructed as one who understands and supports physiologically normal pregnancy and birth and takes

responsibility for recognising any departure from the norm and advising and referring on as required. Crucially in this discourse the woman's autonomy is recognised and her choices, based on her perceptions of risk, respected. The discursive construction of the leaflet and website place the midwife in the community, not just the spaces of the home, but the wider geographical community.

The interviews with the community midwives illustrated the challenges and barriers they encountered in providing information to support truly informed choice and at the same time working with competing discourses. The midwives valued working in the community, believing that this gave them greater insights into the women's lives and more freedom to practice midwifery. The close proximity to the lived experiences of women enabled them to appreciate that choices were often limited by the socio-economic circumstances. This insight however could also lead the midwife to shape options based on her perception of what women might find acceptable. Choices were also influenced by what the midwives knew was possible from an organisational perspective. Through the application of clinical guidelines, the community becomes a disciplinary space where activity can be measured and managed.

The midwives wanted to support women to choose care that was right for them but felt personally and professionally vulnerable when women made choices that they were not comfortable with. The woman's hand-held notes became an object of disciplinary control as they recorded consultations with women in order to create an auditable account in the event of an adverse outcome.

Their relative isolation from the Trust was viewed positively by the midwives but also resulted in the loss of their professional voice. This was seen in the ways they did not advocate for women's choices or did not articulate the community midwifery contribution to care. A discursive transformation from a midwifery discourse to a medical discourse was located, identifying a community midwifery risk discourse. The power/knowledge of the discourse is located in a midwifery discourse with a codicil of risk. The midwives are constituted as practitioners who perceive themselves to have a degree of autonomy but whose practice, and therefore their ability to offer and support women's choices, is constrained by a risk discourse which governs their thoughts and conduct. This risk discourse is amplified by their location in the community, and where the medical discourse identifies a disciplinary space.

# Chapter 1

## 1 Background to the study

### 1.1 The study aim

The aim of this study was to explore the ways in which community midwives negotiate competing discourses when seeking to support women's choices in pregnancy and birth. Much of midwifery practice, in common with healthcare generally, is discursive and effective communication is the bedrock of safe practice (Gluck 2012; Leonard, Graham and Bonacum 2004). The ways in which choice has been presented to pregnant women by National Health Service (NHS) Trusts providing maternity services, through their information leaflets and the websites that host them, offers an indication of how such organisations conceptualise pregnancy and birth. At the same time, midwives must support women to make choices about their pregnancy and birth which are right for them. Community midwives, working in the spaces between the maternity unit and the home, must negotiate competing discourses on choice.

Discourse analysis was undertaken of the leaflets and websites, illustrating the discursive structures in which community midwives worked. Interviews with community midwives explored the ways in which they negotiated competing discourses when supporting women to make choices in their pregnancy and birth. The work of Michel Foucault was used to critique assumptions expressed. Through interrogation of the language, signs and images used to construct pregnancy and birth, discursive formations are exposed. These were analysed through a Foucauldian discourse analysis.

My study has addressed a gap in the research, offering a unique perspective on the challenges and barriers experienced by community midwives in providing information to support truly informed choice. Through an exploration of the information leaflets, the hospital websites to which women are directed, and interviews with community midwives, a map of the terrain midwives must negotiate in order to offer women choice is provided.

### **1.1.1 The rationale for the study**

This study was timely given the focus on midwifery generally, and community midwifery practice specifically in recent policy and practice guidance. In 2014 the Lancet provided a series of international studies on midwifery. The Series provides a framework for quality maternal and newborn care that firmly placed the needs of women and their newborn infants at its centre. The findings showed that in high- and middle-income countries, and in better off groups in low-income countries, there is increasing over-medicalisation of normal pregnancy and birth, with the routine use of interventions unsupported by evidence. Facility-based births continue to rise, and with this an increase in interventions that may not be warranted, raising costs and contributing to women feeling disrespected and abused (McDougall Campbell and Graham 2016). Importantly, the findings of the Series supported a shift from fragmented maternal and newborn care provision that is focussed on identification and treatment of pathology to a whole-system approach that provides skilled care for all. The Series recognises that midwifery is fundamental to improvements in maternity services, providing “*skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post-partum, and the early weeks of life*” (Renfrew, McFaddon, Bastos,



Campbell et al 2014 p1129). It recognises the public health role of the midwife, including family planning and the provision of reproductive health services. Crucially, it emphasises that midwifery is not a discrete segment of the health service, but a core part of universal health coverage (Horton and Astudillo 2014). This recognises pregnancy and birth as social, as well as biological constructs.

The Series identifies the values and philosophy necessary to ensure safe and respectful midwifery care. The values include communication, community knowledge and understanding, and care tailored to a woman's circumstances and needs. The philosophy is to optimise the normal biological, psychological, social and cultural processes of childbirth, reducing the use of interventions to a minimum (Renfrew, McFaddon, Bastos, Campbell et al 2014). Midwives working in the community, whose practice is underpinned by this philosophy, and who reflect the stated values, are fundamental to the wellbeing of women and babies.

The Lancet Series investigated maternity services in high- and low-income countries. In the United Kingdom (UK) rates of maternal mortality are low, with 9.2 women per 100,000 (Knight, Bunch, Tuffnell, Shakespeare et al 2019), however the experiences of women and their families is not always optimum as the following quote suggests;

*“we heard...that women want to be able to choose the care that is right for them, their family and their circumstances, and that they want the care to wrap around them. They understand that there are finite resources, however they expect that their needs are able to be supported. We were told that women do not always feel like the choice is theirs and that too often they felt pressurised by their midwives and obstetricians to make choices that fitted their services”*

*NMR 2016 p 32. (3.3)*

The quote is taken from *Better Births* (NMR 2016) which sets out a vision for kinder, safer, more personalised and professional maternity services in England. The review forms part of the National Health Service (NHS) *Five Years Forward View* (NHS England 2014); the policy document developed in partnership with providers of healthcare services, commissioners and organisations that oversee health and care services, service users and clinicians. The aim of the strategy is to develop a consensus of how the NHS needs to change if it is to address health inequalities, quality of care and the funding of services.

*Better Births* (NMR 2016), reiterates the requirements set out in the Lancet Series that women should receive respectful midwifery care, tailored to their needs, and that care should be provided in the community. Included in the mandate is the requirement for every woman to have access to information to enable her to make choices about her care, and for all staff to be supported to deliver care which is woman centred. The community midwife therefore is key to the successful implementation of this strategy. A more detailed discussion of *Better Births* (NMR 2016) is offered at section 1.1.5.

### **1.1.2 Personal and professional perspective**

This professional doctorate has been prompted by a wish to reflect on and explore a fundamental tenet of my work as a community midwife, and latterly as an educator while still retaining a clinical role. Working in the community was a conscious choice after practising in the maternity wards and consultant led unit. Working as a community midwife enabled me to practice authentically; as an accountable, autonomous practitioner, developing trusting relationships with women and their families, based on an appreciation and understanding of their life

circumstances. It also enabled me to develop and refine my skills in supporting normal pregnancy and birth, away from the technological reference points available in the hospital setting. In addition to clinical competence, the skills of watching, observing and crucially listening to women, enhanced by continuity of care, enabled me to practice midwifery in its fullest sense. Because of these aspects, I consider community midwifery to be a distinct area of practice within midwifery and which has a historical basis which is addressed in more detail in Chapter 2, section 2.1.15.

During my time as a community midwife I also reflected on the wider cultural concepts of “community”. Community is defined as “a group of people with a common background or with shared interests within society” (Cambridge Dictionary 2020) which denotes a sense of belonging or connection. Although I did not belong in this ethnically diverse, economically deprived area, I did feel a strong connection with these women and in working with them gained many new insights. In addition, I strongly identified with being a community midwife as distinct from a midwife that works in the community and had a strong sense of community with other community midwives who also shared my philosophy.

As a community midwife, talking to women about their pregnancy and birth, presenting options for consideration, helping them to make decisions about their care right for them and their family, was the mainstay of my role. Conversations regarding screening tests, parent education sessions or the best place to have their baby culminated in a woman making a choice which was right for them. Sometimes women would ask what I would do in their situation and this could be a source of tension as my knowledge of pregnancy, birth and the maternity system

created a power imbalance. It would have been very easy to guide women towards choices that fitted the system rather than met their needs. An example of this might be a woman considering a home birth having had a previous caesarean section. The current guidance suggests that in this case, a woman should have her baby in a consultant-led facility with ready access to operating theatres and neonatal care facilities. Although the evidence indicates that the incidence of uterine rupture, a primary concern, is very small, between 0.2 to 0.5% (RCOG 2015), and therefore planned home birth a rational choice, my knowledge of the maternity system in which I worked meant that the woman would be discouraged from making this choice, and encouraged to birth in hospital, precisely because of the small risk of uterine rupture. The discouragement may be overt, through verbal or written statements in consultations, or through information leaflets for example. Equally it could be more hidden, demonstrated in the ways health professionals look or speak, conveying disapproval. Women may be discouraged from exercising their preferences by the maternity service providers, including midwives, doctors and others.

### **1.1.3 Community midwifery in context**

Helping women arrive at decisions about their care is recognised internationally as fundamental to the role of the midwife (ICM 2017). The International Confederation of Midwives define the role of the midwife as one who is an accountable and responsible professional working in partnership with women, providing the necessary support and care to promote normal birth, detect complications and access medical care as necessary. In addition to these aspects, the midwife has a role in health promotion and education. Midwives can practise in any setting, including the home, community, hospital or clinic (ICM 2017).

The aim of this study is to explore the ways in which community midwives negotiate competing discourses when supporting choice in pregnancy and birth. Here I define a community midwife as one who works exclusively, or predominately in the community; women's homes and clinics located in Children's centres or medical practices. Community midwives support births in the home or midwifery-led units. Midwifery Led units may be "standalone" in that they are located away from a hospital, or "alongside" a delivery unit. Mainly women experiencing straightforward pregnancy and birth are cared for in these settings. A delivery unit is defined here as a space within a maternity unit where care during labour and birth is provided by a multidisciplinary team, which includes midwives, obstetricians and anaesthetists. Generally, women experiencing more complicated pregnancies and births may be cared for here. Maternity services are provided by NHS Trusts within a geographical area. Midwives employed by NHS Trusts may work across hospital and community settings or work primarily in one or the other.

#### **1.1.4 The history of choice within UK maternal health**

The focus on community midwifery is timely, given the prominence afforded to community midwives in supporting women to make choices about their maternity care. Within *Better Births* (NMR 2016), the community midwife is positioned as a key professional in facilitating women's informed choices. However, this concept is not new; within the United Kingdom the concept of choice in maternity care has exercised policy makers for over 30 years and continues to do so. The *Winterton Report* (Health Committee 1992), *Changing Childbirth* (DH 1993), National Institute for Health and Care Excellence (NICE) Guidance on Antenatal Care

(NICE 2008), Maternity 2020 (DH 2010) and *Better Births* (NMR 2016) reiterate the position that in order to make decisions that are right for her the baby and her partner, women need clear, unbiased information on the risks and benefits of their decisions, so that they may arrive at an informed choice.

The policy documents cited here need to be viewed in the context of the societal, economic and technological changes which have also influenced choice in pregnancy and birth over the past decades.

Technological developments such as ultrasound scans transformed the nature of antenatal care in the 1970's and are now an accepted part of routine maternity care in the UK (Davis 2013). In my practice I have observed that the anomaly scan, usually carried out between the 18<sup>th</sup> and 21<sup>st</sup> week of pregnancy with the aim of identifying structural anomalies in the fetus (NICE 2008, updated 2019), often referred to by women as the scan where they can find out the sex of their baby. This indicates the extent to which this intervention is normalised so that its primary purpose; detecting anomalies which may lead to choices about the continuation of the pregnancy, may not be acknowledged.

Technological developments such as ultrasound scanning and cardiotocography can lead to a “cascade of interventions” (Tracy, Sullivan Wang et al 2007 p41) where interventions such as induction and acceleration of labour may be offered. This large, retrospective descriptive study identified a correlation between interventions offered in labour and a fall in unassisted vaginal birth among low risk women. In 1965, 15% of pregnancies were induced (Davis 2013), compared to 31.6% in 2018 (RCM 2019). Women today therefore face the possibility of

interventions in their pregnancy and birth which may impact on their health and wellbeing. However, the decision to accept or decline interventions is not clear cut as societal discourses of pregnancy as a risky condition and the hegemony of medicalised birth are broader influences (McAra-Couper, Jones and Smythe 2012) which indicates the ways in which choices are presented is significant to the decision-making process.

In addition to technological developments, wider economic and societal changes for women emerging in the 1970's have resulted in more employment and less childbearing, and the recognition that class and ethnicity affected women's expectations and experiences of pregnancy and birth in complex ways (Oakley 2005). Arising from this, several maternity pressure groups formed. A more detailed discussion of the impact of these groups is set out at 2.1.14. More recently *Birthrights* (Birthrights.org.uk 2013) formed in 2013 with an aim to promote human rights in pregnancy and childbirth, demonstrating the continuing need to promote dignity and choice in pregnancy and birth. The emergence of this group indicates that successive policy initiatives have not succeeded in women feeling able to exercise choice and control in her pregnancy and birth.

Malacrida and Boulton (2014) point out that while women's choices regarding their pregnancy and birth are framed by policy as individualised, these choices "occur within a set of structural and social conditions" (Malacrida and Boulton 2014, p45). They go on to state that the combination of an increasingly technocratic medical approach to birthing, an individualized model of patient/consumer risk evaluation and contested discourses concerning the ideal way of giving birth can make women's choice and risk evaluation more difficult than usual. Moreover, the ability

of women to implement her informed choices is constrained by the organisation of maternity services which privileges medicalised births, or births occurring in the hospital setting. Into this arena, *Better Births* (NMR 2016), with an emphasis on community midwifery, offers the opportunity to reframe the discourse on choice.

### **1.1.5 Better births**

There is acknowledgement within *Better Births* (NMR 2016), that although the importance of informed choice has been reiterated through policy documents for over thirty years, many women are not being offered *real* (my emphasis) choice in the services they are offered access and are instead being told what they must do, not being given information to make their own decisions. Further on *Better Births* (NMR 2016) states that all women should receive “*personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine (my emphasis) choice, informed by unbiased information*” (*Better Births NMR 2016, p8*).

The use of the words *real* and *genuine* in this policy document is curious and might suggest that previously choice has not been either of these things. Choice is more frequently described as “informed”. In practice this can mean the clinician imparting information, including evidence and clinical options, in an accessible way, helping her to make a choice. However, MacDonald (2018) argues that for midwives, informed choice should also consider the women’s knowledge, feelings and past experience including previous pregnancies as well as her lifestyle and moral or religious observations. The community midwife is therefore ideally placed



to facilitate informed choice due to her knowledge of the woman and her circumstances.

Unbiased information is identified as key in helping women make informed choices. The case of *Montgomery vs Lanarkshire Health Board (2015)* established that, rather than being a matter of clinical judgement, a patient should be told whatever they want to know, not what the doctor thinks they should be told. Real and genuine choice then can be exercised if women receive information on the risks and benefits of the care options available. The evidence suggests that women use a variety of sources when making choices about their pregnancy including the internet, friends and relatives' recommendations and experiences, and antenatal classes (Lagan, Sinclair and Kernohan 2010, 2011, Hinton, Dumelow, Rowe and Hollowell 2018, Sanders and Crozier 2018). The range of sources identified in the evidence indicate that women locate their pregnancy and birth within a relational framework, which recognises the commonality of their experience, seeking out the views of friends and relatives to help them make choices about their care, drawing on tacit knowledge, not solely relying on the expert knowledge of the midwife or obstetrician.

The community midwife is identified by *Better Births (NMR 2016)* as a key informant on pregnancy and childbirth. As a community midwife I would offer information on pregnancy and birth in discussion with women, and initially provide leaflets produced by the hospital. Later I would direct women to the hospital's websites where the leaflets were hosted. It can be seen, via these leaflets and websites, how pregnancy and birth are conceptualised at the organisational level. In sharing this information on the options/choices available, I was often asked by

women what I would do, or my opinion on the various options. My responses to these requests were frequently based on my beliefs about pregnancy and childbirth, my observations and experiences of working in the field, also being shaped by my knowledge of what would be acceptable from an organisational perspective. In other words, not the unbiased information required to make an informed choice, but that influenced by the discourses of medicalisation, normality and risk, concepts which permeate my practice.

My experiences are mirrored in the literature. O'Connell and Downe's (2009) metasynthesis of midwives' practice in hospitals included fourteen qualitative research studies relating to midwives' accounts of hospital midwifery with a particular focus on labour ward practice. Medicalised care, obstetric hegemony and control were the themes arising from this study, however it was often midwives, rather than the doctors, that influenced how midwives practiced. Lack of support for normal birth was often blamed on doctors, other midwives and even the women themselves. Further studies conducted on labour wards also suggested that midwives were in a double bind of attempting to promote normality and at the same time work within environments which privileges biophysical risks. Surtees (2010), Scamell (2011) and Scamell & Alaszewski (2012) identified that the midwives were concerned about the personal and professional consequences of unintended outcomes, so surveillance was not confined to the woman but also the self. Surtees (2010) found that midwives located risk either within the birthing body, or within the spaces of the delivery ward itself. If midwives viewed the birthing body as risky, they were more likely to minimise risk geographically by increasing their proximity to the labour ward. Conversely, if they viewed the labour ward as risky, they may act to minimise the risk to women by maintaining some

distance, balancing the risk of not protecting herself from claims of risky practice. Surtees (2009) found that midwives had an overwhelming need to protect themselves, so their current practice was influenced by the prospect of future events examined with the benefit of hindsight.

Similar themes were identified by Scamell (2011) and Scamell and Alaszewski's (2012). In their large ethnographic study, which explored how midwives make sense of risk in the intrapartum setting, they found that the action of routine midwifery surveillance was less about confirming normality as it was about searching for an absence of normality. Midwives' discursive practices were at odds with their espoused beliefs as the experts on and guardians of normality. Normality was found to be a temporal concept only recognised in retrospect, that is, when no abnormality emerged and the midwives in this study, including senior midwives, struggled to define normality without reference to the surveillance practices intended to identify abnormalities. The technology orientated environment in which the midwives worked left them with few resources to work within the paradigm of normality. The inability to articulate the midwifery contribution to care was found in a qualitative metasynthesis by McFarland, Jones, Luchsinger, Kissler and Smith (2020). This study found that as maternity units become more medically focused, midwives adapted their approach to mirror that of the prevailing culture. The inclusion of studies from America and Australia limits the transferability of this metasynthesis to UK practice, but the themes are analogous with those studies cited above.

Studies of midwives working across community and hospital settings also identify similar themes. In a study of midwives in Scotland, Page and Mander (2014) found

that determining normality was repeatedly questioned and redefined by the midwives in their study, which explored perceptions of intrapartum uncertainty. They concluded that midwives develop a normality boundary which shapes their clinical judgement and decision making. Interestingly, this border could shift, depending on the birth environment. Midwives who practiced in home and hospital environments were more likely to adopt a broader construct of normality in the home than they would in the hospital. This was often based on the predetermined boundaries of normality in place through hospital guidelines, and primarily based on time limits for labour. The practice philosophy of the midwife determined the degree of uncertainty she was willing to tolerate and sometimes where they chose to practice. The themes arising from this study which used grounded theory, can be generalised to midwives working across similar integrated care settings, and resonates with my stance that choosing to work in the community derives from a philosophical belief in normal pregnancy and birth.

#### **1.1.6 Negotiating competing discourses of choice and risk in community midwifery practice**

Throughout this time, in addition to working as a midwife, I also participated in the Nursing and Midwifery Council's (NMC) Fitness to Practise directorate as a registrant panellist hearing cases where a nurse or midwife's fitness to practise was considered to be potentially impaired through misconduct, lack of competence or serious ill health. This work within the NMC led me to reflect on the nature of professionalism. There have been a number theoretical perspectives informing sociological analysis of professionalism, but one of the most influential has been

the writings of Eliot Freidson, who has been described (Bosk 2006 p637) as ‘a founding figure in medical sociology’, so I have looked to his extensive body of work to guide my reflection. According to Friedson (1970), professions share a number of traits, which include the power to determine the content and regulation of their work, holding a distinct body of knowledge and skills (Friedson 1984) with shared institutional and ideological values (Friedson 1980). In the context of midwifery practice, and in common with much of health and social care practice there is little opportunity to determine the content and regulation of one’s work, as it is largely determined by policy and practice guidelines. Furthermore, knowledge of pregnancy and birth is not “owned” by the midwife in the way complex aspects of law may be the province of the barrister, in this regard midwifery could not be considered a profession as defined by Friedson (1970). The professionalisation of midwifery, through its professional codes of conduct (NMC 2015), statutes and guidance contribute to a method of disciplinary control as described by Founier (1999). If the organisational requirements conflict with professional obligations, the nurse or midwife may be held personally accountable for their actions or omissions and held to account by the NMC. Women may request care counter to national or hospital guidance, yet for the midwife supporting informed choice is integral to her professional responsibilities. Policies and guidance cannot always capture the nuances encountered by community midwives in their interactions with women and families. For midwives working in the community, supporting women to make informed choices about their care may lead to facilitating situations that might be deemed “risky” for the woman or baby and be concerning for the midwives having to care for them. For example, I have observed that women occasionally decline certain aspects of care because they do not consider that the

cost of this care, in terms of time spent at the hospital; travelling, organising childcare or arranging time off work, outweigh the potential risk posed by refusing such care. Women make decisions based on their perspectives of risk in pregnancy, or on their previous experiences. In these situations, as the community midwife, I explained the risks and benefits, acknowledging and supporting a woman's choice, generally based on her risk perception. At the same time, I had to recognise my own perspective regarding the risk for me as a midwife, considering my professional code of practice and position as a Trust employee. These experiences and observations motivated me to consider how other community midwives negotiate the tensions of trying to meet the often complimentary but occasionally competing demands placed on them within the discourses of choice, as risk, medicalisation and normality coalesce around pregnancy and childbirth.

### **1.1.7 The rationale for adopting a Foucauldian lens**

Michel Foucault's work has been fundamentally important to this Professional Doctorate encompassing as it does a detailed critique of discourse, power, knowledge, the body and their inter-relationships. Although widely influential, it is difficult to summarise his ideas. His work over time was part of his own evolution and developing beliefs. Therefore, a segment of his work through the texts on discourse, knowledge and power support this thesis. The decision to use his work was informed by his studies of "histories of the present" (Foucault 1977 p31), in essence, challenging a phenomenon by taking it apart. Foucault's work has been used here to explore the phenomenon of choice in midwifery practice. The most notable limitation of using Foucault's work is an absence in his writing of gender issues and this is discussed more fully in Chapter 4, section 4.1.2.

Foucault's work has been used extensively within social sciences and used to explore the medical regulation of childbirth in the United States of America from the 17<sup>th</sup> through to the 20<sup>th</sup> century (Arney 1982). More recently, Foucault has been used to demonstrate how midwifery knowledge came to be subjugated by a dominant medical discourse in Australia (Newnham 2014), illuminate issues of power and control in the birthing environment (Fahy and Parrat 2006), the discursive construction of contraceptive efficacy and side effects (Hayter 2007) and understanding how power operates in the medical encounter with childbearing women (Fahy 2002). A Foucauldian analysis was also used to explore the role that midwives play in promoting breastfeeding (Simonardottir and Gilason 2018). Foucault's work has also been used to explore organisational structures such as mentorship in nursing (Fulton 2015), the surveillance of new mothers in the health visiting service (Peckover 2002) and the organisation of maternity services in Canada (Douglas 2010).

Foucault did not describe himself as a discourse analyst. Accordingly, this Professional Doctorate uses the work of Foucault, in particular his writings on knowledge/power, identifying how community midwives negotiate discourses on choice and exploring these discourses within the context of knowledge and power through a Foucauldian lens. Discourse analysis was used to examine the leaflets and hospital websites used by community midwives when discussing care options with women. In addition, interviews with seven community midwives were conducted to explore how they discursively constructed choice in their work with women.

## 1.2 Reflexivity

This professional doctorate is rooted in praxis. I was influenced by the writing of Gary Rolfe (1993) who defined praxis as a process of reflecting in action; drawing on my expertise and repertoire of past experiences and encounters, not only from my time as a midwife, but as a nurse, manager, educator, mother and woman. The reading, researching and writing of this thesis has been informed at every stage by a commitment to reflexivity in praxis. Here I draw on the work of Koch and Harrington (1993) who identify three aspects of reflexivity. Self-critique requires an awareness that voices other than mine are heard, and this was achieved through doctoral supervision. Second, I acknowledge that my interpretations exist within a complex matrix of alternative representations, and finally a recognition that all work is incomplete and requires a response from others positioned differently. This final point is demonstrated by the fact that anyone who reads any part of my thesis will have their own perspective over which I have no control.

To illustrate my commitment to reflexivity I have chosen to include extracts from my reflective diary throughout the thesis where appropriate. I wanted to make explicit my own biases, assumptions and experiences as integral to my study and this inclusion is an essential aspect of my post-structural epistemological stance which is clarified in detail in Chapter 4. Each reflexive memo is dated and presented in italics.



### **1.3 Structure of the thesis**

The thesis is presented over seven chapters; Chapter 1 sets out the aim and the rationale for the study, providing an overview of the policy context. My personal and professional positions as a community midwife-lecturer are also stated.

Chapter 2 addresses the concept of choice, in UK healthcare generally and maternity care specifically. It provides a historical overview of community midwifery services and explains their current location in maternity services.

Chapter 3 sets out the rationale for the scoping review of available studies related to choice in maternity care. This chapter describes the search strategy utilised and presents a narrative account of the themes. This chapter concludes with discussion on the limited available evidence related to how community midwives support women to make choices.

Chapter 4 sets out the methodology. The rationale for using discourse analysis, and specifically selected works of Michel Foucault and Judith Butler is provided. My epistemological and ontological stance is discussed along with consideration of my position as an insider-researcher and my commitment to reflexivity. This chapter also explains the methods used to conduct this study, including the rationale for the datasets, the recruitment strategy, data collection and data analysis. The chapter concludes with a discussion on ethical issues.

Chapter 5 presents the analysis of the datasets using the analytical framework derived from the writings of Foucault and Butler. The relevant sections of the leaflets and websites are included to highlight the statements. The voices of the

community midwives are presented utilising quotations from the midwives to support the interpretation of the data.

Chapter 6 presents a discussion of the findings considering their relevance within the existing literature identifying where the literature supports these findings, where new information and understandings have been discovered and the original contribution this research has made to the evidence base.

Chapter 7 provides a conclusion of the findings of the study and considers the implications for policy and practice. Recommendations for future practice and research conclude the study.

## Chapter 2

### 2 Introduction to the study

#### 2.1 Introduction

This chapter has set out an analysis of the patient choice agenda, drawing on the work of Kieran Walshe, Ewan Ferlie and Julien Le Grand, all eminent writers in the fields of health policy, economics and social policy. I have purposefully using the word *patient* to illustrate the asymmetry in knowledge and power which is present in many healthcare encounters. I have offered a critique on the construction of choice in maternity care, highlighting some of the key themes of recent maternity care policy through the lens of the patient choice agenda. The critique has illustrated how the patient choice agenda has been extrapolated to inform a policy to improve maternity care which does not take into account the relational aspects of pregnancy and childbirth among a predominately healthy population.

I have offered a very brief history of midwifery in the UK to show how the role of the community midwife has evolved from one where the midwife was located primarily in community public health to the current position where community midwives working in the NHS are part of an integrated maternity system based around a consultant led obstetric unit. I have highlighted the evidence which indicates that discourses of risk, normality, choice and medicalisation can result in midwives struggling with their professional identity.

##### 2.1.1 The UK Government policy on choice in healthcare

The end of the 1970s heralded an increasing concern with the growth of wealth through to maximising the reach and frequency of market transactions, bringing all

human action into the marketplace (Walshe, Harvey, Hyde and Pandit 2004). It is the context of this political landscape that a series of public sector reforms were introduced by the Conservative Government in 1979. The perception then of the Welfare state was that it was poorly managed, acted as an unaccountable monopoly, was professionally dominated and lacking in client involvement (Ferlie 2017). Reforms involved transferring existing concepts and models from the business world, so words like market, freedom, competition, customer and choice began to be used in health and social care strategy and policy and continue to this day. According to the prominent sociologist and social theorist Nikolas Rose (1999), this permeates all aspects of life as he states, "*all aspects of social behaviour are now reconceptualised along economic lines-as calculative actions undertaken through the universal human faculty of choice*" (p141-142).

The concept of patient choice can be explored from a number of angles, including economic and political, philosophical, ethical and psychological. Patients' opportunities to make choices in healthcare has been advocated from the individual's perspective as a value on its own and as a means to empower patients in managing their own health (Victoor, Friele, Delnoij and Rademakers 2012). The opportunity to choose a care provider may enhance commitment to care, enhancing service users' autonomy and promoting social justice (Saltman 1994, Mladenov, Owens, and Cribb 2015), and it is suggested that choice promotes legitimacy of the publicly funded healthcare among citizens and taxpayers (Costa-i-Font and Zigante 2014). The origins of the patient choice agenda are framed by the language of economics and politics. Following the development of the internal market in the NHS in the 1990's (Le Grand 2009) a number of initiatives were launched that aimed to offer patients the choice of

where and when to receive care, for example *Choose and Book*, which was launched in 2003 (DH 2014). Over time, the range of choices available to users of health care services has increased. The NHS Constitution (DH 2015) now includes a statement on the right to choice. It states; “you have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs” (DH 2015 p9). Choice therefore is conditional, contingent on what is available in the particular circumstances of the patient. Clinical Commissioning Groups are required to make arrangements to enable patients to exercise their choice. It is for the clinician making the referral to decide if it is clinically appropriate. The right to choose extends only to the first appointment (DH 2015). This positions patient choice, and the need to provide appropriate information to exercise it, as a policy objective, despite the lack of conclusive evidence to support it (Fotaki 2006, 2017, Nordgren 2010).

The NHS Choice Framework (2015) suggests that patients can choose the hospital by comparing measures of clinical quality, such as waiting times, infection rates and patient outcomes as well as non-clinical aspects such as the quality of food and car parking. This information is available on the NHS Choices website. When a patient has chosen their preferred provider of healthcare, the money to pay for the service should follow the patient. This places patient choice within a market-forces framework, where choice drives competition between providers and, in so doing, improves standards and ensures an efficient and responsive health care service (Le Grand, Mays and Mulligan 2001, Fotaki 2017). This policy positions patients within a rational choice model, where patients adopt a maximising utility approach (Allingham 2002), by rating the clinical and non-clinical

aspects of their preferred provider, by assigning a value to those aspects. In rational choice theory, people are perceived as rationally acting individuals striving to maximise their own success. In the decision-making process, options are measured against each other by balancing benefits and costs, and the option with the highest utility, or usefulness is chosen. Applying this theory to patient choice, car parking may be rated more highly than patient outcomes when choosing a healthcare provider, and the choice be considered rational.

Placing patients at the centre of decision-making and giving direct control over the services they use was further enhanced through the introduction of the personal health budgets and direct payments in the Open Public Services White Paper (DH 2011). This is provided for patients with long-term or chronic conditions, those with mental health needs and people requiring end of life care. Personal budgets allow patients to buy services from providers either by using monies paid directly to them or agreeing to spend the notional budget held on their behalf by their care manager. The introduction of the personal health budget goes beyond choosing the location and time of care, giving patients a choice over the content of their care, changing the perception of the NHS as a service which does things to and for patients to one which provides patients with the opportunities to do things for themselves (Owens 2012).

### **2.1.2 Drawing on psychoanalytical theories and issues of trust**

Fotaki (2017) argues that market-based freedom of choice and user autonomy occupies a prominent policy position, more so than equity of access or equality of opportunity. While the overt policy discourse is centred on realising better service outcomes and meeting the needs of users-with-choice of healthcare services, the

consumerist market ignores the inevitable facts of human life such as vulnerability, sickness, aging, disease and death (Fotaki 2006, 2017). Drawing on psychoanalytic theories and the work of Judith Butler, Fotaki (2006, 2017) highlights the tensions and contradictions involved in promoting the rhetoric of individual choice and empowerment in collectivist systems; specifically, policy that is unrealistic has a negative impact upon the norms within which the relationships, decision-making processes and practices of healthcare operate. This is particularly the case under conditions of vulnerability and neediness. These emotional forces shape encounters in healthcare environments, influencing choice.

Linking choice to empowerment shifts the balance of power from professionals and the NHS itself in favour of the patient as consumer, implying that a situation whereby the healthcare professional assumes an authoritative position is always undesirable. However, dependency on the healthcare professional is inherent to many encounters between patients and healthcare professionals, in part as a consequence of vulnerability but also due to the asymmetry in information on health conditions and treatment options. Fotaki (2017) argues that users of health care services rarely act as rational utility maximisers that economists such as Allingham (2002) would suggest as vulnerability to injury, disease and frailty sets limits to the fabled self-sufficiency of the autonomous neoliberal subject. The concept of the independent, knowledgeable consumer does not exist in most health situations because health services are rarely consumed out of choice or for the sake of it (Fotaki 2006). For all these reasons, she suggests that patients prefer to rely on trust to counteract this dependency, and therefore the

establishment of a trusting, therapeutic relationship can facilitate informed choice (Fotaki 2014).

It is suggested that the patient choice agenda can adversely impact on the development of a trusting relationship between the patient and the healthcare professional. Owens (2012) argues that equating choice with personalised care is contestable and instead aligns the notion of the personal with intimacy. Personal relationships, he asserts, often involve a closeness between people, based on trust, confidence and mutual understanding. Furthermore, in the context of illness, there is often a requirement for a degree of physical intimacy as part of the healthcare encounter, which demands trust in and between the professional and the patient. The nature of ill health may cause the patient to be in pain, vulnerable or embarrassed and the healthcare professional will, in the context of a trusting, intimate relationship respond to the patient as a person in need of help and support. Owens (2012) suggests that these relationships are developed over time and that the ability of the patient to choose a provider disrupts continuity of care, preventing the development of clinical relationships. This is supported by Fotaki (2017) who suggests that it is continuity of care, rather than one-off choices which results in improved health and social care.

Fotaki (2014) suggests that the embodied and interpersonal forms of trust are important factors against which consumerist choice is likely to be traded off in healthcare. Faced with emotion-laden decisions, individuals are more likely to rely on trust than informed choice. The patient choice agenda, she argues, does not acknowledge the impact of social, relational, affective and embodied aspects of trust on the health system. Owens (2012) concurs with this view by asserting that



while qualities such as autonomy, control and independence are valued, they may need to be traded against intimacy, patient safety and equity.

### **2.1.3 The impact of autonomy**

An uncritical acceptance of autonomy as *the* principle medical value can undermine the therapeutic relationship between healthcare professional and patient (Mol 2008, Agledahl, Forde and Wifstad 2011, Owens 2012,). Agledahl et al (2011) suggest that the principle of autonomy fits poorly with clinical practice, patients are by definition unwell and in need of assistance and therefore lack the competence and independence that the principle demands. They argue that while autonomy is a multidimensional term in philosophy, in healthcare it is explicitly formulated as supporting autonomous choice. Clinical practice is a process over time and space and choice in clinical practice rarely refers to a single detached decision, but actually involves many participants. They conclude that respecting patients as autonomous persons is far more complex than eliciting choices and acknowledging informed consent. This concern is shared by Mol (1998) who suggests that conceptualising autonomy in terms of individual self-governance and choice may inadvertently encourage the mutual isolation of the healthcare professional and the patient. This, according to Owens (2012) may shift the professional role of the clinician from one in which they are a provider of care to one where they are primarily a facilitator of the patient's choices.

