

Women's views on partnership working with midwives during pregnancy and childbirth

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Abstract

United Kingdom (UK) health policy over the past thirty years has been predicated on a partnership model focusing on empowering service users to be fully involved in their care. Within maternity care partnership relationships have been conceptualised as empowering women to have continuity, choice and control (Department of Health (DoH), 1993), within a relationship of personal autonomy between the woman and her carers. In this study I sought to identify the extent to which the Government agenda for partnership working and choice is realised or desired by women during pregnancy and childbirth. In addition, I wanted to examine the level of alignment between the views of midwives with that of women accessing the maternity services.

This study took a qualitative approach, drawing on the principles of grounded theory. In the first phase of the study a purposive sample of sixteen pregnant women were recruited and invited to complete a diary and to take part in two interviews. Women maintained diary entries following appointments with the midwife during pregnancy and childbirth. Semi-structured interviews were undertaken at 36 weeks of pregnancy and four weeks after the birth, based on the diary entries. In the second phase, four focus groups were undertaken with two groups of community midwives and birth centre midwives from two National Health Service (NHS) Trusts. Quotes from the diary-interviews from phase one were utilised to develop three vignettes which acted as a prompt during the focus group interviews.

Following a thematic analysis of the data, I analysed women's views on partnership working and choice. Most women in this study did not feel that they developed a partnership relationship with the midwife. This was associated with a lack of continuity of care and insufficient time to engage in meaningful discussion in an environment which was not conducive to shared decision making. Women described wide variations on the midwives role in supporting decision making. This ranged from decisions being dictated to midwives guiding choices and for some women, being facilitated to make informed choices. Many women described input of family and friends and widespread use of the internet as an information source. Women depicted their antenatal midwifery care as medicalised and felt that whilst their bio-medical needs were met their psycho-social and emotional needs were not. Women described the visits frequently as '*in and out*' or '*ticking the boxes*' to describe this approach to care. A small number of women (n=5) did experience a partnership

relationship. Three of these women knew the midwife from a previous pregnancy; the remaining two women attended a midwifery led unit for all of their care. In relation to the choice agenda, most of the women who participated in this study were not aware that they had a choice about who provided their care or where they would have their care.

The midwife focus groups concurred with the women's findings and suggested that a lack of time was a significant factor hindering the formation of a partnership relationship. Midwives felt that this was exacerbated by the paperwork they were required to complete in order to audit care and meet the 'payment by results' agenda (DoH, 2003b). During the focus groups midwives identified strategies which could be implemented to enhance midwifery led care, including offering antenatal care to small groups of women and undertaking an antenatal home visit towards the end of pregnancy, to provide women with the time to discuss any issues that they wanted to explore in more depth.

The findings from this study contribute to the current body of knowledge on midwifery led care particularly in providing the women's perspective on partnership working. Women want to experience midwifery care that meets their psycho-social needs as well as bio-medical needs through a model of care that provides continuity. In contrast to previous research findings, the women in this study described community based care as mechanistic, clinically focused and time bound, more in line with an obstetric model of care than a midwifery model. However, midwifery led care offered within a birth centre was perceived by women as providing a more holistic, social model of care. Whilst continuity of care is not a new concept, what this study contributes is that despite successive administrations supporting partnership working and informed choice over the past twenty years, most of the women in this study did not experience this level of care. The findings from this study resulted in the development of a midwifery partnership model as a theoretical framework that could be utilised in future research studies to evaluate the extent to which a partnership relationship exists within a range of midwifery care settings.

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Chapter 1: Introduction

In the UK, partnership is a concept that has been espoused in Government documents on the future of health and social care for a number of years (DoH, 1993; DoH, 2000; DoH, 2004; DoH, 2006). However, the term 'partnership' has not been clearly defined, and there has been a lack of guidance on how the maternity services need to adapt to implement a partnership model. Whilst the Government has promoted the principles of partnership working, it is the responsibility of NHS Trusts to implement partnership models of care within the maternity services. Mander (2011) contended that the partnership model has replaced the notion of the midwife being 'with woman' as a result of the increasing medicalisation of childbirth. The loss of autonomy to medical control forced many midwives to be 'with institution', with the idea of midwives supporting women's choices becoming little more than rhetoric.

In the current political and social environment the evidence base for partnership working between midwives and women is lacking (Mander, 2011). Moreover, the percentage of women requiring medical support for complex pregnancies is rising; in some cases as a result of increased levels of obstetric intervention and medicalisation of straightforward pregnancies, resulting in more instrumental and operative deliveries (Johanson et al., 2002). In an attempt to support a partnership relationship, women and their partners risk information overload if they are to be offered truly informed choice (Edwards, 2008), with limited evidence that this is what they want from their maternity care. The majority of midwives in the UK work within the NHS, a large bureaucratic organisation where implementing Government policy to personalise care, and to work in partnership with women, is particularly challenging (Finlay et al., 2009). Maternity units are constrained by financial and organisational targets and a lack of evidence demonstrating the economic benefit of partnership caseload models has resulted in a number of early pilot projects being halted (Hart et al, 1999). Is a partnership model possible or even desirable against the current political landscape? In this chapter the notions of partnership working and informed choice are set within their historical context, the factors which led to the medical control of childbirth are explored, and the chapter culminates with the aims that this study seeks to investigate.

Background

The 'Changing Childbirth' Report (DoH, 1993) heralded a new era for midwives and women, offering women choice, continuity and control, and midwives a platform from which to practise midwifery as truly autonomous professionals (Sandall, 1995). Since the publication of the Changing Childbirth report numerous pilot projects have been evaluated, offering women a more personalised, women centred service and midwives the freedom to manage a caseload, practising the full range of midwifery skills (Page et al., 1999; Walsh, 1999; Benjamin et al., 2001; Spurgeon et al, 2001; Fleming et al., 2007a). However, this has occurred at the same time as NHS Trusts have been required to adopt a risk based approach to care, driven by policies and protocols and subjected to severe shortages of midwives and financial constraints (Beake et al., 2007; National Health Service Litigation Authority (NHSLA), 2011; DoH, 2010b). Effectiveness of the maternity service is measured against a number of quantitative indicators with hospitals encouraged to meet targets to reduce costs and meet the requirements of the NHS Litigation Authority to reduce claims of negligence (NHSLA, 2011). The approach adopted to manage risk in NHS Trusts focuses on meeting women's bio-medical requirements, but is this at the risk of ignoring psycho-social needs? The plethora of government reports (DoH, 1993; DoH, 2000; DoH, 2003a; DoH, 2007) and policies supporting choice for, and partnership with women, aimed to improve the quality of care however, there is evidence of limited implementation in some areas (Beake et al., 2007).

Alternatively, it could be argued that societal views have changed, and women in twenty first century Britain may actually want to benefit from the increased availability of technology that can support a pain free birth at a time convenient to the woman (Oakley, 1984). Whilst maternity focused pressure groups lobby for the rights of women to experience natural childbirth and to be fully informed in the decision making process to work in partnership with the midwife, the question arises as to whether this is indeed what women want. Moreover, the emphasis on risk management has created uncertainty for professionals and women, resulting in women losing confidence in the ability of their bodies to birth naturally (Green et al, 1998) and increasingly seeking the reassurance of obstetric and paediatric support as well as a twenty four hour epidural service, just in case it is needed (Pitchforth et al, 2009; Bryers et al. 2010).

Whilst caseload midwifery practice and continuity of care are associated with better birth outcomes and greater satisfaction for women (North Staffordshire Changing Childbirth Research Team, 2000;

Fleming et al., 2007a; Leap et al 2010), the provision of safe, respectful care, by a competent practitioner, who is kind and has good communication skills, is more important than knowing the midwife who cares for them during birth (Green et al., 2000; Hunt, 2004). There is a dearth of evidence in the literature demonstrating that women want to work in partnership with the midwife or to be given fully informed choices. Studies repeatedly identify that women want to be able to trust the professionals who care for them, and be involved to some extent in decision making, but many then want to 'go with the flow' and allow midwives to guide them on their journey through childbirth (Hunt, 2004; Lundgren et al., 2007; Leap, 2010; Edwards, 2010). If women do want to work in partnership with midwives, having fully informed choices throughout the childbirth experience, then the question of whether midwives are able to provide the time to meet this objective within the current constraints impacting on the maternity services needs addressing.

Changes in the maternity service during the twentieth century

The focus for improving the maternity services has changed significantly over the twentieth century. Historically, childbirth was the preserve of the midwife, who involved barber surgeons and later obstetricians when problems occurred (Arney, 1982). In 1902, the Midwives Act specified that the midwife's role and responsibility was to care for women during normal childbirth (Donnison, 1988). This led to the introduction of training for midwives, supervised by Medical Officers of Health, which aimed to improve the public health of women (Dale et al., 2009). This placed doctors in a position of control over maternity care; introducing the rhetoric that childbirth was a high risk state and could only be considered normal in retrospect (Arney, 1982; Oakley, 1993; Witz, 1992). During the first half of the 20th century concern was focused on reducing maternal and neonatal mortality and morbidity, and ignored issues of maternal satisfaction. This concern increased awareness of the need to improve health promotion and education on pregnancy and childbirth for women and led to the introduction of antenatal care (Oakley, 1984; Tew, 1998). During this time institutional confinements began to steadily increase in midwifery led maternity homes, in a bid to reduce death rates from puerperal fever within large hospitals (Macfarlane, 2008). Working class women demanded birth in hospitals to convalesce and to escape the pressures of domestic responsibilities (Hunt et al., 1995), embracing the facilities that medical care had on offer, particularly the use of pain relieving drugs (Oakley, 1984). By 1958 the hospital confinement rate was 60% in England and Wales and reached the target of 70% proposed by the Ministry of Health under the chairmanship of Lord Cranbrook by 1965 (MoH, 1959; Fryer, et al., 1972).

During this period the Royal College of Obstetricians and Gynaecologists (RCOG) was advocating 100% hospital confinement, arguing that birth outside of hospital was unsafe, although the evidence base for this has subsequently been challenged (O'Brien, 1978; Macfarlane, 2008). In 1970, the Peel Committee recommended that facilities should be provided to enable all women to birth in hospital (Webster, 2002). However, a survey of women's views revealed that 80% of women preferred home confinement, with only 14% preferring hospital birth, suggesting that women's views were not considered when Government policy was being established (Gordon et al., 1960). Midwives' power was further eroded by a recommendation in the 'Cranbrook Report' that home confinements should be attended by the General Practitioner (GP) in case of complications (MoH, 1959; Tew, 1998). This is despite the fact that General Practitioner involvement in maternity care had fallen significantly leading to a lack of expertise (Curzen et al., 1976), except for GP's who maintained active involvement in maternity care (Bull, 1980), although this had also declined (Macfarlane, 2008).

By the 1980s hospital confinement rates were at 98% despite home birth being statistically safer, with lower intervention rates for low risk women (Tew, 1998). Moreover, Campbell et al. (1994) identified that the Government was erroneous in linking the decline in perinatal mortality rate with increased hospital birth rates; findings that they argued were coincidental rather than causal. Parents and women's groups wanted a review of the maternity services due to dissatisfaction with the lack of continuity of care (Page et al., 2000), and sought a return to the cultural norms of a social model of childbirth, where birth was recognised as a normal life event (Oakley et al., 1990).

The Health Committee Second Report on the Maternity Services (1992), under the chairmanship of Conservative Member of Parliament Nicholas Winterton, heard evidence from a range of stakeholders who endorsed the view that there was insufficient evidence to claim that hospital birth was safer than homebirth. Based on the views expressed, the Winterton Report concluded:

'On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospital cannot be justified on the grounds of safety' (House of Commons, 1992, p. 12).

The 'Winterton' committee also concluded that maternal satisfaction should be the prime factor in determining the shape of the maternity services of the future. Based on written evidence from

support groups and women, the themes of continuity of care, choice of care and place of delivery, and the right to have control over their own bodies emerged (House of Commons, 1992).

Background to the Changing Childbirth report

The Expert Maternity Group was set up in response to the recommendations from the Winterton Report, with a remit to '*review policy on NHS maternity care, particularly during childbirth, and to make recommendations*' (DoH, 1993, p. 1). The group collected evidence from organisations, professional groups, and individuals and undertook visits to a variety of maternity units taking oral evidence from a range of professionals and women. Further information was gathered from a consensus conference, and two MORI studies were commissioned to gauge the views of women not represented by interest groups. The outcome of this data collection exercise, Changing Childbirth, was reported on within nine months of the group being set up (DoH, 1993).

Whilst midwives and women broadly supported the recommendations of the Changing Childbirth report, the speed with which the report was published led to concern about the breadth of the review. The quality of evidence on which the findings were based has been criticised, because the report is based on '*impressionistic findings*' from a limited number of visits, and a relatively small survey of only 1000 women. An example of this is the indicator that every woman should have a named midwife, which was based on the views of only 190 women. This is seen as a significant weakness in a document heralded as an agenda for change (Bradshaw et al., 1997).

Nevertheless, Changing Childbirth was perceived as an influential document and was viewed by women and health care professionals as an agenda for change within the maternity services (Page, 1995). As a result of the recommendations of the report, maternity services were included in the priorities for the NHS Management Executive. This required health authorities to develop a strategy to demonstrate how the recommendations of Changing Childbirth were to be implemented (DoH, 1993). Tew (1998) argued that this was a fundamental flaw, because allowing policies to be developed locally played right into the hands of the obstetricians who also had the most to lose by the implementation of Changing Childbirth. Obstetricians were the most powerful of the three groups, comprising midwives, women and obstetricians, but also frequently held positions of power on Executive Boards within local Trusts, therefore, any changes that would threaten the power and position of obstetricians were unlikely to be implemented.

Move to partnership agenda

Implementing maternity care that would offer choice and control to women and enable midwives to lead care in low risk pregnancies within a partnership model, was always going to be challenging. Gallant et al. (2002) argued that health and social care agencies introduced the notion of partnership in order to enhance personal autonomy and choice, because of economic and socio-political changes, which led to a demand for a more egalitarian society. During this period technological advances and spiralling costs, combined with a scientific rational and evidence based approach to care, had resulted in a medicalised, fragmented approach to health care provision (Gallant et al., 2002; Wiggins, 2008). Patients have been defined in some areas as 'pathophysiological objects,' and health care workers have been drawn into this prescriptive model and away from treating patients as individuals, a fundamental requirement of partnership (Jonsdottir et al., 2004).

In the maternity services, pressure groups such as the Association of Radical Midwives, the National Childbirth Trust and Maternity Alliance had, since the 1970s, been championing the normality agenda, and trying to challenge the power of professionals and particularly the principle that birth is only normal¹ in retrospect. However, despite public demand, Government support (HoC, 1992; DoH, 1993, DoH 2007) and professional standards (NMC, 2008), the move towards recognising childbirth as a normal physiological event has been hindered by medical dominance and clinical guidelines, which maintain a pathological focus on childbirth (Oakley, 1993; Benoit et al., 2005; Freeman et al., 2007; Bryers et al., 2010). During this time the normal birth rate has fallen from approximately 70%, to less than 50% in 2006, and has resulted in the definition of the midwife being amended to include the promotion of normal birth (Darra, 2009).

The notion of partnership working within the NHS, and in particular the maternity services has been a strong theme in Government reports and policy documents over the last two decades (DoH, 1993; DoH, 2000; DoH, 2004; DoH, 2006). The Expert Maternity Group identified that health care professionals were providing midwifery care using a medical model predicated on ill health, as opposed to caring for healthy women undergoing a physiological event, planned in partnership with the pregnant woman and her family (DoH, 1993). Within the NHS Plan (2000) the Government

¹ Birth is defined as normal when the onset is spontaneous and the process of birthing is completed physiologically at term (RCM, Normal Birth Campaign)

agenda was to ensure that the patient was at the centre of service provision and that the care provided was based on clinical need and not on where the patient lived or on their ability to pay (DoH, 2000). The report identified that effective partnerships with all elements of the organisation, including the patient, would ensure that the service met individual patients' needs. The rationale for this change in emphasis was that the NHS was still operating in the same way as it had since its inception in 1948 and therefore investing money without fundamentally changing the organisation of the service. It was believed that to continue in this way would not result in patients receiving a consistent standard of care, irrespective of their age, gender, social class, ethnic background or postcode. The NHS Plan was heralded as a radical reform to bring the NHS into the 21st century. However, whilst it is clear from the evidence reported that patients wanted to see improvements in the service, there is no evidence that patients wanted to work in partnership with health care professionals (DoH, 2000: Annex 1). Despite this the notion of NHS staff working in partnership with service users is a fundamental commitment of the NHS constitution (DoH, 2012a).

Partnership in maternity care relies on a model of care that supports continuity and enables a relationship of mutual trust and understanding to develop, between the woman and the midwife providing her care. In this context partnership has been defined as:

'...a relationship that recognises the autonomy of both partners and requires the midwife...to engage with women in a mutual relationship that recognises and supports women's expertise and self-determination' (Leap et al, 2006: p. 267).

The partnership model of care has been implemented across a range of midwifery practices in New Zealand; however Mander (2011) argues that there is a lack of evidence to support its implementation. Furthermore, by incorporating the principle of self-determination, the New Zealand model is expecting midwives to work without any real autonomy, as this model gives primary decision making power to the woman, with a limited evidence base on which to make decisions and without any responsibility for the eventual outcome, putting midwives in an invidious position (Mander, 2011). Pairman (2010) suggested that midwifery partnership means '*professional friendship*', one which is focused and time-limited. Models of partnership caseload in the UK have identified with the concept of professional friendship, developing out of a more personalised approach that combines continuity of carer with the formation of a trusting relationship

(Walsh, 1999). Subsumed within the notion of partnership working is the concept of informed choice, to support women in decision making, which government reports and policy documents also emphasise in relation to maternity care (DoH, 1993; DoH, 2007).

Raising the profile of choice

In order to be offered informed choice during childbirth, women need to have access to sufficient information, in a format that is meaningful to them, to make a reasoned judgement (O’Cathain et al., 2002; Symon, 2006). It has been suggested that midwifery care should be organised in a way that enables the woman to develop a relationship with the midwife, in an unhurried environment, to enable effective information exchange in an environment of trust (Levy, 1999a; Mander et al., 2009). McCourt (2006) found that the model of care significantly influenced the communication style and therefore the relationship established between midwives and women. Caseload midwives who provide one to one midwifery care had a more naturalistic relationship with women compared with midwives providing care in hospital or community settings, who tended to demonstrate a professional/client relationship model (McCourt, 2006).

Symon (2006) suggested that the rhetoric of choice has not been supported in the reality of modern day practice, as women need information to make informed choices, but with a reduced schedule of antenatal visits (National Collaborating Centre for Women's and Children's Health (NCC-WCH), 2008) and less time to spend informing women, midwives have insufficient time to provide the level of information or discussion to support women’s choices. Changes to maternity care are inhibited by organisation constraints, and unless women centred models of care are more widely implemented, women will not experience continuity of care or experience choice and control during childbirth (McCourt, 2006). The challenge for the maternity services is meeting competing demands, within the organisational constraints, in the current economic climate, addressing issues of power and hierarchy between obstetricians, GP’s and midwives (McCourt, 2006) and finding the optimum way of meeting women’s needs for a safe and fulfilling childbirth experience (NCT, 2009).

The Government’s response to the House of Commons Health Committee Report (2004) included a commitment to improving and promoting choice for women. This was largely through the vehicle of the National Service Framework (NSF) for Children and Young People (DoH, 2004). The government maintained that the mechanism for ensuring that women are provided with informed choice and direct access to a midwife should be locally agreed. As midwives are generally not

represented at executive level within NHS Trusts or Primary Care Trusts (PCT's), it is perhaps not surprising that the recommendations were not widely adopted, as this would result in a loss of power and control for GP's and obstetricians.

The policy document '*Our health, our care, our say*' (DoH, 2006) stated that women, although generally satisfied by the support they receive during childbirth, still expressed dissatisfaction with the lack of choice, particularly regarding the place of birth. Banyana et al. (2003) used a grounded theory approach to elicit women's views about the place of birth and the role of the midwife in this decision, and found that women were not given adequate information to make an informed choice regarding the place of birth. The authors suggested that midwives appear uncomfortable to propose home birth as an option for women (Banyana et al, 2003). Kitzinger (2005) argued that this was due to the culture of powerlessness that midwives working in consultant units experienced, with the subsequent lack of confidence to empower women to make informed choices. Moreover, some midwives working in obstetric units, where the perception of risk is higher (Mead et al., 2004), continued to support the medical model rather than take on the autonomous practice of a midwife within a birth centre setting (Bryers et al, 2010).

A national survey of women's experience of the maternity services carried out during the summer of 2006 found that in relation to choice less than a third of women were offered a choice of place or lead professional for their antenatal care (Redshaw et al, 2007). Thirty eight percent of women were only offered the choice of one maternity unit or the option of home birth (Redshaw et al, 2007). The policy document '*Maternity Matters*' (DoH, 2007) proposed to offer women '*four national choice guarantees by the end of 2009*' and was based on the principles outlined in '*Every Child Matters*' (DoH, 2004). By 2009 all women should have been offered choice on how to access maternity care, place, carer and type of care, and in order to meet this target NHS Trusts needed to develop an effective strategy to meet the deadline proposed (DoH, 2007). In 2010, the National Perinatal Epidemiology Unit repeated the survey undertaken in 2006 and found in relation to choice of place of antenatal care that only 27% of women felt they had been offered any choice, and only 14% of women were offered a choice of carer, so despite the Government's assertions (DoH, 2007) women were still only being offered limited choices about their antenatal care. The number of women aware of the option for home birth had risen significantly to two-thirds, but 16% of women said they were still not offered any choice regarding their place of birth (Redshaw &

Heikkila, 2010). Macfarlane (2008) argued that the merging of maternity units, with the resultant opening of stand-alone birth centres did not actually increase choice for women, particularly as due to financial constraints many of these units subsequently closed; therefore, whilst '*Maternity Matters*' promoted choice for women, health care reconfigurations may in fact reduce the choices available to them (NCT, 2009).

Justification for the study

An initial review of the literature on partnership demonstrated a need for further research on whether service users or health care providers fundamentally believe in the principles of partnership, and whether the organisational structures facilitate or inhibit the development of partnership relationships. In the current economic climate where targets are financially driven, it is questionable whether it is possible to achieve the level of care required to facilitate a partnership relationship. Gallant et al. (2002) argued that the concept of partnership was immature as there is a lack of consensus on its application, but recognised that it may have future potential. Further research is required to explore the types of relationships midwives make with women throughout the childbearing period (Freeman et al., 2004; Freeman, 2006), taking cognisance of the organisational setting (Lundgren et al., 2007). The research to date has frequently only considered the woman's or the midwives' perspective without considering the relationship between the woman and her carers, or has been undertaken in the postnatal period and lacked a prospective longitudinal focus. In addition, more research is required to examine the extent to which women are involved in the decision making process (Sandall et al., 2009), which is fundamental to forming a partnership relationship and being provided with accessible information on which to make an informed choice.

Research aims

This research study aims to examine the alignment between the Government agenda for partnership working within health and social care, and the experience of women and midwives, to determine whether the formation of a partnership relationship is either achievable or desirable.

1. To identify the extent to which the Government agenda for partnership working and choice is realised or desired for women during pregnancy and childbirth.

2. To examine the level of alignment between the views of midwives with those of women accessing the maternity services.
3. To explore whether childbearing women would value the opportunity of working in partnership with midwives by providing feedback on midwifery performance.

Personal reflection

As a midwife, lecturer and mother I have become acutely aware, over my professional career, that the maternity service often fails to put women and their families at the centre of the care that it provides. Words like partnership, empowerment and choice are frequently used in relation to maternity care and yet there is limited evidence that women receive care underpinned by these principles. I have been a midwife since 1981 and have predominantly experienced women receiving care which is medically focused and controlled by midwives and doctors, who hold coercive power over women. Providing women centred care in such an environment was often challenging and frequently undermined, as the dominant culture was a medical model of care. I moved into the field of midwifery education early in my midwifery career, believing that education held the key to preparing midwives who were truly women centred. I believed that evidence based learning would provide the midwives of the future with the knowledge and confidence to challenge outdated practice and enable these midwives to support women's choices.

However, over time I realised that this was a naïve assumption, largely because the peer group is very powerful and midwives may comply with the dominant model of care in order to be accepted as part of this group. Midwives who want to make a change frequently end up feeling ostracised or leave the maternity service to set up as independent midwives. The '*Changing Childbirth*' Report (DoH, 1993) provided an opportunity for midwives to truly re-examine the care offered to women and to identify a different model of care which would provide continuity, control and choice for women. However although a number of pilot schemes were implemented the lack of identified resources to support this model of care resulted in many of the pilots failing to continue long term.

The motivation to undertake this study followed a conference I attended where Baroness Cumberledge and Mavis Kirkham were proposing that midwives should all be able to experience caseload practice and that academic midwives should be paid by the Primary Care Trust (PCT) to provide midwifery care. This would have enabled universities to be funded to release midwifery academics to provide caseload practice. It was this conference that inspired me to enrol on a

professional doctorate programme to consider this possibility more fully. However early on in my studies I realised that in order to move forward I needed to understand what it is that women want from their maternity care. I believed that women should be equal partners in decision making and provided with informed choice to enable them to actively engage in the process, however, I did not know if this is what women really wanted. It was this realisation that led me to seek to discover an in-depth insight into what women currently experience during their maternity care.

This study is building on a number of research studies that have been undertaken as a result of '*Changing Childbirth*' (DoH, 1993) to try to provide a model of midwifery care which supports the principles of continuity, choice and control for women during childbirth. Partnership caseloading models have been associated with improved birth outcomes, high levels of continuity and increased maternal satisfaction (Chapter 2 refers). A number of studies have explored women's views in relation to a range of models of care in relation to maternal satisfaction levels (Shields et al., 1998; McCourt et al., 1998; Walsh, 1999; Farquhar et al., 2000; Homer et al., 2002; Williams et al., 2010). However, this study is focusing specifically on the formation of a partnership relationship from the woman's perspective, to capture women's experience during the childbirth continuum, and therefore to provide a more comprehensive picture of the extent to which a partnership relationship develops between women and midwives and to determine whether this is what women want from their experience. Implicit within this question is the notion of informed choice and the extent to which women either want or receive informed choice during the childbearing period, specifically focused on the four national choice guarantees within '*Maternity Matters*' (DoH, 2007).

The professional doctorate

This study was undertaken as part of a professional doctorate in health research, which differs from a traditional doctorate or PhD due to the nature of the cohort and the fact that the taught components assess developing research competence through written evaluations which may contribute to the overall submission. The professional doctorate is a structured programme of research training which incorporates a number of core and optional guided learning units which are evaluated during the part time, six year programme. The Professional Doctorate in Health Research (DH Res) is divided into three phases which incorporate guided learning in theoretical and practical research skills relevant to professional practice. At the end of each phase students

submit a written assessment and undergo an oral examination to determine their readiness to progress to the next phase and ultimately to submit a dissertation and attend a final examination. The focus of the professional doctorate is on the application of research skills and knowledge to an area of relevant professional practice (HHSRI, 2007). Therefore in applying this principle to this dissertation I was able to advance the development of research skills to a practice based study within midwifery.

During the course of the doctoral programme I submitted evaluations which demonstrated the development of research skills but also built towards the research questions that were eventually formulated as part of the research proposal submission in year three of the programme. Inevitably the development of ideas and arguments over this period of time is an iterative process during which the student engages with relevant material. It is therefore improbable that as an experienced midwifery lecturer and a student on a professional doctoral programme that I would not have a working understanding of some of the literature that supported this dissertation. However, whilst I had a working knowledge of the literature and as part of the development for the evaluations searched the literature in some key areas, the process of data collection and analysis was undertaken with an open mind to enable themes to emerge naturally. Therefore whilst preparing this dissertation elements of the literature were utilised from previous evaluations, however, the literature was revisited following data analysis to ensure the critical review required at doctoral level. The progression within a professional doctoral programme is therefore iterative and builds on knowledge and understanding as it emerges from the study. Whilst this is not the '*tabula rasa*' articulated within the original exposition of grounded theory methodology by Strauss and Glaser in 1967 (Annells, 1996), it does meet the expectations of the more interpretivist approach espoused by Kathy Charmaz in her text '*Constructing Grounded Theory*' (Charmaz, 2006).

Summary

In this chapter I have sought to contextualise the notions of partnership working and informed choice in relation to the changing position of midwifery within the maternity services during the twentieth century. The historical overview provided the justification for this study and culminated in the research aims. This study was conducted as part of a professional doctorate programme and the iterative nature of this journey has been outlined. The dissertation has been structured into nine chapters and culminates in the reference list and appendices. A summary of the remaining chapters follows:

Chapter Two: In order to locate partnership within the wider political and policy framework an historical perspective on its emergence is provided. The different models of midwifery and medical care have been examined and discussed in relation to both the women's and the professional perspectives, and have been framed against a background of medical power and dominance.

Chapter Three: Reports the research design and methodology. The research journey is presented from gaining ethical approval to the recruitment strategy and the data collection methods employed. The process of data analysis is described.

Chapters Four to Six: Introduce the research findings from the diary-interviews undertaken with the women in this study. The three themes expounded are organisation of care, relationships and choice.

Chapter Seven: Depicts the findings from the midwives' focus groups which followed parallel themes to those of the women's findings including organisational factors, care provision, choice, partnership relationships and the way forward.

Chapter Eight: Introduces a midwifery partnership model that was developed following data analysis from the emerging themes from this study. This model builds on previous work following the theoretical development of concepts and testing of models in areas of nursing practice.

Chapter Nine: Provides a critical discussion and analysis of the findings from both the women's and midwives perspectives. The analysis is considered alongside current literature and the prevailing agenda arising from the Government as well as the professional and statutory agencies. The limitations of this study are identified and areas for future research are suggested. The concluding remarks present the contribution to knowledge from this study and outline the strategies adopted for dissemination of the findings.

Chapter 2: Literature Review

In this chapter I present an overview of the political context which led to the emergence of the partnership agenda and a critical review of the literature on the development of partnership relationships between health care professionals and pregnant women, the issues that impact on choice and the extent to which this is experienced by women during childbirth. Moreover, the impact of Government policy on maternity care is significant, particularly the emphasis on risk based approaches which militate against autonomy and choice for women and families (Symon, 2006). The existence of medical power in obstetrics and to some extent midwifery practice along with the scientific approach to childbirth, is in contrast to the psycho-social approach some women espouse. The challenge for midwives is managing workload and time pressures which result in the use of strategies of detachment to enable the work to be completed, experienced by midwives as emotional labour (Hunter, 2006a). This is in conflict with forming a socio-emotional bond with women, which is time consuming, but essential, if women and midwives are to form a meaningful relationship. In order to explore the concept of partnership relationships, the issue of trust emerges and this has been examined to determine the extent to which women who form a trusting relationship with the midwife chose to 'go with the flow' and are guided by the midwife, compared with women who develop a partnership relationship with the midwife and are offered informed choice (Pitchforth et al., 2009).

I have also reviewed the literature on models of midwifery care from the midwives' and the women's perspectives, identifying the benefits for women of continuity of care and partnership models on birth outcome and maternal satisfaction, and for the midwife in relation to professional autonomy and satisfaction versus stress and burnout (Sandall, 1997). Within this review it is evident that whilst there is a significant amount of research exploring different models of midwifery care, a recent systematic review identified that little is known about women's views regarding their involvement in the decision making process (Sandall et al, 2009). The complex interplay between medical and social models of care has been examined in relation to the powerful position of obstetrics and, to a lesser extent, midwifery control over childbirth. This is considered against a background of risk and litigation, which is deeply entrenched within the culture of the maternity services making it more difficult for women to experience a natural birth (Bryers et al, 2010). Birth

needs to be situated in its social context, and in an era where birth can be controlled and pain can be managed it is important to examine what women want, rather than assuming that women want to experience childbirth as a natural process. Power is fundamental to any examination of the medical versus social model of care; a contested concept which is explored in relation to the forms of power that are most commonly articulated within the cultural environment of childbirth. The position of choice is explored in relation to the extent to which it is socially acceptable or controlled using the notion of protective steering (Levy, 1999b) or coercion to ensure women make the right choices. The concept of choice needs to be contextualised within the uncertainty of the childbirth environment and the extent to which women want to be offered choice or guided in their decision making by the midwife.

Search strategy

The search strategy adopted for this dissertation utilised a range of methods, undertaken during the seven year period that this part time professional doctorate was studied. The literature review occurred in stages as outlined in the previous chapter. Therefore during these periods standard searches were undertaken as described later in this paragraph as part of an iterative process that culminated in the final submission. However, the final literature review for this chapter was undertaken after the data analysis stage, once the key themes from this study had emerged. So whilst the standard structure of a doctoral submission appears to suggest that the literature review pre-dated the data collection and analysis, in keeping with a grounded theory methodology, the full review occurred after the thematic analysis. Whilst systematic searches were undertaken for key themes that emerged from this study, using standard databases, the snowballing approach described by Greenhalgh et al (2005) also resulted in a number of relevant sources. The building blocks described by Booth (2008) included the use of the following databases: Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Social Science Index, Web of Knowledge, Google Scholar, Cochrane Collaboration and the MIDIRS Database. Key words were identified using truncation to broaden the search and the Boolean operator AND to link concepts (Booth, 2008). This standard search strategy was enhanced by the use of citation searching, hand searching reference lists and contact with experts in the field to ensure all relevant, significant literature was accessed (Papaioannou et al, 2009). In addition, further literature was accessed by searching on publishers' websites, including SciVerse and Scopus from Science Direct. Date filters were applied to limit the literature identified to papers from 1980 onwards (Grant, 2004). The

justification for choosing 1980 as a cut of period for the literature review was based on the political and social policy at that time which was based on the belief that perinatal and neonatal mortality rates were too high, and that midwifery skills were being underutilised. This period is significant as it resulted in a change of focus on the role of service users which resulted in an increased emphasis on partnership working and collaboration.

Introduction to partnership

In this section I will explore the emergence of partnership working as a fundamental feature of health and social care policy within the Labour government's administration since 1997. The relevance of partnership working within the midwifery profession is also illustrated through the adoption of a definition of partnership working. The section concludes with an analysis of the literature on partnership working within midwifery, from a range of western countries where midwives increasingly have the political, professional and social support to practice autonomously as the lead professional in normal midwifery care.

Partnership within health and social care

In 1997 the new Labour government proposed a radical overhaul of the NHS replacing the internal market of the previous administration with a *'third way, ... based on the principles of partnership and driven by performance'* (DoH, 1997), establishing partnership working as a core principle of the labour administration's health and social care agenda (Rummery et al., 2003). This emphasis on partnership continued as a central theme within a number of subsequent government reports (DoH, 2000; DoH, 2004; DoH, 2006; DoH, 2007; DoH, 2012b). In spite of the widespread use of the term 'partnership' within political discourses (Kurunmaki et al, 2011), it was not defined within government reports (Elston et al., 2002). Moreover, despite partnership working continuing to be a cornerstone of government policy it has been argued that its impact is difficult to measure and there is limited evidence that it provides better outcomes than other models of care (Reid et al., 2009). In addition, challenges have been identified regarding the ability to evaluate partnership working due to the lack of a clear definition on what is meant by working in partnership (Rummery, 2009). Rummery (2009) identified a gap in the literature on the outcome of partnership working and undertook a literature review to examine the evidence of improved outcomes resulting from a partnership relationship. She found that user involvement is underdeveloped in health care

settings, despite evidence that collaborative working with users' has resulted in more holistic care provision (Rummery, 2009).

The concept of partnership

The notion of partnership has been critiqued by a number of authors, using a concept analysis to clarify the use of the term in health and social care literature and to provide a reliable definition (Gallant, et al., 2002; Bidmead et al., 2005; Hook, 2006; Wiggins, 2008). Systematic literature reviews were undertaken using a range of health and social care databases covering a period from 1982 – 2007 (Wiggins, 2008). In addition to partnership and concept analysis, search terms included relationship, collaboration, mutuality, participation and involvement. These terms were combined with specific areas of health care and the range of professionals involved. What is interesting is that the authors undertaking the concept analysis were all drawing on care from a nursing perspective. Bidmead et al (2005) explored the meaning of partnership from a health visiting perspective. In the literature review they ordered the literature into sections on paediatric nursing, general nursing and health visiting. Whilst there were clear parallels with midwifery, this body of literature was not included in the review. An example of this is the discussion around Casey's partnership model, which is used in paediatric nursing. Bidmead et al (2005) identified that this model had been developed to be used in a hospital environment (Lee, 1999) and therefore whilst parallels exist with the notion of the parents taking responsibility for the care, and the nurse adopting a supervisory role, health visiting focuses more on promoting health within the family in a community setting. The health visiting model of care has close parallels with midwifery where the emphasis of midwifery led care is in supporting the woman and her family through a normal life event within a community setting. Bidmead et al (2005) also identified the power relationship in decision making, recognising that this does not need to be equal but is predicated on the notion of working together, a concept that closely aligns with Freeman's (2004) shared decision making model in midwifery.

Definitions of partnership

Gallant et al (2002) argued that partnership is problematic to define, but identified that enablement and control are central to some partnership definitions. The following table captures the elements that are described most frequently when the concept of partnership is defined.

Table 1 - Definitions of partnership

Author	Definition of partnership	Evaluative comment
Wiggins, 2008: p 629 (Nursing)	<i>'A relationship between individuals or groups that is characterised by mutual cooperation and responsibility for the achievement of a specified goal'</i>	This definition includes some important fundamental aspects of partnership but needs to be further elaborated, to be applied within the midwifery context.
Bidmead et al, 2005: p 208 (Health Visiting)	<i>'Partnership with clients may be defined as a respectful, negotiated way of working together that enables choice, participation and equity within an honest, trusting relationship that is based in empathy, support and reciprocity....It recognises a high level of interpersonal qualities and communication skills in staff who are, themselves, supported through a system of clinical supervision that operates within the same framework of partnership.'</i>	This definition contains many important key elements of partnership working which have resonance within the midwifery context. It has been adapted to include elements of autonomy and recognition that the relationship is dynamic.
Brinkerhoff, 2002 definition of an ideal partnership (Organisational management perspective)	<i>'Partnership is a dynamic relationship ... based on mutually agreed objectives, pursued through a shared understanding of the most rational division of labor based on the respective comparative advantages of each partner. Partnership encompasses mutual influence, with a careful balance between synergy and respective autonomy, which incorporates mutual respect, equal participation in decision-making, mutual accountability, and transparency.'</i>	This is a business model of partnership which would need to be considered critically before it could be transferred to a personal relationship within a midwifery setting. However the notion of the relationship being dynamic resonates with relationships in health care settings. Also autonomy is recognised as significant within midwifery care. Equal decision making is more challenging, as this is determined based on the circumstances and on the individual's personal preferences.
Leap et al, 2006: p267 (Midwifery)	<i>'a relationship that recognises the autonomy of both partners and requires the midwife.....to engage with women in a mutual relationship that recognises and supports women's expertise and self-determination'</i>	Many of the elements of the following two midwifery definitions have been incorporated into the definition adopted for this study, but the final definition was developed to incorporate additional aspects identified as important within a partnership model of care.
Guilliland & Pairman 1995: p7 (Midwifery)	<i>'A relationship of 'sharing' between the woman and the midwife involving trust, shared control and responsibility and shared meaning through mutual understanding'.</i>	

These definitions of partnership all highlight the importance of working collaboratively, acknowledging that each partner has something to contribute and therefore is seen as an expert. For example, the woman is an expert in her own body and therefore has insight into the way that she would prefer to negotiate childbirth, whereas the midwife has expert knowledge and skills in midwifery. Wiggins (2008) identified the importance of respecting service users' expertise about themselves in establishing a partnership relationship.

The definition of partnership devised by the author and adopted for this study was:

Partnership is a dynamic relationship that recognises the autonomy of both partners and is based on mutual co-operation and shared responsibility. It enables reciprocity and facilitates shared decision making through a process of negotiation based on trust and respect, recognising and valuing the experiences that each partner brings to the relationship.

Bidmead et al (2005) extended the definition of partnership to encompass the role of the organisation in providing a supportive framework to facilitate partnership working. Moreover, Wiggins (2008) discussed the importance of providing a mentor to support the practitioner's skills and confidence in engaging in a partnership relationship with service users. In a midwifery environment, a network already exists in the role of the Supervisor of Midwives who could adopt the role of mentor for midwives to support partnership working. Consultant midwives, who have been employed by a number of maternity units to support the normality agenda, could also assist midwives to develop the confidence and skills to develop a partnership relationship with women.

Partnership relationships in midwifery

From a professional perspective partnership working in midwifery is recognised as a fundamental aspect of care, nationally and internationally. The International Confederation of Midwives has adopted the notion of partnership within its definition of a midwife, models of midwifery care, and Code of Ethics:

'Midwives develop a partnership with women in which both share relevant information that leads to informed decision-making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices'. (ICM, 2008)

The regulatory body which sets standards for nursing and midwifery in the UK also identifies the importance of partnership working within the '*Midwives Rules and Standards*' under the midwives responsibility and sphere of practice:

'A midwife should work in partnership with the woman and her family;' (NMC, 2004, p.18)

The principles of partnership working are embedded within the Code of Practice for nurses and midwives, the values of which underpin the standards expected of practitioners (NMC, 2008) and are supported by the Royal College of Midwives (RCM, 2008). However, whilst this term is widely used within a professional discourse, it has not been clearly defined. The growth of models which incorporate partnership working has been described in the midwifery literature including the identification of some of the challenges that have emerged from partnership working.

Partnership in midwifery relies on a model of care that supports continuity and enables a relationship of mutual trust and understanding to develop between the woman and the midwife providing her care (Leap et al., 2006). In addition to the attributes already identified from nursing models, a midwifery partnership model developed in New Zealand also included the principles of informed choice, consent and equality and described the relationship as a professional friendship where care is based on a model of independent practice and women can choose a midwife or a doctor as their Lead Maternity Carer (LMC) (Pairman et al., 2006). The funding for midwifery care in New Zealand is held by the LMC, which ensures that women receive continuity of care whether with a midwife, GP or obstetrician. In 2001 70% of women chose a midwife as their LMC (Surtees, 2004). Whilst the option for women to be able to choose a lead carer was first mooted as an indicator of success in the Changing Childbirth Report (DoH, 1993), this is still not widely available in the UK, where the majority of midwives are still employed by individual NHS Trusts.

The partnership model has been implemented across a range of midwifery practices in New Zealand, however Mander (2011) argued that there is a lack of evidence to support its implementation. Furthermore, by incorporating the principle of self-determination, the New Zealand model is expecting midwives to work without any real autonomy, as this model gives primary decision making power to the woman, with a limited evidence base on which to make decisions and without any responsibility for the eventual outcome, putting midwives in an invidious position (Mander, 2011).

The notion of equality within the partnership model espoused by Pairman et al (2006) has been challenged by some authors who argued that midwives have power over the relationship, due to their professional knowledge and their position within the maternity services hierarchy. To suggest that equality is a fundamental principal of partnership ignores the position of power held by the midwife (Leap, 2010; Freeman et al., 2004). Freeman et al (2004) undertook a qualitative study involving forty-one midwives and thirty-seven women to examine the role of equal power within a partnership relationship during labour. She concluded that whilst the majority of participants believed they achieved a partnership relationship they did not emphasise the need for equality. Freeman et al (2004) proposed a 'shared decision making' model in which women make decisions in low risk situations with midwifery support, but as the index of risk increases the midwife uses her professional knowledge and expertise to make decisions, demonstrating that partnership does not necessarily mean equality in relation to decision-making. Data in this study was limited to intrapartum care and was collected within 72 hours of delivery, so it could be argued that the women and the midwives memory of the relationship was influenced by the subsequent outcome.

A secondary analysis of several studies undertaken by Lundgren et al. (2007) examined women's and midwives' experiences during childbirth, and led to the identification of six pairs of concepts that are central to the midwife-woman relationship. There is a significant overlap with the concepts outlined within the partnership literature, particularly mutuality, involvement, trust and support; however differences identified were around women surrendering or going with the flow, dealing with feeling different if the pregnancy varied from the norms of a healthy pregnancy and feelings of ambivalence and fear (Lundgren et al., 2007). The midwives' role in this relationship was to be available to provide support in these situations and to help women face their fears and to suggest alternative options if the pregnancy became high risk (Lundgren et al., 2007).

Partnership can be a 'problematic relationship'. Fleming (1998a) undertook a qualitative study, which aimed to investigate the relationship between women and midwives. She recruited twelve independent midwives who approached twenty of their clients to participate in the study, by engaging in up to six semi-structured interviews. Fleming (1998a) found that the notion of partnership espoused by professionals was not experienced by women, who perceived that midwives provided the 'medical bit' but did not feel that the care from midwives was any different from that of doctors. This contrasts with Fleming's analysis of the midwifery care, which she described as ascribing to a midwifery model of care. She argued that midwives' practice follows an oral culture, handed down from previous generations of midwives, but that midwives adopt a written culture when completing records, which paralleled the care documented by physicians and therefore was perceived as perpetuating a medical model of care (Fleming, 1998a). Wilkins (2010) supported this view, arguing that the partnership relationship is hindered by midwives' adoption of a professional paradigm at the expense of their social and psychological self. In her qualitative study of twenty four community midwife:woman dyads she set out to examine what was 'special' about the relationship between the woman and her community midwife. She identified that women valued the personal, emotional and biographical experiences that midwives brought to the relationship rather than a reliance on the more scientific/rational objective approach founded on research principles (Wilkins, 1993).

The quality of the midwife-woman relationship during childbirth has been identified as one of the factors that influenced the level of satisfaction women experienced during pregnancy (Tinkler et al., 1998). The relationship has been described as special by women and for many it has felt like a personal relationship, akin to but not identical to friendship (Wilkins, 1993; Walsh, 1999; Pairman et al., 2006). Models of partnership caseload in the UK have identified with the concept of professional friendship, developing out of a more personalised approach that combines continuity of carer with the formation of a trusting relationship (Walsh, 1999). Women stressed the importance of a confiding, trusting, close relationship, which had their emotions, experiences and concerns at its heart, alongside the midwives providing physical care (Wilkins, 2010; Tinkler et al., 1998). Pregnancy and childbirth can be described in this sense as a process of self-exploration that some women seek to share and understand with their community midwives.

A model developed by Fleming (1998b) suggested that reciprocity is the foundation of a successful relationship between women and midwives. The concept of reciprocity in midwifery needs further development, as many studies on effective reciprocal relationships have been undertaken with small numbers of women in partnership caseload settings (Hunter, 2006a). These models of care are not available to the majority of women experiencing maternity care in the NHS, where practice may be affected by staff shortages and organisational constraints. When Hunter (2006a) studied reciprocal relationships with community midwives she identified that in many situations the relationship was not reciprocal, and that midwives needed to engage in a number of strategies to provide emotional balance such as '*professional detachment, distancing and task orientation*' (p.319), which she described as emotional work.

Wilkins (1993) suggested that although some midwives and women may discuss the development of a 'special' relationship, she was unable to find anything in the literature that identified what it was about the relationship that was special. Wilkins (1993) proposed that a special relationship occurred for women at both a social and emotional level. Women who got to know the midwife at a personal level, which was described as akin to friendship, formed a relationship that was confiding, trusting and close, and which was perceived by women to be important (Wilkins, 2010). This finding was supported by Edwards (2010) who suggested that for women, forming a relationship was about getting to talk to the midwife at an emotional and social level as well as dealing with the 'tasks' required in the visit. If midwives are to provide truly women-centred care in partnership, empowering women to make informed choices, then this relationship must be acknowledged as fundamentally important (Tinkler et al., 1998).

A small qualitative study of eighteen women which explored women's control of their bodies during childbirth, found that women who experienced a midwifery model of care alternated from being empowered to be in control of their bodies to working in a co-operative collaborative relationship with the midwife, whereas women experiencing obstetric care did not experience this collaborative relationship (Carter, 2010). This findings suggest that the partnership relationship, established between the woman and midwife, allows women to embrace body changes during childbirth and to work as Carter suggests in, '*peace and harmony rather than control and domination*' (2010, p1005). Hook (2006) concluded that whilst a number of studies identify the benefits of a partnership relationship, none of the work that she reviewed confirmed that partnership was

present or how it was viewed from the user perspective. This study seeks to respond to this gap in knowledge on partnership working and to specifically explore whether women experience a partnership relationship and whether this is important to them.

Summary

In this section the emergence of partnership working as a central component of government policy and the subsequent integration into professional and regulatory frameworks and guidance are outlined. This section concluded with a critique of the midwifery literature on partnership working, identifying the evidence base for aspects of the partnership model and raised issues around equality, reciprocity and how the relationship is negotiated when women do not want to engage in a partnership relationship with the midwife.

Concept of trust

Trust has been identified as a fundamental element both in the concept of partnership (Gallant et al., 2002; Wiggins, 2008) and when discussing the elements that are important in establishing a meaningful relationship between the woman and midwife (Wilkins, 2010). Trust develops in response to social interactions between individuals and groups, and has been described as a relational phenomenon (Theide, 2005). The widespread usage of the term trust within a number of health and social care disciplines, has resulted in a need to review the term critically to ensure that it is being applied consistently. A concept analysis of trust undertaken by Hupcey et al. (2001), in a range of health and social care disciplines, concluded that the concept remains immature in relation to a rigorous evidence based evaluation of its meaning. However, the authors determined that trust, as a concept, emerged where there was evidence of need and usually occurred following a process of risk assessment by the truster. Clients who chose to trust their carers continually evaluated the outcome of their trust to determine the level of congruence in the person who is trusted. This experience impacted on the extent to which service users felt able to trust the advice and care of health care professionals in future situations (Hupcey et al, 2001).

Kirkham (2000, 2010) suggested that in order to develop a relationship, women need to be able to trust in the midwife and the midwife needs to be able to trust in the service to support her in her role. Higher levels of trust are associated with enhanced co-operation and subsequently better

health outcomes (Goudge et al., 2005; McDonnell et al., 2009). Women experience feelings of trust and reciprocity when they have supportive social networks and therefore experience less psychosocial stress enhancing their health and well-being (Abbott et al., 2008). Moreover, Joshi et al (2008) argued that social relationships are a significant factor in enhancing health outcomes, which Way et al. (2010) linked to serotonin levels. However, a review by Uchino et al (2012) over the past thirty years found no evidence to substantiate the link between social support and enhanced health outcomes. A longitudinal study by Giordano et al. (2012) suggests that perhaps it is not participation that enhances health outcomes but trust, which they postulated may be mediated via psychosocial pathways. Giordano et al. (2012) identified a positive relationship between trust and self-rated health. Midwifery models of care which provide women with a consistent relationship with a midwife provide an opportunity for the development of a relationship of trust.

Huber et al. (2009) defined one to one midwifery care models as providing relational continuity which has been defined as, '*an on-going therapeutic relationship with a provider*' (Haggerty et al., 2003). Relational continuity was associated with feelings of trust being experienced by women who also described having confidence in the midwife's professional skills and being reassured by her calm demeanour. Women described continuity in relation to a feeling that the environment was calm which has been shown to be associated with improved outcomes and increased maternal satisfaction (Lundgren et al., 2007; Huber et al., 2009; Leap et al., 2010). Women who received continuity of carer, with up to two midwives, had confidence and felt able to let go, to trust that the midwives would guide them without the need to write a birth plan. Women that did not experience continuity talked about having a lack of trust in the decisions the midwife would make (Edwards, 2010). Theide (2005) suggested that trust develops within an emotionally and culturally secure relationship. It could therefore be argued that for the midwife and woman to develop a trusting relationship the model of midwifery care is significant.

Models of midwifery care

Introduction

In this section the impact of a range of midwifery models of care will be explored in relation to the impact on both women and midwives, but also on outcomes when compared with traditional

models of care. The evidence base used to examine models of midwifery care draws heavily on work from the UK and Australia, covering the period from the late 1990s until the present day. The organisation of maternity care is different in Australia and was, until relatively recently, dominated by private practice with the obstetrician providing most of the care within maternity units. In contrast the UK has a strong tradition of community midwifery care, where women are supported by a community midwife for the majority of their antenatal and postnatal care. Both countries provide care using a medical model, which is obstetric led. The literature on models of midwifery care, in both countries, provides evidence of a desire to move away from the medical model, to a more social model of care, where women are provided with continuity of care under a range of caseload and team midwifery models.

Continuity versus traditional models of care

The term continuity of care is widely used in the literature but the lack of a clear definition makes it difficult to interpret studies in this area (Sandall et al., 2009). In continuity of care models, women will receive consistent care from a small team of midwives, who are known to the woman, and who communicate effectively, so the woman does not have to update the midwife at each appointment (Green et al., 2000). This is different from continuity of carer where the care throughout pregnancy, childbirth and the postnatal period is given by one midwife, either through a caseload model or the engagement of an independent midwife. The fundamental principle of continuity of care is that a woman will be seen by one or a small group of midwives throughout her pregnancy, birth and postnatal period. However, models of care are varied and sometimes continuity is only achieved during antenatal or postnatal care, but rarely throughout the childbirth continuum, except where a woman engages an independent midwife privately or has one-to-one care in a midwifery caseloading model.

This is in contrast to conventional models of care where women may be seen during the antenatal and postnatal period by a community midwife, GP or obstetrician and in labour will be cared for by whoever is on duty on the day the woman attends the delivery suite. Women can achieve a degree of continuity of care during these periods but this is dependent on staffing levels, organisational and funding constraints (Hart et al., 1999) and hindered by the increasing numbers of midwives working part time (Sandall, 1995). Both *Changing Childbirth* (DoH, 1993) and *Maternity Matters* (DoH, 2007) identify the importance of being cared for by a midwife who is known to the woman.

A range of models of care have been introduced in the UK and other Western countries, from one-to-one midwifery care, based on one midwife providing all of a woman's care throughout the childbearing period, to caseload or team midwifery (Homer et al., 2008). Caseload midwifery is similar to one to one midwifery care but in some areas this is undertaken with two to three midwives and is often referred to as partnership caseload midwifery. In this situation, the second midwife can cover for the primary midwife so that the woman is more likely to be cared for by a midwife she knows (Homer et al., 2008). Another model of care is team midwifery, where care is provided by a team of six to eight midwives, up to a team of twenty five midwives (Flint, 1993). Due to the reduction in the number of antenatal and postnatal visits, in larger teams, it is unlikely that the woman will achieve continuity by a known midwife, but the philosophy of care may be consistent. For this reason some authors term the latter scenario continuity of care whereas when a caseload or one to one scheme is in operation this may be referred to as continuity of carer (Homer et al., 2008).