In their paper on the impact of personalisation and choice on autonomy, Owens Mladonov and Cribb (2017) suggest that the personalisation agenda has often been accompanied by the introduction of measures that seek to bring patients decisions into line with the agendas of policymakers and services providers. For

example, public health strategy in the UK has recently shifted away from enacting structural, top-down strategies in favour of strategies that seek to promote healthier decision-making by encouraging to make healthy choices and adopt forms of behaviour change. They describe this 'choice architecture' approach as a way of 'nudging' patients into making choices that align with the agendas of policymakers and service providers. They argue that using behavioural psychology with the intent of shaping the choices of patients undermines claims that providing greater choice is a means of respecting patients autonomy and delivering genuine empowerment. This suggests that choice is a construct shaped by prevailing attitudes to health.

Owens, Mladonov and Cribb (2017) also question whether the choice architecture provides patients with the level of autonomy that is often suggested. They suggest that providing patients with choices does not necessarily mean that they will be in a position to act on their choices and achieve their aims, as this is especially true of patients who lack material, socio-cultural, political and economic capital.

The perspectives offered by Owens (2012), Owens, Mladonov and Cribb (2017) Mol (1998) and Fotaki (2006, 2014, 2016) illustrate the power/knowledge that is present in many encounters between healthcare institutions, professionals and patients and exercised through the sick or infirm body. The presence of disease or infirmity contributes to a vulnerability in patients which may create an inability to participate fully in decisions about their care. In addition, those patients who occupy positions of significant material, socio-cultural, political or economic disadvantage may not be able fully exercise their choices. The power imbalance between the sick patient and the healthcare professional's knowledge of

conditions and treatment options suggests that partnership working is not always achievable. However, the presentation of patient choice through policy and guidance, even at a superficial, consumerist level, creates an illusion of power; that the patient is a partner in care. Working in partnership with patients can be achieved when a therapeutic, trusting relationship can be established. The importance of this relationship is not confined to encounters with the sick, but also women experiencing pregnancy, creating the conditions for informed decision-making.

#### **2.1.4 The construction of choice in maternity care**

The following section illustrates how the patient choice agenda has been extrapolated to inform policies, aimed at improving maternity care for predominately healthy women undergoing a normal physiological event. This fails to take into account the forces that shape and limit choice in pregnancy and childbirth. In this regard choice is not a discrete concept but socially constructed and constitutive in that it is determined by and defines what is possible to choose.

This professional doctorate takes as axiomatic that pregnancy and childbirth are significant life events, not only for the expectant woman, but also the family and wider society. This is evidenced in the legislative structures which protect the rights of pregnant women, and also in the “specialness” attributed to this life event through art, literature and poetry through the centuries. This construction of specialness is also attributed to the unborn child. Ensuring the unborn child is safe and well forms much of the antenatal care offered to women in the Western world, technologies such as ultrasound scanning, and genetic screening extend that observation of care.

In developed countries, pregnancy and birth do not exist in a vacuum but in a society with a focus on personal responsibility and individualisation (Lennon 2016). Personal responsibility and individualisation extend also to choice, with the health service user positioned as a self-determining part of the health care process (DH 2015), seeking out information about their choices. Through the provision of antenatal care, monitoring, advice and information, the pregnant woman is subject to the scrutinising gaze of midwives, obstetricians and the public, positioned in a “web of surveillance” (Lupton 2012 p121). The pregnant woman’s choices are a matter of import for all those who observe her.

#### **2.1.5 Personal reflections on enabling choice across different services**

Access to unbiased information is identified as essential to enable choices to be made. An example of this involved my work as a nurse with a leading cancer charity to develop clear, evidence-based information pathways for people affected by cancer within the Cancer Network, a geographical area encompassing Cancer Centres, teaching hospitals, district general hospitals, hospices and community services. Here was a shared understanding across all providers of cancer services and service users regarding what constituted robust, unbiased evidence-based information on which patients affected by cancer could make informed choices about their care. Consensus was achieved across all disciplines and users regarding the value of information, and the requirement for this to be consistent across all providers and presented in a way that service users could use to inform decisions about their treatment options. This contrasted with my experiences of maternity care, primarily across the same geographical area, but with different provisions and guidelines resulting in a lack of consistent, evidence-based information being provided to women. Another notable difference between

the cancer patient and the pregnant women is that the former made decisions and choices in which I did not feel a personal investment, so if the cancer patient decided to decline further treatment, I did not consider how this might impact on me personally or professionally but worked with the team to facilitate those choices. In pregnancy and childbirth, the dominant discourses of risk, medicalisation and choice are so pervasive that the locus of choice is blurred. To illustrate this point, I have included an extract from my reflective diary; a key moment for me in my doctorate journey, which encapsulated the professional and personal difficulties I experienced working as a community midwife.

*I have just visited a woman following a referral from the AAU [antenatal assessment unit]. She is 30 weeks pregnant and has hypertension and a raised PCR[protein-creatinine ratio]. We [the community midwives] have been asked to visit and get her to agree to come into hospital for monitoring, but she declines. I check her BP today and it is very high, and I ask her if she would be willing to go in for further monitoring and she refuses. This has been a feature of her previous pregnancies and she sees no cause for concern. In my car I ring the consultant in charge and tell her that she will not come in. She says that as long as I have explained the risk of stroke and stillbirth to her, and recorded it in her hand-held notes, not to worry, but I do.*

*Reflective memo June 2016*

The woman in my reflective memo challenged the ontological privileging of risk in pregnancy, preferring instead to draw on her own subjective experience. The confidence she had in body to safely birth this baby was not shared by me and demonstrated in my need to “run past” the outcome of the consultation with the consultant. In this encounter I deferred to the dominant medical discourse which privileged the risk of what might happen, over the experiential knowledge of the woman. In keeping with the dominant discourse, I created a visible, auditable trail

of my encounter with the woman, and the subsequent conversation with the obstetrician, in her hand-held notes. This acted as a form of “disciplinary control” (Founier 1999), in the event my actions, and by extension the Trust I worked for, would be examined.

#### **2.1.6 The notion of the “good mother”**

Her refusal to attend the hospital challenged the notion of the “good mother” (Wu Song, West, Lundy and Dahman 2012); that is the inclinations, dispositions and practices related to mothering that are culturally constructed. Medically orientated, hospital-based care is often characterised by high levels of intervention and the use of technology in the belief that this leads to better outcomes for women and babies (Hemminki, Heino and Gissler 2011, Wikund Wallin, Vikstrom and Ransjo-Arvidson 2012, Healy, Humphreys and Kennedy 2015). Technological interventions, according to Davis-Floyd (2001), lead to the conviction that pregnancy and birth can be predictable, controllable, safer and therefore less risky. This is irresistible to many pregnant women as societal expectations of maternal responsibility means that women are expected to prioritise the safety of their baby above everything else.

In an in-depth qualitative study of 30 women’s experiences of planning home births in Scotland, Edwards (2004) examines choice from a post-modern, post-feminist perspective. Women in western cultures, she argues, make choices that are not only limited by the intersection of race and class, but the intersection between ideology and resources. This results in a medically orientated menu over which women have limited ability to change. This medical ideology, with its focus on risk and safety means that while minor choices can be accommodated,

conceptual choices cannot. By choosing not to participate in the prescribed care and rejecting the medical framing of her pregnancy, the woman created a challenge for me as a community midwife. Although mindful that I should support her choice, I was anxious about the potential professional and personal sequelae of her decision.

### **2.1.7 The impact of intellectual and social capital on choice**

Mackenzie Bryers and van Teijlingen (2010) suggest that there is a benefit in defining pregnancy and childbirth as a medical event rather than a social experience because by doing so the intellectual and social capital, and therefore the power, resides within the medical model, reinforcing the contextual nature of discourses of medicalisation and choice. The dominance of scientific as opposed to experiential knowledge indicates that this discursive structure is imbued with a “truth” which determines how pregnancy and birth ought to be managed. This is the basis of the “coercive contract” as identified by Romalis (1985) which requires the woman to privilege professional opinion over her own, and so shapes and limits her choices.

The evidence indicates that midwifery-led models of care are safer. The Birthplace study (Brocklehurst, Hardy, Hollowell, Linsell, et al 2011), a prospective cohort study of 64,548 women which compared intrapartum and early neonatal mortality and specific neonatal morbidities for births planned at home, in freestanding midwifery units, and in alongside midwifery units with births planned in obstetric units, for babies of women judged to be at low risk of complications before the onset of labour. The study found that those who planned to give birth in a midwifery led unit, either free-standing or alongside an obstetric unit, had

significantly fewer interventions and more normal births than women who planned birth in an obstetric unit. For women having their second or subsequent baby, birthing at home, or in a midwifery led unit significantly and substantially reduced the risk of interventions. As a result of this large study conducted across all settings, the intrapartum care guidelines (National Institute for Health and Care Excellence (NICE) 2014) included the requirement for commissioners to ensure that all four birth settings were available to women. The benefits of out of hospital births has also been identified internationally. Barclay Longman, Robin, Kruske, Kildea et.al (2016) point out that numerous studies demonstrate that birth in units with limited obstetric, anaesthetic and paediatric support, referred to as primary maternity units (PMU) in the literature, is generally safe for low risk women. The benefit of PMU's in rural and remote communities was also found in a large study examining the all-risk population in rural Canada (Grzybowski, Fahey, Lai, Zhang et al 2015). Here the study population, excluding multiple pregnancies, those with very premature babies or those with congenital abnormalities, had better outcomes than those without local services.

#### **2.1.8 Barriers to genuine choice**

Despite the evidence midwifery-led models of care are safer, and national policy on offering choice of place of birth to women, Coxon, Chisholm, Malouf, Rowe et.al (2017) found that accessing out of hospital birth settings was more complex and contested, women described having to counter the negativity about their decision to birth out of hospital. Strategies adopted by clinicians in response to requests for information about out of hospital birth included telling women they were “not allowed” to birth at home; providing little or no information; using body language to convey disapproval; or telling women that they were being reckless.



Women described how they had to repeatedly prove that they were suitable to have a midwife led birth, and this led to a sense that the decision was tentative and subject to review. Choice here is constrained by the prevailing discursive practices which privileges obstetric hegemony in pregnancy and childbearing.

### **2.1.9 The application of policy to practice**

Societal expectations around pregnancy and birth also limit and shape choice. Rising rates of epidural analgesia and requests for caesarean section are attributed to women exercising their choices (McAra-Couper, Jones and Smythe 2012). However, the normalisation of surgical birth and the increasing use of technology contribute to a social construction that birth that can be conveniently controlled and less messy and less painful, and it is this construction which frames women's choices. However, the rhetoric of choice in maternity care policy is framed in consumerist terms with women able to choose the provider of their antenatal, intrapartum and postnatal care and exercise those choices through their own personalised NHS Personal Maternity Care Budget (PNCB) (NMR 2016), a concept borrowed from the personal health budgets awarded to people with long term conditions ( DH 2011). The rationale for the PNCB is to incentivise the delivery of high-quality care by increasing choice for women, empowering them to choose the provider of their antenatal, intrapartum and postnatal care. The budget is notional, contained within the existing resource envelope and to be used within NHS contracted services. Through this scheme, the woman is encouraged to adopt the role of the consumer by assessing the relative merits of the different providers. Women at the beginning of their pregnancy may not be possessed of all the relevant information on which to make an informed choice but may be able to do so once a trusting, therapeutic relationship has been established with a known

and knowledgeable midwife. However, the establishment of this relationship may be challenged by choosing different providers for antenatal, intrapartum and postnatal care which may adversely impact on continuity of care. Although *Better Birth's* vision is to “break down organisational and professional boundaries” (p9), the reality might be “convenient care from expert strangers” (Adam and Guthrie p129, 2001). Privileging choice of provider over continuity of care repeats and renews the uncritical acceptance of autonomous choice as an unqualified good. Continuity of care is shown to reduce unwarranted interventions and provide safe care for women and babies (Sandall, Devane, Soltani et al 2011), which may be negatively impacted by choosing care across multiple providers.

#### **2.1.10 Women's response to *Better Births***

*Better Births* (NMR 2016) included an online consultation with women to inform the policy. When asked about choices relating to care, most of the respondents to the online survey identified that they wanted more choice on partners staying overnight on the postnatal wards, or the option to stay in hospital longer following the birth. This suggests that the relational aspects of birth are very important to women and where they would like to exercise more choice. This observation from *Better Births* (NMR 2016) reflects evidence from a recent systematic qualitative review carried out to identify what matters to women during childbirth (Downe, Finlayson, Oladapo, Bonet and Gulmezoglu 2018) which found that women viewed their birth choices through the lens of familial, cultural and social norms and values. Supportive, kind, responsive care from care-givers enabled preferences to be shared and understood. This is also supported by O'Brien, Casey and Butler (2017,2018) in their exploration of women's experiences of the concept of informed choice in pregnancy and childbirth. They concluded that

informed choice is defined and experienced as a relational construct, and supportive relationships are key to providing informed choice. Community midwives, working in the homes and community spaces of pregnant and childbearing women are well placed to develop supportive relationships that support informed choice.

### **2.1.11 Information steering**

In Edward's (2004) study, she referred to information giving as "steering" in that the women were ill-informed or mis-informed about the routine procedures during pregnancy and labour, and the extent to which they could exercise choice over their implementation. The following excerpt from my reflective diary captures this point.

*In preparation for a session on induction of labour, I asked the students to bring in their Trust's information leaflet that would be provided to women considering induction. Some leaflets were poorly photocopied, some trusts only provided the information on line and the majority of students were not aware of the contents of the information leaflet or had not seen it given to women. Expectant management of prolonged pregnancy, an acceptable alternative to induction, was not mentioned in the majority of leaflets.*

*Reflective memo February 2017*

Edwards (2004) noted that by controlling the information, women were steered towards a style of care which did not necessarily satisfy their preferences but located within the power/knowledge system of obstetrics. The women were aware that midwives positioned themselves differently to their medical colleagues but struggled to differentiate their role in the medicalised system in which they operated. This has also been observed in studies by Surtees (2010), Seibold,

Licqurish, Rolls and Hopkins (2010), Hood, Fenwick and Butt (2010) Scamell (2011), Pollard (2011) Page and Mander (2014) and Healy, Humphreys and Kennedy (2015). Several of the studies described here have been included in an integrative review (Healy, Humphreys and Kennedy 2015), which presented a perspective of midwives who were subjugated by their obstetric colleagues and saw their role as being eroded by an increasing culture of risk and fear.

### **2.1.12 Midwives' myths**

An alternative perspective is offered by O'Connell and Downe (2009) who suggest that midwives have certain myths about themselves. According to O'Connell and Downe (2009), midwives state that they are committed to women centred care and normal birth but practise as if constrained by the dynamics within hospital which prevent them from doing this, "*even when the factors that are seen to be oppressive are not actually operating*" (O'Connell and Downe 2009 p604). This, the authors suggest, indicates that midwives perceive that they cannot take personal responsibility for the care they provide. The concept of Sartre's "bad faith" comes to mind here to explain the dissonance that can occur when midwives perform their culturally defined role inauthentically. The authentic position, the authors contend, involves recognising in the context of hospital-based care, there are a range of options which include compliance, and discursive, subversive and overt resistance, each requiring the exercising of personal responsibility. While the studies by Surtees (2010), Seibold, Licqurish, Rolls and Hopkins (2010), Hood, Fenwick and Butt (2010), Scamell (2011), Pollard (2011) Page and Mander (2014) and Healy, Humphreys and Kennedy (2015) suggest that midwives' practices conflicted with their espoused beliefs, Pollard (2011) found that some labour ward midwives valued the skills involving technological and medical management of

labour above those required to support normal birth. Her qualitative study, conducted within a critical discourse analysis framework, was located in the labour ward of a consultant led English maternity unit. Observations and interviews conducted with 20 midwives found them struggling with an inconsistent professional identity, sometimes challenging existing power relationships but often reinforcing traditional ideas of gender, professionalism and the medicalisation of birth through their discursive practices. This struggle is, according to Pollard (2011), unsurprising given that midwives simultaneously adhere to a medicalised approach to childbirth, advocate on behalf of women, seek to affirm their professional status and observe their contractual obligations as employees. The findings of this study resonate with those of McFarland et.al's (2020) qualitative metasynthesis, which indicates that midwives continue to struggle with their professional identity.

### **2.1.13 Women demanding choice**

The cognitive dissonance experienced by midwives with regard to supporting women's choices within a medically orientated framework is not new, and it has been women who have traditionally led the way in demanding more choice in maternity care. The male and medical dominance over women's bodies led women to reclaim ownership and control over their reproductive experiences through the establishment of consumer movements. These movements emerged in the 1960's and 1970's to challenge the homogenic structures which threatened and restricted the autonomy of pregnant and childbearing women. One of these groups is the *Association for Improvements in Maternity Services (AIMS)*. Originating in 1960, it was initially known as "The Society for the Prevention of Cruelty to Pregnant Women" (Beech 2011). Their mission statement is to "support

*all maternity service users to navigate the system as it exists, and campaign for a system which truly meets the needs of all”* (AIMS 2017). AIMS, and the National Childbirth Trust (NCT) were established by women not content with the way maternity services were provided, highlighting the lack of consideration, regimentation and the overuse of interventions in care. The emerging activism and assertiveness of women was perceived as threatening by some healthcare professionals (Mander and Murphy-Lawless 2013). It is notable that the impetus for flexibility and choice in pregnancy and birth came from women, and not from the midwives, demonstrating how discourses of choice, medicalisation and risk in pregnancy and birth are historical.

#### **2.1.14 The ontological positioning of community midwifery**

The prominent role afforded to community midwifery in *Better Births* (NMR 2016) shifts the focus on pregnancy and birth as medical events towards one which recognises that they are also social experiences. The ontological positioning of community midwifery supporting normal pregnancy and birth has a historical basis. Prior to the inception of the NHS, community midwifery services were located within local authority public health departments, thereby placing midwifery within a community health system, confirming that for the majority of women pregnancy, birth and the post-natal period were normal physiological events.

Under the provisions of the 1946 National Health Service Act, maternity care was transferred out of the local authority and instead provided by all three branches of the NHS; domiciliary services, general practitioner services and hospital services. Under the new service General Practitioners (GP) now assumed greater responsibility for antenatal care, and as women could now book a GP for care

without paying a fee, the doctor increasingly became the first point of contact of the woman with the maternity services, and not the midwife. This shift marked the beginning of the fragmentation of maternity care between increasing numbers of health professionals and restricted the ability of midwives to provide continuity of care to women throughout the childbearing period. The 1960s and 1970s saw a number of organisational changes to the tripartite provision of maternity services, culminating in the report of the Peel Committee which concluded that all births should take place in hospital as, in its view, hospital delivery was less risky than home birth for mother and baby (The Peel Report 1970). The committee also recommended centralising services under the control of consultant obstetricians, that GP maternity beds should be situated within or very close to consultant units and that a consultant obstetrician should have overall responsibility for these beds, and that all women, irrespective of where they birth their baby, should be seen by a consultant obstetrician at least once during their pregnancy. Robinson (1995) suggests that the hidden agenda of the Peel Report was that obstetricians did not trust the quality of GP care, further isolating maternity care from the community.

The Peel Report was later discredited by Tew (1985) who, using data from the British birth survey in 1970, showed that perinatal mortality was significantly higher in consultant obstetric hospitals, even after allowance had been made for the greater proportion of high-risk births taking place in those units (Tew 1985). By this time however, obstetric dominance in maternity care was firmly established with hospital based medical staff becoming increasingly involved in the care of women with normal pregnancies. Hospital births were actively managed through the implementation of time-based rules on the length of labour. This led to the

belief that “labour is only normal in retrospect” (Percival 1970) and a view that endured throughout my midwifery training in 1990.

The transfer of maternity care services from local authority funded public health services to a medically dominated hospital-based service influenced the way childbearing and maternity care is currently framed. In the former setting, and prior to the inception of the NHS, pregnancy and childbirth was viewed as a normal physiological event, even a “manifestation of health” (HMSO 1992). Ante-natal care provided under the auspices of public health was focussed on promoting and maintaining good maternal health because this contributed to positive maternal and infant outcomes. Ante-natal care provided from a public health perspective encapsulated the wider determinants of health; diet, psychological wellbeing, housing and lifestyle. In the hospital-based service however pregnancy and birth were increasingly viewed through a medical lens as conditions that require monitoring and managing in order to return the woman and the baby to a normal, that is, not childbearing state.

In today’s practice, the community midwife faces a distinct set of challenges. First, she must negotiate a landscape in which her expert knowledge has been destabilised and pregnant women are considered responsible, vigilant and self-aware. Second, community midwives work within organisations which often view pregnancy and childbirth as risk-laden activities. This last point is crucial because in my experience, midwives who choose to work in the community do so because of a belief in the normality of pregnancy and childbirth. This belief does not come at the expense of safety, but rather a recognition that pregnancy and birthing are social experiences as well as clinical events.



The framing of pregnancy and childbirth through a medical lens contributes to discourses of risk and medicalisation, influencing the ways in which I, as a community midwife could practice authentically, meeting the needs of women and “with a foot in both camps.” Foucault’s ideas on the nature of discourse are used to demonstrate how community midwives negotiate competing and sometimes complimentary discourses in their work with women.

### **2.1.15 Conclusion**

Increasing choice in pregnancy and birth is not a new phenomenon but has been demanded by women for many years, pre-dating the various policy initiatives aimed at increasing choice in healthcare. Pregnant women are not patients, but also have an asymmetrical relationship with care providers as they lack knowledge of the system. The evidence suggests that the asymmetry in relationships between healthcare professionals and patients, because the patient is sick and therefore vulnerable, and the clinician is knowledgeable about care and treatment options, means that truly informed choice is anathema. The development of a trusting, therapeutic relationship with a known caregiver can support informed choice and shared decision-making, but the ability to opt for care from multiple providers, as suggested by *Better Births* (NMR 2016) threatens continuity of care, and consequently a trusting, therapeutic relationship with a known care-giver.

Choice is a construct that is shaped by the prevailing beliefs and attitudes towards health, including the acceptability of medico-technological interventions in pregnancy and birth. Risk perception influences choices in that choice is constrained and shaped by what is deemed possible and acceptable from a medical perspective. There is evidence to support out of hospital birth in the UK,

and policies in place to promote this as safe and cost-effective care, but pregnant women who choose this often encounter negativity from their care-givers.

Pregnant women seek out information on pregnancy and birth from a number of sources and receive information from midwives about the maternity services available in the respective Trusts. These texts provide a perspective on how the organisation conceptualises pregnancy and birth. Community midwives have a key role in the provision of information to women in order to support choice and decision-making and must negotiate the discourses that coalesce around pregnancy and childbirth.

This overview has demonstrated that although, at policy level, choice is viewed as a right and a good in maternity care, the operationalisation of choice between the woman and her healthcare providers is less transparent, where issues of power, scientific and experiential knowledge and organisational mores shape and limit choice. Accordingly, the literature review that follows has sought to understand how choice is conceptualised and operationalised by midwives working daily “in the field”, with women.

# Chapter 3

## 3 Literature Review

### 3.1 Introduction

Chapter two demonstrated that although choice is a fundamental tenet of maternity care and policies are in place to promote it, organisational, professional and societal influences meant that choices were constrained by those strictures. Evidence; anecdotal, experiential and scholarly indicates that community midwives often experience conflict between their professional requirements and their obligations to their employer. In this chapter I reviewed key literature; specifically, the barriers and challenges faced by midwives when supporting choice and decision-making in pregnancy, which informed the thesis aims.

A scoping review methodology was chosen, and the benefits of this approach offered in relation to my chosen area are set out. I provided a comprehensive and transparent search strategy and presented a narrative account of the themes. A summary of the findings includes identification of the gaps in the evidence where my study contributes. The limitations of the review conclude this chapter.

### 3.2 The rationale for the literature review

The evidence presented in the background to this study indicates that there are competing discourses which impact on the ability of community midwives to support women to make informed choices about their pregnancy and birth options. Key evidence, such as the Birthplace Study (Brocklehurst et al 2011) and policy developments set out in the NICE Intrapartum guidelines (NICE 2014) and *Better Births* (NMR 2016), demonstrate that midwife-led care, provided in a setting

outside of an obstetric unit, is safer for many women, and places the community midwife as a key informant on choices and decision-making. Yet despite this research being in the professional domain for many years, the implementation of evidence-based practice is slow. This literature review illuminates the factors that influence the ability of midwives to support women to make informed choices.

### **3.3 The scoping review**

This literature review followed the structure of a scoping review (Asksey and O'Malley 2005). Scoping reviews are an increasingly utilised approach to map existing literature in a given field and are particularly useful when conceptual boundaries of a topic are not clearly defined and not adaptable to a more precise systematic review (Peters, Godfrey, Khalil, McInerney et al 2015). Asksey and O'Malley (2005) offer four common reasons why a scoping study might be undertaken, which include the rationale for its adoption in this professional doctorate, namely, to identify gaps in existing literature and clarify key concepts. Unlike systematic reviews, scoping reviews are designed to provide an overview of the existing evidence base regardless of quality, therefore an assessment of the methodological quality of the study does not form part of the remit (Peters, Godfrey, Khalil, McInerney et al 2015, Asksey and O'Malley 2005).

Peters et al (2015) recommend that an *a priori* scoping review protocol be developed prior to undertaking the review itself, whereas Asksey and O'Malley (2005) suggest that the process is not linear, but iterative, requiring researchers to engage with the process in a reflexive way. As the latter position aligns with my position as a practitioner-researcher, Asksey and O'Malley's (2005) framework

was used to guide my review and was documented in sufficient detail to ensure transparency and increase reliability.

### **3.4 The review objective**

Unlike a systematic review which begins with a specific question or series of questions, this scoping review adopted a broader approach aimed at generating breadth of coverage. The review objective should also direct the specific inclusion criteria (Peters et.al 2015). Accordingly, the objective of this review is to identify how midwives negotiate choice and decision-making in pregnancy and birth.

The term “midwife” was chosen in preference to community midwife as this nomenclature is mainly used in the UK and would not always capture midwives working in integrated maternity services, and those studies generated outside the UK. This was necessary to ensure that the broadest range of evidence was identified and reviewed, avoiding limiting the search to studies focussing wholly on midwifery care provided in community settings.

### **3.5 Identifying relevant studies**

To identify studies relevant to the stated objective I adopted a strategy that involved searching for research evidence via different sources. This included electronic databases, reference lists and hand-searching of key journals.

#### **3.5.1 Electronic databases**

CINAHL, MEDLINE, Academic Search Premier and PSYCHInfo were the databases utilised via the EBSCO host platform. These databases were selected to ensure the inclusion of studies from the disciplines of midwifery, nursing,

medicine, social sciences, and psychology. Arksey and O'Malley (2005) suggest that a broad approach should be utilised initially which permits refinement of the search strategy as the scoping review progresses. Accordingly, the initial search utilised CINAHL and MEDLINE using the following search terms;

Choices or decision-making

AND prenatal or antenatal or perinatal or maternal

AND childbirth or labour or birth or labor or delivery.

This initial search yielded 10,593 hits. Brief inspection of the titles demonstrated many irrelevant areas had been identified, so the following inclusion criteria was applied

INCLUSION CRITERIA	RATIONALE
choice or decision/ decision making in the abstract	To identify studies where these concepts are a key theme
peer-reviewed research studies from 2010 to the present	To identify studies published circa the Birthplace Study (2011) & relevant policy changes.
peer-reviewed research studies published in English	Foreign language material would require translation
peer-reviewed research studies conducted in the UK, Europe, Australia and New Zealand	To identify studies carried out in countries which have broadly similar maternity provision to the UK.

*Table 3-1 inclusion criteria*

The application of the inclusion criteria resulted in 1,466 hits, and this was further refined to 620 hits when the results were combined with the terms “midwife” or “midwives” or “midwifery”.

The search strategy was repeated on the Academic Search Premier and Psychinfo databases, but no new studies were identified suggesting that

saturation point had been reached in respect of searching the electronic databases.

#### *3.5.1.1 Reference lists*

Bibliographies of studies found through the database searches were checked to ensure all relevant studies were identified. This snowballing technique yielded additional studies where choice was a theme in the study but not identified as a key word by the authors.

#### *3.5.1.2 Hand-searching of key journals*

The electronic databases identified studies primarily from midwifery and obstetric journals and publications. To broaden the search, *The Journal of Medical Ethics* and *Social, Science and Medicine* were hand searched to include studies from the disciplines of sociology, psychology and philosophy. Although no studies were identified, the search did reveal several papers which contributed to the discussion section of this professional doctorate. The various mechanisms for searching in this scoping review generated a total of 620 references. The next stage of the scoping review is study selection (Asksey and O'Malley 2005).

### **3.5.2 Study selection**

Unlike systematic reviews where clear inclusion and exclusion criteria are developed at the outset, the scoping review allows for *post-hoc* development, based on increasing familiarity with the evidence (Asksey and O'Malley 2005; Peters, Godfrey, Khalil, McInerney et al 2015). After reviewing the citations, the following inclusion and exclusion criteria were developed.

INCLUDED STUDIES	RATIONALE
Studies in which midwives were participants.	To capture the perspectives of midwives.
Studies which focused on choice and decision-making in relation to pregnancy and birth options.	To capture the views of midwives in relation to pregnancy and birth choices.
EXCLUDED STUDIES	RATIONALE
Studies in which focused on the clinical decision-making of midwives i.e episiotomy.	Does not relate to supporting women to make choices and decisions in pregnancy and birth.
Studies which focus solely on antenatal screening for genetic conditions.	Focus of study very specific and limited to early pregnancy

*Table 3-2 inclusion and exclusion criteria*

The inclusion and exclusion criteria were applied to all the citations. For those studies that appeared to represent a “best fit” with the stated scoping review objective a copy of the full article was obtained. After reading the full article, a decision was made as to whether it should be included in the review. Peters et al (2015) and Arksey and O’Malley (2015) state that two reviewers are required to undertake a scoping review and although none of those authors state why, it can be inferred that this is due to confirmation bias; that is including studies that fit with the researcher’s assumptions. To mitigate against this, I utilised the supervision process to discuss my included studies with my supervisors. The place of care, community, home or hospital, was not used to silo papers as I wanted to ensure all papers on choice were examined, given that women access maternity services at different points in their pregnancy. Out of 620 citations identified through searching, 203 were identified as a potential “fit” with the scoping review objective. Having read those articles in full, 18 were selected for inclusion in the review.



### 3.5.3 Charting the data

The next stage involved charting and sorting the material according to key themes. A data charting form was developed to record essential information about the study and included a study identification code. (Appendix 1). The country in which the research took place was noted so that meaningful comparisons could be drawn with UK service provision. The location of the study, delivery unit, community, home or an integrated service was recorded, as well as the characteristics of the participants, that is hospital or community-based midwives, or those working across integrated services, the chosen methodology, and the key themes were also included. This essential information from the studies will now be explored in more detail.

#### 3.5.3.1 The countries where the studies took place

Country	Number of studies
United Kingdom	6
Australia	5
New Zealand	2
The Netherlands	2
Sweden	2
Canada	1
Switzerland	1

Table 3-3 Country of origin

The inclusion criteria set out at the beginning of the scoping review aimed to include studies with broadly similar maternity care systems to that of the UK. However, women in the countries included in the scoping review are able to

access maternity services in different ways, often via a payment system which enabled them to choose their care provider. Choosing to have a midwife, GP or obstetrician as your maternity care provider creates a dynamic where the woman is free and responsible, exercising her autonomy. A woman may choose her provider based on her perceptions of pregnancy and risk, or her location to services as many parts Australia, New Zealand and Canada are rural and remote from services. Buying care, either directly or through an insurance scheme creates the concept of “consumer”, which suggests the purchasing of services. It is not within the scope of this review to consider why women choose a specific maternity care pathway, but to highlight the ways in which women in the countries identified in the review are able to engage with providers in a different way to the majority of women in the UK, and how this shapes and limits choices.

Five studies were located in Australia where maternity care is provided in both the private and public sector by obstetricians, general practitioners and midwives (Horner 2016). Women can opt for private maternity care, where all care is provided by a private midwife or group of midwives, in collaboration with doctors when needed. Women may choose to have all their care provided by the public hospital maternity services, where antenatal clinics are provided in hospital, and intrapartum and postnatal care provided by hospital midwives and doctors. Shared care is also available, and this comprises antenatal care in the community in collaboration with the hospital, and intrapartum and early postnatal care provided in the hospital (Donnolley Butler-Henderson, Chapman and Sullivan 2016). The latter option resembles most closely the current provision in the UK. Women in Australia can exercise choice in terms of who will provide her maternity care, even within the publicly funded systems of care. Women with health insurance may

choose to give birth in private hospitals under the care of private maternity care staff.

In New Zealand, women can choose a Lead Maternity Carer who may be a midwife, General Practitioner or an Obstetrician. Most women here opt for publicly funded care. This is similar in Sweden, The Netherlands and Canada. In Switzerland, basic Swiss health insurance allows women to choose a midwife, obstetrician or GP to provide maternity care, and have the option to birth at home, in hospital or a birth centre. Within these studies it is not clear how women make choices on the type of care they access. It is difficult to use these as a basis for meaningful comparison with UK services where the community midwife is the primary care coordinator and the gatekeeper to choice. Women outside the UK generally enter maternity services having made a choice about their provider based on their individual social and economic circumstances, although the extent to which this is circumscribed by insurance companies remains unknown. Although choosing where to receive NHS treatment has been part of the NHS plan since 2006, women in the UK cannot elect to have a specific midwife or obstetrician to provide their care as part of their NHS care. It is possible that paying for care does not provide more options but introduces a transactional element where the woman/patient has power. The studies have been included in the literature review because they inform the discourses on choice, medicalisation and risk. The differences in the way women access maternity services is relevant in the context of this study as it illuminates issues of power and control, addressing the aims of the study.

### 3.5.3.2 Study setting

Location	Number of studies
Integrated (hospital & community)	8
Community (including home & FBU)	2
Hospital	7

Table 3-4 Study location

The location of studies was relevant when looking to understand how community midwives negotiate competing discourses when supporting choice in pregnancy and birth. Most studies identified included both hospital and community settings. Two studies did not state the setting, and this was inferred on reading the paper and the vignettes attributed to the respondents. Research conducted in the hospital setting was also well represented in this scoping review. The distribution of study locations indicates that research on choice and decision making in pregnancy and birth is primarily located in hospital settings. *Better Births* (2016) recognise that maternity services should be based in the community. The low number of studies based in the community identified in this review demonstrate that it is an area that is poorly researched, highlighting a gap in the research on community midwifery practice. The dominance of the hospital setting determines the discourse of choice and is influenced by discourses of medicalisation and risk. This study has addressed the gap in the evidence base, exploring the constraints and challenges for community midwives when negotiating the reach of the hospital into community spaces.

### 3.5.3.3 Participants.

Participants	Number of studies
Women	7
Hospital midwife	9
Community midwife (inc. FBU)	4
Integrated midwife	5
Obstetrician	9
Obstetric nurse	2

Table 3-5 Participants

Most studies in the scoping review stated the primary workplace of the participants. When this was not clear, it was assumed, based on my understanding of the maternity care provision in the country where the study took place, to be a midwife working in an integrated maternity system. One study, (McCourt, Rayment, Rance and Sandall 2012) referred to “service providers and other key stakeholders”, with no further definitions of service provider or stakeholder which was disappointing as this study was the “best fit” in terms of meeting the scoping review objective.

The analysis of the participants indicates that in this scoping review, the views of hospital midwives and obstetricians in relation to choice and decision making are well represented. The perspectives midwives working in integrated services, and community midwives were not prominent in this review. According to *Better Births* (NMR 2016), community midwives are key individuals in the provision of information to women, to enable them to make informed choices about their care. This scoping review has highlighted a gap in the research in relation to the views

of community midwives on choice and decision-making, which my study addresses.

### 3.5.3.4 Methodologies used

Qualitative studies	Number of studies
Ethnography	3
Interpretive phenomenology	1
Feminist theory	1
Discourse analysis	1
Hermeneutics	1
Grounded theory	1
Not stated	7
Quantitative studies	Number of studies
Systematic review	1
Questionnaire	2 (51% & 15.1% response rates)

Table 3-6 Methodology

The aim of a scoping review is to provide an overview of the existing evidence base regardless of quality (Arksey and O'Malley 2005; Peters et al 2015)).