Studies of partnership caseload midwifery care have demonstrated lower rates of induction and augmentation of labour (North Staffordshire Changing Childbirth Research Team, 2000; Fleming et al., 2007a), epidural usage, reduced levels of perineal trauma and higher rates of normal births (Benjamin et al., 2001; Page et al., 2001; Milan, 2005; Fleming et al., 2007a) when compared with conventional models of care. In addition, partnership schemes have been shown to achieve high levels of continuity during birth, with between 85-95% of women being delivered by a known midwife (North Staffordshire Changing Childbirth Research Team, 2000; Fleming et al., 2007a; Leap et al 2010). A comparison with independent midwifery practice in the UK by Milan (2005), with four caseload models undertaken within the NHS, showed similar outcomes across all or some of these studies in relation to birth outcomes, specifically use of epidural analgesia, mode of delivery, perineal trauma and delivery by a known midwife. Milan (2005) argued that the women who employed an independent midwife were generally older and had more risk factors. The outcomes when compared with largely low risk NHS caseloading models raised questions about the risk scoring tools used to determine the lead carer for women, particularly when the outcomes for women experiencing independent midwifery care were comparable to NHS low risk caseloads.

In contrast to this, the Albany Midwifery Practice was a model of care established by a group of midwives in an area of social deprivation in South London. This practice was made up of six midwives, who were self-employed but funded under a contract from King's College Hospital. The midwives had a caseload of thirty-six women for whom they were the primary carers, but also provided back-up for another group of women as the second midwife. The midwives in this group were able to provide women with continuity of care and carer because they were on call continuously, 24 hours a day for nine months of the year (Leap et al., 2010). The outcomes for women under this model were impressive with 40-50% of women delivering at home, against a national average of 3% (NPEU, 2007). The breast feeding initiation rate was also exceptional at 95% when the national figure was 76% (SACN, 2008), which was maintained at 72.5% at four weeks after birth (Leap et al., 2010) when the figure for the UK was 48% at six weeks (SACN, 2008). Despite these statistics the Albany Midwifery Practice (AMP) group lost their contract with Kings College Hospital in December 2009 on the grounds of safety, following the recommendation of the Centre for Maternal and Child Health Enquiries (CMACE) in a confidential report not open to public scrutiny (Walsh, 2010; Harrington, 2010). The Royal College of Midwives following a review of this report requested that the report was made public as in the view of the College the midwives at Albany needed management and leadership support rather than for the NHS Trust to withdraw support for this innovative model of care (RCM, 2010). This view was supported by the NCT, who held a rally in support of the Albany midwives in March 2010 and will continue to lobby until Kings retracts the statement that the AMP group was unsafe (NCT, 2010). The General Secretary of the RCM, Cathy Warwick stated:

'Albany was a very innovative model and helped to accelerate the provision of women centred services. There is no doubt that there are lessons to be learned from this report. With the right structures and processes in place, the model of service offered by Albany can and should be replicated and adopted by other maternity services.' (RCM, 2010)

A statement from Kings College Hospital outlines the rationale for this decision, which was based on the fact that a significantly larger proportion of babies delivered by AMP suffered from hypoxic brain injury. However, this judgement has been challenged by the AMP following support from an independent statistician, which questions the validity of the inferences drawn by the Trust (AMP,

2010). The CMACE review identified that the Albany midwives did not comply with the Trust policies at Kings and the risk management protocols. It was for this reason that Kings College Hospital terminated their contract with the Albany midwives (Kings College Hospital NHS Trust, 2009). The challenge for the midwives working independently is how much autonomy they can exercise when they hold a contract with an NHS provider who is required to manage risk. Moreover, as the CMACE report did not recommend terminating the service and data selected has been suggested to be flawed, it raises questions as to what the reason was behind the termination of this service. The AMP midwives also conclude that if it was on grounds of safety it was interesting to note that Kings offered employment to all of the AMP midwives (AMP, 2010), and continue to support community based initiatives.

In a UK study undertaken by Benjamin et al (2001), caseload women were more likely to choose to deliver at home or in a midwifery led birth unit and have a more active labour compared with women experiencing conventional team based care. This study was non-randomised and the findings may have been influenced by the types of midwives who would elect to join a partnership caseload, which requires a different level of commitment than conventional care. These midwives may also have been more supportive of active birth in a non-medicalised environment (Benjamin et al., 2001). However, a Cochrane review undertaken in 2008 supported these findings and concluded that units should look to reorganise services to support midwifery led models of care, if they aspire to increase the normal birth rates and reduce the use of technology (Sandall et al., 2009).

A study undertaken in the UK by Spurgeon et al. (2001) compared two models of team midwifery led care with conventional care and whilst continuity during labour and birth was high in the midwifery led models, the authors did not find any differences in intrapartum outcomes. The study was retrospective and was also described as naturalistic, suggesting a lack of rigour with the study design which could have impacted on the findings. The study used a postnatal questionnaire at six weeks after the birth, so this also could have impacted on the reliability of the findings, particularly in relation to women's memory of their antenatal experiences. However, despite this, women who experienced midwifery led care reported higher levels of satisfaction and felt they were better informed and were given more choices than the women receiving conventional care (Spurgeon et al., 2001).

Midwives' views of continuity

Continuity of care models are not without challenges; Midwives who provide regular on calls frequently complain of 'burn-out' (Sandall, 1997), because the invasiveness of regular on call patterns impacts on the midwives family and social life over time (Stevens et al, 2002b; Homer et al., 2008). Annandale et al. (1996) stated that ensuring continuity of carer for women should not be a result of exploitation of the midwife. Management support is essential to ensure that midwives are provided with periods when they are not on call, to ensure an appropriate work life balance (Homer et al., 2008; Sandall, 1997). Midwives working in a caseload model need to establish realistic strategies to ensure an effective work-life balance, if they are to sustain this way of working, and manage women's expectations about what the caseload midwife can realistically achieve within her role (Stevens et al, 2002b; Page, 2003; Fereday et al., 2010).

Page (2003) found that midwives working in a partnership caseload scheme or one to one midwifery model experienced higher levels of satisfaction and autonomy, as they were given the freedom to organise their workload around their home commitments, and were not tied to working rigid shift patterns. Midwives evaluated caseload practice as fulfilling, in that they were able to practice all aspects of midwifery autonomously and establish satisfying reciprocal relationships with women through offering continuity of care (Stevens et al., 2002a). However, evaluation of midwives who left the partnership caseload model revealed that this model of care impacted adversely on family life, particularly with childcare (Stevens et al., 2002b), and was more of an issue for midwives who could not 'switch off' from thinking about the women that they caseload (Fereday et al, 2010). Midwives also found adapting to the autonomy of caseload practice challenging, experienced poor organisational support in providing cover for sickness and identified interprofessional tensions, both with hospital colleagues and for some with their caseloading partner (Stevens et al., 2002b).

Midwives who worked in a team midwifery model also reported high levels of stress, depression (Flint, 1993) and burnout and were more likely to leave the profession (Sandall,1997). Todd et al (1998) undertook a quantitative study in the UK, using a postal survey of seven community based teams and compared the findings with hospital midwives. The response rate to the survey was good at 87%, which is higher than average response rates to postal surveys found in health

research, which is in the region of 50% (Ford et al, 2009). Todd et al (1998) identified that the impact of non-response bias was limited as responses were equally represented across all teams (MacDonald et al., 2009), increasing the validity of the findings. Community midwives working in a team midwifery model, felt that women received better antenatal and postnatal continuity in conventional community care models, because of the size of the teams. A small qualitative study undertaken by Shallow (2001) concurred with this finding. Community midwives spoke of being '*disconnected*' from women because the integrated teams meant that they were rarely able to form a relationship with the woman. The researchers concluded that the level of continuity of care in labour was low, relationships with women were rarely established and the midwives themselves found the on-call requirements impacted adversely on their social lives, leaving them feeling disillusioned with this model of care (Todd et al., 1998; Shallow, 2001). Despite this, community midwives preferred the team model of care because they felt it offered more variety and enabled them to fully utilise their skills, although the majority of midwives felt that team midwifery had not improved care for women (Todd et al., 1998). The disadvantage of using a quantitative survey to explore participants' views in the study by Todd et al (1998), is that the questions were closed, using a likert scale, and at the point of analysis conflated to agree or disagree. Whilst the researchers achieved a very good response rate, the use of a postal survey resulted in a lack of meaningful dialogue that would have been enhanced by the addition of a qualitative element to explore the findings in more depth.

A qualitative study by Walker et al (2004) undertaken in Australia, explored midwives' views of team midwifery using focus groups, and reported that team midwives experienced increased autonomy and accountability when providing holistic midwifery care, resulting in midwives taking more responsibility for their practice. Walker et al (2004) concluded that for team midwifery to be effective it needed organisational support and a process implemented to enhance and promote inter-team relationships, including team building and stress management to equip midwives to cope with the added workload resulting from this model of care. The midwife-woman relationship was a significant factor in enhancing midwives satisfaction. However, whilst this paper examined a move from a medical model to a midwifery model, with teams of eight to nine midwives', it is unlikely that women experienced a significant improvement in continuity of carer, which may have limited the extent to which the midwives in this study could practice autonomously (Walker et al., 2004).

Women's views of continuity

Women's views on their midwifery care are essential if we are to provide truly women centred care and a review of the literature has identified a wealth of evidence from the woman's perspective. The main focus of the literature is on women's views of their experience of different models of midwifery care and specifically their level of satisfaction, but not on women's views on whether they experience a partnership relationship with the midwife, and whether in this relationship they feel they are offered informed choices regarding their care. The main impetus for undertaking this study was to explore this gap in the literature, particularly in the context of the Government agenda for partnership working and the choice guarantees identified in *Maternity Matters* (DoH, 2007). I was interested to explore the nature of the relationship women experience with the midwife, but also to examine the extent to which women wanted to develop a partnership relationship with the midwife.

Green et al. (2000) reviewed a number of models of midwifery care that were evaluated during the late 1980s and 1990s, to determine women's views of these schemes. Continuity of care or carer was not as important to women as consistent care by a midwife who they trusted (Green et al., 2000). Green et al. (2000) argued that the evidence does not support that maternity units should prioritise the *Changing Childbirth* indicator of success, that 75% of women should be cared for in labour by a midwife who is known to them (DoH, 1993), when to achieve this may drain resources from other aspects of care and result in 'burnout' of midwives (Sandall, 1997). However, studies examining women's satisfaction with partnership caseload models identified that women felt better prepared for birth, more confident and had higher levels of satisfaction with their care, when compared with women who received conventional models of care (Walsh, 1999; Page et al., 2001).

Shields et al. (1998) undertook a large randomised controlled trial of nearly 1300 women in Glasgow, to compare satisfaction levels in women cared for using a caseload model with those who received conventional shared care between the midwife and General Practitioner. The researchers found that overall satisfaction levels were higher in women who experienced caseload midwifery, particularly during antenatal and postnatal care. The differences were less marked during intrapartum care. Shields et al (1998) concluded that schemes that support continuity of care and carer increase women's satisfaction levels, and therefore should be encouraged. What was interesting to note in this study was that when women commented on choice, the most

significant issue for them was the length of waiting times for consultations, and during the postnatal period, not knowing what time the midwife would visit. The political, professional and service user agenda has more recently focused much more on the extent to which women engage in significant choices related to their care, particularly around choice of carer and place of birth. This change of emphasis in the UK may relate to differing expectations, particularly following the publication of the National Service Framework (DoH, 2004) and Maternity Matters (DoH, 2007).

A UK based mixed methods study that compared conventional care with a one-to one midwifery care scheme (caseload), found that women from both groups preferred continuity of midwifery care provided in a community setting (McCourt et al., 2001). However, caseload women experienced more consistent advice and support, which appeared to meet their psycho-social and emotional needs, and resulted in lower levels of intervention and enhanced adaptation to parenting (McCourt et al., 1998). A similar model of care was explored using a qualitative methodology with ten women who experienced caseload midwifery practice in the UK, and these women reported forming a relationship of professional friendship with the midwives, which increased women's feeling of confidence and empowerment, where midwives were seen as acting as advocates to women (Walsh, 1999). However, a key issue in this study was termination of contact with the midwife at the end of the care, which many women described as being difficult (Walsh, 1999). Walsh (1999) conducted interviews two to three months after the baby's birth and it is possible that the women's memory of the birth experience was affected by the time lag between the event being studied and the collection of data. Alternatively, it has been proposed that women's levels of satisfaction may be masked by a halo effect in the first six months after birth, particularly when they birth a healthy baby, and they are therefore less likely to criticise the care received (Bruggemann et al, 2007). Researchers need to take cognisance of these factors when interpreting the results of their work, particularly in relation to memory of negative events (Simkin, 1992).

Williams et al (2010) in an Australian study, set out to establish whether there was a link between continuity of care and women's experience of satisfaction when receiving caseload midwifery care. The researchers used a postal questionnaire which included both open and closed questions, and used a five point likert scale ranging from strongly disagree to strongly agree. Williams et al (2010) concluded that there was no correlation between continuity of care and satisfaction, however, there was an association between satisfaction, birth outcome and parity. Women who had previous

experience of childbirth and who had normal births were more satisfied than women having their first births or women who had complicated labours. From an evaluation of continuity of carer, women did not rate highly being cared for during labour by a midwife who was known to them, and perhaps the effort maternity services are putting into meeting this indicator could be better spent providing a more personalised service in other ways (Green et al, 2000). Williams et al (2010) concurred with this view, arguing that consistency of care may be more important to women than continuity.

The issue of knowing the midwife caring for women in labour was also explored using a team midwifery model. A comparison of women's views of conventional care compared with team midwifery revealed that being provided with safe care and clear explanations during labour was more important to women than knowing the midwife previously (Hart et al., 1999). In contrast, an Australian study by Homer et al (2002) found that women cared for by a small team of six midwives, who experienced continuity of carer during labour, reported a '*higher sense of personal control*' (p.110) due to the fact that they had the opportunity to discuss preferences with the midwife during their antenatal care. However, Homer et al (2002) noted that increased personal control was not associated with a perceived better childbirth experience. The authors argued that their study was quantitative and recruited a significantly larger sample of women than many previous qualitative studies exploring the impact of continuity of care. However, they did acknowledge that the quantitative methodology used did not facilitate an exploration of the complexity of continuity of care and what is important to women (Homer et al, 2002). A comparison of a team midwifery model compared with conventional care by community midwives in England concluded that women were more satisfied with their antenatal care under a traditional model of community midwifery care (Farquhar et al, 2000). Teams of six to eight midwives provided less continuity during antenatal and postnatal care than conventional models of midwifery care; as the evidence of increased satisfaction when being cared for by a known midwife in labour is limited, it is provided at the expense of the continuity provided by the community midwife during antenatal and postnatal care (DoH, 1993; Farquhar et al, 2000).

Moreover, the philosophy of care has been suggested as an important factor in satisfaction measures; the calm environment provided by birth centre care has been shown to enhance maternal satisfaction irrespective of whether the woman knows the midwife caring for her

(Waldenstrom, 1998). Davey et al (2005) found that women discriminated between continuity of carer and the quality of the interaction, and concluded that continuity of carer alone is not enough to improve care for women. It is important that midwives personalise the interaction and get to know the woman if women are to experience higher levels of satisfaction. A clear issue raised by Hart et al. (1999) was the fact that the Changing Childbirth recommendations were expected to be implemented without any resources being allocated to support them; the scheme in Brighton was abandoned due to a lack of obvious benefit and the fact that it was considered to be resource intensive.

Summary

In this section midwifery models of care, partnership caseload and team midwifery, have been compared with conventional models of care in relation to the experience from the women's and midwives' perspectives and the impact on childbirth outcome. Intervention rates are found to be lower when women receive continuity of carer, and women are more likely to choose to birth in midwifery led or home settings. Women reported higher levels of satisfaction when they knew the midwife and received consistent advice, although the findings on the importance of being cared for by a known midwife in labour are inconsistent. Continuity of carer may be more important in relation to the woman's psycho-social well-being, which may empower women to feel more in control during labour, irrespective of whether they are cared for by a known midwife. Midwives providing continuity of carer in team and caseload schemes reported higher levels of satisfaction and greater feelings of autonomy. However, key to the success of continuity of care models was good management support and leadership, to reduce organisational constraints and promote effective inter-professional relationships between staff. This reduces tensions between midwives working in caseloading models and staff working in conventional settings. Moreover, midwives need to establish clear boundaries to provide a sustained work life balance by ensuring that women's expectations of the caseload model are realistic.

Medical versus social models of care

Introduction

Research exploring medicalisation of childbirth and its impact on midwifery practice has been drawn from a range of developed countries including the United States of America (USA), Canada,

Australia and the UK, where birth predominantly takes place in hospital settings under the overall management of doctors. The position of midwifery in these countries has differed in that the lead professional for normal birth in all but the UK has until recently been the doctor. Changes in Government policy in all four countries has led to an increase in midwifery led care for healthy women, and changes in legislation to legalise midwifery practice particularly in America and Canada. Doctors attend over 90% of births in the USA and midwifery practice is still illegal in twelve states. In addition, health insurance only covers payment for a midwife licensed as a Certified Professional Midwife (CPM) in eleven American states (Carter, 2010). CPM's usually practice within the home or birth centres and are similar to independent midwives and community midwives in the UK whereas Certified Nurse Midwives (CNM's) are more commonly hospital based, working alongside doctors (Foley et al, 2003). Midwifery was legalised in some Canadian provinces from the early 1990s, and in 2002 between 3-5% of women were cared for by midwives (Benoit et al., 2010; Canadian Institute for Health Information, 2004). However, midwifery care is fully supported by the Society of Obstetricians and Gynaecologists who promoted the development of inter professional collaboration with midwives and the importance of choice for women (SOCG Policy Statement, July 2009). In contrast, the Royal Colleges of Obstetrics and Gynaecology in Australia and America perpetuate a risk averse stance to childbirth particularly in relation to home birth. For example, the American College of Obstetricians and Gynaecologists committee opinion on planned home birth states:

Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. (ACOG, 2011, p.1)

The power of language when using a medical discourse, with the emphasis on risk, reduces choice and further excludes woman from the decision making process (Williams, 1997). Despite the apparent support for midwifery models of care in Australia and Canada, Benoit et al (2010) argued that the neoliberal rhetoric, which ostensibly supports choice for women, in fact masks on-going support for medical dominance. This is reflected by the high rates of operative delivery and variations in funding for private health care which impede women's access to midwifery care. Van Teijlingen (2005) has argued that in using the term medical model it is necessary to critically

evaluate its application to avoid the concept and the framework of medicalization becoming a blunt instrument, and therefore, of limited practical use as an explanatory framework. He suggests analysing the two positions using different approaches depending on the level on which the term is being used, and proposes a clear distinction between practice, ideology and sociological analysis. Within the debate on childbirth from a practical level, he suggests using the term midwifery practice to distinguish the natural physiological approach from the risk averse position adopted by many doctors, that pregnancy is potentially pathological, an approach he termed obstetric practice (Van Teijlingen, 2005).

In this section the increase in medicalisation of childbirth and the characteristics most commonly identified with the midwifery and obstetric models of care will be explored, identifying the main areas of differentiation, but also recognising that in practice care may contain elements from both. The emergence of a risk based approach and its impact on maternity care will also be examined.

Characteristics of the different models of childbirth

A social or midwifery model of care is philosophically different to an obstetric or medical model. The medical model places reliance on surveillance using technology, to support the identification of abnormality and therefore, to identify the need for intervention and control. In contrast, the midwifery model assumes that birth is a normal, physiological process and that the midwife should work in partnership with the woman in a continuous relationship, providing advocacy and supporting autonomy (Bryers et al., 2010; Pollard, 2011; Soltani et al., 2012). Midwives caring for women in the community and birth centre settings more closely align with the social model, whereas doctors and midwives caring for women in obstetric units frequently subscribe to a medical model (Van Teijlingen, 2005). To what extent this is influenced by the culture within these environments is questionable; do practitioners who subscribe to a medical model choose to work in an environment where technology prevails, or does working in such an environment change an individual's practice over time? In table 3, the key elements from a range of studies have been combined to describe the main characteristics found in midwifery practice when compared with obstetric practice. Davis-Floyd (2001) developed three paradigms representing a technocratic (medical) and holistic (midwifery) dualism but also adding an in between model which she termed humanistic. The humanistic paradigm was not included because although this recognises the continuum of practice it added a dimension not reflected in the work of other authors, thereby hindering the clarity of a dualistic model. Both Van Teijlingen (2005) and Davis-Floyd (2001)

identified the notion of body mind dualism or separation within the medical/technocratic model and contrasted this with holistic or oneness. All four authors identified holistic care within a midwifery model, which resonates with practice whereas mind body dualism as a concept related more to sociological theory rather than obstetric practice, and therefore was not included. Van Teijlingen (2005) also identified the medical model as a male perspective and midwifery as female. This dichotomy was not described by the other authors and was excluded as it related more to ideology than practice. However, within the model male and female were identified as women centred versus doctor centred which is more relevant at a practice level. The remaining elements were identified by all four authors, who also drew on a number of other workers to support their ideas.

Table 2: Recognised aspects of the social and medical models of care
(Davis-Floyd, 2001; Walsh et al, 2002; Van Teijlingen, 2005; Bryers et al, 2010)

Midwifery Practice (Social Model)	Obstetric Practice (Medical Model)
Physiological/natural	Rationale/scientific: only normal in retrospect
Subjective, intuitive	Objective
Women centred, holistic, individual authority and responsibility	Doctor centred; authority and responsibility sits with the practitioner
Choice: Woman births where she wants to with support of family and friends	Control: birth in hospital under medical scrutiny
Care is individualised	Care is hierarchical and standardised
Watchful waiting, following woman's body	Technological/interventionist – used to 'help' the woman
Life event	Medical event
Aims for a live, healthy mother and baby and satisfaction of woman/family	Aims for a live, healthy mother and baby

Emergence of medicalisation

Childbirth, and especially the process of giving birth within institutions, has been described metaphorically as a mechanical production line, with women seen as reproductive machines that, in a childbirth analogy, need obstetricians to repair their faults, and regularly service them to ensure smooth functioning (Oakley, 1993; Davis-Floyd, 2001). Martin (1992) in her study of women's experience of childbirth compared the process of childbearing within an obstetric model to the mechanical metaphor of production; the woman as the labourer supervised by the Obstetrician has

resonance with this concept. Martin (1992) argued that although women's groups have challenged the obstetric model in relation to enhancing women's experience, the medical authority still controls birth ensuring that power is retained by the doctors.

Arney (1982) identified a further phase, after the Second World War, where he suggested the metaphor of the body as a machine was replaced by the concept of the body as a series of complex interconnecting processes, requiring close surveillance. He argued that in obstetrics data was collected and the process of childbirth closely monitored, culminating in a managed birth, ensuring that obstetricians maintained a firm hold on their power base (Arney, 1982). This notion of surveillance resonates with Foucault's description of the panopticon, a prison with a central tower from which the guards observed the inmates in their cells which surrounded the tower (Foucault, 1977). Foucault (1977) argued that power relations function through medical surveillance, presented as expert knowledge, which when internalised by the patients and other health care professionals, resulted in acceptance of the medical position, however this position can be resisted if the subordinate individual or group are empowered.

Walsh et al (2002) further contended that as long as midwives continue to be employed by the NHS, and are based in Consultant units, where birth continues to be managed using an obstetric model, change will continue to be slow. They argued that if midwives were all community based and more closely aligned with women and social care workers, the social model of care would be enabled to flourish (Walsh et al., 2002). Moreover, Fisher et al (2006) found that women experienced childbirth fear at both a personal and social level, which was exacerbated by the medicalised environment that birth takes place in. In this qualitative study undertaken in Western Australia, women's experience of fear was mediated when women experienced continuity of care with a midwife that they could trust, and with whom they were able to establish a relationship. Fisher et al (2006) concluded that women can achieve psycho-social balance if they are provided with community based midwifery care, using a model that supports a partnership relationship.

Maternity care is still largely predicated on the biomedical model, strengthened by a shift of childbirth from taking place within the community to the hospital where it would be managed by doctors (Cahill, 2001; Lewis, et al, 2004; Benoit et al., 2010), ignoring the social contexts in which people live (Oakley, 1993). This is despite political, economic and social pressures to provide

midwives with more autonomy when caring for healthy pregnant women. Midwifery led care is associated with lower levels of perinatal mortality (Porter, 2004), however one-to one models of midwifery care have been difficult to sustain due to economic challenges. Despite this, an economic analysis comparing midwifery led with medically led care has identified that midwifery led care is more cost effective (Hatem, et al, 2008). Lowis et al (2004) concur that in countries where midwives are the lead carer during childbirth, there are reduced levels of medical intervention, and the perinatal and infant mortality rates are lower than in the United States where maternity care is largely medically controlled. However, recent findings from a Cochrane review did not identify any difference in overall fetal loss or perinatal morbidity, therefore concluding that midwifery led care is as safe as doctor led care (Hatem et al., 2008).

The impact of risk on medicalisation

Medical dominance over childbirth has evolved as a result of health care professionals promulgating the rhetoric that childbirth is inherently dangerous to the mother and more particularly to her unborn child (Williams, 1997; Tew, 1998; Fisher et al., 2006), despite a lack of evidence that improved mortality rates are directly correlated to medical interventions (Oakley, 1993; Davis-Floyd, 2001; Soltani et al., 2012).

A qualitative study of twenty-seven licensed lay midwives in Arizona explored the change in midwives' practice as a result of the licensing process, which required midwives to adopt rules and regulations that impacted on their practice. Weitz et al (1985) found that over the five years of licensure midwives moved from a social model of midwifery care to adopting elements of medicalisation because of fear of censure, changes in expectation of clients and the impact of increased perception of risk associated with childbirth. Van Teijlingen (2005) argued that medicalisation is a process of social change, in which both women and midwives are immersed in a culture that perceives childbirth as inherently risky, thereby needing medical supervision (Brubaker et al, 2009). This may provide some explanation for the change in behaviour of lay midwives.

Scamell (2011) undertook an ethnographic study in the UK to explore how midwives perceive risk and how the discourse of risk is reflected in their practice. This study covered a wide range of settings including an obstetric unit, midwifery led units and home births and included observing

forty-two births. In addition, twenty five interviews were conducted involving midwifery managers, midwives, students and members from midwifery pressure groups. Scamell (2011) established that in providing routine care during labour to facilitate normality midwives, in fact, focus on excluding the abnormal and that therefore this focus on health surveillance perpetuates an obstetric model of care. She concluded that this study *'goes some way towards explaining how midwives are active agents in the medicalisation of childbirth performance'* (Scamell, 2011: p 997):

The struggle for power coincided with an increase in the medicalisation of childbirth and a widespread view that childbirth is only normal in retrospect (Oakley, 1993). This medical hegemony has influenced society's view of childbirth which is seen as 'risky' and in need of technological support in order to achieve a safe birth, despite the fact that many interventions have been introduced without any evidence base to support them (Tew, 1998; Page et al., 2000; Cahill, 2001; Macfarlane, 2008). The contrast between the medical model adopted by obstetricians and the natural, biological or maternal model adopted by women and many midwives can be explained using the notion of a frame of reference. A frame of reference examined from an ideological perspective views differences in attitudes and beliefs through which different groups view a situation, in this case women and obstetricians (Oakley, 1980). Whilst these findings are over thirty years old, more recent work by McCourt (2006) identified that despite changes in medical education, and socialisation of health care professionals, these differences continue to emerge in practice. Graham et al. (1986) describe the obstetricians' frame of reference as relating to a medical episode, from the diagnosis of pregnancy until the moment of birth. The birth of a child, from the woman's frame of reference, is a natural process resulting in a significant life event which has lifelong consequences associated with the change in role that culminates in motherhood (Hunt et al., 1995).

Graham et al. (1986) identified dimensions of disagreement in their research. As well as the medical versus social dimension, they also identified the isolated medical event versus the life experience, the way success is measured and who controls childbirth. The dissonance between the medical and the maternal frame of reference can result in dissatisfaction with the maternity care the woman receives (Oakley, 1980), particularly for women who wanted to participate in decision making but were not offered the choice (Blix-Lindstrom et al, 2004). The Expert Maternity group within the Changing Childbirth report sought to redress this balance by empowering women to have

choice, continuity and control in the care that they received (DoH, 1993). Benoit et al. (2005) argued that rather than focusing on health and social care needs, the Changing Childbirth report was jumping onto the consumerist bandwagon, which from a political perspective would be particularly attractive even if the principles extolled in the report never resulted in a change in the local health care economy. However, in a system which maintains the power hierarchy of obstetricians, without a fundamental change to the organisation of the maternity services, giving all players equality of position, the obstetric model will continue to dominate maternity services (Benoit et al., 2005; Bryers et al, 2010).

Kitzinger (2005) argued that obstetricians, adopted a post-structuralist stance, and used their dominant position of power to 'shroud wave', thereby frightening women to accept the medical position (Campbell et al., 1997). Interestingly, many midwives working in obstetric units have adopted the mantle of the obstetric model and have become the '*agents of oppression and control*' (Anderson, 2004, p. 263) adopting the ruling hegemony of the NHS (Walsh, 2010). Kirkham et al. (2004) identified that in Consultant units, the prevailing culture of risk and litigation resulted in midwives meeting the organisational demands rather than supporting women or providing evidence based practice. In order to meet the needs of the institution, midwives were seen to use coercion to encourage women to comply with prevailing medical opinion (Bryers et al, 2010), arguing that it is less stressful to 'go with the flow'. However, a small qualitative study examining the work of direct entry licensed midwives and certified nurse midwives in Florida found that both groups of midwives legitimised their practice by blending aspects of midwifery and obstetric models of care (Foley et al., 2003). In this approach midwifery care was recognised as fundamentally different from obstetric care, but at the same time utilised a discourse of collaboration to equate midwifery care with obstetric care. Foley et al. (2003) argued that these competing positions enabled midwives to '*construct a sense of identity that legitimates their work and occupation*' (p. 182), by effectively utilising the competing perspectives of the obstetric and midwifery model of care.

Machin et al. (1997) identified a class distinction in relation to adoption of the dominant technocratic birth culture, suggesting that women from higher socioeconomic groups are more likely to expect informed choice and to adopt a more natural model of childbirth, many influenced by the prevailing culture within NCT classes. This qualitative study involved forty primigravid women in the north east of England. The study compared the experience of women in lower social classes (NHS

group), who had no antenatal education, with women from higher social classes (NCT group) and concluded that the behaviour of both groups during birth was remarkably similar. Machin et al. (1997) used the structuralist theory of ritual to explain why both groups of women accepted the medical model within the culture of the delivery suite, despite the fact that the NCT group expressed a desire for a natural, drug free birth. Women in this study described feeling bewildered by the process of labour and in this vulnerable position clung onto the dominant medical cultural environment of childbirth, accepting the full range of technological equipment and medication (Machin et al., 1997). The findings from this study suggest that a cultural shift needs to occur for women to move from the dominant medical hegemony, to a social model of care in which women feel empowered to make informed choices. Whilst this study is now somewhat dated, the provision of midwifery care still follows a similar model to that provided in the 1990s and therefore, the findings remain relevant for midwifery practice occurring within consultant units in 2012. Brubaker et al. (2009) concur with this view, arguing that women who choose to give birth in hospital hand over control to the doctor as this is the cultural norm in most countries. They assert that on admission to hospital:

‘...a cyclical pattern of doctors’ intervention and women’s loss of control develops once the natural physiological process is interrupted’. (Brubaker et al., 2009, p . 36)

However, birth that takes place at home or in a birth centre is more natural, and in this context women are in control, which supports the normal physiological process of childbirth (Brubaker et al., 2009). It has been argued that without a strategic plan to decentralise maternity care from obstetric units to birth centres, and a re-balancing of the social-medical continuum, attempts to provide a social model will fail (Johansen et al., 2002; Walsh et al, 2002; Bryers et al, 2010). However, some women choose a medicalised form of birth, because they fear the pain of childbirth, and willingly give over their bodies to be managed by doctors, to achieve a technological pain free birth (Barry et al, 2008), and perceive consultant-led care as safer (Pitchforth et al., 2008). Moreover, the culture of medical dominance may influence women at a subliminal level; Westfall et al (2004) undertook a qualitative study to explore women’s views of induction of labour for prolonged pregnancy from a sample of twenty seven women who as the researchers stated were from:

'...a less conventional, more radical or 'fringe' end of the spectrum where medical technology and artificial intervention... are likely to be viewed with scepticism, if not totally rejected out of hand...' (p 1401).

The researchers selected a purposive sample of women who ideologically favoured 'self-care' and rejected notions of medicalisation, viewing pregnancy as a healthy event and favouring a natural approach to childbirth. The study was undertaken in British Columbia where women are primarily cared for by doctors, with less than four per cent of births being managed by midwives, either certified or lay birth attendants. Women in the study received care from physicians, certified midwives, lay birth attendants and a small number were unassisted, supported by friends and family. During the antenatal interview, half of the women who were generally cared for by doctors, stated they would adopt a proactive approach to avoid prolonged pregnancy using herbal remedies, dietary supplements and if post forty-two weeks medical induction of labour. The other half maintained that they would let nature take its course. However, during the postnatal interview it emerged that all but one of the women adopted proactive measures once they had passed their due date at forty weeks. The researchers concluded that, from a sociological perspective, women were utilising personal agency by choosing a natural method to induce labour, as opposed to immediately adopting a medical approach. However, an alternative explanation was that women were influenced by the dominant culture of biomedicine and the competing definitions of potential risk associated with prolonged pregnancy (Westfall et al., 2004).

Hunt et al. (1995) maintained that the adoption of technology in childbirth has resulted in deskilling of the art of midwifery. Martin (1992) argued that midwives would regain their skills by moving childbirth back to the home, where midwives could hone the art of midwifery and truly be 'with woman'. This raises the question as to whether midwives wish to continue to be obstetric nurses working as handmaidens to obstetricians, or would prefer to be re-skilled to be truly with woman, by providing care in the home or within a birth centre environment. Moreover, are the aspirations of midwives in accord with what women want from their carers?

It could be argued that medical control and dominance are fundamental elements that have impacted on the success of partnership relationships and reinforced women's fears about childbirth

(Fisher et al, 2006). The traditional obstetric practice model reinforced that decisions were made by the medical professionals and service users, nurses and midwives were socialised into this level of medical control (Fleming, 1998b; Gallant et al., 2002). Empowering service users to be equal partners in decisions relating to their care has been challenging. Health professionals have found it difficult to give up the position of power they have over service users, and service users have become accustomed to the 'experts' taking decisions, and in some cases did not want to be involved in decision making (Gallant et al., 2002; Hunt, 2004; Mander et al., 2009; Bryers et al, 2010). Moreover, not all women would choose a midwifery model of care and therefore, the normal/abnormal divide that tends to polarise discussions on medical versus social models of care, could be seen as unhelpful in providing women with a fully informed choice regarding their care during childbirth (Annandale et al., 1996; Brubaker et al., 2009).

Summary

In this section, the impact of medicalisation has been explored from an international perspective, where maternity care is typically managed by doctors, despite the fact that midwives are increasingly the lead carer for low risk women. Whilst the obstetric and midwifery models of care have been presented as a dualism, the reality is that maternity care is provided along a continuum with the extreme positions at either end of this spectrum. It is also clear that women, midwives and doctors adopt a position along this spectrum based on their personal experience, but also largely based on the cultural environment in which care is provided. It is simplistic to attribute doctors to a medical model and midwives to a holistic model, as in reality maternity care is far more complex and whilst the working environment may have a significant impact on the model of care adopted, professionals may choose to work in an environment that resonates with their personal philosophy of care. There is a suggestion that the childbirth environment impacts on women's ability to maintain control of the birth process, but there is also evidence that some women chose technological advances over nature for a multitude of reasons. For many women, the choice of place of birth has been limited to hospital until relatively recently, and therefore, the social expectation is that women will be cared for in hospital under the management of a doctor, which may have had a significant impact. Moreover, even when there is a choice of birth centre or home, women may fear the unknown or perceive that birth outside of hospital is unsafe for their unborn child. Changing the perceptions of women and health care professionals, that childbirth is safe

outside of hospital, and that midwives are fully equipped to be the lead carer for low risk women, will take time.

The position of power

Introduction

In this section the meaning of power is discussed and various forms of power are explored in relation to maternity care. The strategies that obstetricians, midwives and women adopt when negotiating decisions and choices within a relationship where a power dynamic exists, are considered. The emphasis on partnership working and informed choice has challenged the traditional power base of health care professionals, which for midwives has resulted in emotional labour.

Forms of power

Lukes (2005) has suggested that there is no clear definition about what is meant by power and how it is operationalised, arguing that it is a contested concept that scholars have struggled to define. The concept of power is defined by Lukes (2005) as having 'power to' or 'power over' others. In contrast Foucault identified two forms of power, power as either disciplinary power or knowledge power (Bradbury-Jones et al, 2008) which when exercised can disempower the recipients (Cheyney, 2008). Disciplinary power in medical discourse is experienced as a form of social surveillance or as Foucault terms this, the 'gaze'. This can in relation to maternity care, be extrapolated to pregnant women as public property, who are subliminally influenced by the power of the medical establishment and respond by accepting medical opinion without question, the underlying power base remaining hidden (Cheyney, 2008). However, Hayter (2006) argued that in his later work, Foucault identified a form of 'productive power' which was utilised when service users became active participants in their care and where power was exerted more subtly using persuasion. Lukes (2005) identified some of the contradictions with power as a concept in relation to the extent to which a conflict of interests occurs. He argued that without a conflict, influence and authority may not be a form of power, as this may be considered to be a form of consensual authority (Lukes, 2005). Lukes (2005) questioned whether A can be seen to be exercising power over B if it is in the real interests of B? He argued that this power is short term which ends once B

identifies that actually it was meeting his real interests. The risk is that A is perceived as paternalistic and B may perceive that their autonomy has been violated.

The position of power in maternity care

Kirkham (2000) argued that it is hard for midwives to meet the agenda for choice and control for women, when midwives themselves are frequently not given choice and control over decision making; this explains why midwives may be seen as resistant to change when alternative models of care are introduced. Kirkham (2000) asserts that midwives climbed onto the professionalisation bandwagon in an effort not to be disadvantaged by medical professionals and in order to gain status and an acknowledgement of their specific expertise. To relinquish this position in an attempt to realign the power relationship with women, could be perceived as potentially detrimental if midwives wish to champion women's causes. However Wilkins (2010) argued that if midwives are to be truly with women they have to consider rejecting the professional paradigm which underpins the medical model, in order to meet the psycho-social needs that are fundamental to providing an holistic model of care.

The change in the balance of power for midwives and women has meant that the traditional hierarchical position of the midwife as the expert and the woman as the recipient / patient, has been challenged by the notion of partnership working. This shift in the dynamic relationship to enable women to exercise informed choice and for midwives to engage in partnership with women is not without its challenges. Hunter (2006a) undertook an ethnographic study exploring the emotional work of community midwives, and found that reciprocity in midwife-mother relationships was only rewarding when there was 'give and take' from both the midwife and the woman in the interaction, which Hunter defined as a '*balanced exchange*' (p. 315). When the interaction was not balanced midwives found the relationship emotionally difficult and used a number of strategies to protect themselves emotionally, including detachment, and task orientation (Hunter, 2006a). Midwives who feel disempowered can use language to control the agenda, particularly in a hospital environment where the biomedical model is the dominant model of care (Hunter, 2006b).

Pregnancy is still defined as a biomedical process and even when identified as low risk there is still a belief that it is a condition associated with risk, therefore needing constant monitoring and potential intervention (Surtees, 2010). This view was supported by Fahy (2002) who used a

feminist praxis research design, to study 33 women during pregnancy using interviews, participant observation (acting as a community midwife to these women) and reflective journaling. She used Foucault's concepts on disciplinary power, a subtle form of coercive power used by health professionals to 'encourage' clients to submit to their authority (Fahy et al., 2006), to describe the interplay of power relationships between the woman, midwife and obstetrician during pregnancy. She found that the power hierarchy was strong when the obstetrician was challenged either by the midwife or the woman, and in these circumstances the obstetrician was likely to utilise coercive disciplinary power, frequently by threatening women that not to conform could result in a poor outcome either to herself or her unborn child (Fahy, 2002).

Interestingly, Fahy (2002) found that midwives often did not act as an advocate to women in the face of the obstetrician using disciplinary power. Women were most likely to be able to subvert the obstetrician's power when they themselves were not physically vulnerable or were well informed (Fahy et al, 2006). Lorentzen (2008) suggested that it is the concept of agency that enables some women to negotiate with obstetricians, based on their own embodied or experiential knowledge, and therefore rebalancing the power relationship. The midwife clearly has a role to play in supporting women to access appropriate knowledge so that they are empowered in their decision making, although with the widespread availability of information on the internet and through peer networks, many women are able to be self-sufficient in relation to knowledge accumulation, enabling them to resist medical power (Lorentzen, 2008). However, not all women are in a position to engage with this knowledge and use it in a meaningful way and therefore it could be argued that it is only articulate, middle class women that are able to negotiate with health care professionals and be involved in decision making and choice.

Kirkham (2000) suggests that the power dynamic has arisen as a result of oppression of midwives by the organisation in which they practice, largely the dominance held by obstetricians. Keating et al. (2009) explored midwives experiences of facilitating normal birth in an obstetric led unit in Northern Ireland. At the time of this research midwifery care in Ireland was largely dominated by obstetricians who utilised a medical model of care, underpinned by technological intervention, in an attempt to speed up and control the birth process (O'Driscoll et al. 1993). Senior midwives in this environment adopted the medical model of care, but more junior midwives felt frustrated and

disempowered at their inability to support women to achieve physiological birth, or provide evidence based care (Keating et al., 2009).

In Foucauldian terms this discourse of power knowledge held by obstetricians and midwives provides them with a social position that is rarely challenged by women (Bryers et al, 2010). It is based on a language known and shared by the professionals and therefore seen by women as often the only possible course of action (Williams 1997; Holstein et al., 2005). Midwives strived for professional status in an attempt to redefine the power dynamic between themselves and their obstetric colleagues, adopting scientific and technological approaches in order to be maintain their professional status (DeVries et al., 1997), or using technical language to retain the role of expert rather than empowering women by sharing information (Poat et al, 2003). Midwives can use this power to coerce women to accept their advice, midwifery domination, or as a form of '*midwifery guardianship*' that involves protecting the birth environment to allow the woman to use her own '*integrative power*' in order for the women to experience an undisturbed labour and birth (Fahy et al., 2006). For a partnership relationship to exist there needs to be a move from a hierarchical relationship, where obstetricians and midwives have power over women, to a position where women and health care providers share their collective knowledge and skills and therefore share power and control (Gallant et al, 2002). Moving maternity care away from the district general hospital back into the home or within a midwifery led birth centre may support a move to empower women and facilitate choice.

Summary

In this section the forms of power that operate within the maternity services have been explored in an attempt to explain why health care professionals exert power to maintain their position as the expert in maternity care. Adopting a partnership approach, where women engage with their carers in a shared decision making model, challenges the dominant model of care. Midwives working within obstetric units where the bio-medical model of care persists have struggled to support women in a partnership relationship whilst seeking to maintain control over normal birth. Midwives need to redefine their relationship with women in order to provide an environment where women's experience is valued and contributes equally to the partnership model of care.

Informed choice

The 'Great Expectations' study undertaken more than twenty years ago found that over half of women were not offered choice in relation to place of birth and concluded that this only became an issue if they were dissatisfied with the outcome (Green et al., 1998). This study was instrumental in changing maternity care policy and influenced the myriad of Government reports that have been published since the Winterton Report in 1992 (House of Commons). What is surprising is that despite nearly twenty years of Government policy supporting choice and partnership in maternity care, a significant number of women are still not being offered choices in relation to their care (Redshaw et al., 2007; Redshaw et al., 2010).

Mander et al. (2009) argued that providing women with choices enhances the woman's autonomy and gives her some degree of control over her childbirth experience, whilst Pitchforth et al. (2009) additionally aligned choice to an individual's right of self-determination. However, the notion of choice is not clear cut, Anderson (2004) argued that women only have choice to the extent that their choice is socially acceptable to the caregiver; where information may be manipulated by midwives using 'strategic communication' (Hindley et al., 2005). Thachuk (2007) suggested that choice is a fundamental moral right, but recognised that women can be coerced and sometimes are poorly informed and therefore unable to make choices. Women who seek a choice outside of the accepted norm quickly discover that they are in a position of enforced compliance (Anderson, 2004; Levy 1999b). However, Mander et al. (2009) found that both women and midwives use strategies to subvert the system, to achieve the choices they want when these are not supported by the maternity unit policies or health care professionals providing care.

Stockbill (2007) supported the notion of enforced compliance arguing that women only have limited choices based on the options that the service-providers make known to them. She concluded that, *'informed choice is a situated and highly contingent concept enacted in irrevocably unequal social and political relations'* and suggested that Changing Childbirth failed because the notion of giving women choice is *'idealistic and impractical'* (Stockbill, 2007, p. 575). Moreover, the cultural environment within obstetric units where most births take place is immersed in a blame culture, based on fear of litigation, making it difficult for midwives to offer informed choice when working in a highly technological environment (Hindley et al., 2005). Additionally, women may choose the extent to which they want to process information in order to maintain a sense of balance, as

information, whilst helping women in making choices, can also result in increased stress and anxiety to them (Levy, 1999a).

Levy (1999b) identified a concept of protective steering which is used by midwives to meet women's needs in relation to choice. In this model she used the analogy of a tightrope, identifying that midwives adopt a line depending on stereotypical notions of what women want, ensuring midwives maintain control of information to avoid women becoming distressed or being given unrealistic expectations, whilst at the same time ensuring that the midwives wellbeing is maintained. Time was an important element in this relationship as midwives have limited time in which to explain all the available choices in sufficient depth, so inevitably have to select what is possible in the time and resources available (Levy, 1999b).

Hunt (2004), examining the impact of poverty on childbirth, found that women were more interested in being treated respectfully than in having continuity, choice and control. Although in the research women acknowledged valuing continuity within the community setting, they did not feel the need to make choices, instead they were happy to be advised by the midwife who they saw as the expert (Hunt, 2004). In addition, Green et al. (2000) found that it was not important to women whether they knew the midwife caring for them in labour, rather it was more important that they were treated by a competent professional. Pitchforth et al. (2009) undertook a qualitative study of women's choices in relation to place of birth in rural Scotland and identified that women could be categorised on a continuum of being either 'acceptors' or 'active choosers'. Acceptors go with the flow and are guided by health care professionals, whereas active choosers perceive that they have to fight to get their voices heard. Piichforth et al. (2009) concluded that few women know or are offered a choice in relation to place of birth, but for those that do, issues of safety have a higher priority than quality of care, resulting in women opting for a Consultant unit when they might have preferred midwifery led care in a birth centre or at home. The notion of choice is questioned as to whether women really want to have the level of choices promoted by the Department of Health (Pitchforth et al., 2009; DoH, 2007).

Leap (2010) argued that instead of concentrating on the range of choices available, women should be encouraged to embrace uncertainty, to be given confidence that sometimes you have to 'wait and see' and that this prepares women to cope with whatever childbirth brings to them. Crossly

(2007) suggested that the notion of choice needs to be contextualized, in that women should be educated so that they have options, but in a context where birth is not idealised and risks are explained in an honest and balanced way, rather than birth being described as a natural process and complications being glossed over. Leap (2010) argued that embracing uncertainty enables women to truly take control and to make choices, allowing women to hold the power rather than the power being held entirely by the health care professionals. Stockbill (2007) suggested that context is a significant factor in the provision of informed choice. The over admittance of women with low risk pregnancies to high risk consultant units may undermine women's ability to trust their bodies, resulting in disempowerment in an environment where practitioners define normality in retrospect (Stockbill, 2007).

Research questions

Following a review of the literature on partnership models of care and the factors which impact on the ability of women and midwives to form a partnership relationship, it is evident that there remains a gap in the current evidence on women's views about the relationship they form with midwives when pregnancy has been designated as low risk. Whilst the notion of partnership working is widespread within reports and policy documents, how this is interpreted in practice has not been clearly defined. Moreover, a small number of maternity units have developed partnership caseload models of care, which appear to provide women with a more personalised approach to care in which they are able to develop a meaningful, trusting relationship with the midwife (Walsh, 1999; Fleming, 2007a). However, the majority of pregnant women in the UK are not provided with care using a partnership model, so does the lack of such a model support or hinder the women from forming a partnership relationship with the midwives caring for her? More importantly, is this what women want from their maternity care? Integral to the formation of a partnership relationship is continuity of care and the provision of informed choice. This study also sought to determine the extent to which women are being offered the four 'national choice guarantees' contained within *Maternity Matters* (DoH, 2007). Whilst this study was being undertaken research has been published which suggests that whilst for some women, choice of place of care and carer is more widespread, (Redshaw et al., 2010) there are still areas of the UK where choice remains limited (NCT, 2009).

The research questions have been formulated to disentangle whether women actually want to experience their care in partnership with midwives and if they do, the extent to which they want this. It was deemed important to ascertain the extent to which women want or feel that they are experiencing informed choice during childbirth. The extent to which midwives view the care they provide as incorporating the input and decisions of women, will also be analysed.

1. Do women experience a partnership relationship with the midwife and is this an important aspect of their maternity experience?
2. Do childbearing women either want, or perceive that they are offered, informed choice from the midwives who care for them?
3. How closely aligned are the views of midwives with the views of childbearing women in relation to what women want from the midwives who care for them?
4. Can the findings be incorporated into a model of care to strengthen partnership working between women and midwives?

Summary

In this chapter I have reviewed the current evidence around partnership working and informed choice. In examining these areas there appears to be a level of discord between the concept of partnership and personal autonomy being experienced within a hierarchical medical environment, in which women have been shown to act in a submissive manner (Edwards, 2008). Within this review I have discussed a range of midwifery models of care and explored these models both from the perspective of the woman and the midwives who provide their care. Medical dominance has had a significant impact on the organisation of maternity care and therefore issues of power, particularly in relation to the medical versus the social model of care have been considered. In the next chapter I have outlined the methodological approaches I utilised to undertake the study, providing details of the research process that I undertook to meet the study aims and to answer the research questions.

Chapter 3: Methodology

Introduction

In this chapter I present the rationale for the methodological approaches I used in undertaking the study, illustrating how the qualitative approach adopted was the most appropriate to meet the aims of the study and to address the research questions. The recruitment strategy utilised and the issues around gatekeepers are explored, specifically in relation to the challenges I experienced recruiting participants for this study. The chapter concludes with detail of the thematic process I adopted to analyse the data and identify themes that were important for women and midwives. This helped to explain the factors that influenced the formation of a relationship and the extent to which women were able to participate in choices.

The study was undertaken in two phases, the first phase involved recruiting sixteen women to complete a diary of their encounters with the midwife during their pregnancy and childbirth focusing on how the women felt about the care they received from the midwife (Appendix 1: diary format). The diary was used to support two in depth semi- structured interviews, one towards the end of pregnancy and the other a few weeks after the baby's birth. In the second phase four focus groups were undertaken with midwives who worked in community midwifery or birth centre settings, spanning two district general hospitals in the South East of England. Focus groups were used to ascertain midwives' views about their role in relation to midwifery led care, specifically around notions of partnership working and the extent to which women are offered informed choice to support their decision making.

Research design and methods

In order to meet the aims of the study and to answer the research questions, I used a qualitative research methodology and drew on the principles of grounded theory. A qualitative approach was chosen because in exploring relationships I was interested in the social meaning (Avis, 2005) that the participants attributed to the midwife-woman relationship. I wanted to gain an in-depth insight into the thoughts and feelings of the participants and to try to make sense of what the women were saying about their experience of partnership working with the midwife. A qualitative methodology

was more appropriate as this enables the researcher to gain a deeper, detailed understanding of women's perceptions from the small number of participants that were recruited (Silverman, 2010). Themes that emerged from analysis of the data from the diary-interview method were as Creswell argued, '*grounded in the data from the participants*' (Creswell, 2007, p. 63) and fundamentally provided women with an opportunity to identify issues that were important to them. Vignettes were created based on issues that emerged as significant to the participants from the interview transcripts, and were used during the focus groups as a prompt to encourage in-depth discussion and feedback from the midwives (Appendix 2).

A reflexive methodology is an important aspect of qualitative research. As a researcher I am constantly critiquing my experience, both from the perspective of the data that are generated and my own role in interpreting that data (Fox et al., 2007). Reflexivity helped to support a critical, interpretive perspective (Alvesson et al., 2009), recognising that my personal experience impacts on and shapes the research environment (Arber, 2006). As a practising midwife and a mother, interviewing women, I was as Oakley (1981) argued, '*both inside the culture and participating in what I am observing*' (p. 57). An example of this was when I contacted Amelia² to discuss her participation in the study at around seventeen weeks of pregnancy. She told me her mother had suffered from high blood pressure during pregnancy (pre-eclampsia) and that she was born preterm. She said that her blood pressure was normal but wondered if this might also happen to her. I talked with her a little about the signs and symptoms of pre-eclampsia as she was clearly anxious about this. I also suggested that she contact a charitable organisation that provides information and supports sufferers of pre-eclampsia and agreed to send her the web link for Action on Pre-eclampsia (APEC). After speaking with Amelia I reflected on our discussion on pre-eclampsia. I also documented this experience and how it made me feel in my research journal. I wondered if I had crossed the boundary between researcher and midwife by discussing this condition. I decided that by suggesting that she contacts a support group that this did not compromise me as a midwife. However, I decided that any advice I would offer women in the future, would be based on information readily available to the general public and if this was not the case I would refer the woman back to her midwife to seek advice and support.

² To protect the participants confidentiality pseudonyms were used

I aimed to engage with women in an open relaxed manner, in an effort to equalise the power dynamic between myself as interviewer and the women I interviewed. If asked, I reciprocated with information about myself, in order to encourage women to actively engage in the interview process by gaining a greater level of rapport (Oakley, 1993). For example, I needed to reschedule my first interview with Ruby as one of my children had been unwell. When I met up with Ruby we spent some time talking about my son and I felt that by sharing something about me, the relationship was more open and the level of communication was similar to when speaking with a friend. This was clearly an insider communication as we shared a lot of my personal experience and related that to her own son who was a little older than mine. This would not be appropriate for all women, who may prefer to talk to someone that they do not know and are, as Letherby (2003) suggests outsiders and strangers. I decided in this study to allow women to choose the level of engagement and sharing that we experienced. If they asked questions about my own experience as a midwife or mother I would share with them openly, but if this did not come up I would not offer any information about myself beyond the fact that I was an academic midwife undertaking research as part of a doctoral study. However, in my analysis I needed to be cognisant of the impact my relationship may have had on participants, and it would be important for me to acknowledge this.

The dominant paradigm that underpinned this study was the social constructivist position which I chose because its naturalistic focus and interpretive nature (Holstein et al., 2005) aligned well with a qualitative study exploring relationships. Constructivism focuses on behaviour and studies how phenomena are constructed using a range of methods (Silverman, 2010) and regards social reality as constructed through social interaction (Avis, 2005). In this study I was interested in the social processes that participants engage in when forming a partnership relationship and how these are interpreted, which is why qualitative research, using a constructivist paradigm, appeared to be the most appropriate to address my research questions. Moreover, qualitative research involves interpreting phenomena occurring in natural settings and providing rich description (Denzin et al., 2008) by the researcher, conscious of his or her own experience, interpreting data in order to explain what is going on (Creswell, 2007). When I was reading around the different methodological approaches, the social constructivist paradigm appeared to fit well with a grounded theory method, from my personal interpretation of the questions I sought to answer in this study.