Therefore, a formal assessment of methodological quality is not undertaken. This section sets out the range of approaches used in the evidence, highlighting key points and identifying which methodologies might be usefully adopted in further studies.

Most studies used to inform this review are qualitative studies, primarily using interviews for data collection and using vignettes to illuminate the findings which contributes to the trustworthiness of the studies (Guba and Lincoln 1989). When

exploring social constructs such as choice in pregnancy and birth, qualitative methodologies are more likely to provide rich, useful data.

Most qualitative studies included in the review did not state explicitly the philosophical underpinnings of their chosen research methods. Clarity about the nature of reality and how we gain knowledge of it is fundamental to the research process as it gives coherence and credibility to chosen research methods (Walsh 2014). According to Walsh, failing to critique the ontological and epistemological underpinnings of research methods may mean the wrong questions are being asked resulting in research that is inadequately justified, lacks wider credibility and has little impact on women's outcomes and experience. In order to understand how community midwives, negotiate competing discourses when supporting choice in pregnancy and birth, epistemological and methodological issues required attention. It is not sufficient to simply describe how midwives negotiate this tension, but what influences their behaviour; the discourses that influence contemporary maternity care. Therefore the methodology chosen in my study was based in constructionist epistemology as meaning comes into existence in and out of engagement with the world.

Three studies (McCourt et al 2012, Scamell 2014, Newnham et al 2017) utilised ethnography which included interviews, non-participant observation and document review, providing robust evidence on which to base their findings. The three studies were all part of larger, nationally or internationally funded research projects, demonstrating the importance of choice in maternity services to the national and international care agenda but the concept of choice was often poorly understood and often meant different things to women and midwives. This tension

was explored more fully by Jenkinson, Kruske and Kildea (2017) and Holten, Hollander and de Miranda (2018) using a feminist theoretical perspective, which is appropriate given midwifery is a female-dominated occupation serving an exclusively female clientele. Although not explicitly stated, the social location of midwifery as an occupation for women by women informed the theoretical frameworks of McAra-Couper, Jones and Smythe (2011) and Noseworthy and Phibbs (2013).

Licqurish and Evans (2016) used discourse analysis informed by Foucault's theories of governmentality to explore the professional stances of midwives and obstetricians in relation to parental choice of place of childbirth. This approach illuminates the organisational, structural and professional stances of the two bodies, providing context and perspective. Unlike the other qualitative studies in this review which sought to describe and explain from the perspective of the participant, discourse analysis in this study sought to question and challenge those assumptions. This study provided a robust example of how Foucault's theories can be used to explore power and knowledge.

The scoping exercise contained one systematic review, which are regarded as providing the highest level of evidence (Aveyard and Sharp 2017). They stressed however, further high-quality research was needed to explore the main influences on midwives' place of birth discussions with women, with the aim of identifying appropriate strategies and interventions to improve those discussions. Discourse analysis is an approach which helps illuminate those influences and this scoping review has identified that there are very few studies utilising this methodology.



### 3.5.3.5 *Summary of essential information*

- Although the countries where the studies took place have broadly similar maternity care systems to the UK, women in those countries enter the system by choosing their provider. The widespread use of insurance backed healthcare in those countries means that private maternity care is more widely used, positioning the woman as a consumer of services.
- Research undertaken in community settings, including free-standing birth centres is not well represented in this review.
- Hospital midwives and obstetricians' observations on choice and decision-making are well represented in this scoping review but the views of community midwives and midwives working in integrated maternity care systems were not prominent.
- Most studies in the review did not explicitly state the philosophical underpinnings of their research methods. The majority of studies adopted qualitative approaches which sought to give voice to the respondents. The organisational, structural and professional impact on choice and decision-making was in part addressed by adopting an ethnographic or discourse analysis approach.

## **3.6 Narrative account of the themes**

Scoping reviews do not aim to synthesise evidence or aggregate findings from different studies, nor present a view regarding the weight of evidence in relation to a particular perspective (Arksey and O'Malley 2005). However, in order to present a narrative account of the existing literature, a thematic framework was utilised to provide clarity. Clarity of the reporting strategy is crucial for the reader to determine any potential biases in reporting (Arksey and O'Malley 2005). For the

purposes of this scoping review my analysis is based on the factors that influence the ways in which midwives negotiate competing discourses when supporting choice in pregnancy and birth.

The themes are presented diagrammatically and include the number of studies in which this theme occurred. Each theme is explored in depth and referenced to the relevant study by the study identification code. In this way any potentially subjective decision regarding thematic analysis is transparent.

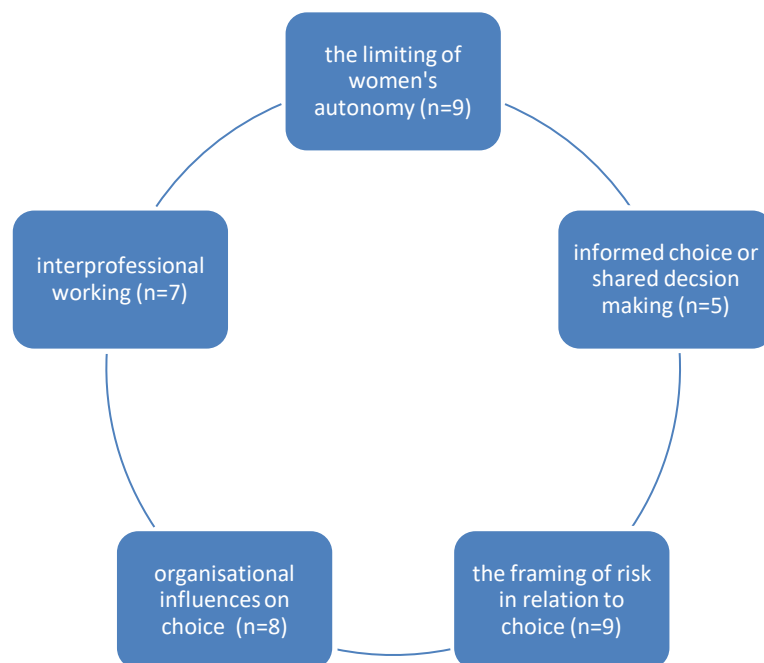


Figure 3.1 themes arising from the studies

### 3.6.1 The limiting of women's autonomy

Study identification codes: 1,2,3,5,7,11,12,15,18.

Respect for autonomy is a guiding ethical principle (Agledahl, Forde and Wifstad 2011). Respect for autonomy means that respect is afforded to an autonomous individual or an autonomous action or decision (Osamor and Grady 2018). To

respect an autonomous individual is to acknowledge that person's right to hold views, to make choices and take action based on their own personal values and beliefs (Beauchamp and Childress 2001). The right of women to make their own choices about how they manage their pregnancy and birth is set out in the Human Rights Act 1998 (HRA 1998), case law and health policy (DH, 1993, 2016).

Only one of the studies identified respected the autonomy of the woman in line with the definitions set about above (Catling, Petrovsk,Watts, Bisit and Homer 2016). The study included 4 hospital midwife respondents experienced in facilitating vaginal breech birth. The respondents, including 5 obstetricians worked in "breech" clinics where women with breech presentations were referred. The study authors highlighted the importance of continuity of care and saw this as vital in supporting women's choices. However, the women accessed the clinic late in their pregnancy, and although not stated in the study, likely to be around the 36<sup>th</sup> week of pregnancy when the impact of a breech presentation at the onset of labour needs consideration. Therefore, most of the care will have been provided by others. Consistency of approach rather than continuity is a key theme to emerge from this study, with clearly shared goals and interprofessional respect evident in the vignettes used in the paper.

The belief that women would not or do not understand enough about pregnancy and birth to make appropriate choices was a theme in Henshall, Beck and Kenyon's (2016) systematic review. They found that midwives made assumptions about the needs and capabilities of women and this was done through stereotyping women according to their social background, age, literacy levels, ability to speak English and previous births. The midwives then tailored the

information they made available or presented in such a way that the woman was unlikely to disagree with their suggestions. This patriarchal approach was also found in Welsh and Symon's (2014) study on birth plans. In this study women are exercising their autonomy by setting out their preferences for birth, but the dominant feeling expressed by midwives working in the midwifery led unit and the obstetric unit was of irritation that their professionalism was being challenged, particularly when birth plans suggested that the midwife might not always act in the woman's best interests. In this situation, women were perceived as not being sufficiently informed about the role of the midwife, which suggests that midwives believe it to be the responsibility of women to inform themselves of their roles.

The midwives in the midwifery led and obstetric units believed that birth plans created unrealistic expectations for women, but it is interesting to note that the midwives working in the obstetric unit believed this because birth was chaotic, unpredictable and not amenable to planning. This observation is interesting given the setting in which these midwives work, with its emphasis on the management of birth. The midwife respondents from the midwifery led unit felt that birth plans did not respect their skills and experience and would act inconsiderately towards women and so diminish their voice. Maternal autonomy as a threat to professional autonomy was also identified by Thompson (2013) in her study of the experiences of delivery unit midwives who care for women who request care out of guidelines. In common with Welsh and Symon's (2014) study, women were often perceived as difficult, with midwives sensing relief when the infant was born, indicating the challenges faced by midwives in respecting maternal bodily autonomy.

The bounded nature of support for maternal bodily autonomy was a theme found in 3 studies. Jenkinson, Kruske and Kildea's (2017) study included 12 hospital midwives. They identified that clinicians had a "line in the sand" which depended on the clinician's profession and the perceived reasonableness of the woman's birth intentions. Perceived reasonableness appeared to correlate with gestation with the refusal of induction of labour after 42 weeks of pregnancy proving particularly challenging as the personhood of the fetus was afforded greater prominence as the pregnancy progressed. The study found that obstetricians and midwives adopted a range of strategies to gain compliance, from manipulation, judgement and badgering. Interestingly the clinicians discursively constructed this as "counselling" the woman on the risks of refusal and telling women that their baby could die was the end point of this counselling. Shroud-waving strategies aimed at getting women to comply with interventions was also found in a quantitative study by Danerek, Marsal, Cuttini, Lingman et al (2011). Two hundred and fifty-nine midwives working across 13 maternity units in Sweden responded to a questionnaire. They were provided with two fictitious cases; one where a woman declines a caesarean section for cultural reasons, and one where a woman requests a caesarean section without any medical or fetal indications. In the first case, only 21% of midwives would respect the woman's right to refuse, with a quarter of midwives participating in the study believing the obstetrician should inform the woman that her life was in danger. This is despite there being no indication in the vignette that there is any risk to the woman.

The perceived willingness to request a caesarean section in the absence of clinical indication is presented in the literature as a way in which women exercise autonomy. The fictitious case offered by Danerek et al (2011) found that 77% of

midwives felt that this request should not be acceded. McAra-Couper, Jones and Smythe (2011) go further and suggest that respecting a woman's request for a caesarean section in the absence of clinical indication risks the charge of maleficence. They argue that the primary ethical principle of "do no harm" often comes into conflict with the concept of respecting autonomy. If, following a discussion about the risks and benefits of caesarean section in the absence of a clinical indication, the women chose to proceed, then she is entitled to receive one (NICE 2012). Yet guidance set out by the General Medical Council (GMC 2008) states that doctors are under no legal or ethical obligation to agree to a patient's request for treatment if they consider the treatment is not in the patient's best interests. McAra-Couper, Jones and Smythe (2011) suggest that the normalisation of surgical birth has reduced the professional to one of an opinion-giver, and places the ethical principle of autonomy above beneficence, maleficence and justice. This is an interesting observation when considering the normalisation of routine interventions in pregnancy and birth, for example ultrasound scanning and screening for fetal anomaly, but nonetheless require the woman to make an informed decision based on information from the community midwife.

Women refusing the care they had requested was found in 3 studies. In studies by Scamell, (2014) Jenkinson, Kruske and Kildea (2017), Holton, Hollander and de Miranda (2018) women were denied access to facilities or, for those in insurance backed services, obstetricians withdrew care. The women in these studies were not requesting interventions, but declining interventions such as continuous fetal monitoring, induction of labour or intravenous antibiotics in labour. From the evidence in this scoping review, autonomy therefore appears to be more

respected if the woman is asking for an intervention, even though that may cause harm.

The limits placed on autonomy by societal expectations of women and motherhood was identified in three studies. In two studies (Jenkinson, Kruske and Kildea 2017, Holton, Hollander and de Miranda 2018), women who declined care were perceived as unfit mothers, willing to risk their infant for their preferred birth experience, and Child Protection Services were invoked on occasions when women were perceived to have put their experience above the safety of their baby. McAra-Couper, Jones and Smythe (2011) suggest that choice is influenced and determined by social change and the gendering of women. When women make autonomous choices, they do so within a milieu that views birth as inherently risky, requiring medicalisation, hospitalisation and technology. Surgical birth, they argue is increasingly normalised and part of the range of surgical interventions aimed at women, such as liposuction and cosmetic surgery. Women making a choice for a caesarean section in the absence of a clinical indication do so within the context of what is being promoted as increasingly normal for women.

In summary, autonomy is a guiding ethical principle and is a central tenet of healthcare. The scoping review indicates that midwives limit women's autonomy, either overtly, by withdrawing care, or covertly, by presenting a range of options based on the midwife's preconceived ideas on what is acceptable. Women making autonomous decisions about their care can result in professionals seeking to exercise their professional autonomy and declining to provide care. This was found in studies where private, or insurance backed schemes were common, which suggests that the transactional nature of purchasing care enabled clinicians

to withdraw services more readily. In the UK, midwives have legal duty of care and are obliged by the NMC to “*put the interests of people using midwifery services first*” (NMC 2015 p6), so withdrawing care is not an option. However, the midwives in the UK studies expressed anxiety and irritation when it was perceived that women’s choices were unreasonable or excessive.

Bioethical definitions of autonomy imply that decision-making is a linear process, occurring in a vacuum, where a woman understands all risks and benefits before arriving at a fully informed decision. The scoping review demonstrates that choice in pregnancy is socially constituted and constitutive in that choice is influenced by discourses of risk, medicalisation and societal expectations of motherhood, and the choices made available to women reinforce this narrative.

The next section explores in more detail how the framing of risk influences midwives when considering choice and decision-making in pregnancy and birth.

### **3.6.2 The framing of risk in relation to choice**

Study identification codes: 2,3,4,5,7,8,14,15,16.

Constructions of risk in pregnancy and birth has been addressed in the background to this study. Nine papers in this scoping review include descriptions of how risk is framed in relation to choice in pregnancy and birth. Three studies (Holton, Hollander & de Miranda 2018, Jenkinson, Kruske and Kildea 2017 and Scamell 2014) indicated that women rejected biomedical definitions of their birthing bodies as inherently risky. In the first study women constructed their birthing body as a site of knowledge and capability, a belief made more powerful because many had a previous traumatic birth experience. By trusting their intuition



about their bodies, they challenged the expert knowledge of the professionals. In this study, professionals recalled counselling the women on the risks associated with their choices, but the women reported this as a loss of autonomy and agency. To these women the risks of birthing their baby in hospital was greater than staying at home because they perceived that their choices regarding birth would not be honoured. The interventions that women in this study were declining are the same as those declined in Jenkinson, Kruske and Kildea's (2017) study, namely caesarean section for breech birth, repeat caesarean section and continuous fetal heartrate monitoring. The evidence suggesting that declining these practices is harmful is scant or contested. For example, a study by Catlin et al. (2016) discusses the importance of supporting vaginal breech birth to prevent caesarean section, particularly in primiparous women. This study found that the obstetricians and midwives supporting women to consider vaginal breech birth did not discuss very rare complications of vaginal breech birth with women as they considered this unhelpful, thereby providing some context for potential risks.

Risk talk was a feature in 4 studies. Van Wagner's (2016) study explored how the implementation of evidence-based practice had the effect of making women more likely to opt for intervention. The participants found that the inclusion of numeric estimations of risk creates risk talk and it was essential to put risk into perspective. Many of the respondents in this study saw a tendency in maternity care to emphasise the risks of non-intervention and the benefits of intervention, and as a result tried to consciously include the evidence that supports normal birth. It should be noted that the study participants had an identified interest in evidence-based practice through published literature or conference participation and so their perspectives may not be representative of other maternity care providers.

Three studies highlighted how clinicians used “maternal altruism” (Van Wagner 2016) to ensure compliance. Danerek et al (2016) showed that midwives were willing to exaggerate the risks to the fetus in order to persuade women to undergo a caesarean section that they had already declined for cultural reasons. Jenkinson et al (2017) found that in discussions with women, risks to the fetus were over-emphasised and the risks to the women were downplayed. In Scamell’s (2014) study, the midwife informed the woman that her baby might die if she chose to birth in a setting which could not provide antibiotic cover in labour for Streptococcus B colonisation. The emerging theme from these studies, is the woman, positioned as a threat to the fetus and the escalation of risk in these studies demonstrates an appeal to maternal altruism, where the good mother always acts to protect her baby from harm, however remote the possibility.

Three studies described how eligibility to use services was set out in guidelines aimed at minimising risk. In Scamell’s (2014) study, access to the free-standing birth centre was contingent upon women meeting certain criteria aimed at ensuring women accessing the service were as “low-risk” as possible. Similarly, Newnham, McKellar and Pincombe (2017) found that women requesting a water birth needed to be assessed as eligible and complete documentation to that effect antenatally. Water birth was not something you could opt into during labour and discussions about it were framed by a sense of prohibition and restriction. The study authors compared this with the normalisation of epidural analgesia and the lax way informed consent for this invasive procedure was usually obtained. These two studies indicate that the midwives perceived birth as risky and that facilities and practices to support normal birth required policing through guidelines and

checklists to ensure that those using the services were in fact eligible to do so. Only then could eligible women have autonomy over their birthing choices.

Midwives' acceptance of discourses of risk and normal birth were illuminated in Licqurish and Evan's (2016) discourse analysis of position statements on home birth from the midwifery and obstetric colleges in Australia. In their analysis of the midwifery document, it is recognised that the woman's choice to birth at home must be respected, but in order to support women to do so, midwives must adhere to numerous rules to reduce risk. These rules instruct midwives how to conduct themselves should they decide to attend a woman at home to ensure professional accountability. Here the midwifery college places the responsibility on the midwife to determine if the woman is eligible for home birth by stating "*should they decide*" to attend. In these circumstances the rules may act as a form of disciplinary control (Founier 1989), placing limits on the practice of the midwife, and by extension the autonomy of the woman. The authors concluded that these rules reflect a subordinate position and subjugation to risk discourse.

The scoping review highlighted tensions impacting on midwives' abilities to support choice and decision-making in pregnancy. The studies illustrated women, considered as "high-risk," reject biomedical constructions of risk and opt out of obstetric care and instead request care that would facilitate normal birth. Women who are "low risk" must pass the "eligibility" test before they can exercise their choices to birth in midwifery led settings, including home and use techniques, such as waterbirth to support them. The guidelines which set out which women may access services act as a form of disciplinary control over midwives, creating boundaries around their practice and limiting the choices of women.

Clinicians will appeal to maternal altruism and, on occasion, overplay fetal risks at the expense of maternal ones in order to increase compliance with recommended care. Contextualising risk for women was identified as a way in which the lean towards technology could be halted. Good interdisciplinary relationships were evident in one study which supported women who wished to have a vaginal breech birth. The impact of professional relationships on midwives' ability to support choice and decision-making will be explored in the next section.

### **3.6.3 Interprofessional working.**

Study identification codes: 1,2,3,5,8,9 & 15.

Effective interprofessional working supports safe, personalised care (Birch 2015). Nine studies identified factors where interprofessional working helped or hindered midwives in supporting women to make choices regarding their care.

The different professional cultures and visions held by midwives and obstetricians is set out in three studies. Licqurish and Evan's (2016) discourse analysis set out the fundamentally opposing positions held by the Australian colleges of midwifery and obstetrics on home birth. The obstetric college posited that there was an inherent risk in planned home birth as opposed to the ready availability of safer options in hospital. Their case against home birth was based on the risk of perinatal death of the infant, supported by evidence. The midwifery college argued that a woman's choice should be respected but did not present a strong evidence-based argument to support this. Through their Foucauldian analysis of these statements, the authors propose that obstetric power is exercised through the authoritative knowledge presented in the document. The inability of the midwifery

college to strongly articulate their position results in midwifery led care being viewed as subordinate to obstetric care. This is supported by Henshall, Beck and Kenyon (2016) in their systematic review, where midwives did not always offer home birth as an option because they wanted to avoid confrontation with medical colleagues, therefore prioritising obstetric care. Danerek et al's (2011) study suggests that midwives perceive obstetricians as the ultimate decision-maker in maternity care. In this study which explored midwives' perceptions of a woman who declined emergency caesarean section for cultural reasons, 89% felt the obstetrician should persuade the woman to agree, with 11% stating that the obstetrician should perform the operation without consent. The study authors conclude that this stance was adopted because the midwives do not have direct responsibility, as the responsibility to make such a decision lies with the obstetrician.

There was closer alignment between the views of obstetricians and midwives in studies of high-risk pregnancies. In Jenkinson, Kruske and Kildea's (2017) study, midwives and women perceived that midwives were more supportive of maternal autonomy but retained a "line in the sand" which limited this, although this line was further afield than that of the obstetricians. In Holton, Hollander and de Miranda's (2018) study, there was no distinction between obstetricians and midwives; women reported that both adopted a paternalistic decision-making model resulting in a lack of autonomy. Catlin et al (2016) showed how good interprofessional communication contributed to care when supporting women contemplating vaginal breech birth. In this study, as with the other studies of high-risk pregnancies, the obstetrician is the lead professional. It is possible that the midwives are comfortable aligning with the obstetric model of maternity care, with its boundaries

and limits, midwives lack of willingness to support midwifery led care was noted in Henshall, Beck and Kenyon's (2016) systematic review where the unsupportive attitudes of some midwives towards home birth meant that women were not always presented with this option. Even if the midwife was positively promoting home birth, she may have difficulty engaging other midwives to be supportive.

The scoping review illustrated that the position midwifery led care occupies in relation to supporting choice is not articulated clearly or understood by midwives. Obstetricians on the other hand, use evidence in their position statement which gives their words greater authoritative knowledge. Midwives caring for women with high risk pregnancies are seen to adopt similar beliefs and approaches to obstetricians when working with women. Midwives do not always offer home birth as an option to women because of a perceived lack of support from midwifery and obstetric colleagues. In this situation midwives can be seen as relinquishing their responsibility to provide women with information to inform choice. However, the scoping review identifies that organisational norms can influence how midwives can support choice and decision-making and this will be addressed in the next section.

#### **3.6.4 Organisational influences on choice**

Study identification codes: 1,6, 14,17 & 18.

Three studies identified the pressure to conform to organisational norms as a limiting factor in supporting choice. Henshall, Beck and Kenyon (2016) found that midwives felt they had to be selective in the options they offered women, steering them towards obstetric birth settings reinforcing organisational norms. This was

also a finding in Newnham McKellar and Pincombe's (2017) ethnographic study. Their observations of midwives facilitating antenatal classes noted mixed messages were given. Although espousing normal birth and exhorting women to trust their bodies, the midwives also had to convey the fact that the organisation did not really trust women's bodies. Midwives felt obliged to inform women of the reality of the hospital in which they were working but did so in a way that left women struggling to interpret the message. A mismatch between women's expectations of individualised, non-institutionalised care and midwives' obligations as employees resulting in midwives feeling anxious and often irritated with women was also found in Thompson's (2013) study. Such communication strategies do not equip women with the information to make informed choices.

McCourt et al (2012) identified that the community midwife service in their study was relatively peripheral to the rest of the service. While this might prove beneficial to community midwives in terms of retaining a community, rather than hospital orientation, the study found that the midwives did not have the opportunity to participate in clinical governance processes, team meetings and training and development opportunities. This study suggests that community midwives are therefore not able to participate fully in the discourses on choice, medicalisation and risk because their peripheral position within the Trust prevents their meaningful contribution. The lack of training and development opportunities meant that community midwives lacked confidence to support home birth, contributing to a situation where midwives did not offer home birth to women.

The observation that community midwifery services were peripheral to rather than integral to the maternity services was compounded by the view held by the Trust

that out of hospital birth was an expensive add-on, mainly because two midwives were required to attend a home birth. Furthermore, home birth provision was inequitable in that more than one birth at a time could not be facilitated due to a lack of staffing. This study is the only one to refer to community midwifery in the UK, which is noteworthy given the importance of community midwives in supporting maternity policy. This demonstrates a significant gap in the evidence and confirms the timeliness and relevance of my study.

Lack of engagement with governance, specifically research evidence was also a key finding in a study by Soltani, Fair and Duxbury (2015). Their online survey of obstetricians and midwives' knowledge of midwifery models of care and sources of information yielded a very low response rate and indicated that professionals were not using the most reputable sources of robust evidence on which to inform their discussions with women regarding care options.

The scoping review shows that midwives are cognisant of organisational norms when presenting information to women, attempting to manage expectations and at the same time promoting choice. The peripheral nature of some community midwifery services in the UK means that community midwives are not participating fully in governance processes, including training and development and utilising research in their work. Midwives therefore are not able to make a meaningful contribution to the discourses of risk, normality and medicalisation informing pregnancy and birth.



The scoping review has so far identified themes from the evidence which influence how choice is presented. The following section discusses the ways in which choice and decision-making are constructed in the evidence.

### **3.6.5 Informed choice and shared decision-making**

Study identification codes 2, 9,10, 12 and 13.

The construction of choice in maternity care is set out in Chapter 2. Within the scoping review, the term “shared decision making” was also used and presented as a qualitatively different approach to that of informed choice.

Two studies are critical of the presentation of informed choice in maternity care. McAra-Couper, Jones and Smythe (2011) argue that choice does not exist in isolation but within a social and cultural context. Informed choice in pregnancy and birth is influenced and predetermined by the milieu in which pregnant women inhabit, which is constrained by guidelines, medicalisation and fear. This point is also made by Holten, Hollander and de Miranda (2018) who found that when clinicians use guidelines, the preferences of women are generally not elicited or overruled and options not given, suggesting that clinicians find it difficult to discuss options they do not personally or professionally support. Clinicians in this study believed they were a shared decision-making model, a concept defined in a study by Molenaar et al (2018). This study looked at developing an intervention to improve shared decision making in maternity care. The researchers used Elwyn’s (2010) framework of *choice talk*, *option talk* and *decision talk* to explore the needs of parents and professionals regarding shared decision making in maternity care. They found that while *choice talk* and *option talk* were part of everyday practice,

*decision talk* was not. Although professing to facilitate shared decision-making, professionals tended to adopt the informed consent approach, and did not see a role for themselves in *decision talk*. In line with Holten, Hollander and de Miranda's (2018) study, professionals experienced difficulties when parents' choices were not in line with professional values or what might be considered medically justified. This theme is picked up by McAra-Couper, Jones and Smythe (2011) who suggest that the rhetoric of informed choice can be harmful, in that the woman's informed choice is always viewed as the right choice, and the authority of the expert is secondary, reducing them to little more than an opinion giver. This is exemplified in the study by Hertig, Cavalli, Burton-Jeangros and Elger (2014). They identified three typologies in their study of how professionals mediate their role when women ask them to become involved in the decision-making process. One profile was described as enforcing responsibility, where the professional delivers information as a series of choices to the woman who is assumed to be able to make a decision and declines to participate further in the decision. Emotions, subjectivity and values are therefore removed from the consultation. The second profile is described as sharing the decision-making process. This profile emphasises the role of dialogue, helping the woman to express her values and preferences, assisting them to make their decision accordingly. The final profile is described as getting involved in the decision. The professionals fulfilling this profile believed that it was not up to the woman alone to judge how to manage risks, and that some forms of directiveness are legitimate and necessary. This stance was possible because they developed caring, supportive relationships with women.

The relational aspects of decision-making were examined by Noseworthy, Phibbs and Benn (2013), situating decision-making in a matrix of relations and

connections and demonstrating that choices are relationship and values based. The importance of relational decision-making became apparent when complications occurred, or unexpected events arose. In these circumstances, when alternative decisions had to be made, trust that the health professionals would make the right decisions was paramount.

The scoping review identified that the concepts of informed choice and shared decision-making are not clearly understood by practitioners. Choice is value-laden and situated. It is constrained by organisational norms and the personal and professional preferences of practitioners. Where shared decision-making is said to occur, practitioners often fail to participate in *decision talk*. The importance of establishing a relationship with women, where values and preferences can be shared and understood contributes to informed choice and decision-making, but this was not evidenced.

### **3.6.6 Summary of findings**

The countries included in the review all recognise the autonomy of the woman and her right to make choices about her pregnancy and birth that are right for her and her baby. The countries recognise the right to maternal bodily autonomy, prioritising the health and wellbeing of the woman above the fetus. With the exception of the UK, the countries included in the review comprise a mixture of public and private maternity provision. This option is available in the UK but exercised to a far lesser extent. Women enter the maternity services by selecting their provider; public or private, midwife, GP or obstetrician. By exercising this choice the women are making a statement at the outset about their care preferences.

Women in the UK are likely to see a community midwife first in their pregnancy and discuss their options and choices for pregnancy and birth. Community midwives as research participants are not well represented in this review. Perspectives on choice and decision-making are mainly drawn from hospital midwives and obstetricians, and not community midwives, therefore highlighting a gap in the evidence.

The review highlighted that in practice women's autonomy, and therefore the ability to make choices about her care, are bounded by professional, organisational and societal constraints. The studies included in the review ranged from women declining recommended interventions, to requesting the ultimate intervention in the absence of clinical indication; caesarean section.

Women declined recommended care often because they felt their autonomy and choices were not respected in previous births. The case studies presented in some of the studies indicate a significant breakdown of trust between the clinicians and the woman, and not reflective of the main body of midwifery practice, carried out daily in community clinics, reflecting the common experiences of community midwives and women. This indicates a lack of evidence into the ways community midwives support choices in their everyday practice.

Women exercising their autonomy can be a source of anxiety for midwives as they seek to balance their professional obligations and their role as an employee within an organisation. The review showed that in high risk birth situations, midwives aligned themselves with obstetricians in that they too had a "line in the sand" which limited maternal autonomy and delineated their professional practice.

Adopting obstetric practices may be preferable when the responsibility for the care of women with high risk pregnancies resides with the obstetrician. However, midwives in this review were not confident in articulating the importance of midwifery led care, and out of hospital birth, citing organisational norms as limits on their practice. Communicating information to women about their choices, via antenatal classes for example, was framed in such a way as to reinforce the organisation's perspective on pregnancy and birth, but this was not explicitly stated, just inferred, leaving women to second guess what midwives were trying to say. Although a distinction was drawn between the concepts of informed choice and shared decision-making, the review showed that in practice, shared decision-making often lacked *decision talk*, where the clinician and the woman arrived at a shared decision, attributed in part by the unwillingness of clinicians to discuss an option that they personally do not support, or believe the organisation would not support. There is a lack of evidence to show how, and in what ways, organisational norms are communicated and how they influence the way choice is presented to women by midwives.

The methodological approaches of the studies included in the scoping review were varied. The ethnographic studies provided a rich description and although the quality of the studies was not reviewed, these studies demonstrated transferability. One study used discourse analysis to illuminate the organisational, structural and professional stances of two key midwifery and obstetric organisations in Australia. Unlike the other qualitative studies in this review which sought to describe and explain from the perspective of the participants, discourse analysis in this study sought to question and challenge those assumptions. Discourse analysis therefore would be an appropriate approach to explore the way

choice and decision-making in pregnancy are framed by organisational and professional norms.

### **3.6.7 Consultation exercise**

Arksey and O'Malley (2005) identify a final, and optional stage of their case which involves stakeholders contributing to the review. At this point I used an opportunity afforded to me to "sense check" the themes emerging from the review with community midwives in practice. The stakeholders in this case were community midwives based within a Clinical Commissioning Group's *Better Birth's* implementation programme. My role within this was to deliver a nationally agreed training package aimed at raising awareness of the importance of offering choice to women and therefore increasing the number of women who were offered choice in line with the aims of *Better Births* (NMR 2016). A valued part of these training sessions was enabling community midwives from different organisations to meet, discuss common experiences and propose solutions to common problems. The sessions (n=13) also provided a safe space for them to share their thoughts and concerns about the local implementation of the *Better Birth's* strategy. My research diary indicated several recurring themes, namely the midwives believed they offered women choice, but acknowledged that this was conditional, in that they offered what they thought could be achieved. The idea that women could "choose anything" alarmed them and they felt they needed to manage expectations. The examples they offered of women making choices were the "worst case" scenarios where women with multiple risk factors might choose to birth at home, even though they acknowledged that this was rare. At the same time, they spoke of a reduction in the number of women having out of hospital births because of an increased rate of "low risk" women becoming "high risk"

during their pregnancy as a consequence of increased surveillance. Responses to risk differed in teams and between teams with midwives adopting different practices to risk factors such as raised body mass index (BMI). They clearly valued continuity of care and believed the option to choose different providers was a threat to this.

Recording my observations from the sessions provided some assurance that the themes identified from the literature review reflected the experiences of the community midwives, and so was a useful sense check for the solo researcher. Additionally, I reflected on the themes contemporaneously with my supervisor, who was also present during the sessions. This helped to refine the aim and objectives of this professional doctorate.

### **3.6.8 Limitations to the review**

This review has several limitations. First, excluding studies published before 2010 may have meant that a number of relevant studies have not been included in this review. Although the review was restricted to countries with similar maternity care systems to the UK, the mix of public and private provision in these countries is a factor when exploring choice and decision-making in pregnancy and birth.

### **3.6.9 Conclusion**

This literature review provided an overview of the evidence related to midwives' involvement in choice and decision-making in pregnancy and birth. It has showed that a range of factors; organisational, professional and societal, contribute to the way choice is perceived and offered to childbearing women. Community midwives as a group within maternity services provision are not well represented in the

evidence, and when they are present, the research suggests that they are often perceived as isolated from the maternity services. Given the prominence afforded to the community midwife role in supporting choice, this study is timely. The review has provided the rationale for the study and its unique contribution to understanding the barriers experienced by community midwives in supporting women to make informed choices about their care. There is a paucity of evidence to explain how community midwives negotiate competing discourses of medicalisation, risk and normality in their work with women, supporting choice. My study has addressed this gap, providing insights into the barriers and challenges faced by community midwives when fulfilling this aspect of their role.



## **Chapter 4**

### **4 Methodology**

#### **4.1 Introduction**

This chapter sets out my epistemological stance and the rationale for the chosen methodology. I have discussed in detail the methods used to undertake the research. When I refer to methodology, I mean the perspective and frameworks I have adopted; whereas methods refer to the tools and techniques used to collect the data. My chosen methodology was discourse analysis, viewed through a Foucauldian lens and informed by post-structural and feminist principles (the rationale of which is explained below). The methods used for data collection were interviews with community midwives and content analysis of two information leaflets, provided to pregnant women by Trusts and are aimed at helping women make choices about their pregnancy and births, and the websites which host the information leaflets, supplemented by a reflexive diary. My commitment to reflexivity, which enhances the rigor of my study is also set out. The chapter concludes with an explanation of how the study was ethically conducted.

#### **4.2 My epistemological and ontological stance**

My epistemological stance is that of constructionism, which asserts that all knowledge, and therefore all meaningful reality is constructed in and out of interaction between human beings and their world and communicated within an essentially social context (Crotty 2013). Essential to these relationships are ways of speaking and writing. In constructionism, meanings are constructed by human beings as they engage with the world they are interpreting. In constructionist

inquiry, the content and the process of language use are examined (Gergen 2015). Content studies illuminate people's constructions of the world, so, here this refers to how perspectives on pregnancy and birth are variously described and explained by midwives, clinicians, women and organisations. Process studies consider how realities are generated in ongoing interactions and seen in the ways in which the varying representations of pregnancy and birth are repeated and renewed by midwives working with women, and how these impact on choice. Constructionism therefore is an epistemological "fit" for my study as I set out to discover how community midwives negotiate competing discourses when supporting choice in pregnancy and childbirth, and to consider the extent to which power and knowledges shape and constrain those discourses. This stance is in contrast with other ways of knowing, for example objectivist epistemologies. Such an approach would follow the methods of the natural sciences (Crotty 2013) and by way of detached observation, seek to identify universal features of choice in pregnancy that offer explanation and may be predicted and controlled. My ontological position as midwife, woman, wife, mother and scholar is predicated Stanley and Wise's (1993) notion of the "personal is political" (Stanley and Wise 1993 p74) Systems and social structures, whether concerned with family, work, power or subjugation can be understood through relationships and experiences within everyday life. Accordingly, ontologically and epistemologically, constructionism is justifiably the appropriate approach.