Social constructivism is frequently used in phenomenology and grounded theory approaches (Creswell, 2007). Glaser and Strauss originally described the grounded theory approach in 1967 and by the 1990s its structured approach to data collection, analysis and theory development, through the use of a constant comparative method, was widely adopted by quantitative researchers, because of its positivist assumptions (Charmaz, 2006). For others it is the interpretive nature of the grounded theory method that provides an explanatory framework in qualitative studies and answers some of the 'why' questions (Bryant et al., 2007). Grounded theory is a systematic approach that results in the researcher generating theory from the data (Glaser, 1998) and is an inductive process derived from the study of the phenomena that it represents (Corbin et al., 2008). The grounded theory method uses an iterative process during which data are collected and analysed concurrently, allowing the researcher to explore emerging themes and to focus on specific areas during the data collection process to facilitate a targeted approach, known as theoretical sampling (Bryant et al., 2007). This allowed me to refine my prompts during interviews with the participants so that I could drill deeper into aspects that were emerging as significant for women and determine whether themes were isolated incidents that were particularly significant for one or two women, or found in the majority of participants. An example of this was found in the data coded as 'in and out'. The majority of participants referred to their antenatal appointments in this way and on further questioning it emerged that most women experienced their antenatal care as a very brief bio-medical experience. Analysing the transcripts during the process of data collection allowed me to focus on emerging themes and to target my recruitment strategy in an attempt to achieve data saturation (Charmaz, 2006) within the limitations of a doctoral study.

Grounded theory is the collection and analysis of data from which the researcher develops theory that is 'grounded' in the data (Bryant et al., 2007). Charmaz (2006) adopted an interpretive approach using a constructivist paradigm in grounded theory, arguing that the researcher's past and current experience is integral to the construction of theory through interpretation of the data. I planned to utilise an interpretive stance in adopting a grounded theory approach as I believed that this resonated more closely with a belief that the context between the researcher and the participants are inextricably linked and cannot be excluded from the analysis.

Ethical approval

As part of the preparation to gain ethical approval I needed to develop the participant information leaflet and consent form (Appendix 3 and 4). I asked service users through the Maternity Service Liaison Committee at a local NHS Trust to review the documents. The feedback from the group was particularly helpful to ensure that the information leaflet was written clearly and was accessible to the women who would participate in this study.

When I attended the Research Ethics Committee (REC) I became aware, from the questions I was asked, that members of the group were more familiar with reviewing quantitative, experimental studies as opposed to more qualitative approaches. For example, I was challenged about my role as a midwife researcher that is, being able to maintain my role as a researcher and not act as a midwife. I explained that I recognised I was adopting an insider perspective and that this would be acknowledged in my research and I would reflect on the impact of my professional status. Furthermore, I would refer any professional issues that emerged during my involvement with the participants back to the appropriate health care professional. I was also asked questions about heterogeneity which was clearly inappropriate for a small qualitative study, the results of which I would not attempt to generalise to any other population.

The Department of Health (2005) recommended that Ethics Committees should consider developing areas of specific expertise. The problems experienced by qualitative researchers may be ameliorated if some committees were set up with the specific expertise to review the ethical issues arising from qualitative research alone. Cheek (2008) argued that ethics committees may unfairly reject qualitative studies because they are deemed unscientific as they cannot be generalised. It is important to recognise that the REC has a regulatory responsibility that may extend into all aspects of the research, to ensure the research meets ethical standards but also supports best practice (McGuinness, 2008). Queries raised by the committee enable the researcher to strengthen the research proposal and therefore ensure ultimately that the research is more robust and ethically sound.

All data collected for this study have been stored in a safe place to protect confidentiality. Hard copies of consent forms have been stored in a locked office in a locked filing cabinet. Electronic data has been stored on a desk-top computer which is password protected. All data will be

retained for ten years following completion of the study as advised by the Medical Research Council (2012). A favourable ethical opinion was granted by the Joint UCL/UCLH Committee on the Ethics of Human research (Committee A: Ref 08/H0714/73) on the 10th September 2008 and was followed up with local host Trust approval before the study commenced in October 2008 (Appendix 5).

Recruitment strategy

The study was undertaken in two NHS maternity units within Hertfordshire and North London. These NHS Trusts cover a multicultural population and are responsible for delivering care to over 9000 women a year. There are a number of community based teams and it was through the community midwives that participants were accessed. Recruitment was from a purposive sample (Gobo, 2007) of women attending local NHS Trust antenatal clinics and accessing midwifery led care. A purposive sample was appropriate for this study to ensure that the participants could provide insight into the area being studied (Burns et al, 2005). All of the women approached were over 18 years of age. Women who were unable to communicate sufficiently well in English to give informed consent to the study were excluded due to a lack of funding for interpreters.

The women who participated in this study were recruited through their community midwives when they attended their initial booking interview at around ten weeks of pregnancy. The community midwife initially gave the women a participant information leaflet to read and explained that if they would like to be involved in the study that they should telephone the researcher to discuss this further. This process only resulted in four participants being recruited over a three month period and raised questions as to whether the use of the participant information leaflet was the most effective way of recruiting women. I went back to the Ethics Committee and sought a substantial amendment to allow midwives to recruit women using a letter (Appendix 6). The letter was much shorter and therefore should have been less likely to be lost in all the documentation women are given during the initial interview. At this point I also proposed that if a woman seemed interested in the study and consented, the midwife would be able to provide me with the woman's contact details so that I could approach her directly to discuss the study in more detail and gain informed consent.

In keeping with a grounded theory methodology, initial data analysis occurred concurrently with data collection and categories were developed as part of the process of theory development. Once

broad categories were defined a theoretical sampling approach was used to target women from specific groups, in order to fully develop emerging categories. For example, midwives were asked to approach women from; a broader ethnic mix, younger age groups and lower social classes, to determine whether the issues emerging were related to sociological factors. By specifically targeting underrepresented groups my aim was to try to ensure a breadth and depth of category development until no new elements emerged, a process called data saturation (Charmaz, 2006).

I anticipated that a sample size of 15-20 women would be sufficient to achieve data saturation, recognising the limitations of a doctoral project and acknowledging that data saturation may only be partial. However, it is difficult to be precise regarding the number of participants as the process itself relies on an in-depth interpretation of the data until no further properties emerge, therefore it is only whilst undertaking the study that a decision can be made about whether the sample size is sufficient to develop a robust theory. Sixteen women completed all aspects of the study and from the analysis of the transcripts I did not identify any new categories in the later data analysed. Glaser (1998) argued that there are no numbers in grounded theory, only a process of sampling until data saturation and therefore completeness, is reached.

Sample characteristics

Twenty-two women were recruited to the study but over the period of the data collection six women withdrew, three as a result of moving out of the area, one because she did not meet the inclusion criteria (her pregnancy was high risk and she received obstetric care throughout), one due to a pre-term birth and one due to pressure of work. The remaining sixteen women completed the study (Table 1). Nine of the women were having their first baby, the remaining seven women had from one to five children already. The majority of the women (Ten) were University educated and professionally qualified and were classified as managerial and professional. Four of the women were classified as working in semi-routine occupations identified as working class (Rose et al., 1998). Fifteen of the women were Caucasian and one woman was a black African. The women's ages ranged from 21 years to 41 years with the majority of women being in their thirties.

Table 3: Women in Partnership Study Participant Data

Pseudonym	Age	Birth Order	Due Date	Occupation	Socio-economic classification ³	Partners Occupation	Ethnicity
Ruby	37	third	18/04/09	Phlebotomist	L12.3	Sales Advisor	Caucasian
Olivia	41	sixth	24/05/09	Hairdresser	L12.2	Hairdresser - (own business)	Caucasian
Jessica	36	first	25/05/09	Lecturer	L3.1	Lecturer	Caucasian
Chloe	21	second	13/06/09	Hairdresser	L12.2	Electrical Engineer	Caucasian
Emily	37	second	04/07/09	Investment Banker	L2	IT Consultant	Black African
Sophie	38	first	06/07/09	IT Service Manager	L2	Heating engineer	Caucasian
Lily	36	second	01/08/09	Marketing Director	L2	Finance Director	Caucasian
Evie	40	first	17/08/09	Finance	L2	Finance	Caucasian
Grace	33	third	20/08/09	Journalist	L3.1	Journalist	Caucasian
Amelia	35	second	06/10/09	Nursery Manager	L7.2	Security Manager	Caucasian
Daisy	29	first	6/11/09	Paediatric Nurse	L3.2	Airport Security	Caucasian
Isabelle	32	first	16/11/09	Relocation agent/student	L9.1	Mature student	Caucasian
Megan	36	first	25/11/09	Head of Marketing	L2	Genetics Researcher	Caucasian
Ella	29	first	02/12/09	Property lawyer	L3.1	Product Manager, Publishing	Caucasian
Lucy	31	first	08/02/10	Bar Worker	L12.1	Retail Manager	Caucasian
Ava	30	first	09/03/10	Industrial Engineer	L3.1	Construction Site Manager	Caucasian

Further information about each participant is detailed in Appendix 7

³ ESRC Classification L1-6 – Class 1: Managerial and Professional; L7 – Class 2: Intermediate; L8-9 – Class 3 Small employers and self employed; L12-14 – Class 5 working class

Data collection method

The diary as a data collection tool has a strong tradition within feminist research (Elliott, 1997) and is most commonly completed by women (Keleher et al., 2003). Milligan et al. (2005) described the use of diaries as a narrative method that has the advantage of allowing participants' control of the amount they chose to reveal and to identify the areas most important to them. Researchers who have used the diary method argue that its value lies with its contemporaneous nature, allowing participants to record events, feelings and experiences accurately and therefore is not dependent on memory recall. As a consequence it is particularly beneficial for identifying events that are socially situated and significant to the diarist. (Elliott, 1997; Clayton et al., 2000; Plummer, 2001; Moffat et al., 2007).

Some authors have argued that diaries enable researchers to follow events in a way that observation often cannot, yet allowing researchers to 'observe situations' in a similar way to participant observation (Zimmerman et al., 1977; Jacelon et al., 2005). This is particularly the case in the diary-interview method, which allows the researcher to clarify diary entries to ensure a clear understanding of the participants' meaning, thereby improving internal consistency. This method also allows exploration of significant issues in more depth, using the diary as a memory prompt allowing the researcher to move the agenda forward (Zimmerman et al., 1977; Jacelon et al., 2005; Moffat et al., 2007), and is considered to be one of the most reliable methods of obtaining information (Corti, 1993).

Diary formats vary. Commonly a log book or journal is used which may incorporate a questionnaire or be supplemented by interviews (Jones, 2000; Keleher et al., 2003) and may be solicited or unsolicited (Milligan et al., 2005). The difference between solicited and unsolicited diaries is that with solicited diaries the participant is fully informed that the contents of the diary will be used in a research study, will be analysed and the findings published. An unsolicited diary is the subsequent use of a private diary in which the contents were not originally intended for the public gaze, which may raise additional ethical issues (Milligan et al., 2005). Diaries may be structured to provide responses to specific lists or questions, a method more widely used in medical research and can contribute towards quantitative data collection, however 'open or solicited' diaries are used more rarely, despite the fact that they provide rich and deep insights into events which may be considered 'routine' or run of the mill (Milligan et al., 2005).

The period of diary keeping ranges from one to two days to more than six months, although typically is in the range of two to four weeks (Keleher et al., 2003). The length of time that a diary is maintained will impact on the richness of the data, one to two days may be too short to get a sense of any pattern whereas periods of two to three months may result in diary fatigue (Elliott, 1997). However if participants do not drop out in the early period, completion rates have been found to be high and diaries kept for more than three months result in richer data (Elliott, 1997).

A disadvantage of the diary method is that respondents may be selective about what they record (Corti, 1993) or may record the type of information that they think the researcher wants to see written in the diary (Jones, 2000). Using an interview to explore issues in more depth can ameliorate this problem to some extent. Also this method tends to be biased towards respondents with a reasonable level of literacy who are more likely to be good diarists (Corti, 1993). In order to overcome the literacy issue I planned to offer women the opportunity to complete the diary by hand, using a word processor or by recording their experiences, using an MP3 player, which I planned to loan to the woman for the duration of the study. Jacelon et al. (2005) found that the use of oral methods such as audio-recorders supported participants who had difficulty writing, although they found the use of telephone interviews less helpful.

In phase one of this study, data were collected by means of a diary-interview method using a solicited diary with an open format to enable women to write about the issues and events that were most significant to them (Appendix 1). Women maintained the diary throughout pregnancy, childbirth and the postnatal period which was for a period of around 30 weeks. It was intended that diary entries would only be made when the woman was provided with midwifery care and therefore an average of 12 to 14 events would be diarised. In practice women often entered all of their visits so that the diary became a record of their experiences in pregnancy, including visits for ultrasound scans and when they saw a doctor, as well as midwife led appointments. The format was piloted on two women before the study commenced. This was an excellent opportunity to collect data on which to practice the analytical skills learnt during the professional doctorate, whilst at the same time refining the format of the diary. Analysing the diary entries, I soon discovered that a software package is invaluable when managing large amounts of data, particularly for formulating memos during line by line analysis, the method I was using. It also gave me a more in-depth opportunity to explore the 'Nudist' software which I personally found quite cumbersome to use. The outputs were very basic and quite difficult to set up so I decided that I needed to research other software

packages. The feedback also reminded me of the importance of not only looking for themes but also to explore the data critically for disconfirming evidence, thereby enhancing rigour (Creswell, 2007).

Following the pilot study minor amendments were made to the design to enhance the guidance provided to women. Biographical data were also included to enable collection of data in relation to age, ethnicity and employment status. During this phase of the study I contacted participants regularly, every two to four weeks, in order to maintain their motivation to complete the diary. This communication varied from e-mail communication to telephone conversations. I maintained a reflective log of my interactions with the women and used my journal entries to enrich the study.

All of the women recruited maintained the diary using a written format, either handwritten or using an electronic version of the diary. One woman did express some anxiety about her literary ability but was reassured when I told her that I was more interested in her experiences than in her ability to write grammatically. During the conversation I shared my own poor spelling with her and this seemed to reassure her. She was offered an MP3 player but said she would rather hand write her diary, which she did. Women were asked to return the diary to me prior to both of the interviews to allow me to use the diary entries as a prompt to explore in more depth the meaning underpinning the diary entries. The diary was returned either by e-mail or by post using a prepaid self-addressed envelope at between 32 to 34 weeks of pregnancy and again 2 to 4 weeks after the birth. Hand written diaries were returned to the women after the interview had taken place at around 34 weeks of pregnancy.

Gatekeepers

In the study midwives acted as the gatekeepers between the researcher and the participants. Therefore as a researcher I was reliant on the midwives informing women about the research study and taking time to provide women with background information. Effective communication with health care providers is fundamental to ensure that the recruitment strategy has the best chance of being successful. This communication should ensure that gatekeepers fully understand the research protocol and are cognisant of the ethical principles underpinning their role (Sutton et al., 2003). Despite this and regular communication with individual midwives and midwifery managers, recruiting women to this study was challenging. This finding was supported by Barnett et al. (2008)

who used the diary–interview method in a study to investigate how pregnant women felt about being sent home when in the latent phase of labour. The researchers experienced difficulty with recruitment despite using several NHS Trusts. They stated that the reasons for non-recruitment were that the midwives were too busy, forgot or were confused about the study protocol (Barnett et al., 2008). Whilst I suspect these factors also impacted on recruitment to this study, additionally for some midwives there may have been some reticence in recruiting women to report on their relationship with the midwife as this would have a direct correlation to the way that women perceived the midwives' care.

Opt-in recruitment strategies are increasingly required by ethics committees, where researchers only approach participants once they have agreed to participate in a study following an approach from a health care professional. The rationale for this approach is that it avoids the risk that the researcher could coerce the participant into taking part, despite the fact that there is limited evidence of this (Hewison et al., 2006). Hewison et al. (2006) provided examples on how the opt-in approach has resulted in a significant reduction in participants becoming involved in research, suggesting that this is a theoretical risk rather than an actual occurrence.

Furimsky et al. (2008) found that clinicians could be a barrier to recruitment if they did not value the research or if they perceived that it would impact on their relationship with the client. Sutton et al. (2003) supported this position arguing that if health care workers, acting as gatekeepers, cannot identify personal or institutional benefit from the research they will not support the recruitment strategy. Gatekeepers may present information about the research study in an inconsistent manner and this may influence the desire of the client group to participate in the research (Seymour et al., 2005). If the gatekeeper presents the study in a positive way the user is more likely to agree to participate (Sutton et al., 2003). Seymour et al. (2005) also identified the problem of silent 'users' who may not be encouraged to participate in a research study because the gatekeepers do not encourage them to participate or take the time to explain the research fully because they are busy with other aspects of their role. This can result in only participants with strong or dominant views being given the opportunity to express them whilst quieter users are overlooked (Seymour et al., 2005).

Health care workers acting as gatekeepers may decide whether a user should be informed or encouraged to participate in the research. Sutton et al. (2003) identified that clinicians have the

power to encourage participation or not in a research study. In this study the fact that the researcher is examining the relationship between the pregnant woman and the midwife may have been another reason for the difficulties experienced with recruitment. As an experienced midwife and midwifery lecturer my position in the professional hierarchy may also have been perceived as intimidating to the midwives. Midwives may have felt threatened by the outcome of the research as, although they may have aspired to provide informed choices and to develop a partnership relationship with women, the pressure of work in the current climate of staff shortages may have mitigated against this. This is an area that was explored during the focus groups with midwives in phase two of the study.

Interviewing women

I conducted qualitative interviews with the women at the end of their pregnancy, at around thirty-four to thirty-six weeks of pregnancy and again during the postnatal period, between two to four weeks after the baby was born. Women were asked where they would like the interview to be conducted, with suggestions made including the woman's own home, the local surgery or birth centre, maternity unit or a local café. All of the women chose to conduct the interview in their own home at a time and date agreed in advance. Conducting interviews in an environment that was chosen by the participants was empowering for the women, who were generally more relaxed in their own homes. King and Horrocks (2010) also argued that holding an interview in the participants' own home can reduce any perceived status issues which can result in a more open and comprehensive dialogue. The women were informed verbally and in the information leaflet that the interview was expected to last approximately 60 to 90 minutes and that they were free to terminate the interview at any point. The actual interview length varied from 32 to 99 minutes with the average length of interview, during both the antenatal and postnatal period, lasting 60 minutes.

The diary was used as a basis for the interview to enable me to delve more deeply into significant issues raised by the women. When I received the diary, prior to undertaking the interview, I read the diary entries carefully and identified areas of the commentary that appeared relevant to the study. This was specifically related to comments about the relationship the woman had formed with the midwife, whether she had seen the same midwife for her appointments and any comments that she had made, either positively or negatively about any aspects of care. In the guidance at the front of the diary I had asked women to identify the midwife that had undertaken the care and

specifically to write how she had felt about the care received at each appointment. I also asked the women to comment on whether they felt all of their questions had been answered satisfactorily and whether they had received any conflicting advice. For example, Daisy wrote in her diary about the lack of continuity of midwifery care she had experienced. This extract was following her antenatal appointment when she was twenty seven weeks pregnant;

'Another midwife!! I don't think I will ever meet the same one twice. It makes me wonder how women build a trusting relationship with a midwife, especially if they are intending on having a home birth. If anything was going to put me off a home birth it would be that I am now more than half way through pregnancy and have never seen the same person twice'. Daisy, diary extract at 27 weeks gestation

I used this diary extract as a prompt during the antenatal interview that I held with Daisy at thirty four weeks gestation. Daisy talked about how she expected to have continuity of care with a named midwife with whom she would form a relationship. She identified her disappointment that this did not happen for her.

Another example was identified by Ella who wrote in her diary about conflicting advice because the doctor had said her blood pressure was high and needed to be monitored weekly but the midwife Freda did not agree with this assessment;

'Freda seemed very dismissive of the fact that I've been advised to have weekly check ups and made no secret of the fact that she thought my blood pressure was fine'. Ella, diary extract at 34 weeks gestation

The above examples demonstrate how extracts from the diary were used to explore aspects of the relationship that the participants developed with the midwife providing care. In addition I used the questions developed by Green et al. (2000) as a basis for ascertaining the quality of care the woman perceived she had experienced (Appendix 9, Interview guide). As the data collection and analysis progressed, interview questions became more focused in order to explore the theoretical frameworks that emerged, using the constant comparative method (Charmaz, 2006). An early theme that emerged from the analysis was the fact that women described their antenatal care as

very biologically focused and raised issues about the fact that their appointments were very short and did not meet their psycho-social needs. Women frequently described this as:

'Yeah um, I think it is very um, non-individual because it's a case of you have urine done, you have your blood pressure done, you have your measured bump thing and then if there's nothing else that you want to talk about or ask about you're out the door again. So it is literally getting the stats done and that's about it, I think um impersonal sometimes'. (Lucy, first pregnancy)

'It's all just very much, uh...go in, yes your blood results are fine, keep taking tablets, hear the baby's heartbeat, blood check, blood pressure check and right you're gone'. (Evie, first pregnancy)

Because of this I amended the focus of my interview schedule to allow me to explore this area more fully and to ascertain whether women's experiences varied depending on whether they received care at the surgery or in the birth centre, where midwives have more time to explore psycho-social issues with women.

Whilst undertaking this study I maintained a reflective diary which facilitated the collection of ideas as they emerged during my interactions with the participants. After each communication with the women, either during my regular contacts to support maintenance of the diary or following an interview, I reflected on what I perceived to be the key issues emerging from the dialogue. This supported the development of themes as they emerged and allowed me to identify areas in the research that I could explore in more depth. The ideas that developed also formed the basis of discussion during regular supervisory sessions and led to a deeper understanding of the themes that were emerging from the study. As a practitioner researcher, studying an area that I am familiar with by virtue of my professional status and my experience as a mother it is important that I recognise the impact that this insider perspective will have on data analysis. However, by recognising and acknowledging potential bias from my experience and by critically reflecting on the participants' experiences it increases the likelihood that their perspective was being truly represented (Corbin Dwyer et al., 2009). I was further able to test out the assumptions I made by

engaging in debate with peers and service user groups as discussed later in this chapter (see Pg. 81).

The qualitative interview is an active process between interviewer and participant which results in the interpretation and construction of meaning between both parties (Holstein et al., 2004). In choosing to use the diary-interview method, the interview component used the data collected from the diary as a prompt, to drill down more deeply into the issues raised by the participants. The interview style I adopted in this study was semi-structured, loosely based on the diary entries and on exploring specific thoughts and experiences around partnership working and informed choice.

Hoffmann (2007) has identified the power dynamic within the interview setting. Despite the fact that qualitative interviews are considered an active process, the power dynamic shifts depending on the situation. The researcher, as the person setting the agenda, initially holds power over the respondent, as the researcher initiates the questions and is seen as having authority (Hoffman, 2007; Nunkoosing, 2005). The power shifts to the respondent when the interviewer needs to hear the story, for example as a doctoral student, I needed women to tell me their story in order to answer the questions posed by my study. Women hold, what Hoffman (2007) calls, 'third dimension power', as they could choose what story they wanted to tell me and this could have been a full disclosure or only part of the story. However, the researcher transcribes and analyses the text from interviews and constructs the story, therefore holds the ultimate power (Nunkoosing, 2005).

Critical reflection on the initial interviews I undertook revealed a level of dissonance between my role as a midwife and that of a researcher. Reviewing the questions I asked from the early transcripts, my questioning followed a logical progression but was based on elements of the pregnancy which were not really relevant to the research questions I was trying to answer. I also tended to speak too much rather than to have confidence in allowing silences and on occasion would ask a multiple question or leading question rather than adopting a more open approach. These fundamental errors noted in novice researchers practice were identified by Roulston et al. (2003) and demonstrate a need for careful preparation before undertaking a research interview. Following critical feedback on the early transcribed interviews from my supervisors, in later interviews, I attempted to focus my questioning to align more closely with the research aims and questions. I was also consciously asking more open questions and using non-verbal cues to encourage fuller responses.

Focus groups with midwives

Focus groups have become widely used in social care and their use in health care research has increased since the 1980s (Twinn, 2000). Focus groups have been described as group interviews, the key difference with the one to one interview being the interaction that is generated between the participants (Sim, 1998; Wilkinson, 1999; Morgan, 2010). The role of the facilitator is to provide an environment which encourages active participation and interaction within the group, in order for ideas raised by one participant to stimulate a broader range of ideas from other group members (Kitzinger, 1995; Sim, 1998). However, the facilitator needs to be aware that in seeking to control the direction of the interaction, to meet the research agenda, the potential exists for the facilitator to disrupt group interaction (Morgan, 1996). Morgan (1997) argued that focus group data can be affected by respondent conformity or polarisation of responses, an issue that does not occur in individual interviews. However, comparative analysis of the interview over focus groups has revealed that it would be necessary to undertake ten individual interviews to achieve the same depth and breadth of data as could be achieved in two focus groups (Morgan 1997). Therefore, it could be argued that focus groups are a more effective way of achieving a rich data source within a minimum time period.

Setting up the focus groups

Focus groups were held with hospital and community midwives in order to share the broad themes that emerged from the diary-interviews held with women and to gain some understanding of the midwives' views about what they think women want from them. This method was chosen because through group interaction I was able to gain some insights into the midwives' conscious and sub-conscious thoughts about the women's views (Lundgren et al., 2007). I aimed to achieve a purposive sample of midwives, to include midwives who had provided care to the women in this study. Nine of the midwives who participated in the focus groups provided care for thirteen of the women either in the community or birth centre setting. The midwives were approached by a senior midwife who explained the study and gave the midwives an information leaflet (Appendix 10) detailing the study and explained the parameters of participating in the focus group. This was to allow the midwife participants sufficient time to read the information and make an informed choice about whether they wanted to take part in the focus group or not. I asked the midwifery manager if she could book me a quiet room in which to undertake the focus group with sufficient room for the

midwives to be able to sit in a circle, so that the group could all make eye-contact with me as the facilitator and with each other. I had developed a prompt sheet to encourage all of the groups to discuss broadly similar areas that had emerged from the diary-interviews with the women and also that focused on my research questions (Appendix 11).

I undertook four focus groups with midwives covering community and birth centre care in two NHS Trusts. The number of midwives ranged from four to six in each group. After gaining written consent (Appendix 12) and agreement to audio-record the discussion to facilitate transcription, I reminded the midwives about the aim of my study and explained the principles around using a focus group. I established ground rules in relation to participants giving each other space and not talking over each other and agreeing that all discussions within the group would be anonymised to maintain their confidentiality. I also explained that by using a focus group I wanted to encourage conversation and the exchange of views between the participants, based on minimal prompts from me. I explained the role of the observer who was positioned outside the circle. I had enlisted an observer, a midwifery lecturer colleague, to observe the non-verbal behaviours and to maintain a time line to help me identify who was speaking, for use when transcribing the session. This also enabled me to focus on the participants and maintain eye-contact without feeling the need to note down significant events that occurred between them. I found the observer feedback invaluable for transcribing as the timeline helped me to identify who had been speaking, but it also revealed some very interesting behaviour patterns between the midwives. For example in one focus group, which was held in the Hawthorne Unit (birth centre), the midwife who managed the birth centre was one of the group, and on a number of occasions she used non-verbal communication to control the contributions of the other midwives in the group:

SB 'But in this unit you seem to be suggesting that the staffing levels are good here (in the birth centre) but not anywhere else, so why aren't you moved to other areas?'

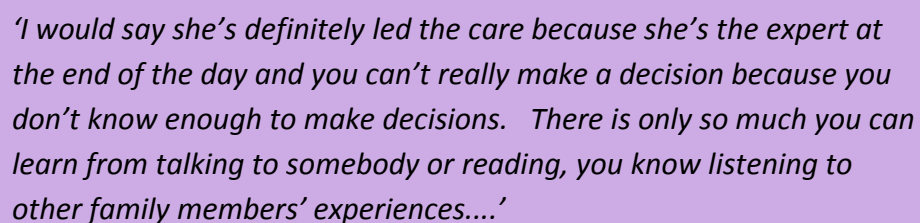
Carol⁴ 'And we have community midwives that we can call in to support our workload, whereas other areas don't have that ...'(Ruth raised her hand to silence Carol)

⁴ Names of the midwives and maternity units have been changed to protect their anonymity

Interestingly Carol frequently avoided eye-contact with Ruth and made her points quite openly, not appearing to be inhibited by Ruth's presence. In contrast Alice maintained eye contact with Ruth throughout and rarely offered an opinion during the focus group, without appearing to seek Ruth's approval. While it is important to be aware of potential power dynamics within a group and to acknowledge these, the full impact of the non-verbal behaviour pattern can only be surmised as the response by participants varied.

During the focus groups I used vignettes as a method of eliciting the midwives' thoughts and feelings about some of the key themes that had emerged from the participants' diary-interviews. I selected quotes which I felt encapsulated key areas for the women and presented these as a series of speech bubbles depicting a woman's journey throughout childbirth. The three vignettes covered; antenatal care up to 36 weeks, late pregnancy and postnatal care and intrapartum and early postnatal care. I used the first two vignettes in the community midwife focus groups and the first and third for the birth centre midwives, as these were the area's most closely aligned with their practice.

For example:



'I would say she's definitely led the care because she's the expert at the end of the day and you can't really make a decision because you don't know enough to make decisions. There is only so much you can learn from talking to somebody or reading, you know listening to other family members' experiences...'

Vignette 2: Later pregnancy through to postnatal care: Gina (pseudonym) talking about her experience following the birth of her first baby

In devising the vignettes I wanted to ensure that I balanced positive and negative elements of care and that the unfolding journey was plausible, which is an important element in order to gain in depth responses (Jenkins et al., 2010). A significant issue that emerged in the first focus group was around dissonance. Midwives described the care that they gave to women as very women

centred before they read the vignettes. When they read the quotes that made up the vignettes, some of the midwives found the feedback distressing as it clearly presented a very different picture of the care women received, particularly in relation to lack of choice and the bio-medical approach to care. Brondani et al. (2008) suggested that vignettes are a useful tool when discussing sensitive or personal topics and by using two different research sites the midwives could distance themselves from findings that were difficult to handle. The midwives generally managed this by assuming that any negative aspects must have been from the other Trust that the research was being conducted in, although some midwives clearly identified that they felt unable to provide the level of care that they had been trained to provide, due to workload constraints. The following extract illustrates how the community midwives in the first focus group dealt with difficult feedback:

SB 'Are you surprised at some of the findings?'

Anna 'If it was our area just, yeah I would be very surprised, very...'

Paula 'Yeah because you said it was the whole area'

Anna 'Because you've said it's across two trusts. I felt disappointed for the women that they are not getting what I would consider to be an ideal, that they are offered a choice of where they want to deliver, if they get continuity of care and they get as much and as many visits as they want and need. In that sense I'm disappointed for the women that they are not getting what I would like as a mother. But with the restrictions on the service these days...'

Focus Group 1, Community Midwives Spruce Hospital

Wilkinson (1999) argued that the setting for focus groups is naturalistic and the power dynamic between researcher and participant is reduced by giving control over to the participants to lead on the discussion. I felt that the use of focus groups enabled the midwives to express their thoughts and feelings openly and to discuss these thoughts between the group, particularly once they had read the vignettes and had time to settle into the focus group. A challenge was finding an appropriate environment to explore ideas without being disturbed and for some groups there was insufficient time to really get the group actively discussing, because the room was booked for a limited time or the midwives had to go to work. For one group this meant that I had to end the

discussion even though the midwives at that point were actively debating the issues. This was disappointing but must be acknowledged as one of the challenges of undertaking practitioner based research. The midwives were offered an opportunity to review the transcripts of the focus group interview and to provide feedback if they felt that their comments did not accurately reflect the point they were trying to make, however none of the midwives chose to accept this offer and to review the transcripts.

Testing out analytical assumptions

During the process of data collection and analysis I had a number of opportunities to share my emerging findings and to discuss these with midwives, student midwives and women. This has been as a result of presenting my work as it has been progressing to my peers and supervisors on my professional doctorate course, to student midwives as part of a research methods course and to midwives from the units where the study was undertaken. I also had the opportunity to present the work during the analysis phase to a conference of professionals and peer supporters, who are lay people, and to engage in debate about my findings and what I had interpreted these to mean. This has been invaluable in terms of testing out some of my assumptions as it provided me with an opportunity to debate my interpretations and to reflect on the views of women and health care professionals in order to refine my thoughts. Largely the discussion helped me to think laterally about the findings and to consider alternative possibilities for the findings. However, the discussion I had with a wide group of women did not change the fundamental themes that had emerged during the process or my interpretation of the data. In many ways these opportunities helped me to clarify my thinking and to select the most significant aspects from a large amount of data. In addition, the women and midwives were offered a copy of the transcript from the interviews and focus groups so that they could provide feedback or clarify any aspects of the transcript. However, none of the women in this study choose to take up this opportunity.

I have also had a number of discussions informally with professional colleagues and peers on my course and the opportunity to present ideas as they emerged and to justify my interpretation has also helped with my reflections. This process has occurred quite naturally during my research journey and has emulated the status of co-worker as it has allowed me to draw on a wealth of views from a range of women and thereby to increase the validity of my assertions. As a doctoral student it would have been beyond the scope of my research to have a co-worker independently

reviewing the transcripts and identifying themes, whereas this organic process of sharing and debating ideas from segments of the data has enabled me to move some way towards achieving this end.

Reliability and validity in qualitative research

The notions of reliability and validity are challenging concepts in qualitative research resulting in many authors suggesting strategies or typologies to prove that they exist. A number of strategies have been proposed to enhance the validity and credibility of qualitative studies including the use of multiple methods to triangulate, thick description, peer validation and external review (Creswell et al., 2000). Validity in qualitative research is assessed through the notion of trustworthiness and includes credibility, transferability, dependability and conformability (Creswell et al., 2000). However Angen (2000) argued that in trying to prove objectivity within qualitative research the researcher actually loses the subjective reality that an interpretive approach seeks to identify. She argued that all interpretations are open to re-interpretation because an individual's interpretation of events is based on their own social construction.

Angen (2000) also suggested that it is important that the researcher locates the research within a subjective understanding, using self-reflection. Substantive validation is also strengthened by integration of previous research findings and presentation of cases of disconfirming evidence. Angen concluded that:

'...the notion of validity as truth or certainty must be abandoned, we can reformulate it as a process of validation, an evaluation of trustworthiness taking place within a human community. (Angen, 2000, p. 392)

In this study validity was enhanced by carefully identifying examples of disconfirming instances in the findings chapters, which were critically analysed before conclusions were posited. For example, in Chapter 5, page 109, Lily identified that formulating a partnership relationship was not important to her which was in contrast to the view expressed by the majority of the participants. The identification of disconfirming instances improves the rigour of qualitative studies which have been criticised for their anecdotal nature (Silverman, 2010). The notion of validation recognises the inter-subjectivity of interpretive approaches and therefore acknowledges that the research findings are open to re-interpretation. The robustness of this study was demonstrated by the use of

verbatim quotes from the participants to illustrate the emerging themes. Throughout the process of data analysis the coding tree was reviewed regularly to test out that the segments of the transcripts were being coded to the appropriate code. This process followed periods of self-reflection and acted as a sense check to ensure that coding was consistent over time, which is consistent with the constant comparative process. The findings were supported by analysis of the number of occurrences of a code, as well as the number of participants attributed to a specific code which was highlighted within the process of comparative analysis. Therefore whilst the interpretation of the findings was inevitably subjective, the interpretation from the women's voices is presented to enable others to judge the trustworthiness of the findings. Additionally, the findings were further validated by the integration of previous research findings within the literature review which was undertaken following data analysis. Examples of disconfirming evidence were also presented where they emerged during the research process.

Analytical approach

The data analysis method I utilised is qualitative and is drawn from a grounded theory methodology as defined earlier in this chapter. Glaser (1995) suggested that there is a risk that the researcher may inhibit the process of data analysis by introducing his or her own special interests whilst interpreting the data, rather than focusing on the participants' perspective. In his later work Glaser (1998) argued that the process of data analysis was objective and excluded interpretation by the researcher and that data should be categorised by constant comparison and the development of patterns, not by the researcher assigning any meaning to what is collected.

Other proponents of grounded theory acknowledged the interpretive nature of the approach and recognised that the researcher's interpretation is fundamental to the process (Charmez, 2006; Corbin et al., 2008). I was interested in the social processes that participants engaged in and how these were interpreted by the participants and the researcher and felt that a constructivist paradigm was the most appropriate for this study, which is congruent with the latter interpretation. Additionally, there is a view that principles of grounded theory are a useful tool for researchers to structure the analytical process, but that the adoption of interpretive principles should help to guide the development of theory as opposed to the more purist notion of generating theory (Pigeon et al., 2009; Gibbs, 2007).

I used a thematic analytic approach, which Simons et al. (2008) describe as an inductive process resulting from the identification of categories from a critical review of the data, followed by careful comparison of those categories to enable commonalities to emerge. Gibson et al. (2009) extended this definition to include additionally identifying relationships and differences within the data. Charmaz (2006) argued that when analysing data using a grounded theory approach it is important to interrogate the data for categories to emerge, rather than to approach the data with a conceptual framework in mind on which to base the analysis. Gibson et al. (2009) explained this differentiation by using the term 'empirical codes', which are codes that emerge whilst exploring the data as opposed to 'apriori codes'. These are identified prior to the data analysis stage as a result of the questions or issues raised by the researcher whilst undertaking the study. The rationale for choosing a grounded theory approach was that it provided a structured process that enabled the data to be interrogated, categories to emerge and ultimately a theoretical framework to be developed. However, it is an interpretation of the data from the researcher's standpoint and as such is influenced by the researcher's background knowledge, skills and experience. Whilst it is acknowledged that interpretation is an in-depth process that aims to result in a theoretical framework, it is also the case that different researchers would view the data from a slightly different focus and therefore may arrive at different conclusions (Corbin et al., 2008).

The coding processes in grounded theory methodology include open, axial and selective coding (Dey, 2004). Open coding is about stimulating ideas and undertaking a line by line analysis to develop categories, keeping an open mind but using ideas derived from the coding families (Dey, 2004), whilst maintaining a critical analysis of the data (Charmaz, 2006). Corbin et al. (2008) recommended that initially open coding should be 'microscopic' in an attempt to avoid the researcher interpreting the data too narrowly. They suggested that a more general approach to coding should be adopted once initial concepts/themes have been identified (Corbin et al., 2008).

Axial coding is the development of connecting categories from the open coding analysis. This process enables the researcher to order the data into meaningful categories. Selective coding is the formation of a framework from which core and sub categories are developed. Gibbs (2007) recommended maintaining an index of all codes including the memos used to define them, in a 'code book'. This code book can be used as a record to describe decisions made during the analytical process when the structure of the coding tree is amended or refined (Gibson et al.,

2009). The use of the MAXqda software enabled an electronic codebook to be automatically maintained.

I refined the initial open codes to enable me to identify the main categories that emerged from the analysis. In order to achieve this I reviewed the coded segments to ensure that these had been appropriately coded. I then re-ordered the codes into broad subject areas or categories for example, organisation of care, in an attempt to reorder the data into more meaningful sections. Each category is composed of a number of sub-categories which are the codes that have been assigned under each category. Conventionally a code network is described as a code tree and the sub categories are branches, this hierarchy is further described using the metaphor of a family with the main category being the parent (root) and sub categories being the children (branches). Siblings are codes which share the same parent (Gibbs, 2007).

Process of data analysis

As a practising midwife and a mother I have dual insider perspectives and it is important to develop open, honest relationships with participants and to acknowledge the impact that my experience brings to the collection, analysis and interpretation of the data (Burns et al, 2012). For example during the antenatal interview with Grace, who was expecting her third baby, she was talking about her low iron levels and how the midwife had said that could impact on her ability to have a home birth:

'I can show you if you are interested. Let me show you, but C said yeah you do need to take supplements because if you lose even a little bit of blood then there will be transfusion issues she said'. (Grace, third pregnancy)

The insider-outsider space has been debated in the literature in relation to boundary maintenance and the notion of adopting the middle ground so that as a researcher working in a professional domain, you are able to draw on the benefits of both perspectives (Corbin Dwyer et al., 2009; Burns et al., 2012). It was very clear that Grace wanted to show me her maternity notes to get my opinion about her iron levels. As a researcher that could be seen as stepping over a professional boundary but as a practising midwife I felt a professional obligation to reassure her about her iron levels. She also asked me to feel her abdomen to see if her baby was still presenting bottom first (Breech), which I did.

'No I don't think so, but would you mind feeling to see if it's still breech though'?

(Grace, third pregnancy)

The baby was still presenting bottom first so we talked about positions she could adopt to facilitate her baby turning around to be head first. She told me her midwife had already talked to her about this so I did not feel that I was crossing a professional boundary. This is a challenging position though. Some of the women that I recruited did ask for my professional advice and I would always think very carefully about whether the advice I gave them crossed a line between what would be seen as acceptable. Before speaking to any woman that sought advice from me I decided that if I felt that the question suggested any risk to the woman, or would result in a conflicting opinion with the care she was receiving, that I would either empower her to contact the midwife or seek permission to speak to the midwife on her behalf. The advice I generally offered was widely available in the public domain and I never felt that I transgressed a professional boundary. On two occasions I asked the women to contact their midwife because they had not been given a follow-up appointment and had clearly been lost in the system, having waited several weeks without any antenatal care.

Gibbs (2007) concluded that data analysis involves the dual process of data handling and data interpretation. Whereas, Corbin et al. (2008) argued that analysis is giving meaning to the data. In order to manage the data effectively I utilised a computer package to support the data analysis. This decision was taken early on in my doctoral studies when I piloted the data collection tools, the diary interview, with two women. When I reflected on the experience of analysing the data I felt that it was an incredibly time consuming process and that without a really comprehensive document management system it would be very easy to become overwhelmed with data. Initially I had decided I would adopt a paper based approach but I was half way through the process before I realised that during the process of selective coding, when I was engaged in writing memos to record what I thought was going on at each point, using the N6 programme may be a more effective method of recording my thoughts. I found using a computer assisted package was much more flexible in terms of organising the data, managing the coding schema and maintaining memos. Computer packages also make it much easier to retrieve coded segments and to review and reorganise them during the process of analysis. However, I really struggled with elements of the N6 programme, particularly running reports and exporting sections of the data. I attended a

workshop by Christiana Silver and following a review of Lewins et al. (2007) guide to using software in data analysis decided to use MAXqda 7 to help me to analyse the qualitative data for this study.

Once the files were imported into MAXqda I developed initial codes; these emerged generally from sentences or short paragraphs. Following the initial line-by-line analysis I re-immersed myself in the data and analysed the areas that emerged as significant in more depth by identifying concepts. In order to achieve this, the guidance from Corbin et al. (2008) was followed to interpret significant events, identifying labels and writing memos to explain the rationale for my thinking. Corbin et al. (2008) recommended asking questions such as 'who, what, when, where and how' in relation to the events being analysed. They also suggested that in immersing oneself in the data that the researcher asked questions such as 'what is going on here' or more theoretical questions which aim to conceptualise the data.

When I ascribed a code to a segment of data I tried to encapsulate a word or phrase that would explain what I thought was going on at that time. I developed a memo to explain the thinking behind the code name, to explain what I interpreted to be the meaning from the coded segment. This helped me to ensure that as I progressed through a number of different transcripts that coded segments were attributed to the most appropriate code. This continual review of codes fits with the notion of constant comparison espoused by grounded theorists which enhances the rigour of the analytical process (Gibbs, 2007). At regular points during the analysis stage I reviewed the segments from each code and checked that I had identified the most appropriate code to each segment. This was particularly the case when I was returning to the analysis after a period away from the data. By retrieving the coded segments for each code I was able to realign any segments which on review I did not think had been aligned to the most appropriate code. I also found that as the number of codes increased I needed to regularly review the coding tree to identify patterns in the data and to reorder the codes into a more logical sequence. From this early analysis the code tree was refined into main themes, and sub-categories began to emerge.

The diary-interview data

I found that themes started to emerge during the process of transcribing the interviews. I read each of the transcripts a few times and made notes on my thoughts around issues that were emerging from the data. Reflective diary entries and field notes maintained during data collection

are also part of the analytical process (Gibbs, 2007) and helped to shape later ideas and to some extent the research questions. Early themes that emerged from the antenatal interviews helped me to focus on significant areas that were emerging from the women, which I was able to focus on more clearly in subsequent interviews. This was particularly relevant to women's experiences of their antenatal care and the frequency with which women described their care as being very medically focused and organised to meet the needs of the midwives. The women appeared to suggest that the midwives concentrated on information that they needed to collect, rather than the experience being meaningfully focused on what the women sought to get out of the interaction. There was also a strong sense both from the diary entries and the interviews that most women wanted to develop a meaningful relationship with the midwife, but that for some of the women the lack of continuity was a barrier to achieving this.

The main themes that emerged from the analysis of the diary interview were: Organisation of Care, Relationships and Choice. The code tree was further refined once I had completed the analysis of the postnatal interviews. During this process I reviewed the codes, analytical memos and coded segments and recognised for example that '*organisation of care*' could be re-organised using the sub-categories of '*knowing the system*'; that is the strategic level of organisation and '*experience of the midwife: woman interaction*' which involves the care at an operational level. The main themes are fully explored in the findings chapters four through to seven (Appendix 13, coding tree).

Focus group data

The focus group data were more complex to organise initially because of the number of participants in each group. I used a timeline to transcribe the focus groups, which helped me to identify clearly which midwife was talking at the time. The midwives were allocated a code to maintain their anonymity; this was CX or CC for community midwives at C unit and X unit followed by a number from 1 – 7 and BX and BC for birth centre midwives from C unit and X unit followed by a number from 1 – 7. I denoted myself as R for researcher, which I subsequently changed to SB in the dissertation. I subsequently used a pseudonym to name the midwives and the maternity units to aid the flow of the dissertation.

I used the computer programme MAXqda 7 to organise the data and used a thematic analysis to code the data. The initial coding was undertaken all at one level so that after I had attributed codes

to the four focus group interviews I then reviewed the allocated codes and organised them into main codes and sub codes. The initial 39 codes were categorised into five main codes:

1. Organisational Factors
2. Care Provision
3. Partnership Relationship
4. Choice Agenda
5. Way Forward

As part of developing a code hierarchy some of the codes were combined into a broader code heading. For example when I was initially coding I identified a number of codes about antenatal care, that is place of antenatal care; challenges of venue; antenatal classes and pressure on antenatal care. Three of these codes only ended up with between five and nine coded segments. In my reorganisation of the coding tree I decided that I could combine these four codes under the one sub-code of '*Factors impacting on antenatal care provision*' and that this sub code would be attributed to the main code '**Care Provision**'. Also I reviewed each sub-code and reviewed the coded segments to ensure that I had attributed them to the most appropriate code. This process allowed me to realign some segments into more appropriate sub-codes. (Appendix 13, coding tree).

Comparative analysis

The next step in the analytical process was to undertake a comparative analysis across codes from both the diary-interview data and the focus group data, to help to identify patterns in the data. Gibbs (2007) argued that by tabulating codes and attributes to show the whole sample response, this enables a more analytical approach to be adopted. This moves the researcher away from a tendency to just describe what appears to be happening. Moreover this approach helps the researcher to get a sense of how frequently a code arises and whether this is as a result of one or two participants feeling strongly about a particular issue which they raise a number of times during the interview process, or an issue that is more widespread across the whole sample. It also makes it easier to identify examples of disconfirming evidence emerging from the data and led me to reflect more critically on the relevance this had to the conclusions that I made.

Chapter summary

In this chapter I have described the process that I undertook to conduct this small qualitative study. I have explained my rationale for using a qualitative methodology drawing on the principles of grounded theory. The data collection tools and analytical strategies that I adopted have been clearly articulated.

The next four chapters are based on the findings from this study. Chapters four through to six contain the findings from phase one of this study, where the women's experience of partnership are explored and which incorporate the three main themes, *organisation of care*, *relationships* and *choice*. Chapter seven focuses on the findings from the midwives' focus groups. The findings clearly align with the themes identified by the women who participated in this study.

Chapter 4: Organisation of Care

In this chapter I discuss women's access to and experience of midwifery care during childbirth. Organisational factors which impact on the provision of women-centred care are discussed to provide a context for this dialogue. I examined the organisation of care at two levels. Firstly, at a strategic level, which described how maternity services were organised in relation to women's contact with the service and subsequent midwifery care (*knowing the system*). Secondly, at an operational level, which described women's experience of care by the midwife and the factors that impact on the quality of that experience (*experience of midwife-woman interaction*).

From the category 'organisation of care' I undertook a comparative analysis of the codes that I perceived to be most relevant to women, which were the areas which resonated most frequently with the experience of the participants and I compared these against all sixteen women (See Appendix 14) to look for similarities and differences in the women's experiences (Gibb, 2007).

Knowing the system

Women's first contact with the maternity services usually follows a consultation with the GP to confirm pregnancy. However, a minority of women approach the midwife directly on becoming pregnant, but this is usually only those who have been pregnant previously (Redshaw et al., 2010), despite the fact that the 'national choice guarantees' identified in 'Maternity Matters' (DoH, 2007) explicitly identifies that women can choose who to access for their antenatal care, either the midwife, GP or directly to a maternity unit

Schedule of visits

The schedule of visits related to the frequency of antenatal appointments that was introduced nationally as a result of research evidence supporting a more flexible approach to care, but based on a reduced number of visits (NCC-WCH, 2008). Women who had older children identified that the frequency of visits had reduced:

'You don't have as many appointments so whereas like I've got an appointment next week but then there was like three and a half weeks between appointments that means you have big gaps'. (Chloe, second pregnancy)

Some of the women in this study appeared concerned with the frequency of antenatal appointments, particularly when there was a long time period between visits:

'It's just the three week thing and having that six week gap you know, I would have liked to have another appointment. The only thing I would say is that um, I don't know why or whether there is any possibility of having more frequent appointments. It would be good if they said come back in three weeks unless you think you need to come back earlier'. (Grace, third pregnancy)

'...where we have the appointment every two weeks it's not too long to wait, whereas before, one appointment a month, that's quite a long time to wait if you've got concerns'. (Sophie, first pregnancy)

So whilst a reduced schedule of antenatal visits for healthy women may be economically sound and not associated with adverse physical outcomes for the mother and baby, it does not always meet women's needs for psychological support and information and is associated with lower levels of maternal satisfaction in relation to midwifery care (Dowswell et al., 2010).

A few women commented on a lack of clarity about when to make the next appointment following the initial booking interview:

'It would be good to have a tick sheet so we know when we should be seen next'. (Emily, second pregnancy)

In addition, for women pregnant for the first time, the gap between first and second appointment was particularly long:

'...so from thirteen weeks through to twenty four weeks I haven't seen anybody in respect of my pregnancy and so I then phoned my doctor's surgery and they said no you've got to be referred from the hospital to be able to see the midwife here...' (Lucy, first pregnancy)

Lucy rang the surgery following a prompt from me. I rang Lucy as part of my regular contact with the women in this study to ask how she was getting on with keeping the diary. It was during this conversation that Lucy told me she had not had an appointment since her first booking appointment when she was thirteen weeks pregnant. She also told me that she had felt anxious a couple of days previously when she had not felt her baby moving. I suggested that she should contact her community midwife through the GP surgery so that should she be worried about anything she would have a point of contact. During the thirty six week interview Lucy told me that when she rang the hospital they told her to go to her GP. In her diary Lucy wrote:

'Firstly I'm not referred to a midwife and so don't see one until I arrange it after a thirteen week gap and now this. Does anyone care? I feel let down!'

Lucy's feelings of being 'let down' suggest that the maternity services fell short of her expectations in relation to the care she would receive during her pregnancy. This would appear to be related to a breakdown in interprofessional communication between the maternity unit, which she attended for her initial visit, and the subsequent antenatal care she expected to receive from the community midwife based at the GP's surgery. Lucy did not appear to know how to negotiate the system to ensure that she received her antenatal care at the appropriate time.

In summary, women in this study identified that the schedule of antenatal visits was reduced from their previous experience of childbirth. For a few of the women the length of time between appointments felt too long and made them feel anxious as they did not feel they could contact a midwife to discuss any concerns that they had. In a couple of cases women did not appear to know when or how they should make the next appointment, and for them the gap between appointments was particularly long. It would appear that the communication between the maternity unit and community services could be improved in a small number of cases to ensure that women knew how and when to make an appointment with the community midwife. The recommendation

to reduce antenatal appointments emerged from a bio-medical model of care and was based on rational scientific findings that failed to show improved biological outcomes with increased appointments (NCC-WCH, 2008). However, this may not meet women's psychosocial needs for support in between appointments.

Access to the midwife

Women spoke about the issues that they had experienced when trying to access a midwife between the scheduled appointments. A number of women stated that they knew if they needed to get in contact with a midwife, that they should ring the central delivery suite and from here a message would be transferred to the local midwife. This was also the established communication mechanism for women booked for a home birth:

'But no you ring the central number. It does feel a bit weird ringing the Delivery Suite to notify them that everything has kicked off rather than ringing the midwives. It kind of depersonalises it to a degree'. (Lily, second pregnancy)

For some of the women this appeared to present a barrier which inhibited women from calling a midwife unless they perceived that the issue was significant. Women with concerns that may have been perceived as not requiring medical treatment were more likely to wait until the next appointment before raising these queries:

'I could have accessed the central number and left a message for her, but I didn't really feel that I should, I didn't feel that it was an emergency if I could see my GP'. (Ava, first pregnancy)

'I did ask who's going to check my stitches then, and she said I could phone if I thought that I had problems with them, which I didn't think I had an infection or anything like that, I was just really sore, but then I felt that I didn't need to call a midwife, I don't know you feel that you would be calling them out for nothing...'
(Daisy, first pregnancy)

From these comments it would seem that both Ava and Daisy perceived that they should not contact a midwife in between scheduled visits unless there was a significant issue or 'an emergency'. Other women rang the local antenatal clinic and left a message for the midwife with the receptionist or rang the birth centre directly. These women knew when the midwife would be available and this appeared to be a suitable communication strategy for non-urgent queries:

'If there's anything that I need to talk to anybody about I either speak to my midwife, on a Thursday afternoon, when she's in the clinic, or I've called the hospital and spoken to the midwives...' (Amelia, second pregnancy)

'I've phoned her up on a couple of occasions when I know she's been working at the birth centre, just to ask questions and she has been very, very informative and helpful, but you know she encouraged me at those times to phone her...' (Sophie, first pregnancy)

However, in a minority of cases the community midwives could be contacted on a work mobile phone, enabling direct contact with a known midwife:

'I have contacted the midwife in between appointments if I've just wanted to query something. My midwife had said you can call me direct...' (Ruby, third pregnancy)

'I text or ring her. She gets back to me and reassures me. I'd had a show and I text my midwife and she said if you need me I will come straight back. About four o'clock I text her and I said they were coming every five minutes, and she was with me really quick, and it was all systems go from there.' (Olivia, sixth pregnancy)

For some women though the lack of clarity or a clear communication strategy on how a woman should contact a midwife between visits was evident:

'I suppose the only thing is if they said look if you have any problems then you can phone (the clinic), although in the end I did, but it would have been good to have been told that, ...' (Grace, third pregnancy)

'You expect the health care to be more structured, and if I choose to be casual about it that is my choice. I could have missed some appointments and they wouldn't have noticed'. (Emily, second pregnancy)

A few women identified that they would have liked to see another midwife:

'I try and avoid seeing midwife Freda⁵ but she just seems to always be working. I'd like to see another midwife...' (Ella, first pregnancy)

However, whilst she tried to arrange appointments on days when her designated midwife would not be working, she rarely actually managed to see a different midwife during the antenatal period. Below is an extract from Ella's diary:

'Once again I turned up expecting to see Betty only to see Freda instead. At least this time she did not make such a big deal about the fact that she thought it was a waste of her time. However the appointment was still very brief and she even made a phone call during the appointment to confirm her availability for on call work over Christmas - not exactly professional in my opinion'. (Ella, diary entry at 33 weeks gestation, first pregnancy)

Ella was one of two participants in this study who identified that she would like to see a different midwife and actively tried to arrange her antenatal appointments to try to see another midwife. However, she did not speak to anyone to formally organise a change of midwife. Whilst women have the right to request a change of carer perhaps Ella either felt too uncomfortable to request this or did not know how to try to arrange to transfer to the care of another community midwife.