As stated in Chapter 1, section 1.1, so much of midwifery practice, in common with healthcare generally, is discursive, and effective communication is the bedrock of safe practice (Gluck 2012, Leonard, Graham and Bonacum 2004). The broad focus is on the culture of community midwifery practice and how the terrain that

community midwives negotiate is influenced by their location in a Trust. The ways in which choice is discursively constructed by the Trust is seen in the presentation of the information leaflets they provide, and on the websites, which host them. The ways in which the community midwives interpret these worlds is seen in the interview transcripts. The research therefore lends itself to a discourse analysis methodology as this method illustrates the ways in which language, signs and images construct pregnancy and birth, and subsequently the choices that are made available to women. Acknowledging that multiple realities exist and that alternative inferences may be drawn required me to consider the theoretical perspectives offered by post-structuralism. It was important this study was underpinned by feminist principles. The table below provides a representation of my research process

Epistemology	Theoretical perspective	Methodology	Methods
Constructionism	Post-structuralism Feminism	Discourse analysis	Interviews Content analysis theme identification

*Table 4-1 Representation of research process*

In exploring the theoretical perspectives, I have identified the rationale for utilising influences of poststructuralism and feminist principles. This demonstrates how my methodological stance fits with the work of Michel Foucault.

#### **4.2.1 Post-structuralism**

Structuralism holds that all human activity, including perception and thought are constructed and not natural. Everything has meaning because of the language system in which we operate. Structuralism is thought to have its origins in the work of Ferdinand de Saussure, the Swiss linguistic theorist. In the early 20<sup>th</sup> century he

maintained that language is a complex system of signs that express ideas and rules which govern their usage (Young 1981).

A number of key philosophers and writers were linked with this movement, including Foucault, Roland Barthes and Louis Althusser. They were considered instrumental in developing the theory and techniques of structuralism in France in the 1960's (Young 1981). In the 1970's structuralism came under increasing criticism from those who accused it of being too rigid and of favouring structural forces over the ability of individuals to act, leading to the emergence of post-structuralist thought (Crotty 2013, Young 1981).

Within post-structuralism the concept of self is that of an individual comprising conflicting tensions and knowledge, influenced by factors including but not limited to gender, class or profession. In post-structural approaches to textual analysis, the interpretation is contingent upon the reader's personal concept of self (Crotty 2013, Young 1981). The intent of the author is secondary to the meaning that the reader perceives. Post-structuralist approaches to textual analysis deem it necessary to draw on a variety of perspectives; for example, other literature or aspects of cultural norms, to create an interpretation of a text, even if those perspectives are in conflict with one another (Young 1981). This is not problematic for the aim of post-structuralist analysis is not to establish "the truth" but to question how some "truths" are taken for granted (Crotty 2013). Although much of Foucault's later writing is post-structuralist, it is important to note his earlier work, including *The Archaeology of Knowledge* (1972), was informed by his early ideas on structuralism. The inclusion of post-structuralist principles in my thesis provides intellectual and conceptual clarity to a methodology which might be considered

lacking in objectivity and precision, by recognising that truth is always contingent and subject to scrutiny.

#### **4.2.2 Feminism**

As stated in Chapter 1, section 1.1.7, a criticism often made against Foucault is the absence of a feminist stance. Although his writings are sympathetic to the women, children and the “sexually deviant” (MacCannell and MacCannell 1993), Here I looked at the work of philosopher and ethicist Monique Deveaux who has written extensively on political philosophy, ethics and feminist theory. In her essay *Feminist Empowerment; a critical reading of Foucault*. She argues that his ideas about power erase women’s specific experiences of power, particularly in relation to the body where she suggests that Foucault did not distinguish between male and female bodies, therefore implying the effects of institutions on the male and female body were the same (Deveaux 1994). Foucault’s assertion that “power is everywhere” (1972 p63) appears to be a cause for concern for those who view Foucault as not sufficiently feminist, because this ignores the systematic nature of gender oppression.

Midwifery is an almost exclusive female occupation serving the female population and, in this field, power is indeed everywhere. As identified in many of the studies cited in the literature review, and in other midwifery related studies, power is exercised vertically through organisational structures and horizontally through peers (Levy 1999, Curtis, Ball and Kirkham 2006, Bryson and Deery 2010). Midwives exert power over women, and women exercise power over their caregivers through their choices. Therefore, notwithstanding Foucault’s implied silence on gender oppression, the use of his writing in this thesis is justified.

However, it is important for the research to be underpinned by feminist principles which in this context is respectful of the respondents, acknowledges the subjective respondent of the researcher and commits to making a difference to women's lives through a process of material and social change (Leatherby 2003).

These principles have been informed through my reading of the seminal work of Liz Stanley and Sue Wise; specifically, *Feminist Praxis: Research, Theory and Epistemology* and *Breaking Out Again: Feminist Ontology and Epistemology*. In these works, they set out the defining assumptions about feminism. They state that "woman" is a valid and necessary category because all women share, by virtue of being women, a set of common experiences. These derive from women's common experiences of oppression. Although women share experiences of oppression, they will not be the same experiences and are influenced by the social contexts within which women live and work. Therefore, the term "woman" is a socially and politically constructed category, the ontological basis of which lies in a set of experiences rooted in the material world. This defining assumption recognises that women's oppression is not a single, determined state. Nor does it necessarily indicate powerlessness as women may adopt a range of resources, including discursive strategies, to retaliate against oppression. This recognises that the experience of oppression for women as midwives, users of maternity services and researchers are temporally, intellectually, politically and emotionally grounded in their specific context (Stanley and Wise 1990, 2002). Accordingly, I have not felt it necessary or desirable to adopt a feminist theoretical framework for my study, but instead adopt frameworks which reflect the multiple potential perspectives. Rather I will be guided by Stanley and Wise's (1990, 2002) feminist epistemological principles underpinning behaviour and analysis in the research

process. The principles should underpin research behaviours and be evident in the analytical processes involved in the study. The principles address five related themes:

- The researcher-researched relationship
- Emotion as a research experience
- The intellectual biography of the researcher, and therefore
- How to manage the differing realities and understandings of the researcher and researched and therefore;
- The complex question of power in research and writing.

The primary theme here is that of the researcher-researched relationship. While acknowledging that my study derived from the material experiences of me as a researcher, I share experiences with the researched. Despite our ontological distinctness, I as the researcher and the midwives consenting to be in the study share common experiences in that I will be able to readily recognise myself in their world, and they in mine, as my disclosure is fundamental to the second theme; that of the place of emotion as research experiences. Keeping a reflective diary throughout the research study, and maintaining it particularly throughout the interview schedule, was integral to ensuring alignment to the feminist principles set out here.

#### **4.2.3 The importance of reflexivity**

As set out in Chapter 1, section 1.2, reflexivity fundamental to this thesis. The epistemological act of reflexivity is an essential aspect of post-structuralist and feminist research (Letherby 2003). Reflexivity demands that I acknowledge and explore my social location and how this has impacted on the study, including the

identification of the research question, interaction with the data and its analysis. This is particularly the case when undertaking a Professional Doctorate as research-practitioner. This study has been conducted alongside professional relationships, and at times within my workplace. Drake and Heath (2011) identify the challenges of conducting insider research in public service institutions, in that the prevailing ideologies may allow for little dissent and create hegemonies for practice which maintain power relations. In researching one's own workplace they suggest, the researcher is necessarily positioned by these prevailing ideologies, as are the research respondents and so the research can never be neutral or objective. Adopting a reflexive stance and placing myself within the research provides a degree of integrity and authenticity, recognising that my research offers *an* interpretation of the data, based on my location, and there may be other equally valid interpretations.

Reflexivity extends beyond my relationship with the institution but also with the information leaflets, and by extension, the websites. Mindful of Barthes (1977 p148) assertion that "the unity of a text is not in its origin, it is in its destination", I am aware that I am not the target audience for the information leaflets. They are aimed at pregnant women seeking information on pregnancy and birth. My interpretation of this data is based on my experiences as a community midwife, a woman and a mother.

In this regard, my work as a community midwife, and my views on choice, were shaped by writing on feminism and choice by authors such as Shelley Budgeon.. In her critique of choice feminism; described as a perspective which shares an orientation to feminist politics informed by the interpretation of freedom as the



capacity to make individual choices, she argues that socio-structural conditions continue to limit choices available to many women and shape access to economic, political, cultural and emotional resources needed to make informed choices. She adds that because choice is socially conditioned women may not always be placed to reliably know and act in their own best interests (Budgeon 2015).

Working within an economically and socially deprived area of a city, I could see how women's lives were shaped by economic, political and social factors, over which they had little control. I observed that the ability of these women to make choices based on their personal histories, desires and individual goals was not possible because of the limits placed on them. Talking to women about their choices therefore became highly significant.

In my role as a community midwife I also acknowledge that I have experience of the personal and professional anxiety and tension that can arise when attempting to support women's choices, or when women's choices are not honoured. My authorial power enables me to make decisions about what I choose to include and omit and how this is presented.

#### **4.2.4 Discourse analysis**

Foucault defines discourse as "*the general domain of all statements, sometimes as an individualizable group of statements and sometimes as a regulated practice that accounts for a number of statements*" (Foucault 2002 p80). This definition can be interpreted as suggesting that all statements and texts have meaning, and some are produced by particular rules and structures. He defines this discursive practice as "*a body of anonymous historical rules, always determined in the time and space that have defined a given period, and for a given social, economic,*

*geographical, or linguistic area...*” (Foucault 2002 p131). These practices “*systematically form the objects of which they speak*” (Foucault 2002 p49).

In his work *Madness and Civilisation* (Foucault 1971), medical discourse about “madness” came into being through the categorisation of rationality, responsibility and “madness”. Later, in *Discipline and Punish* (Foucault 1977), he linked these discourses with discipline, surveillance and power. Discourses therefore are formed by a pattern of words, figures of speech, concepts and values and gather round an object, person or event providing a way of making sense of that object, person or event. In this sense, discourse produces something else rather than something which exists in isolation. A discursive structure can be identified through the way’s opinions, concepts and ways of thinking and behaving are formed and the effect of those ways on behaving and thinking. Discourses are textual in that they are expressed in texts; intertextual in that they influence and are influenced by other texts to achieve meaning and are contextual in that they are influenced by political, historical and cultural factors.

The background to my study demonstrates how, discourses of normalisation, medicalisation and choice are seen to coalesce around pregnancy and childbearing. The intertextuality can be seen in the way discourses of medicalisation inform the ways of thinking, speaking and the actions of maternity care providers as they seek to meet the needs of pregnant and childbearing women. The contextual nature of discourse can be seen in the way midwifery culturally and historically positions pregnancy and childbirth as a normal physiological event, and obstetrics, with a medical focus on pregnancy and childbirth, coalesce alongside the NHS with a political mandate, exercised through

the Secretary of State for Health, to ensure robust risk management strategies are in place across all organisations. This can place community midwives in the paradoxical position of attempting to practise midwifery as intended; that is inspiring a sense of confidence and well-being in women to enable them to birth safely and spontaneously, but within an organisational structure that views pregnancy and birth as risk laden activities.

The methodological framework developed for this study was derived from the writings of Foucault and specifically *The Archaeology of Knowledge* (Foucault 1972) which is a critique of the assumptions that are made in studying the history of ideas. He postulated that historians coalesce unified ideas; namely tradition, influence, evolution and the book (Foucault 1972 p23-25). He argued that “these pre-existing forms of continuity” (Foucault 1972 p28) should be subjected to interrogation designed to determine legitimacy. Through interrogation, discursive formations are exposed, illuminating the rules of formation “*by what right they can claim a field that specifies them in space and a continuity that individualises them in time; according to what laws are they formed; and whether they are not, in their accepted and quasi-institutional individuality, ultimately the surface effect of more grounded unities*”(Foucault 1972, p29).

The action of isolating and illuminating discursive formations, the role of the speaker, conceptual connections, and locating points of transformation from one discursive formation to another, illustrates three primary constitutive dimensions of discourse; knowledge, power and ethics. Drawing on Davidson’s (2003) interpretation of ethics illustrates the forms in which our subjectivity is constituted and experienced, as well as the forms which govern our thought and conduct.

Foucault's ideas on the complex archaeological history of human experiences such as sexuality, madness, medical practices, punishment and surveillance, have been documented as domains of knowledge, power and the relationship with the self. By analysing discursive practices, it is possible to locate what counts as knowledge, how power is exercised by subjects and how the self is conceptualised and presented.

Discourse encompasses actions and ways of behaving. The example here being the discourses on ante-natal care and concept of choice; but also the ways in which women are observed and their wellbeing and pregnancy monitored through words and actions (such as the booking appointment, ultrasound scanning and the measurement of fetal growth). Discourse analysis illuminates the discursive practices used by community midwives as they work with women, supporting choice in pregnancy and birth.

#### *4.2.4.1 The statement*

Returning to Foucault's definition of discourse, it can be seen that the "statement" is the primary datum when analysing discursive formations (Foucault 1972 p130).

Foucault defines the statement negatively in that he stipulates that it is not equivalent to a sentence, proposition or speech act (Foucault 1972 p90-98).

Rather, the statement is a transcribed and/or uttered set of signs or symbols to which a particular knowledge may be ascribed, which establishes or maintains power relationships between individuals or groups, and which enact a particular view of the self. A statement gains its attributes of knowledge, power and ethics only in relation to its connection with other statements (Foucault 1972 p120-132).

The statement is a material, temporal event, providing the analyst with clues to the

epistemological structures, power relations and ethical stances operating in a society at a given time. According to Foucault, there are three aspects to each statement which require the analyst to consider; specifically, its rarity, exteriority, and accumulation. Rarity refers to the constitutive rules that constrain or enable legitimate utterances, in other words it is vital to consider what is not said in order to determine the legitimacy of the discourse. For example, normality in pregnancy and childbirth cannot be fully understood by examining medical discourse because the latter is based upon the identification and management of deviations from normality.

The exteriority of the statement refers to its relationship to other statements, and, in particular, how they allow for or limit the utterance. In addition to considering rarity and exteriority, statements can accumulate in various ways, for example repetition or appropriation. For example, the prevailing belief that birth is inherently risky is repeated and renewed in public discourse through visual representations of birth on television, via the media, or through some of the information leaflets and websites directed at pregnant women. So, the statement, because of its materiality, may be placed in a discursive context other than its original environment. It is this final aspect that illustrates the importance of my study; that is information generated by the Trust, with a focus on medicalisation and risk, has been placed in a community midwifery discursive context, with a focus on supporting normal pregnancy and birth.

As stated in Chapter 1, section 1.1.7, Foucault did not describe himself as a discourse analyst, therefore some latitude was required. Drawing on the work of Ian Parker (Parker 1992) discourse is a “system of statements which construct an

object” (Parker 1992, p5). Discourses, he maintains do not merely describe the social world, but categorise it, bringing subjects and/or objects into sight. They provide a framework for debating the value of one way of viewing human experience over other ways. Discourses have a historical context; in that they have become formed and reformed over time. Discourse analysis therefore steps back from the language and requires the researcher and the reader to adopt a reflexive approach and focus on the words and images used, to consider what is said by whom, where and when and focus on the way’s discourses can both facilitate and limit and enable and constrain.

#### *4.2.4.2 Approaches to discourse analysis*

A number of discourse analysts, including Parker, adopted a Foucauldian perspective when describing approaches to discourse analysis. Norman Fairclough (2001), argued that language is analysed within the specific context of the social practices of which it is a part. Describing discourse as a social practice suggests a dialectical relationship between the discursive event and the individuals, institutions or situations which frame it. In my study, pregnancy is the discursive event, framed by the pregnant woman, the community midwives and the Trust providing maternity services. Pregnancy shapes the interactions between the women, the midwives and the Trust, but is also shaped by them. The interactions between women, midwives and the Trust. Discourse is socially constitutive and socially conditioned (Fairclough and Wodak p.258 1997), in that it constitutes objects of knowledge and situations and the social identities of and relationships between individuals and groups. Discourse helps to both maintain and reproduce social practices and contributes to transforming them.

Wodak and Meyer (2016) assert that analysing hidden, opaque and visible structures of power and control, and how social inequality is constituted, legitimised and expressed by language is the basis of critical discourse analysis.

Discursive practices which maintain and reproduce unequal power relations between individuals, for example men and women, or groups, in the case of minority ethnic or cultural groups or situations, for example being in receipt of health or social care can be illuminated through discourse analysis.

Although I have read widely on discourse analysis, most writers are unable or unwilling to offer a definitive “how to” guide on how to carry out discourse analysis.

Nixon and Power (2007) identify the absence of congruity between the epistemological and ontological basis of a research study and the actual analysis conducted or reported as a significant threat to rigour in discourse analysis.

This absence of congruity can be overcome by clearly linking the textual analysis to the theoretical framework, so the reader can understand how interpretation is being drawn and inferences made. Without this explicit link to theory, the interpretation could remain at the level of textual analysis. Graham (2005,2011) for example writes of the risks of claiming to use Foucauldian framework, when there is in fact no such thing, cautioning against claims of truth and objectivity when using Foucault because there are always other perspectives from which to interpret the material under review. Instead she draws a distinction between the prescription of a scientific method; with the aim of standardising research activity and assist in the generalisation of results, and the development of methodological guidelines which are clear about objectives, limits and what one is actually doing.

The methodological framework should, according to Graham (2011), explicate statements that function to place a discursive frame around a particular position,

that is statements which construct a reading of all forms of signification such as text, behaviour, gestures, symbols and other forms of imagery. This allows statements to be analysed not so much for what they say but what they do. Graham (2011) draws a distinction between this methodological framework, focussing as it does on the macro, that is what is *made up* by the text, rather than the micro; the structural, grammatical, linguistic and semiotic features that *make up* the text and are features of Fairclough's (2003) approach to discourse analysis using Foucault. At this point I will digress from Graham's (2005, 2011) perspective and justify inclusion of Fairclough's (2003) ideas into my methodological framework. Attention to the words and images that make up the text contained within the information leaflets and websites is valid as the preparation of leaflets and their hosting on the websites are acts carried out for a defined audience and for a specific purpose. Although mindful of the fact that the reader of the text has the ultimate authority over its interpretation and meaning and not the author, it is important to consider how and why some words, metaphors, allusions or evocations were used and to what effect. My experiences of preparing information for patients affected by cancer demonstrated that it is not an action undertaken without planning or consideration of consequences. Information put out on behalf of a Trust is subject to the various governance processes within the organisation, and therefore analysis at the micro level warranted. This is not to form a view about the author's intention, but what might be inferred by the reader. Similarly, the transcripts produced by the interviews with the community midwives will be analysed using this approach.



#### **4.2.5 Judith Butler**

Judith Butler was important to this research, specifically her ideas on discourse and power in *Gender Trouble* (1990) and *Bodies That Matter* (1993). The philosopher and gender theorist incorporated Foucauldian ideas in her earlier work. Her notions of performativity and interpellation present a view of the productive operation of power as linguistic rather than social. In her work *Excitable Speech* (Butler 1997), writes of commonplace speech acts and non-verbal communication that are performative in that they serve to define and maintain identities. My framework will consider how the words and images used in the datasets perform to produce phenomena, and how those words regulate and constrain subjects or practices.

The methodological framework developed through my reading of Foucault, specifically the *Archaeology of Knowledge* (1972), and the work of Graham (2005, 2011) and Butler (1997) is set out in the analysis section of this chapter.

### **4.3 Methods**

This section describes the datasets used in the study; the information leaflets, websites, and the interview transcripts. The rationale for choosing those particular leaflets and their context is addressed. Recruitment of community midwives and the data collection strategy will be outlined, demonstrating the rigor of this process. Reflexivity is demonstrated throughout.

### **4.3.1 The datasets**

#### *4.3.1.1 The information leaflets and websites*

Two information leaflets prepared by two Trusts were selected. Although many information leaflets are offered to women, I chose to focus on just two. My decision here was informed by my reading of Foucault, and specifically where he speaks to the rarity, exteriority and accumulation of statements. Consideration of these factors means that here it is not the amount of statements that I identify in the information leaflets, but the wider exegesis of those identified. In addition, I looked to the work Newnham, McKellar and Pincombe (2015) who compared two information leaflets for using epidural or water in labour, Licqurish and Evans (2016) who provided a discourse analysis of Australian obstetric and midwifery college's position statements about homebirth, and Graham (2005) who undertook a discourse analysis of a school behaviour management policy. These studies demonstrate that a rich exploration of power, knowledge and presentation of the self can be achieved focussing on a select number of statements.

The leaflets were chosen because of their relevance to the central theme of choice in pregnancy and birth. The topics are those that the women and the community midwife are most likely to discuss on a number of occasions throughout the pregnancy. Through their preparation and distribution, the information leaflets are considered a measure of the perspectives on choice in pregnancy and childbirth held by the Trust, and a perspective that could assumed to be held by Maternity units in Trusts offering comparable levels of service to a similar sized population. This provided some context of the environment in which the community midwives worked. Here, I define a Trust as a provider of NHS maternity services within a geographical area. The Trusts were purposively

selected to identify any differences in discursive formations in a large unit providing tertiary services in addition to secondary care to its local population, and those discursive formations in a small unit providing care mainly to the local population. In addition, I recognise that I have professional and personal attachment to the larger unit having worked there for many years and continue to work there on an occasional basis. For that reason, I purposefully selected the smaller unit as this was my former training hospital, and I feel similarly invested in it.

Information leaflets are provided to pregnant women by midwives during their ante-natal care. During the course of my study, the printed copies of leaflets have largely been replaced by websites where the women are directed by their midwife to access the information independently. On these websites these same leaflets are reproduced in their entirety and this remained the case in October 2019. After accessing the information leaflets via the respective Trust's websites, I decided to include the maternity services webpages in the analysis as the process of locating the leaflets raised a number of relevant issues which warranted further exploration. The inclusion of visual texts within my analysis recognises that discourses are formed not only through language but through other semiotic modes( Jancsary, Hollerer and Meyer 2016) .

#### *4.3.1.2 Leaflet 1 Choosing where to have your baby*

*Leaflet 1* is provided by a large teaching hospital in the North West of England accommodating approximately 10,000 births per year, and provides services to an economically deprived, ethnically diverse area, and also provides tertiary services to a larger geographical area. From this unit the leaflet "*choosing where to have*

*your baby*” (Appendix 2) was selected as one in which the content was most likely to reflect many of the discussions between the midwife and woman in the antenatal period. *Leaflet 1* sets out the places where the woman may choose to birth her baby at this Trust. The options set out here include home birth, the midwifery led unit and the delivery unit.

Choice in place of birth is usually discussed at the antenatal booking appointment. Prior to this, a woman may have contacted her General Practitioner, or local maternity unit after undertaking a pregnancy test, to arrange a meeting with a midwife. She may therefore attend her booking appointment without an awareness of the full range of options available to her regarding where she can receive care and birth her baby. The booking appointment therefore may be the first contact the woman has with her midwife and occurs around the 10<sup>th</sup>-12<sup>th</sup> week of pregnancy. Women are provided with or directed to the information leaflet and her choice in place of birth is discussed again periodically throughout the pregnancy. These discussions usually take place in the community clinic, or the woman’s home, so placing these conversations firmly in the spaces occupied by the women and the community midwives. During their pregnancy, women are offered the opportunity to visit the maternity unit and view the places in which she can choose to birth.

*Leaflet 1* is accessed via the Maternity Unit webpages on the Trust’s website. Until recently, printed hard copies of eight information leaflets were handed to women during the booking appointment. The pack of information leaflets was assembled and placed in an envelope and formed part of the booking appointment information. It was my usual practice in the booking appointment to open the envelope and briefly discuss the leaflets, advise the woman to look at them, and

bring any questions she may have to the next appointment, which usually took place around the 16<sup>th</sup> week of pregnancy. This process had the advantage of me being able to remove any leaflets that were not relevant, for example information leaflets for those women with a raised body mass index were not always required, and prompt women to look at the remaining leaflets. It also meant that as midwives, we were familiar with the content of the information leaflets and would discuss this with the women. In addition, the printed copy contained images of new born babies which women, and partners if present, often commented upon favourably, demonstrating the impact of imagery when seeking to engage people with the content. Latterly, the printed leaflet was reproduced online, and women were directed to the Trust's maternity services website (Appendix 3), the address of which is contained within her hand-held antenatal notes. To obtain this information leaflet she would have to access the internet and work through a series of pages until she located it. The information contained within *Leaflet 1* posted on the website contains no images and comprises only text. Despite the cultural diversity of the area, and the wide range of languages spoken, the information is provided in English and there is no information contained within the leaflet or on the website on how one might obtain the information in another language. However, locating the information on the maternity unit's website has the advantage of enabling women to obtain prior knowledge of the services available at this unit. Possession of this information may help her decide if she wants to book for care at this Trust which may influence her choice of provider.

#### *4.3.1.3 Leaflet 2 Planning a home birth*

*Leaflet 2* was taken from a Trust with a small unit accommodating approximately 2700 births a year. It is also located in an economically deprived area with a

predominately south Asian population. From this unit the leaflet “*Planning a home birth*” (Appendix 4) was selected as one in which the matter of home birth is one most likely to be discussed in the context of antenatal care and the subject matter is firmly within the province of the midwife. As such it could be anticipated that this leaflet would reflect the values of midwifery, positioning pregnancy and birth as a normal physiological event. Black and white A4 photocopies of *Leaflet 2* are available in the hospital ante-natal clinic and provided to women when they attend the hospital for their first ultrasound scan, usually around 12-14 weeks. The leaflets are also located on the Trust’s maternity services website (Appendix 5).

#### *4.3.1.4 Isolating statements*

My discourse analysis focused on the exercise of power (Foucault 1972), performativity, interpellation and subjectivity (Butler 1997), but I wanted to undertake a wider exegesis and so included other aspects of discourse analysis. Specifically, I chose to isolate statements which referenced how choice was presented, to whom, and in which circumstances. Therefore, the intentionality of the statement, based on my reading and interpretation was analysed. The statements therefore did not always refer to choice directly, but through metaphor, allusion or evocation, or the location of the statement in relation to other statements, might infer a position on choice in pregnancy and birth. Statements at the level of the sentence and paragraphs were included. I also included visual images and considered how women were both visually represented in the dataset, and also constructed as the recipients of the information.

For clarity, consistency and to ensure analysis remains ontologically grounded in the work of Foucault, I have used the word “statement” throughout to refer to the segments of text or images under analysis.

#### **4.3.2 Sampling strategy**

A preliminary analysis of the leaflets and the respective maternity unit websites informed the sampling strategy and provided the framework for the interviews with the community midwives. The comprehensive analysis of the datasets is contained in Chapter 5.

Having identified the information leaflets and websites the next step was to identify my sample of community midwives to fulfil the aim of the study which is how community midwives negotiate competing discourses when supporting choice in pregnancy and birth.

Midwives were recruited from a post graduate course run by a University in the North West of England. Midwives were from a range of Maternity Units and not just those units which provided the information leaflets, and in doing this I achieved a range of perspectives. The course they were enrolled on was funded through continuous professional development funds and available to all midwives throughout the area served by the University. The midwives on the course were all experienced from a number of trusts across the local area served by the University, including the Trusts already identified, and worked in hospital or community settings. All community midwives registered on the course were invited to participate in the study, (n=14). The module leaders of the post graduate course provided the community midwives on the module with an information sheet,

explaining the aims of the study and what would be required from them as participants. It informed them that the study was being conducted as part of a Professional Doctorate qualification supervised by the University of Salford and provided my contact details and those of my supervisors so that they could contact us with any further questions or concerns.

Midwifery is a “small pool” and that some of the prospective participants knew me, personally and professionally, which may have resulted in feelings of obligation or discomfort. In addition, I was aware that my role as a lecturer contributes to a power imbalance and may have made the midwives feel coerced or obliged to participate. The information sheet stated that as a lecturer I would not participate in any assessments relating to the module that they were currently registered on.

Ten community midwives initially expressed an interest in participating in my study and provided their email address. I then emailed the information sheet to them and asked that they confirm if they were willing to participate. If I received no response, I prompted the midwife again via email after one week and did not pursue non-respondents further after this point. Eight community midwives agreed to be interviewed. Participants were asked to state where they would like the interview to take place, and most opted for it to take place in the University on a day when they were attending for their studies. I booked a small classroom and placed a sign on the door to avoid interruption. The midwives were provided with refreshments and at this point I discussed the study with them, and talked through the consent form, ensuring that they were completely happy to proceed. The principle of autonomy is achieved through ensuring that each person makes a free, independent and informed choice to participate (Beauchamp and Childress



2001). The principles of non-maleficence, and beneficence are based on the obligation of the researcher to explain the potential risks and benefits of the study in order that respondents can make an informed choice as to whether to participate or not.

I was aware that the research might generate issues for participants. I did not anticipate that these would be painful or difficult to discuss. I made it clear to participants that they could withdraw from the research at any point without explanation and could request that their interview transcript may be withdrawn from the analysis up to three weeks after the interview. After this point participants were advised that data may be included in the study.

Three of the midwives opted to be interviewed together in their clinic at the end of their working day, because logistically it was proving very difficult to coordinate their individual interviews. Here, I was mindful of the distinction between individual and group interviews and drew on the work of Parker and Tritter (2006) to provide guidance. According to Parker and Tritter (2006), the researcher adopts the role of investigator by asking questions, controlling the dynamics of the group and engaging in dialogue with specific participants. This enables the principles of the one-to one in-depth qualitative interview to be replicated on a broader, collective scale, and avoided the disadvantages often associated with group interviews (Koshy, Koshy and Waterman 2011), by ensuring the contribution of each participant was recorded. I have reflected on how this exchange was different from the interviews held with individual midwives at the University in section 4.3.4.

### **4.3.3 Data collection: Interviewing**

The epistemological feminist principles required that I be prepared to engage on a personal level with the midwives rather than aiming for professional detachment. To this end, when interviewing the midwives, I shared my own thoughts and experiences. A conversational approach to the interview is more likely to elicit a more linguistically accurate account of the midwife's perspective, and the words used by the midwife to describe how she works with women formed the basis of the analysis.

The interview followed Bryman's (2008) description of an "almost totally unstructured interview" (p438), with the intention of generating a conversation with the midwife. A single question; "tell me about your work with the women" was used to open the conversation. Each participant could offer this with clarity, providing me with insights into the discursive structures used by the midwives when describing their work with women and how they perceived their role in the community in relation to the Trust, and gave me the opportunity to consider issues of power within their accounts through the ways in which they discursively constructed their relationships with the women. It was important that I did not try to prompt or question the midwives in ways that would result in a "question and answer" format as I was aiming to understand how they linguistically constructed their work with women and needed their authentic speech.

Using Mason's (2002) principles of life history interviewing, I asked questions that triggered a personal narrative around their experiences of supporting choice, and then tried to facilitate rather than direct each midwife's story. In this way, sensitivity to the context of the midwife's experience was honoured and made explicit. This

was important to achieve because the purpose of the interviews was to construct knowledge about the experience of the community midwives, *vis a vis* the dominant discourses emanating from the Trusts as evidenced in the information leaflets. Context, therefore, in terms of experience, location, and practice philosophy was important.

The interviews held individually with the community midwives lasted between 1-1.5 hours, yielding lengthy transcripts which on reading and noting my contribution, confirmed a conversational approach had been achieved. Two of the respondents were personally and professionally known to me and one of these interviews prompted a significant moment of reflection and this is discussed further in the following section. Overall, I found the process of interviewing the midwives profoundly affecting in ways I had not anticipated. Their willingness to disclose challenging aspects of their work to me was very humbling and a point I return to in the discussion of my findings.

#### **4.3.4 Reflections on power in the interview process**

Authorial power though was not solely confined to the writing of the thesis, but in my interactions with the midwives. This was exemplified by an interview with a former colleague which I recorded in my reflective journal.

*N agreed to be interviewed, which surprised me as we often did not see “eye-to eye “at work. We had a good discussion and were laughing as the interview came to a close. She then said, “can I just tell you this” and went on to discuss a very stressful incident she had been involved in and how it left her feeling. Afterwards I reflected on the fact that in any other circumstance, she almost certainly would not have told me this.*

*Reflective note, December 2017*

I had considered myself, prior to this interview, an “insider”, in possession of a shared understanding of important concepts and historical and political knowledge of the field (Burns, Fenwick, Schmied, and Sheehan 2012). The respondent however, while knowing me as a midwife also saw me in a different role, highlighting to me how the researcher may be perceived by the respondent as being a safe person, or an “outsider”, and the power that this affords the researcher. By being attentive to the feminist principles I’ve set out, reflecting on this power will enable me to explain and justify each stage of my research.

The interview with the three midwives who opted to be interviewed together was different in that it occurred in their workplace and I was a visitor in their space. This meant I had less control over the environment and the interview was interrupted on a couple of occasions as the midwives were called to the telephone. Because of this I was more conscious of the time they were giving me. The midwives knew each other very well and engaged and debated issues with each other, for example the management of raised BMI generated discussion which indicated that they had differing approaches to this. In this regard the interview was very useful as it highlighted variations in practice within teams, not just Trusts.

In line with the midwives I interviewed, I was struck by the honesty and candidness with which this group of highly experienced midwives spoke of the organisational impact on their ability to carry out their roles as they believed they ought to. This point will also be discussed further in chapter 5.

All of the interviews were digitally recorded, and the interviews transcribed verbatim by a professional transcriber. The group interview proved a challenge to transcribe correctly, as the midwives quickly stopped saying their names before speaking and so the audio recording was played and replayed to ensure comments were correctly ascribed to the right midwife. Immediately following each interview, I made reflective notes on the interview, recording my thoughts and perceptions and this contributed to my reflexive journal. Ensuring the anonymity of the participants was achieved by assigning each participant a number and referring only to the number of years worked as a community midwife, and the size of the trust in which they worked to provide some comparison. Participants were aware that direct participant quotes from interviews may be used, but they would be anonymised. In making participants aware of this, they were clear about the distinction between confidentiality and anonymity. The interview data, including tape recordings and reflective memos were kept in a locked filing cabinet in the University to which only I had access. Tape recordings were destroyed once they had been transcribed by the professional transcribing service.

<b>CMW number</b>	<b>Years on community</b>	<b>Size of Trust</b>
CMW 1	2	Small Trust <3000 births per annum
CMW 2	5	Large Trust>9000 births per annum
CMW 3	3	Large Trust>9000 births per annum
CMW 4	2	Medium Trust > 4000 births per annum
CMW 5	17	Medium Trust> 4000 births per annum
CMW 6	30	Medium Trust> 4000 births per annum
CMW 7	14	Medium Trust> 4000 births per annum

*Table 4-2 Characteristics of the midwives*

#### **4.3.5 Data analysis framework**

The framework used to analyse all the datasets incorporated elements from Butler (1997) and Graham (2011), who draw on the work of Foucault in their own writing.

The framework adopts the semantics used by Foucault so that my analysis is ontologically grounded in his writings.

Data analysis involved four key stages. Stage one, repeated reading and reviewing of the information leaflets, websites, interview transcripts and reflexive memos to ensure that I was fully immersed in the data. Stage two of analysis, the analytical framework was applied to the data, leading to the third stage. This involved a conceptual mapping of the emerging themes. In stage four, broad themes were identified which explicitly linked to the theories of Foucault, uncovering a number of new insights.

Throughout the process of analysis, I have maintained a feminist perspective by considering how power is exercised through the inclusion, exclusion and presentation of the data (Letherby 2003).