In summary, women expressed a range of approaches that they used to access a midwife during their childbirth experiences. There did not appear to be a clear communication strategy informing

⁵ Names of midwives changed to preserve anonymity

women what they should do if they needed to see a midwife in between visits. There was also inconsistency in the information women received; this ranged from a few community midwives giving women a work mobile phone number to contact them on, to a message that midwives should be accessed through ringing the hospital central delivery suite so a message could be passed on to the midwife responsible for the woman's care. Some women circumvented the system by calling the antenatal clinic, surgery or birth centre to get a message to their midwife but this was an informal network rather than a formal mechanism. There would appear to be a need to provide a clear written communication strategy so that all women know how to contact a midwife if they have any concerns during the pregnancy.

Experience of midwife-woman interaction

This code was used to describe how women perceived the interactions that they experienced with a midwife during their care. The sub-codes identified within this code included women's description of the antenatal consultation, frequently described as '*in and out*', the impact that long waiting times had on women asking questions and the extent to which care decisions were shared in partnership or were led by the midwife.

'In and out'

Women described their experience of antenatal care, in the majority of cases, as being very medically orientated in that they talked about appointments being focused on measuring the body's physiological response to pregnancy. The antenatal consultation was perceived as being geared towards identifying changes in maternal and fetal physiology which suggested a medical approach to care. Women commonly described their antenatal care as '*in and out*' and on further discussion they would all describe the medical process of supplying a urine specimen for testing, extending an arm to have their blood pressure measured and then having their 'bumps' felt and sometimes measured. For some women, particularly those who had good continuity of care with their midwife or easy access by telephone, this was not perceived to be an issue:

'It's usually in, blood pressure, pop on the couch and then I'm out again, which is fine'. (Olivia, sixth pregnancy)

'... it's not a big deal for me so...Yeah, it's not, you know so long as they're all doing the same thing you know, you get your blood pressure checked, they check your urine and you know they feel the baby and they do the heart beat so...For me that's, as long as I get all that done, to me it doesn't matter who does that'. (Amelia, second pregnancy)

*'I just go in, get checked and come out, I'm not really that worried about it'.
(Chloe, second pregnancy)*

The women who accepted this medical model of care had generally had babies previously (multigravid) and appeared to be socialised into the 'routine' and may therefore have accepted it as the norm. Porter et al (1984) evaluated a new model of antenatal care introduced in Aberdeen in 1980 and found from their research that women reported a preference for care that they were familiar with, assuming uncritically that the care provided was the best. However, Scambler (2008) argued that medical dominance is so entrenched that women do not appear to realise that they have choices in the care they receive and that interventions such as antenatal screening for fetal abnormality, although optional, are frequently accepted unquestionably by women as a routine aspect of care.

However, this was not the case for all multigravid women. Some women in this study talked about the midwife '*ticking the box*', and some suggested that the midwife spent so much time completing the paperwork or the computer based records, that there was no time left for anything other than the physiological measurements:

'...all the way through it has felt very much like a very medical exercise so it's like, we've got to get your history, we have a number of very basic checks we've got to do, we've got to check your blood pressure, your urine, we've got to check any swelling etc, like tick, tick, tick, so very functional, very medical in that respect, not anything that was different from that, anything more emotional anything that was different'. (Lily, second pregnancy)

This was compounded if the midwife had not met the woman before because precious minutes of the consultation were spent reviewing the woman's notes:

'...it's very functional, the check-up, yeah it's very um remote, you know, it's almost like there's this list of things to do, tick, tick, tick, yeah, basically its tick, tick, tick you're fine, they check your urine, they say everything is fine. They feel the baby and say it's fine. No, no advice, just keep on keeping on, ticking the box. ...but I think it there was access to read the notes I think it would speed up the appointment as well and um probably free up time to actually do and to talk about stuff that you really want to talk about'. (Emily, second pregnancy)

The descriptions by Lily and Emily of their antenatal appointments resonate with the idea of the production line, the midwife ticking off that she has completed her checks, but also the suggestion that this created a barrier between the women and the midwife. Whilst appearing to recognise that the midwife needed to complete certain medical checks, these women identified that this process did not give them any space to talk about the things that were important to them, to gain information and advice or to enable them to engage in the process of decision making.

For many women, when a consultation is generally between five and ten minutes long, this leaves very little time, if any, for the woman to develop a relationship or to ask the midwife questions and to receive advice. This very bio-medical focus, whilst meeting the organisational requirements, largely omits to provide any psycho-social or emotional support for the women, which has been shown to improve pregnancy outcomes (Oakley, 1993; Orr, 2004).

'...it is very non-individual because it's a case of you have urine done, you have your blood pressure done, you have your measured bump thing and then if there's nothing else that you want to talk about or ask about you're out the door again. So it is literally getting the stats done and that's about it, I think impersonal sometimes'. (Lucy, first pregnancy)

In addition to women using phrases such as 'impersonal sometimes' and 'it's very functional' others likened the process to a 'production line' or to being on a 'conveyor belt'.

'...a little bit more interest maybe just general, how are you, rather than just a production line, in and out, in and out which I guess there's an inevitability about that sort of thing but it's a shame'. (Jessica, first pregnancy)

'I felt a bit like I'm on a production line'. Go in, yes your blood results are fine, keep taking tablets, hear the baby's heartbeat, blood check, blood pressure check and right you're gone, she just wants to see you, get you out of the room and go onto the next patient, in the quickest possible way...'. (Ella, first pregnancy)

For many of the women in this study the notion of their antenatal care being described as '*in and out*' was widely held. On further discussion women identified that the short time available to midwives to complete the consultation resulted in the focus of the appointment being on completing the 'medical checks'. Women perceived this experience as very mechanistic using terms like 'functional,' 'conveyor belt' or 'production line'. Some women described this in relation to ticking the box, further emphasising the systematic approach midwives appeared to use to get through the work. Women identified that this approach meant that whilst their bio-medical needs were met this left very little time for the women to engage in dialogue with the midwives, and to discuss options for their care. Women also identified a lack of emotional care in this environment. Midwives have concurred with the conveyor belt metaphor, describing practising in Consultant units as like *working in a factory*, forced to process women through the system because of a lack of time (Hunter, 2003).

Not asking questions

The code 'not asking questions' encompassed the factors women identified that impacted on their ability to ask questions. A few women identified that they did not ask the midwife any questions because they perceived that the midwife was already under time pressure:

'Sometimes I get the impression that they're under time pressure and so that makes me less likely to ask any questions that I might have...'. (Grace, third pregnancy)

'...just in general worries that you don't want to always ask because you know there's women outside waiting to come in or probably know that the midwife's

been asked this by the previous five women and you kind of don't want to say it again, so that's the way I feel...' (Olivia, sixth pregnancy)

Olivia identified that she did not ask some questions because she thought the midwife was probably regularly asked particular types of questions, so she did not feel she could ask them again. Other women identified either not feeling comfortable to ask questions or feeling the questions that they wanted to ask were silly, which became a barrier to asking some questions:

'I felt a bloody idiot keep asking these silly questions, so in the end I tended to not ask, and if I want to find anything out I will talk to other people, talk to friends, use the internet or read a book. I was expecting a bit more of a lead from her as the experienced person, I don't know what to ask, sometimes your questions come as a result of someone telling you some bits and you think oh what does that mean.' (Jessica, first baby)

'In the back of my mind I had lots of questions, but didn't ask any of them because I just didn't feel comfortable in asking them. I'd hoped that, every time I went to see the midwife she might say, 'have you thought about this or that'?' (Daisy, first pregnancy)

Both Jessica and Daisy identified that it would have been easier to ask questions if the midwife had instigated the conversation. Other women indicated that the midwife made it clear she did not have time to answer questions. Isabelle was expecting her first child and had only lived in the UK for a short while before becoming pregnant so did not have a clear understanding about how the maternity services operated. Because her family all lived in mainland Europe she did not have a readily available support network to guide her through the process. Her issues were compounded by the fact that English was not her first language:

'Um...as I said I felt really rushed because at the end of the day, you know, what they tell you is, 'you've got to read the booklets'. You know, this is quite hard to understand what it is, so you know, probably I would have liked someone to explain to me, you know, what it was and, if I had it, what it would lead to, these kind of things.' (Isabelle, first pregnancy)

For some working women the stress of the midwife being late or overrunning for the appointment impacted on them asking questions:

'...they do ask if you have any questions, but particularly when I've been at work I'm like, I've been sat in the waiting room for half an hour, I haven't got time, just do it and I can leave, so they give you the opportunity but it's all so rushed and late...' (Ava, first pregnancy)

From the women's comments there appeared to be a relationship between not asking questions and time, which related both to the time available during the consultation as well as the perceived pressure of time both for midwives and women when the antenatal clinic session is running late. The next section presents some of the findings from the perspective of the length of the time women waited for their appointment.

Long waiting times

Many of the women talked about long waiting times and difficulty making appointments at the surgery or clinic which seemed to relate to the availability of clinic sessions. This is particularly a problem where antenatal care is undertaken at the GP's surgery as the clinic session is time-bound because surgeries do not run a twenty-four hour service, whereas when antenatal care is undertaken at the birth centre⁶ this time constraint is removed.

'I think that's one thing I'd observe is that throughout the whole of the midwifery services that I've had that time has been a massive issue. They over-run all the time.' (Megan, first pregnancy)

'I just think, obviously the service is not that great down there, if somebody comes and is late, I mean an hour and fifteen minutes late, that was quite bad, you expect that they're not going to rush you and answer your questions and talk about things properly.' (Isabelle, first pregnancy)

⁶ Birth centres provide 24 hour care and are either stand alone midwifery led units or units that co-exist within the Consultant maternity unit within a District General Hospital

Whereas a few of the women who went to the birth centre for their antenatal care described a different experience which tended to focus initially on discussing how the women were feeling or answering their questions. These women did not talk about long waiting times or experiencing any difficulty making appointments to see the midwife:

'...but I think I've been lucky with my scheduling,...they always give you the time and they always make you feel like they know you and they are always very reassuring, and you can go in with ten questions and they will go through all of them with you, there won't be just a yes no answer, um and you just always come out feeling very reassured and everything's fine and if you've got any problems come back'. (Evie, first pregnancy)

'Yeah, they are not very long the appointments, I would probably say we are in there for about half an hour if that, um and then we just go through the usual, you know how was I feeling, um did I have any concerns at that stage, I think with my pelvic girdle strain that that got talked about at every appointment...'
(Sophie, first pregnancy)

In this study there was a clear difference between women's experience of GP based antenatal appointments and antenatal care which took place at a birth centre in relation to the amount of time allocated to the appointment. At the GP surgery this was between five and ten minutes but at the birth centre women talked about having appointments which lasted up to thirty minutes. Waiting time was not raised as an issue for women who attended the birth centre for their antenatal care.

Midwife leading care

The code 'midwife leading care' emerged following a question to the women regarding their perception of the relationship that they formed with the midwife. Most of the participants stated that the midwife led the care and that they were supportive of this position:

'...yet when you go to an appointment, you kind of, just let them take the lead, or I do. But I...just...kind of...go with the flow. I think because you just think

that they know what they're doing and...until something goes wrong you just kind of let them get on with it really. I would expect that the midwife would, not take the lead, but kind of, well yeah take the...I suppose really, take the lead...' (Daisy, first pregnancy)

'I would very much describe it as my midwife giving me guidance and leading the way, providing me with options, I think you still need to be told that this is the plan and these are the options...' (Ruby, third pregnancy)

For some women this was because they did not feel they knew what was going on for them. Pregnancy was a new experience for many of these women and therefore they looked to the midwife as the person who knew what they were doing to lead in care decisions. Ruby identified that whilst she saw the midwife as leading the way she still wanted to know what the options were so that she could participate in decision making, even if the midwife was guiding the plan of care. A few women did describe the relationship as a partnership, even though they identified that they expected the midwife to take the lead:

'Well I still think that it's up to them to take the lead,... you know you can be a partner without being an equal partner can't you and I think that I still would have liked more input from her end ... No I didn't sort of say what could I have or what would it, I let her lead it really ...So I guess I was expecting her to say this will happen then that will happen and visit come week twelve and you know I was expecting her to lay out – and I was happy with that, I was happy with being directed at that point'. (Jessica, first pregnancy)

A few women talked about the health professionals being the experts and this seemed to be a rationale for the midwife leading and guiding care. It appeared to be recognised that the midwives and doctors were professionals and a belief that they would want what was best for the mother and baby. Olivia talked about doing whatever the midwife said because she trusted her:

'...but I think you just get to a point that whatever you say I will do because at the end of the day I'm not trained to do this. Yes whatever they say, whatever is the best for this baby I will do basically. I trust everything she says; I don't challenge anything she says...' (Olivia, sixth pregnancy)

In summary 'midwife leading care' was seen as the professional offering guidance and direction to pregnant women because they were seen as the experts with the knowledge and experience to lead care, whilst many of the women felt they did not know enough to make decisions. However, some women did identify that they would want to be given information so they can participate in decisions about their care or be provided with options where there was a choice of care pathway.

Chapter summary

Overall, most of the women described the antenatal appointment as being focused on the bio-medical aspects of care which the midwives needed to complete to 'tick the boxes'. Some women described their care in mechanistic terms, using industrial metaphors such as production line, functional and conveyor belt to describe the care they received. For the majority of the women in this study the antenatal appointment only lasted five to ten minutes and due to the organisation of the appointments, most women described long waiting times and in some cases women were unable to make appointments at the designated time because of a lack of available clinic slots. Because women were acutely aware of the time pressures and staffing issues they frequently felt rushed through their appointments and generally did not ask questions because the environment may not have felt conducive. Moreover, when the appointment felt rushed the women may not have had sufficient time to either formulate or remember the questions they would like to have asked. In most cases, women who experienced continuity of care did not identify a lack of time to discuss issues and ask questions, as the midwife did not need to review the antenatal notes before providing care and therefore for the women, there was a sense of a continuum, of picking up from the last appointment. This was particularly the case if the midwife provided a channel of communication through which the woman could contact her between appointments. Additionally, women who received care at the birth centre identified that there was time to discuss any questions or concerns that they may have as well as completing the bio-medical aspects of the antenatal appointment. The few women who went to the birth centre for their care did not identify issues with long waiting times and generally identified having longer appointment times than the women who were seen by the community midwife at the GP's surgery.

In the next chapter I will be further examining the factors that impacted on the relationships that women were able to form with midwives and the extent to which this was experienced as a partnership relationship.

Chapter 5: Relationships

In the previous chapter I have identified some of the organisational constraints that can impact on the formation of effective relationships between women and midwives. The definition of a partnership relationship, adopted for this study (Chapter 8 refers), identified the importance of trust and respect to enable women to make a psychosocial and emotional connection with the midwife providing their care. As has been shown in Chapter 4, time is a significant issue that impacts on midwives being able to meet women's psycho-social and emotional needs and this lack of time has resulted in some midwives adopting a mechanistic approach to care in order to get their work done.

Whilst undertaking this research, I was particularly interested to explore the extent to which women wanted or achieved a partnership relationship with the midwife and if they did, what they perceived that this meant to them. Within the literature reciprocity has been identified as a significant element within a partnership relationship; the notion that women can get to know the midwife at a personal level, to achieve emotional engagement alongside the bio-medical elements of care seemed to be important, within an environment of support and trust.

From the theme relationship I identified three subcategories; women's perspective, interpersonal interactions and attributes of the midwife. The codes that appeared the most relevant, based on the number of excerpts attributed to a code, were tabulated into a grid to enable a comparative analysis to be undertaken between the participants in this study.

Women's perspective

This was defined as the components that women identified as important to ensure a positive experience of midwifery care and included the factors that they felt impacted on this experience. The comparative analysis of 'women's perspective' was based on the sub codes which were deemed as the most significant areas for the majority of participants. The most noteworthy of these was the extent to which women experienced continuity of care from a midwife with whom they were able to build a trusting relationship. Some women experienced continuity of care but did not feel that they formed a relationship of trust with the midwife and this impacted on the extent to

which they felt involved in decision making and the degree to which they felt confident to be guided by the midwife.

Continuity of care

This study was undertaken in two NHS Trusts that offered a conventional model of midwifery care whereby women either saw a community midwife for antenatal and postnatal care, or attended the birth centre and saw one of a team of birth centre midwives. In the majority of cases intrapartum care was normally conducted by a midwife not known to the woman. In order for women to form a meaningful relationship with a midwife, they need to spend sufficient time together to explore the nature of the relationship, to move beyond the bio-medical aspects of the pregnancy and to have time to explore the social and emotional issues that are relevant to the woman. The women in this study were more likely to achieve this if they already knew the midwife from a previous pregnancy and therefore were building on an established relationship.

Table 4: Relationship between continuity of care and participants who perceived they had formed a relationship with the midwife and identified the attributes in the Midwifery Partnership Model.

Pseudonym	Parity	Knew midwife from previous pregnancy	Continuity of care/carer	Formed a relationship with the midwife	Antenatal Care
Olivia	Sixth pregnancy	✓	✓	✓	Community midwife
Ruby	Third pregnancy		✓	✓	Community midwife with medical input –
Chloe	Second pregnancy	✓	✓	✓	Community midwife
Emily	Second pregnancy				Shared care GP and birth centre
Sophie	First pregnancy		✓	✓	Birth centre, continuity of care philosophy
Jessica	First pregnancy		✓		Community midwife
Grace	Third pregnancy	✓	✓		Continuity by two community midwives
Lily	Second pregnancy	✓	✓		Continuity by two community midwives
Amelia	Second pregnancy	✓	✓		Community midwife
Evie	First pregnancy		✓	✓	Birth centre, continuity of care philosophy

Ella	First pregnancy		✓		Community midwife
Isabelle	First pregnancy				Community midwife
Megan	First pregnancy				Community midwife
Daisy	First pregnancy				Shared care between midwife and GP
Lucy	First pregnancy				Shared care between midwife and GP
Ava	First pregnancy				Community midwife

Most of the women who received continuity of carer felt they were able to pick up from where they had left off at the last visit and therefore the length of the consultation was less of an issue. This was the case for five of the women in this study:

‘But all my other appointments were lovely. And I got to see, like the student midwife, that I saw when I was pregnant with my daughter. I saw her again this time; it was really nice. And I only saw my community midwife all the way through this time, whereas with my daughter had a couple of different midwives. So it was nice I got to have continuity’. (Chloe, second pregnancy)

‘...to see the same person and discuss your birthing plan and things that are going right and wrong with the same person so, you know, that has been a bonus. ...because I’ve seen her all the way through, you do feel at ease, with her, and you know able to talk to her about things...’ (Amelia, second pregnancy)

Two of the women in this study, Evie and Sophie, described developing a positive relationship with the midwives at the birth centre where the interaction between woman and midwife was not inhibited by availability of clinic space and time constraints in the same way as appointments at the GP surgery. These women were often seen by a small team of midwives but because the consultation was more likely to last for around twenty five to thirty minutes as compared with five to ten at the GP’s surgery, they received more personalised care from the midwifery team.

'I saw the same midwife as last time which was great. I understand that I will not have the same midwife everytime but it was really nice to see the same person again. ...it was clear that the midwife was very passionate about more natural remedies. I found this to be very reassuring and totally in tune with the ethos of the birth centre where the birth should be as natural as possible. I felt that a midwife with this sort of attitude would be really beneficial during labour and incredibly supportive of any choices I would like to make'. (Evie, first pregnancy, diary entry at 28 weeks)

'...no it was a good experience; and it's continued that way so I probably seen my midwife probably now, must have had about four, five, six appointments with her, and she's been lovely, really nice, I've phoned her up on a couple of occasions as well when I know she's been working at the birth centre, just to ask questions and she has been very, very informative and helpful, so they all just seem to take a real keen interest in you as a person, as well as obviously, as a patient so, yes, I've had a very good experience so far, so hopefully it will continue'. (Sophie, first pregnancy)

Women attending the birth centre do not always see the same midwife. Continuity of care in this scenario is where care is provided from midwives who have a shared philosophy of women centred care, adopting a social model of care (Kirkham, 2003). In this study some of the women did experience continuity of carer, however they did not feel that they developed a partnership relationship with the midwife and described the lack of emotional support that they experienced during pregnancy:

'I think she's met it in terms of the mechanics of it but maybe a bit lacking in the, the emotional sort of thing... maybe it's my unrealistic expectation of what a midwife is supposed to do, you know, they might think, 'I'm not an agony aunt, I'm not a counsellor'.... (Jessica, first pregnancy)

However, in contrast to the dominant view around the importance of forming a partnership relationship within a midwifery model of care, one participant identified that forming a partnership relationship was not important to her:

'...it kind of feels like a potential investment in time, of getting to know somebody and then in the end you then get somebody completely different which could just throw you out completely, and I'm quite independent, I'm quite rational rather than an emotional person anyway. It's kind of in some respects, from my perspective good I hadn't really invested, or worried about investing too much time in building the relationships there; because it could have thrown you, I guess, if you got attached to one particular person who wasn't there on the day...' (Lily, second pregnancy)

Lily was the only participant who actually stated that she would not invest time in forming a relationship with the midwife because for her this was not about the antenatal journey and building towards her birth experience, but more about who would care for her during her birth. She did however experience continuity of care with two midwives who she also knew from her previous pregnancy so that may have impacted on her attitude. She had also had an uncomplicated pregnancy with her first child, but despite planning a home birth with her first baby actually delivered in the local maternity unit because her boiler had broken down and she therefore did not have any hot water for her planned water birth. The fact that her careful plans were sabotaged by something totally outside of her control and unrelated to her pregnancy, may also have contributed to her views. She clearly recognised that despite excellent planning there are a myriad of factors that can impact on the actual experience of childbirth.

However, a number of women in this study did not experience continuity of care and many of the women reported very short consultations. For some women consultations happened quite infrequently and these women did not describe that they had formed a partnership relationship with any of the midwives providing care, which was frequently described in very mechanistic terms. A number of the participants who were expecting their first baby, described an expectation that they would see the same midwife and build up a relationship with her:

'I imagined that I would have one midwife and I would see that midwife throughout my pregnancy and build a relationship with her. But that's really not the case. I just imagined that you'd get to know your midwife quite well, on a professional basis, not so much personal. I find that very frustrating, because you are going in there expecting to see somebody, and it's somebody you've never met before.' (Daisy, first pregnancy)

'I sort of hoped that you would see the same midwife..., but because I keep seeing different people they are just all very functional, and I think I expected more of a relationship; ...so I think that's the thing I found the most frustrating is, you just never see the same person so it's very difficult to build any kind of rapport with anybody...' (Ava, first pregnancy)

In summary, women who knew the midwife because they experienced continuity of carer and particularly if they knew the midwife from a previous pregnancy, were more able to develop a relationship with the midwife even when the consultations were relatively short. A number of women received care from the community midwives attached to the GP surgery and seemed to be frustrated with not having the same midwife providing all of their care because the care they received was fragmented, medically focused and did not meet their emotional needs. This resulted in a negative experience for these women, because they were unable to develop a relationship with any of the midwives. A few women experienced continuity of care at the birth centre, where the philosophy of care was consistent and these women described a positive experience of their care.

'Go with the flow' – Involvement in decision making

The two codes 'go with the flow' and *'involvement in decision making'* have been considered together as the concepts are linked to the quality of relationship that women experience with the midwives providing care. Most women when discussing their plans for the birth talked about *'going with the flow'* and for some women this expression appeared to suggest an underlying confidence in the maternity services either as a result of having developed a positive relationship with the midwife, or as result of a number of positive interactions with midwives within the maternity unit. These women had built up a relationship of trust with the midwife, felt that they had been fully involved in decision making throughout pregnancy and felt confident that, when appropriate, they would contribute to decision making, but if required they trusted the midwives' judgement to guide them in relation to care decisions:

'I know I need to go with the flow. I can control what goes on here in terms of not panicking and being rational about things but I also know I've got to let my body get on with it, and its capable of doing it, I've just got to get on and let my body do what it's got to because you don't know what's going to happen and you do need to keep an open mind. [The midwives] are there to support me in

my choices and what I want to do, accepting that, you know, that they're the medical people so if there's something then I totally accept what they're saying or what they want to do...' (Evie, first pregnancy)

'I'm planning for a home birth unless my midwife says otherwise; I'll just go with the flow with her. I just think when you're in labour you can't stick to your plans always can you, you have to go with what your body wants you to do...' (Olivia, sixth pregnancy)

However, whilst the majority of participants identified that they were involved in decision making, even if this was at quite a simplistic level, one woman felt that she could not be fully involved in decision making because she did not have sufficient information on which to make a judgment.

'I think it's really difficult when you're talking about decision making because of the control of information so far, you can't really make a decision because you don't know enough to make decisions'. (Megan, first pregnancy)

Megan's comment about the control of information was interesting. Although Megan stated that she did not know enough to make a decision, she is also inferring that the midwives and obstetricians chose what information they would share with her, so it could be argued that she was blocked from being involved in decision making because the midwives providing her care did not give her the information to empower her to share in the decision making process and therefore to be able to make choices regarding her care.

However, other women in this study gave examples of where the midwife identified all of the options or ensured sufficient time to provide the information to support women to be involved in decisions about their care:

'...ok this is what we'll discuss at this antenatal appointment and um then the discussion is more of an equal partnership from there. ...this is what we, you know the recommendations are if you feel that you want to go a different way we can discuss that and explore it. (Ruby, third pregnancy)

'I think we had five minutes left and she purposefully said right I still need to talk to you about vitamin K but I'm not going to talk to you now because I need longer to go through it, you know, I need more time to talk to you about it, so we

will leave it then, you know so I think that's quite nice because she could have easily just rushed through it and left us to make the decision but we are going to talk about it at length when we see her on Monday'. (Sophie, first pregnancy)

Ruby was referring to a discussion she had with her midwife in relation to place of delivery. Ruby had previous medical complications which would have made it advisable for her to deliver her baby in a consultant unit, however her midwife advocated for her in relation to other options that could be considered.

In summary, most of the women in this study accepted that they could not control a number of the factors that could impact on their childbirth experience, so there was a sense that they would go with the flow. Women identified that generally they would be guided by what the midwives advised as they are seen to be the people with the knowledge and medical expertise to support women in their decision making. Some women identified examples when the midwives provided information to support women to contribute to the decision making. However, Megan identified that she did not know enough to contribute actively to the decision making process.

What women want?

In all the interviews I asked the women what they wanted from their care and what was most important to them. The women who had experienced continuity of care and appointments in which they were given enough time to move beyond a very bio-medical focus, were more likely to have described a supportive relationship in which they were readily able to seek answers to questions and felt that they experienced a partnership relationship. The women who did not experience this kind of relationship described wanting a more intimate or personal relationship with the midwife that would meet their emotional needs:

'I just feel that the emotional part of the journey hasn't been considered really. Well, you know, perhaps it would have been nicer to have had a more holistic approach'. (Jessica, first pregnancy)

'I think I would just like it to be a bit more personal, say, you know maybe just have, obviously you can't always see the same midwife, but um, as you say, I still don't know how many midwives work at my surgery, and it would have been nice to have that information to start off with, ' (Ava, first pregnancy)

There was also a need to have more time to ask questions and a feeling that the antenatal appointments were not exactly building towards anything, with a lack of forward thinking in relation to plans for birth and whether these were realistic:

'So, I think it's just the whole forward, forward thinking aspect of it. They look at me there and then; if everything's fine then bye. They don't think, 'oh everything's fine, we've still got five minutes left of the appointment, let's just see how things go'. I mean never had that impression from anyone'. (Ella, first pregnancy)

In summary women mostly wanted their care to be personalised so that their psycho-social as well as biological needs were met. Women also wanted care to be more individualised to their own needs so that time was spent by the midwife talking to the woman about what she would like to get out of the experience. Time spent reviewing the woman's birth plan or by asking women about aspects of their care that may be relevant at specific stages of pregnancy, for some women, in essence, forward planning.

Interpersonal interactions

Interpersonal interactions were defined as the extent to which the midwives' communication style met the women's needs. This included sub-codes on 'sources of information', 'advice and response to questions', 'communication issues' and 'lack of information or explanation'. These codes were tabulated to allow a comparative analysis to be undertaken.

Sources of information

The code 'sources of information' encompassed the range of people and places that women accessed to find answers to questions or concerns they had or to help them to make informed decisions. When women talked about where they got their information from, nearly everyone talked about the internet and using childbirth forums or 'Google':

'I should probably ask the midwife because getting all your information from Google is probably not the best, but there are certain websites like midwife centre where you do get midwife consultants...' (Grace, third pregnancy)

'But you know thank god for Google. You have to be careful of the sites that you take notice of, but I'm pleased that I knew enough to ask the questions...'
(Ava, first pregnancy)

From the comments made, some women appeared to recognise that it is important to choose internet sites carefully to try to ensure the information is reliable. Grace identified that she had accessed a site where women received answers to questions from midwife consultants which may have reassured her about the quality of the responses. Women also identified that books, family and friends were other significant sources of information:

'I've been finding it out through alternatives, as I say reading my book. Looking on line or speaking to friends who've had babies'. (Jessica, first pregnancy)

'I mean a lot of it I just looked up myself. I asked my family, friends, as well, you know, about your anxieties and things. Yeah, mostly from the internet, books, things on TV that we've watched, that we wouldn't have watched otherwise. So, yeah that's kind of how we've made our choices, just by asking people really. But not professionals. Just by asking people's personal opinions, how they found it, you know...'(Daisy, first pregnancy)

The comments from Daisy and Jessica suggest that a range of sources were used as an alternative from seeking professional advice. Daisy identified a range of sources but specifically stated that she did not access information from professionals to support her in making choices. Jessica identified that she had been finding things out 'through alternatives', suggesting that these sources were an alternative from asking for professional advice or information.

Women identified that they were given a lot of booklets and leaflets at the initial appointment, but questioned how relevant this information was:

'I think maybe some of the information should be available upfront. I spent the whole nine months with hardly anything or some of the things they give you are not even that relevant... There's lots of wasted paper, is there no way they could put everything in one little handy booklet. A lot of it you're never going to read and they're not really that relevant'. (Emily, second pregnancy)

'I felt at the booking in you are given all this bumph, and what I really wanted was you know a sheet of A4 that said, um these are the things you need to know to start off with, these are where you are going to give birth, these are the appointments you're going to have and just like a fact sheet instead of piles of leaflets,...' (Ava, first pregnancy)

One woman, at odds with the majority of participants, felt that women have a responsibility to seek information for themselves, recognising that it would be impossible for the midwife to provide the level of information that most women require in the time available:

'I think pregnant women shouldn't expect to be spoon fed and there's a lot of information that you need to know and you can't expect the midwife to tell you everything, you've got to be reading books. You know, you should be definitely going to classes.' (Ella, first pregnancy)

There was also a clear distinction between women who attended parenthood education classes and those who, for a variety of reasons, chose not to. Women who attended classes tended to suggest that the classes had met a lot of their information needs and therefore they did not need to ask the midwife to provide detailed information around key issues:

'...if I hadn't been doing NCT I probably would have discussed more with the midwife.' (Evie, first pregnancy)

However, some women felt that if you did not attend the classes or seek advice from alternative sources, important information and guidance would be missed:

'I did the NCT, but if you didn't do that for whatever reason or hadn't done the reading you know, it's quite valuable information I think, and the kind of information again building towards the birth. And preparation both mental and physical preparation for the birth is quite a positive thing to do. So, you know had I not read up on it I think I would have missed out on, some valuable guidance I guess, had I not done it...' (Lily, second pregnancy)

In summary, women identified a range of sources of information from the internet, books and family and friends. Antenatal classes were also seen as an important source of information. Women did not identify midwives as a significant source of information and some recognised that this was

because they had gleaned this information from alternative sources or in the case of Ella that it was not reasonable to expect midwives to provide all of the information that a woman may want.

Advice and response to concerns

This code focused on the extent to which women discussed being able to ask specific questions and receive a response that met their specific needs. Women who received their antenatal consultation in a birth centre environment were generally allocated much longer than women being seen by a community midwife in the doctor's surgery or health clinic. As a result of this, these women identified that they could go to the birth centre with a long list of questions and would feel that at the end of it, all of their questions had been answered:

'I go in armed with quite a lot of questions. C and I will talk about things and we will make notes like the vitamin K jab, so we've written it down so we know we need to remind her to talk us through that. I suppose now I am keen over the next couple of weeks to maybe really pump the midwives for as much information on labour and any bits of advice they can give me really'. (Sophie, first pregnancy)

Sophie felt that the antenatal appointment provided the time and space for her to ask as many questions as she needed to, as she clearly saw the midwife as a valuable source of information, describing the interaction as 'pumping' her for information. In addition, a few women talked about the level at which the midwives responded to questions, which was described as straight-forward and presented in an understandable format:

'She is just very down to earth, just very straight forward, there's no, I just feel like if I asked her a question she would just sort of answer it, there wouldn't be any, I don't know, mock sympathy type of thing, you know, she just says the answer, you know. I'm not interested in any of that touchy feely stuff; I just want to ask the question and then have the answer'. (Grace, third pregnancy)

'I feel like I'm looked after, like when I go and see her I feel like she covers everything but without, it's hard to explain, without dragging it out and using all medical terms that I won't understand, she can explain something, quite quickly, and I understand it and if I've got a question she's quite reassuring, she answers it always in a way I understand'. (Chloe, second pregnancy)

From Chloe and Grace's comments what seemed to be important to them was that the midwives responded clearly to questions using appropriate language, whilst at the same time adopting a reassuring manner. Most women reported that midwives responded well to questions but a few women identified that midwives generally did not instigate discussions in relation to specific stages of pregnancy and birth:

'No discussion whatsoever. I mean I asked a question just to check my knowledge was accurate, potentially gas and air and a waterbirth... I just was double checking that I can have gas and air. I asked about using gas and air at home and I talked about when I might not be able to be at home, but apart from that in terms of, no there's nothing and I was really surprised the first time around. (Lily, second pregnancy)

Lily was discussing her impending home birth and her surprise that the midwives did not initiate a discussion regarding her preparation for a water birth at home. Overall, most women identified that the midwives responded at an appropriate depth and breadth to the questions they were asked but did not instigate discussions specifically related to the woman's stage of pregnancy or preparation for birth.

Communication issues

Another aspect of care that was identified as unsatisfactory by a small number of women, related to the quality of interpersonal interaction. Women described incidents where the midwife made telephone calls or sent text messages during their consultation or spent time completing the computerised records of the previous client whilst responding to their questions:

'...let me just carry on typing up these notes, I am listening while you talk', so she was just typing other peoples' results into the computer. I don't know whether that was that appointment but that was another excuse she gave me while I was going through my list of questions, she was on the computer, 'I am listening' she said'. (Ella, first pregnancy)

Some women felt that as long as they received answers to their questions they did not care that the midwife was not giving them her undivided attention, but more commonly women perceived this

behaviour as rude and felt strongly that the midwife should concentrate on them fully during the short consultation. This was more commonly mentioned in relation to the midwife working alongside a student midwife and it was felt that the midwife was multi-tasking to contain the workload rather than fully engaging in the student's activities:

'Well, it's rude isn't it really? I'd feel annoyed in any work, professional situation I appreciate obviously I was being dealt with by someone else, you know the student, it wasn't like I was just sitting there twiddling my thumbs, I just thought it was a bit discourteous really and even if it was to be texting another pregnant lady to say yes your appointments at 2, while you're in there that's your time isn't it, and you just think, even if you are not interested, look interested, you know...'(Jessica, first pregnancy)

However, other women identified examples where the communication with the midwife was a positive experience:

'Um they are very good at it, actually. There interpersonal skills are just very, very good, they make you feel like you're kind of remembered...' (Evie, first pregnancy)

'...it was just the communication. And they, you know, they spoke to you about everything. And they went through your notes with you...' (Amelia, second pregnancy)

Evie talked about a sense that the midwives remembered her from the previous appointment which made her feel important and personalised her experience of antenatal care. In summary, women identified good communication where the midwife actively engaged with the woman during the consultation, building on previous experience and ensuring women had been fully informed during the appointment. Midwives who are trying to multi-task during a consultation left women feeling that they were not being fully engaged with, which at times women found quite rude.

Lack of information or explanation

This code contained excerpts where the participants felt they were not provided with sufficient information or explanations to help them to engage as a partner in their care:

'I think talking; the real benefit I would get out of the midwife as opposed to the medical support would be just talking about birth. Because that's ultimately what you're building towards and I felt like that's the only thing we didn't really, talk about particularly. Um but to have, kind of two or three points where you meet with the midwife, or maybe even the team of midwives, to say 'right, this is what I would like, let's discuss the options, the pros and cons, you know,...I didn't feel like there was one person that I was building up to an event with, that was involved in any of the decision making in any way...' (Lily, second pregnancy)

Lily was talking about how her care was focused on the medical aspects but there was not enough time to really talk about the things that were important to her, which was about planning for her water birth at home. Moreover, without guidance by the midwives about the subjects that should be discussed at particular stages of the pregnancy, there is always the assumption perhaps that the subject was raised at an earlier visit. This is particularly so when time is short and there are a queue of women waiting to be seen and this reduces any guilt the midwife may feel about not meeting women's needs. But for women it is often the most basic aspects of care that they feel the midwife could so easily provide, that they feel are omitted during the consultation:

'I think that was the thing as well it's like this bloody secret code they've got going on. They do a lot of things and don't tell you why. It's the packets of information, to be honest, that seem so obvious to them because they do it all of the time that they completely miss'. (Megan, first pregnancy)

Megan was referring to stages during her pregnancy when she was sent for investigations or to see a doctor but did not really know if she was being referred for a reason or whether it was just part of the standard care package, because of her age and medical history. The theme of women feeling that midwives were not explaining fully what was happening was expressed by a number of women in this study:

'...there are all these things that obviously they know but they didn't tell you, so I think when you are a worried pregnant woman I think it's quite good to have this kind of knowledge'. (Isabelle, first pregnancy)

'...and then you lose confidence a little bit in, sort of, not in them as midwives, but just, I don't know, sort of not knowing what's going on and just sort of being left there'. (Amelia, second pregnancy)

'I was literally in the dark about everything. So I just didn't have a clue, I just didn't have a clue, and like I said, from one meeting to the next I didn't, well unless I'm told what pre-eclampsia is I'm not going to know...' (Lucy, first pregnancy)

Amelia was describing an incident that took place when she was admitted to the delivery suite to monitor her pregnancy because her blood pressure was high. The care was disjointed and resulted in Amelia and her husband waiting for several hours not knowing what was happening and what they were waiting for. She described this experience as very different from the care she had received when she attended the day assessment unit for monitoring where she described the midwives as very friendly and ensuring that she was fully informed about what was happening at all times. Isabelle and Lucy were talking about the antenatal care that they received and appeared to be suggesting that the midwives did not provide them with information they felt that they needed. Lucy suggests that she would not know about anything unless the midwife informed her explaining her comment about being *'literally in the dark about everything'*.

In summary, some of the women in this study provided examples of situations where the midwives did not share their knowledge about what was happening to the women during pregnancy. The importance of keeping women informed at all stages of pregnancy was highlighted. Women expected midwives to provide information and explanations to help them to be involved in decision making and to make plans for birth.

Attributes of the midwife

Attributes of the midwife were described as the behavioural traits, qualities or characteristics that the women described the midwife exhibiting during their care. The comparative analysis of attributes of the midwife comprised the codes that I identified from the data as 'positive attitude', 'trust and reassurance', 'support, friend or advocate' and 'caring and empathic'. Disconfirming evidence was identified where women stated that they did not feel the relationship was supportive, that the midwife was not interested or caring and did not work in partnership with the woman.

Positive attitudes

Overall women described the experience of being cared for by a midwife during childbirth as a positive experience. This was because the midwife made the women feel that they were important to her and that the women's feelings and views were valid. Most of the women described their experience with midwives as being very supportive, friendly and generally perceived that the midwives were there for them which made the women feel good about themselves:

'...but I think I've seen at least three different [midwives], and they were all absolutely brilliant, they were all lovely so...So not dictatorial at all, just very supportive, someone being there to help me have the best experience that I can have'... (Evie, first pregnancy)

'...the whole labour and delivery was a really positive experience, despite having to be induced and everything, it wasn't how I planned it to be but the midwives made sure it was still going to be a positive experience for me, so I was pleased with the outcome...' (Daisy, first pregnancy)

One exception to this was Megan who expressed a strong view that the lack of continuity of care during her antenatal appointments and the overriding feeling that her carers, both midwifery and medical, were not keeping her fully informed led to her lack of confidence in her care:

'...she had a recognition that I felt uncomfortable with where I'd got to along this process so I may...And she's like, you know, she accepted that I may have a lack of confidence in her. And not because of anything she's done, about when I met her, but because of everything that had gone before. And she recognised that there was a level of confidence building that needed to happen...' (Megan, first pregnancy)

In summary, most of the participants identified experiences with the midwives that reflected a positive attitude to care, irrespective of the outcome. Only one woman, Megan, did not describe her midwifery care as a positive interaction, because her early experiences left her lacking confidence in her carers.

Trust and reassurance

Trust and reassurance was a strong theme that the majority of women highlighted during the interviews. This was largely about feeling able to relax and let go because the midwife was viewed as being competent, knowledgeable and supporting women in their choices. This is clearly illustrated in the comments from Olivia and Ruby who were talking about their experience of pregnancy and birth during the postnatal interviews:

'It's like I say, I've got one hundred per cent trust in her really, so I just let her guide me'. (Olivia, sixth pregnancy)

'I knew that I was thinking I relaxed a little bit because she was there, just because she knew me and she knew what I had been through and I just think that she's a fantastic midwife and I just felt safe with her, so yeah it did feel different to me and I think if I had been holding back at all I think I let go when she was there...'. (Ruby, third pregnancy)

Both Olivia and Ruby knew the midwife who had been present at their births because she had provided all of their antenatal care, so their feelings of trust and safety were underpinned by the relationship they had formed with the midwife. However, other women described feelings of trust and reassurance with some midwives who they had only met once:

'Mmm, it was brilliant. I literally, within five minutes of arriving just felt like I'd known her for ages and trusted her implicitly'. (Lily, second pregnancy)

Lily was describing her experience with the midwife who came to her home to care for her during her planned home birth. She had never met this midwife before but she talked about how quickly she and her husband formed a relationship of trust with the midwife. Although most of the participants described feelings of reassurance and trust, one woman's comments stood out in stark contrast. Daisy had been talking to me during her antenatal interview about the choices she was offered about her place of birth. She felt strongly that her early experience of antenatal care was very disjointed and because of the lack of continuity of care she did not establish any form of relationship with the midwives. She did not feel confident that she could exercise any choice in relation to place of birth because she had not formed a relationship with a midwife:

'I mean, if I'd chosen to have a home birth, I wouldn't feel comfortable doing that now because I haven't built a relationship with the midwife to be able to trust her to come into my home and look after me safely and look after my baby during delivery because I wouldn't know the person. But because I haven't had that relationship built up with somebody that I trust, then it's not an option that I would be able to choose'. (Daisy, first pregnancy)

In summary, most of the participants described examples where they felt reassured and trusted the midwives' judgement. In many cases this was associated with forming a relationship with the midwife which for many women occurred because they had met the midwife on a number of occasions. There were however a few examples where women formed a trusting relationship with a midwife that they had only met once. This was particularly the case during a women's labour and birth experience, where typically the midwife would be caring for the woman for a number of hours.

Relationship of support, friend or advocate

When I was defining the relationship as one of support I was considering this in relation to the notion of partnership and the extent to which the relationship is perceived to be a partnership. Frequently this was expressed in relation to the midwife empowering the woman to be able to make informed decisions and to provide support and guidance which was often articulated around the midwife being kind, friendly and having very good communication skills:

'Her whole demeanour really, very friendly, very open minded in terms of encouraging you to ask questions, elaborate on fears and concerns you might have, yes she was just a really nice lady and I suppose, that's part of the role isn't it, having the ability to talk to the public and building up a rapport...'
(Sophie, first pregnancy)

Sophie was describing the antenatal care the midwife provided in the birth centre where she experienced a good level of continuity and felt she had formed a partnership relationship with the midwife:

'Which I probably needed to be honest, someone to say do this, do that but this time I like it that she's supported me. I see her as like a friendly professional that... You know she was really, really friendly, but, she's my midwife'. (Chloe, second pregnancy)

'Yeah I definitely felt it was a partnership, definitely, and definitely that she is there for me and my care. I would say I felt it was a very close relationship, very at ease, I felt that nothing was too much trouble...' (Ruby, third pregnancy)

Both Chloe and Ruby experienced continuity of care with a community midwife who was known to them from a previous pregnancy. For Chloe whilst she felt the midwife supported her in her choices she also talked about needing someone to tell her what to do, to guide her in her choices. Whereas Ruby described the relationship with the midwife as a partnership in relation to the decisions that she was supported to make.

However, not all women experienced this level of support and where the participants did not establish a relationship with the midwives, care was seen very much as a process that the carers undertook in a task orientated manner and in which the participants did not feel involved. Ava who went to the doctors' surgery for her antenatal care felt that she did not get any continuity of care and was also very frustrated by the fact that her appointments were frequently late and because of this quite hurried; she described her care as:

'I've found it very impersonal, detached, so I think I've sort of struggled to say much about it, it's all been very functional, and like I say I've got more of a relationship with the radiologist than I do with the midwives.' (Ava, first pregnancy)

Megan also felt strongly that she had not developed a partnership relationship with the midwife providing her care:

'I just didn't feel like there was any partnership. I felt it was, 'we're going to do this, we're not even going to really consult with you or tell you much about it. If I'm honest, I just, I see every appointment as something that I just get through. I want to get through the end, but it's not felt like a partnership, it's felt like, something I have to keep tabs on.' (Megan, first pregnancy)

In this extract Megan was responding to a question about choice, specifically in relation to antenatal screening. She expressed the view that in her experience the midwife had not discussed the options to enable her to make an informed choice, but had instead told her what would be done

to her. This left Megan feeling that she did not have a partnership relationship with the midwife, she stated that she felt her antenatal care was something she 'had to keep tabs on'.

One factor that does seem significant is the pressure on midwives to provide antenatal care where time for the consultation is limited to five or ten minutes in an environment over which they have no control. Where women receive care in the maternity unit or in their own homes, time pressures are removed and therefore the midwife has longer to establish a meaningful relationship. Many women described the midwives as very friendly and in a number of cases actually described the midwife as a friend:

'It was like meeting an old friend again and so it was good. I think it's because you go the nine months with your midwife and then they're there at the most special time of your life and then they're there for that week afterwards. I mean you kind of get a bond and you've got a lovely memory of them...'(Olivia, sixth pregnancy)

'...you just feel comfortable with them and easy, you know, find it easy to talk to them and just have that sort of, almost like a friendship with them; so at the end of the day, that's what you need because, what you're going through is a big thing so...'(Amelia, second pregnancy)

The participants in this study who talked about the midwife in terms of friendship frequently described this around a relationship of good continuity of care, predominantly during the antenatal period. However, for some women this related to one significant interaction by a midwife who was not previously known to them, suggesting that the quality of a single interaction can be perceived as important to a woman as a continuous relationship throughout pregnancy and childbirth.

Caring and empathic

Empathy and caring were two other attributes commonly attributed to the midwives in this study. Three quarters of the participants specifically talked about midwives who they felt were very caring or empathic and identified examples of how these attributes contributed to them experiencing a positive interaction. They felt the midwives understood how they were feeling or at that particular moment spent time focusing on the aspect of pregnancy that was causing the woman anxiety. Women frequently described such interactions as an example of the midwife, 'going the extra mile' or showing a more human side to how they may have perceived the doctors:

'Oh brilliant. I couldn't fault any of them. I mean there was a couple that were very, very, um, I'd say they had great empathy in terms of how I was feeling.....I think, you know some, some, some you know some go the extra mile in terms of looking after you, but that's just their way...' (Sophie, first pregnancy)

*'So they are very empathetic and very keen to take the time..., 'Rowan unit is brilliant and the staff are fantastic', all the midwives have been just really nice'.
(Evie, first pregnancy)*

Sophie and Evie went to the birth centre for their antenatal care and in the excerpts above were describing the relationship they had formed with the midwives. Both women experienced good continuity of care from two to three midwives. In contrast, one woman actually provided an example of where she felt the midwife was not caring enough and talked about how disappointed she felt that she had not met her named midwife:

*'But I was really disappointed because, first I thought I was going to meet my midwife, which she wasn't again. And I didn't feel she was caring enough. You know, it's like, 'ok, you're just another pregnant woman' and that's it. Not even trying to know you, nothing. When I was asking questions, she wasn't actually answering, very happily, you know. It was like, 'uhh...' like a chore kind of thing. And to me, if you've got questions, it needs answering and that's it'.
(Isabelle, first pregnancy)*

Isabelle had written in her diary that the midwife at her twenty-three week appointment was not very communicative which made Isabelle feel uncomfortable about asking her any questions. I had asked Isabelle how she had felt about this appointment and she had explained that she was disappointed that she was not seeing the midwife who she had been told was her named midwife and because of this she had not formed a relationship with a midwife.

In summary, whilst most of the women in this study provided examples of midwives' behaviour which appeared caring and empathic, this was not the case for all of the women. Women who received continuity of care were more likely to describe a positive relationship with the midwife. However, some women described a single event where the midwife was perceived to be empathic in her care.

Chapter summary

The women in this study, who experienced continuity of carer from a community midwife or continuity of care from a small group of midwives in a birth centre setting, identified that they had formed a relationship with the midwife which many described as a partnership and this enabled shared decision making to take place. The attributes in the partnership model were described by most of these women. However, a few women who experienced continuity of care did not form a relationship with the midwife and for these women a partnership relationship was described as not important to them. Most of the women in this study who did not experience a partnership relationship were either unable to engage with the midwife at a psycho-social level, despite receiving continuity of care, or in most cases did not receive any continuity of care.

Women who were cared for by midwives in a birth centre again generally experienced longer appointments and therefore had time to discuss any issues that were worrying them and described feeling that their emotional needs as well as medical needs were more fully met. Where midwives are constrained by surgery appointment times consultations were generally identified by women as much shorter and women described it as a very mechanistic experience with the midwife generally not having time to answer questions, leaving women feeling that they were not being adequately prepared for becoming mothers.

Trust and reciprocity are fundamental concepts embedded within social interactions (Thiede, 2005) that enable women to feel confidence in the care that the midwife is providing. Women frequently talked about 'going with the flow' and within this recognised that there were some decisions that could be made as equal partners but that more complex choices need a steer from the midwife. The extent to which women are offered choices in relation to care options will be explored in the next chapter. This is particularly around the choice guarantees proposed by the Government in the 'Maternity Matters' document (DoH, 2007)

Chapter 6: Choice

Choice has been a central concept in health care policy within Britain over the last two decades, ostensibly as an attempt to give service users a sense of control regarding the care options available to them (Symon, 2006). In this study I wanted to explore women's experience of choice, particularly around the 'choice guarantees' within the 'Maternity Matters' document (DoH, 2007), and to determine the extent to which women either wanted to be involved in decisions, or contributed to decision making during their pregnancy and birth. The rationale for choosing this aspect was that the Maternity Matters report identified that these choice guarantees would be available by 2009, but did not identify any supporting evidence that this is what women wanted. Also it is important to remember that not all choices are available to women, either because the area does not provide the full range of choices or because of the women's medical history which may limit choice. Also choice aligns closely with responsibility and not all women want to take responsibility for the choices available, as safety is paramount for many women and therefore the guidance from health care professionals is an important factor to consider (Pitchforth, 2009).

From the analysis of the data two subcategories emerged in relation to choice; the extent to which women are offered choice and influences on decision making. Since undertaking this study the NPEU repeated a survey undertaken in 2007 to determine women's experiences of maternity care which identified that choice was still limited for many women in the UK in relation to place of care and carer (Redshaw et al., 2010; NCT, 2009). The findings of the NPEU study were based on a large quantitative survey of 10,000 women, so whilst this provided clear data regarding women's choice, it was not possible from this report to ascertain the depth and meaning that a small qualitative study can achieve.

The extent to which women are offered choice

Within this category six codes were identified; four of these linked to the 'choice guarantees' (DoH, 2007) and were around the choice of carer, place of care, place of birth and postnatal care. The two other codes that appeared to be important to women were around choices that emerged in relation to antenatal screening for fetal abnormality and finally a perception that women were not being offered a choice.

Choice of carer

Choice of carer was identified to determine whether women were offered a choice as to which health professional provided their care, either the midwife, general practitioner or obstetrician. The women in this study did not remember being offered a choice regarding who would provide care, it was just assumed that it would be the midwife attached to her GP's surgery:

'I don't think that I was actually offered a choice. I don't know that I was actually sort of told, well you can see this person, or you can see that person. I think I was probably asked are you happy to have shared care with the GP' (Ruby, third pregnancy)

'No, I was just told who'd provide it. I was told, you know...as I'm under that surgery, this was... It was between the midwife and the GP, alternate. I would have preferred just to have midwife led care, rather than shared with the GP...'
(Daisy, first pregnancy)

From the comments made by Ruby and Daisy the assumption was that they would both receive antenatal care, shared between the GP and community midwife attached to the surgery. Daisy identified that she would have preferred midwife led care but that this was not offered to her as an option. The women who specifically talked about choice of carer generally mentioned this in relation to being offered shared care, however, they all stated a preference for midwifery led care because this was perceived to be more pregnancy focused:

'I like the, even though I've said it's quite a medical focus through the midwives, I still prefer the midwives than the GP's. I think there's something about seeing a GP which makes it feel like a medical condition, whereas, I think it happens to be the GP's surgery where I have the appointments but its midwife led definitely and makes it feel pregnancy related rather than illness related'. (Lily, second pregnancy)

This is an interesting distinction and raises the question of what it is about the consultation that is seen as a medical focus and is this different from a medical model of care? Women described the physical care undertaken by midwives as medical, for example the physiological measurements of blood pressure and analysis of the constituents of a urine sample. However, Lily describes it as the

focus on pregnancy as opposed to illness that makes this distinction between midwifery led care as opposed to the medical led care provided by the GP.