Analytical themes	Questions asked of the text/transcript
Defining and locating statements	What does this statement do and with what effects?
Recognising the subject/object	How is this subject/ object defined, delimited and named? How do the words/images perform in defining and/or maintaining the identity of the subject/object?
Tracing the positivity of a particular power/knowledge	From where does the statement derives its power/knowledge? Can other texts help the interpretive process?

Identifying the discourse	What other discourses are associated which may contradict or validate this discourse?
---------------------------	---

*Table 4-3 Analytical framework*

#### **4.3.6 Issues of rigour**

Trustworthiness refers to the degree of confidence in data, interpretation and methods used to ensure the quality of a study (Polit and Beck 2014). Criteria outlined by Lincoln and Guba (1985) are accepted by many qualitative researchers (Connolly 2016) and will be used here to demonstrate the trustworthiness of the study. These criteria include credibility, dependability, confirmability and transferability.

Credibility, or confidence in the truth of the study and therefore the findings is the most important criterion (Polit and Beck 2014). Credibility can be judged by the audit trail that allows the reader to track the decisions made through the research process. This includes the extent of engagement with the participants, keeping a reflective journal and using supervision sessions for debriefing and sense checking. Section 4.1.4.2 details the way in which I located statements within the information leaflets and the interview transcripts. My interrogation of the statement can be mapped onto the data analysis framework. Peer review was achieved by data findings being scrutinised by my supervisory team.

Dependability and its corollary, confirmability, refers to the extent to which the methodological processes are established, trackable and documented and to which interpretations and assertions can be tracked to their sources (Polit and Beck 2014). It is achieved through the use of an audit trail that includes the all data, such as the interview transcripts, information sheets, reflexive memos and

the stages of analysis. The audit trail in my research is apparent in the findings chapter where data is analysed using a transparent framework. Dependability also includes connectedness to theory, which is demonstrated in the links made between the findings of my study and the literature.

Transferability refers to the degree to which the reader of the study can recognise the extent to which salient conditions overlap or match (Polit and Beck 2014). In order to make transferability judgements, extensive and careful description of the time, the place, the context and the culture in which the study took place are required. This is achieved through the rationale offered for the choice of information leaflets and the midwife sampling strategy, including characteristics of the midwives in terms of community midwifery experience and the size of the Trust where they were employed. Describing the findings in rich and dense detail and which is context-specific also aids transferability.

The rigor of my study is also enhanced by my commitment to reflexivity, which I set out at section 4.1.3

#### **4.4 Ethical issues in research**

The ethical process in research primarily focuses on issues of autonomy, informed consent, the right to privacy and protection from harm (Beauchamp and Childress 2001). Ethical approval was sought from the University ethics committee where my professional doctorate was registered, and approval obtained prior to data collection (Appendix 6).

The process of applying for ethical approval for a research study foregrounds these aspects in ways that application process can appear as an end in itself.

Rather, ethically informed thinking throughout the process is essential, especially



when undertaking a professional doctorate where the practitioner-researcher needs to occupy the middle ground between insider and outsider (Burns, Fenwick, Schmeid and Sheehan 2012). This was relevant in my study as participants were registered students on a programme in which I taught. I was also aware that in my dual role as midwife and researcher there might be the potential for conflict. As a midwife I am professionally accountable to the Nursing and Midwifery Council, with a responsibility to act on any examples of poor practice or unprofessional conduct (NMC 2015). This demand was amplified by my ongoing participation in the NMC's fitness to practice proceedings. However, I did not come across any instances of poor practice or unprofessionalism.

My more significant ethical dilemma relates to the power I held as researcher, first in relation to the participants, and second in the presentation of the respondents' views in a fair and balanced way that did not compromise the midwives. This is particularly relevant in a study that seeks to trace the positivity of knowledge/power in discourse because as Råheim, Magnussen, Sekse, Lunde et al (2016) argue, defining what knowledge is to count in a concrete researcher-researched encounter is not necessarily the sole privilege of the researcher because participants bring their own agenda to the research situation. In this situation I as the researcher and the participant occupy a similar role or status, possess a similar body of knowledge, and share an ongoing professional relationship. In Coar and Sim's (2006) study of interviewing one's peers, participants viewed the interview as a test of their knowledge despite being reassured to the contrary. Participants also expressed professional vulnerability in relation to possible scrutiny of their practice or knowledge. I endeavoured to

ensure a relaxed environment and assured the participants that confidentiality and anonymity would be maintained.

The second point relating to the presentation of findings. I am aware that one conclusion which could be drawn from the interviews with the midwives is that they seek to protect themselves personally and professionally from women's choices. In presenting the findings from the interviews, it is an ethical requirement that I did so within the context of the ways in which the midwives work which I believe provides a rationale for their views.

## Chapter 5

### 5 Analysis of the datasets

#### 5.1 Introduction.

This chapter details the findings from the analysis of the datasets using the analysis framework derived from the writings of Foucault and Butler and set out in Chapter 4, section 4.2.5. Excerpts from the leaflets and websites are included to identify and locate the statements under analysis. The themes arising from the analysis of statements informed the interviews with the community midwives. The themes arising from the interviews will be detailed using quotes from the midwives to support the analysis.

#### 5.2 Locating statements

Foucault describes the statement as a function where words and signs become invested with power leading to an interpellative event (Butler 1997), in which one can “recognise and isolate an act of formulation” (Foucault 1972 p93). Put simply, in this analysis I have located statements that function with constitutive effects, and interpreted statements as things said that privilege particular ways of seeing things and codifying certain practices.

##### 5.2.1 Analysis of Leaflet 1 and the host website

###### 5.2.1.1 *Defining and locating statements*

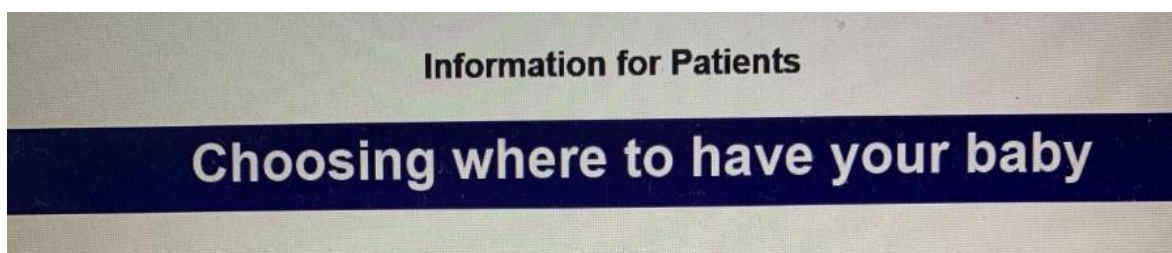


Figure 5.1 Statement 1, Leaflet 1

In *Leaflet 1 Choosing where to have your baby*, the statement *Information for Patients* is defined and located. Of interest is how this particular statement functions, that is, what does this statement *do* and with what effects?

#### 5.2.1.2 *The pregnant patient*

The statement functions to “enable the subject to appear...” (Foucault 1972 p50).

In this case the patient is the pregnant woman, who, through the process of interpellation, (Butler 1997), has been located and made visible in this leaflet.

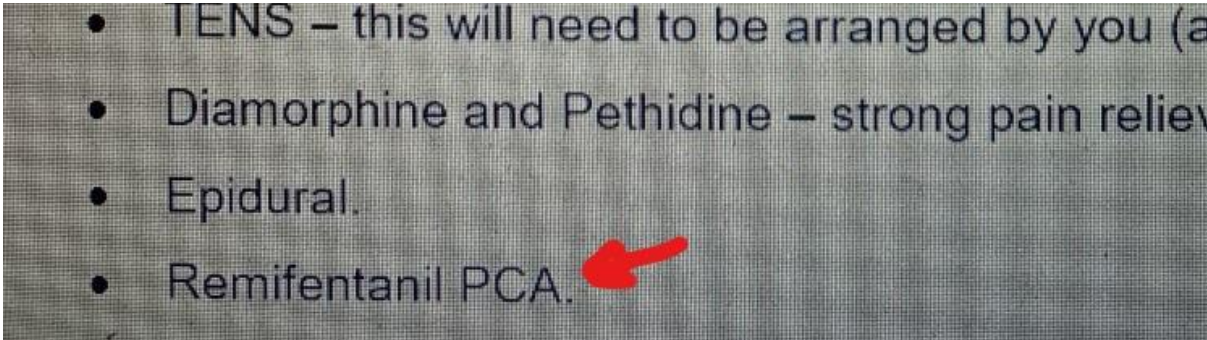

Here I utilised Butler’s description of interpellation as an act of speech which indicates and establishes a subject in subjection. According to Butler interpellation is not descriptive but inaugurative. It seeks to introduce a reality rather than report on an existing one, achieving this through a citation of existing convention (Butler 1997 p33). The citation of “patient” within a document about a normal physiological process positions the woman in space and time. Space here refers to the confines and structures of the maternity services, during the time of her pregnancy and birth.

The etymology of the word “patient” originates from the latin word “*patiens*” which means “one who suffers”. The noun *patient* refers to a person receiving or registered to receive medical care (OED 2017). The use of the plural, as in *patients*, has the effect of homogenising all pregnant women. The subjectification of pregnant women as patients enables the subject to “be placed in a field of exteriority” (Foucault 1972 p 50), so that the pregnant woman as patient exists in relation to other subjects or objects located within this text. The statement *Information for Patients* therefore constitutes both who the object is and how the

object is seen or known. In making the object (the patient) “*manifest, nameable and describable*” (Foucault 1972 p46), I can trace the positivity of a particular power/knowledge. Here I read the pregnant patient as a medical/obstetric construct which views pregnancy and birth as an abnormal state that requires medical management to mitigate risks. This power/knowledge places a discursive frame around the action of choosing where to have a baby by naming, establishing and limiting those choices, as viewed through a medical lens. This is achieved in two ways, firstly on the performative properties of the words used, and secondly in the inclusion of other discourses. I have addressed each of these separately.

#### 5.2.1.3 Reinforcing the medical discourse

When I refer to performativity, I refer to Butler’s (1997) notion of performativity that speech acts and non-verbal forms of communication serve to define and maintain identities. In other words, the performative properties of words can reinforce and maintain the dominant discourses. For example, *Leaflet 1* uses a lot of medical terminology; intermittent auscultation, epidural, Remifentanil PCA [patient-controlled analgesia], Group B strep [ Group B streptococcus] and treatments, for example, the use of which reinforce and maintain the medical discourse, and which might not be widely understood by the recipients of the information.

- 
- TENS – this will need to be arranged by you (a
  - Diamorphine and Pethidine – strong pain relief
  - Epidural.
  - Remifentanil PCA. 

Are having your first baby, or have had a previous uncomplicated pregnancy and birth.  
Have no concerns about your expected baby's health.  
Go into labour naturally between 37 and 42 weeks of pregnancy with the baby in the head down position.  
If you have been diagnosed with Group B Strep and require antibiotics in labour.  
If you are healthy and have a trouble free pregnancy the method of monitoring your baby heart beat on MLU is known as intermittent auscultation using a hand held Doppler or Pinard's stethoscope.

The image shows a photograph of a medical leaflet with a textured background. The text is in a standard sans-serif font. Two red arrows are drawn on the page: one points to the word 'Strep' in the fourth line, and the other points to the word 'auscultation' in the fifth line.

Figure 5.2: Example of medical terminology Leaflet 1

The places where the pregnant patient can birth their baby are listed. The suitability of patients to birth in these spaces is expressed through the use of explicit predicates and imperatives. Returning to the question of how these statements function and the performative properties of words, the use of imperatives such as “*we plan*” or “*you will*” or “*this is the best place for you*” reinforce the notion of the expert knowledges dominating the medical discourse and limiting choices. There is no attempt to mitigate the illocutionary force of these statements with verbs of saying or thinking, such as “your midwife will discuss with you the reasons for .....”. The dominant medical discourse can be seen in the way it extends into the private spaces of the home. As pregnant women are constituted as patients, they can be dispersed into the disciplinary spaces (Foucault 1977) of the home, the midwifery led unit and the Delivery unit, and through their continual subjugation, as expressed through the words used, come to know and accept their place as natural (Graham 2005).

In *Leaflet 1* a further statement is located.



## Home Birth – What are the risks?

If complications develop during labour or birth you would need to be transferred to hospital (delivery unit) by emergency ambulance. Common reasons for transfer are that you need:

- An epidural.
- A drip to speed up the contractions if your labour is not progressing.
- An assisted delivery with forceps or ventouse or a Caesarean section.
- Medical care if you develop other problems during or after your labour or delivery.
- Medical care if your baby is in difficulty when born.

If you need any of the above treatments you will need to be transferred in an ambulance accompanied by a midwife to hospital. The journey time from your home to hospital will depend on where you live and the time of the day the journey takes place.

Figure 5.3 Statement 2, Leaflet 1

### 5.2.1.4 The risky pregnancy and birth

This statement, functioning with a constitutive effect, illustrated the discursive subject of risk, where the performative properties of the words “*emergency*” and “*common*” speak into existence the ubiquitous risky pregnancy and birth as a recognisable subject of discourse.

The constitutive subject in this statement is the risky pregnancy and birth, and it derives its particular power/knowledge from a medical perspective which views pregnancy and birth as inherently risky. Medical power/knowledge can be seen in the selection of common reasons for transfer from home. The risks identified are not risks confined and solely attributed to birthing outside the hospital but can also occur within the hospital. Concern about maternal or neonatal wellbeing would always require medical review, irrespective of location. The request for epidural analgesia or the slowing of established labour are not risks in themselves, but their inclusion here as a risk in relation to birthing outside the hospital reinforces the

claim to medical involvement in birth as a right, as these are interventions which require medical input to manage.

Power is readily observed in this statement, but it is likely not visible to the woman/reader. In fact, such hidden powers of discourse would be visible to only a fairly sophisticated reader or interpretivist. The final sentence is powerful in that it places the burden of risk on the woman choosing home birth by bringing to the fore factors which may influence transfer to hospital if necessary, but over which she has no control. Here power is “hidden” under the guise of providing information about an aspect of birthing at home that is unknown, and therefore not based on knowledge, but may be sufficiently unsettling and disruptive to her wishes to birth at home. Exercising power in this way has the effect of limiting choice, as prioritising the safety of their baby over their preferences may be irresistible to women.

#### *5.2.1.5 Intertextuality and the discourse of choice*

Intertextuality, according to Graham (2005) is a technique that calls upon other texts to help the interpretive process by informing and enhancing the reading of the current text. The requirement to provide information to women is set out in the National Institute for Clinical Effectiveness (NICE) guidance on antenatal care for uncomplicated pregnancies (NICE 2008, updated 2019). The guidance suggests that women should be the focus of maternity care with an emphasis on providing choice, easy access and continuity of care. Good communication, they state, should be supported by evidence-based written information. Acknowledging that information can also be given in other forms, the guidance reiterates the importance of written information in supporting other formats. Information should



be accessible to all women with additional needs such as a physical, sensory or learning disability, and women who do not speak or read English. This is reiterated in *Better Births* (2016 p 8), which states that “genuine choice, informed by unbiased information” contributes to the vision of personalised care for women. NICE guidance (2008) and *Better Births* (2016) contribute to the interpretation of the information leaflet, by offering a rationale and some context. In the case of the former, the text sets out the ways in which this information might be presented to ensure it meets the needs of all pregnant women. Within *Better Births* (2016), I returned to the words “*genuine choice*”, and the statement “*women do not always feel like the choice is theirs and that too often they felt pressurised by their midwives and obstetricians to make choices that fitted with their services*” (*Better Births* 2016, p32).

*Leaflet 1* is titled “*Choosing where to have your baby*”, and as such implies concordance with the aims of the NICE guidance (2008) and the vision expressed in *Better Births* (2016). The use of the performative “*choosing*” conveys an action that can be exercised, in the widest sense of the word, and women might approach this leaflet believing that it will help them to choose where to have their baby, in the spirit intended by *Better Births* (2016). Rather, this information leaflet offers a list of options a woman is required to consider when having her baby at this Trust. The following statement is isolated from the information on the Delivery unit and intertextuality used to aid the interpretation.

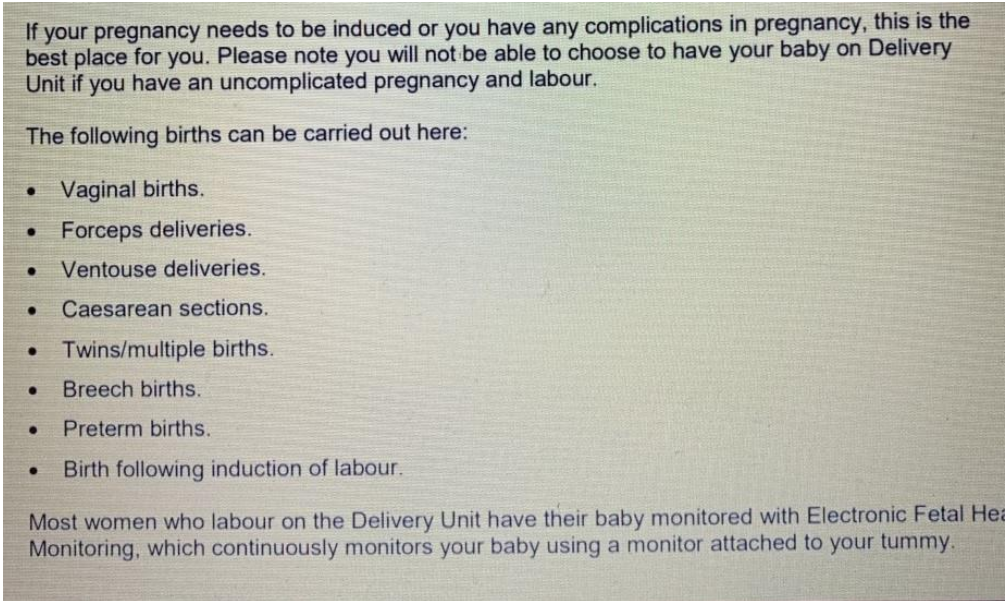


Figure 5.4 Statement 3, Leaflet 1

Of concern here is how this statement functions, that is, what it does.

#### 5.2.1.6 Hidden discourses

Although located in an information leaflet titled “*Choosing where to have your baby*”, the statement functions to exclude those with uncomplicated pregnancies and births from the delivery unit. There will be some women experiencing uncomplicated pregnancy and birth however who might actively choose to birth in a Delivery Unit as they seek reassurance from the close proximity of specialist staff and resources. There is evidence to indicate that women experiencing uncomplicated pregnancy and birth are subject to unnecessary interventions when cared for in consultant lead delivery units (DH 2010, Brocklehurst, Hardy, Hollowell et al 2011, Renfrew M, McFadden A, Bastos MH et al 2014, NHS England 2016, Sandall, Soltani, Gates, Shennan and Devane 2016) but this rationale is not included in the information. However, if women were furnished with this information, and still chose to birth on the delivery unit, it could be interpreted

as a genuine choice. The leaflet states though that birthing on the delivery unit in the absence of complications is not a choice a woman can make. Here it is important to adopt caution in my post-structural analysis and not attempt to uncover why this context is omitted from the statement. Instead I question the function of this statement and this can be explored by looking at the second half of the statement.

The list of births carried out on the Delivery Unit appears to be an unnecessary inclusion for a leaflet ostensibly aimed at helping women choose where to have their baby. After all, women do not choose to have a preterm birth, or a forceps birth so the inclusion of this list is questionable. They may also consider in what circumstances may they be permitted to deliver their baby on the delivery unit. I have argued that the second half of the statement functions to support the first part.

Setting out the births that can be facilitated on the delivery unit defines uncomplicated birth by exception. The word "*uncomplicated*" performs to bring into focus a state that is normal, straightforward and manageable. Correlatively, the opposition is formed, and the antithesis of uncomplicated is a state that is capricious, risky, unpredictable and *complicated*. The births and deliveries that can be facilitated on the delivery unit are, according to the Trust, complicated otherwise they would not be listed as births that can be facilitated on the delivery unit. The second statement supports the "truth" of the first in that the medical power/knowledge determines "*what is labelled as a problem and what is not labelled as a problem*" (Scheuich 1997 p98). The inclusion on the list of births which may not be complicated, such as vaginal birth reinforces the medical

power/knowledge as the Trust can determine which vaginal births are complicated, and those that are not.

Returning to the concept of intertextuality and my interpretation of the NICE guidance (2008), choice is presented through a dominant medical discourse, and reflects the position set out in *Better Births* (2016) that women are offered a “menu” of options that fit in with existing services, rather than genuine choice.

The information leaflet is located on the Trust’s website. Women are directed to the website by the community midwife during the booking appointment. The website can be viewed as the “shop front” of the Trust, where words and imagery present an impression of the organisation. For this reason, the websites formed part of the dataset for my study and the following section contains the analysis of the relevant page (appendix 2).

### **5.2.2 Data analysis of website 1**

Statements include not only words but signs and images (Foucault 1972). On this page a number of statements can be identified, but for the purposes of this analysis I have chosen to focus on the visual image of the pregnant woman which accounts for approximately a third of the page.



Figure 5.5 Leaflet 1: website

#### 5.2.2.1 *The disembodied pregnant woman*

Here I identify a statement in the image of a woman in a semi-recumbent position, holding a pair of baby shoes on her abdomen. The woman's face is only partially visible. I interpret this statement as functioning with constitutive effects. The discursive object here is the *disembodied* pregnant woman and the fetus, made visible by the pair of baby shoes on her abdomen. Returning to the focus of my analysis, I have considered how this statement functions.

The statement functions to emphasise the primary focus is on the pregnant body and the fetus, and the woman's essential self; her face, expressions and demeanour, is obscured. Using intertextuality, my analysis of this statement is informed by the work of Descartes and writings on Cartesian dualism.

Descartes argues that a human being consists of two incompatible substances *res cognitans* and *res extensa*, the mind and the body, and are completely separate and distinct. Cartesian dualism is often referred to as a cause of the reductionist

treatment of patients in the medical setting (Switankowsky 2000). The medical theorist Toombs (1988) argues that medicine has adopted a dualistic notion which separates mind and body, and which conceptualises the physical body in purely mechanistic terms. She goes on to say “*The physical machine-like body is assumed to be extrinsic to the essential self....The body-as-machine is susceptible to mechanical interventions; it can be divided into organ systems and parts which can then be repaired, removed or technologically supplemented....*” (Toombs 1988 p201). Using Graham’s (2005) concept of intertextuality, Cartesian dualism and its impact on medical practices have informed and enhanced my interpretation of the statement. The positivity of the statement is grounded in medical knowledge/power which deconstructs the pregnant body and the fetus into its component parts or “problems”. This is seen in the narrative that accompanies the image which states;

*“we have many specialist clinics to look after women with complex medical problems. These include clinics caring for women with diabetes, heart problems, HIV, blood disorders, joint disorders, kidney problems and high blood pressure, obesity, and also for women at risk of problems in their babies (fetal medicine, placental problems and preterm delivery)”.*

The presentation of medical conditions and concerns about fetal wellbeing serves to “carve up” the pregnant body into parts that can be “repaired, removed or (in the case of fetal wellbeing surveillance) technologically supplemented” (Toombs 1988, p201). The narrative accompanying the image repeats and renews the dominant medical discourse which constructs the pregnant body as problematic and imbued with risks which need to be monitored and managed. This approach limits the

choices available to pregnant women as the problematisation of the pregnant body interpellates the pregnant woman as subject in subjection.

#### *5.2.2.2 The threshold of epistemologization*

Taken together, the statements located in the leaflet and the website on which it is found creates, what Schurich (1997) refers to as a “*network of social regularities*” (Schurich 1997, p98) that is constitutive of the emergence of a particular social problem, and how this problematic group is recognised. The statements are therefore epistemological, in that they constitute who the problem group is, and ontological in that they define how the group is seen or known as a problem (Schurich 1997, p107). Pregnant women are constructed as patients, and this repeat and renews the dominant medical discourse which sees patients as sick and in need of help. Pregnancy and birth are constructed through statements that define it as a risky, problematic, complicated and disembodied state. Of note here is how, through the formation of statements, the Trust, through its information leaflet and website crosses a “threshold of epistemologization” (Foucault 1972 p 206), in that pregnant and childbearing women are constituted as a problem group in need of interventions to limit risks. This is achieved through the articulation of statements which make claims to validity and domination by exercising medical power/knowledge. The epistemological stance of the Trust frames the presentation of choice by limiting what is available, to whom, and in which circumstances.

As stated earlier, a number of statements could be isolated on the website. It is noteworthy that the noun “midwifery” is absent from a site providing information to women about pregnancy and birth. It is therefore appropriate that the second

leaflet included in the dataset is entitled “*Planning a Home Birth*”, an event which is in the domain of the midwife. The analysis of this leaflet, and the website on which it is located is analysed in the next section.

### 5.2.3 Data analysis of the leaflet 2 *Planning a Home Birth*

*Leaflet 2* is presented as an information booklet compiled by midwives for women who are planning a home birth. As with the previous leaflet, it is billed as “Patient Information Leaflet”, but I did not choose to consider this statement here. Instead I have located a number of statements contained within the text.

The first statement located is “*Giving birth at home can be a very fulfilling experience for you and your family*”.

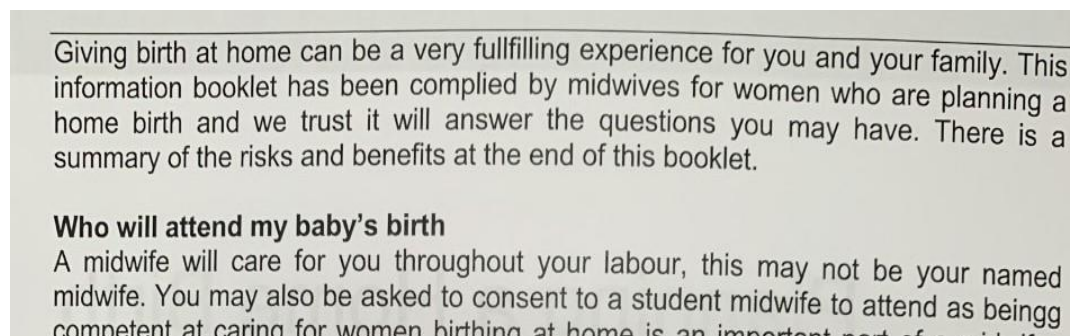


Figure 5.6 Leaflet 2: statement 1

#### 5.2.3.1 *Birth as an embodied experience*

The statement functions to enable the subject /object to appear and how that subject/object is seen or known (Foucault 1972 p50). The subject here is birthing at home and it is seen and known as a positive, fulfilling experience. The location of this statement as the first sentence in the leaflet performs to set the tone for the information that follows, presenting home birth a positive choice. Here I have identified a midwifery discourse that recognises and constructs pregnancy and

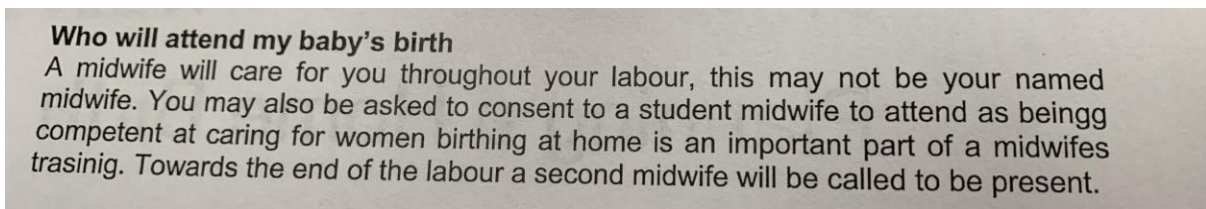


birth as an embodied experience (Butler 1997), and this is seen in the way the relational aspects of pregnancy and birth are foregrounded in the statement. In locating this statement and its constitutive properties, it is possible to isolate the positivity of power/ knowledge. In midwifery, it is acknowledged that the body in pregnancy and childbirth is a material, biological body that nurtures another human being within, and labours, experiences pain and bleeds. A complex arrangement of hormonal and physiological processes enables this to happen (Davis and Walker 2010). The environment in labour can have an impact on these processes and its effective functioning in labour (Perez-Botella, van Lessen, Morano and de Jonge 2019), so the creation of an environment that is conducive to helping women feel safe and supported when birthing their baby is an established tenet of midwifery care. Increasing awareness of the impact of the environment on health (Ulrich et.al 2008) has led to increasing domestication of birth spaces within maternity units. This has occurred as a consequence of the growing body of evidence which recognises that the environment may facilitate normal birth and the positive experience women and their birth partners require.

A qualitative study by Mondy, Fenwick, Leap and Foureur (2016) explored the concept of domesticity within the birth space. Situated within a larger ongoing project exploring birth unit design, the study used video ethnography and reflexive interviewing to understand the impact of different domestic characteristics of birthplaces on labour. Women labouring and birthing in different spaces; a conventional delivery unit, a birth centre and home were videoed. The women, their birth partners and the attendants were also interviewed. The study found that those women and birth partners in the conventional spaces became passive. They did not seek to adjust the space to their needs, storing their belongings away so

as not to take up space and made very few demands. The researchers suggest that when women feel the space is not comfortable, homely adaptable and private, they will potentially feel unsafe, releasing catecholamines, which interrupt the hormonal and physiological processes described by Davies and Walker (2010) as essential for birth. This stress response may manifest as passivity. By way of contrast, the women labouring and birthing at home or in the birth centre and their birth partners used all the space; moving about freely, making refreshments when required, interacting with their birth partners and attendants and generally owning the space. The women in these environments asserted their requirements, directed their birth partners and were noisy, banging on furniture or stamping to manage the contractions. The researchers concluded that the domestic birthing spaces meant it was easier for the labouring woman to place themselves or remain at the centre of care and support. Although a small study of six women, the findings are credible and resonate with my knowledge of supporting home birth. Therefore in midwifery discourse home birth is a positive, rational choice.

Midwifery power/knowledge is also found in a further statement located in the section headed "Who will attend my baby's birth?".



***Who will attend my baby's birth***  
*A midwife will care for you throughout your labour, this may not be your named midwife. You may also be asked to consent to a student midwife to attend as being competent at caring for women birthing at home is an important part of a midwife's training. Towards the end of the labour a second midwife will be called to be present.*

Figure 5.7 Leaflet 2: statement 2

### 5.2.3.2 Community midwifery knowledge

Here I located “*you may also be asked to consent to a student midwife to attend as being competent at caring for women birthing at home is an important part of a midwife’s training*”. This statement functions to enable the subject of birthing at home to be recognised (Butler 1997) as an episode that demands specific skills and competence of the midwife. Here I have used intertextuality to help with the interpretive process. The NICE Guidelines on Intrapartum care (2014) has a section on helping women choose their preferred place of birth. Here, NICE (2014) uses evidence from the Birthplace study (Brockelhurst, Hardy, Hollowell, et al 2011), which demonstrates that birthing at home is a safe choice for women experiencing a low-risk pregnancy, however the NICE Guidelines on Intrapartum care (2014) assumes that women are not birthing at home. For example, the guidelines state that health care professionals should “*knock and wait before entering the woman’s room, respecting it as her personal space, and ask others to do the same*”. Or “*encourage the woman to adapt the environment to meet her individual needs*” (NICE 2014 1.2); requests that are redundant in the woman’s home. The significance of NICE guidelines is their widespread adoption in practice, but as observed here, they may not be applicable in all practice settings. Using intertextuality to inform my interpretation, the statement functions to locate home birth as practice distinct from birthing in a facility. The statement locates home birth in a field of exteriority (Foucault 1972) alongside statements that constitute birth as a problematic and risky activity that requires medical management, such as those located in *Leaflet 1*. The power/knowledge of this statement can be traced to a midwifery discourse that recognises that midwives are required to be skilled and knowledgeable about birthing at home. Midwives

who are confident in facilitating home birth are more able to support women who choose to do so. This is also captured in the following statement.

- Raised blood pressure
- Exhaustion. Occasionally labour may be very prolonged or difficult to cope with despite good support and good preparation for the birth. However if you need stronger pain relief you may choose to be advised to transfer to hospital where additional help is available i.e. methods of increasing the efficiency of the contractions and/or epidural anaesthesia.

Figure 5.8 Leaflet 2: statement 3

#### 5.2.3.3 “Holding” the woman

When considering how this statement functions, I reflected on the performative properties of the words used. This statement might have been worded differently. It might have referred to “delay in labour”, or “failure to progress”; words that are common parlance in maternity care, implying that labour is an activity that ought to be completed within a given timeframe, and when this is not achieved labour is viewed as something defunct or broken. However, the performative properties of the words chosen make the subject of the statement, birth, recognised as something that may be long, difficult and exhausting. That this may occur “despite good support and good preparation” functions to make visible the investment women and community midwives make in choosing to birth at home, and despite adequate preparation, sometimes birth does not go according to plan. Here I have identified a community midwife discourse, as distinct from a midwifery discourse, which constructs recognisable subjects such as home birth, the woman and the community midwife through statements that describe and define elements of those subjects. The community midwifery discourse here is located in the

knowledge that birth may be prolonged, difficult to cope with and exhausting, and still essentially normal. This authoritative knowledge is derived from watching, waiting and listening to women experiencing uncomplicated normal birth. If birth plans are not realised, this may not be anyone's "fault". This statement functions to speak into existence the community midwife's role in "holding" the woman, through her authoritative knowledge of normal pregnancy and birth, enabling the woman to feel safe and confident in her pregnancy and birth choices, The role of the community midwife in holding women safely is exemplified in the following statement under the heading "What if there are any problems during the labour?".

In the unlikely event of you being unwilling to accept the advice of the midwife and you decline transfer to hospital the midwife will inform a supervisor of midwives and the medical staff, and she will continue to care for you at home. However, it must be appreciated that the midwife **does not have access to more sophisticated equipment and medical expertise that is available in the hospital.**

Figure 5.9 leaflet 2: statement 4

#### 5.2.3.4 *Being with women*

The constitutive effects of this statement are clear. The statement enables the subject, in this case the midwife, "*to appear, to juxtapose itself with other objects, to situate itself in relation to them, to define its difference, ...to be placed in a field of exteriority*" (Foucault 1972 p50). The statement places the midwife in the community and alongside the woman, supporting her choices, and I would also add working alone. My interpretation of this statement does not mean to infer that midwives working in other settings do not work alongside women supporting their choices, but I have drawn on an intertextual reference to support my claim.

In another information leaflet provided by this Trust and available through the website which describes Midwifery Led Care it states; “*if there are any problems during your pregnancy your midwife will refer you to a consultant for their opinion. If the problem is ongoing you will remain under the care of the consultant for the rest of your pregnancy and delivery.*” Here the performative properties of the words “*your midwife will refer you*” and “*you will remain*” act to reinforce a dominant medical discourse, and one which excludes any element of choice. This text illuminates the interpretation of the statement by juxtaposing the language used in community midwifery discourse and medical discourse, situates the community midwife in relation to her medical colleagues and also the woman, whom she must continue to care for, rather than refer on.

In locating *statement 4*, it is possible to isolate the positivity (Foucault 1972 p214) of a power/knowledge- where community-based midwifery is more able to support an individualised, physiologically normal model of pregnancy and childbirth reflecting a “with woman” ideology (Hunter 2004), where the woman is the primary reference point for the community midwife. In Hunter’s (2004) study of community and hospital midwifery practices, she found that for the community midwives the women were a source of affirmation and support, whereas in the hospital environment colleagues and peers fulfilled this role, thus highlighting a difference between the areas of practice. *Statement 4* speaks into existence the “with woman” ideology referred to by Hunter (2004), by articulating the midwife’s commitment to support the informed choices of the woman.

## 5.2.4 Data analysis of website 2

Leaflet 2 is also located on the Trust's website and accessed via a "services" page. The maternity page contains no images, but a series of drop-down boxes providing specific information, and links to the leaflets. Under the tab "Welcome to our multi-award-winning Maternity Unit", the following statement is located.