Choice of place of care

Choice of place of care was described as the choice women were offered in relation to place of birth, whether this was at home or in hospital. In relation to hospital birth the choice was in relation to which hospital and whether birth would take place in a maternity unit or a birth centre. For most of the participants, particularly those who were pregnant for the first time, they did not have a discussion with the midwife about where they would give birth. The general impression was that it was assumed that women would give birth in their local maternity unit:

'I went to the booking in session, the early pregnancy session and it was explained either X or R; um...but we really want you to go for X ... I had no idea what the choices were. I'd known other people who had given birth at X hospital I did assume that's where I'd be going, but I didn't know that there was a choice and I didn't know I had a choice.' (Ella, first pregnancy)

'...asked about whether I would think about, whether I would want to go to N Hospital, D Hospital or B or anything like that.' (Lucy, first pregnancy)

Both Ella and Lucy identified that the choices offered to them were in relation to which maternity unit they would have their baby in. Lucy was describing her first visit to her GP after she had confirmed that she was pregnant. A few women who were either in a second or subsequent pregnancy or had spoken to friends who had recently given birth knew about midwifery led birth centres and chose this option:

'I said right from the beginning I wanted to go downstairs (the birth centre) because I heard such good things about it and my friend had said it's more like being in a normal, at home, it's not like being in hospital, and there was so many machines and things around me upstairs last time, I wanted it to be different...' (Chloe, second pregnancy)

Chloe had been told by a friend that the birth centre was similar to giving birth at home and she contrasted this with her experience of giving birth the first time where she talks about 'so many machines' and wanting this experience to be different from the first time. Evie had read about the

birth centre and it was following this that she decided that the birth centre was where she would like to give birth:

'I really wanted to go to X hospital because I had read about the birthing centre rather than going to just, as well as the normal maternity wing...' (Evie, first pregnancy)

A further issue for some women was that they were asked to make the decision about place of birth at the initial booking appointment at around ten weeks of pregnancy, without any information on which to make a decision:

'...they said, 'well, which hospital do you want to go to?' and I said, 'well, I'm not from the area so how would I make a decision about which hospital? How do I find out information about it?' 'Well they're all good or bad, they're much of a muchness really'. (Megan, first baby)

From an organisational perspective this is largely around the payment by results agenda (DoH, 2010b), but women clearly need more written and verbal information up front to enable them to make an informed choice. Women also talked about how useful it would be to revisit those discussions later in the pregnancy, when they had more of an idea about what the options were:

'...home versus hospital like versus more birthing centre environment you know, that's something that you kind of discuss, you're asked at the booking in appointment which is so early that you know to revisit that discussion later on'. (Lily, second pregnancy)

Lily identified that although she had researched the options, she would have valued during her antenatal care, to have had the opportunity to discuss the options in more depth with the midwife. However, with antenatal appointments only lasting five to ten minutes there was not time to discuss the nuances of care decisions. A few women were informed about the range of birth options during early pregnancy and were able to make a more informed choice:

'...because I was given the choice of at the point thinking about what I wanted to do. Did I want to go down the epidural route and go on to delivery suite or did I want to go down the birth centre route and go for maybe a birthing pool or just the more relaxed environment'. (Sophie, first pregnancy)

Sophie attended the birth centre and was able to spend more time discussing birth options with the midwife as appointment times were generally longer than at the GP's surgery. What was interesting is that she did not identify home birth as an option, the birth centre or the delivery suite were discussed, with the differentiation appearing to be largely about the type of pain relief Sophie might want to use. Jessica however discussed the full range of birth options with her midwife:

'Yes, well I think well after the first one she just said about where to have, and she said you could have a home, you know she did offer the option of a home birth and said that you know, and I said what even for a first time and she said oh yeah, increasingly women are... But again not a lot of detail but she did say well later on you will get a tour so you can have a look'. (Jessica, first pregnancy)

Whilst Jessica identified that her midwife raised the possibility of birth at home, she also identified that whilst the options were presented they were not followed up with a discussion about the advantages and disadvantages of each place. It is therefore questionable whether she was truly offered an informed choice regarding place of birth.

In summary, choice of place of care for this group of women was generally assumed to be the local maternity unit. Most women identified that they were not offered a range of birth options. Women who did know the options mostly had heard about these as a result of family or friends or because of their own research. A few women identified that the full range of options were discussed with them, but for some of the women these options were not presented with an opportunity to discuss the benefits of each place.

Choice of postnatal care

Choice of postnatal care identified women's view about the reduced schedule of home visits by the midwife after birth and women's experiences of attending postnatal clinics as an alternative to the midwife visiting a woman in her own home. The provision of community based postnatal care received mixed responses from women in this study. Until 1986, when selective postnatal visiting was introduced, women were visited at home daily following discharge from hospital up to ten days and if necessary more infrequently up to twenty eight days (Demott et al., 2006). Despite the proposal of a more flexible approach to care, daily postnatal visits were still experienced by many women in the late 1990s (National Audit Commission, 1997). This pattern of postnatal visiting in

the home changed as a result of recommendations by the National Collaborating Centre for Primary Care report on Postnatal Care (NCC-PC, 2006). The NCC-PC group evaluated current evidence and undertook a financial evaluation to enable the formulation of a postnatal care plan to ensure efficient, cost effective postnatal care. Within this care plan three time bands were identified as providing optimum postnatal care for healthy women (Demott et al., 2006). This pattern of postnatal care has been adopted by the local maternity units and also incorporates weekend visits being undertaken in drop-in clinics, frequently held within health or children's centres. Women generally viewed the clinics negatively, as they felt that to have the stress of transporting themselves and their new baby to a clinic so soon after giving birth was unsupportive:

'...the pressure to also come in to the clinic to see somebody rather than them come for home visits, yes she was putting a lot of pressure, I just thought on the one hand you're saying to new mothers make sure you get lots of rest, take it easy and then you want me to come in to the clinic. Really as far as I saw it the only benefit was for them, and you know that's not really a fair thing because if you weren't stronger you'd just say yes, you'd just go with the flow otherwise you're not comfortable with going out. I definitely wouldn't be comfortable going out my first week'. (Emily, second pregnancy)

'But it was more the sense that 'why's it different to last time?' I have just had a child, carrying car seats and stuff like that and strolling down there just didn't seem like something I particularly, I didn't feel like I was being particularly looked after. It was kind of like, almost like look after yourself. You're going down there. Get yourself checked out type kind of approach'. (Lily, second pregnancy)

For both Emily and Lily the drop-in clinic had been introduced since the birth of their previous children. They both identified that to expect a new mother to go to the clinic rather than to have a home visit did not benefit the mother or make her feel cared for. Emily mentioned that she felt a lot of pressure to attend the drop-in clinic, however, for her to go out in the first week after the birth was culturally unacceptable so she actually refused and asked for a home visit. Attending the drop-in clinics was more frequently raised as an issue for women who already had other children, whilst women who had just given birth to their first child found the drop-in clinics complemented the home visits. Women who had recovered well after birth liked the fact that they had control over the timing

of the visit at the drop-in centre whereas when the midwife was visiting the home the women had no idea what time of the day the midwife would actually turn up:

'That's another thing actually that I found really frustrating, um that you are just told that it's going to be between eight and six, that is no help at all, because you can't, you want to be at least, up and washed, you know, even if you are not dressed, you know...'(Daisy, first pregnancy)

Interestingly, the reduction in the number of home visits was not identified as an issue by any of the women in this study. Jessica contrasted her postnatal visits with the antenatal appointments she had experienced:

'...postnatal the whole emphasis seemed different, they seemed to have more time and maybe it's different because they come to your house, maybe you feel a bit more relaxed about it and it's in your own surroundings, I don't know but you just have a bit more time, not sort of like quick weight the baby and go, I think if I'd wanted to chat I think they would have stayed longer...And they said and we will be here at this time and they are, great so yeah very well organised, they've come when they've said they'll come and I've felt I've had regular enough, you know it hasn't been like oh no not again but it hasn't been oh crikey I haven't seen anyone for weeks, am I doing it right. I think the timings of it seem quite good...'(Jessica, first pregnancy)

Jessica identified that the home visits were relaxed and that the midwives were able to give her enough time to answer all of their questions. Unlike a few of the participants who felt that they were waiting at home all day not knowing what time the midwife would come, Jessica felt the midwives visited when they said they would and that this was very well organised.

In summary, women that had other children found the drop-in clinics unsupportive as they needed a lot of organisation to plan as well as frequently feeling tired in the first week after giving birth. Some women in contrast found attending the drop-in clinic was positive because they could decide what time they attended rather than waiting in all day for the midwife to visit, which was an issue for some women. The reduction in postnatal visits did not seem to be an issue for the women in this study. Home visits were viewed positively and women identified that midwives had sufficient time to answer all of their questions.

Not offered choice

The code 'not offered choice' included examples provided by the participants of where they were not offered a choice in relation to their care. Overall when considering the choice agenda almost all of the participants felt that they were not offered any truly informed choices in relation to who cared for them, where and how they planned to birth their child or patterns of postnatal care.

In response to being asked about choice during her antenatal care Daisy said:

'I don't feel really at any of the appointments I've chosen anything because they've all been so routine and minimal. I mean I've gone in, they done my blood pressure, checked my urine and sometimes they've listened to the babies heartbeat, sometimes they haven't and that's it, and they don't really say anything else. And there's no choice'. (Daisy, first pregnancy)

Daisy's suggestion that care is routine and her description of the physical care she received identified a lack of emotional engagement with the midwife. Also the comment that 'they don't really say anything else' confirms that the midwife has not provided any unsolicited information on which Daisy could make a decision or have a discussion with the midwife. Emily also felt that she had not been offered any choices in relation to her care:

'I think you should give people the choice rather than assume that people don't want it, would be good. I would never pick a home birth, but no, nobody mentioned that. We had to do what was offered which is nothing really. Yeah. Well very strangely asking suggesting that there was a choice but there was definitely no choice...'. (Emily, second pregnancy)

Emily had told me that she had chosen to have her baby at the birth centre which is where she delivered her son four years previously. I asked her how she felt about a home confinement and she identified that she was not offered a choice about home birth. Her final comment related to choice overall in relation to her care, she said that she was definitely not offered any choice. There was also a sense that during antenatal consultations care was provided, but this was perceived to be in a routine manner and consent for care was largely assumed as opposed to the midwife having a discussion with the woman to gain informed consent. A clear example of this was in relation to blood tests that are offered as part of the antenatal screening programme:

'...but she didn't actually ask for my approval for all the tests which, as I read before you're supposed to ask, she just did it and that was it'. (Isabelle, first pregnancy)

'No it's just, 'we're going to do this. We're going to test your for this, this, this and this'. There was no sort of like...'we're going to need to take some bloods and this is why, are you ok with that?' (Megan, first pregnancy)

These quotes suggest that the midwife assumed that the participants would allow her to take blood for routine testing. It could be argued that by allowing the midwife to take a blood sample, that implicitly these women were consenting. However, it was clear that any implied consent was not informed from these examples. Another area where women talked about a lack of choice was in relation to the way they would give birth:

'I didn't feel I had a choice at all over the Caesarean, even though I knew I could have demanded to go into labour naturally, even though I don't feel that was really an option. I only know what I know because I went on the internet and had various books but no, nobody spoke to me and said it was an option it just, it was your babies breech, you're having a C section'. (Ava, first pregnancy)

Ava's baby was a breech presentation and because the obstetrician was unable to turn her baby to a cephalic presentation she was told she would be delivered by caesarean section. She said she felt she did not have a choice because the obstetrician did not discuss the options with her, it was assumed that she would consent to an operative delivery but without any opportunity to consider the alternative options:

SB *'What about choices, do you think you were given choices about your care?'*

'No choices really until I got to hospital when I said I want a second opinion, is there any other option other than a Caesarean?' (Ella, first pregnancy)

Ella had been admitted to hospital because her blood pressure was raised and the doctor wanted to induce labour. After several attempts the doctor wanted Ella to have a caesarean section. She asked for a second opinion but although they said she could wait for two more days the decision regarding a caesarean section remained the same. One woman concluded that perhaps women

should not be given choices at all because, she argued, that women could never have enough information with which to make an informed choice:

'Maybe what you should do, is stop having an idea that there's any choice because maybe that creates a lack of confidence in the individual that's there. I think that, if there's not going to be choice because you can't be that informed, or maybe you shouldn't be that informed, I don't know, that what people should do is just say, 'hey, we have a standard protocol'. And if it was a standard protocol you wouldn't have this...lack of confidence, ...do you need choice?'
(Megan, first pregnancy)

Megan felt that she was passed between a number of midwives and obstetricians and this resulted in her losing confidence in the health care professionals, as she felt that there was a lack of consistency in relation to decisions made about her care.

In summary, a number of women in this study felt that they were not offered choice in relation to their care. There was an over-riding impression that routine care was assumed and therefore midwives conducted this care without any discussion about whether it was what women wanted. On further review, the women that identified that they were not offered choice were all women that either did not receive continuity of care or carer or did not form a relationship with the midwife.

Influences on decision making

Within the category of 'influences on decision making' four codes were identified, these were; 'care dictated by staff', 'guided choices', 'pressurised to make decisions' and 'provided information to aid decision making'.

Care dictated by staff

This code was defined as care provided by health care professionals who made choices for women without consultation or providing informed consent. In the majority of cases this situation arose when the pregnancy became complicated and the obstetrician was involved in care. However midwives also at times dictated care decisions without any involvement with the woman and her partner:

'I felt really cross at that point because I didn't want it and I felt like I was being drugged almost, you know like against your will, I didn't like that and I didn't really want it. But I suppose in hindsight it did speed it up, it made the contractions really strong then and it got her out. Which was the main thing I guess, but I didn't like it'. (Olivia, sixth pregnancy)

Olivia is referring to the midwife's use of Clary Sage during the birth of her daughter, an essential oil which is used by some midwives to strengthen contractions (Burns et al., 2000). Olivia had used the oil in a previous birth and really found the smell nauseating. Despite telling the midwife that she did not want to use it the midwife used it anyway, because she felt that the contractions were not as strong as she would like them to be to allow Olivia to birth in a timely way. So despite the fact that Olivia was birthing at home, in her own territory, the midwife still exercised control over fundamental decisions in her care.

Health care professionals argue that this paternalistic approach to care is based on the fact that as holders of the knowledge they are acting in the best interests of mother and child by acting to reduce risk. This use of coercive power ensures that women comply with the wishes of obstetricians and midwives (Horton-Solway et al., 2010). In maternity units, where medical power is at its most dominant, the doctors and midwives are perceived as the experts and argue that interventions are necessary to ensure a safe birth for both mother and baby (Anderson, 2004). This experience is illustrated by Emily who had planned to birth in a standalone birth centre, but because her pregnancy went twelve days beyond her due date she was transferred to the Maternity Unit, for her labour to be induced as dictated by the hospital policy:

'...things you're told is that they're the medical people and you basically must listen, um to what they're saying and they decide certain things and that really was determined I guess the way we behave and you know again what happened at my labour as well. They're the professionals and even though I kept asking they decided. Um, so that is generally the impression that most people get is you don't have much choice, they decide on your behalf'. (Emily, second pregnancy)

Emily felt strongly that her pregnancy was low risk and she was unhappy about the rigid application of the twelve day rule. She talked in her interview about having friends who had been fourteen

days past their expected date of delivery before induction was mentioned. An issue for Emily was that she did not have an opportunity to discuss options around the decision to induce her labour once she had passed her expected date of delivery by twelve days. Another example of care that is driven by hospital policy without any opportunity for the woman to be involved in decision making was provided by Grace, who was admitted to hospital for induction of labour as she also had gone twelve days past her expected delivery date. She had been told that she would be given a prostaglandin pessary to soften the cervix prior to an oxytocin infusion being used to induce labour:

'...and he was saying, 'right, well the consultant wants to go straight on to the drip, without the gel'. And um, I'd said, 'well...' you know, 'why couldn't...have we got a choice?' and he said 'no, not really'. And I thought, 'actually we do have a choice'. But um, but by then I just thought, 'fine, just...just do it, just get it done'. (Grace, third pregnancy)

Grace asked if she had any choice but was firmly told that she did not have a choice. Even though she thought to herself, 'actually we do have a choice' she still allowed the doctor to provide the care dictated by the Consultant. What was interesting about this interaction is that Grace did not describe the doctor explaining the rationale for the decision which may have influenced how she felt about being involved in the decision, but also that having challenged the decision she then accepted the doctors' response, without questioning why she did not have a choice. After her baby was born Grace described the midwife administering an injection to help the uterus to contract to reduce the risk of postpartum bleeding:

'I said, 'I don't want the injection' and she just jabbed me and said 'sorry, you have to'. I thought, 'oh alright, ok'. And um...she said, 'doctors' orders'. (Grace, third pregnancy)

This is another example of care being dictated by staff, following the unit's guidelines, but without any discussion with Grace about how the third stage of her labour would be managed. The comment 'doctors' orders' is interesting because this could be seen to be reinforcing the power dynamic between service user and medical professional. The idea perhaps if the doctor orders a treatment that it will be accepted unquestionably by the service user. From the midwives' perspective it could be seen as a distancing strategy from the decision maker, that the midwife is just following the doctors' orders.

In summary, when care was dictated by staff the women were not consulted about the care they received, doctors and midwives decided the care that was most expedient in the situation, or dictated by the relevant hospital policy and provided the care without discussing any alternative options with the women concerned.

Guided choices

Guided choices described examples of where the women identified the midwife as providing options but also making recommendations to guide the woman through her pregnancy. Most of the women in this study talked about the midwife guiding them to make decisions and viewed this as a positive aspect of care:

'I know the midwives are there to, you know to help you through it and I know they're there to guide you. And I will take every single bit of help and guidance that they give'. (Amelia, second pregnancy)

'...it's more sort of a suggestion and recommendations are made but I can explore other avenues if I wanted to. I was given choices but also I was given recommendations'. (Ruby, third pregnancy)

Amelia and Ruby were responding to a question I had asked about the role of the midwife in relation to supporting choice. They appeared to want the midwife to guide them to support decisions in relation to their care. A few of the women in this study identified that whilst there are aspects of care where women can be offered choice there are other aspects where safety may override options for choice:

'And I think also the one thing that I think should be reinforced in midwifery care is you know, yes there's an element of choice, but there's also an element of what's real, what's safe and you know what you need to kind of think about. You need to be sure that you're kind of aware of that and like a home birth; you want this kind of pain relief then a home birth is not going to work for you. I think it's more important that the midwife, like guides the kind of pregnant mother through that, the dangerous side..'(Lily, second pregnancy)

Lily was discussing options for pain relief when a woman has opted for a home birth. She was talking about women who may want to consider using an epidural for pain relief. She felt it was

important that the midwife made it clear that this would not be an option in a home birth scenario, providing the rationale for this so that women could make an informed choice.

In summary, most women identified that they saw the midwife offering advice and guiding them in the decisions that they made, largely because they felt that they did not have the knowledge and experience to decide about the many choices available during childbirth. As stated previously, women are more likely to want the midwife to guide care when they have a relationship of trust and this in many cases is associated with knowing the midwife providing care (Edwards, 2010). Being guided does not exclude informed choice or being involved in the process of decision making, this is more about the woman choosing the level at which she wants to contribute to this process and the extent to which the midwife provides the information to inform the decision.

Pressurised to make decisions

A few women felt that they were pressurised to make decisions at the antenatal appointment, rather than being given information, followed by a period of time in which to assimilate and make sense of the options available to them. This was particularly the case when questions arose about screening for fetal abnormality. Amelia described one of her early antenatal appointments at which the midwife was asking her if she wanted to have an ultrasound to measure the nuchal fold, which is a screening test to identify the risk of the baby having Down's syndrome (Borrell et al, 2007). This was particularly difficult for Amelia as her husband was not with her at the appointment and she knew he was opposed to antenatal screening. Because the test has to be undertaken within a short time frame in early pregnancy she had to make the decision during the appointment, which she had not been prepared for:

'...but I did feel a little bit like well it is now or, or never. And I did, you know ...I mean as it happened we did have a date scan and then a nuchal scan because when we went for our nuchal scan we weren't as far, uh gone in our pregnancy as we first thought we were, so they could only date us. So, in the end we did end up having both, um...But I just felt a little bit, pressured at that time that I had to make a decision'. (Amelia, second pregnancy)

Another area where women sometimes felt pressurised to make a decision was regarding the hospital that they would attend for the birth. This is about the timing of decisions for women. Decisions about place of birth, if offered at all, occur very early in pregnancy, at a time when

women do not always have all the information concerning the options available to them from which to make an informed choice:

'But, um...they, they just kind, they wanted you to make a choice there and then ...I did feel pressurised into saying, 'yes it is X hospital that I want to go to'. So to be told, 'oh yes you've got a choice but you need to make that choice now'...(Ella, first pregnancy)

Ella said during the interview that she had not realised there was a choice, so had not considered the option of place of birth before the early pregnancy session, where the midwife outlined the choices available. Later in the interview Ella identified that she would have chosen Spruce hospital but would have liked time to consider this decision in detail before confirming her choice. Sometimes women felt under pressure when the midwife made assumptions about the decisions the women would make. Isabelle was talking about a conversation that she had with the midwife during her antenatal consultation about how she was going to feed her baby:

'But they, I know they always try to sway you in one direction anyway. Like for the breastfeeding, I think, I don't know if I wrote it down but um...the first midwife I saw was like, 'you are going to breastfeed obviously?' you know...'
(Isabelle, first pregnancy)

Isabelle had not considered breast feeding as her mother had bottle fed all of her children. It was this conversation that prompted Isabelle to research the benefits of breast feeding over formula feeding and following this she did decide to breast feed her baby. Isabelle did comment however, that she felt the midwives should present both options to women.

In summary, a few women identified situations where they felt under pressure to make decisions without being given either the time or the information on which to make an informed choice.

Provided information to aid decision making

This code described extracts where women identified that they were either provided with written information prior to an appointment, or were given information during an appointment to support decision making. When women were talking about choices and the factors that impacted on their ability to make informed choices, they felt most empowered to contribute to the decision making process when they were provided with sufficient information to help them to make a judgement:

'I felt that I was fully informed actually and also I felt if there was anything that I wanted to look into a bit more I was quite happy to ask about that and I was never fobbed off, I was always told that that was an option to look into and where to get the information from...'(Ruby, third pregnancy)

*'Yes because I got the leaflet beforehand and the midwife did go through and asked us as to whether I wanted to know what the risks were and whatever'.
(Lucy, first pregnancy)*

Lucy was referring to a leaflet on the antenatal screening tests offered by the Trust. Because she had an opportunity to read this in advance of her appointment and the midwife also went through the tests, she felt she had been fully informed and supported to make decisions that were appropriate for her. Most of the participants were able to cite examples of where they felt that they had been fully informed to contribute to the decision making process. However, this did not always occur and sometimes there was an issue of whether the information was provided in a timely manner:

'Yes I think so, I did actually get the information after, but I did feel it was a little bit too late. I think it's better to be up front, to give everybody the information they need, so you can make your own informed judgement'. (Emily, second pregnancy)

Emily was talking about the information she received about antenatal screening tests. She did not receive the information prior to having an early scan, so when she was asked if she wanted a blood test she declined it because she did not understand what it was for. Later, when it was explained to her, she felt that had she known what the test was for she would have agreed to the blood test. That is why she made the comment about receiving the information up front, so that she could have read it in advance to inform her decision making.

In summary, most of the participants cited examples where they felt that they had been provided with sufficient information to aid decision making. Often this was associated with written information provided in advance to back-up the discussion with the midwife. However, a few women felt that the information could have been provided earlier to give sufficient time to consider the options.

Chapter summary

In this chapter the extent to which women are offered choice in relation to the four national choice guarantees articulated in Maternity Matters (DoH, 2007) has been analysed. Whilst there were examples where women were offered choice in relation to their care, for most of the participants in this study they were not aware that they had any choice in relation to who provided their care or where they would have their care. It was assumed, for women with an uncomplicated pregnancy, that they would be cared for by the midwife, or with shared care between the midwife and GP. Generally it was assumed that women would give birth at the local maternity unit, and many women identified that they were not aware of the range of options relating to place of birth. A number of women provided examples of decisions regarding birth based on discussion with family, friends and using books and internet sources, but rarely following a discussion with the midwife. The reduction in postnatal visits was not identified as an issue by most women, but for a few women attending postnatal drop-in clinic was problematic, particularly if they had other children to organise in order to make this visit. Most women talked about not being offered choices about many aspects of their care during pregnancy and childbirth.

In relation to influences on decision making, some women identified that their care was dictated by staff, with no consultation and often influenced by hospital policies which were implemented without any discussion. Most of the participants identified that they felt that the midwife guided them in their choices and most women were supportive of this, as they felt that they did not have sufficient information or experience to make the choice without support from the midwife. In a small number of cases women provided examples where they felt pressurised to make decisions, largely due to a lack of information in advance to enable the woman to think about the options available to her. Where women were provided with written information in advance and this was supported by a discussion with the midwives, women felt empowered to make informed decisions.

In the next chapter the midwives' perspective on the partnership relationship is considered in an analysis of data from four focus groups of birth centre and community midwives.

Chapter 7: Midwives' Focus Groups

In this chapter I discuss the midwives' perspective on the concept of partnership working and the issues around providing women with informed choice. The focus groups with both hospital and community midwives, provided the midwives with an opportunity to talk about their perception of the relationships they form with women; the extent to which care meets women's psychosocial and medical needs and the extent to which they are able to offer women evidence based information, on which to make informed choices (see Appendix 11 Focus Group prompt sheet). The discussion was facilitated using a small number of quotations from the diary-interview data, which I formulated into three vignettes. Five main codes were finally determined from the analysis of the focus group transcripts (See Appendix 13 coding tree). This chapter presents the key areas that emerged from this analysis and provides an explanatory framework for the care that women experience from the midwives' perspective. Following a discussion around the issues that can impact on the formation of a partnership relationship and the provision of informed choice, midwives started to identify strategies to overcome some of the barriers that they felt had an adverse impact on the provision of women centred care. Midwives identified a number of changes to their current practice which could enhance care for women and strengthen the partnership relationship.

Organisational factors

The code 'organisational factors' was defined as factors and managerial constraints which impacted on the ability of midwives to form a relationship with women and to provide women with informed choice based on evidence based woman centred care. The sub-codes within this included availability of the midwife, conflict of role, lack of knowledge or experience to offer choices and pressure of work.

Availability of the midwife

The code, availability of the midwife, was defined as the formal and informal strategies in place to enable women to contact the midwife, to respond to any questions or concerns that arose between visits. Midwives described the information given to women about how to contact a midwife between visits:

Susan⁷ *'In our area we give them the number at the health centre, or labour ward or the postnatal ward or the community office'. (Focus Group [FG] 1, community midwives, Spruce Hospital⁸)*

It appeared from this answer that there was a lack of consistency regarding the contact numbers given to women who attended Spruce Hospital. One midwife stated:

Anna *'But they always have the phone number for the community office put on the front of the notes, and on the front of the notes they've got the labour ward as well so they know they can always contact someone. Mine have my number still...'* (FG1, community midwives, Spruce Hospital)

Anna was referring to the fact that she gives all of the women that she cares for her mobile phone number so that they can contact her directly when she is working. At Cedar Hospital the approach appeared more consistent:

Rose *'We give ladies a sheet with 24 hour contact numbers so they know between 9 and 5 they call our pager, but I do find that quite unsatisfying, because our team works long days, so it's really quite hard to get hold of a particular midwife because she's only going to be working two or three long days that week, so we do explain to them that it's a team and they can talk to anybody in the team, and then we give them a night time number from 5 pm till 9 am so they can always get somebody, it might just not be the person that they want to speak to'. (FG 2, community midwives, Cedar Hospital)*

Whilst the approach at Cedar Hospital is consistent, the midwife identified that this approach is unsatisfactory because of the working pattern of the midwives, so that the woman may not be able to contact a midwife that she has met before. Midwives in one focus group also talked about the impact of the National Institute for Health and Clinical Excellence (NICE) guidelines on their practice:

Nancy *'Well you know they are trying to say that we can see women you know,*

⁷ The names of the midwives have been changed to protect their anonymity

⁸ A pseudonym was used for hospital and unit names to preserve anonymity

multips⁹ five times, primips¹⁰ um seven times, um you know, should we be going outside the um NICE guidelines, we should be sticking to that, but you know women need to be seen, high risk women need to be seen, sometimes the low risk women need to be seen more often, you know, if they need reassurance or they've got other concerns, social concerns, you know'. (FG 1, community midwives, Spruce Hospital)

The midwives in this focus group identified that some women need to be seen more often than the guidelines would recommend, particularly if there are medical or psycho-social issues which would require more frequent visits. The NICE guideline recommended a schedule of ten antenatal appointments for women expecting their first child whilst women in subsequent pregnancies should receive only seven appointments during pregnancy (NCCWCH, 2008). Midwives in FG1 talked about the need to justify additional visits for some women:

Nancy '...one lady, you know I used to see every week, she was a multip, she was a planned section, you know she had problems with her marriage that she couldn't ever talk to anybody about, so she just wanted to offload what was happening, and we feel as though they are counting up, you know how many times was she seen antenatally...' (FG 1, community midwives, Spruce Hospital)

In this extract the midwife is identifying the challenge of meeting a woman's emotional needs with the constraints placed on the service. There is a suggestion from this comment that midwives feel that their practice is under scrutiny; the comment '*we feel as though they are counting up*' implies that midwives feel that they need to justify if a woman is seen more frequently than the recommended schedule advocated in the NICE guidelines:

Anna '...she's (the midwifery manager) got to explain to the PCT that some women do need more visits than NICE says so, and so it's always justifying what, you know and you're not supposed to give women free access to come and see you and we're supposed to say to them stick to the schedule and nothing else...' (FG 1, community midwives, Spruce Hospital)

⁹ A woman who already has at least one child – 'multiparous'

¹⁰ 'primips' is an abbreviation for primigravida referring to a woman who is pregnant for the first time

Anna places the onus on the midwifery manager to challenge the guidance with the commissioners in order to enable the midwives to offer women the number of visits they perceive women need. In summary, availability of the midwife was constrained not only due to financial resources, but also the differing strategies adopted by the units and midwives themselves. There was a range of approaches given to women regarding contacting a midwife between visits, but there appeared to be a lack of consistency in one unit which offered four different ways of contacting a midwife and for some women, in addition, direct contact by using the midwives' work mobile phone. The team approach adopted by Cedar Hospital was consistent but did not offer any continuity for the woman, as the midwife responding to the bleep could be any member of the team, who may not be known to the woman.

Conflict of role

This code was defined as where the midwives' role is extended to meet organisational priorities which conflict with the provision of midwifery care. A theme that arose a number of times during the focus group interviews was around the administrative burden, which has increasingly encroached on the time that midwives have to provide midwifery care and therefore be available to women. Midwives in a number of the focus groups talked about the challenges of completing all of the required documentation, as well as meeting women's care needs during the limited time allocated to a consultation:

Irene '...and it's sort of been a drip, drip effect and like certain managers would say to you, but that only takes a minute or two minutes, yeah but when you've got twenty things that only take a minute or two minutes it all adds up'.

Anna 'And it's the forms we sign, the Mat B1 the SSMG, the HIP grant the FW8, that's four more forms that we've got to fill in for these mothers'. (FG 1, community midwives, Spruce Hospital)

The midwives in this focus group were referring to the audit and benefit forms that need to be completed during the antenatal consultation, leaving less time available for the midwife to actually provide antenatal care, when a consultation is only allocated between ten and fifteen minutes. The midwives at Cedar Hospital discussed how initially they would resist being asked to take on additional tasks but over time they accepted the additional workload:

Judy *'Sometimes it's very difficult to keep, you know remember what we're here for, there are so many pressures, do we do this or that...'*

Linda *'Pick up the pieces'*

Judy *'Yes that's right, and there's something else we've got to do, something else they're gonna add to what we've got to do and it just gets, I think we've reached, initially we used to say oh we can't possibly do that but now we just go, oh whatever, you know we've just given up'. (FG 2, community midwives, Cedar Hospital)*

In saying, *'it is difficult to remember what we're here for'* Judy appears to be referring to the challenge of providing midwifery care, whilst meeting the additional burden required by the service. Midwives working in the maternity unit, on the birth centre or delivery suite, also identified the challenge of providing midwifery care around the time of birth. Citing the pressure of maintaining all of the records required, with the competing demands from other women that also require care at different stages of the birth process as problematic:

Jane *'...it's not just community, its delivery as well, you spend what an hour and a half going through every paperwork or forms after a delivery, computer documenting it there, repeating that documentation there and it's mad'. (FG 3, Birth Centre midwives, Rowan Unit)*

Alice *'I do feel even on labour ward, midwives feel enormous pressure to get the task done, you know they deliver that woman, you've got to get your notes done because you've got another woman coming in, quick you haven't got time to, I don't know, probably help with breast feeding or things like that because you've got to get the job done and get on with the next one'. (FG 4, Birth Centre midwives, Hawthorne Unit)*

The comment about getting the job done suggests quite a mechanistic approach to care and a lack of time to meet women's individual care needs because of the pressure of work that Alice appears to be referring to. There was a sense from some midwives that the pressure to meet targets could impact on the ability of the midwife to form a relationship with the woman:

Janet *'Now we're back to ticking the boxes again, and if you don't tick these boxes*

god help you, you know you could sit there talking to a woman, a woman has a problem, you're not going to go through the check list on breast feeding because you're dealing with what's going on here at the moment, if that woman goes to hospital and anybody sees those notes you're pulled up, you didn't tick the breast feeding boxes, you know'.

SB *'So there's a bureaucracy now that there wasn't?'*

Janet *'Well I think it probably is what gives the woman the impression of production ...'*

Linda *'Yeah, it reduces the flow, yeah it reduces the flow of the conversation, the whole relationship thing...'* (FG 2, community midwives, Cedar Hospital)

The midwives at Cedar Hospital were talking about the difficulties they faced managing competing priorities from the Trust, to ensure specific aspects of care were addressed at the scheduled time, as for example the discussion of breast feeding at a key point, and the woman's needs, which may not fit in with the Trusts priorities. Midwives described a sense that if the relevant section of the maternity notes was not fully completed as detailed in the care pathway, that they would be called to account for the omission, even if in their professional judgement at that particular appointment there was something far more important that the woman needed the midwife to spend time on. They identified that this may impact on the relationship, the comment that *'it reduces the flow of conversation'* and *'the impression of production'* as midwives attempt to provide individualised care within the time constraints imposed by the workload.

In summary, midwives identified conflict of role when they were unable to provide individualised, women centred care because of the challenge of completing an increasing amount of documentation, including audit forms, benefit forms and care plans. Care is provided in time constrained packages, from the allocated appointment in the antenatal clinic to the pressure of workload on a busy delivery suite. Midwives identified that the increase in bureaucracy was taking them away from having the time to care for women, as a priority.

Pressure of work

Pressure of work was defined as the work related stressors which impact on midwives being able to provide optimal care for women. An important area identified by a number of midwives was the burden placed on the service due to staffing pressures. This may be about: skill mix, the availability of the correct level of staff when required, or it may reflect the ability of the maternity

services to respond to changing demands. This is particularly an issue for the delivery suite, as the workload there can fluctuate from hour to hour and can range from a unit that has no women at all in labour, to a delivery suite with all of the rooms full. In addition an increasing number of women will have complex needs requiring one-to-one care throughout their time in the unit. Managers on delivery suite respond by calling staff in from the community or from the postnatal wards to provide emergency cover:

Irene '... if you're going to get called out on your on call time, which happens quite a lot more now that's it, I can only do what is it six or calls a month, so er...'

Anna 'Just because we're having to cover the unit, when we're on call more, so we're called in, every third month were first on call for the unit so if they're short of staff or they're busy they call us in and we still have to go back to work the next day'. (FG 1, community midwives, Spruce Hospital)

The community midwives at Spruce Hospital identified that because of staffing shortages, they were increasingly called in to work at night on the delivery suite, but still had to cover their community work the next day. In addition, when the delivery suite was busy community midwives at Cedar Hospital talked about being required to cancel their community visits to cover the delivery suite:

Janet 'I think the postnatal's are all poor cousins when it comes to care, they come low down on the priority list, I know it's very important in delivery suite that the core midwife or whatever, but it's always, cancel postnatal visits...' (FG 2, community midwives, Cedar Hospital)

The midwives talked about the fact that postnatal women were expecting a visit from the midwife so when they were required to cover delivery suite they inevitably had to disappoint the women. Postnatal care in the hospital was also identified as an area that is left short staffed to meet the requirements of a busy labour ward:

Lydia 'I think it's very territorial, we all move to other areas when needed but labour ward see themselves as the priority of the whole department and as soon as it gets busy they snap their fingers, 'Get down here now', because we're the

priority, but it's not as easy as that, the postnatal wards have always been the Cinderella service anyway and they are worse off for it...' (FG 4, Birth Centre midwives, Hawthorne Unit)

What is interesting from this extract is how labour ward is perceived by midwives from other areas in the hospital; the notion that the staff on labour ward demand support, they '*snap their fingers*', and staff from other areas instantly comply, leaving the postnatal ward without staff, as the '*Cinderella service*'.

In summary, pressure of work was illustrated by the midwives as situations where staff, in the community or on the postnatal wards, were re-deployed to cover the fluctuating workload on the delivery suite. The impression given was that postnatal care was the area that was most expendable when there was a demand elsewhere in the system.

Lack of knowledge or experience

This code was used to describe examples where a lack of knowledge or experience by the midwife could impact on the woman's care. Midwives who worked in the hospital, predominantly from focus group four, talked about how, when they are faced with situations that they do not feel confident in they may encourage a woman to adopt a mode of care that they do feel more familiar with:

Alice '*...the midwife's, how she feels, how confident she feels about what the woman wants, so if you've got a woman on labour ward that wants to deliver kneeling on all fours and that midwife doesn't feel comfortable with it, then she's going to sway the woman's wishes isn't she...' (FG 4, Birth Centre midwives, Hawthorne Unit)*

This midwife appears to be suggesting that a woman's choice could be compromised if the midwife caring for her did not feel confident in that aspect of care, therefore she may encourage a woman to adopt a birth position with which she feels more confident to provide care. Midwives identified that in order to offer women choice, they needed the evidence supporting that particular aspect of care to be confident in the information provided:

Ruth '*I think it helps if you know, um the information behind offering the choice, you*

know if you don't know the evidence behind what you're saying then it's very difficult to offer the choice...' (FG 4, Birth Centre midwives, Hawthorne Unit)

The range of experience a midwife has, either as a result of rotating to different areas of midwifery practice or because of the years of experience that she has worked, impacts not only on feelings of stress but also on her ability to offer women truly informed choice. Midwives identified issues arising from this:

Ruth '...if you have got midwives that don't work in labour ward, midwives who work in clinic, midwives who work in the birthing centre so they're expertise is going to be, I mean we do get staff that rotate, but there are a lot of staff that stay where they are and is that a good thing, don't know, does that mean that we are deskilled in some of those areas'. (FG 4, Birth Centre midwives, Hawthorne Unit)

Mary '...one skill that I would like to have learnt, but didn't achieve and I'm still no further on with it, how you get a woman with an epidural, because she's chosen an epidural for pain relief, to birth her baby spontaneously. I asked every single experienced midwife, could you come in and help me, because I knew that there were some midwives that did achieve it, ... it's not a skill that I have, and it's one that I really wanted to develop...' (FG 3, Birth Centre midwives, Rowan Unit)

These two midwives identified the challenge of gaining sufficient experience to be confident and competent in all areas of midwifery practice. Ruth identified that when a midwife works for a long time in one area of practice, she becomes very skilled in that area often to the detriment of other aspects of care. This becomes an issue, if she is required to move to provide cover in an emergency. Mary talked about the challenge of learning advanced skills from very experienced midwives in an aspect of care that she needed to develop. However, she identified that she did not develop the skill and talked about the loss of expertise, as these very experienced midwives retired and took their skills and knowledge with them. Another area of inexperience that the midwives in focus group four identified, was antenatal screening options which were perceived as a specialised area of care:

Ruth *'I might not be so au fait with screening for fetal abnormalities or something, so I think if you're going to be offering choice to women you have to have the knowledge behind it to make proper informed choices'.*

Carol *'We do have midwives in the antenatal clinic that um they are the lead for screening aren't they, so obviously we do have access to other areas, not just within our own area that we can call on'.*

Both midwives identified a lack of knowledge with regards to antenatal screening, which could impact on women's choices. Whilst Carol identified that there is expertise that can be accessed through the antenatal screening lead, she identified that this was not available in the area that she provided care.

In summary, midwives may use professional power or coercion rather than admit that they do not have the experience to support the woman's choice. In an ideal situation the midwife would identify another midwife who does have the skills to offer choice in this regard, but this may not always be possible at the time it is needed. When it comes to supporting choice in relation to antenatal screening, there is time to refer a woman to another practitioner with more experience, but when a woman is in labour this may not always be practicable. Midwives, in addition to this, rarely get an opportunity to learn from senior midwives who have years of experience supporting women in active or natural birth situations. Midwives expressed a sense that experienced midwives with a wealth of knowledge and experience would take these abilities with them into retirement, leaving a skills deficit for more junior midwives to try to fill. The organisational pressures on midwives were summed up very simply by one midwife, who said:

'We know ideally what we want, and we also know what we've got, and they don't match up...' (FG 3, Birth Centre midwives, Rowan Unit)

Midwives were clearly able to articulate the pressures that they are working under which impacts on their ability to provide women with individualised, evidence based care. So whilst the strategic vision of the Government identifies a clear choice agenda with joined up local services which place the woman and her family at the centre of the service, provided with excellent care to ensure families have a good start towards a healthy future (DoH, 2010a), there are still a number of barriers which are hindering this vision. From an organisational perspective this appears to be

about having sufficient numbers of well supported and educated staff to provide women with the choices the Government believe they should all be entitled to. The bureaucracy surrounding realising such a vision seems to be a key factor in preventing midwives from having the freedom to offer women true choice and partnership. Whilst midwives are required to spend a significant amount of their working day filling out forms to justify the care they are providing, there will remain a tension regarding providing women with the care that they need, when they need it.

Care provision

The code 'care provision' was defined as the factors which impact on the ability of midwives to provide midwifery care during the childbirth continuum and particularly focused on midwives' perception of continuity of care. The sub-codes identified in this category cover the continuum of care provision from antenatal to postnatal care and the role of the midwife in providing care.

Factors impacting on antenatal care provision

This code defined the factors which impact on the time the midwife has to complete the antenatal appointment. Midwives identified that antenatal care is particularly challenging because, there is so little time within the antenatal consultation to cover all of the required aspects, to give women information on which to make informed decisions. This was summed up in two of the focus groups as:

Linda '...we know the aim is to try and build that relationship and to um, pick up anything that needs to be picked up, but I think we actually don't have enough time, and I think that's the problem, we have fifteen minutes per antenatal visit in the clinic and it's not enough time to build up that relationship..' (FG 2 Community Midwives, Cedar Hospital)

Norma '...fifteen minutes, you do literally feel like you're sitting there and your rambling at a hundred miles an hour trying to get everything done and dusted, and it's not individualised care in that setting because at however many weeks you've got to do this, at twenty eight weeks you've got to do the bloods and it's very difficult to, to change anything I think in this environment'. (FG 3, Birth Centre midwives, Rowan Unit)

Both midwives from these two extracts identified the lack of time as a significant issue in providing women with sufficient information and in trying to develop a relationship. Norma also identified the difficulty in trying to change the way care is delivered in the time available. Midwives are also aware that this time poverty results in the care that is provided being very bio-medically focused and routine. For the midwives this feels very dissatisfying but it is an approach that they feel under pressure to adopt in order to get through the workload. The community midwives at Cedar hospital described the antenatal care they provide as:

Linda 'It's so regimented, it's very unsatisfying actually'

Judy 'Like tick boxing really'

Karen 'I feel like we're focusing on what can you find wrong with them medically rather than sort of emotionally, you're focusing on blood pressures you know and you've got your set time to quickly do this, do that, check them over, um and it's all out of the door and the next one, you don't really have enough time...'(FG 2, Community Midwives, Cedar Hospital)

What is interesting is that both the midwives and the women used the analogy of ticking the box and that midwives recognised that the antenatal care many of them are providing is not managing to achieve any level of psycho-social support and care to women. However, midwives working in the Hawthorne Unit identified differences that they perceived between community based care provided at the GP surgery and antenatal care provided at the birth centre. This is illustrated in the following extract:

Carol '...but I think it is a nice focus here that we're able to give a little bit more time as well, to antenatal appointments and we have a bit more time than the community midwives do in the clinics, if they come here [The birth centre] for antenatal care'.

Alice 'And they also, I think feel more comfortable within this environment, if they're familiar with it. If they haven't just been just for a one off really short sort of meet and greet, but they do come again for a few checks, they feel perhaps a little bit more relaxed and get a chance to meet just a few of us rather than just coming in in labour'.

Carol *'It's nice for us as well I think as midwives, because you feel like you know someone, and I don't know about the other guys but when you have a mum that comes in and you've met her before, or you know her briefly from before it kinda builds up that relationship a little bit quicker'. (FG 4, Birth Centre Midwives Hawthorne Unit)*

Carol identified that there is more time available when providing antenatal care in the birth centre and later she suggests that time and the fact that you may see a woman more than once, helps to build a relationship with the woman.

In summary, midwives identified that the lack of time for the antenatal consultation at the GP surgery results in care being bio-medically focused and leaves midwives feeling that they are 'ticking the boxes' and in this environment it is hard to form a relationship with a woman. Midwives in the birth centre however, felt that they had more time to provide both the medical and emotional aspects of care and if women attended regularly then they were more likely to achieve continuity of carer and to form a relationship with the midwife.

Place of birth and birth plans

This code incorporated discussions about place of birth and birth plans. When discussing preparation for birth, and specifically birth plans, it was clear that as with other aspects of antenatal care time was a significant factor and this was particularly identified by the community midwives at both units:

Irene *'If you've got to get it all done, you will say, oh hello, your 36 weeks pregnant today, right we're going to go through your birth plan, we're going to do this and do that and by that time they will let you do everything else that you've got to do because they know that you are going to actually spend that time at the end, but let's get this bit done first, because we've got to get that done'.*

Lisa *'So we all feel under pressure, time limits, plus to make sure we do cover everything...'*

Nancy *'And document everything...'* (FG 1, community midwives, Spruce Hospital)

The midwives at Spruce Hospital identified that they normally discuss a woman's birth plan at the 36 week antenatal appointment. Irene talked about telling women this at the beginning of the

appointment to ensure that she was able to complete the other aspects of care, to allow time for this discussion at the end. Her colleagues confirmed that time pressure to complete all aspects of care and record this left the midwives feeling under pressure. The Cedar midwives adopted a different strategy to the birth plan:

SB 'Women say all this focus on my birth plan and no one talks to me about it'.

Judy 'Because it's in the notes and if I see it I will say, I will go through it with them, in the clinic but not a lot of people do it'.

Linda 'But what I tend to do is actually say this is the birth plan, you have options about this, that and the other, have a read through it because I don't have time to go through every option under the sun, I just give them a brief overview of what the options are and have a read around it and come back to me if you want to discuss anything'.

Karen 'You find with the second time mums, I'll say have you looked at it and it will be like oh well there's no point because you know, you don't know what's going to happen (all laugh) and they've realised that actually, because they've been through it before...' (FG 2, Community Midwives, Cedar Hospital)

These midwives appeared to suggest that they would discuss the birth plan if a woman filled it in but may not raise the subject if not. Linda identified that she did not have time to discuss it in detail and so provided an overview, with the offer that women could discuss any issues at subsequent appointments if they wanted to. There appeared to be a consensus that women who have birthed before are less likely to complete a birth plan because they '*don't know what's going to happen*', so what is the point of planning for an event that you cannot control.

There was also a view from the midwives in the Rowan Unit that by offering women a range of choices about a process that they have not experienced before, this may raise their expectations, which could result in feelings of disappointment or inadequacy if they do not achieve the plans they have set themselves:

Sara 'I think the women that struggle to cope with that are the ones who have got everything rigidly fixed in stone beforehand...'

Jane *'With that true birth plan'*

Sara *'...so I sometimes wonder whether actually we've almost gone too far with this birth plan issue and the women that come in with a, b, c and d and that's what I want are the ones that then really struggle afterwards because things haven't gone right'. (FG 3 Birth Centre midwives, Rowan Unit)*

These midwives were talking about women that compose specific lists of how they would like their birth to be managed, what Sara identified as *'rigidly fixed in stone'*, who then have difficulty coming to terms with a birth if it is very different from the one that they planned. The other aspect of this code was about the choices midwives offer to women with regard to place of birth:

Linda *'I find we do promote home births but most women are no, no, no, they'd rather be in a birth centre'*

SB *'What do you think that's about?'*

Karen *'I don't know, you try to explain it and nobody's interested, you know whatever you say it's just don't seem to want to deliver at home or even a birth centre, just got a fixed idea, they want to go to the hospital and that's the end of the conversation'*

Rose *'That's funny we find the opposite, that an awful lot of our women don't want to come to a hospital and I think part of that is that we book them at the birth centre, we just give them a quick tour so by the time they leave they go, I want to deliver here'*

Karen *'I suppose if they see it they will change their mind, I mean a lot of people live quite near this hospital they say why am I going to go pass this hospital to Hawthorne unit because it is further away and that seems to be one of the main sort of issues...'* (FG 2, Community Midwives, Cedar Hospital)

The community midwives based at Cedar Hospital felt that they did promote the range of birth options, but they felt that women preferred to deliver their baby either in the hospital or the birth centre, rather than opt for a home birth. They identified that for some women it was about whichever was closest to their home and for other women, if they actually visited the birth centre

they decided that is where they would like to have their baby. Another issue raised by the midwives at the Hawthorne Unit was whether midwives have enough confidence to support home birth:

Lydia 'There's been a push though hasn't there to promote the birth centres as opposed to home birth I think, you know so...'

Carol 'Which is funny because the Government were not long talking about offering, trying to increase home births lately ...'

Lydia 'Yeah, but when you talk to some of the midwives, they say, 'I don't feel confident', or you know they feel quite negative about it, they feel that they've been deskilled some of them by being out in the community for so long and not being able to provide that intrapartum care confidently kind of thing, so it's the wider context of it all as to why we are not promoting real choice'. (FG 4, Birth Centre Midwives, Hawthorne Unit)

The midwives at the Hawthorne Unit suggested that the decision to, not promote home birth, was a combination of: loss of confidence due to community midwives having less experience of intrapartum care and insufficient staff to offer home birth as an option. As a consequence the unit promoted the birth centre as a home from home birth experience instead.

In summary, some midwives discussed birth plans at the 36 week antenatal appointment but this was dependent on having sufficient time to complete the other aspects of antenatal care first, however, other midwives identified that they only discussed birth plans if the woman had completed this section of her maternity notes. There was a view that women who had given birth previously were less likely to complete a birth plan as they knew that they could not control what happened, so tended to 'go with the flow'. Other midwives suggested that promoting birth plans could raise women's expectations, which if not met could result in disappointment during the postnatal period. In relation to place of birth there was a general feeling that women preferred to deliver in the maternity unit and for some women they opted for the unit that was closest to their home, rather than choosing a birth centre or delivery suite specifically for the different level of care offered.

Postnatal care and support

This code was defined as where the midwife can provide postnatal care that supports women's needs rather than being driven by constraints. Two key areas arose in relation to postnatal care;

this was selective visiting and the use of postnatal clinics as an alternative to home visiting and support for breast feeding. The community midwives discussed the different approaches that the two units have on postnatal visits at home. The midwives from Spruce Hospital discussed selective visiting:

Nancy 'The majority are seen three times and they seem to accept it quite well don't they'.

Anna 'I feel that we've lost a lot of, even though they say we can visit more we have to be able to justify why we are seeing more, I don't think our breast feeding rates as good as it used to be, and I do feel sorry for primips, and I always document in the notes that they must call if they want another visit'.

Paula 'But then I think that's because it's all gone wrong on the postnatal ward. (Yeah, talking over each other) Yeah the majority of them they get home and the breast feeding is already gone belly-up'. (FG 1, community midwives, Spruce Hospital)

In this dialogue the midwives confirmed that the unit had adopted the NICE guidelines of offering women three postnatal visits, unless women needed additional visits to support any issues that arose (Demott et al., 2006). However, Anna suggested that the midwives have to justify additional visits and, in her experience, this had impacted adversely on breast feeding rates. Paula suggested that the lower breast feeding rates were due to a lack of support on the postnatal ward, which the other midwives in the focus group generally agreed with. The midwives at Cedar Hospital in contrast discussed the fact that women continue to receive daily visits once they leave hospital:

Judy '...at the moment our community, our postnatal community is working for the women not for the NHS, I think we're fairly women led at the moment, just about by the skin of our teeth, before we become NHS led which like we hear other NHS Trusts have, you know, they allow two postnatal visits, and that's it, sort of thing, we do...'

Linda 'If a woman needs a visit every day for the first few days we'll do that, if they need breast feeding support or something, and we see success actually. When we come in every day and we give them the support they end up fully breast

feeding, if we don't give the support they'll be on the bottles, simple things like that, just coming in half an hour a day, it's vital really...' (FG 2, Community Midwives, Cedar Hospital)

Judy commented that care at Cedar Hospital were still women led and that the community midwives are able to determine how many postnatal visits a woman needed. This was reinforced by Linda's view that extra visits were more likely to result in women successfully breast feeding. The other area of contrast between the two units was in relation to the use of postnatal drop-in clinics. Midwives at Spruce Hospital were encouraged to book women to attend drop-in clinics, as this was seen as a better use of midwifery resources. Whilst women, as discussed in previous chapters, identified a mixed response to drop-in clinics midwives also identified times when this was not appropriate:

Anna 'Postnatal we're told we're not allowed to visit at weekends either, unless they're new out, Caesarean section, lots and lots of children which you don't want them bringing down the clinic or they have no transport. I won't tell a woman she's got to get on a bus on day five to come down to clinic, so we will do visits for that, but otherwise at a weekend if they're either day five or ten then they're expected to come to drop-in...' (FG 1, Community midwives, Spruce Hospital)

Anna suggests that whilst it is hospital policy for women to attend the drop-in clinic at weekends that she does not enforce this if, in her professional opinion, a woman needs a home visit. However at Cedar Hospital postnatal drop-in clinics have not been implemented. The midwives at Cedar discussed their experience of this type of care during the focus group:

Rose '...postnatally if we get the impression that we've got a mum who's a bit twitchy and wants to not wait in for you, then we offer them postnatal care at our base, at the birth centre, so she knows that she can be in and out at half past nine in the morning, a lot of women do take up on that choice, and I believe one of our midwives is looking into starting up a postnatal clinic, although I have absolutely no idea how that's going to work, but they are looking into setting one up, but I'm reserving judgement on that one'.