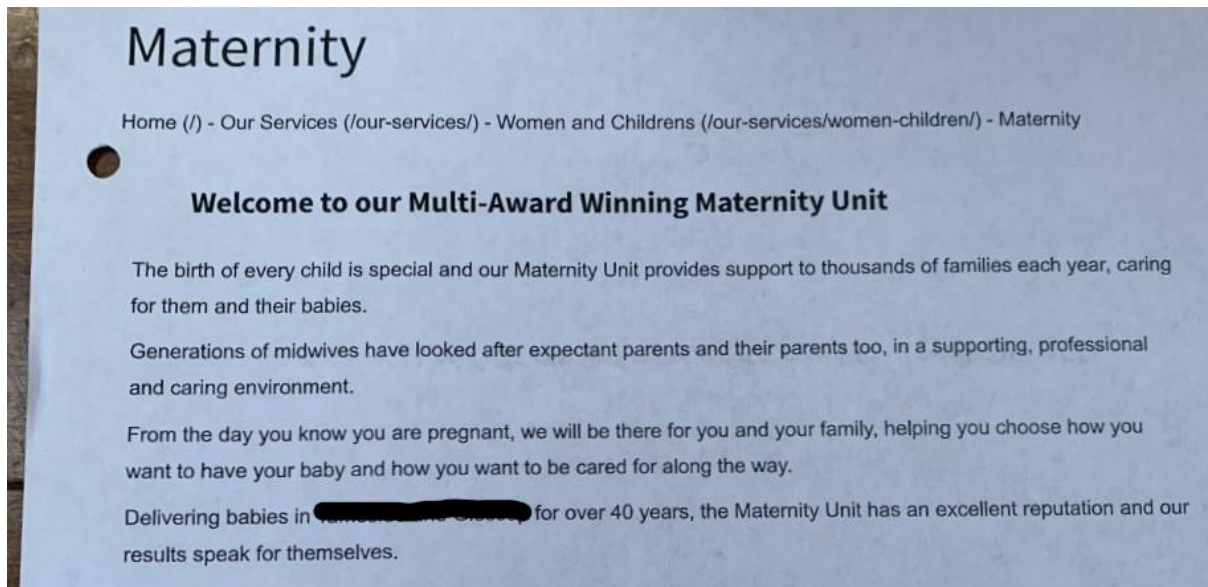


Figure 5.10 Leaflet 2: website

I found this statement interesting because of the way it is written. Of interest here is how the words perform, that is how they evoke images that increase the effect of the statement.

### 5.2.4.1 Community

The statement invokes images of longevity, dependability and familiarity. The statement speaks into existence the long-serving, experienced and known midwife, working in a familiar, dependable environment, qualities that are intended to appeal to the pregnant woman and her family. Initially I questioned the relevance of this statement. For example, do women value those familial ties,

working with midwives who may have helped their mothers' birth too? Of note here is the absence of any reference to state-of-the-art technologies or facilities that may serve to entice the pregnant woman to birth her baby at this Trust. However, I adopted post structural caution in my analysis of the language used as it is not possible to know what the author intended to convey. Of concern here is how this statement functions. When considering this, I looked to Foucault's ideas on the history of knowledge. He defines discourse as "*a body of anonymous historical rules, always determined in the time and space that have defined a given period, and for a given social, economic, geographical, or linguistic area....*" (Foucault 2002 p131). The construction of the solid, dependable midwife caring for women in the professional and supportive environment is significant both historically and geographically to this maternity unit. The Trust is in an area that was profoundly impacted by the activities of Harold Shipman; the general practitioner responsible for up to 400 deaths in the locality (Dame Janet Smith 2009). Consequently, trust and confidence in health care professionals generally, but doctors specifically, was diminished nationally, but nowhere more so than in this small community. The statement, located as the second sentence in the opening paragraph on the webpage, functions to position the midwife as the primary professional providing maternity care in this Trust, reassuring the woman and her family that the midwives at this Trust have and will continue to provide supportive and professional care.

The primary position of the midwife is reiterated further in the webpage under the tab "Having your baby at xxx Trust". Here the following statement is located.



*“All pregnancies require the care of a midwife, and some will need input from doctors too”*. The subject of the statement here is the midwife, and *“the rules or forms [which have] become manifest”* (Foucault 1972 p99) is the requirement for midwifery care to be provided in all pregnancies, irrespective of risk.

Locating and identifying constitutive properties in the language, it is possible to isolate the positivity (Foucault 1972 p214) of power/knowledge. The position statement provided by Midwifery 2010 (DH 2010) is used to repeat and renew the midwifery discourse that the midwife provides an essential function in supporting all women through pregnancy and birth.

#### **5.2.5 Summary of analysis**

The information leaflets and websites form part of the dataset for my study. I have interpreted the information leaflets as indicative of the perspectives on choice in pregnancy and childbirth held by the Trusts, with the aim of providing some context of the environment in which the community midwives work. The analysis has illustrated the dominant discourses on pregnancy and birth which influence how choice is conceptualised and presented to women. *Leaflet 1* and its host webpage is shaped by a dominant medical discourse which views pregnancy and birth through a medical lens. The medical gaze constitutes pregnancy and birth as problematic, capricious and risky states. Medico-technological involvement in pregnancy and birth is presented as necessary and right in order to observe for and control risk. Risk discourse permeates *leaflet 1* and the website, to the extent that the choices available are shaped through the lens of risk. This is seen through the presentation of risks in relation to birthing outside the hospital setting.

Returning to Foucault’s ideas of what is unsaid, the unspoken subject of *statement*

2 is the risk associated with timely transfer to hospital in the event of concerns about labour or birth. The silence is powerful because it invites speculation. This may be sufficiently unsettling to women, impacting on their ability to make genuine choices about their pregnancy and birth. The ontological privileging of risk in relation to pregnancy and birth seen in *Leaflet 1* and the website legitimises the dominant medical discourse imbuing it with a “truth”. The interpellation of pregnancy and birth as risky activities locates them within a “disciplinary space” (Foucault 1977) where subjects are formed through subjection. Once constituted as an object in this space, the community midwife is then subject to the dominant discourses of medicalisation and risk.

In *Leaflet 2* and the host website on the other hand there is a dominant midwifery discourse which constitutes normal pregnancy and birth as safe and home birth as a rational, positive choice. Pregnancy and birth are social as well as biological constructs, and the midwifery discourse recognising that birthing is a family concern. Supporting home birth requires skills that are different than those required to support birth within a facility. Through the processes of interpellation, the midwife is identified as dependable, knowledgeable, skilful and “with woman”. Midwifery is located in the community, not just the geographical sense, but also the social sense. The authoritative knowledge underpinning the midwifery discourse is an understanding of the factors that enable normal birth and the primacy of women’s choices. The midwifery discourse demonstrates awareness that deviations from the usual trajectory of pregnancy and birth can occur, and frames these in a way to quantify any risk and arrive at a shared decision.

The contrasting discourses identified in the two leaflets and host websites capture the milieu which community midwives must negotiate in their work with women, supporting choice in pregnancy and birth. The themes emerging from the analysis of the leaflets and webpages; namely the discursive formation of pregnancy and birth as risky in contrast to the midwifery discourse and the presentation of midwives as either absent, the lead professional, or integral to the community, provided a template for my interviews with the community midwives.

### **5.2.6 Data analysis of the community midwife transcripts**

The analysis of the community midwife transcripts followed the same structure as that applied to the information leaflets and websites. I located statements that function with constitutive effects, and interpreted statements as things said that privilege particular ways of seeing things and codifying certain practices. The analysis of the leaflets and website offer an insight into the community midwife's world; working relationally with women to support choice in their pregnancy and birth, with a codicil of risk. Therefore, I have located statements which a connection to the relational, organisational and professional aspects of supporting choice in pregnancy and birth can be inferred and applied my analysis framework to those statements.

#### *5.2.6.1 Locating the women in the community*

In response to my opening question; "tell me about your work with the women", the community midwives articulated the following;

*"so I have my own caseload of women, so it's around about 100 women, so it's quite a big caseload. Sometimes it varies, so it can go a bit over 100, a bit under 100, and I work in an area where I see all kinds of different women, so women from loads of different ethnic*

*backgrounds. They could come from all kinds of different families, they have varying jobs, some of them don't work, some of them [are] doctors. And quite a lot of safeguarding involved in the area I work in". (CMW 2 Community midwife for 5 years, large unit)*

*"I've worked since I've been on community, all over, from X town, which you know is quite socially deprived, and as our team worked then that was, from a midwife's perspective that was a good group of women to be looking after because it was very mixed, so we got socially deprived, middle of the road, and then high achievers in Y town so we were quite a mix". (CMW 6, community midwife for 30 years, medium unit).*

*"my caseload is very similar to K's, and I think, those women, because they're working and things, and some have moved into the area, they haven't got their mums and partners around, whereas in the more deprived areas, they seem to have a better family network I would say, although not always, great" (CMW 5, community midwife for 17 years, medium unit).*

The responses from the community midwives enable a statement to be located, which constitutes pregnant women as the subject, visualizing these subjects as relational beings, placing them in a "field of exteriority" (Foucault 1972 p50).

Pregnant women are recognised (Butler 1997) by the midwives in their relation to others, their roles and the characteristics of the environment in which they live, conceptualizing the holism of pregnancy and birth. The positivity of this particular power/knowledge can be located in the social determinants of health and wellbeing which recognizes that childbearing women who experience social or economic disadvantage are known to experience greater health risks and worse health compared with men (World Health Organization 2016). By locating the statement in the articulations of the community midwives it is possible to identify a community midwifery discourse which acknowledges pregnancy and birth as a social construct where aspects such as the degree of support and economic

deprivation experienced by women forms authoritative knowledge in midwifery (Davis-Floyd and Davis 1996), which recognizes the authority of an holistic model of pregnancy and birth in the realm of technomedicine. By describing their caseload through reference to the degrees of social and economic resources available, the community midwives recognised implicitly that pregnancy and birth is a social construct and that women's choices were shaped and constrained accordingly.

#### 5.2.6.2 *Locating community midwifery in relation to hospital midwifery*

In seeking to describe the uniqueness of community midwifery, the midwives draw comparisons with hospital midwifery, *“for a statement always defines itself by establishing a specific link with something else that lies on the same level as itself... something foreign, something outside”* (Deleuze 1988, p11). From the transcripts :

*“there are massive benefits to being in someone else's environment, I mean for a start you get to see their environment, like the midwives in the hospital wouldn't have a clue, they could only be guessing how someone lives”* (CMW 2 community midwife for 5 years, large unit).

*“in my own environment, out in community, I know those guidelines and polices inside out and I can freely talk to the woman and sort of, erm, fit the guidelines to her if you like”* (CMW 1 community midwife for 3 years, small unit)

*“it gives me a little bit more freedom in my practice, I'm not bound to a hospital, I don't have to answer buzzers, I don't have, kind of managers coming round putting pressure on me, I feel I can just go out, I can manage my own work load, so I have more control over my work to an extent”* (MW2 community midwife for 3 years, small unit).

*“you're just a completely different midwife than you are in the hospital, its every decision, I mean you've got a phone there if you want to speak to someone, but you know, you can't be doing that every 15 minutes,*

*you just have to be confident that you're making the right decision"*  
(CMW3 community midwife for 3 years, large unit).

*"Like we say on community, there are not many delivery suite midwives who'd be happy to go on home births on their own" (MW1 community midwife for 3 years, small unit).*

*"all the safeguarding and all the referrals, all the work that gets put in, everything we pick up and then send them in, would never be known if it wasn't for us, or anything like that, and you just think, all the work"*  
(MW2 community midwife for 5 years, large unit).

The constitutive effects of these statements enable hospital-based midwifery to be viewed as a practice that is largely unaware of women's wider circumstances, where pressure is applied and work interrupted by managers and buzzers, and the responsibility for care is shared. Correlatively, an opposition is formed, and the statements located in the midwives' accounts speaks into existence community midwifery as an autonomous, woman-centred, holistic practice, largely unhindered by the practices of the Trust. To clarify this interpretation, I have used intertextuality by drawing on the following examples from the transcriptions. The textual references demonstrate the ease with which the midwives exercised autonomy in decision making, adapting guidelines to suit the particular needs of women and facilitate her choices. In one case, a woman was referred to the specialist mental health team but declined to go.

*"...so in that situation, I saw that woman every two weeks for pretty much the whole of her pregnancy, because I thought if no one is keeping an eye on her, she wouldn't go to the GP, she took herself off antidepressants, so yeah, there was none of this, I'll see you at 16, 21 [weeks], I pretty much saw her every two weeks for the whole of her pregnancy" (MW3, community midwife for 3 years, large unit).*

In this instance, the community midwife is choosing to work outside the national and trust guidance which sets out the ante-natal contacts a woman should receive in an attempt to minimise the risk of an adverse outcome for the woman, and in doing so supports the woman's care choices. In this case the midwife is provided care above and beyond what is set out in the guidance on ante-natal care (NICE 2008), and although professionally defensible, doing so risks censure from her managers because of the extra time taken and additional costs incurred. Similarly, in the group discussion, three midwives indicated that they had a differing approach to the requirement to refer to a consultant obstetrician if a woman's BMI was greater than 30Kg/m<sup>2</sup>, with two indicating that they never referred women if their BMI was just above the threshold because they were aware that this would limit her choices. Working relationally with women, observing them, and drawing on their years of midwifery authoritative knowledge and experience, enabled these midwives to work with a degree of autonomy, which they believed would not be available to them if they practised in the hospital setting.

#### *5.2.6.3 Responding to risk*

The midwives were aware that women had to make decisions about a number of aspects relating to their pregnancy and birth, and that their choices were often constrained by the circumstances in which the women found themselves. This was demonstrated in the discussion with one midwife who recounted a typically frequent conversation with women.

*“you could be sending someone in, you know your baby's measuring a bit small, I need you to go in for a scan, yeah like its half two now, I've got to pick the kids up from school and you know I've got three kids, and childcare is a big one.*

*I can't force her in. I'd give her all the risks of not attending and a lot of them say I'll go tomorrow, you know. I'd be quite confident that I've thoroughly documented, risks explained, patient's still refusing to attend despite x, y and z". (MW3 community midwife for 3 years, large unit).*

The performative properties of the midwife's words take on the pregnant woman's providing a rationale and some context for her inability to go to the hospital. Here the midwife acknowledges the social and economic constraints on the woman that prevent her from accessing the recommended care. Therefore, it is not a choice that the woman is exercising. In the second part of the statement, the document is the object. The document is recognised as the form in which the risks of not following the advice of the midwife are clearly recorded acting as a "*document for possible use*" (Foucault 1977, p191). The document, in this case the woman's hand-held maternity notes, records the advice given by the midwife and the response of the woman, and in doing so "*functions as a procedure of objectification and subjection*" (Foucault 1997, p192). The process of documenting care in the hand-held notes becomes an act of interpellation by which the subject; in this case the patient, is formed in subjugation (Butler 1997).

Intertextuality can aid the interpretation of this statement. The NMC (2015) state that for midwives to practise effectively, they must keep clear and accurate records relevant to their practice. Specifically, they must "*identify any risks or problems that have arisen, and the steps taken to deal with them*" (NMC 2015 10.2). This requirement placed on the midwife functions as a disciplinary mechanism that reduces the pregnant woman to a "case" in which "*[s]he is linked by [her] status to the features, the measurements, the gaps, the marks that characterise [her]*" (Foucault 1977p192). Although the midwife is aware of the



constraints on the woman that prevent her from being able to follow the advice offered, the manner in which she documents the exchange would suggest that this is not her primary concern. Again, using intertextuality, I have drawn on an excerpt from the interview transcripts to illuminate an additional interpretation.

*“Because they look at everything. Alright, somebody’s had a bad outcome, which is unfortunate, but they go back and look at anything, any little thing that’s not ticked, the outcome will be because you didn’t tick that box, like no it wasn’t, no it wouldn’t have done, it wouldn’t have changed the fact that it [the fetus] didn’t move from Saturday till Sunday or whatever and [the woman] didn’t go in [to hospital]. The information is there, but because you didn’t tick that box there at 28 weeks, so it’s your fault...they want to blame someone for it happening, but sometime there isn’t a blame at all” (CMW6 community midwife for 30 years, medium unit ).*

#### *5.2.6.4 Disciplinary power*

This excerpt captures the experiences of community midwives who work relationally with women and at the same time must fulfil the operational and professional demands of their employer and regulatory body. This can be viewed through the lens of Foucault’s (1977) concepts of disciplinary power. In *Discipline and Punish* (1977), Foucault describes how disciplinary power over subjects no longer relied upon violent physical punishment but targets the soul of the prisoner. Like the “docile” prisoner, the community midwives are subject to *“habits, rules, order and authority exercised continuously around him and upon him, and which he must allow to function automatically in him”* (Foucault 1977 p128-129).

In Foucault’s writing, the Panopticon provided the ability to observe the prisoner without them being aware, resulting in self-surveillance and exercising self-control. The midwives interviewed all practised a form of self-surveillance in that they were

acutely aware that their actions in the community spaces were being monitored, judged and sometimes found wanting, as seen in the following excerpts.

*“people do things defensively in a way, not just to protect themselves from like, what women would say, you think of litigation, things like that, but you also practice defensively because of the Trust, and people higher up than you, potentially pulling you up and saying why have you done this, why did you not do that, and having to justify it” (MW2 community midwife for 5 years, large unit)*

*“I think that whatever decision you make, there’ll be someone in the hospital thinking hmmm. If somebody says they want to see me, I’d immediately think, oh what have I done” (CMW 7 community midwife for 14 years, medium unit).*

So pervasive was this awareness that a request to speak to a manager was immediately perceived as a censure.

#### 5.2.6.5 Midwives exercising power

Foucault perceived power dynamically, as indicated in his assertion that *“power is everywhere not because it embraces everything, but because it comes from everywhere” (Foucault 1976 p83)*. Power is not held by a dominant agent or exercised through relations to those dominated but instead located through complex social networks. Domination requires that those dominated act in concert with the dominant agent. Midwives exercise power through surveillance of women and of each other, and through their documentation, demonstrate compliance with the care pathways. The ways midwives exercised power over women’s choices can be seen in the following excerpt.

*“if you say you are going to travel all this way for your booking and your bloods and your scans, but I’ll do everything else here, or you can go here and you only have to go here for your things, they go ooh” (MW3 community midwife for 3 years, large unit).*

The presentation of this information to women, focussing on the requirement to travel, influences decisions women make about place of care, because the midwife is aware that the ability to travel may be a limiting factor for the woman. The way in which the midwife refers to the women in the plural would suggest that this is a frequent exchange. Although the midwife's intentions may be benign, she is exercising her power over the women's choices. More direct expressions of power could be seen in the way women's choices were discussed. Comparing the approaches in the two trusts in which she had worked, MW1 offered;

*“So at xxxx trust, you would have heard about a woman [requesting care out with guidelines] and be like ah right, okay, good for her kind of attitude. At xxxx [trust] it's very much like oh my god what's this woman saying, have you seen this?”*

The midwives recognised that supporting choice was integral to their role as a community midwife, and this was captured in the following excerpt.

*what I would say is, if they, sometimes they come with you and they know what they want, so that's quite easy, isn't it, because they've made their decision, with whichever pathway they've come through, either family, friends, research or whatever. But if they say, where shall I go, that's obviously not for me to give them the answer to that, but to explore, well what do they want, what's available, who offers what. It doesn't matter where I'm employed, this is your choice, and I say, you can go anywhere..... I just think that's one of the most important things, in my opinion, where they want to be. Because, regardless of how that birth goes, they have to have faith in that trust that's looking after them, don't they? Not say, well, see, I should've gone to [Trust], and if I'd gone to [Trust] I wouldn't have ended up with a section. (CMW 6 community midwife for 30 years, medium unit).*

#### 5.2.6.6 Institutional power

Choice though was sometimes constrained through the processes of care, or organizational factors, as located in the following statements.

*“it’s that culture in [location A]; if you know someone who’s had a home birth, it’s sort of the norm in your area... so at [location], if a primip [primiparous woman] wanted a home birth, well that was fine, there wasn’t any supervision issues about that, where as if a primip in [location B] wanted a home birth it’s a big deal, it’s, you know, in front of a supervisor” (CMW1 community midwife for 3 years, small unit)*

*“Sometimes they develop a risk factor because their last baby was 6 pounds 12 which is in proportion to them, and when they generate their growth chart, and then they have to have serial scans... You want to say that, though, don't you, you want to say. They're fussing about nothing and yet you go down that pathway to a serial scans and it's not, if it's a centimetre out, then it's another scan, and then their choices are getting a bit limited” (CMW 7 community midwife for 14 years, medium unit).*

*“sometimes you know, that it's gonna be fine, but, you have to act anyway, so, for example, sometimes, you might know, that when a woman's really close to the due date, and she says "ooh, I've really dropped", yeah, that kind of thing, and you can see she has because you've seen her two weeks ago, four weeks ago, but then if you measure her correctly and according to the guidelines, she would maybe, it wouldn't reflect - you can tell, it's probably just dropped, she has grown, but, it's showing a static growth on the grow chart, but, because of the guidelines we have, I'd have to send her in” (CMW 2 community midwife for 5 years, large unit).*

These statements functioned with constitutive effects where the subject/object was the perception of risk. In the first statement, the primiparous woman can birth at home without question in location A, yet a short distance away in Location B, that option is conditional and subject to approval. That this variation in practice occurs speaks to the dominance of the medical knowledge/power, where options for women are shaped not on evidence, but on perceived risks. Similarly, in the second statement, the process of risk assessment brings into being the potential

risks contained within the pregnant body, resulting in what Scammell and Alaszewski (2012, p207) call “an ever-narrowing window of normality”.

Absent here is any evidence to advocate for women, or defend midwifery led care.

In relation to the lack of choice for women in location B, CMW 1 stated:

*“it sounds awful, but, I’m having times now where I think, I’m not paid enough to even bother with this, now. To even bother arguing for the sake of the women, to, get myself a name as a sort of some kind of cavalier midwife, [laughter] you know, I’m not paid enough to do it, so I’ll just have an easy life.”*

Similarly, women were expected to argue for their choices themselves as seen in this excerpt.

*“those women try to speak up against the system I suppose, so those women who are very vocal and are specific over what they want, if they don’t fit that criteria, perhaps they make people sit up and listen.....and, you know, women who do pose risk factors who don’t want to be in a higher risk pathway, they end up often getting seen by [consultant midwife]” (CMW5 community midwife for 17 years, medium unit).*

However, women who did speak up and were specific about their choices were seen as exercising power over the midwives, as their choices sometimes left the midwives feeling personally and professionally vulnerable. MW6 stated:

*“one difficult case was a twin lady who decided to have a home birth, but in the fact she got all her choices , the midwives didn’t get any choices you know to look after her.... There was a lot of people quite frightened, obviously having not been in that situation either for a very long time or they were newly qualified*

*“they did a couple of informal sessions on the central delivery suite....about twins at home and I remember saying to a couple of my pals, try and go today because what you have to look after is your registration because she knows all the risks, she’s had that explained to her at length, but our risk is that you’re risking your registration if you*

*aren't adequately trained..... so when you're in court because one of them has died you can say m'lord, I tried to update myself because I did this session before, which is a terrible defensive thing, but that's what I did think"*

The birth of twins would normally take place on a consultant led unit, with easy access to obstetric operating theatres and a skilled neonatal care team and facilities (RCOG 2016). The lead professional in the care of a multiple birth is a consultant obstetrician. Such a birth occurring in the home is, by virtue midwifery led, as obstetricians and neonatologists are not present in the home.

Reflecting on the same case, the following statement is located.

*"They have seen the consultant midwife, seen the consultant obstetrician, and then they have come up with a plan. And I feel like maybe the community midwife could be more involved with that plan, rather than it goes to the consultant midwife and she write a plan in the notes" (MW5 community midwife for 17 years, medium unit).*

I interpreted this statement as an articulation that functions with constitutive effects. The constitutive object in this case is the plan that is recognisable as a document for use "possible use" (Foucault 1977 p191). The plan functions as an object of medical/obstetric discourse. This is illustrated by Foucault's (1977) concept of disciplinary space as the birth plan devised in and by the hospital seeks to "*supervise the conduct of each individual, to assess it , to judge it, to calculate it qualities or merits" (Foucault 1977 p143)*. Here the hospital's reach extends into the home determining the activities and behaviours necessary to support the birth that will be midwife led. The exclusion of the community midwife in the planning of the birth is noteworthy and repeats and renews the assertion

that obstetric led care is the dominant discourse, even though obstetricians are not physically present in those spaces.

In the statements located in the midwifery transcripts, it is possible to identify the community midwife navigating her way through the dominant midwifery and medical discourses. A theme that has emerged from the data is that community midwives believe that working with women in the community setting affords them more awareness of the factors that shape and limit choice for women, and in particular the economic and social constraints placed on women which force them into a choiceless choice. Awareness of these factors however may mean that the midwives have made assumptions about what matters to women, and they present options in a way that also limits choices. For example, assuming women will not want or cannot travel for care reduces a woman's agency.

The midwives viewed their practice in the community as qualitatively different to that provided by midwives in the hospital setting. Here their ideas and beliefs reflected the midwifery discourse identified in *Leaflet 2*, in that they were more aware of the woman's circumstances, and this enabled them to work outside the guidelines, making care fit the needs of the woman, rather than the other way around. In this way, the community midwives had a more relaxed attitude to risk, and were comfortable in exercising their power as autonomous, accountable midwives.

The midwives demonstrated a contradictory approach to choice in that they recognised that it was important that women were offered choices, however that the dominant medical discourse which views pregnancy and birth as inherently

risky and located in *Leaflet 1*, permeated their practice in a number of ways. First, they sought to protect themselves when women would or could not accept the advice offered by the midwife through documenting their conversation in the woman's hand-held notes, demonstrating that the woman was made aware of the consequences of not complying with the recommended care. Second, they managed the information given to women so that the options presented fitted with what they knew was possible from an organisational perspective. For example, information on birthing at home to women expecting their first baby was deliberately not offered to women booked at one Trust because of the response that request would receive.

The midwives expressed feelings of powerlessness, first in their requirement to advocate on behalf of women, and second, when women made choices which they felt placed them at professional risk. They recognised that some women railed against "the system", acknowledging that some of the surveillance offered, such as serial ultrasound scans to determine fetal growth, reduced her options, but at the same time women who chose to birth out of "the system" were perceived as placing the midwife unfairly at risk.

#### *5.2.6.7 A community midwifery risk discourse*

From this analysis, I have identified a community midwifery risk discourse. To explicate this, I return to Foucault's three primary constitutive dimensions of discourse; knowledge, power and ethics.

The knowledge of the community midwifery risk discourse can be traced to midwifery knowledge which recognises pregnancy and birth as a biological and



social construct, where care and choices are determined by the prevailing social and economic conditions. Power is located in a dominant medical discourse which views pregnancy and birth through a medical lens. Through this lens pregnancy and birth is conceptualised as risky and problematic. Within the community midwifery risk discourse a point of transformation from a midwifery discursive formation to a medical discursive formation can be located. Within this community midwifery risk discourse, the midwives are constituted as practitioners who perceive themselves to have a degree of autonomy but whose practice, and therefore their ability to offer and support women's choices, is constrained by a risk discourse which governs their thoughts and conduct. This risk discourse is amplified by their location in the community, and where the medical discourse identifies a disciplinary space.

### **5.2.7 Summary**

We can see how choice is discursively and semiotically constructed through the information leaflets and websites pregnant women are directed to by midwives in the course of their care. In *leaflet 1* and its host website, the positivity of power/knowledge was traced to a medical discourse which viewed pregnancy and birth through a medical gaze. Options for birth were presented through a risk lens which, through overt and hidden risk discourse shaped the choices available. Conversely, *leaflet 2* and the host website was located within a midwifery discourse which recognised that pregnancy and birth are social constructs and the primacy of women's choices.

The leaflets and websites have been used here as indicators of organisational perspectives of choice in pregnancy and birth, against which the lived experiences

of community midwives are compared. In the statements located in the community midwife transcripts, the ways in which they negotiated their responsibilities as midwives and employees was recognisable. The midwives all spoke of supporting women in their choices, even if this left them feeling vulnerable and exposed to personal and professional risk. The concept of risk, emanating from a dominant medical discourse, was so evident that a discursive transformation to a community midwifery risk discourse could be located. These findings are now discussed in Chapter 6 with reference to the relevant literature.

## Chapter 6

### 6 Discussion of findings

#### Introduction

This study has explored the ways in which community midwives negotiate competing discourses when supporting choice in pregnancy and birth. It has highlighted the challenges and barriers experienced by community midwives when attempting to provide information to support informed choice. The study has found that although their location in the community affords the midwives insight into the lives of women, the dominant medical and risk discourses emanating from the hospital, and evidenced in *Leaflet 1* and the respective website, extend into the community spaces, acting as a form of disciplinary control. The concept of midwifery led care, espoused by the midwives and evidenced in *Leaflet 2* and the respective website, is challenged by the dominant medical discourse which, through the application clinical guidelines, extends the medico-technological reach into the community, resulting in an “ever narrowing window of normality” (Scamell, & Alaszewski (2012). The community midwives were aware that the limits of normality were being stretched and were happy, to an extent, to accommodate women who chose to have care out with the clinical guidance provided by the Trust. The midwives used their authoritative knowledge and demonstrated flexibility when applying clinical guidelines to women experiencing perinatal mental ill-health or raised BMI but did not display the same level of confidence when it

came to concerns about fetal wellbeing. Although recognising the importance of choice to women, the midwives expressed feelings of powerlessness when they perceived that women's choices left them personally and professionally vulnerable, such as the decision to birth twins at home. The midwives also exercised power over women by using their knowledge of the woman's socio-economic circumstances to tailor the information presented. Working in the community, the midwives used the woman's hand-held notes to record and justify care offered. The hand-held notes became an object of disciplinary control as they could be scrutinised for errors and omissions in the event of an adverse outcome. The community midwife, an autonomous, accountable practitioner with the skills and knowledge to facilitate physiological normal pregnancy and birth, and a responsibility to support women to make choices about her care, must do so within an organisational structure that views pregnancy and birth as risky. Their location in the community leads the midwives to think that they are somewhat distant from this, but their thoughts and actions indicate that they are aware of the surveillance placed on them. From this, a community midwifery risk discourse can be located.

### **6.1.1 Community as a disciplinary space**

The midwives spoke of the benefits of working in the community, compared to working in the hospital. They perceived that it afforded them greater awareness of the woman's life circumstances and how this might shape the choices made by women, and the options offered by midwives. The benefits of working in the community were often expressed in relation to what they perceived as "hospital midwifery", with its managers, buzzers and lack of agency. The community midwives believed themselves to be free of these constraints. The ways in which the midwives describe working in the community are similar to the ideas

expressed by McCourt (2003) who suggests that community is not defined in itself, but by what it is not. Hospital and community can be seen as places with separate domains of activity and separate functions. In healthcare generally, the community traditionally obtains activities which no longer require the input of the hospital. The watching, waiting and monitoring activities which often follow an active episode, an operation or acute intervention for example, often occur in the community. In the context of midwifery, the watching, waiting and monitoring activities frequently precede the active episode, for example the birth, as antenatal care in the main is provided in the community and births mainly occur in the hospital. The community midwives recognised the value of the skills of listening, watching and being with women; fundamental midwifery values, and captured in *Leaflet 2*. This finding was also noted in a study by Davis and Homer (2016) on the impact of place of birth on the midwife's practices. They found that midwives working in the home or midwifery led units felt more able to practice in line with their midwifery ethos, in comparison to the ways in which they worked in the delivery unit or birth suites in the hospital. Davis and Homer (2016) describe these settings as the midwife's workplaces. In seeking to make distinctions between "hospital" and "community" midwifery practices, the community midwives in my study sought to define the differences in the workplaces.

Workplaces, according to Davis and Homer (2016) have a distinct culture; a nebulous concept that has a powerful impact on the wellbeing and behaviours of employees. Workplace culture is comprised of four elements; artefacts, behavioural norms, values and assumptions. Artefacts include the symbols and objects which convey cultural messages, for example the buzzers referred to by a community midwife, and present in every clinical area in the hospital so that help

may be summoned quickly in an emergency. Behavioural norms are the behaviours and practices that are expected and “allowed” within a workplace. Values are illustrated by the practices, outcomes and priorities encouraged and rewarded by a workplace. The assumptions contained within *Leaflet 1* for example include that birth is inherently risky and that all women require pain relief in labour. The community midwives expressed the perception that their position in the community enabled them to practise midwifery in a qualitatively different way than their peers in the hospital, more in line with the assumptions contained within *leaflet 2*, in that pregnancy and birth are normal physiological events and women are at the centre of their care, and able to make choices that are right for them.

However, this perception was illusory as the behaviours and practices of the community midwives were shaped by the dominant medical discourse which viewed pregnancy and birth as risk-laden activities, and this shaped the way choices were communicated to women. Risk discourse was evident in the ways the community midwives referred to documenting actions and discussions with women to protect themselves from the repercussions of a potentially adverse outcome, which may arise as a consequence of not following the recommended care pathway. In this way the midwives conformed to the behavioural norms and values of the hospital workplace by exercising self-surveillance to ensure their practice reflects the dominant discourses and practices of the environment. This subjection extends also to spaces through the portioning and enclosure of activities and behaviours. Foucault (1977) refers to this as “disciplinary space” and its aim “... *to establish presences and absences, to know where and how to locate individuals ... to be able at each moment to supervise the conduct of each individual, to assess it, to judge it, to calculate its qualities or merits*” (Foucault

1977 p143). In the community spaces; the home, clinic or the GP medical practice become the disciplinary space, occupied by the community midwife where although working outside the confines of the hospital, the midwives were aware that their activity is measured, monitored and managed through clinical guidelines and pathways developed in a different, sometimes complimentary but often contradictory disciplinary space. This finding was supported a study by Harris, van Teijlingen, Hundley et.al (2011) which explored how community midwives in rural or remote areas had to work to maintain their professional credibility when they encountered overt or implied criticism of their decision making from midwives and doctors based in urban settings. The community midwives worked in rural areas and demonstrated highly developed decision-making skills and confidence. Based in rural Scotland, they were aware that their decisions were linked to local geography, weather reports and traffic conditions; factors which hospital-based midwives and doctors would not normally need to consider in the context of providing midwifery care. Being mindful of the travelling time meant that there were some false positives in their assessments of potential difficulties. For example, a potential problem may resolve en route or not materialise. This often meant that hospital midwives did not respect the assessment skills of the rural midwives and this was conveyed in words and actions to the midwives. The researchers contend that *“it is not the space or place, but the way it has been constructed and “imagined” by more powerful “urbanites” that has an impact on rural practice”* (p306). This statement by the researchers is powerful in that it reinforces the rhetoric that centralised, urban based maternity units are the sites for state-of-the-art maternity care, and this position influences the organisation’s perceptions and management of community services. It also suggests that the

activities and working in urban based maternity units are more prestigious and desirable than working in community settings.

#### *6.1.1.1 Utopia and Heterotopia*

The conceptual differences between community and hospital can be examined using Foucault's (1986) writing on spaces. Foucault's (1986) spaces possess a set of relations by which a given site can be defined. In this way, a hospital can be defined by its wards, operating theatres and clinics. Foucault (1986) identifies two types of site that although are in relation with the other spaces, "*are in such a way as to suspect, neutralise or invert the set of relations that they happen to designate, mirror or reflect. These spaces...which are linked with all the others...contradict all the other sites*" (Foucault 1986 p 24). The first space is described as utopia; sites of no real space, presenting society in a perfected form but fundamentally an unreal space. The second is a space where all the other spaces in the site are simultaneously represented, contested and inverted, and Foucault (1986) describes this as heterotopia. Foucault (1986) describes these concepts using the analogy of looking in a mirror. The mirror is a utopia, because it is a placeless place, but it is also a heterotopia in that it does exist in reality and exerts a counteraction in that it makes the viewer appear real and connected with the space around them and also unreal in that the connectedness is illusory. Foucault's (1986) ideas provide a useful framework for discussing the concept of midwifery led care in home and community spaces. Conceptually, midwifery led care is utopia, a space where the community midwives work autonomously to assess, plan and deliver care to women experiencing normal pregnancy and birth. Midwifery led care is also heterotopia, a space where women's and midwives' autonomy is contested, often inverted in that medicalised models of care are



sometimes espoused by midwives, and care is midwife led to the extent that midwives are providing the care that has often been obstetrically determined and based on assessment of risk to the pregnant population, not the individual woman. The community midwives are working in the spaces, that ought to enable midwifery led care and to an extent believe that this is so, but this is illusory as the space is an extension of the hospital, as evidenced by the use of guidelines developed by the hospital and the effect of disciplinary gaze exercised over the midwives, creating docile bodies. The space therefore does not determine the type of care provided, as obstetric led care is carried out in the home and community spaces, as seen in the birth of twins at home. Midwifery led care is therefore a temporal concept, constructed by the community midwives to describe the care which they are able to provide, determined by the personal, professional and institutional constraints placed on them.

If midwifery led care is a temporal concept, the pregnant body becomes a space where it is located, but this too is a contested space. Midwifery led care should promote and protect normal pregnancy and birth in a way that recognises women's individual, embodied experience and ensures woman centred care (Davies and Walker 2010). This includes acknowledging the impact of emotions such as fear and stress, and the environment has on pregnancy and birth; all aspects captured in *leaflet 2*. At its most fundamental level, embodiment encapsulates the nature of physical experience as mediated through the body (Walsh 2010). Various theories of embodiment are described in the literature, and Davis and Walker (2010) identify the "essential body", as one with a masculine or feminine essence arising from their biological sex. This is defined as essentialism and within this paradigm the female body is essentially smaller, weaker and

generally inferior to the male body. This paradigm characterises the biomedical, reductionist approach to the human body where its workings could be measured and so managed (Davis and Walker 2010). Walsh (2010), drawing on Foucault's theories of a socially constructed understanding of embodiment posits that a constructed body arises through the practices and exercising of power within the social and cultural world. In this way the pregnant body is subject to the beliefs and practices of the care providers which may be at variance with the fundamental tenets of midwifery led care. The image of the pregnant woman on the website hosting *leaflet 1*, affords greater prominence to the fetus, made visible by the inclusion of baby shoes, than to the woman. The response of the community midwives to potential risks to the fetus demonstrated that they were aware of their position in this space, how they contributed to the dominant discourses of risk, and how they strived to maintain woman centred care, recognising pregnancy as an individual, embodied experience.

### **6.1.2 The document and issues of power.**

Foucault (1977) describes documentation as “the first stage in the “formalization” of the individual within power relations” (Foucault 1977 p 190). Within a written document, the individual becomes a “case” that may be “*described, judged, measured and compared with others*” (p191). The individual must also be “*trained or corrected, classified, normalised [or] excluded*”. The document then provides the rationale for intervention. In this study, two forms of documentation; clinical guidelines, and the woman's hand-held notes, constituted an object for a source of medical power/knowledge.

Issues of power are central in the facilitation and making of informed choices. The community midwives possessed the power to help and support women, and consequently possessed power over women. This could be seen in the ways in which the community midwives used their knowledge of woman's social and economic circumstances to shape the choices offered and based on their understanding of the Trust guidelines. Assumptions were made about the women's ability or willingness to travel, or childcare commitments before selected options were presented. While the midwife's intentions may have been benign, or even well-meaning, it nevertheless prevented the woman from making a fully informed choice. This was also found in Henshall et al's (2016) systematic review which found that midwives made assumptions about the needs and capabilities of women, based on their social background, literacy levels and previous births. The information was then presented to women in such a way that the women were likely to agree with their suggestions.

The literature review identified that the concepts of informed choice and shared decision-making are not clearly understood by practitioners. The studies by Noseworthy, Phibbs and Benn 2013, Hertig, Cavalli, Burton-Jeangros and Elger 2014, and Molenaar et al 2018 suggest that choices and decision-making are situated within a matrix of relationships and connections with care givers. This could be seen in the way the community midwives valued their knowledge of the woman and her circumstances. Continuity of care, according to Noseworthy, Phibbs and Benn (2013), allows for a longer time frame for the development of an open and trusting relationship, which may contribute to shared decision making. The midwives in my study believed their position in the community, ensuring continuity of care, enabled them to know and understand the women well, but this

knowledge was used to steer women towards decisions rather than involving women in the process. Continuity of carer in this instance may lead the carer to perceive that not only do they know the woman, but that they also know what is best for her. Even when it appeared that the midwife was encouraging women to consider their options for place of birth, the purpose of the information was to distance the midwife from the repercussions of an unwanted outcome, in this case an unplanned caesarean section. In this situation, the onus was placed on the woman to make the correct choice, so that she was responsible for the events arising out of that choice. This stance is not wholly compatible with the concept of mutual trust between midwives and women, and the bedrock of midwifery practice, so it is important to consider the barriers and challenges faced by midwives when facilitating choice and shared decision making. Henshall, Taylor and Kenyon (2016) found that time pressures limited midwives from presenting all available options. An earlier study by McCourt (2006) showed how midwives steered the antenatal booking appointment to ensure that key areas were addressed within the timeframe. Although time is undoubtedly a factor in current healthcare provision, my study showed that choices were limited by what was deemed possible from an organisational perspective, and this was located in the Trust's clinical guidelines.

The Trusts where the midwives worked possessed power over the midwives, and power to influence the actions of the midwives and the women in their care. This was seen in the ways in which options were not presented, such as home birth to primiparous women, because this would not be supported by the Trust. This finding was also noted in studies by Scamell (2014) and Newnham, McKellar and Pincombe (2017). In these studies women had to meet certain eligibility criteria to

access services or spaces, for example to birth in a midwifery led unit or use water during labour and birth, and the midwives acted as gatekeepers to the services. The conditions for accessing services or spaces was evidenced in *leaflet 1*, even though one of the spaces included the woman's home; a place where she might assume that she has complete autonomy. In this way Trusts, through their clinical guidelines, replicated in the information leaflets on pregnancy and birth, viewed through the lens of risk, exerted power over the midwives, controlling what they can offer women.

Trust guidelines are usually based on the best available evidence. The emergence of evidence-based practice in 1990's offered a new paradigm for clinical practice in healthcare. Evidence from high quality studies would replace tradition, anecdote and theoretical reasoning from basic sciences, and combined with clinical expertise and the wishes of service users, ensure optimal care (Greenhalgh, Howick and Maskrey 2014). More recently within evidence-based practice, there has been a move from investigating and managing established diseases to detecting and intervening in non-diseases, through the development of risk assessment tools based on scores or algorithms (Greenhalgh, Howick and Maskrey 2014). The focus of care then shifts from the individual to the population sub-group. In this way evidence-based practice standardizes the patient, so that they might be "*described, judged, measured and compared with others*" (Foucault 1977 p191). Greenhalgh (2018) also contends that it standardizes moral considerations too, as the requirement to consider what is the best thing to do, for this patient in these circumstances, is removed from the clinician and ascribed to the processes contained within the guideline. Steel, Abdelhamid, Stokes, Edwards et al (2014) also point to the relevance of guidelines developed for the hospital

population applied to primary care patients. They argue that taking evidence from a higher risk population and applying it to a lower risk population may result in overtreatment and adverse effects. The community midwives all spoke about the impact of guidelines on their practice, and by extension their ability to facilitate the woman's choices, for example supporting a primiparous woman to have a home birth. The midwives also demonstrated that they were willing to disregard the guidelines in the case of raised BMI or perinatal mental ill-health. Here, the midwives were able to consider what was the best thing to do, for the women in the circumstances using their clinical expertise and taking into account the preferences of the woman. Their awareness of women's lives, in particular the socio-economic circumstances in which the women lived, could contribute to a more holistic approach to the assessment of wellbeing and prevent over-pathologization. For example, anxiety may occur as a consequence of financial or work-related issues which, once the woman is signposted to appropriate services, begins to resolve. Hospital derived clinical guidelines focussing on discrete clinical problems or potential risks lack the nuance and contextualisation community midwives were able to bring to the assessment process, using their midwifery knowledge. In these circumstances, the community midwives felt comfortable about working outside the guidelines and in doing so, supporting choice by making the guidelines fit the woman.

However, the community midwives were also aware that nuance and contextualisation could not always be applied, and this was apparent in guidelines relating to fetal wellbeing. Any concern about the fetus usually involves an ultrasound scan. This makes the fetus visible and as a consequence the fetus can be seen as a patient and therefore potentially treatable. An ultrasound scan may

provide reassurance to the woman and the midwife or obstetrician, and it may also result in a cascade of interventions, including further scans, which may mean her pregnancy is considered “high risk” and culminating in induction of labour which has an attendant number of risks.

The Saving Babies Lives Care Bundle (NHS England 2016) is identified in Better Births (NMR 2016) as good practice in reducing stillbirths. The care bundle identifies modifiable risk factors, such as smoking cessation, alongside aspects of fetal wellbeing such as growth, movements and intrapartum monitoring as measures to be addressed to reduce stillbirths. The community midwives were responsible for implementing the measures set out in the care bundle, and at times when assessing fetal growth, prioritised the scientific knowledge expressed in the guidelines over their own authoritative midwifery knowledge and knowledge of the woman made possible through continuity of care. The prospect of fetal death; the ultimate bad outcome, was identified by all the midwives interviewed as a personal and professional risk. The threat of this ultimate bad outcome meant that the midwives were not able to trust their authoritative midwifery knowledge, in which they would understand that the risk of fetal death is small, but instead adopt a rules-based approach and refer the woman to the hospital for an ultrasound scan as required by the guidelines. The community midwives were aware that the consequences of this intervention may impact on the woman’s ability to make choices about where and how she births her baby, noting that with each intervention, the woman’s choices were limited further.

An evaluation of the *Saving Babies Lives* care bundle indicates that there is no clear correlation between the implementation of the measures set out in the care

bundle, and the reduction in stillbirths, but does demonstrate a 19% increase in labour inductions (Widdows, Roberts, Camacho and Heazell 2018). The care bundle is an example of how the “scientific” knowledge of the guideline is privileged over authoritative midwifery knowledge, because despite the lack of clear evidence on the benefits of the care bundle, midwives can be held at account by the Trust for not following the guidelines. Although maintaining the woman’s right to autonomy, the midwives in this study demonstrated through their words and actions the ethical tensions they experienced, by discursively constructing women who declined interventions such as scans as “patients”, suggesting they are adopting an authoritative stance, and describing copious record keeping justifying their discussions in the event of an adverse outcome.

The discursive construction of the care bundle; “*Saving Babies Lives*” further increases the imperative for midwives to act and women to respond, as the construction of the fetus as a baby, with all the ethical and emotional connotations that term invokes, implies a right to treatment independent of the woman. Although the woman is responsible for her unborn child, she also has the right to bodily integrity and this right is threatened by interventions which may not be warranted.

Here, the woman’s hand-held notes became the document where power/knowledge was located, as the midwife recorded their interactions with a woman who did not follow the recommended care pathway, even though the midwife was aware of the factors; childcare and transport, that impacted on the woman’s ability to do so. That this was the same midwife who was prepared to work outside the guidance to support a woman with perinatal mental ill-health is noteworthy and captures the dichotomy of the community midwife role, when



negotiating competing discourses of risk, choice and medicalisation in her work with women.

The hand-held notes exerted a form of disciplinary power over the community midwives. The midwives knew the notes could be scrutinised for errors and omissions following an adverse event, so the recording of care and consultations was important. This is particularly so in the community, where the notes form an auditable decision trail. The literature indicates that hospital midwives often overcame the perceived risk to their professional accountability by adopting practices which created an auditable decision trail (Surtees 2009, Scamell 2012), where doing something, even though not clinically warranted, was considered preferable to being perceived as doing nothing, and this frequently involved the use of technology, such as cardiotocograph recordings. This created a visible, tangible record of activity. The community midwives interviewed here were working in spaces away from the gaze of their supervisors and obstetricians, and without access to many technologies which would create an auditable decision trail, and the threat to their personal and professional status was pervasive. In the context of the hand-held notes, the community midwife became the “case” that may be “*described, judged, measured and compared with others*” (Foucault 1977 p191). The disciplinary power of the hand-held notes as a “*document for future use*” (Foucault 1977 p191) is an aspect of community midwifery practice that has not been previously identified.

### **6.1.3 Technocracy and the contextualisation of risk**

Davis-Floyd (2001) uses the term “technocracy” to suggest an ideology of technological progress as a source of political power. Technocracy expresses not

only the technological but also the hierarchical, bureaucratic and autocratic elements of this culturally dominant ideology. Pregnancy and birth are viewed as chaotic, uncontrollable and therefore risky, so must be managed with technology. In order to achieve this, pregnancy and birth must be deconstructed into identifiable sections or conditions, as seen on Leaflet 1's website accompanying the image of the pregnant woman, and then controlled with technological interventions, such as ultrasound scanning, electronic fetal monitoring and epidural analgesia. That these interventions are so widespread in contemporary obstetric care confirms the hierarchical, bureaucratic and autocratic elements of Davis-Floyd's (2001) model, and interventions such as serial ultrasound scans are now part of routine ante-natal care. Although the midwives did not have access to technology in the community, the Trusts, through their guidelines, extended their medico-technological reach into the community spaces.

The medico-technological milieu in which the community midwives worked challenged the espoused belief in the normality of pregnancy and birth for the majority of women. This conflict was also found in a number of other studies (Surtees 2010, Licqurish, Rolls and Hopkins 2010, Scamell 2011, Page and Mander 2014, Pollard 2014 Healy, Humphreys and Kennedy 2015). These studies primarily focussed on the dissonance occurring when caring for women in the birthing spaces in the home or the hospital. My study suggests that this cognitive dissonance also occurs during the ante-natal period, when midwifery care is primarily located in the community and home spaces; the spaces where community midwives should be able to practise authentically through working relationally with women and supporting choice. However, the reach of the hospital into the community spaces through the implementation of clinical guidelines

results in the deconstruction of ante-natal care into measurable segments. The *Saving Babies Lives Care Bundle* (NHS England 2016) requires the identification and measurement of aspects of fetal growth and well-being that can be quantified; symphysis –fundal height and amniotic pool depth for example. It does not address the social determinants of health which predispose some women to an increased risk of stillbirth. Similarly, the measurement of BMI over a certain threshold would indicate referrals to an obstetrician and anaesthetist is required, suggesting that the risks of obesity are only evident when this threshold is met, ignoring the antecedents to obesity and its relationship to poverty for example (O'Dare Wilson 2017). Public health and health promotion are fundamental aspects of the midwives' role (RCM 2017). The community midwife, with her appreciation of the lived circumstances of women and families is perfectly placed to provide culturally sensitive and appropriate health promotion and advice, but this aspect of their role did not feature in their discussions, beyond an awareness of how their circumstances impacted on the woman's ability to participate in care and exercise choice.

The deconstruction of ante-natal care into its discrete risks, and the application of the attendant guideline in an attempt to manage those risks leads to a situation where every individual recommendation made by a guideline may be rational and evidence based, but the sum of all recommendations in an individual is not, as it frequently fails to take into account the context in which women live. An evaluation of the *Saving Babies Lives* (NHS England 2016) care bundle indicates that there is no clear correlation between the implementation of the measures set out in the care bundle, and the reduction in stillbirths (Widdows, Roberts, Camacho and Heazell 2018). In fact, the stillbirth rate in 2019 was the lowest since records

began in 1927, and a 4.9% decrease compared with 2018 (ONS 2019) which suggests factors other than the increased surveillance of pregnant women have contributed to the reduction. Smoking prevalence for example has shown a statistically significant decline since 2011 (ONS 2019) and this may have had a greater impact on stillbirth rates.

The evaluation of the Saving Babies Lives care bundle (NHS 2016) does demonstrate a 19% increase in labour inductions. This suggests that maternity care aimed at avoiding extremely rare risks of significant harm takes precedence over the more likely outcome of exposure to morbidity because of unwarranted interventions. The consequences of this intervention may impact on the woman's ability to make choices about where and how she births her baby. The community midwives, working relationally with women in their homes and community spaces spoke of their intention to provide the individualised, women centred care which is a central tenet of midwifery care, yet were required to practise in a way which reduces midwifery care to a series of discrete components which may require a bespoke response.

In a study by Browne (2014) of midwives working in Australia, their geographical remoteness meant that they could not easily refute or confirm their clinical assessment with the use of technology. The midwives were reliant on their highly developed clinical and observational skills to determine maternal and fetal wellbeing, demonstrating that in these spaces, this knowledge was privileged over technological knowledge. In my study, the community midwives were geographically and figuratively closely aligned with the hospitals which meant that they often privileged technological, biomedical knowledge as authoritative

knowledge. McAra Couper, Jones and Smythe (2011) assert that the power of technology means that skills and processes that sit outside the technological network are viewed as quaint and old-fashioned. For example, the pinard stethoscope has traditionally been used by midwives to listen to the fetal heartbeat. This has been largely superseded by a handheld Doppler which uses ultrasound to detect movement of the fetal heart muscle or valves which are converted into a sound that can be heard and counted. The Doppler has the advantage of the sound being audible to the woman and provides an audible record of fetal wellbeing which can be confirmed by the woman. Technology is therefore associated with safety and reducing risk, which in this case is risk to the practitioner. Normal pregnancy and birth, in this technological age, may be viewed as physiologically inefficient, messy, risky and painful and in need of technological interventions to control, predict and organise pregnancy and birth. For the community midwives in this study, the ready availability and close proximity of technology meant that not using it, or declining its use, was considered risky.

#### **6.1.4 Docile bodies and midwifery abdication**

As lead professionals for normal pregnancy and birth, the community midwives were impacted by this ever-narrowing window of normality (Scamell and Alaszewski 2012, p207) recognising that as fewer women were considered “low risk” they had to redefine their scope of practice, accepting that women who would usually be advised to birth in hospital could be cared for in the home. The community midwives indicated that they supported choice for women, but this was often within the window of what they deemed possible. What they deemed

possible was contingent of their experience, and the support they received from their supervisors.

The inability of midwives to choose not to support community births considered high risk was highlighted by a number of midwives in their interviews. This was invariably followed by a discussion on the perceived risk on their personal and professional status as a consequence of women's choices. The primacy of this concern to midwives is supported by the literature (Surtees 2009, Scamell 2012, Thompson 2013, Skinner 2016). In line with the studies included in the literature review which indicated midwives resisted maternal bodily autonomy in situations considered risky (Danerek, Marsal, Cuttini, Lingman et al. 2011, Jenkinson, Kruske and Kildea 2017), the community midwives here also feared the censure of peers and managers relating to their decision making. This was in part due to the relative isolation in which they worked which meant that they could not discuss aspects of care with anyone and so felt accountable for their actions and decisions. The community midwives described examples of overt behaviours from peers, such as eye rolling, or mocking tones in response to their decisions, but also provided examples where wrongdoing was insinuated, as in the request to speak with a manager. It was interesting to note that perceptions of risk did not diminish with years' experience. Those midwives who had the most years of service recognised that they were more comfortable with degrees of clinical risk because of their experience but perceived the risks to them personally and professionally were very high, in part due to a belief that, from an organisational perspective, an adverse outcome was always someone's fault. It was sobering to hear them remark that they just wanted to finish their careers without censure, a sentiment supported in a study by Skinner and Maude (2016) who found that

experienced midwives were more comfortable with dealing with the women's risk than in dealing with their own.

Their willingness, albeit reluctantly at times, to support births that would normally be managed in the hospital put them at odds with the Trust's stance, articulated through the information leaflets, and left them feeling personally and professionally vulnerable, demonstrating how discourses of choice and risk impacted on the midwives' practice. The dominant medico-technological discourses of the *leaflet 1* and the host website determined the roles of midwife, doctor and woman as patient, identified the determinants of a "low risk" pregnancy and birth, and identified the strategies for the management of pregnancy and birth. This stance is analogous to Foucault's disciplinary power (Foucault 1970), creating docile bodies (Foucault 1979 p126) in that the subjects; midwife, doctor and woman/patient are properly ordered and normalised to the extent that they repeat and renew this discourse. The discursive construction of the women as patients in the leaflets and websites undermines the concept of women as self-determining choosing agents, instead reinforcing a hierarchal framework where healthcare professionals are knowledgeable and authoritative and therefore able to direct choices. The interview transcripts showed that the community midwives were not docile to the extent that they were prepared to broaden their scope of practice and care for women who would normally be advised to birth in hospital but were clearly conflicted by working outside the established guidelines, even if they did not necessarily agree with them. This conflictual state was not stable though, but contextual and dynamic, occasionally influenced by events that may have resulted in an unexpected outcome for a woman, fetus or colleague, and influenced by their own perceptions of risk. Although the community midwives valued working in

the community because they perceived that they had greater autonomy away from the surveillance of the hospital-based managers, they still exercised self-surveillance, shaping their identity and purpose under the influence of the dominant medico-technological discourses. Midwifery led care according to the community midwives was not a bounded scheme or defined concept, but more a temporal construct, based on the midwives' own experience, knowledge and perceptions of risk. That women would not know the contingencies placed on their midwife further demonstrates how the midwives exerted their power to influence choice.

The effects of attempting to overcome the barriers and challenges when supporting choice may lead to what Jefford, Jomeen and Wallin (2018) refer to as midwifery abdication, defined as when,

*“a midwife surrenders one’s voice and/or forsakes one’s midwifery skills and/or knowledge, consciously or unconsciously, failing to fulfil and be accountable for one’s professional behaviour in accordance with professional frameworks as primary maternity care provider for the woman”*

(Jefford, Jomeen and Wallin 2018 p1).

They argue that some midwives may abdicate their professional role as a result of seeing herself to be disempowered by someone, or something within or outside the childbearing setting. Communication, cultural safety or being in an environment with raised stress levels were found to be contributing factors to midwifery abdication (Jefford, Jomeen and Wallin 2018).



The midwives' internal perceptions of community midwifery practice, working autonomously as experts in normal pregnancy and birth, supporting women to make choices that are right for them, were challenged by a pervasive medical discourse that viewed pregnancy and birth as risky, and steps must be taken to mitigate risk. If the external environment has a risk philosophy that is not supportive of a midwife's professional autonomy and scope of practice, therefore failing to support or erode normality, the midwife may become silent, disempowered and obedient (Jefford, Jomeen and Wallin 2018).

Obedience was the focus of a study by Hollins-Martin and Bull (2007) who found that midwives struggled to support the safe, evidence-based choices of women in their care because they felt obliged to follow hospital guidelines and were reluctant to challenge senior staff, particularly the consultants. To circumvent acting in ways that the midwives perceived were not in the woman's best interests, the midwives relinquished responsibility to senior staff. They concluded that midwives were placed in positions of relative powerlessness, but that actions and strategies adopted by the midwives also reinforced the fundamental power structures and status quo. The findings from this study are also supported in later studies by O'Connell and Downe (2009) and Pollard (2011). These studies are conducted in hospital maternity units, where the presence of senior staff can be seen to curtail the midwife's ability and willingness to practice autonomously. In the community, midwives were not directly supervised, and stated that working independently was a prized aspect of their work, but also demonstrated a degree of powerlessness. This was seen in the ways the community midwives consciously and unconsciously withheld information from women in order to fit in with the external environment, and unwillingness to advocate for women's choices to be heard. It

was also seen in the ways in which the midwives felt unable to articulate their concerns about supporting women to birth at home who might normally birth in hospital, with one midwife commenting that it would have been helpful if the community midwife was involved when planning for a birth that would normally take place in hospital. Here her loss of professional voice might be attributed to her perception that the woman belonged to the obstetrician and therefore it was safer for the medical team to decide the plan of care.

Jefford, Jomeen and Wallin (2018) identified three associated concepts occurring in midwifery abdication; knowing but failing to act, perceptions of midwifery practice, and prioritisation of the woman's needs to the exclusion of anyone and everything else. From my study I have identified an additional concept, where the midwife consciously or unconsciously disengages from the organisation and management of community midwifery services. The community midwives enjoyed the benefits that their location in the community afforded them, and at the same time felt their role in the community was poorly understood within the wider maternity services. The community midwives in my study were, to a greater or lesser extent, separate from the trust's maternity services. Three of the midwives were required to start and end their shift at the trust, but another three had not been to their employing trust for many months, and there was a sense that they cultivated this separation, discursively referring to the Trust as another place, as in "up there", or being "called in".

Community midwifery services were found to be relatively peripheral to the wider maternity services in the study by McCourt, Rayment, Rance and Sandall (2012). In their analysis of high performing maternity services, they found that community

midwife participation in the organisation's clinical governance and audit procedures was low. In this environment, midwives that did participate saw value in clinical guidelines, not only as integral to safe care, but also to clarify and protect the midwifery-led scope of practice. Involvement in the trust's governance processes would seem to provide an opportunity to ensure community midwifery practice was articulated by knowledgeable midwives who understood the constraints and possibilities of the workspace. Returning to Mackenzie Bryers and van Teijlingen's (2010) assertion that there is a benefit in defining pregnancy and childbirth as a medical event rather than a social experience because by doing so the intellectual and social capital, and therefore the power, resides within the medical model, the midwives' isolation in the community, and their lack of participation in the Trust's processes, has the effect of making the midwifery contribution to pregnancy and birth invisible, perpetuating obstetric hegemony. However, their willingness to be interviewed, and the extent to which they disclosed their sometimes-difficult experiences of community midwifery would suggest that opportunities to reflect on and share practice would be welcomed by the midwives. This would have the effect of making the community midwifery contribution to maternity care visible, highlighting training and development needs across the service.

#### **6.1.5 Community midwifery risk discourse**

The findings point to the emergence of a community midwifery risk discourse. As stated at 4.1.4, discourses are formed by a pattern of words, figures of speech, concepts and values and gather round an object, person or event providing a way of making sense of that object, person or event. Discourses are textual in that they are expressed in texts; intertextual in that they influence and are influenced by

other texts to achieve meaning and are contextual in that they are influenced by political, historical and cultural factors.

The community midwives ontologically privileged pregnancy and birth as social as well as biological constructs. This could be traced to midwifery philosophy where historically, childbirth is viewed as a natural healthy phenomenon, trusting and valuing the woman and her body to undertake this event. The midwifery knowledge includes assessing for and identifying risks to the wellbeing of the woman and fetus, and referring on when appropriate, but always recognising the woman's autonomy and her perception of the risk. This position was expressed in *Leaflet 2* and also in the transcripts of the interviews with the community midwives.

The community midwives occupy a space where there is a cultural acceptance of the medical presumption that a woman's body will fail, so intervention is necessary. This can be traced to a medical knowledge which views pregnancy and birth as risky, requiring medico-technological approaches to manage the risk, and expressed through clinical guidelines. Maternal autonomy is boundaried because the woman is discursively constructed as a patient, and in the patient/clinician encounter, the power/knowledge resides with the clinician. This position was expressed in *Leaflet 1*, and the host website, and also in the transcripts of the interviews with the community midwives.

The medical discourse, derived from "scientific" knowledges expressed in clinical guidelines and which is then re- appropriated in information leaflets aimed at helping women make choices about their care, is the dominant discourse. Within

the community, a point of discursive transformation can be recognised as the discourse of community midwifery and the medical discourse merge.

The community midwifery risk discourse coalesces around pregnancy and birth, enabling the subjects; woman, community midwife and doctor to appear. The power/knowledge of the discourse is located in a midwifery discourse with a codicil of risk. The risk is not necessarily of the kind that midwives are educated and competent to assess and manage, but the risk of censure, threats to their professional status, and the consequence of adverse outcomes. The woman's hand-held notes become an object of discourse through which midwives attempt to manage the effects of risk. Their position in the community, working alone and without access to the resources available in the hospital setting, yet bound by the clinical guidelines determined by the hospital, means that the community becomes a disciplinary space where the midwives exercise self-surveillance. The location of the woman and the midwife within the discourse means the subject of choice becomes conditional and contingent upon factors that may not be known to the woman.

## **Chapter 7**

### **7 Conclusions and Recommendations**

#### **7.1 Introduction**

This chapter sets out the conclusions from my research and outlines the implications of the study for policy and practice. The study's contribution to

knowledge is highlighted and the limitations of the study are also discussed. The chapter concludes with recommendations for practice.

## **7.2 Conclusions**

This original study provides a unique insight into the barriers and challenges experienced by community midwives when supporting women to make choices regarding their pregnancy and birth. The paucity of literature on the experiences of community midwives has been addressed, making a significant contribution to the evidence base. The study provides understanding of the milieu the midwives work in, and the impact of overt, opaque and hidden structures of power and knowledge on their thoughts and actions.

The study findings are supported by the existing literature, but they also highlight new discoveries through the identification of a community midwifery risk discourse. The significance of community as a workplace, with its own behavioural norms, values and assumptions has been highlighted. Their position in the community, working alone and without access to the resources available in the hospital setting, yet bound by the clinical guidelines determined by the hospital, means that the community becomes a disciplinary space where the midwives exercise self-surveillance. The location of the woman and the midwife within the discourse means subject of choice becomes conditional and contingent upon factors that may not be known to the woman.

The findings of this study offer insights into community practice which complement the existing literature. For example, the bounded nature of maternal autonomy was more evident in the literature than in this study. Much of the literature is

focussed on what may be described as the “worst case”; when trust and confidence has broken down and women choose to birth out of the system, or practitioners withdraw their services or access to facilities. In contrast, the findings of this research often captured the everyday interactions between midwives and women regarding choice, and as such is more reflective of contemporary midwifery practice. The findings indicate that although the midwives knew that maternal autonomy was limited to an extent by the Trust through their guidelines, they were prepared to work outside them to support women centred care. Common in this study and the literature are the professional and personal concerns that these actions raise for midwives.

The professional and organisational barriers to choice placed on the community midwives in this study are also found in the literature. The qualitative methodological approaches used in the literature explored the experiences of women midwives and medical staff, but the methodologies used do not analyse the hidden, opaque and visible structures of power and control that inform those experiences. By adopting a Foucauldian discourse analysis, this study provided insights in the ways organisational power and professional knowledge, expressed through written guidelines and images, but also ways of speaking and looking, informed the ways in which the midwives felt able to present options to women. In line with the existing evidence, the fear of censure was pervasive, compounded by their perceived lack of managerial support and relative isolation from the Trust’s governance procedures, contributing to a loss of a professional voice. Adopting strategies to minimise this was a finding in this study and the literature, but the relative isolation in which the community midwives worked meant that the woman’s hand-held notes became the vehicle in which to create an auditable

decision trail. The importance of robust documentation is not new and is a legal and regulatory requirement, but this study indicates that the hand-held notes are particularly significant in community midwifery practice.

### **7.3 Implications for policy and practice**

This study is timely, given the expectations placed on community midwives to support women to make choices about their maternity care. As discussed at 1.1.3 the concept of choice in maternity care has exercised policy makers for over 30 years. *Better Births* (NMR 2016) positions the community midwife as a key professional in facilitating women's informed choices but as this study shows, she faces a number of barriers and challenges.

The barriers and challenges faced by community midwives when attempting to offer choice to women are not new, but until they are addressed, genuine choice in maternity care will remain at the level of policy but not practice. The ontological positioning of hospitals as places that treat the sick, infirm and vulnerable means that maternity services within a hospital are part of the system. Community midwifery services are, by extension, part of the same system, evidenced in the use of guidelines which reach into the community, determining practice and therefore shaping choice.

This study had shown that the community is a distinct workplace with its own behavioural norms, values and assumptions. To work safely and effectively in a workplace, midwives need training, support and supervision. For policy that requires the community midwife to be a key professional in facilitating informed choice, as well as supporting normal pregnancy and birth, the community needs to



be seen as a separate domain that requires a distinct set of skills requiring specific development and training needs. Here it may be worth considering the ways community midwifery services were initially established in the years before the inception of the NHS and described at 2.1.15. Community midwifery services provided through the lens of public health, rather than ill health would encapsulate wider determinants of health; diet, psychological wellbeing, housing and lifestyle and this study shows that these can be the barriers experienced by women which impact on genuine choice and importantly, the health and wellbeing of future generations. The significant evidence that demonstrates the impact of midwifery continuity of care indicates that the community midwifery model of care is key to improving the health and wellbeing of the woman, her family and the wider health economy. Development of the community midwife role to incorporate a specialist public health remit could help to raise the status of the community midwife and attract funding for training and development.

For the community to be acknowledged as a distinct workplace, community midwives need to articulate the differences and propose solutions. Their relative isolation from the Trust makes this difficult, but the study finds that currently, their professional voice is not heard. Trust guidelines applied in the community setting, with a concomitant impact on meaningful choice, such as primiparous women not being “allowed” to birth at home, are a source of personal stress and professional conflict. Through participation in Trust governance and audit processes, community midwives can ensure guidelines reflect the environment in which they practice and work autonomously within their full scope of practice.

Midwifery education needs to ensure that it is based on the midwifery philosophy that pregnancy and birth are normal, healthy events and that midwives trust and value the woman and her body to undertake this event. A focus on wellness, as opposed to seeking out potential complications, facilitates autonomy and accountability in the midwife, as opposed to leaning towards medico-technological solutions, enabling her to work within the full scope of practice.

## **7.4 Limitations of the study**

The selected leaflets may not be representative of the perspective of other Trusts of similar size and service provision. Similarly, the number of community midwives interviewed was small, and therefore the findings cannot be generalisable to other maternity settings but does set out a credible exploration of the challenges faced by community midwives when supporting choice.

The interpretation of the datasets; the leaflets, websites and interview transcripts are mine and I am aware that others might interpret the data differently. Although I have used supervision sessions to discuss my interpretations, an additional researcher would have strengthened the analysis.

## **7.5 Recommendations**

### **7.5.1 For practice:**

- i) Midwifery education should aim to prepare midwives to work autonomously within their full scope of practice.

- ii) Community midwifery practice could be considered as a distinct area of practice with a defined philosophy, skill set, education and training requirements, clinical guidelines and supervision structure.
- iii) Representation of Community midwifery services at Trust governance processes and committees ought to be considered.
- iv) Community midwives should be encouraged and enabled to participate in local governance processes, such as audit and guideline development
- v) Closer alignment of community midwifery services and public health bodies may help to address the determinants of health which impact on the ability of women and families to make meaningful choices.

### **7.5.2 Research Dissemination**

To improve understanding of how community midwives can facilitate informed choice;

- i) Research findings from this DProf to be shared in the practice setting so that findings facilitate opportunity to discuss barriers to choice for women.
- ii) This was a small study; an opportunity to build on these findings aligned to the impact of policy implementation, such as *Better Births* (NMR 2016) to measure influence on choice.