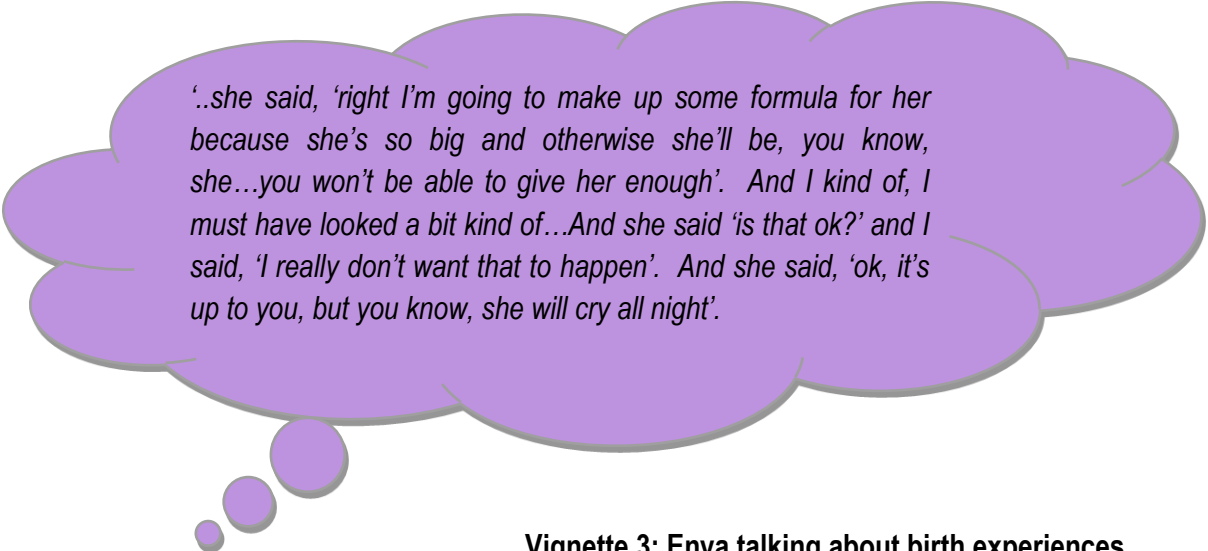
Linda 'I think, I feel that the clinics will move us away from the time, you know the post, visiting them at home unless they want to, but I have heard, Chinese

whispers, that we want to do this on a more regular basis and I worry about this actually'.

Rose *'We did one at a Children's Centre, and it really didn't work, the babies were asleep or the mothers were too tired, or the babies slept for the first time and we're telling the mums to rest while the baby rests and then asking her to come all the way out of her home to a clinic, just to weigh the baby when actually we could probably walk 400 yards to her house to do it. So actually that didn't work, and they didn't particularly like it, and we didn't like it particularly as well for the same reasons that they were not happy to come so when they came they weren't happy and we couldn't connect with them so'. (FG 2, Community Midwives, Cedar Hospital)*

The midwives at Cedar identified that for some women, to be seen at the birth centre was preferable to waiting in all day for a midwife to visit. However, their experience of a drop-in clinic at the Children's Centre did not appear to enhance care or enable midwives to establish a relationship with the women, as Rose states, *'we couldn't connect with them'*. There was concern expressed that the Trust plan was to establish drop-in clinics in the future, which did not appear to receive support from this group of midwives.

The other main area identified in relation to postnatal care was about support for infant feeding. This was raised for midwives as a result of one of the quotes in the vignette around large babies being offered formula top-up feeds if the woman was breast-feeding. This had become guidance in some units following a request by paediatricians, who felt that breast milk alone in the first few days of life would not provide sufficient nutrition to maintain the blood sugar level of larger babies, within normal limits.



‘..she said, ‘right I’m going to make up some formula for her because she’s so big and otherwise she’ll be, you know, she...you won’t be able to give her enough’. And I kind of, I must have looked a bit kind of...And she said ‘is that ok?’ and I said, ‘I really don’t want that to happen’. And she said, ‘ok, it’s up to you, but you know, she will cry all night’.

Vignette 3: Enya talking about birth experiences

The midwives in the focus groups were not certain whether this was actually unit policy but were familiar with the concept:

Ruth ‘It might not be a policy but the paediatricians often suggest, certainly we had a baby here, a biggish baby and the paediatrician had seen the baby and advised the mother to, just to give formula, which the mother had been quite keen to breast feed’. (FG 4, Birth Centre midwives, Hawthorne Unit)

However, for some midwives again time pressures influenced the support they were able to give women who wished to breast feed:

Jane ‘Yeah and I have heard that on the postnatal ward, oh particularly on the night shift, ‘Oh she’s bottle feeding so that’s okay’. (mimic midwives, stage whisper) (FG 3, Birth Centre midwives, Rowan Unit)

Carol ‘Or the other point of view is that she’s looking after fifteen women on the postnatal ward and she hasn’t got time to support her with breast feeding. I mean I’ve worked on the postnatal ward here and it can be absolutely horrendous and you don’t have that time to sit down and help a woman to breast feed. And you feel bad, I mean I felt terrible there were so many things that I couldn’t do, couldn’t give good care, so it’s not always their fault’. (FG 4, Birth Centre midwives, Hawthorne Unit)

At Rowan Unit the midwives suggested that women who chose to bottle feed their babies were easier, from a workload perspective, as Jane identified there would not be any feeding issues. But

as Carol suggested from the midwives perspective, the lack of midwives means that if a number of women are breast feeding the midwife knows she will not be able to provide them all with sufficient support and acknowledged how 'bad' that leaves the midwife feeling.

In summary, in relation to postnatal care there were two key issues identified by the midwives during the focus groups. The first related to postnatal visiting and the implementation by some Trusts to reduce visits to a minimum number and to introduce postnatal drop in clinics to reduce the staff burden of visiting the woman at home. The challenges associated with this strategy were identified. Infant feeding was another area that the midwives talked about in relation to providing sufficient support to enable the woman to successfully establish breast feeding, and the challenge for the midwives when the hospital policy required large babies to be given top-up feeds of formula milk for women trying to establish breast feeding.

Midwives' perception of continuity

The code 'midwives' perception of continuity' of care encapsulated the views from midwives about continuity of care and carer and the factors which may impact on this. The issues identified were around staffing levels and the lack of time in which to meet women's emotional needs, as well as completing the medical aspects of the consultation during the antenatal period. Whilst issues around continuity of care arose in response to an open prompt about what it is that midwives are trying to achieve in relation to their care, midwives were also responding to a particular comment from the vignette on antenatal care as follows:

.....most of the time you go in, it's somebody different or somebody you haven't seen for weeks and weeks and weeks, and they don't remember you, they have no idea what's gone on

Extract from Vignette 1: Antenatal Care

This was the response from the community midwives at Spruce Hospital:

Anna 'It's very sad that they come away with this is how it feels, but yes it can be, I mean we have fifteen minutes for appointments, Susan unfortunately in her surgery only has ten minutes, so...'

- Lisa* 'And you've got to do the scan forms, the blood forms, you've got to take blood, you've got to hand write some labels and then you've got to do the new, you know status in health, what is it?'
- Anna* 'Health in Pregnancy Grant. As the Head of Midwifery said this morning, we cannot guarantee continuity of carer, continuity of care but not carer, so you're gonna get lots of quotes like this because they don't care if the same midwife sees the women, as long as the women get seen, that management do not care...'
- Paula* 'It takes longer though when you don't know someone. I start at the beginning of the notes to go through to make sure you're not missing anything, why are they on iron, when should we be doing the next FBC¹¹'. (FG 1, Community Midwives, Spruce Hospital)

The midwives in this extract appear to acknowledge the difficulty of meeting the women's needs against a time constraint of ten to fifteen minutes especially, as Paula identified, if the midwife has not met the woman before and therefore has also to review all of the woman's maternity notes. Anna and Lisa describe all the administrative aspects that also have to be completed in the short time available in an antenatal consultation. Anna then went on to talk about a meeting that morning where the Head of Midwifery who was explaining that they did not have the staff resource to achieve continuity of carer any more. She concludes that '*management do not care*' as long as women are seen by someone.

A community midwife who attended the birth centre focus group who also worked at Spruce Hospital concurred with Paula's view in relation to the provision of continuity of care:

- Mary* 'If I have a woman that I've booked and I'm going to see her regularly through the antenatal period I can probably do an antenatal appointment in fifteen minutes because we start off where we left off last time, 'oh and how's this now', you know where you are starting off from'. (FG 3 Birth Centre midwives, Rowan Unit)

¹¹ FBC – Full blood count

She later went on to talk about the challenges she experiences when caring for women she has never met before:

Mary 'I don't have a problem meeting the needs of my caseload, where I have a problem is where I have to fill in at a clinic where they don't have a midwife and it is a different midwife every single visit, and you see all the signatures, every single one of them is different. And the poor woman as she walks in her face drops, whereas I'm used to my women walking in and you know big smiles and how's so and so ...' (FG 3 Birth Centre midwives, Rowan Unit)

The community midwives at Cedar Hospital also identified the challenges of achieving continuity of care and the impact that this has on the relationship with the women:

Karen '...whereas antenatally, it's a lot more difficult to guarantee the same midwife, every week, and often they haven't met you before so they are not going to really want to tell you everything, but then you don't realise that so your sort of next, next, you know and you don't really think about it so it's hard, its hard and you feel you wish you could do more at the antenatal'.

Rose 'And the woman know don't they, they know that they've got fifteen minutes or ten minutes, or whatever and if you've got a chatty lady that just wants to chat they must surely pick up on our body language that, okay I've done everything, you've been here for ages and I've got two more people waiting, but in a fifteen minute slot it's so hard'. (FG 2, Community Midwives, Cedar Hospital)

The above two quotations appear to be referring to the fact that women may want to disclose something to the midwife, but may not because they have not met before and the midwife, knowing she has other women to see, fails to recognise this so is mentally moving on to thinking about the next woman. As Karen said, '*your sort of next, next*', referring to the next woman to be seen or utilising strategies to encourage a woman to leave such as the use of body language as identified by Rose. The midwives at the Hawthorne Unit also talked about the feedback they had received from women who had not received continuity of carer:

Ruth *'I have spoken to women about what they feel about their care, and currently they are disappointed with the fact that they are not seeing the same midwife, it used to happen much better and it's not happening currently in the Trust'.*

Carol *'I think that's staffing, its staffing...'*

Ruth *'I do feel continuity is important antenatally, I don't know how women can make decisions without having that trust relationship with a midwife that they are seeing regularly; I think, seeing the same midwife is very important to women'.*

Lydia *'I think Ruth is right, you know I think the service could be improved and there be some form of continuity, whether it's a team continuity or you know, one to one'. (FG 4, Birth Centre midwives, Hawthorne Unit)*

These midwives identified that staffing levels may be the reason why they are no longer able to offer the levels of continuity of carer that they had done previously. Ruth linked continuity of carer with decision making, in respect of the relationship that can form between a midwife and woman when they see each other regularly. This led on to a conversation about other models of care which could be implemented to improve the service. In summary, midwives identified that continuity of carer is not as prevalent in the units due to staffing levels and pressure of time, which also impacted on the quality of care women received. Midwives talked about the increasing burden of administrative tasks which left them with very little time to talk to women about any issues that they may have. This is exacerbated if the midwife has not met the woman previously, as some of this time is spent reading the woman's notes to establish the progress of the pregnancy to date. Where women experience continuity of care the midwife is able to pick up from the last appointment at the next one, therefore giving a sense of a continuum which provides an opportunity for a more meaningful dialogue. In this environment midwives and women are more likely to describe their interaction in terms of a relationship.

Partnership relationship

I defined the partnership relationship as the way that the midwife and woman work together in an environment of mutual trust and respect, supporting women to be actively involved in decision making and feeling empowered to make choices regarding their care. The codes that emerged from the analysis of the focus group data that will be discussed in this section were; the midwives'

'relationship with women' and 'are women's expectations met'?

Relationships with women

Midwives within the focus groups identified a range of factors that are important in forming a relationship with women. The midwives at Spruce Hospital talked about a relationship of partnership forming when there is a named midwife for the women and therefore this would be a relationship that forms over the length of the childbirth period and would build up over successive visits:

Anna 'Well I think it's a partnership because we are there for them, we're their named midwife and we would like to work with them to have a healthy outcome of the pregnancy'.

Irene 'I think you should try and empower them really, you know to be someone that they can go to for information, so you know you're their advocate really you know, you can empower them...' (FG 1, Community Midwives, Spruce Hospital)

Anna identified how she would like to work with women to support a healthy pregnancy outcome although she does not state in fact whether she is able to do this within her workload, she says, 'we would like to work with them', not whether she actually can. Irene identifies empowerment being supported through the provision of information, but interestingly talks about the woman seeking information. Irene does not identify within this quote, anything about the midwives' role in being proactive in providing information to women, acting as a roadmap to help women to identify the potential opportunities for informed choice and decision making.

In one of the focus groups the midwives suggested that the ability to form a close relationship is also something to do with the midwives' personality:

Sara 'I actually think that it doesn't have to come over time either, I think there are some midwives that are really good at establishing really good relationships very quickly, especially when they come in, in labour, and they need somebody to focus on, and then obviously not all midwives are the same, but...' (FG 3, Birth Centre, Rowan Unit)

Sara refers specifically to forming relationships quickly during labour; a time of particular intimacy during which being able to form a good relationship, she suggests, helps the woman to focus. Additionally, a number of the midwives talked about forming a relationship akin to friendship:

Linda 'I think when I'm in their house it feels like, sometimes it feels like a really good friendship, um the listening and the drinking in everything I say and they want to know more sort of thing, but when I go out of the doors it's like okay, that's just the client, for me it's a client and I tend not to have that relationship outside work'. (FG 2, Community Midwives, Cedar Hospital)

Jane 'I like to think that you can develop almost a type of friendship,... but not the sort of friendship that would carry on for years or whatever, but just that closeness where you can enable someone to divulge some quite, you know private information to you, and know that you can be trusted with it...' (FG 3, Birth Centre, Rowan Unit)

What seems to emerge from these comments is that the friendship is within the boundaries of a professional relationship and it is time limited. As Linda suggests, this is a relationship which only exists within the environment of the consultation, so when the midwife leaves the woman's house, 'she's just the client'. However, one midwife also identified that forming a close relationship which becomes a friendship with a woman can be problematic:

Sara '...you have to be really careful when you make these relationships with women, and you know exactly what they want, that it doesn't cloud your professional judgement, which I think can be so easy to do, when you really become friends with somebody, you can want so much for them what they want that if things start to go a bit pear shaped, you almost don't see it yourself...' (FG 3 Birth Centre midwives, Rowan Unit)

By suggesting that forming a friendship with a woman may result in the midwife not recognising when a woman's progress deviates from normality, Sara seems to also imply that if her professional judgement is compromised she may fail to refer appropriately, should a woman need obstetric intervention. The midwives in this focus group were talking about forming a close

connection with a woman, in a safe environment. A partnership relationship was identified as important by the midwives in all four of the focus groups, and fundamental to this for most midwives appeared to be having sufficient time during the antenatal consultation in which to form a relationship. Additionally, having continuity of care with the women, so that women were confident in their carers and formed a relationship of trust, was also important. This relationship of trust was recognised by midwives as important, for women to feel able to share in the decision making process and to feel empowered to consider the choices available to them. However, time is a significant issue if a partnership relationship is to be established:

Linda ‘...we know the aim is to try and build that relationship and to, pick up anything that needs to be picked up, but I think actually we don’t have enough time, and I think that’s the problem, we have fifteen minutes per antenatal visit in the clinic and it’s not enough time to build up that relationship...’ (FG 2, Community midwives, Cedar Hospital)

The midwives from Hawthorne Unit also reiterated the importance of trust, which Ruth suggested was fundamental if women are to be confident in the advice the midwife is giving and to feel able to contribute to decision making:

Ruth ‘Yeah so building up a trust, like a trust relationship, if they don’t trust or don’t believe what you’re saying, you don’t come across confident or confidently their gonna, then there’s no trust there so therefore probably feeling a bit ill informed probably or making the right choices possibly...’

Carol ‘I think trust is a big part, the way that you work together in labour, because it is a massive thing that they are going through and to be able to trust their care giver and like they’ve said, believe in what you’re telling them, it will impact on them, ... mums that you have a good bond and have a good relationship with, things kind of flow a bit better...’ (FG 4, Birth Centre midwives, Hawthorne Unit)

Carol suggested that in labour particularly, the relationship of trust helps to form a bond between the midwife and woman and in her experience this is associated with a better outcome, she suggests *‘things kind of flow a bit better’*.

In summary, the formation of a partnership relationship does not occur between all women and

midwife interactions and is affected by a number of factors. Some midwives are able to form a close relationship with women more readily than others and sometimes, as in any relationship, it is influenced by the chemistry between the midwife and woman. For many midwives and women a partnership relationship is more likely to develop if they see each other regularly and have time to get to know each other in a deeper way; frequently this was referred to as like a friendship. Time is a significant factor impacting on the opportunity to form a relationship antenatally as many midwives and women in this study identified the fact that a partnership relationship can be established during birth, when both partners spend a longer period together getting to know each other, at an emotional as well as physical level. However, the constraints imposed by antenatal appointment slots, giving the woman and midwife only a few minutes to establish any form of dialogue, can be a hindrance to forming a relationship. Moreover, for some midwives and women, even when there is continuity of care, a partnership relationship does not develop and this may be related to the personality types of the individuals, but can also be that either the midwife or the woman does not want to invest in forming a relationship.

Are women's expectations met?

This code 'are women's expectations met' incorporated the challenges midwives experience in trying to meet women's expectations within the constraints of the service. The community midwives at Spruce Hospital talked about women's expectations, particularly around the midwife being present at the birth:

Anna 'Yeah I booked somebody last weekend, she came for her booking and she said, 'you will deliver this one as well won't you', her last one is eight years old and I said no I'm sorry I can't, well I'm going to go to Oak Hospital then, she said if you're not coming to Spruce Hospital with me I'm not going there I'm going to Oak Hospital'.

Lisa 'But they don't like it if you're not there, for whatever reason a home birth, whatever, they don't like it and they don't perhaps appreciate sometimes that you know that we are entitled to have a holiday sometimes and...' (FG 1, Community Midwives, Spruce Hospital)

The midwives in this conversation were particularly talking about how they used to provide care during birth as well as antenatal and postnatal care, but that the unit now does not allow community midwives to attend women for births in the unit. They were also identifying that it is unreasonable of women to expect them to be available whenever they go into labour, as Lisa states, *'we are entitled to a holiday sometimes'*. The midwives at Rowan Unit were discussing another aspect of expectation; that is how midwives can support women that do not achieve the birth that they had planned for:

Norma *'...sometimes like you say you don't get the birth that you plan for yourself, you don't get the waterbirth, you end up on delivery suite, having whatever it is you need to birth a healthy, happy baby, but you can still come out of this having a positive experience from what's gone on, you know if your involved in your care, you can still come out with a positive experience...'*

Mary *'I think talking to a lot of women who have been in they don't really understand why a lot of things happened, and you know that they clearly have not been given informed choices, because if they had of been they'd understand, they'd have the information to have known what happened, even if they didn't feel that they truly made that choice in the end'. (FG 3, Birth Centre, Rowan Unit)*

Norma and Mary were discussing the importance of ensuring that women are fully informed when the care that they planned has to deviate because of complications in labour. What is interesting is Mary's experience in the community, where she says that many women do not understand what happened to them which she appears to suggest is because they were not fully informed. Another area that came up during the focus group with the midwives at Hawthorne Unit, was about the use of labels to denote women's risk status. I asked the midwives how they thought women perceived this:

SB *'It's interesting because you clearly have criteria that you use for women who are low risk and high risk, but what do women think they are?'*

Ruth *'Yes, I mean that label is, I mean I would hope we don't, I certainly in a conversation people wouldn't say your low risk so therefore you fulfil the criteria, I would hope we don't say that but I know what you mean that label, and again*

if you're told you're high risk, what does that mean to you as a woman, how you feel, I totally understand that; we need to be careful about that don't we'.

Lydia '...when women phone up the hospital, I think midwives do try and address that appropriately, I mean have you seen a doctor in your pregnancy or is it just a midwife, have there been any problems, they don't say are you high risk or low risk. I don't think midwives put labels on women and I think women who see the Consultant, understand that they see the Consultant for a reason so I don't think we're quite that bad'. (FG 4, Birth Centre, Hawthorne Unit)

It was interesting from this discussion that the midwives appear to suggest that women are not labelled by risk status even though they acknowledged that criteria are used to determine place of birth and carer. The midwives did suggest that they are careful not to apply a risk label however, they also acknowledged that women may react to being labelled as high or low risk. It is interesting that this conversation appeared to describe risk allocation negatively, when in an environment of transparency it could be argued that women are fully conversant with the notion of risk. However, Lydia's use of the word 'bad' would suggest some discomfort with the use of these labels.

Choice agenda

The code 'choice agenda' encapsulated the midwives' views on the extent to which women were offered choices during their care. Within the focus groups a general prompt was used to ask all four groups about the choices they felt that they offered women and the factors that impacted on the midwives' ability to offer choice. Midwives identified that at times there is not the infrastructure to be able to offer the full range of choices identified within government policy documents. This left midwives feeling that the maternity service was paying lip service to notions of choice. In one focus group the midwives were talking about the woman's choice in relation to who provided care. This was specifically in relation to offering alternative carers should there appear to be a personality clash between the midwife and woman:

Lisa 'They can come to drop in but that's the only alternative really. So you know if there is a, if they do have an issue then it gets complicated, you know and then either a colleague takes them on you know, or you can say to them about drop

in but, yeah its more word service I feel, don't you, to give women choice...' (FG 1, Community midwives, Spruce Hospital)

From Lisa's comment it would appear that women are not offered a choice at Spruce Hospital regarding who they see for their antenatal care. Lisa used the phrase 'word service' which seemed to suggest that the impression is given that it is possible to choose but it may not be possible in reality. In relation to women being offered a choice regarding the place of birth, there were a number of issues raised by the midwives' in the focus groups. One issue that emerged is how women find out about the choices available to them regarding place of birth and the midwives role in facilitating choice for women. The midwives at Spruce Hospital stated that women are always offered choice:

Anna 'We always offer them homebirth first, then hospital birth, and they have the choice of hospitals locally to go to, so we cover place of birth, they get choice, I don't think anybody refuses home birth in this area because we are all for it aren't we...' (FG 1, Community midwives, Spruce Hospital)

The midwives in the focus group generally murmur agreement to Anna's statement regarding choice of place of birth. Midwives in one focus group suggested that women who attend antenatal classes mostly seem to choose to have their baby at the hospital:

Jane 'Choice is about place of birth, be it home, birthing unit or the delivery suite, and a lot of the mums who come through parent education particularly the first time around are very much the hospital, we'll give birth in the hospital, but it's, well is it going to be the birth centre is it going to be delivery suite...'

Norma 'Or if the hospital that the GP has recommended that they go to, I will be you or you are booked at and that's where they go, not really asked...'

Jane 'Well they don't realise until they're booked. They often don't realise that there is a choice, some of them don't'.

Mary 'I don't think that it's necessarily something that a lot of midwives even cover in the booking appointment, to offer them, it's an assumption...' (FG 3, Birth Centre, Rowan Unit)

From the above quotations the midwives in this focus group appear to be suggesting that both during the antenatal education classes and the antenatal appointments, the assumption both from midwives and doctors, is that women having their first babies will give birth in hospital. So despite the Government position that all women will be offered information to enable them to make an informed choice regarding place of birth, the midwives in this study seemed to suggest that this conversation is not taking place consistently in practice. An alternative perspective was suggested by one group of midwives, that women are not interested in discussing the choices available to them. The midwives identified that they are required by Cedar Hospital to complete documentation as evidence that a conversation has taken place between the midwife and the mother in relation to the choices available to her:

Karen 'I don't know, you try to explain it and nobody's interested, you know you have to fill in forms about offering every choice and just nobody seems interested, you know whatever you say it's just don't seem to want to deliver at home or even a birth centre, just got a fixed idea, they want to go to the hospital and that's the end of the conversation'. (FG 2, Community midwives, Cedar Hospital)

The midwife seems to be suggesting that there is organisational pressure to comply with the requirements to fill out the forms, to demonstrate that women have been offered choice against a background of disinterest. When referring to the fact that '*nobody seems interested*', is she referring to the woman that she is caring for or is the '*nobody*' a more general term, suggesting that meeting the organisational targets is challenging for her and that she is not being supported to achieve these? There seems to be a sense of frustration that in trying to comply with her employer's request she is not meeting women's needs, or perhaps it is a need that women do not have at this time. Additionally, some midwives question offering women experiencing a healthy, uncomplicated pregnancy a choice of place of birth:

Ruth '...if you're talking about staffing and as a Trust there are going to be limitations sometimes to the choices that you offer to women. The offer of home birth is not available are we really being able to offer that choice...'

Lydia 'I mean were clearly not offering real choice to women, it's an option, I think in

the future, um, I just feel we shouldn't give women choice, I mean there's a national research study going on, looking at where the best place is for low risk women to give birth. So that when the findings have been established we will have a clearer picture of what we should be giving women as choice really, because not every woman...'

Ruth 'I think sometimes, you know, you feel the women should have a choice and you give them all these options and then some women don't understand, it's too much...' (FG 4, Birth Centre, Hawthorne Unit)

Whilst the midwives in the above quote are acknowledging that women are not being offered choice, largely as Ruth identifies because of staffing issues, there is also an underlying thread suggesting that women should not be offered choice. This seems to be about the fact that women should give birth in the environment that the professionals believe is the most appropriate one, based on the woman's risk factors. Lydia refers to the Birthplace study (Hollowell, 2011), which was being conducted at the time of this focus group and she suggested that once the results were published the unit would have a clearer idea about how they should support women's choices regarding place of birth. Ruth also appears to suggest that perhaps offering women a range of choices is more than they can assimilate, she says, *'it's too much'*. The issue of informed choice throughout pregnancy is also affected by time constraints but also in some cases a lack of knowledge on which to offer women information to support decision making:

Linda 'I really feel that we don't have enough time antenatally to explore the choices properly, we just say like, do you want to breast feed and quickly go through the checklist because we only have five minutes, but to offer proper choice you've got to weight up the balances, go through everything and have enough time to do that.' (FG 2, Community midwives, Cedar Hospital)

Ruth 'I think it helps if you know the information behind offering the choice, if you don't know the evidence behind what you're saying then it's very difficult to offer the choice, obviously we're all fairly au fait about place of birth and those kind of choices, I might not be so au fait with screening for fetal abnormalities, so I think if you're going to be offering choice to women you have to have the knowledge behind it to make proper informed choices. When you talk to some

of the midwives, they say, 'I don't feel confident', or they feel quite negative about it, they feel that they've been deskilled, so it's the wider context of it all as to why we are not promoting real choice'. (FG 4, Birth Centre, Hawthorne Unit)

These quotations suggest a significant barrier for midwives in being in a position to offer women informed choice, both due to lack of time but also lack of knowledge. The birth centre midwives suggested that knowledge regarding place of birth is perhaps more readily accessible, but if for example the midwife, worked in a birth centre as this group of midwives does, then knowledge about aspects of antenatal care, such as screening, are more difficult to keep up to date with. In summary, the midwives in these focus groups suggest that while in some areas women are offered choices, particularly in relation to place of birth, this is not consistent. A number of reasons were proposed for this including the suggestion that health care professionals make assumptions about women's care and do not always think to offer women choices. Additionally, lack of staff and time available to discuss the range of choices exacerbates this problem. Some midwives also suggested that women do not always want to make choices, or indeed should not be allowed to and for the midwives some lack the breadth of evidence based knowledge to offer women the full range of choices available to them.

The way forward

The 'way forward' was defined as midwives reflecting on their care, following feedback from the vignettes, and focusing on how they would like to see midwifery care in the future. Three of the codes from this theme will be discussed in this section; 'midwives response to vignettes', 'what midwives want' and 'strategies to enhance care'.

Midwives response to the vignettes

The code 'midwives response to vignettes', incorporated the midwives' thoughts and feedback from the women's comments encapsulated in the vignettes. The community midwives in focus groups one and two were shown vignettes one and two because this predominantly covered antenatal and postnatal care. Whereas, the midwives working in the birth centres, in focus groups three and four, were shown vignette one and three which covered the antenatal period and the period from birth to the first few hours after birth. Many of the midwives in the focus groups viewed the quotations as negative and were disappointed that women talked about their care in that way. In three of the

focus groups the midwives expressed their sadness that women described their care in the way portrayed in the vignettes:

Anna 'I feel disappointed for the women that they are not getting what I would consider to be an ideal, that they are offered a choice of where they want to deliver, if they get continuity of care and they get as much and as many visits as they want and need. In that sense I'm disappointed for the women that they are not getting what I would like as a mother...' (FG 1, community midwives, Spruce Hospital)

Rose 'Sad, it's very sad to hear that that's how people feel, even though we assume that's how women feel, it's very sad to see it written down...' (FG 2, Community midwives, Cedar Hospital)

Sara '...it's a sad, sad thing when there are four quotes here and there's only one that makes me at all proud to actually be a midwife and work here...' (FG 3, Birth Centre, Rowan Unit)

Anna appears to present her idealised model of midwifery care, perhaps what she feels all women should experience and this may explain why she is disappointed to hear feedback from the womens' experience which differs from her expectations. What is interesting is the comment from Rose, who talked about recognising that women were probably dissatisfied with the care midwives in her unit are able to provide, but still feeling sad to actually see it verbalised. There was some acknowledgement from the midwives at Cedar Hospital that they do not have time to answer women's questions or provide the information to enable women to make choices:

Rose 'And we're trying, try our best, I'm sure all of us not to make women feel like that, but like I said if you ask a question, how are you, do you actually have time to hear the answer, and that's just what they are saying, isn't it, that's exactly what they are saying, the midwife doesn't have time for me'.

Karen 'You have to run through the check list of all the potential problems to rule that out because that's really what you're looking for, it's like is there anything abnormal that I need to follow up, and if you find none, that's fine, see you next time'. (FG 2, Community midwives, Cedar Hospital)

These midwives appear to suggest that in the limited time available they need to focus on the 'check list', and this is all they have time for. Rose suggested that midwives may avoid asking women how they are because they recognise that they do not really have time to respond if they are to complete the medical elements on the check list. The midwives working in the birth centres responded to vignette three, which covered women's experience during birth and the early postnatal period. Midwives in Hawthorne unit discussed how women perceive the midwife as the expert:

Ruth 'I don't think I am, I mean she's defiantly saying, she's the expert and she knows what she's doing kind of thing and that's definitely what we'd said, you know, some women do come in and have the notion that the midwives the expert and therefore I'll just take what she says, and maybe that's a thing from you know, a cultural thing from way back, you know, the midwives are the experts, the doctors are experts...'

Lydia '...you know at the end of the day we are the professionals and perhaps we have a little bit more knowledge than them; I don't do it because I want to do it, you do it for their best interests, at the end of the day, and I think you do have to give some guidance'. (FG 4, Birth Centre midwives, Hawthorne Unit)

This is an interesting discussion in which Ruth appears to deny the label of expert but instead suggests that it is women that see midwives as the expert, however, Lydia identifies that midwives, as the holders of greater knowledge, should guide women in their choices as this is, 'in their best interests'. An area that both focus groups discussed was the issue of offering additional formula feeds to large babies, whose mothers plan to breastfeed, because of concern that initially breast milk will provide insufficient calories:

Mary 'I was going to say before, choices is all very well but we're also governed by what we know to be policies and protocols and that's not so bad when we can challenge midwifery or obstetric protocols but it's very difficult when it comes to paediatrics, because they have very, very different mind-sets and they just, I mean breast feeding and babies, especially big babies...'

Laura 'The policy it actually takes away all of our ability to clinically judge ourselves doesn't it, and it is difficult'.

Sara *'And almost the minute you get them on that BM¹² roller coaster isn't it, you know the BM's aren't going to be good in the first twenty four hours, so why get onto that, let's look at the other things clinically that would indicate a healthy baby, but it's very, it is difficult sometimes when you're giving the women information...'* (FG 3, Birth Centre, Rowan Unit)

Ruth *'And certainly the feeding, I would imagine that midwife, you know definitely wanted her to bottle feed her baby, you know because that's her strong views was that that baby was starving hungry, we've had that before, baby's starving hungry, needs some milk.'* (FG 4, Birth Centre midwives, Hawthorne Unit)

The discussion by the midwives in Rowan Unit appeared to identify the difficulty they face if the paediatrician requests that a large baby has blood sugar monitoring and is also offered formula feeds to supplement breast feeding. Sara suggests that blood tests taken at this stage are not helpful, but also identifies the challenge in giving women conflicting information. This may be an inference to the difficulty the midwife faces when a paediatrician advises a mother to give formula when the midwife does not agree with it. Ruth however, suggests that some midwives also support offering formula feeds feeling that breast milk alone is inadequate for a very hungry baby. Laura encapsulates the midwives' views when she suggests that medical policies may impact on the midwives ability to exercise their own clinical judgement.

In summary, the midwives generally seemed disappointed with the feedback from the vignettes but at the same time recognised the constraints that impact on them being able to form a relationship with women and provide information to support choices. Some of the midwives also discussed the impact of hospital policies and protocols on midwives being able to use their clinical judgement, when proposing care options.

What midwives want

The code 'what midwives want' was derived from a question I asked the midwives regarding what they would like to change about the way they provided care. The midwives at Spruce Hospital identified that having more staff would enable them to give more time to women, which was felt to be a significant factor in enabling them to discuss care options and provide information against which women could make informed choices:

¹² BM – blood sugar monitoring

Paula *'Well just to have more staff because then you'd be able to give people longer appointments and the result would be that you could give more like twenty minutes, you could do bookings longer, you know, that would be the answer wouldn't it.'*

Lisa *'You can't have more than a certain number on one day anyway so you know we never do, do we.'*

Nancy *'I would bring back the antenatal classes to the local clinics because we used to do classes wherever they were going to deliver, to the local mums'. (FG 1, Community midwives, Spruce Hospital)*

However, Lisa identified that they are constrained by the environment, saying *'You can't have more than a certain number on one day'*, she was referring to the fact that the community midwives provide care at the GP's surgery, so availability of time slots impacts on the time available for consultations. Nancy talked about reinstating parenthood education classes in the local communities where women live. These classes allowed women to form social groups with other women in the area having children. Some midwives felt that the current environment did not allow midwives to practise autonomously in the way that they had been educated to and within the parameters of the definition of a midwife (NMC, 2004), so for them a positive change in practice would be to have more autonomy:

Jane *'To be able to use my clinical judgement and not be governed so religiously by policies, time limits, just to use the clinical judgement that I've gained through twelve years of being a midwife, and just being able to use that more, would be fantastic.'*

Sara *'It's great that we should be answerable to everything that we do, I'm not saying that we shouldn't be answerable, however I do think that it's, we all know that there are so many different ways of achieving the end result, and it doesn't mean that one way is right and one way is wrong, but I think that nowadays there is more of a judgement if you do something slightly out of the box...'* (FG 3, Birth Centre midwives, Rowan Unit)

Jane and Sara appear to be suggesting that the unit policies inhibit them from using their

professional judgement. Sara's suggestion that midwives are judged by doing '*something slightly out of the box*' appears to infer that midwives cannot adopt alternative strategies, based on their experience, if this is not clearly stipulated in a policy. The midwives at Hawthorne Unit also suggested that midwives would offer women choice if they themselves were empowered in their practice. This was linked with low morale so it is difficult to know whether it is the low morale which impacts on midwives offering women choice, or the lack of support from senior staff who are seen either to enable or discourage midwives from developing their practice:

Lydia 'The whole package, it's empowering midwives again to have the confidence to offer women real choice, and yeah the morale's quite low across the region, it's changing that attitude from being really negative and miserable, moaning all the time, to say look, I really like my job and I want to do the best for the women really'.

Ruth 'We've got a caesarean section rate that's quite high, but I'd love to be able to think that we could have more normal births, but that's my idea, to see our normal birth rate improving and women being able to get the same kind of support on labour ward as they do up here, and that's to do with staffing but also lots of other issues'. (FG 4, Birth Centre midwives, Hawthorne Unit)

Ruth talked about improving the normal birth rate and appeared to be suggesting that the difference in care offered during labour at the birth centre compared with the delivery suite may impact on birth outcome, suggesting that this was due to staffing levels but also other issues. From previous discussions this appeared to be related to the philosophy of care that is geared towards normal birth, in the birth centre but has a more medical focus in the delivery suite:

Carol 'It feels like, I don't know but I feel like we're fighting a bit of a battle between the philosophy here on the birth centre and the philosophy on the labour ward'. (FG 4, Birth Centre midwives, Hawthorne Unit)

In summary, what midwives said they would like is to have more staff so that they can give women longer appointments to discuss care options in more detail. Midwives also discussed feeling a loss of autonomy and the inability to use their clinical judgement due to the strictures placed on them by hospital policies. Some midwives talked about losing confidence and needing to be empowered to use the full range of their skills which, if used across all areas of midwifery care, may increase the

normal birth rates. Within the focus groups midwives were able to propose strategies to enhance care for women based on the women's feedback.

Strategies to enhance care

The code 'strategies to enhance care' was derived from ideas that the midwives proposed for enhancing care to increase the possibility of developing a partnership relationship with the women. Midwives recognised that one of the factors affecting their ability to engage in a partnership relationship with women and to be able to offer them informed choice on which to make decisions, was around time constraints in the antenatal clinics held in GP surgeries. They identified that they did not experience similar time pressures when visiting women at home during postnatal visits. It was this discussion that led the midwives from Cedar Hospital to a discussion on antenatal home visits:

Judy 'So as we were saying having the visits at home at thirty six weeks is quite attractive really, because that is really quite a good time when women do need more reassurance perhaps...'

Rose 'I wonder if one great appointment per woman antenatally, you know like a postnatal visit, you go in not expecting to come out at a certain time, I wonder if that might change their view of their care, so that for once we actually sit down, we have that cup of tea that they offer us and just really try and connect with them'.

Linda 'But the focus would be different, so maybe we could have, some of us do home bookings so whether or not we do that, let's say maybe a twenty eight week visit at home and then a thirty six of thirty four week visit at home, as I say one in each trimester of pregnancy'. (FG 2, Community midwives, Cedar Hospital)

The midwives proposed undertaking a home visit towards the later stages of pregnancy, to discuss the issues that they did not have time to discuss during the clinic visits. This visit would combine the clinical aspects of the antenatal visit but would also include time to discuss any other issues that the woman wanted to discuss, in an environment where time pressures are reduced. They felt that in the more relaxed home environment that they would be able to 'connect with them', suggesting that this would provide an opportunity to develop the partnership relationship that is so widely

proposed within maternity care. Linda developed this idea further and suggested that they could undertake one home visit in each trimester of pregnancy, starting with the initial booking visit.

An alternative proposal was suggested by the midwives at the Rowan Unit; to provide antenatal care in a group setting similar to the early booking sessions that have been introduced across the two Trusts to help them to meet the Government targets, to see all pregnant women before the twelfth week of pregnancy. The practice of group antenatal sessions has been tried in other areas and is referred to as CenteringPregnancy® (Walker et al., 2008). Women drop into an antenatal session where there is a group discussion covering the aspects of antenatal care that women want to discuss. Women can then see the midwife briefly for the clinical aspects of care where required:

Mary 'Women gain so much from each other, and to be honest the idea of sitting them in a waiting room, seeing women individually, for fifteen minutes and then sending them away is nonsense. It's not time effective at all, I mean we've tried with the early booking to get them together and to give all that information, because it is repetitive and not a very interesting way of doing it, to do it one to one and it makes it much more fun to do it with a group of people, to see that they're not the only one'. (FG 3, Birth Centre midwives, Rowan Unit)

Mary talked about women learning from each other in a group setting, but also recognised that this would be a very time efficient way of conducting antenatal care. She also talked about how women would 'see that they're not the only one', providing women with an opportunity to discuss concerns with other women going through a similar experience and recognising that many experiences women have in pregnancy are shared by others. The group then started to discuss how group sessions could also enhance the postnatal discharge on the wards:

Jane 'I'm itching to get on that ward so that you can get the women that are going home together that day in the bay, you talk about the whole discharge thing, you give them all the information at the same time so that they're having a bit of a chat and everything else and then you just fill in the paperwork in the back. How much easier would that be than going around eight women, eight times, and giving them the same piece of information'.

Mary 'You're right and the women complain about that at home. And when you do get around to the women you just go through a tick list, have you read that and

it's nothing really that was so important that they had to hang around for'. (FG 3, Birth Centre midwives, Rowan Unit)

From the midwives' perspective it is clear that this would be a more effective way of managing time than by continuing with the individual discharge planning. For the women the benefit is that they would all benefit from the questions that other women may ask. However, postnatal discharge is also a time when midwives discuss postnatal contraception and this may be a conversation that women may find embarrassing to share in a group. Midwives would need to be mindful of the women's individual needs because whilst this would undoubtedly save midwives time, it may not always be a positive experience for women. Mary identified that women complained to her about the length of time they had to wait before they were allowed home, then being provided with information that women did not find that important.

In summary, the midwives identified two strategies to enhance care for women and to help to develop a partnership relationship. Firstly, the introduction of some of the antenatal visits in the woman's home, so that the time constraint caused by clinic availability is removed. Secondly, consideration could be given to conducting group antenatal and postnatal sessions, providing women with an opportunity to share experiences and learn from each other as well as the midwife. These strategies would allow midwives more time to spend with a small group of women therefore developing the attributes within the partnership model and ultimately empowering women.

Chapter summary

The use of vignettes within the focus groups, was a reliable mechanism to stimulate conversation around the key issues raised by women around partnership and informed choice within their midwifery care. The midwives' comments resonated closely with those of the women and it was clear that in many cases they were acutely aware of the challenges midwifery practice faces in trying to meet the organisational requirements, whilst trying to establish a partnership relationship with women. Time emerged as a significant factor relating to both midwives' and women's experience of a rushed and for women, a very bio-medical, experience. Whilst midwives may still claim that they meet women's psycho-social and emotional needs, as well as the more clinical aspects of care, when faced with feedback from the woman's perspective, they recognised that the care provided was not meeting women's needs. Whilst the suggestion that midwives need to be empowered was perhaps simplistic in its proposed operation, midwives were able to identify some

very practical solutions to the challenge of time management, particularly when providing care in the GP's surgery. Midwives proposals included implementing group antenatal appointments and postnatal discharge sessions, alongside antenatal home visits, which would enhance the partnership relationship and provide more holistic care for women.

In chapter eight the emergence of a midwifery partnership model is described. This model has been developed by drawing on concepts from existing partnership models used within health care and further elaborating on these, using the themes that emerged from this study. The result is a model that specifically focuses on midwifery relationships that could be used as a theoretical framework to determine the extent to which a partnership relationship exists between women and midwives. The contribution that this model makes to new knowledge will be identified.

Chapter 8: The Emergence of a Partnership Model for Midwifery

In this chapter the development of a partnership model of midwifery care is considered within the context of the current political context. The model emerged from the core themes in this study and is presented as a theoretical framework that could be utilised in future work to determine the extent to which a partnership relationship exists. In developing the model cognisance had been taken of previous literature analysing the concept of partnership and descriptive models developed within nursing and health visiting practice from the United States, Canada and the UK, (Gallant, et al., 2002; Bidmead et al., 2005; Hook, 2006; Wiggins, 2008). In addition, midwifery models of partnership and practice have been critically analysed to identify areas of constructive alignment with the midwifery partnership model (Fleming, 1998; Freeman et al, 2004; Pairman et al, 2006). The unique contribution that the midwifery partnership model adds to the debate in this area is defined.

The political context

The concept of working in partnership and the formation of partnership relationships are frequently cited in Government documents and within the literature around women's experiences during childbearing, as discussed within the earlier chapters of this dissertation. During the last two decades key stakeholders have sought to change the philosophy of care for healthy women from a medical model to a midwifery / partnership model of care (social model). However, significant barriers to achieving this change in care still exist, including a lack of adequate funding to ensure there are sufficient midwives to provide the level of care required. This shortage of midwives has been identified in a recent Kings Fund report which presented statistics showing that whilst the birth rate in the last decade has increased by 19% the number of midwives has only increased by 12%, with a consequential increase in the workload for midwives (Sandall et al., 2011).

Additionally, the midwifery establishment¹³ has not been increased to take into consideration the increased use of technology and the increasing number of women requiring high dependency care because of pre-existing health problems (Curtis et al, 2006a), which increase maternal morbidity

¹³ The midwifery establishment in the number of midwives the organisation employs to provide maternity care for the women in the locality

and mortality (Lewis, 2007). Birthrate Plus®, a workload planning model, has been developed for use in maternity care. Where this has been implemented, organisations have been able to present a robust case for increasing staffing numbers and have presented options for workforce redesign (Ball et al, 2010). However, it has been suggested that this process is time consuming and expensive to implement and does not take adequate account of the needs of rural maternity services, with data across regions said to not be comparable because assessments are not undertaken concurrently (Midwifery 2020 Workforce and Workload Final Report, 2010). In order to deliver the level of midwifery care required to meet the Government's policy directives for a world class service, transformational change is needed to develop a workforce that can influence and lead the service. Future leaders need to be identified and channelled through a structured career pathway so that they have the skills to influence policy makers. In addition, midwives need to be supported to engage fully as the lead carer for pregnant women from the first point of contact until the end of the childbirth continuum (DoH, 2009). In this way the organisational challenges may be ameliorated to enable midwives to provide a more women-centred service.

Care for healthy pregnant women should be focused within the community, in midwifery led units, Children's Centres and in the women's homes, providing joined up services (DoH, 2010a) where the culture focuses on pregnancy as a normal life event and women are empowered to trust their abilities to birth (Bryers et al, 2010). The recent findings from the Birthplace study have provided strong evidence that birth in midwifery led units is safe for low risk women and that home birth for women having their second or subsequent baby is a safe alternative to hospital (Hollowell, 2011). Moreover, midwifery led care has been shown to be safe and cost effective (Hattem et al., 2008) when compared with medically led intrapartum care. In addition, the continuity of carer, offered within partnership caseload models, offers benefits in relation to outcome over other conventional models of care (Sandall et al., 2011). The midwifery partnership identifies the antecedents, attributes and consequences for women and midwives or working within a partnership relationship.

The theoretical development of the model

The development of the midwifery partnership model involved an interpretive process, based on the concepts that emerged during the thematic analysis of the diary-interviews and the focus group data. Whilst interpreting the data, using a comparative analysis of the codes, the elements that make up the theoretical model began to take shape. Incorporated within the model are aspects

from other health care partnership models and significant findings from related research which resonated with the themes emerging from this study (Fleming, 1998; Freeman et al, 2004; Bidmead et al., 2005; Hook, 2006; Pairman et al, 2006; Wiggins, 2008). These themes have been organised into a model based on the antecedents, attributes and consequences which define a conceptual framework (Rodgers, 1989) and describe significant features of a partnership relationship. This model forms a theoretical framework which could be utilised in future studies to determine the extent to which a partnership relationship exists within a range of care settings. Mertz et al (2006) argued that a theoretical model helps to frame the research, identifying that it provides the lens through which to conduct the study and present the findings. There were a number of synergies between the findings from the literature and the codes that emerged from this study. However, there were also a number of differences identified which may be explained by the different client groups and relationships that exist within nursing. In addition, the unique contribution that the midwifery partnership model adds to existing knowledge is delineated in the following paragraphs.

The midwifery partnership model

The midwifery partnership model has been developed based on the findings that emerged from this study (Table 5). In the midwifery partnership model the notion of the 'midwife leading/guiding care' is presented along a continuum with 'women as active partners' at the other end. The extent to which this happens is represented by a fulcrum identifying the delicate balance of shared engagement and decision making that occurs within a partnership relationship. The identification that partnership relationships in midwifery reflect this balance is unique to this model.

Within the model the antecedents are divided into the values and experiences that midwives and women bring to the relationship and also the impact that environmental factors have on the development of a partnership. Organisational and professional support is important if a partnership model is to be successful (Stevens et al, 2002b). Having sufficient time to move from a very bio-medical approach to care towards a holistic partnership approach is fundamental for the development of a partnership relationship. This emerged as a core theme in this study and was linked to a lack of time to engage in forming a relationship which was compounded by a lack of continuity of carer. Partnership in midwifery relies on a model of care that supports continuity and enables a relationship of mutual trust and understanding to develop between the woman and the midwife providing her care (Leap et al., 2006). Partnership caseload models of care support

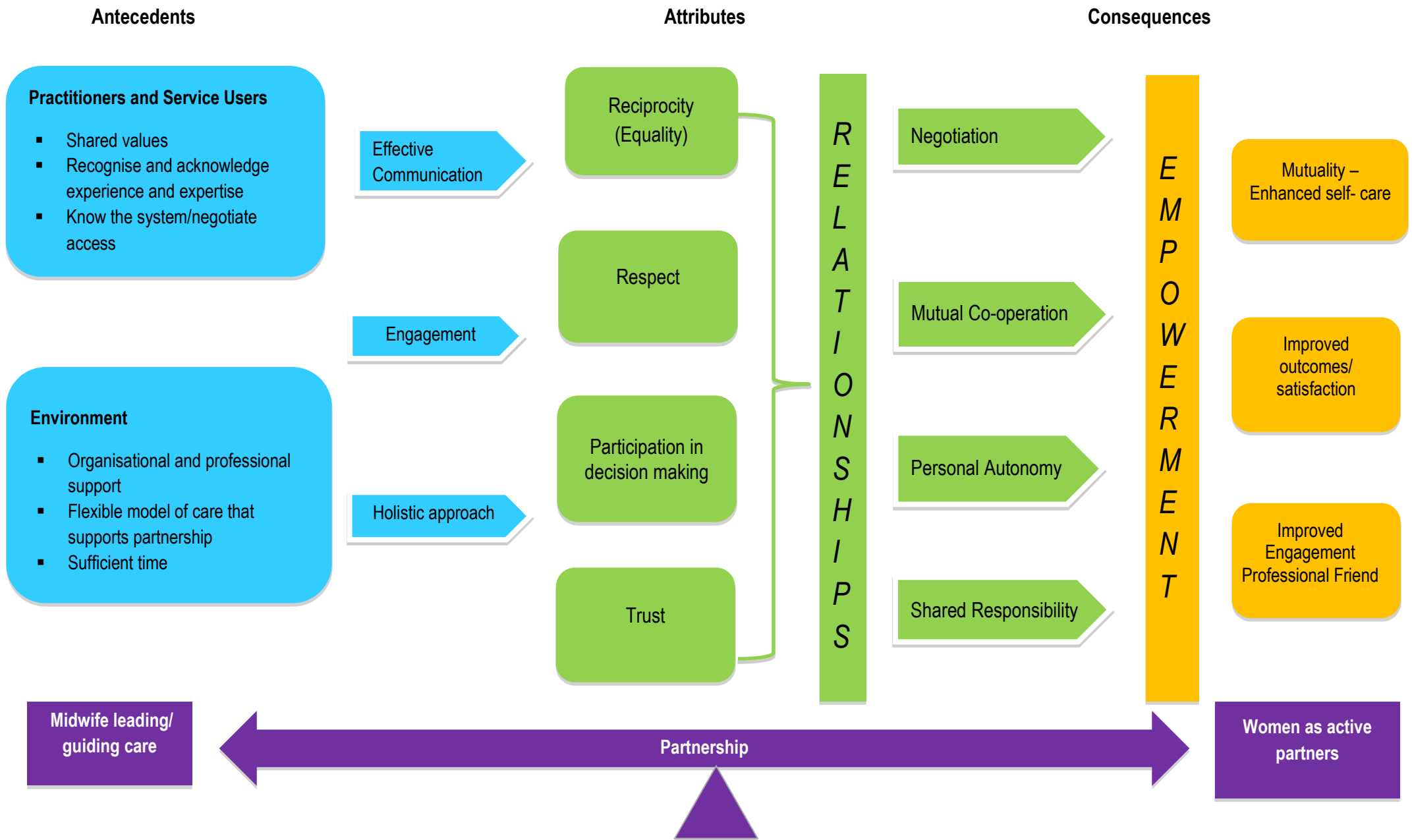
continuity and partnership relationships (see Chapter 2) and have been found to be most successful where organisational support is available to help midwives to work within this model of care.

The attributes that emerged as significant for partnership working were a relationship built on reciprocity, mutual respect and trust, where women were able to participate in decision making because the midwife provided sufficient information to enable them to make informed choices. These attributes have not been identified clearly in other models of partnership from nursing, which focused more on the qualities exhibited by the professional rather than those that foster an effective partnership relationship. Trust was described as a fundamental attribute that enabled women to feel confident with the midwife guiding care. This finding supported the work of Freeman et al (2004), who described a shared decision making model (chapter 2 refers). The model identifies that the development of a partnership relationship is associated with shared responsibility and mutual co-operation based on negotiation. Where this exists both partners are able to achieve a level of personal autonomy.

The model identifies the consequence of working in partnership as empowerment both for the woman and the midwife. The experience of empowerment was derived from the user and professional sharing knowledge and learning from each other, the concept of mutuality resulting in a satisfying relationship (Gallant et al., 2002) and enhanced self-care. Empowerment is associated with increased satisfaction, improved birth outcomes and a relationship described by many participants as that of a professional friend, for the duration of the episode of care.

Table 5: Midwifery Partnership Model

(Themes emerging from the study and building on the work of Gallant et al, 2002, Bidmead et al., 2005; Hook, 2006; Pairman et al., 2006; Wiggins, 2008)



The midwifery partnership model in context

The factors that influence the formation of a partnership relationship are underpinned by the values, beliefs and assumptions held by service users and health care professionals (Gallant et al, 2002; Hook, 2006). In this study women and midwives clearly identified the importance of effective communication strategies to ensure women understand how to negotiate the system and ensure that they receive the care that they need when they need it. This finding is supported by other studies that have identified the importance of effective communication skills and the ability to relinquish the position of power that knowledge and status ascribe to the role (Gallant et al, 2002; Bidmead et al., 2005). In addition, the professional needs knowledge and competence to support the autonomy of service users (Hook, 2006). From an environmental perspective the model of care is significant, as this needs to acknowledge the importance of the partnership relationship with the service user (Bidmead et al., 2005). However, the findings from Bidmead et al (2005), Hook (2006) and Gallant et al (2002) were all based on the use of a critical literature review to undertake a concept analysis as opposed to empirical research. In addition, a number of descriptive models of partnership, when identifying antecedents, have focused on the health care professional but excluded the impact of the service user (Bidmead et al., 2005; Hook, 2006). The midwifery partnership model focuses on the service user and the midwife throughout the partnership continuum. The key factors identified in the midwifery partnership model were working in an environment that enables the midwife and woman sufficient time to engage at a personal level as well as meeting the woman's bio-medical needs. The women in this study described a partnership relationship with the midwife if they knew the midwife from a previous pregnancy and received continuity of care from her, or alternatively where the midwives provided care in a birth centre setting.

Midwives described the competing pressures of meeting organisational demands, which placed a considerable administrative burden, and being able to provide holistic midwifery care. In addition, staffing pressures increased the burden on midwives' ability to provide optimal care to women. The impact of government policy and NICE guidance constrained midwives ability to provide an individualised approach to care. In addition, the model of midwifery care is important if a partnership relationship is to be achieved or desired. As identified in Chapter Two, partnership caseload models provide the flexibility needed to allow midwives and women to engage in a meaningful way and are associated with improved maternal satisfaction and lower rates of

intervention. The midwives in this study concurred with other researchers and identified that organisational support, including sufficient resources and professional development are important factors to support the effective implementation of partnership working (Stevens et al, 2002b; Bidmead et al., 2005; Hook, 2006). Women identified the importance of being cared for in an environment that met their personal as well as bio-medical needs, with the midwife providing holistic midwifery care.

Many women in this study acknowledged the expertise of the midwife in relation to knowledge and experience of childbirth and recognised that inevitably there is an imbalance between the knowledge and expertise of the midwife and the experience of the woman. This was particularly the case for women pregnant for the first time who did not have previous experience to draw on. As previously identified by Freeman, (2004), women recognised that in some matters they could be fully involved and participate in decision making but in other more complex areas, if a relationship of trust existed, they recognised the autonomy of the midwife in guiding them to make decisions (Edwards, 2010). In establishing a structure for the relationship both partners need to agree on their respective roles and responsibilities early on in the relationship; the professional as a facilitator and the user as an active participant in the process (Gallant et al, 2002).

The fundamental attributes of partnership were negotiation, mutual co-operation, shared responsibility, information and participation in decision making, resulted in personal autonomy. Service users need to commit to shared responsibility, risk and accountability (Gallant et al., 2002; Wiggins, 2008) in order to actively participate in a partnership relationship. Without this collaborative relationship and time spent agreeing the boundaries to care decisions, both women and midwives are placed in a vulnerable position (Mander, 2011). To be effective these attributes need to be supported by effective interpersonal skills, trust, respect and reciprocity (Lee, 1999; Gallant et al., 2002; Bidmead et al., 2005; Hook, 2006; Wiggins, 2008). The findings from this study concur with this, specifically identifying trust and reciprocity as important elements to enable women to contribute to decision making in partnership with the midwife. Women described being guided by the midwife and 'going with the flow' because they had formed a relationship with the midwife, usually associated with receiving continuity of care or carer, and feeling involved in the decision making process to the level that they wanted to be. This finding supports the work of Fleming (1998) who identified reciprocity as a core category within a model of interdependence that

co-exists between the midwife and woman during midwifery care. Gallant et al (2002) identified the importance of effective models of negotiation in the partnership process; they argued that win-win models support the development of consensus and are more conducive to partnership working.

Women, who were able to form a partnership relationship with the midwife, described examples of where they were able to develop a collaborative relationship, based on negotiation and shared responsibility and that this resulted in a more positive experience and enhanced satisfaction. Many of the women who achieved this described feelings of being in control which resulted in a more positive experience of childbirth. The midwives in this relationship were often referred to in terms of friendship, which concurs with previously documented findings of the midwife as professional friend (Walsh, 1999).

Hook (2006) argued that this shared decision making increased user compliance and ultimately improved user outcomes. However, the notion of user compliances suggests a 'power over' model which conflicts with the notion of partnership working. The midwives identified the factors that inhibit the formation of a partnership relationship and were clearly able to articulate these during the focus group interviews. Lack of time, combined with an increase in bureaucracy were significant factors that appeared to inhibit the formation of a partnership relationship. Midwives in this environment described strategies where professional power was utilised to ensure that the bio-medical aspects of care could be completed in an environment of time poverty.

The potential for conflict within a partnership relationship needs to be acknowledged. Service users and professionals may not want to engage in a partnership relationship, which may lead to excessive burden and distress for users and make interactions between both more complex. Women who formed a relationship with the midwife were much more likely to describe their care as being guided by the midwife, because whilst they wanted to be able to contribute to discussions about care options, they did not always feel that they had sufficient knowledge of childbirth to make complex decisions. In establishing a partnership relationship, therefore it is important for the midwife and woman to agree early on how they would like to work together. Women who described a partnership relationship valued the more personalised approach to care and wanted to be involved in decision making and to be able to make informed choices in discussion with the midwife. However, one woman, in contrast to this dominant view stated that she did not want to expend energy forming a relationship with the midwife during the antenatal period when she could

not guarantee that this midwife would care for her during birth, which for her was the most significant relationship as she planned a water birth at home. It is important for the midwife therefore to clearly establish the boundaries of the relationship to ensure this meets the woman's individual needs.

Gallant et al (2002) concluded by questioning '*whether partnership is a truly egalitarian concept or an elitist idea*' (p. 156). In an environment where health care professionals continue to exercise power over service users this remains a relevant question. The findings from this study have resulted in the development of a midwifery partnership model which has been informed by previous literature on the concept of partnership (Gallant et al., 2002; Bidmead et al., 2005; Hook, 2006; Pairman et al., 2006; Wiggins, 2008). However, whilst there are a number of elements of the midwifery partnership model which resonate closely with nursing models other themes were not identified. Examples of these include introspection, praise, shared power and changes in attitudes and behaviour (Bidmead et al., 2005; Hook, 2006). This may reflect the difference in the nature of the relationship that a midwife develops with a woman as compared with the service user relationship with a nurse or a health visitor.

The contribution of the midwifery partnership model

Partnership in midwifery relies on a model of care that supports continuity and enables a relationship of mutual trust and understanding to develop between the woman and the midwife providing her care (Leap et al., 2006). Whilst the model of care available to the women who participated in this study did not ensure continuity, a small number of women achieved good continuity of care or carer and therefore described forming a relationship with the midwife. These women described the attributes that have been recognised in other partnership models in midwifery (Pairman et al, 2006), a relationship built on mutual respect and trust, where they were able to participate in decision making because the midwife provided sufficient information to enable them to make informed choices. What is interesting about the similarities found between this study and Pairman's work is that Pairman undertook her study in New Zealand and the midwives taking part all practised as independent midwives'. Therefore, it could be argued that the midwives philosophy of care may be as important as the model of care in promoting a partnership relationship.

Both the woman and the midwives who participated in this study talked about the importance of time. For women the lack of time available in the antenatal consultations left them describing a very bio-medical approach to care. Woman also talked about not asking questions because they perceived midwives to be too busy to answer them. Midwives concurred with this feeling and described the strategies that they adopted to achieve the medical components of the examination within a time constrained environment. Midwives described not exploring issues with women because they knew that they did not have the time to deal with the issues that might emerge. Time is an important antecedent in the model and this links closely with working in a model that supports partnership and organisational support.

The midwifery partnership model has drawn on previous models of partnership working but is distinct from these models in relation to the following elements. The antecedents clearly identify the perspective from both the women's and the midwives' perspective. Hook (2006), Wiggins (2008) and Bidmead (2005) all focus on the qualities and skill of the practitioner within this relationship, ignoring the contribution that the service user makes. Women clearly identified the importance of knowing how to negotiate the system to gain access to the midwife, which enhanced partnership. The importance of an holistic approach to care is fundamental to the model if women are to feel that their psycho-social and emotional needs are equally as important as their bio-medical needs. In addition, personal autonomy is included from the perspective of both partners. The notion of improved engagement as a consequence of partnership working is also specific to this model. This model identifies that each relationship is unique and for it to be effective both parties need to negotiate early on to ensure that the relationship is effective. This is represented by the continuum of midwife leading/guiding care to women going with the flow. Developing a relationship to meet the woman's needs reduces the risk of conflict identified by previous authors on partnership working (Gallant et al, 2002).

Summary

Within this chapter the political context that has influenced the notion of partnership working has been outlined. Partnership as a concept closely aligns with a midwifery or social model of care. The challenges in providing this level of care within the current economic climate are explored. The concept of partnership has been critically analysed and the synergies identified between the themes emerging from this study and relevant literature on partnership. This has led to the development of a midwifery partnership model which incorporates the antecedents, attributes and

consequences implicit in the formation of a partnership relationship. Whilst only a small number of women in this study achieved a partnership relationship both women and midwives were able to articulate the factors that they perceived as important in the development of a partnership relationship. The specific contribution that the midwifery partnership model adds to current knowledge is discussed.

In the final chapter the findings from this study are critically analysed and synthesised to determine the extent to which this research study addressed the research questions. The midwifery partnership model's contribution to midwifery will be debated and opportunities for future development will be considered.

Chapter 9: Discussion and Conclusion

Introduction

In this study I set out to explore whether women and midwives achieve a partnership relationship during midwifery care and if they do, to what extent this facilitates informed choice to support shared decision making. Data was analysed and interpreted using a thematic approach and the categories that emerged from this were used to develop a theoretical model of partnership. The contribution that the midwifery partnership model makes and its potential in future research studies will be elaborated on. The themes that emerged from this study were similar for women and midwives and related to: organisational factors, the partnership relationship and the choice agenda. In addition women were asked what they wanted from their midwifery care and midwives discussed how they would like to see midwifery practice developed.

Organisational factors

Organisational factors that impacted on the midwives' ability to develop a partnership relationship included: the model of midwifery care operating in the maternity unit, strategies for communication and frequency of visits. Antenatal care was also affected by the location of care. The midwife: woman interaction was influenced by the organisation of care but also by the cultural environment that care was provided in. Midwives who adopt an holistic social model of care accept risk, respect the natural process and act as a supportive partner, guiding women as they journey through childbirth without the constraint of time (Walsh et al, 2002; Bryers et al., 2010). However, some midwives practice in a highly medicalised way, utilising all available technology to support birth, under the direction of obstetricians. It is interesting to speculate whether the environment impacts on the model of care provided or whether midwives who subscribe to a particular model select to work in an area of practice that supports that philosophy.

Adopting Foucault's theory of power, midwives and women may be affected by 'the Gaze', the notion that in hospital there are certain expectations of behaviour and that both midwives and women will comply with these because they know they are being observed (Rabinow, 1984); for example compliance with hospital policies approved by doctors. Midwives who chose to work in a community setting, historically have experienced more autonomy of decision making and therefore

were less influenced by the medical power of obstetricians, although may still have utilised coercive power under the guise of providing midwifery guardianship to women (Fahy, 2008). However, that does not always mean that the midwife will adopt a social model of care in the home and for some women care will continue to be medically focused. Additionally, community midwives from one unit in this study discussed their loss of autonomy, as a result of the organisational constraints imposed due to funding shortages, arguing that this impacted on their ability to form effective relationships with women.

In contrast to previous research findings, in this study women received a more woman centred approach to care when they attend a midwifery led unit (MLU) for their antenatal care than when they received care in the community, at the local surgery, supported by the community midwife. Whereas historically community midwives provided continuity of care during the antenatal and postnatal period, this study identified that community midwives, in the areas studied, were increasingly unable to provide continuity of care to women. In addition, community midwives were constrained by appointment slots, unlike midwives working in MLU's, resulting in consultations of between five to ten minutes in length. In this environment women felt that whilst their medical needs were met, their psych-social and emotional needs were not. To what extent this is because midwives have been socialised within a medical culture and are therefore unable to meet women's psycho-social needs is questioned, because even when women experienced a degree of continuity of care the biomedical model still prevailed. Women identified the factors that influenced the quality of their experience with the midwife, which was affected by the frequency of antenatal appointments and the time that was allocated to the woman for the individual consultation. The pressure of time and the strategies the midwives used to complete the task in the timeframe available, resulted in women not asking questions and midwives only seeking to find out answers to the medical aspects of care. However, there are many factors which impact on the midwives' ability to provide holistic care to women, including the organisational demands on midwives, increasing workloads and also professional and personal relationships (Deery, 2009).

From the midwives' perspective, midwives achieve increased job satisfaction if they are able to provide women with a woman centred, holistic approach to care (Stevens et al., 2002a: Page, 2003; Fleming et al., 2007b). However, for the majority of midwives in NHS practice the model of care does not support a woman centred approach. Midwives who leave the profession described

suffering from workload stress, feeling unsupported by managers and feeling that they had insufficient time to form effective relationships with women and were therefore unable to provide the quality of midwifery care required to meet women's psycho-social needs (Ball et al., 2002; Curtis et al., 2006a). Conversely, midwifery managers described feeling disempowered because they were unable to support midwives to provide women centred care within the resource constraints of the NHS (Curtis, et al, 2006b). Organisational constraints appear to be a key factor in mitigating against women achieving an holistic approach to care and an effective partnership relationship with midwives. The community midwives in this study concurred with the women's views regarding the organisation of care, with many midwives identifying that they had insufficient time to do any more than meet the basic medical examination required at each antenatal visit. Additionally, the midwives from Spruce Hospital discussed the challenge to their autonomy by the imposition of strict adherence to the NICE guidelines regarding frequency of antenatal appointments. Midwives expressed dissatisfaction with the current situation but appeared disempowered by what they perceived as management constraints to meet the government agenda.

The time constraints imposed on community midwives, providing care in GP's surgeries meant that in order to meet the medical elements of the antenatal visit, there was insufficient time to meet the women's psycho-social needs. Women described this care as functional and used the term '*ticking the box*' to describe their care. This mechanistic process was described by women as like a production line or conveyor belt, metaphors that have been described in medical approaches to care (Arney, 1982; Martin, 1992; Oakley, 1993, Bryson et al., 2010). This is in conflict with a philosophy of care recommended by numerous Department of Health reports which promote the importance of midwives building a relationship with women and working in partnership (DoH, 2000; DoH, 2004; DoH, 2006). The conflict of trying to establish a relationship with women whilst keeping an eye on the clock, knowing that the consultation has only been allocated five to ten minutes, has been found to place even more pressure on midwives who are expected to work in a bureaucratic environment whilst meeting women's needs to develop personal relationships (Bryson et al., 2010). The dominant perspective is from the masculine medical model which uses time as a powerful tool to control and disempower women versus the feminist midwifery model which uses time to support women's activity (Simonds, 2002). Midwives working in this time bound culture can become anxious about the dissonance between providing holistic care and meeting their employers'

requirements, tend to adopt a medical approach in order to reduce this anxiety (Bryson et al., 2010). Midwives working under the time constraint enforced by the availability of surgery time, ultimately adopted an 'industrialised conveyer-belt model' in an attempt to meet their work needs, fully recognising that they were not meeting women's relationship needs (Finlay et al, 2009). Both the midwives and the women in this study recognised that they were functioning in this very mechanistic way in order to complete the task in the time available. If midwives are to provide women with the personalised care identified in Government policy documents, then the way care is organised needs to be reviewed. Women in this study clearly identified that lack of time was a major factor in facilitating a relationship with the midwife that would enable the woman to ask questions and to receive information to support decision making. The lack of focus on women's emotional and psycho-social needs is a fundamental concern that needs to be explored further. There is evidence to support that, from the woman's perspective, psycho-social needs are significant in relation to achieving a positive childbirth experience (Oakley, 1993; Orr, 2004).

Do women experience a partnership relationship?

In this study a partnership relationship was defined as:

Partnership is a dynamic relationship that recognises the autonomy of both partners and is based on mutual co-operation and shared responsibility. It enables reciprocity and facilitates shared decision making through a process of negotiation based on trust and respect, recognising and valuing the experiences that each partner brings to the relationship.

In order for this type of relationship to develop both parties need time to get to know one another, to understand what each partner brings to the relationship and for the midwife to find out what the woman wants from this experience (Leap et al., 2006; Fahy et al., 2006). The majority of the women in this study did not form a partnership relationship with the midwives caring for them because there was insufficient time during the antenatal period for this to happen, even though ten of the sixteen women described achieving continuity of care from the midwife.

Five of the participants in this study did describe developing a relationship with the midwife; three of the women had been cared for by the same midwife during a previous pregnancy and described the relationship they had with the midwife as like a friend, however acknowledging that this 'friendship' only lasted for the duration of their midwifery care. The remaining two women were cared for by a small group of midwives in a midwifery led unit where the philosophy of care was very woman centred. These two women talked about having time to have all of their questions answered and also described feeling that the midwives remembered them and could build on issues occurring earlier in pregnancy in subsequent visits. The women felt that this helped them to develop a relationship at a psycho-social level as well as meeting their bio-medical needs. These five women described the attributes identified in the partnership model to achieve a partnership relationship. Interestingly, two women who did not form a partnership relationship during their antenatal care did in fact describe the attributes outlined in the partnership model with the midwife who cared for them during labour and birth. The one factor that was common in all of these relationships was time. The women who formed a partnership relationship knew the midwife because they had experienced good continuity of care or, for Daisy and Lily, they were cared for over a long period of time by a midwife in labour who developed a relationship of trust with them and empowered them to participate in decision making.

Additionally, for the women who did not form a relationship, a lack of continuity of carer was also remarked upon. Some of the participants mentioned that they had expected to be seen by one midwife throughout pregnancy and were disappointed when they saw a range of different midwives. Forming a relationship of trust was mentioned as important to the women because childbirth is such a significant event in a woman's life. When women saw a different midwife at each visit they did not feel able to form a relationship leaving some of the women feeling disappointed and frustrated with their care. However, continuity of carer alone did not always result in women forming a relationship with midwives in this study. Five of the women who had good continuity of carer throughout pregnancy did not form a relationship with the midwife. Ella and Megan developed strategies to address this by trying to organise their antenatal appointments so that they could be seen by another midwife from their GP's practice. This was because they expressed a lack of confidence and trust in the midwife and they did not feel that she listened to them. This is a significant issue where continuity of carer is well established because for women to have continuity with a midwife in such circumstances is detrimental to the woman's physical and

emotional well-being, because they are unlikely to ask questions or divulge concerns to the midwife.

Lily, in marked contrast to the remaining participants in the study, stated that she would not waste energy in developing a relationship with the midwives during the antenatal period because there would be no guarantee that these midwives would care for her during birth. So whilst she did experience continuity of care with two midwives who had also cared for her during her first pregnancy, for her the midwives' role was to manage the medical aspects of pregnancy; she saw her friends as providing the psycho-social support that so many of the other participants sought from the midwife. However, unlike the majority of the other participants who did not express concern that they would not know who would care for them during birth, Lily felt that the relationship with the midwife during birth was the significant relationship for her. Moreover, if the community midwives could not guarantee that one of them would be present at her birth then establishing a relationship during pregnancy was not important to her. Interestingly Lily did form a partnership relationship with the midwife who cared for her during labour, describing all of the attributes identified in the model.

The findings from this small scale exploratory study, suggest that the majority of women do want to be cared for by a small number of midwives with whom they can form a relationship. In order to achieve this, women need to be cared for in an environment where there is sufficient time for them to ask questions and to be seen by a small group of midwives who share a philosophy of care which is women centred, or within a partnership caseload model where the woman gets to form a relationship with one or two midwives. Women's experience of maternity care has been seen to be enhanced if they are cared for by a known midwife and form a relationship of support and trust with that person (Kirkham, 2000; Edwards, 2010; Wilkins, 2010). In this environment, women appeared to feel in control within a trusting relationship because they felt that the midwife would endeavour to provide care in response to their wishes as far as possible (Green et al., 1998).

The challenge for the maternity services is to recognise that women are individuals and therefore one model of care will not meet all women's needs. At the beginning of the relationship midwives need to try to ascertain what women want from this relationship and this should be revisited throughout pregnancy. Also, if the relationship is not working, perhaps due to personality differences, women and midwives should have a system to facilitate a change of carer for the

woman. The midwives in this study recognised when they were not able to form a relationship with a woman and in a team situation said that this could be resolved by asking a colleague to take over a woman's care. However, this is not always possible and there should be a confidential system to enable women to speak to someone in the maternity service to ask for a change of carer, where a positive relationship is not being established.

The extent to which women are offered informed choice

In relation to the four 'national choice guarantees' (DoH, 2007), women in this study were largely not aware, nor were they offered a choice in relation to access to the maternity services and choice and type of care. Whilst the women in this study identified that they preferred midwifery led care, seeing this as more pregnancy focused, they were not offered an option to choose who they saw or where they were seen. Maternity care in this study was provided in a prescriptive 'one size fits all' model and women were slotted into this system, not enabled to participate actively in the way that care was provided, thereby not empowering women to be partners in their care. The exception to this was where women were seen for all of their care in the midwifery led unit; where care was provided within a woman centred philosophy and women were given time to actively participate in decision making.

Choice of place of birth is a particularly contentious area historically, with proponents of the medical model arguing that birth is only normal in retrospect, whereas supporters of the midwifery/social model of care have argued that birth is a natural process and that women should be empowered to follow their instincts and let go, to facilitate a safe and satisfying birth experience (Walsh et al, 2002; Bryers, 2010). Women in this study were not offered the full range of birth options, despite the fact that within both NHS Trusts all of the options were available. The three women who planned for home births actually led on this agenda as opposed to midwives offering home birth as a realistic option for them. For the majority of women in this study the place of birth was assumed by the midwife depending on the woman's parity and medical history. Most of the women in this study talked about not knowing that there was a choice in relation to place of birth. If women are to be empowered to share in the decision making then they need information, provided in a timely manner and the opportunity to discuss the ramifications of the options available to them. The recurring theme of a lack of time, identified by both the women and the midwives in this study, appears to be a significant factor hindering women's choice.

The relationship with the midwife was also an important factor in the extent to which women felt they were offered information on which to make decisions. The women who had continuity of care in this study and who felt that they had formed a partnership relationship with the midwife, talked about '*going with the flow*', the sense that they had trust in their midwives and were happy to be guided by her and supported in decision making. However many of the women in this study did not develop this type of relationship; for these women there was a sense either of dissatisfaction regarding this process or resignation because they did not feel they had sufficient information on which to make choices.

Despite this, the evidence base for whether women want choice in relation to their maternity care is limited and is bound up with issues around power and coercion as discussed in the literature review. Moreover, it would be simplistic to suggest that choice is readily available to women accessing the maternity services because women need information with which to make choices and it is the availability of this information which can impact on the extent to which choice is a realistic option. Whilst information is readily available to women it is the sheer volume of information, much of which is contradictory, that needs to be considered before informed choices can be made. Within this study women identified that midwives are limited in their ability to provide women with informed choice, by a lack of time in which to provide both the information, and opportunities to discuss the significance of the information, in relation to the woman's personal situation. Women in this study identified that most of their information was gathered using the internet, books and friends and family. For many of the women this was not only due to the relatively short and infrequent visits to the midwife but also because they were unclear how to access a midwife for advice between visits.

A web based survey on internet use in pregnancy concurred with this finding and identified that most women used the internet to supplement professional advice or to aid decision making, identifying a lack of time to discuss issues and dissatisfaction with professional advice as key drivers to internet usage (Lagan et al., 2010). The concern with women accessing the internet is around the accuracy of the information. Some maternity organisations and NHS Trusts are considering the development of web based resources for women, which are evidence based and therefore a more reliable source of information. This would clearly help to bridge the gap caused by a lack of midwifery time to discuss the evidence women need to make choices and would

overcome concerns about the accuracy and reliability of information currently sourced by women on the internet. However, providing women with information without any opportunity to come back to the midwife to ask questions later may raise women's anxiety levels and not improve care. The use of web based resources needs to be fully evaluated before it is adopted more widely within the maternity service.

The review of the maternity services conducted by the Care Quality Commission in 2010 found that fewer women were offered antenatal education in 2010 than in the previous survey in 2007 (CQC, 2010). In addition women are now offered a reduced number of appointments for antenatal care (NCC-WCH, 2008) so midwives do not have an opportunity to discuss options and then to encourage women to go home and think about the options available, before they need to make a decision. This is particularly the case with antenatal screening which is undertaken within a narrow window of time. Therefore maternity services need to adopt alternative strategies to enable women to have sufficient information and time to be involved in decision making. Shared decision making can be supported by a variety of decision aids including leaflets, interactive websites and DVD's which present the evidence based choices available to the service user (Coulter et al, 2011; Stapleton et al. 2002). However the use of decision aids alone does not guarantee engagement in a partnership relationship because for such strategies to be successful there needs to be support and buy in at all levels of the organisation. If decision aids are to effectively support partnership and shared decision making, the culture of care needs to change. Support for this process needs to come from the top of the organisation, reinforced by appropriate resources and effective policies (O'Cathain et al., 2002; Stapleton et al., 2002; Coulter et al., 2011). Women in this study identified that a lot of irrelevant information was provided and that for some women this was either given to them at the wrong time or was not specific to the particular NHS Trust and therefore was perceived to be of limited value.

The community midwives also recognised that they are not meeting women's needs in relation to the choice agenda. The pressure to undertake the medical aspects of the consultation, whilst also collecting audit data to meet the payment by results agenda (DoH, 2010b), forced the midwives to adopt a mechanistic approach to care. Some of the midwives in this study protected themselves from the emotional labour of meeting women's needs by being detached and not asking women questions, because they knew they did not have time to answer them fully (Hunter, 2006). Interestingly, the community midwives from Cedar Hospital identified that the pressure of time only

related to the antenatal appointments and that for postnatal care they had as much time as the woman needed to provide care and answer questions. This is because postnatal care in the community is largely undertaken in the woman's home and the midwife does not have a waiting room full of women with timed appointments to see. So whilst lack of time was widely promulgated as the reason for the mechanistic approach to antenatal care, the midwives suggested that this time poverty is largely due to a lack of surgery slots where antenatal care takes place. This was not the case for the other group of community midwives at Spruce Hospital however, who were under pressure to justify the number of postnatal visits they undertook and were actively discouraged from visiting women at home at the weekends, being required instead to encourage women to attend drop-in clinics.

Most of the women in this study described their postnatal appointments positively and for the majority of women the selective community postnatal visiting met their needs. However, there were mixed views about the use of postnatal drop in clinics at the weekend. For some women this was viewed positively because it meant that they were not left waiting all day wondering what time the midwife was going to visit. However, other women talked about the difficulty of organising this visit, particularly if they had other children. There was also a sense that drop-in clinics are quite disorganised because there is no guidance about how long you will have to wait and so the quality of experience is more down to luck than judgement, as some women were seen immediately whilst others had to wait a long time to see the midwife. The other area where selective visiting was problematic was around establishment of breast feeding. If breast feeding was successfully established then women did not identify a need for an increased number of visits. However, for women who were experiencing difficulty with establishing feeding, three visits were perceived as inadequate to support successful breast feeding. Therefore, in order to enhance care in the postnatal period, a more flexible approach to visiting may need to be adopted for some woman.

In summary, most of the women in this study were not offered informed choice regarding their care and without significant changes to the organisation of care this is unlikely to change. Whilst midwives identified that an increase in staffing levels would alleviate this issue any change to the midwifery model of care needs to be financially viable. The Care Quality Commission in its evidence stated:

'There will be a need to be mindful that choice needs to be realistic, balancing wants (and sometimes needs) with what is affordable and what resources can be made available'. (Healthcare Commission, 2008).

The challenge for the health service is to develop strategies that enable the realisation of a partnership agenda and for women to engage in decision making in order to make informed choices within the resources that are available. In the next section proposals made by the midwives to enhance care, are examined.

How can partnership working be strengthened?

As previously stated, midwifery led models of care, and in particular partnership caseload models, are associated with: improved outcomes for low and medium risk women, are safe and appear to be economical when compared with traditional care models (Devane et al, 2010). The lack of continuity experienced by the women in this study would be negated if a caseload model of care was adopted. Studies of partnership caseload models have demonstrated improved outcomes and levels of satisfaction for both women and midwives (Walsh, 1999; Stevens et al., 2002a; Page 2003). Whilst a lack of midwives may be cited as a reason for not adopting this model, Sandall et al (2011) argued it is not necessarily a case of increasing midwifery numbers, but may be about reviewing how staff are deployed and using support workers effectively to ensure midwives concentrate on the role that they have been prepared for. Increased use of administrators and midwifery support workers has been shown to increase effectiveness within the midwifery workforce.

Technological advances could be enhanced to improve the experience of maternity care for women. Women complain that midwives spend a lot of the valuable appointment time reading their notes so that they know what has been happening before this appointment. Whilst continuity of care reduces this time loss, midwifery records could be computerised and replace hand held notes, so that whilst women could have access to her own computer file, midwives could access the record before each consultation just to refresh their memory about what has happened previously. With the use of lap-tops and particularly tablet computers, this could be an invaluable time saving device for both women and midwives. The Government information strategy published in 2012 provides a framework for sharing of user records and information across health and social care

settings and could revolutionise health care (DoH, 2012b). Additionally, women complain that they do not know what time the midwife is going to visit during the postnatal visit, sometimes resulting in women waiting in all day. Text based technology is becoming more widespread enabling an administrator to send women a text giving a short time slot when the midwife is likely to attend. This could be updated if the midwife gets caught up with a birth or takes longer with previous visits due to unexpected circumstances.

Antenatal care could be reorganised to provide a more meaningful experience for women and make better use of the time available to midwives. Group antenatal care has been introduced in America in the last decade. The groups are organised so that women of a similar gestational age are seen in a small group of eight to twelve women and facilitated by a range of health care professionals including midwives, obstetricians, health visitors and midwifery support workers. Women share experiences and learn together providing education and health promotion opportunities. The visits are longer, lasting for around ninety minutes and are scheduled ten times during pregnancy (Walker, et al., 2008). This approach, known as CenteringPregnancy®, was recently piloted in Australia where it was found to increase maternal satisfaction and provided opportunities for social support, friendship as well as education and care (Teate et al, 2011).

The centering pregnancy approach is an area of care that could be implemented more widely in the UK and would provide a venue to share information and discuss options therefore empowering women and supporting a partnership approach to decision making. Within this approach opportunities could exist for women to have one to one discussions for the medical aspects of pregnancy to be conducted in privacy. Whilst this approach might not be chosen by all women, midwifery care could be enhanced if different options were available for women to choose from, particularly if these were offered within midwifery led units or birth centres so that time constraints were removed. During the Rowan Unit focus group the midwives discussed opportunities for group antenatal and postnatal care as a means of providing more effective and meaningful care.

Additionally, midwives in this study identified that antenatal care could be enhanced by introducing a home visit at around thirty to thirty six weeks of pregnancy, to give women time to ask questions and to discuss any issues they have in relation to late pregnancy and preparing for birth and motherhood. This visit would provide women with an opportunity to discuss their birth plans, an area that both women and midwives in this study identified rarely happened, due to time pressures.

However, in caseload models of care, a birth talk at around thirty six weeks is well established in many areas and empowers women, enabling them to achieve their potential (Kemp et al., 2010). If home visits were also re-introduced for the antenatal booking appointment in early pregnancy, as well as in the latter half of pregnancy to prepare for birth, this could really address women's concerns and help the midwife to form a partnership relationship with the woman.

The midwifery partnership model

The midwifery partnership model was developed as a theoretical framework based on the themes that emerged following data analysis. Many elements of the model resonate with previous models from nursing (Bidmead et al., 2005; Hook, 2006; Wiggins, 2008) but advance the notion of partnership by addressing the issue from both the women's and the midwives' perspectives. This is a unique contribution of this model. Additional areas of difference have been articulated in Chapter 8 and include the importance of an holistic approach to care and the fact that both the women and midwives strive for personal autonomy within the relationship. The partnership continuum recognises the importance of the distinctiveness of the relationship, facilitating women to determine the level of engagement that they chose during their journey through childbirth. From the analysis it is apparent that women may engage at different levels with the midwife depending on their own needs. For example, women could chose to what extent they wanted to share in decision making, the important thing is that they should be provided with the relevant information in a format this is acceptable to them but which is also mindful of the clinical situation. As Freeman (2004) found, women will chose to engage at different levels and this depends on the complexity of the decision. As one woman in this study stated, a partnership relationship can exist without it being an equal partnership. The women and midwives that established a partnership relationship articulated the importance of respect and trust in this relationship. This provided the foundation for a sharing of knowledge and decision making, principles that left the women feeling empowered and more satisfied with the outcome of the relationship, which many women described as a friendship. Whilst the model identifies characteristics that support partnership, it is important to recognise that the majority of the women in this study did not perceive that they experienced a partnership relationship. Testing the model within an environment where women experience continuity of care in a partnership caseloading situation would determine whether these characteristics are in fact the most important when forming a partnership relationship.

Limitations of the study

The limitations of this study are that it was a small qualitative study and therefore the findings, whilst providing rich descriptions of the women's experience of midwifery care, cannot be generalised more widely. Moreover, doctoral students undertaking research are disadvantaged during the analysis phase of the study as they do not have co-workers available to review data and therefore to improve the robustness of the findings by comparing themes and categories as they emerge. I was able to test out assumptions by engaging in discussion with supervisors, colleagues and participants at Conferences, which enabled me to reflect on the interpretations I was making. However, the benefit of being part of a research team is the reduction of personal bias in the interpretation of data. Another potential limitation in this study was the impact of the midwives acting as gatekeepers to the women recruited to the study. It is possible that midwives may have selected women to take part in the research being mindful of the fact that an exploration of the partnership relationship could reflect on their own practice. However, whilst it is not possible to determine the extent that this may have occurred, the women in this study appeared to present a very balanced view, identifying positive and negative aspects of the midwifery care that they received. There was no obvious bias in favour of any of the midwives in this study. However, in view of the number of women available to be recruited to this study it is more likely that midwives may have chosen not to recruit women. In previous studies there have been a number of reasons for recruitment issues, including practitioners forgetting, not valuing the study or just being too busy to recruit women (Barnett et al., 2008; Furimsky et al., 2008). It is possible that midwives actively chose not to recruit women because of concerns that the findings may have reflected poorly on their practice.

A final limitation was the impact of my role as a researcher. This could have impacted on both the women and the midwives in this study. I was undertaking this study in two maternity units where a number of the midwives were known to me. In addition, I was a senior member of staff and therefore it could have been perceived that I held a position of power over the midwives. This may have inhibited them during the focus group interviews, despite the fact that I had assured them of confidentiality in anything that they shared with me. The women may also have been selective in their responses because I am a midwife researcher. Some women may have been more comfortable talking to a researcher who was not a member of the profession being explored. However, an alternative view is that women were more likely to share their experiences with me

because I was a midwife and therefore had an insider position (Oakley, 1981). The fact that I was a woman and mother may also have encouraged women to respond to me more openly. Whilst undertaking this study I was mindful of the impact that my position may have had on the participants. However, whilst I was aware of this limitation, and made great efforts to reassure both women and midwives of the confidential nature of the information that they shared with me, I cannot know what impact this may have had on the findings.

Concluding remarks

This qualitative study has provided a small group of women, with an opportunity to identify the issues that are important to them, from the perspective of the relationship that they form with the midwife providing their care and the extent to which they are offered choice in relation to their care. The concept of partnership working has been promulgated for almost twenty years and whilst a number of studies have addressed women's satisfaction with maternity care, this study contributes a perspective specifically on partnership relationships from the women's point of view. Women in this study wanted to experience midwifery care that was personalised and provided by a small group of midwives. Whilst the desire for continuity of care has been recognised previously as discussed in the literature review, this study contends that, despite the current political climate, which through successive administrations has supported the notion of partnership and informed choice, women in this study were predominantly not experiencing a partnership relationship or information on which to contribute to the decision making process.

Despite the guarantees outlined in '*Maternity Matters*', in relation to the four national choice guarantees, most of the women in this study were not offered choice in relation to the personnel or the place that care would be provided (DoH, 2007). The women in this study were predominantly articulate middle class women, but despite this they were unable to negotiate the system to engage fully in their care. In addition to this, midwifery promotes itself as being predicated on a social model of care but the women in this study identified that the care provided by community midwives was mechanistic, bio-medically focused and time bound, therefore more in line with a medical model of care (Bryers, 2010). Partnership relationships are founded on a shared decision making model where both partners have autonomy and where the women's views and expertise are valued. However, the lack of time for midwives to provide information to women and to discuss

options, made it very difficult for many of the women in this study to engage at a level of partnership or to be offered informed choices.

Further research is needed to identify clearly what is meant by partnership and if a relationship between a health care professional who holds coercive power can ever be equal to that of the service user receiving care from that professional. Whilst shared autonomy is important in a partnership relationship, can this truly exist when the health care professional holds the responsibility for the decision making and the service user has no accountability for choices made within the partnership, especially should there be an adverse outcome? If a relationship is truly to be a shared partnership, issues of responsibility and accountability between the midwife and the woman need to be further examined. The Government information strategy plans, over the next ten years, to ensure that high quality, evidence based information is available to everyone. Alongside this approach to information exchange is a plan to provide on-line access to user records, to enhance a culture of '*no decision about me without me*' (DoH, 2012b, p. 6). Further research into the practical application of this approach to improve information exchange to support informed choice is clearly needed. In addition, further research is needed to explore the extent to which a centering pregnancy approach to care could improve women's experience of midwifery care in the UK.

Finally, the midwifery partnership model has been developed as a theoretical framework that could be used to determine the extent to which a partnership relationship exists within a range of midwifery models of care. The contribution that this model makes to the existing body of knowledge on partnership working has been elaborated. The unique contribution of this model is that it equally values both the women and the midwives unlike other models that focus on the impact of the professionals' input to the experiences of service users. This suggests that the service user has a passive role in the relationship. In addition, the midwifery partnership model acknowledges the importance of constant dialogue within the relationship to determine the extent to which the woman wishes to be an active partner in care decisions, or to be guided by the midwife, to go with the flow. Further work to test this model in a range of midwifery environments would determine the extent to which this model is an effective tool to evaluate partnership relationships. In addition, dissemination of the model to midwives managing services and providing midwifery care would enable them to reflect on the themes that have been shown to influence the development of a partnership relationship and to determine the extent to which the model of care

currently offered to women addresses these areas. This model could be used as part of a change process to enhance partnership working within the maternity services.

The findings from this study have been disseminated at a number of local, national and international conferences. The discussion and debate during these events contributed to the final dissertation. The findings will be further disseminated through the publication of papers in professional peer reviewed journals over the coming months.

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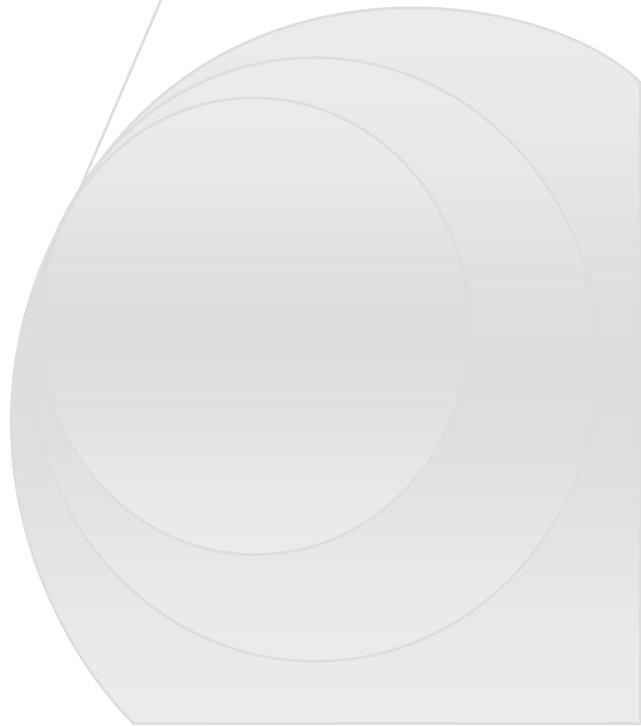
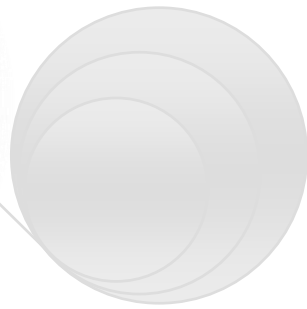
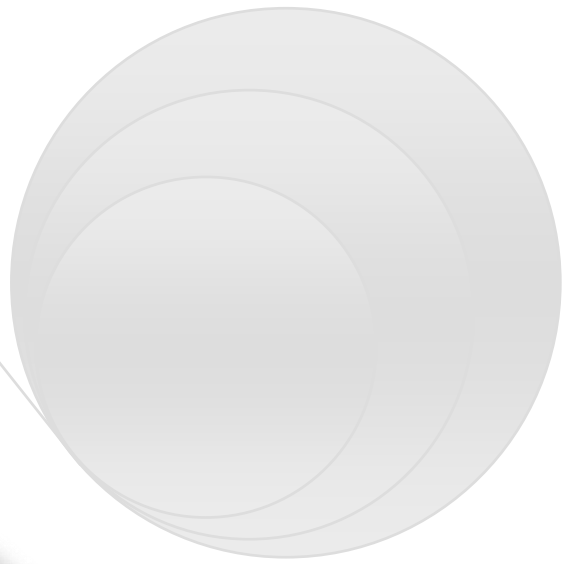
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Appendices

Appendix 1: Diary Format



Name:



Guidance

- In this diary I would like you to write how you felt after each of your appointments with the midwife. This will be during your antenatal appointments and after the baby is born when you have gone home. If you can it would be good if you could record your feelings about the care you receive in labour.

Can you try to include the following in your diary entries?

- Date and reason for the visit e.g. antenatal appointment at 20 weeks or Day 3 postnatal visit
- Whether you have met the midwife before (you can refer to her by her first name if you would like to but please do not refer to her by her full name in your diary)
- How you felt about the care you received by the midwife
- Whether the midwife answered all your questions to your satisfaction?
- Were there any aspects of your care that were dealt with particularly well or particularly poorly?
- Whether you found any of the advice confusing or conflicting?

If you have any queries please contact me, Sally Boyle, on 01707 285242 or 07730 672060. You can also e-mail me on s.boyle@herts.ac.uk. If you leave me a message and contact details I will get back to you as soon as possible.

Background Information

Can you tick your age range?

- Less than 20
- 20 – 24
- 25 – 29
- 30 – 34
- 35 – 39
- Over 40

What is your occupation?

If you have a partner what is their occupation?

How would you describe your ethnic origin?

Please tick the category that you feel best describes your ethnic origin using the 2001 Census

White

- British
- Irish
- Any other Black Background (please write in)

Black or Black British

- Caribbean
- African

Asian or Asian British

- India
- Pakistani
- Bangladeshi
- Any other Mixed Background (please write in)

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian

Chinese or Other Ethnic Background

- Chinese
- Any other (please write in)

- Information Refused

Can you tell me a bit about this pregnancy so I can get a sense of your experience? Include whether this is your first pregnancy or if not how many children you have.

When is your baby due?

Do you have any medical conditions or family history that will affect your pregnancy? E.g. Diabetes

Appendix 2: Vignettes

Vignette 1: Antenatal Care

Vignette 2: Late pregnancy to postnatal care

Vignette 3: Intrapartum to postnatal care

Vignette 1: Antenatal Care

Phily is pregnant for the first time and describes some of her experiences of antenatal care

I don't feel really at any of the appointments I've chosen anything because they've all been so...routine and minimal. I mean I've gone in, they done my blood pressure, checked my urine and sometimes they've listened to the babies heart beat.....

a little bit more interest maybe just general, how are you, how's work just stuff to make you feel a bit more rather than just a production line, in and out, in and out which I guess there's an inevitability about that sort of thing but it's a shame

..... it has felt very much like a medical exercise so it's like, we've got to get your history, we have a number of very basic checks we've got to do, we've got to check your blood pressure, your urine, we've got to check any swelling etc, like tick, tick, tick, so very functional, very medical in that respect...

.....most of the time you go in, it's somebody different or somebody you haven't seen for weeks and weeks and weeks, and they don't remember you, they have no idea what's gone

on

Vignette 2: Late pregnancy to postnatal care

Gina talking about her experience following the birth of her first baby

...that whatever you say I will do because at the end of the day I'm not trained to do this. Yes whatever they say, whatever is the best for this baby I will do basically. I think I've got a 100% trust in my midwife, and I just think whatever she says I will do. I trust everything she says

I would say I felt it was a very close relationship, very at ease, um I felt that nothing was too much trouble really and a very open relationship in that I could contact her whenever I wanted really, I couldn't really fault it you know

in terms of where you're able to give birth, again that wasn't mentioned until my antenatal classes, by which point I knew, but no-one had said, your choice is X hospital, birthing centre, delivery suite or home, and still actually in my midwife appointments no-one has mentioned

Well I still think that it's up to them to take the lead, I would have liked more information actually, I mean I was, you know you can be a partner without being an equal partner can't you and I think that I still would have liked more input from her end to sort of say, and just like you know, you just don't know because they say your this or the scan says that but it would be nice to have some context to say if that's normal

Vignette 3: Intrapartum to postnatal care

Enya talking about experiences leading up to her birth

...everyone I met was just so friendly I just thought 'god is anyone having a bad day here?' you know, because they were amazing. And also listening to the banter between them morale was quite high generally in the department. And really efficient as well. Everything was really efficient. And it just seemed like everyone really knew what was going on. And so I just felt kind of really secure the whole

I would say she's definitely led the care because she's the expert at the end of the day and you can't really make a decision because you don't know enough to make decisions. There is only so much you can learn from talking to somebody or reading, you know listening to other family members' experiences....

...the general impression is that they are the medical people and you basically must listen to what they are saying, and they decide certain things and that is what happened in my labour as well; she said, 'no you have to push' and she put my feet in stirrups and I was on my back and I said 'well can I go on all fours?' and she said 'no, you've just had an epidural, you'll fall off'. But I thought 'I can feel everything'.

...she said, 'right I'm going to make up some formula for her because she's so big and otherwise she'll be, you know, she...you won't be able to give her enough'. And I kind of, I must have looked a bit kind of...And she said 'is that ok?' and I said, 'I really don't want that to happen'. And she said, 'ok, it's up to you, but you know, she will cry all night'.

Appendix 3: Participant Information Leaflet

Participant Information Leaflet

Women in Partnership Study

Study Number: 08/H0714/73

Women's views on partnership working with midwives during pregnancy and childbirth.

This is an invitation for you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you have any questions my contact details are at the end of this leaflet.

What is the purpose of the study?

The purpose of the study is to identify what you want from the midwives who care for you, particularly in relation to working in partnership and informed choice. I will compare your views with those of some of the midwives who may care for you. Anything you say to me will be anonymous as I will use a false name to protect your confidentiality. The findings will be used to improve the care for pregnant women in the future.

Why have I been invited?

You have been invited to take part in this study because you are pregnant and have met with your midwife in the antenatal clinic or your G.P.'s surgery. I will be asking a number of women who are pregnant if they would like to take part in this study.

Do I have to take part?

No, it is up to you to decide whether you would like to take part. If, after you have had time to read the information sheet and discussed it with others, you would like to take part I will meet up with you. I will go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive in any way.

What will happen to me if I take part?

If you agree to take part I will ask you to keep a diary of your meetings with midwives during your pregnancy, birth and after your baby is born. I will ask you to write about how you felt about the care you received. I am interested in what you liked about the care. I would also like to know if it was what you expected and if there were areas that you were unhappy with. I am interested in

whether you felt you were involved in decisions about your care and whether you were given enough information to make an informed choice? I will give you a booklet to write your experience in. If you would prefer you could write this up using a computer or speak into a tape recorder or MP3 player, which I will provide for you to use for the duration of the study. The time taken to complete the diary will vary for each participant but on average will be around 30 minutes following each meeting with the midwife, which would normally be about seven-eight times before the baby is born and three – five times after the baby is born.

I will ask you if you would be prepared to meet with me during the pregnancy and after birth so that I can check out things that have been written in the diary. This will be a one to one interview which again will last for about an hour to an hour and a half and will be recorded with your consent. The interviews will take place as follows:

- When you are about 34-36 weeks pregnant
- Around 2 weeks after your baby is born

The interviews will be arranged in a place that is convenient for you. This could be at home, in the G.P's surgery or at the hospital. All of the sessions will be led by me. The information you provide will remain confidential and the tapes will only be heard by me and my research supervisor. The record of the tapes will not identify you by name and so anything you say will be confidential.

Participation in this study is voluntary and there is no funding available for you. For this reasons disturbance to you will be kept to a minimum and all meetings will be held at a location that is convenient for you.

What will I have to do?

You will need to meet up with me so that I can explain the diary and gain your permission in writing. At this meeting I will answer any questions you may have. If you would be willing to take part in the interviews you will need to meet with me on two occasions to talk about your experiences. Each interview will again last one to one and a half hours. You are free to stop at any point during the interview or withdraw from the study at any time without your care being affected.

What are the possible benefits of taking part?

Taking part in this study will not directly benefit you in this pregnancy. Your views may help to ensure that women are able to work in closer partnership with midwives in the future.

Are there any risks?

There are no significant risks or disadvantages to you in taking part in this study. It is possible that discussing your aspirations for your pregnancy with what actually happens may cause you some distress if the outcome is not as you planned. I will take every precaution to try to prevent this happening. Also although I will take every effort to maintain your confidentiality it is possible that this could be breached during the study. The study only involves you keeping a diary about your care and talking to me about your experiences during your pregnancy. Your care will not be affected in any way. If you have any concerns about this study you should contact me, Sally Boyle on 01707 285242 or e-mail S.Boyle@herts.ac.uk, so we can discuss them.

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints should be addressed to:

PALS, Address; Telephone number and e-mail included

Will my taking part in the study be kept confidential?

Yes. Your name will only be known by me during the research study and I will use a false name for you when I write up the study. No information will be given to anyone other than me and my research supervisors. If you disclose information to me in the diary or the interviews that I feel your midwife or obstetrician should know about, I will discuss it with you and ask for your permission to let them know. At the end of the study all audiotapes and transcripts will be stored in a locked filing cabinet for a period of ten years. After this period they will be destroyed.

What will happen to the results of the research study?

The study will be completed in the summer of 2011. Results from the study will be shared with midwives and doctors during workshops and conferences to help us to determine the best ways of using this information in future care. The findings will also be made available in magazines for pregnant women and health care journals. If you wish I will send you a summary of my findings. At no stage will you be identifiable during this process.

Who is organising and funding the research?

I am undertaking this study as part of a professional doctorate at the University of Hertfordshire. I am not receiving any external sponsorship for undertaking this work. The University of Hertfordshire is my academic sponsor.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Joint UCL/UCLH Committees on Ethics of Human Research (Committee A).

What if you have some questions about the study?

If you would like to find out more about this study before deciding whether to take part, you can contact me, Sally Boyle on 01707 285242 or e-mail on S.Boyle@herts.ac.uk You may have to leave a message on an answer phone but I will get back to you as soon as possible. If you have other concerns about taking part in this study, your midwife may be able to answer them.

What happens now?

- If you agree, your midwife will give your name and telephone number to me, Sally Boyle, the study researcher; I am also a midwifery lecturer.
- Alternatively you may meet me when you attend the clinic or your Doctor's surgery for the first time in this pregnancy. If you are interested I will give you a letter explaining the study.
- In a few days' time I will phone to ask if you are interested in taking part in the study. I can answer any questions you may have.
- If you are still interested in taking part I will arrange a date to meet up with you to discuss in detail what you will need to do. If you have decided you do not want to take part, I will not try to persuade you.
- I will explain more about the study when I meet you, answer any further questions, and, if you decide to take part, I will ask you to sign a consent form.

Thank you for taking the time to read this information and please do not hesitate to ask for any more information if you need it.

Sally Boyle
Principal Investigator
School of Nursing and Midwifery, University of Hertfordshire
College Lane, Hatfield, HERTS, AL10 9AB
Tel: 01707 285242
E-mail: S.Boyle@herts.ac.uk

Appendix 4: Consent Form

Study Number: 08/H0714/73

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Women in Partnership Study**

Women's views on partnership working with midwives during pregnancy and childbirth.

Name of Researcher: Sally Boyle

Please initial in the box

1. I confirm that I have read and understood the information sheet dated 28th August 2008 (version 8) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. Any information collected before I withdraw from the study may be used by the researcher, providing it has been anonymised.
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the researcher, Sally Boyle, where it is relevant to my taking part in this research. I give permission for her to have access to my records.
4. The content of any discussions that I have with the researcher will normally remain confidential. However if during completion of the diary-interview significant information arises that could impact on, or be detrimental to, my care I understand that the researcher will seek permission to share this information with the relevant health care professional(s).
5. I understand that I will be offered an opportunity to review the transcripts from my interviews with the researcher.
6. I give permission for the researcher to use quotes that have been anonymised, in any reports or publications that arise from this research.
7. I agree to take part in the above study.

Name of Participant Date + Signature

Name of person Date Signature
taking consent

Local midwives, general practitioners and obstetricians are aware that this study is taking place.
When completed, 1 copy for the participant; 1 copy for researcher site file

Appendix 5: Letter confirming Ethical Approval

The Joint UCL/UCLH Committees on the Ethics of Human Research (Committee A)

ICH Research & Development Directorate Office,
1st Floor, 3 Long Yard, London, WC1N 3LU

POSTAL ADDRESS:

R&D Department, Institute of Child Health,
30 Guilford Street, London,
WC1N 1EH.

Telephone: 0207 599 4144

0207 905 2705

Fax: 0207 599 4138

a.mittu@ich.ucl.ac.uk

08A 401

10 September 2008

Ms Sally A Boyle
Associate Head of School
University of Hertfordshire
College Lane
Hatfield, AL10 9AB

Dear Ms Boyle

Full title of study: **Womens' views on partnership working with midwives during their pregnancy and childbirth**
REC reference number: **08/H0714/73**

Thank you for your letter of 18 August 2008 responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair at the sub committee meeting of 10 September 2008.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the research site(s) taking part in this study. The favourable opinion does not therefore apply to any site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at sites requiring SSA.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		30 June 2008
Investigator CV	Sally Boyle - v2	01 January 2007
Protocol		01 June 2008
Covering Letter		07 July 2008
Covering Letter		18 August 2008
Letter from Sponsor		30 June 2008
Compensation Arrangements	Certificate	01 August 2007
Interview Schedules/Topic Guides	1	27 June 2008
Advertisement		
GP/Consultant Information Sheets		
Participant Information Sheet	6	28 May 2008
Participant Information Sheet	7	18 August 2008
Participant Consent Form	5	18 August 2008
Participant Consent Form	4	26 June 2008
Response to Request for Further Information		
Letter from deputy chair of the Research Degrees Board		10 July 2008
CV - Robyn Martin	2	26 July 2008
Research Proposal	3	26 June 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0714/73

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



A Mittu
Committee A Co-ordinator

Enclosures: "After ethical review – guidance for researchers" [SL-AR1 for CTIMPs, SL- AR2 for other studies]
Site approval form

Copy to: Prof. Robyn Martin
[R&D office for NHS care organisation at lead site]

Appendix 6: Letter to Women

Women in Partnership Study

Dear Mother to Be

I am writing to invite you to take part in a research study that I am planning to undertake with a small group of pregnant women in the area. I have asked your community midwife to give you this letter to allow me to introduce the study to you. The study is being undertaken to meet the requirements of a professional doctorate programme that I am undertaking at the University of Hertfordshire. I am a midwifery lecturer at the University of Hertfordshire and I am studying '*Women's views on partnership working with midwives during pregnancy and childbirth*'. I want to know what it is women want from their midwife whilst receiving care during pregnancy and after the baby is born.