## 8 Appendices

## 8.1 Data charting form

Author(s), Title, year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Henshall C, Taylor B &amp; Kenyon S (2016)</p> <p>A systematic review to examine the evidence regarding discussions by midwives, with women, around their options for where to give birth.</p> <p>Europe, North America or Australasia</p> <p>Study 1</p>	<p>3087 Midwives working in any midwifery setting, who were practising or had practised in Europe, North America or Australasia</p>	<p>What is known about midwives' views of their discussions with women about their options for where to give birth?</p> <p>Have any interventions been implemented to support midwives' place of birth discussions (POB) with women? If do, what were the barriers and facilitators to implementing them and have the interventions been effective?</p>	<p>Systematic review with clear inclusion &amp; exclusion criteria.</p> <p>11 studies were eligible for review</p>	<p>Midwives felt pressured to recommend hospital birth or be selective in the POB options presented due to hospital policies, risk of conflict with medical colleagues, the pressure to conform and the risk of litigation. The lack of time to have POB discussion, and staff to support HB were also factors.</p> <p>A lack of knowledge and confidence meant midwives would not offer HB as an option.</p> <p>Midwives alter the content of their POB discussions according to assumptions about whether women could or should have access to POB options.</p> <p>Interventions, such as leaflets, did not increase the proportion of women who reported exercising informed choice. Women attending a birthplace workshop reported being more likely to be offered a choice of POB.</p> <p>None of the studies provided sufficient evidence of effectiveness of the interventions.</p> <p>Further high-quality research is needed to explore what the main influences are on midwives POB discussions to identify appropriate strategies and interventions which support informed choice.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Holton L, Hollander M &amp; de Miranda (2018)</p> <p>When the Hospital is no Longer an Option: A Multiple Case Study of Defining Moments for Women Choosing Home Birth in High-Risk Pregnancies in The Netherlands</p> <p><a href="#">Study 2</a></p>	<p>10 case studies and the associated women, their partners and health care professionals</p>	<p>To explore how the wish to birth outside the system was negotiated in consultations/clinical encounters between pregnant women and their health care professionals (HCPs).</p> <p>Special attention was given to the defining moment in the decision to leave the regular maternity care system</p>	<p>Multiple case study design using grounded theory &amp; triangulation. 10 cases in which Dutch women with high risk pregnancies chose to birth at home against medical advice</p>	<p>Previous trauma can influence a woman's choices.</p> <p>HCP's were convinced that they had counselled women adequately, but women perceived it as paternalistic and reduced their autonomy.</p> <p>Child protection services were invoked by the HCP in 3 cases.</p> <p>Women were perceived as inflexible and would disengage with services. In some cases, women were denied admission to facilities.</p> <p>The defining moment occurred when the hospital was no longer perceived as a safe place.</p> <p>HCP's find it difficult that the women question their biomedical risk definitions.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Danerek M, Cuttini M, Lingman G, Nilstun T &amp; Dykes A (2011) Attitudes of Midwives in Sweden Toward a Woman's Refusal of an Emergency Caesarean Section or a Caesarean Section on Request</p> <p>Sweden</p> <p>Study 3</p>	<p>259 midwives from 13 maternity units with neonatal care facilities</p>	<p>Describe the attitudes of midwives in towards a woman's refusal of an emergency caesarean section or a caesarean section on request</p>	<p>Quantitative study using a structured self-administered questionnaire for data collection.</p> <p>Attitudes of the midwives were investigated using fictitious cases.</p>	<p>Results compared with the Perinatal Technology &amp; Ethical Decision-Making During Pregnancy &amp; Birth: Monitoring the Attitudes of Obstetricians from Eight European Countries (EU-ROBS)</p> <p>Only 21% of the midwives would respect a woman's autonomy to refuse an emergency LSCS with the midwives appearing to focus on the health of the baby.</p> <p>Approximately a quarter of the midwives believed that the woman should be told that her life might also be in danger, despite the absence of indicated risk for the woman in the vignette.</p> <p>The midwives at university hospitals were less likely to accept a woman's autonomy in this respect.</p> <p>77% of the midwives stated that a women's request for a CS in the absence of any medical indication should be refused.</p> <p>A small group (8.1%) felt that a woman's request for a CS should always be refused</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Van Wagner V (2016)</p> <p>Risk Talk: Using evidence without increasing fear.</p> <p>Canada</p> <p>Study 4</p>	<p>50 Canadian midwives, doctors and nurses involved in maternity care.</p> <p>Sample drawn from practitioners who had identified an interest in EBP through publication or conference presentation or online forums.</p>	<p>The application &amp; misapplication of evidence-based practice (EBP) in Canada.</p>	<p>Qualitative study using semi-structured interviews and thematic analysis of maternity care conference presentations</p>	<p>EBP functioned less of a way of providing information &amp; choice and more as a risk management approach.</p> <p>Info based on evidence creates risk talk, creating a culture of fear and risk aversion with women appearing to “lean towards technology”.</p> <p>Respondents aware that they needed to put risk into perspective and noted that maternity care tended to emphasize risks of non-intervention and the benefits of intervention.</p> <p>Active listening, sharing uncertainty and contextualising information in a way that respects women’s goals and values were considered to be the way forward</p>



Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Jenkinson B, Kruske S &amp; Kildea S (2017)</p> <p>The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis.</p> <p>Australia</p> <p>Study 5</p>	<p>9 women, 12 midwives &amp; 9 obstetricians.</p> <p>Setting(s) not stated</p>	<p>to analyse the experiences of women, midwives and obstetricians when women decline recommended maternity care.</p>	<p>Feminist thematic analysis of semi-structured interviews.</p>	<p>Clinicians invoked negative judgements of women as mothers and reported concern over fetal wellbeing.</p> <p>Evidence of risk for women's preferences (VBAC2, VBB, no CFM) is contested and indicated a refusal, rather than a request for intervention.</p> <p>Women's decisions took account of the needs of their families, their born children and themselves.</p> <p>Clinicians described "a line in the sand" which bounded women's autonomy and their clinical practice. In some cases, care was withdrawn from women.</p> <p>Differences were noted between professional groups, but midwives still adopted intrusive strategies to get women to conform.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>McCourt C, Rayment J, Rance S &amp; Sandall J (2012)</p> <p>Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies UK</p> <p><a href="#">Study 6</a></p>	<p>Professionals &amp; stakeholders (n=86)</p> <p>women (n=64)</p> <p>partners (n=6)</p> <p>50 observations</p> <p>200 service documents across 4 maternity services selected from the Birthplace cohort study</p>	<p>To examine the factors affecting the readiness of community midwives (CMW) to provide women with choice of out of hospital birth</p>	<p>Organisational ethnographic case studies focussing on the systems of care.</p>	<p>"Stakeholder" not defined.</p> <p>Out of hospital birth was perceived by Trusts as an expensive add-on and not necessarily part of an integrated maternity service.</p> <p>Shortage of CMW's resulted in inequity as not all planned home births could be facilitated.</p> <p>CMW's lacked confidence in HB through lack of exposure. Higher birth rates in FMU's suggest midwives were more confident attending births and arranging transfer.</p> <p>Despite having a CMW service in the UK, little attention has been given to their training &amp; preparation, and their integration within the overall service.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
Scamell M (2014) “She can’t come here!” Ethics and the case of the birth centre admission policy in the UK.  UK  Study 7	Case study drawn from an ethnographic study involving 33 midwives responsible for intrapartum care	To be attentive to the UK maternity policy mantra of <i>women-centred care</i> with a focus on autonomy, and ethically scrutinise birth choice in relation to place of birth.	Secondary data from an ethnographic study involving 33 midwives responsible for intrapartum care in a variety of settings.	Women have a choice of where to give birth provided their bodies fit within a predetermined risk parameter set by guideline recommendations. Guidelines set by professional bodies such as the RCM.  Rights here are conceptualised through the medico-judicial system, which is inconsistent with a woman-centred approach to care. Care at the birth centre is conceptualised as a “treatment” which according to tort law, patients do not have the right to demand.  Draws analogy with hospice care when people decline further treatment.

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Licqurish S &amp; Evans A (2016)</p> <p>“Risk or Right”: a discourse analysis of midwifery and obstetric colleges’ homebirth position statements.</p> <p>Australia</p> <p>Study 8</p>	<p>Australian obstetric and midwifery college’s position statements about homebirth</p>	<p>To investigate the apparent tensions between the professions of midwifery and obstetrics positions on home birthing.</p>	<p>Discourse analysis</p>	<p>The obstetric statement is an academically strong paper and persuasively presents the risks to the neonate in home birth.</p> <p>The midwifery statement does not develop a scientific argument about fetal wellbeing but puts forward a number of assertions about choice. Although the position is that women’s choice is paramount, the implicit assumption is that to support HB, midwives need to adhere to prescriptive rules in order to reduce the risk.</p> <p>The underlying assumption made by the obstetric paper is that women who pursue home birth must be counselled to ensure that they make an informed choice, but women who choose to birth in a hospital do not. Therefore, there is an implicit assumption that hospital is the only normal and rational choice.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Molenaar J, Korstjens I, Hendrix M, de Vries R &amp; Nieuwenhuijze M (2018)</p> <p>Needs of parents and professionals to improved shared decision-making in interprofessional maternity care practice: a qualitative study</p> <p>The Netherlands</p> <p>Study 9</p>	<p>10 parents 15 obstetricians 15 maternity care assistants 13 hospital-based midwives/obstetric nurses based in two regional obstetric units</p>	<p>To explore the experiences and needs of parents and professionals regarding shared decision making in interprofessional antenatal, natal, and post-natal care.</p>	<p>Qualitative design using focus groups</p>	<p>Parents and professionals recognised the steps of introducing a decision (choice talk) and discussing options (option talk) but most parents did not discuss preferences and weigh options before reaching a final decision (decision talk).</p> <p>Professionals preferred it when parents were well prepared and informed.</p> <p>For shared decision making to work, good interprofessional communication is required.</p> <p>Researchers draw a distinction between informed consent approach and shared decision making, where the decision is made in conjunction with the professional</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Noseworthy D, Phibbs S &amp; Benn C (2013)</p> <p>Towards a relational model of decision making in midwifery care.</p> <p>New Zealand</p> <p>Study 10</p>	<p>Eight midwife-woman pairs in urban settings in NZ</p>	<p>To critically explore current issues around decision-making in the midwife-woman relationship</p>	<p>Qualitative study involving pre and post-natal interviews around decision-making within childbirth in general and the 3<sup>rd</sup> stage of labour in particular.</p>	<p>Women in this study appointed a m/w that shared a similar birthing philosophy. Midwives were able to set out their boundaries, and women then chose to opt into the care.</p> <p>Decision-making is influenced by complex human, contextual and political factors.</p> <p>Relational trust was salient when difficulties arose in labour which reduced a woman's autonomy and choices.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Welsh J &amp; Symon A (2014)</p> <p>Unique and proforma birth plans: a qualitative exploration of midwives' experiences.</p> <p>UK</p> <p>Study 11</p>	<p>9 midwives; 4 of whom worked in an MLU, 5 on a consultant led unit in the east of England.</p>	<p>To explore midwives' experiences of birth plans.</p> <p>To compare the experiences of midwives in two different environments.</p>	<p>Qualitative study using an interpretive phenomenological analytical approach</p>	<p>Two types of birth plans were identified; the <i>proforma</i> type in the HHN and <i>unique</i> plans which were free-text documents.</p> <p>MW's in both groups felt the term plan was misleading in that it led women to have unrealistic expectations about the birth and that it created pressure for midwives.</p> <p>MLU midwives felt that plans did not reflect how women might cope, but CLU midwives felt women did not understand that they were not in control of their labour.</p> <p>Both groups expressed irritation at the implication they would not act in the woman's interests. The NCT were identified as key to this.</p> <p>Both groups felt under pressure, with CLU midwives feeling more constrained by rules &amp; regulations</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>McAra-Couper J, Jones M &amp; Smythe L (2011)</p> <p>Caesarean -section, my body my choice: The construction of “informed choice” in relation to intervention in childbirth</p> <p>New Zealand</p> <p>Study 12</p>	<p>Nine midwives and obstetricians, and 33 women</p>	<p>To investigate the shaping of understanding and practice in relation to rising rate of intervention in childbirth</p>	<p>Hermeneutics</p>	<p>Choice is not an independent, value-neutral entity, but is influenced and constructed by the surrounding context and culture.</p> <p>Choice is always situated; surgical birth is part of the normalisation of surgical procedures aimed at women.</p> <p>Clinicians supporting women’s requests for C/S face ethical dilemma regarding choice, autonomy &amp; maleficence.</p> <p>Choice and decision making are vested in the pregnant woman and the expert is left presenting a series of options. The woman’s informed choice is always the right choice, and the authority of the expert is seen to be secondary.</p>



Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Hertig S, Cavalli S, Burton-Jeangros C &amp; Elger (2014).</p> <p>“Doctor, what would you do in my position?” Health professionals and the decision-making process in pregnancy monitoring.</p> <p>Switzerland</p> <p>Study 13</p>	<p>26 obstetricians and 15 midwives in a large Swiss city.</p>	<p>To describe how professionals negotiate their role when a pregnant woman asked them to become involved in the decision making process in pregnancy monitoring.</p>	<p>Qualitative study using semi-structured interviews</p>	<p>Three profiles were identified:</p> <p>Enforcing responsibility: the professional role is restricted to that of a service provider. They perceive that risk is a personal decision to be borne by the woman. Emotions, subjectivity and values are removed from the professional’s role.</p> <p>Sharing the decision-making process: these professionals were situated between distance &amp; proximity. They acknowledge that non-directiveness is important but sometimes depart from this in order to match the woman’s requests. These professionals did not hide the impact of their personal philosophy however their reflexive stance and awareness of the power imbalance conforms to professional ethics.</p> <p>Getting involved in the decision: these professionals define their involvement as a sign of quality in the woman-professional relationship. They are critical of the excessive formalism related to medicolegal fears arguing that a close relationship with the woman is a stronger guarantee of medicolegal protection than a defensive attitude.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Newnham E, McKellar L &amp; Pincombe J (2017)</p> <p>“It’s your body, but..” Mixed messages in childbirth education: Findings from a hospital ethnography</p> <p>Australia</p> <p>Study 14</p>	<p>16 women &amp; hospital staff, primarily midwives and doctors participated during six months of participatory fieldwork in a tertiary hospital.</p>	<p>To investigate the personal, social, cultural and institutional influences on women making decisions about using epidural analgesia in labour</p>	<p>Ethnography</p>	<p>Midwives were observed in antenatal classes and not explicit about the effects of epidural analgesia—they would explain the process of insertion, but not the associated risk factors.</p> <p>Midwives encouraged women to trust their birthing ability and at the same time constantly referred to the rules of the institution. Midwives attempted to espouse midwifery philosophy of normal birth but needed to moderate this to convey the fact that the institution does not really trust this.</p> <p>Women recounted the consent process for epidural analgesia, often humorously, but it was not evident that fully informed consent had been secured.</p> <p>The researchers compared this with information on water birth. Women needed to complete documentation antenatally and this was discussed in the antenatal classes with a sense of restriction and prohibition. Women needed to be “eligible” for a water birth.</p> <p>Midwives felt obliged to provide women with the reality of the hospital in which they were working, and women felt they had to “read between the lines” of what the midwives were saying.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Catling C, Petrovska K, Watts A, Bisits A &amp; Homer C (2016)</p> <p>Care during the decision-making phase for women who want vaginal breech birth: Experiences from the field.</p> <p>Australia</p> <p>Study 15</p>	<p>5 obstetricians and 4 midwives from two tertiary hospitals.</p>	<p>To explore how experienced clinicians facilitated decisions about external cephalic version and mode of birth</p>	<p>Descriptive exploratory design involving face to face interviews and thematic analysis</p>	<p>Four key themes were identified.</p> <p>Pitching the discussion: clinicians stressed that BB was not bad but required a different approach. Clinicians needed to gauge the woman's feelings about mode of delivery, frame risk information in an accessible way and take account of the woman's medical and obstetric history.</p> <p>Discussing risk and safety: clinicians used evidence (term breech trial) but contextualised this for women. Discussing very rare potential complications was not thought to be helpful. Women's choices were respected after full information regarding mode of birth had been provided.</p> <p>Being calm: clinicians were aware that this information was being provided late in pregnancy. Women needed time to make decisions.</p> <p>This was enabled by ensuring continuity of care and it ensure effective shared decision making.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Panda S, Daly D, Begley C, Karlstrom A, Larsson B, Back L &amp; Hildingsson I (2018)</p> <p>Factors influencing decision-making for caesarean section in Sweden- a qualitative study.</p> <p>Sweden</p> <p>Study 16</p>	<p>11 midwives and 5 obstetricians from 2 Swedish maternity hospitals</p>	<p>To explore Swedish obstetricians' and midwives' perceptions of the factors influencing decision making for CS in nulliparous women in Sweden.</p>	<p>A qualitative design with four recorded focus group interviews</p>	<p>All participants shared the belief that normal birth is best for women and babies and offers the best possible outcomes. CS was only performed when there was a sound justifiable reason and usually in an emergency and when normal birth was no longer an option. Midwives agreed that obstetricians always promote normal birth.</p> <p>Maternal request for CS was uncommon.</p> <p>Participants described a team approach to improving outcomes and included group discussion and retrospective case analysis as key factors in MDT working. There was a shared understanding of the place of MWLC and the care pathways.</p> <p>Fear of litigation was not a concern.</p> <p>Women played very little role in decision making when a CS was performed in an emergency.</p> <p>Clinician experience was thought to be a factor in the decision to perform a CS, with more experienced clinicians inclined to leave women longer. Avoiding induction of labour was also seen as key to minimising CS rates.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Soltani H, Fair F &amp; Duxbury A (2015)</p> <p>Exploring health professionals' and women's awareness of models of maternity care evidence.</p> <p>UK</p> <p>Study 17</p>	<p>Practising midwives and obstetricians' at large teaching maternity unit in the Yorkshire and Humber region, where labour care is organised into midwifery-led care either at home or in an alongside midwifery unit or obstetric care in an obstetric unit.</p> <p>Eligible women for the survey included those who were currently pregnant or those who had given birth from 2008 when the original Cochrane midwife-led care review was published.</p>	<p>To evaluate maternity users' awareness of midwife-led care supporting evidence and the extent to which it influences their choices from both the mothers' and practitioners' perspectives.</p>	<p>An online survey explored awareness of evidence regarding maternity care models with a focus on advantages and disadvantages of midwife-led continuity models versus other models of care. It contained both open and closed questions that explored what specific evidence professionals were aware of regarding midwife-led care, what evidence they had recently accessed, what evidence they would consider accessing in the future, and how they provided information to women to enable them to make choices about place of birth.</p>	<p>Fifty-nine health professionals completed the professionals' survey, which gave a response rate of 15.1%. Forty-eight respondents were midwives, five were obstetricians and six did not complete this question. When asked about their awareness of evidence, 82% of professionals were aware of homebirth evidence and 78% aware of midwife-led care evidence. Professionals reported reading the Cochrane review less frequently (23.1%) than the NICE (2007) guidance (90.4%) or the local hospital guidance (88.2%). When professionals were asked what evidence they had accessed for place of birth information in the last 6 months, the Cochrane library had been accessed less (19.0%) than other sources such as journals (64.3%) and national guidance (52.4%). Of the 59 respondents, 39 directly provided women with information about place of birth, of which 100% provided verbal information, 36.8% written information such as leaflets and 18.4% guidance to look at specific internet sites.</p>

Author(s), year of publication, study location & code	Study population	Aims of study	Methodology	Important results
<p>Thompson A (2013)</p> <p>Midwives' experiences of caring for women whose requests are not within clinical policies and guidelines.</p> <p>UK</p> <p>Study 18</p>	<p>A group of ten midwives within one NHS Trust in the south west of England. The midwives had experience of caring for women who made requests outside of accepted guidelines.</p>	<p>To explore midwives' experiences of caring for women whose requests fall out of the realms of clinical guidelines and the impact on their practice.</p>	<p>Qualitative study using semi-structured interviews and thematic analysis</p>	<p>Midwives found it very difficult to make accurate clinical assessments on which to base their care in cases where women decline examination or direct contact with the midwife.</p> <p>Midwives felt vulnerable and uncomfortable in giving such care.</p> <p>Midwives tried to negotiate and compromise on care, and felt relieved often when the baby was born so they regain some control,</p> <p>Midwives relied on their documentation to justify and support their practice.</p> <p>There were some situations where increased maternal control and autonomy was perceived as less control and autonomy for the professional. Women were perceived as difficult.</p> <p>Midwives have professional and employment responsibilities, but the women wanted individualised, non-institutionalised care.</p> <p>Experienced midwives could deal with this tension more easily.</p>

## 8.2 Leaflet 1: Choosing where to have your baby

# Choosing where to have your baby

This leaflet is designed to explain to you the options which are available at [REDACTED] Hospital regarding where you can give birth to your baby. It is important that you become involved in these decisions and know what issues you need to consider when making your choice. The leaflet will explain each of the options and the benefits and risk associated with each option. During your pregnancy you will have the opportunity to discuss this with your midwife and/or doctor.

The options available to you are:

- Home Birth.
- Midwifery Led Unit at [REDACTED].
- Delivery Unit at S [REDACTED]

This leaflet does not include statistics specific to [REDACTED]'s services as this information changes, but this information is available from your midwife or your doctor.

## Home Birth

Home Birth is suitable for you if you:

- Were fit and well before you became pregnant and have no underlying health problems.
- Are having your first baby or have had a previous uncomplicated pregnancy and birth.
- Have no concerns about your expected baby's health.
- Don't want to have an epidural.
- Have not experienced any complications during your nine months of pregnancy.
- Go into labour naturally between 37 and 42 weeks of pregnancy with the baby positioned head down.

### Home Birth – What are the benefits?

You will be able to stay at home for labour and birth and will be cared for by a highly skilled community based midwife. The Community Midwifery Team is available 24 hours a day. The following can be used to help you manage pain at home:

- Relaxation and breathing techniques.

- Being active and changing positions regularly.
- The use of water – a pool will need to be arranged by you (ask your midwife for more information).
- TENS – this will need to be arranged by you (ask your midwife).
- You can have Entonox (gas and air), the midwife will provide this.
- You will be in familiar surroundings and can have your partner, or other family members present.
- You have more privacy and can sleep in your own bed afterwards.
- If you are healthy and have a trouble free pregnancy the method of monitoring your baby's heart beat at home is known as intermittent auscultation using a hand held Doppler or Pinard's stethoscope.

All clinical waste will be returned to the hospital by the midwife.

Please note: Epidural, Diamorphine and Pethidine are not available at home.

### **Home Birth – What are the risks?**

If complications develop during labour or birth you would need to be transferred to hospital (delivery unit) by emergency ambulance. Common reasons for transfer are that you need:

- An epidural.
- A drip to speed up the contractions if your labour is not progressing.
- An assisted delivery with forceps or ventouse or a Caesarean section.
- Medical care if you develop other problems during or after your labour or delivery.
- Medical care if your baby is in difficulty when born.

If you need any of the above treatments you will need to be transferred in an ambulance accompanied by a midwife to hospital. The journey time from your home to hospital will depend on where you live and the time of the day the journey takes place.



## **Midwifery Led Unit (Co-located MLU)**

The Midwifery Led Unit is a co-located MLU which is situated on the third floor at Hospital.

The Unit has eight relaxed birthing rooms including two pools. All rooms have ensuite facilities. The Midwifery Led Unit is suitable for you if you:

- Were fit and well before you became pregnant and have no underlying health problems.
- Are having your first baby, or have had a previous uncomplicated pregnancy and birth.
- Have no concerns about your expected baby's health.
- Go into labour naturally between 37 and 42 weeks of pregnancy with the baby in the head down position.
- If you have been diagnosed with Group B Strep and require antibiotics in labour.
- If you are healthy and have a trouble free pregnancy the method of monitoring your baby's heart beat on MLU is known as intermittent auscultation using a hand held Doppler or Pinard's stethoscope.

## **Midwifery Led Unit - What are the benefits?**

The unit is led by a team of skilled midwives with the support of health care support workers providing care 24 hours a day.

The following things can be used to help manage pain:

- Relaxation and breathing techniques.
- Being active and changing positions regularly.
- Using water (there are two birthing pools available).
- TENS – this will need to be arranged by you (ask your midwife).
- Entonox (gas and air).
- Diamorphine and Pethidine – strong pain relieving medication given by injection.

We plan to transfer you home to the care of the community midwife 6-12 hours after delivery. Your chosen birth partner can stay with you during labour and birth but cannot stay over with you if you are transferred to the postnatal bay once baby is born.

## **Midwifery Led Unit - What are the risks?**

Sometimes your labour may not progress as you had envisaged so there is a risk

that you may need to be transferred to Delivery Unit for the following reasons:

- If complications develop during labour or birth you would need to be transferred to the delivery unit which is located on the second floor.
- In some emergency situations the medical team would attend you and or your baby in the Midwifery Led Unit.
- There is no epidural service here. If you request an epidural you will need to be transferred to Delivery Unit, subject to the availability of appropriate staff and rooms.

## **Delivery Unit**

The Delivery Unit is located on second floor at [REDACTED].

The Delivery Unit [REDACTED] has 19 delivery rooms, all with en-suite facilities including four high dependency rooms and two dedicated obstetric theatres. There is one pool available.

Your chosen birth partner can stay with you during labour and birth but cannot stay over with you once you are transferred to the postnatal ward.

If your pregnancy needs to be induced or you have any complications in pregnancy, this is the best place for you. Please note you will not be able to choose to have your baby on Delivery Unit if you have an uncomplicated pregnancy and labour.

The following births can be carried out here:

- Vaginal births.
- Forceps deliveries.
- Ventouse deliveries.
- Caesarean sections.
- Twins/multiple births.
- Breech births.
- Preterm births.
- Birth following induction of labour.

Most women who labour on the Delivery Unit have their baby monitored with Electronic Fetal Heart Monitoring, which continuously monitors your baby using a monitor attached to your tummy.

## **Delivery Unit – What are the benefits?**

The unit is led by a team of skilled midwives, doctors and health care support

workers providing care 24 hours a day.

Midwives will carry out most of your care but they will share responsibility for your care with the medical team should any problems arise.

The following things can be used to help manage pain

- Being active and changing positions regularly.
- Using water (there is one birthing pool available).
- TENS – this will need to be arranged by you (ask your midwife).
- Diamorphine and Pethidine – strong pain relieving medication given by injection.
- Epidural.
- Remifentanil PCA.

### **Will I always be able to choose?**

It is always your choice. In some cases, however, the doctor may recommend one option or the other, given your circumstances. The reasons for recommending an option will be explained to you.

### **What support will I have in making a decision?**

This leaflet has been produced as a decision aid to support you in making an informed choice. Your midwife and doctor are here to support you and will be happy to discuss any questions or concerns you may have. Your options and your choice will be discussed with you at various stages in the pregnancy. Whether your baby is delivered vaginally or by caesarean section, we want your experience to be safe, rewarding and satisfying.

### **When do I have to make a decision?**

Ideally, you need to have made a choice by 36 weeks of your pregnancy so that we have enough time to plan your option.

### **What happens if I go into labour before my planned caesarean section?**

This question will be discussed with you early in the pregnancy and the doctor will document what has been agreed. You can, however, change your mind at any time before birth.

## 8.3 Website for leaflet 1

# Maternity Services (Obstetrics)

Hospital provides full maternity care for women including pre-conceptual counselling, antenatal care, delivery and postnatal care. This care is provided by obstetricians (doctors who specialise in the care of pregnant women) and midwives with areas of expertise in a particular field.



Although the majority of women we care for are fit and healthy, we have many specialist clinics to look after women with complex medical problems. These include clinics caring for women with diabetes, heart problems, HIV, blood disorders, joint disorders, kidney problems and high blood pressure, obesity, and also for women at risk of problems in their babies (fetal medicine, placental problems and preterm delivery). The teams caring for the women are multi-disciplinary and include midwives, healthcare support workers, physiotherapists, anaesthetists, clinical geneticists and theatre practitioners, to name but a few.

Our Maternity Service is a regional tertiary referral centre for Genetics and Fetal Medicine and we have a co-located Newborn Intensive Care Unit (NICU) to care for babies who need additional support after birth.

At Hospital, we aim to provide you with individual woman centred care, and to support you

## 8.4 Leaflet 2: Planning a home birth

# Planning a Home Birth

## Patient information Leaflet

June 2014

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Giving birth at home can be a very fulfilling experience for you and your family. This information booklet has been compiled by midwives for women who are planning a home birth and we trust it will answer the questions you may have. There is a summary of the risks and benefits at the end of this booklet.

### **Who will attend my baby's birth**

A midwife will care for you throughout your labour, this may not be your named midwife. You may also be asked to consent to a student midwife to attend as being competent at caring for women birthing at home is an important part of a midwife's training. Towards the end of the labour a second midwife will be called to be present.

### **How do I contact the midwife?**

Our contact numbers is  
The delivery suites number is

When you are in labour, contact the midwifery led care unit, if there is no answer then contact the delivery suite on the above number. Inform them that you are booked for a home birth. Give your name address, telephone number and the name of your midwife. The midwife taking your call will discuss all aspects of your labour to date and advise you accordingly. When a midwife has been contacted, she may telephone you and make arrangements to visit you, either immediately, or later as appropriate.

The home birth rate is on the increase and on **some occasions** if several women are labouring simultaneously, deploying the services of all the available midwives, **you will be advised and requested by a hospital midwife, to go to the maternity unit for your labour and delivery.**

### **When should I call the midwife?**

All women should contact the MLC unit or the delivery suite **at any time if they have any concerns or anxieties.**

If labour begins during the day it is useful for us to know early in the labour so that your team of midwives can reorganise their workload.

- if labour begins at night, contact the MLC/Delivery suite when your contractions are coming every five minutes.

If your 'waters break', with or without contractions please phone the MLC

unit/delivery suite straight away. It is particularly important to let us know if the 'waters' appear green, brown or yellow.

Once labour is established a midwife will stay with you at your home. **Please ensure your home is easily identifiable by the midwife.** If she is attending you at night please put on all your house lights until she has arrived. If your home is not easy to access or does not have a number or name plaque displayed, please arrange for an adult to meet the midwife at the door, gate or nearest accessible tarmac road.

### **How will the midwife monitor my well being during labour?**

Throughout the labour the midwife will take your temperature, pulse and blood pressure and will test a sample of your urine at regular intervals.

The midwife will encourage you to have a regular intake of fluid, a light diet and to have a rest as well as active periods of labour.

### **Support persons at the birth**

Most women choose to have a birth 'partner' present for support in labour. This may be the baby's father or a relative or friends. In addition another adult should be present at the home to:

- Take care of other children
- Make or answer telephone calls
- Assist in making drinks for you and your partner

### **What to arrange or supply**

- 24 hour access to a telephone
- Ensure there are adequate heating in the room you plan to give birth in
- Means of gently warming baby linen i.e. hot water bottle with cover (not used for the baby)
- A clean hot water supply
- Clean hand towel and soap for the midwife
- Bucket or washing up bowl for wet rubbish
- Plastic bin liners to protect cushion/pillow etc
- Plastic sheeting or old shower curtain for the floor (available from DIY store)
- Plastic mattress cover to protect mattress/futon etc (available from chemists)
- Old clean sheets and towels
- Pack of full sized maternity sanitary towels

### **For the baby**

- 2 soft towels (old but clean)
- Vest
- Babygro/nightdress
- Cardigan
- Socks or booties
- Nappies
- Cotton wool
- Cot sheets
- Blankets

The equipment necessary for the birth will be delivered to your home when you are approximately 36 weeks pregnant. The entonox (gas and air) and oxygen will



be brought to your home when you are in labour.

### **Pain relief**

The entonox will be available and if any more is required the second midwife will bring this from the hospital. Midwives do not carry pethidine.

You may like to hire an obstetric **tens machine** to aid with pain relief at home.

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## Syntocinon

Syntocinon is a drug, given by injection, which is used to speed up the delivery of the placenta and membranes and to minimise blood loss. It is your choice as to whether this drug is given as a preventative measure or only used in the treatment in the event of a problem occurring. Please discuss this with your midwife prior to birth.

### **What if there are any problems during the labour? .**

In certain circumstances the midwife will advise that the transfer to hospital is necessary. This journey is **always made by ambulance** the midwife will accompany you. By this means, heavy traffic can easily be negotiated and good communication links with medical staff maintain in the event of a difficulty. Your partner may wish to accompany you or follow in his/her own vehicle.

In the unlikely event of you being unwilling to accept the advice of the midwife and you decline transfer to hospital the midwife will inform a supervisor of midwives and the medical staff, and she will continue to care for you at home. However, it must be appreciated that the midwife **does not have access to more sophisticated equipment and medical expertise that is available in the hospital.**

### **What if I need stitches?**

Your midwife will endeavour to assist you to deliver your baby as easily as possible to prevent tearing the perineum.

Small tears may be left to heal naturally. Should you require stitches most midwives are able to suture simple tears at home. If the tear is more complex you will need to transfer to hospital for stitching. If this is necessary your baby and your support person could accompany you in the ambulance, or follow in their own vehicle. You would be discharged afterwards using your own transport.

### **What about vitamin K?**

All babies are offered the routine injection of vitamin K. (you have already received a leaflet which gives you information on this.)

### **After the birth**

Your midwife will stay with you for at least one hour after the birth of your baby.

She will assist you with breastfeeding as soon as possible after the birth. When the midwife leaves she will ensure that you have a telephone number which you can call if you have any worries or concerns and arrangements will be made for a further visit later in the day or early the following morning.

It is recommended that all new mothers be cared for by a friend or relative for the first few days after your baby is born.

The baby will have a neonatal examination between 6 - 24 hours following the birth. This is carried out by a midwife who has taken extra training in order to carry out this examination; it may not be your own midwife.

### **Circumstances in which transfer to hospital would be recommended**

- Labour starting before 37 weeks or after 42 weeks of pregnancy
- If labour has not started within 24 hours of the waters breaking. You are advised to have labour induced in hospital. Your midwife will discuss this issue with you.
- If the waters are brown/green (meconium) when they break. This indicates that the baby has opened his/her bowels, which may be a sign of distress. We therefore recommend that in these circumstances the baby's heart rate be monitored continuously during labour.
- Abnormalities in the baby's heart rate. Both a very fast and a very slow heart rate can be a sign of distress. If either was to occur and persist and the birth is not imminent, you will be advised to transfer to hospital for closer monitoring.
- Excessive blood loss. This may occur during or after the birth.
- Raised blood pressure
- Exhaustion. Occasionally labour may be very prolonged or difficult to cope with despite good support and good preparation for the birth. However if you need stronger pain relief you may choose to be advised to transfer to hospital where additional help is available i.e. methods of increasing the efficiency of the contractions and/or epidural anaesthesia.
- Retained placenta. Some placentae do not deliver in the normal way and transfer to hospital is necessary for removal.
- For perineal suturing
- If there are any concerns regarding the baby's wellbeing after the birth. You will be advised to transfer to hospital for assessment, observation and/or treatment.

The majority of women who plan to give birth at home succeed in doing so. Complications are uncommon; however they do sometimes occur and for this reason this booklet has been produced to provide information on what to expect in these circumstances.

We wish you a happy and fulfilling experience.

### **Benefits and risks associated with home births Benefits/advantages**

- There is no evidence to support the common belief that home birth is a less safe option for women experiencing uncomplicated pregnancies and not anticipated to need medical

assistance of birth (House of Commons Health Committee 2003)

- Planned home birth is associated with good outcomes for both mothers and babies (Chamberlain et al 1997)
- You may feel more relaxed and in control in your own home
- There is ample evidence showing that labouring at home increases a women's likelihood of a birth that is both satisfying and safe (RCOG and RCM joint statement 2007)

### **Risks/Disadvantages**

- You will be unable to have an epidural at a home birth
- You may have to transfer to hospital in any complications arise during labour. If transfer is required there will be a delay in delivery, this could compromise the outcome

## **8.5 Website for Leaflet 2**

### **Welcome to our Multi-Award Winning Maternity Unit**

The birth of every child is special and our Maternity Unit provides support to thousands of families each year, caring for them and their babies.

Generations of midwives have looked after expectant parents and their parents too, in a supporting, professional and caring environment.

From the day you know you are pregnant, we will be there for you and your family, helping you choose how you want to have your baby and how you want to be cared for along the way.

Delivering babies in for over 40 years, the Maternity Unit has an excellent reputation and our results speak for themselves.

### **Having your baby at Integrated Care NHS Foundation Trust**

## 8.6 Confirmation of ethical approval



Research, Innovation and Academic  
Engagement Ethical Approval Panel

Research Centres Support Team  
G0.3 Joule House  
University of Salford  
M5 4WT

T +44(0)161 295 2280

[www.salford.ac.uk/](http://www.salford.ac.uk/)

2 September 2016

Dear Helen,

**RE: ETHICS APPLICATION HSCR16-78 – To examine how community midwives promote normal pregnancy and birth and at the same time work with policies and guidelines which aim to minimise risk.**

Based on the information you provided, I am pleased to inform you that your application (HSCR16- 78) has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting [Health-ResearchEthics@salford.ac.uk](mailto:Health-ResearchEthics@salford.ac.uk)

Yours sincerely,

pp. Andrew Clarke (Deputy Chair)

*on behalf of:*

A handwritten signature in black ink, appearing to read 'Sue McAndrew'.

Sue McAndrew  
Chair of the Research Ethics Panel

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