If you would like to take part in this study I will ask you to complete a diary during pregnancy about the visits that you have with the midwife. I will meet up with you at the end of your pregnancy to interview you about the things you have written in your diary at around 34-36 weeks of pregnancy and again at 2- 4 weeks after the baby is born.

If you would like more information about this study you can either ring me on 01707 285242 or e-mail me on S.boyle@herts.ac.uk. If you would prefer your midwife can contact me and give me your details and I will contact you. If you decide that you would like to take part in the study I will meet up with you to gain your written consent and to give you the diary. You are free to withdraw from the study at any time, without giving a reason. This would not affect the standard of care you receive in any way

Thank you for taking the time to read this letter and I look forward to hearing from you if you decide you would like to take part.

Kind Regards



Sally Boyle
Chief Investigator, Women in Partnership Study
Lead Midwife Education
School of Nursing and Midwifery
University of Hertfordshire
College Lane
HATFIELD
AL10 9AB

Appendix 7: Details of Study Participants

Study Participants: Brief Summary by Pseudonym

Olivia

Olivia was a 41 year old white British woman who has five children from her previous marriage. This was her first pregnancy with her new partner. Olivia and her partner are both hairdressers and they own their own salon. Olivia had her last baby at home and planned to have this baby at home also. She knows her midwife who looked after her during the last pregnancy and stated in her diary that she is very confident with her midwife. Olivia's pregnancy was quite straight-forward and she had continuity of care from her midwife throughout. Towards the end of her pregnancy she had an appointment with an Obstetrician because it is unusual to have a home birth with a sixth child because of the risk of heavy bleeding. This made her anxious and question whether a home birth was safe. However after this appointment she did decide to have her baby at home. Olivia gave birth to a daughter at home and was delivered by her community midwife, who she described as a friend. Olivia chose to maintain a handwritten diary.

Ruby

Ruby was a 37 year old white British woman who has two children aged 17 and 12 years. She is married and lives in a local town. She had studied midwifery at the University for a couple of years but decided it was not the right career choice for her. She now works at the local hospital as a phlebotomist. Her third pregnancy was unplanned but she wrote in her diary that whilst she and her husband were slightly apprehensive they were excited about having another child. Ruby had a pulmonary embolism in November 2006 and discovered that she has an abnormality that gives her a slightly higher risk of a thrombo-embolism. Because of this she has booked for Consultant Unit delivery. Ruby had continuity of care from her community midwife who had also been her mentor whilst she was a student midwife so they had an established relationship. At 26 weeks of pregnancy Ruby slipped and fell resulting in a broken leg so had some of her antenatal care at home. Five days after this she was diagnosed with a deep veined thrombosis in her groin and had to be treated with anti-coagulants. Ruby went over her due date and was given two cervical sweeps in an attempt to stimulate labour. At nine days over her due date her waters broke spontaneously and she started to labour. She was admitted to the local hospital where her community midwife came in to deliver her son. Her delivery was straight forward. Ruby was discharged home the next day. Ruby chose to maintain a handwritten diary

Chloe

Chloe was a 21 year white British woman who was expecting her second child; she has a two year old daughter. She lives with her partner Ben who is an electrical engineer. This is Ben's first child. Chloe chose to keep the handwritten diary. Chloe is an articulate young woman who is trained as a hairdresser. Chloe had continuity of midwifery care from the midwife who had

delivered her daughter. She wanted to have a waterbirth for this baby in the local birth centre. At thirty one week's her baby was bottom first but turned naturally during pregnancy. She saw the Consultant midwife at thirty two weeks to discuss the water birth. At term she had a cervical sweep as contracting irregularly. Three days later following irregular contractions since the sweep she went into strong labour. She delivered her baby in the birthing pool and went home later that day. Chloe did not know the midwife who delivered her daughter, but she described the experience as fantastic because the midwife stayed with her throughout her labour.

Emily

Emily was a 39 year old black African woman who was expecting her second child. She planned to deliver at her local birth centre which is where she had her son. Emily appeared a very confident woman who stated that she would ask to make sure she achieved the kind of experience she wanted. Emily works in finance. Her antenatal care was shared between the midwife and GP at the GP surgery. In addition a small number of her visits were undertaken at the birth centre. In fact Emily only ever saw the GP at the surgery and the midwife at the birth centre so did not have any continuity of care. Her pregnancy was overdue so she was admitted to the Consultant Unit for induction of labour. She had a short labour and normal delivery. Emily was discharged home the next day. Her postnatal care was provided by midwives from a different area so she did not know them. Emily's postnatal recovery was good and she successfully established breast feeding. Emily did not perceive that she developed a relationship with any of the midwives who cared for her. She maintained an electronic diary.

Sophie

Sophie was a 38 year old white British woman who was expecting her first child. She was an IT manager. She planned to have her baby at the local birth centre but this was dependent on her weight as her BMI was quite high. Her antenatal care was undertaken by a small group of midwives on the birth centre where she received good continuity. During pregnancy she suffered from lax pelvic joints which caused her a lot of pain on mobilising. She went twelve days overdue and required an emergency caesarean section for prolonged labour. Her son had a cerebral bleed after birth and was transferred to a specialist unit for observation. She was told that he would be monitored during infancy to observe for long term side effects. Sophie maintained an electronic diary but did not complete this postnatally because she was busy visiting her son who needed to stay in hospital for some time for observation. Sophie felt she had formed a relationship with a small number of midwives at the birth centre.

Jessica

Jessica was a 36 year old white British woman who was expecting her first baby. Both Jessica and her husband were University lecturers in life sciences. This pregnancy resulted from in-vitro fertilisation treatment (following 3 unsuccessful cycles of infertility treatment). Her infertility resulted from polycystic ovaries. In early pregnancy some of the cysts burst resulting in a short

hospital admission. Jessica planned to have her baby at the local birth centre and wanted a water birth. Jessica planned to work until she was 38 weeks pregnant. She maintained the diary by hand. Jessica remained well throughout the remainder of her pregnancy, went into spontaneous labour at thirty nine weeks and delivered in the birth centre. The labour was quite quick and she did not have time to use the birth pool. She came home later that day. Had some problems with breast discomfort postnatally so attended the drop-in clinic for advice. Otherwise adjusted well to parenthood. Jessica did not feel that she formed a relationship with the midwife despite having continuity of care – she described this as being because the midwife was busy and her care felt like a ‘production line’. Because of this she did not ask any questions and did not feel she was offered any choices.

Grace

Grace was a 33 year old white British woman who was expecting her third baby. Grace and her husband both work in journalism; Grace is freelance so works from home. Grace was well throughout pregnancy. Her baby was presenting by the breech towards the end of pregnancy but turned spontaneously. However, her labour was induced because she went 13 days overdue and whilst her membranes had ruptured there was no sign of any contractions. Grace ended up requesting an epidural for pain relief and soon after delivered her third daughter. After the birth Graces suffered from severe headaches and was treated twice for a dural tap, both times requiring readmission to the maternity unit. Grace received continuity of care from two midwives who had looked after her in a previous pregnancy. However she did not feel that she had a partnership relationship as she was not offered any choices or given an opportunity to discuss anything about her care. She did not know the midwives who cared for her during her daughter’s birth but described the experience positively even though it was a very medically orientated birth and very different from the water birth she had planned for. Grace maintained an electronic diary.

Lily

Lily was a 36 year old white British woman who was expecting her second child. Lily is a marketing director and works flexibly with her husband so that they can both share the care of their son who was only 19 months old when I met them. Lily had planned a home birth for her first child but this had to be abandoned due to a boiler failure so she planned a water birth in the midwifery led unit. In fact because her baby was showing signs of distress during labour she ended up delivering him by vacuum extraction. In this pregnancy Lily is planning a water birth at home again but recognises that she may not achieve this. She was cared for by two community midwives who cared for her with her son. However, Lily did not feel it was worth expending energy in developing a partnership relationship with the midwives as she said there was no guarantee that they would care for her in labour. Lily delivered her daughter at home in a birth pool. She had not met the midwife who cared for her before but felt a good rapport with her and described having a very positive birth experience. Lily maintained an electronic diary.

Amelia

Amelia was a 35 year old white British woman who was expecting her second child. She worked as a manager at a children's nursery and planned to work until she was 36 weeks pregnant. Her last baby was born by emergency Caesarean Section because of high blood pressure. This time she was having community based care from the midwife who cared for her with her son, although her baby was being delivered at the local Consultant unit. She would like to have another Caesarean section but feels she has to tell the midwives she would like a natural birth. Amelia's pregnancy was complicated by raised blood pressure and at the end of pregnancy she had a small bleed. Because of this she was delivered by an emergency Caesarean Section. She stayed in hospital for three days and was seen seven times postnatally. Amelia had good continuity of midwifery care antenatally but not postnatally. However when the midwife that provided her antenatal care visited her after the birth she talked about feeling like it was a relationship of professional friendship. Amelia maintained a hand written diary.

Evie

Evie was a 40 year old white British woman who is expecting her first child. She works in financial services and her partner is a Banker. She wanted a natural birth stated that if she found this difficult she would have an epidural. Her care was provided by a small group of midwives in the midwifery led unit. Her pregnancy was straightforward. Evie had good continuity of care from the birth centre midwives and had long appointments to discuss all her queries; she felt that she had developed a relationship with them and was a partner in care. She also attended NCT antenatal classes. Evie went into spontaneous labour at term. She found contractions very painful and wanted an epidural so was transferred to the delivery suite. When she arrived the baby was distressed so she ended up with a forceps delivery. Evie went home two days later and had good support from the midwives and the breast feeding advisor and drop in clinic. She successfully established breastfeeding. Evie kept an electronic diary.

Ella

Ella was a 29 year old white British woman who was expecting her first baby, conceived following infertility treatment and two cycles of intrauterine insemination (IUI). Ella trained as a property lawyer but had recently been made redundant. She planned to have a natural birth in the midwifery led unit. However, Ella's pregnancy was complicated by an over active thyroids and she had a number of additional appointments with both the midwife and the medical staff at the combined clinic. Ella also had raised blood pressure towards the end of pregnancy. Despite having continuity of midwifery care Ella did not form a relationship with the midwife and was not offered an opportunity to make informed choices about her care. Her birth was also induced because of her high blood pressure and her baby was born by emergency Caesarean Section as the induction failed. Her baby also spent the first few days in the neonatal unit because of Ella's medical problems. Ella maintained an electronic diary.

Isabelle

Isabelle was a 32 year old white French woman who was expecting her first baby. Isabelle and her husband were both students studying in the UK. Isabelle also ran a small business as a relocation agent but closed this down as the business was not doing well. Isabelle received care from the community team but did not feel she received continuity of care or that she was able to build a relationship with the midwives because of the biological focus of the visits and the short time given to the appointment. Isabelle was very anxious during pregnancy and used internet forums as a source of advice and support. Towards the end of her pregnancy, Isabelle visited the midwifery led unit and birthed normally there. She found the environment of the MLU better than the visits to the community midwife because here the midwives had more time and she felt they were more professional. Overall Isabelle did not receive continuity of care and did not form a relationship with the midwives; in fact she talked of a sense of distrust following a number of her visits, suggesting that during her birth that the midwives were lying to her. Isabelle suffered from postnatal depression during her early postnatal weeks, aggravated by feelings of anxiety about her baby's progress; she was supported by her mother who came over from France. Isabelle maintained an electronic diary.

Megan

Megan was a 36 year old white British woman who was expecting her first baby. This pregnancy was unexpected as she is sub-fertile due to polycystic ovarian syndrome and is also overweight with a high BMI. Megan works in marketing and appears to have quite a high pressure job. Despite her health issues she is hoping she will be able to have her baby in the midwifery led unit. Megan confessed to being anxious about the pregnancy and tried to reduce her anxiety by avoiding searching internet sites and by taking advice from the midwife. She did not form a good relationship with the midwife identified as her named carer so used strategies to try to ensure that her appointments were with the other midwife at the surgery who she felt confident in. Megan was induced following spontaneous rupture of her membranes. Her birth was induced and her daughter was born using forceps for delivery. Postnatally Megan developed a breast infection and had to stop breast feeding. Despite a number of contacts with Megan, I was unable to get her to agree to meet me for the second interview which was a shame. Megan kept an electronic diary.

Daisy

Daisy was a 29 year old white British woman who was expecting her first baby. She was a paediatric nurse and because of her background initially wanted to deliver in the Consultant unit. During her pregnancy she was tested for gestational diabetes as her baby was large on the scan and she had glucose in her urine. The results were negative. Daisy was quite anxious in pregnancy and disappointed that she did not receive any continuity of care. She shared care between the midwife and her GP. Towards the end of pregnancy she was admitted because of high blood pressure and her labour was induced. Daisy had a normal delivery but because her baby was quite large he had to go to special care for blood sugar monitoring. Daisy was

discharged home two days later. Daisy maintained a hand written diary.

Lucy

Lucy was a 31 year old white British woman expecting her first baby. She had a history of depression and polycystic ovarian syndrome and had been told that she would need infertility treatment to get pregnancy so she was shocked to find she had become pregnant naturally. She devised an extensive birthing plan wanting a waterbirth but was open to medical intervention if required. Lucy was a bar worker and lives with her partner in a one bed roomed flat; she also had a dog and three cats so it is very busy. Lucy booked late at thirteen weeks and was not seen again until 26 weeks because she did not know she had to make an appointment. Lucy had not continuity of care and felt very unhappy about the disjointed nature of her care. This is concerning given her history of mental health issues. She was admitted to hospital with raised blood pressure at term and her labour was induced but she delivered normally. Lucy kept a hand written diary. Postnatally she managed well with her baby who she successfully breast fed. Lucy maintained a hand-written diary.

Ava

Ava was a 30 year old white British woman expecting her first baby. She worked as an electrical engineer. Ava's pregnancy was quite straight forward until the last few weeks when her baby was found to be presenting by the breech. Ava was seen by the obstetrician who tried unsuccessfully to turn the baby around. As the baby remained breech Ava was booked for an elective caesarean section. During this period Ava became very anxious. When I met her at 36 weeks she was tearful and expressed feelings of anxiety due to the fact that in her family there had been a number of complicated births. She had not received continuity of care from her midwives and had not formed a relationship with any of her carers. She was very concerned that the medical staff were suggesting her baby should be born whilst she was awake using an epidural anaesthetic and felt she had to fight hard to get agreement from the medical staff for her to have a general anaesthetic. The birth itself was very traumatic because the staff she met on the day again tried to persuade her to have an epidural. She discussed afterwards that she had a panic attack because she was so anxious about this. When I met Ava in the postnatal period it was clear that the trauma of her birth was still an issue for which she was receiving support and counselling. She was unable to breast feed her son because she found the close proximity of this interaction too difficult so was expressing breast milk and feeding him from a bottle. I found it surprising that from the very early days after her son's birth that she wanted space to be alone. Ava appeared depressed but was receiving medical and psychological support for this. Ava maintained an electronic diary.

Appendix 8: Study Participants Outcome Data

Women in Partnership Study Outcome Data

Pseudonym	Age	Parity	Plan	Outcome	Date of Birth	Sex	Birth Weight	Method of Feeding
Olivia	41	P5	Home birth	Home Birth	27/5/09	Girl	3.628g	Formula
Ruby	37	P2	Birth centre	Birth Centre	26/4/09	Boy	4.082g	Breast
Chloe	21	P1	Birth centre	Birth Centre	13/6/09	Girl	3.770g	Breast
Emily	37	P1	Birth centre	Obstetric Unit, Post mature, Birth induced Normal delivery	16/7/09	Girl	3100kg	Breast
Sophie	38	P0	Birth centre	Obstetric Unit – Emergency Caesarean Section, prolonged labour	19/7/09	Boy	3.885g	Formula
Jessica	36	P0	Birth centre	Birth centre	27/5/09	Girl	4.053g	Breast
Grace	33	P2	Home birth	Obstetric Unit, Post mature, Birth induced, Normal Delivery	2/9/09	Girl	4.650g	Breast
Lily	36	P1	Home birth	Home birth	3/8/09	Girl	3.400g	Breast
Amelia	35	P1	Obstetric unit, previous CS	OU, Emergency Caesarean Section, antenatal bleed	6/10/09	Boy	2.720g	Formula
Evie	40	P0	Birth centre	Obstetric Unit, Forceps Delivery for fetal compromise	22/8/09	Boy	2.835g	Breast
Pseudonym	Age	Parity	Plan	Outcome	Date of Birth	Sex	Birth Weight	Method of Feeding

Ella	29	P0	Visiting Birth centre	LSCS failed induction for post maturity	6/12/09	Boy	3.315g	Breast
Isabelle	32	P0	Birth centre	Birth centre	11/11/09	Girl	3.160kg	Breast
Megan	36	P0	Birth centre but high BMI	Obstetric Unit, Prolonged rupture of membranes, Normal Delivery	29/11/09	Girl	3.120g	Formula
Daisy	29	P0	Birth centre	Obstetric Unit, Induction of labour for post maturity, Normal Delivery	15/11/09	Boy	4.620g	Breast
Lucy	31	P0	Birth centre	Obstetric Unit, Induction of labour for pre-eclampsia. Normal Delivery	11/2/10	Girl	3.400g	Breast
Ava	30	P0	Birth Centre	Obstetric Unit LSCS for Breech, failed External Cephalic Version	4/3/10	Boy	3.855g	Mixed, expressed breast milk and formula

Appendix 9: Interview guide

Interview Guide

General introduction

Thank you for agreeing to see me today. Would you mind if I record this session so I can concentrate on what you have to say?

The session should take between an hour and an hour and a half today and you are free to stop at any time – is that OK with you?

I will write up what you say but I will not use your name in the transcripts but will refer to you by a Greek letter to protect your anonymity. I will also send you a copy of the transcript if you would like to read it so you can check it to see if I have made sense of what you said or for you to clarify anything later.

As I have already discussed with you, today I want to talk with you about your experiences during your antenatal appointments with the midwife. I have read your diary and will use this to explore in more detail what has happened so far.

Tell me about your first visit with the midwife?

What information did you receive before your visit?

Prompts – Tell me more about.....reflect back to gain more depth
What was it aboutreflect back issue raised

Did the midwife offer you choices about your care / place of birth?

How do you feel about your relationship with the midwife?

Do you feel you have been offered choices by the midwife?

Prompt Can you give me an example?

Do you think the advice you have received from the midwife has been consistent?

Is there anything else that you would like to share with me?

Eg of specific issue from the diary: [Examples drawn from the pilot]

Can I take you back to the discussion on pain relief (stated that she was considering an epidural at the first visit); what has led to your change of mind?

When you talked about breast feeding ...How do you feel about the fact you have been unable to see the breast feeding advisor?

Prompt? That's interesting, why do you think that?

From Green (2000) – questions that may result in assessing women's experiences of the quality of their care:

Asking, for example:

1. . whether she ever had conflicting/confusing/inconsistent advice
2. . whether there was always someone available when wanted
3. . whether she felt adequately informed
4. . whether she felt in control of what caregivers did
5. . whether care was felt to be deficient in anyway.

Appendix 10: Midwives Information Leaflet

Midwife Information Leaflet

Women in Partnership Study

Study Number: 08/H0714/73

Women's views on partnership working with midwives during pregnancy and childbirth.

This is an invitation for you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you have any questions my contact details are at the end of this leaflet.

What is the purpose of the study?

The purpose of the study is to identify your views about the relationship you develop with women during the time you provide midwifery care, specifically in relation to partnership working and informed choice. I will compare your views with those of some of the women who have been cared for by midwives in this area. Anything you say to me will be anonymous as I will use a false name to protect your confidentiality. The findings will be used to strengthen partnership working between midwives and women in the future

Why have I been invited?

You have been invited to take part in this study because you are a community or hospital based midwife who provides midwifery led care.

Do I have to take part?

No, it is up to you to decide whether you would like to take part. If, after you have had time to read the information sheet and discussed it with others, you would like to take part I will meet up with you. I will go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you agree to take part I will ask you to participate in a focus group with around six to eight midwives. I will ask for your views and will also share some of the issues raised by the women in the first phase of this study so I can hear your thoughts about the key areas identified.

The time taken to participate in the focus group will be about one hour and will be recorded with your consent. This time will vary depending on how much you want to say to me. I will also ask

permission to bring a colleague with me to act as an observer to note down any non-verbal elements in the focus group. This will allow me to concentrate fully on what you are saying to me.

The focus group will be arranged in a place that is convenient for you. This could be at a local clinic, in the G.P's surgery or at the hospital. The session will be led by me. The information you provide will remain confidential and the tapes will only be heard by me and my research supervisor. The record of the tapes will not identify you by name and so anything you say will be confidential.

Participation in this study is voluntary and there is no funding available for you. For this reasons disturbance to you will be kept to a minimum and all meetings will be held at a location that is convenient for you.

What will I have to do?

You will need to meet up with me so that I can explain what will happen during the focus group and gain your permission in writing. At this meeting I will answer any questions you may have. If you would be willing to take part in the focus group you will need to meet with me on one occasion to talk about your experience.

What are the possible benefits of taking part?

Taking part in this study will help to identify aspects of care that may help to enhance the relationship between midwives and women. Your views may help to ensure that women are able to work in closer partnership with midwives in the future.

Are there any risks?

There are no significant risks or disadvantages to you in taking part in this study. I will take every effort to maintain your confidentiality although it is possible that this could be breached during the study. The study only involves you taking part in a focus group with a small number of your colleagues and talking to me about your experience of providing midwifery led care. If you have any concerns about this study you should contact me, Sally Boyle on 01707 285242 or e-mail S.Boyle@herts.ac.uk, so we can discuss them.

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study.

Will my taking part in the study be kept confidential?

Yes. Your name will only be known by me during the research study and I will use a false name for you when I write up the study. No information will be given to anyone other than me and my research supervisors. At the end of the study all audiotapes and transcripts will be stored in a locked filing cabinet for a period of ten years. After this period they will be destroyed.

What will happen to the results of the research study?

The study will be completed in the summer of 2011. Results from the study will be shared with midwives and doctors during workshops and conferences to help us to determine the best ways of using this information in future care. The findings will also be made available in magazines for pregnant women and health care journals. If you wish I will send you a summary of my findings. At no stage will you be identifiable during this process.

Who is organising and funding the research?

I am undertaking this study as part of a professional doctorate at the University of Hertfordshire. I am not receiving any external sponsorship for undertaking this work. The University of Hertfordshire is my academic sponsor.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Joint UCL/UCLH Committees on Ethics of Human Research (Committee A).

What if you have some questions about the study?

If you would like to find out more about this study before deciding whether to take part, you can contact me, Sally Boyle on 01707 285242 or e-mail on S.Boyle@herts.ac.uk. You may have to leave a message on an answer phone but I will get back to you as soon as possible. If you have other concerns about taking part in this study, your midwife may be able to answer them.

What happens now?

- If you agree, your midwifery manager will give your name and telephone number to me so that I can discuss the study with you
- If you are interested in taking part I will arrange a date to meet up with you to discuss in detail what you will need to do. If you have decided you do not want to take part, I will not try to persuade you.
- I will explain more about the study when I meet you, answer any further questions, and, if you decide to take part, I will ask you to sign a consent form.

Thank you for taking the time to read this information and please do not hesitate to ask for any more information if you need it.

Sally Boyle, Principal Investigator
School of Nursing, Midwifery and Social Work
University of Hertfordshire
College Lane
Hatfield, HERTS
AL10 9AB
Tel: 01707 285242, E-mail: S.Boyle@herts.ac.uk

Appendix 11: Focus group prompt sheet

Focus group: General introduction and prompt sheet

Thank you for agreeing to see me today. Would you mind if I record this session so I can concentrate on what you have to say? The session should take about an hour and you are free to stop at any time – is that OK with you?

I will write up what you say but I will not use your name in the transcripts but will refer to you by a letter to protect your anonymity. If you would like a copy of the transcript so you can check it to see if I have made sense of what you said or for you to clarify anything later I will send you one. As I have already discussed with you, today I want to talk with you about the relationship you develop with the women you provide care for during childbirth and the extent to which you think this is could be or should be a partnership.

Prompts

What do you feel the antenatal / postnatal visits are about – what are you trying to achieve?

Psychosocial versus medical

Time/frequency of visits – how is this determined?

How would you describe the relationship that you develop with women?

Prompt How do you see your role in the relationship?

Do you see this as a partnership?

What choices do you feel you offer women?

What factors impact on this?

What do you feel about continuity of care?

Are you able to provide this?

Does this include intrapartum care?

Are there any changes that you would like to see in the way you provide care?

Is there anything else that you would like to share with me?

Appendix 12: Midwives Consent Form

Study Number: 08/H0714/73

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Women in Partnership Study**

Women's views on partnership working with midwives during pregnancy and childbirth.

Name of Researcher: Sally Boyle

Please initial in the box

1. I confirm that I have read and understood the information sheet dated 1st April 2010 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. Any information collected before I withdraw from the study may be used by the researcher, providing it has been anonymised.

3. I understand that I will be offered an opportunity to review the transcripts from the focus group with the researcher.

4. I give permission for the researcher to use quotes that have been anonymised, in any reports or publications that arise from this research.

5. I agree to take part in the above study.

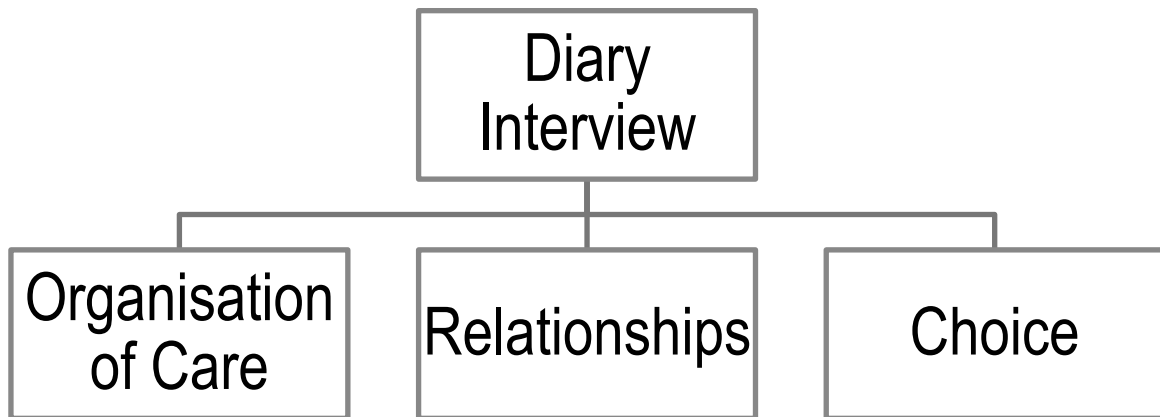
Name of Participant Date _____ Signature

Name of person Date _____ Signature
taking consent

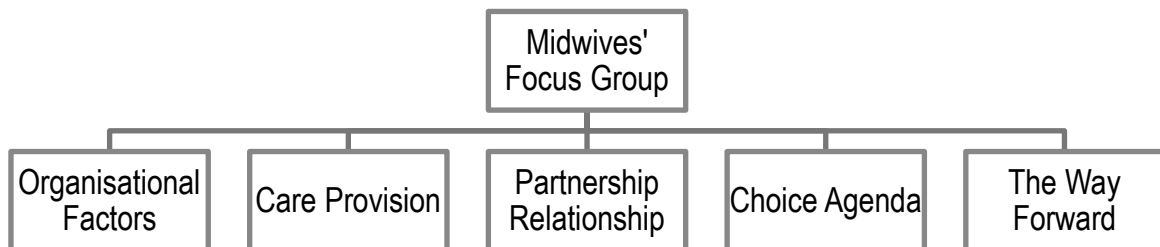
Local midwives, general practitioners and obstetricians are aware that this study is taking place.
When completed, 1 copy for the participant; 1 copy for researcher site file

Appendix 13: Coding Tree

Diary Interview: Overview Coding Tree

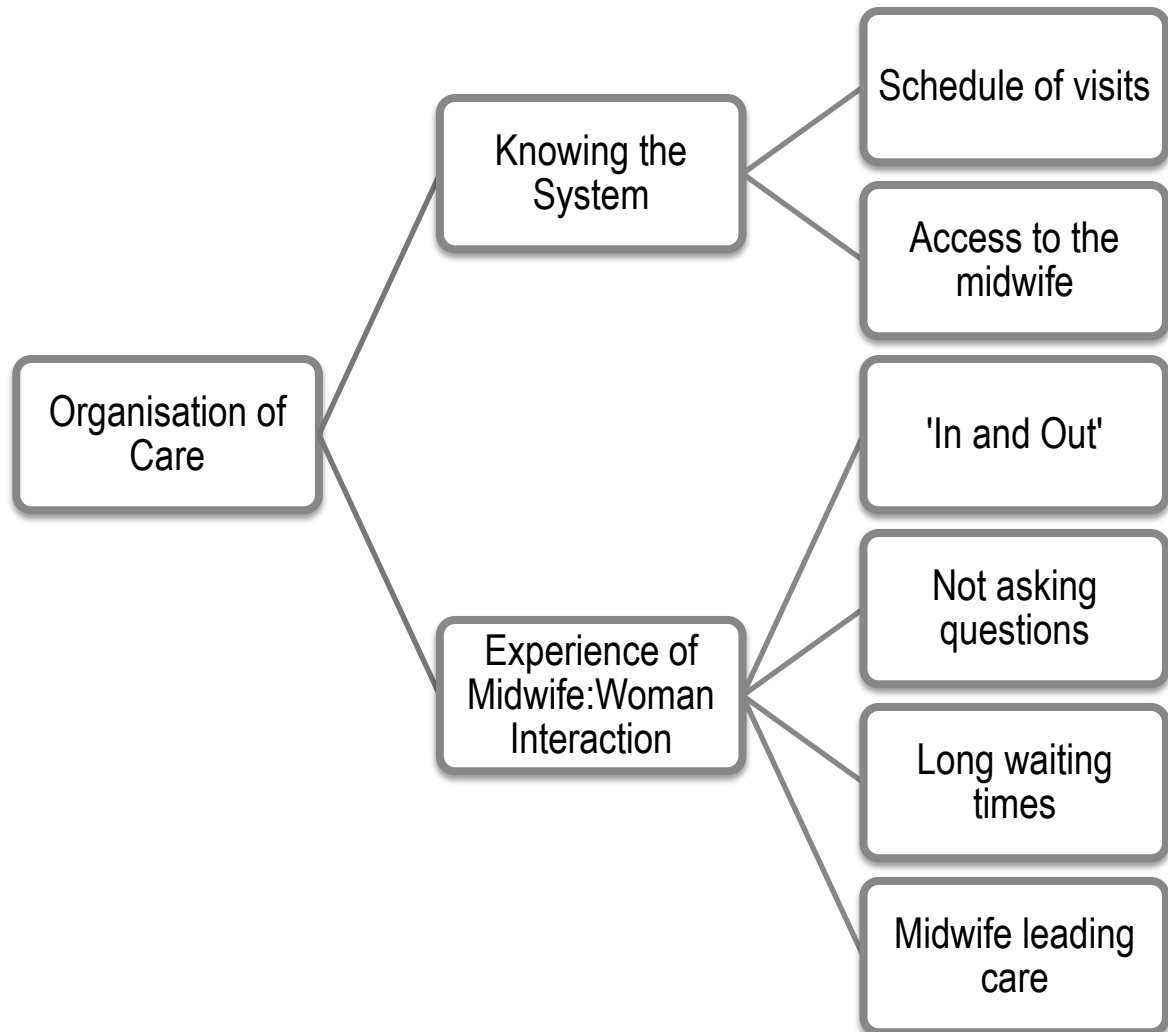


Midwives' Focus Groups: Overview Coding Tree



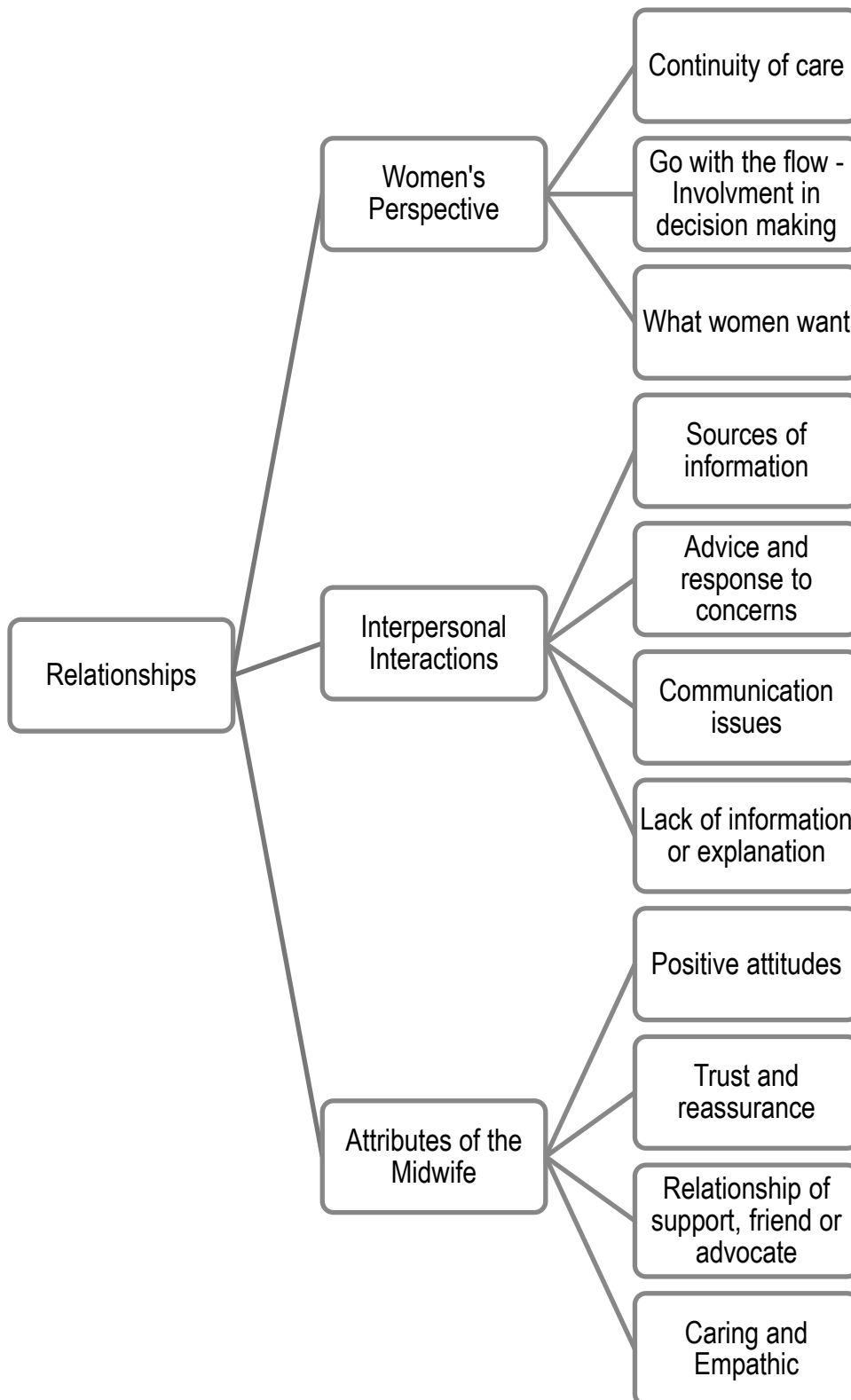
Diary Interview: Overview Coding Tree

Sub-codes: Organisation of Care



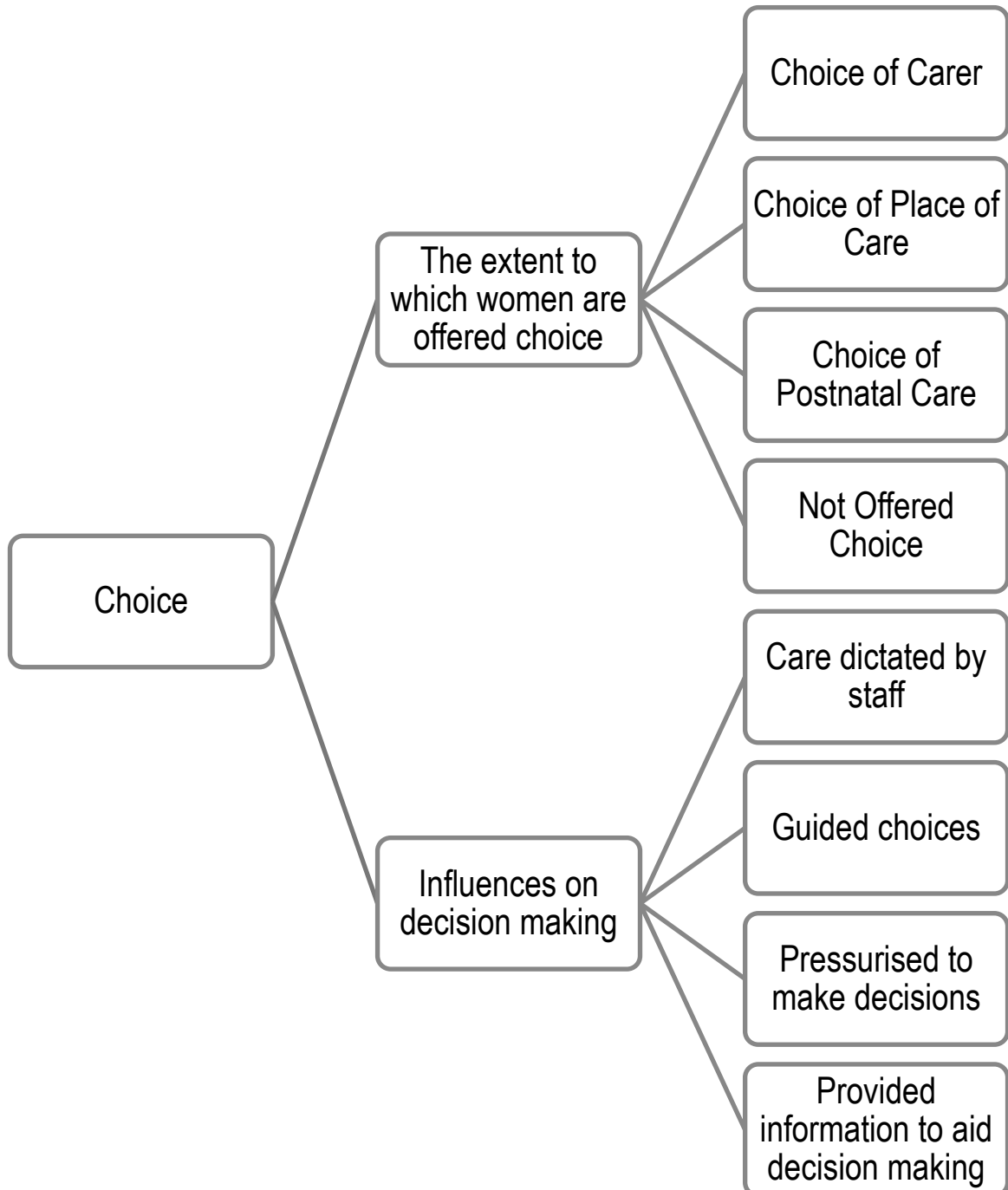
Diary Interview: Overview Coding Tree

Sub-codes: Relationships

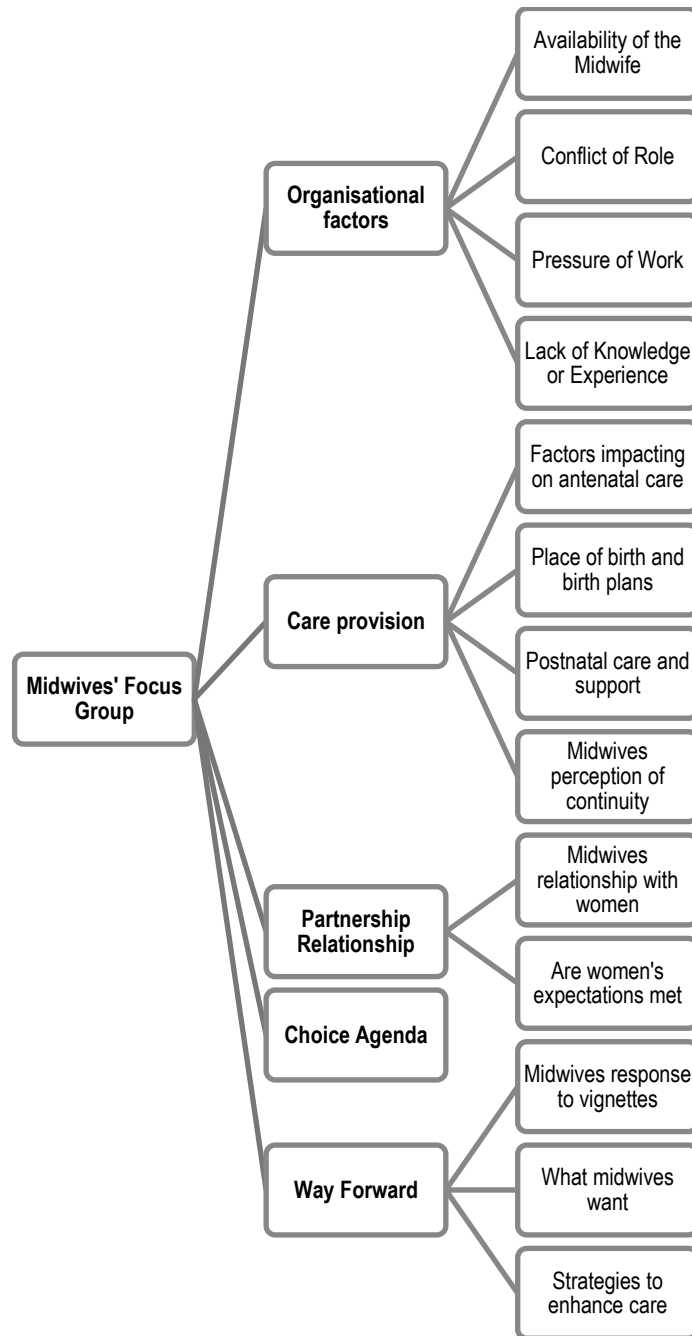


Diary Interview: Overview Coding Tree

Sub-codes: Choice



Midwives' Focus Groups: Coding Tree



Appendix 14: Example of a comparative analysis

Comparative Analysis: Organisation of Care

	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Olivia	I felt that this time you don't seem to be seeing the midwife very much. Is it right that the aftercare has been reduced as well	I text or ring her. She gets back to me and reassures me. I'd had a show and I text my midwife and she said if you need me I will come straight back, About four o'clock I text her and I said they were coming every five minutes, and she was with me really quick, and it was all systems go from there.	It's usually in, blood pressure, pop on the couch and then I'm out again, which is fine – about ten minutes	just in general worries that you don't want to always ask because you know there's women outside waiting to come in, or probably know that the midwife's been asked this by the previous five women and you kind of don't want to say it again, so that's the way I feel		
Ruby	I've had so many appointments to go because I've seen the Consultant as well, so actually I've felt like perhaps I didn't sort of need to have any more.	I have contacted the midwife in between appointments if I've just wanted to query something. My midwife had said you can call me direct, and my husband phoned her and she was there. I was worried that she wouldn't get there in time. I was always made to feel that my care was paramount which was lovely actually because I did worry about that.				
Emily	It would be good to have a tick sheet so we know when we should be seen next.	You expect the health care to be more structured, and if I choose to be casual about it that is my choice. I could have missed some appointments and they wouldn't have noticed.	it's very functional, the check-up, yeah its very remote, you know, it's almost like there's this list of things to do, tick, tick, tick, basically its tick, tick, tick your fine, she is very busy and chock a block with appointments, so she just needs to churn them out so I think that unfortunately is the problem, because they just		I think that kind of affects everything, but in general I think they were just too busy that day. I waited a long time and she was distracted, probably she had another appointment, it was just not flowing, I think there was something going on, so it impacted on everything. She apologised but nothing else. I	I think the waiting really is the killer, most appointments I've had, haven't been on time. It seems that health care can be late but if you are late they make you feel so bad but we are supposed to be understanding if they are running late. I think it there was access to read the notes it would speed up the

			churn people out (5-10 mins). There needs to be bits where it's not just a box you're ticking. You are trying to remember that it's a relationship; it's a real person not a machine sort of thing.		think if there's resourcing issues that needs to be sorted out internally, it shouldn't be something that's so obvious to the patient. I felt that determined a lot of the treatment, and the ward was understaffed. There were actually lots of midwives around, but they must be doing different things but for our room there was only one. The community midwives as well seem to be stretched	appointment and probably free up time to actually do and to talk about stuff that you really want to talk about. But if we are going over the notes again it is just like...
	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Sophie	I should have asked this and where we have the appointment every two weeks it's not too long to wait, whereas before, one appointment a month, that's quite a long time to wait if you've got concerns.	I've phoned her up on a couple of occasions when I know she's been working at the birth centre, just to ask questions and she has been very, very informative and helpful, but you know she encouraged me at those times to phone her	just follow a pattern really, how you feeling, taking in your urine sample, bloods need to be taken she would do those, but no its, I think it's because I haven't had any issues it's been quite straight forward each appointment (30 mins)		I don't think we ever got to the bottom of that (requesting pain relief in early labour - refused as on ward). I'm assuming that, I, that it was busy, or there wasn't enough staff up there, I'd say it was probably because it was busy, um...	
Grace	It would be good if they said come back in three weeks unless you think you need to come back earlier. It's just that six week gap; I would have liked to have another appointment. I don't know why or whether there is any possibility of having more frequent appointments	I suppose the only thing is if they said look if you have any problems then you can phone (the clinic), although in the end I did, but it would have been good to have been told that.	I know the routine, they take your blood pressure, have a feel, measure the bump, ask if you've got any questions, it just follows a routine, about 5 minutes	Sometimes I get the impression that they're under time pressure and so that makes me less likely to ask any questions that I might have		

	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Chloe	You don't have as many appointments so whereas like I've got an appointment next week but then there was like three and a half weeks between appointments that means you have big gaps.	It did seem like a long time but she did say to me if you have any questions or if you want to come in, in between just to be reassured then come in but if you're feeling her moving around then don't worry too much. if I've got a question I can ring her	I just go in, get checked and come out, I 'm not really that worried about..			
Jessica	I just wanted to know about how many appointments I would need and when the routine scans were; that was what I wanted to find out at that time and she was forthcoming with that.	She seems to communicate quite a lot with people and when I had that really high blood, urine sugar, she said this is absolutely sky high I'm going to take some blood and I'm going to get back to you and I didn't hear anything so I texted her about a week later and she said oh yes, sorry, I forgot to tell you it's all fine, forgot to tell me.	It's just a production line, in and out, in and out. I think she's met it in terms of the mechanics of, blood, blood pressure, all that sort of stuff but maybe a bit lacking in the, the emotional; maybe it's my unrealistic expectation of what a midwife is supposed to do, they might think I'm not an agony aunt, I'm not a counsellor, I've got seven minutes per appointment, I've only got limited time and the most important thing is your physical health and maybe that's more important rather than the emotional side of things.	I felt a bloody idiot keep asking these silly questions, so in the end I tended to not ask, and if I want to find anything out I will talk to other people, talk to friends, use the internet or read a book. If I don't feel I'm going to get a good rapport from someone I tend to not say anything. Once I knew that that wasn't what was going to be on offer (emotional support) I withdrew and just thought oh well, fair enough I've got it wrong I was expecting a bit more of a lead from her as the experienced person, I don't know what to ask, sometimes your questions come as a result of someone telling you some bits and you think oh what does that mean.		
Daisy	There's such a gap in between seeing the midwife, 'come and see us in eight weeks time' and that was it. Now they're two-weekly but when it's four-weekly, that's quite a gap,	I did ask who's going to check my stitches then, and she said I could phone if I thought that I had problems with them, which I didn't think I had an infection or anything like that, I was just	It's just been, 'right, we'll do your blood pressure, check your urine and perhaps feel your tummy and that's it, off you go'. I've only seen them once for five minutes; it's not	In the back of my mind I had lots of questions, but didn't ask any of them because I just didn't feel comfortable in asking them. I'd hoped that, every time I went to see the	I think because possibly there's a shortage of midwives and you know, the people aren't there to do the classes because they're delivering babies. You know, every	

	when you've got questions and anxieties. PN I felt that it was very poor to be honest, I expected to be seen a whole lot more than I was, I thought it would be ten days and it was three.	really sore, but then I felt that I didn't need to call a midwife, I don't know you feel that you would be calling them out for nothing, (PN)	enough time to get to know somebody. The others wouldn't prompt the questions actually, because they were probably overrun with the amount of people that they had to see and needed to get me in and out, that's how I felt.	midwife she might say, 'have you thought about this or that? Because we're health care professionals we feel we should know. But at the end of the day we're not midwives, we're nurses, you know, it's completely different	where's short staffed and who knows when you're going to deliver, that person might not be on duty	
	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Ella	Fairly often for first time mums. For second time mums it seems very few. I can imagine that being quite disconcerting going six, seven weeks without seeing the midwife. Also why don't they schedule the visit to fit with the HIP grant?	I try and avoid seeing E but she just seems to always be working. I'd like to see another midwife	'I felt a bit like I'm on a production line'. Go in, yes your blood results are fine, keep taking tablets, hear the baby's heart beat, blood check, blood pressure check and right you're gone. She probably provides the bare essentials of care. It's just, bog standard. Probably what I expect, but nothing beyond that. Certainly hasn't ticked the 'exceeds expectations' box, she just wants to see you, get you out of the room and go onto the next patient, in the quickest possible way	I found them reassuring to hear the baby's heart beat but they didn't answer any of my questions. Not that I really had any perhaps but after going to one or two, I didn't go with any questions.		When you're sat in the waiting room and you've been waiting for twenty-five minutes and she comes out and there's no apology or, 'sorry I'm a bit late or... 'that's not very good'. But when you go to the doctor's you usually have to wait don't you so you never really expect to be on time
Isabelle	The first time I saw the midwife was at week seven and the next time I actually saw someone it was at week twenty-three; which I thought was a huge gap.	I was still not sure how to book the appointments and I wasn't sure if she was supposed to do my antenatal care, or if I had to go to my midwife. So I thought, just in case I'll book it. If you can't make an appointment they will actually squeeze you in the next day or try to accommodate you. I'm quite happy with it (birth centre)	The same routine really, checking the blood pressure, the urine and then checking, you know, the baby's fine, moving. Then they check the position and the heart beat, and that's it. You know, not much. She had to go through the breast-feeding with me, 'ah ok, do you know the advantages and the negative points?' And I was like, 'yes I do', 'ok, that's fine, tick'. And	I felt really rushed because at the end of the day, you know, what they tell you is, 'you've got to read the booklets'. You know, this is quite hard to understand so probably I would have liked someone to explain it to me, you know, what it was and, if I had it, what it would lead to, these kinds of things. I'm not pushy enough.	I think because she wasn't the midwife that was supposed to see me, she just kind of saw me in between two other clients and I felt quite rushed in there, even though she was really nice and helpful, I felt quite rushed. I think at week twenty-three, that's when I felt rushed because I, I think she was actually a bit delayed and she wanted to see the next client	I just think, obviously the service is not that great down there, if somebody comes and is late, I mean an hour and fifteen minutes late, that was quite bad, you expect that they're not going to rush you and answer your questions and talk about things properly. But obviously, I mean she gave me a DVD so...I've got a DVD to watch now

			she didn't actually go through it with me. And again she was supposed to go through every point, but she just ticked it and that was it.			
	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Amelia	She said 'come back and see me in two or three weeks'. Something come through the nursery 'I'm going to go see her next week' and so I booked in to see her again, and it didn't matter	if there's anything that I need to talk to anybody about I either speak to my midwife (on a Thursday afternoon – when she's in the clinic) or I've called the hospital and spoken to the midwives	it's not a big deal for me as long as they're all doing the same thing, you get your blood pressure checked, they check your urine and you know they feel the baby and they do the heart beat. As long as I get all that done, it doesn't matter who does that.	I suppose time, you know for each of her patients, I suppose she would not just say 'right your time's up' and off you go sort of thing. So, you know, I'm not saying the opportunity's not there but there is some times where you know she's sort of like filled everything in and you sort of think 'ok I wanted to ask you that and you sort of know that your time's come to an end and on a couple of occasions I have felt that perhaps um, it has been slightly, slightly rushed.	The midwives on delivery suite were not very friendly and they were very busy; they were very short staffed. And they literally came and did what they had to do and they went	Like I say, couple of occasions it felt a little bit rushed but she was very much behind. I mean, I know she allocates ten, fifteen minutes per person and there has been a few times where she's been running quite late so there are times when I have felt a little bit rushed. You just felt a little bit like you were just left, behind this curtain on this bed. I'd been monitored, they were coming to do the blood pressures and I'd had my bloods taken, and you were just, waiting and waiting and waiting and thinking well, 'what am I waiting for?'
Evie	I go on a Monday and I tend to, be seen at two o'clock, so I don't know if I get the first one after lunch or something, so I have been quite lucky really. PN You just get left on your own with this, little thing so that you don't really know what you're doing		I expected it to be a bit more scientific. I thought there might be a bit more gadgety stuff that they would use for monitoring what's going on. It just seems to be that if your blood pressure is alright, your wee's alright and your feeling fine, there's not a lot else to do. Just check that baby is alright, heartbeat is fine, so that's it.			

			PN Whereas afterwards, as I say very much just, production line, really, doing the medical checks			
	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Lily	The routine check up for me apart from occasionally retesting my urine there has been nothing to discuss. I think a longer appointment once per trimester, where you can discuss the things that you want to in more detail or the medical things you should be looking out for	But no you ring the central number. It does feel a bit weird ringing the Delivery Suite to notify them that everything has kicked off rather than ringing the midwives. It kind of depersonalises it to a degree. I think C gave me a number last time. I don't know if they've done it to try and get more efficiency. (Home birth)	To be honest all the way through it has felt very much like a very medical exercise so it's like, we've got to get your history, we have a number of very basic checks we've got to do, we've got to check your blood pressure, your urine, we've got to check any swelling etc, like tick, tick, tick, so very functional, very medical in that respect, not anything that was different from that, anything more emotional anything that was different. I didn't, I didn't really feel like I was building towards anything in particular; it was pretty much 'tick yep you want a home birth, let's move on' PN it was like 'ok have you thought about contraception' I was like 'yes. I'm probably going to do this, this, this and this', 'right, ticked it off' is pretty much how it went. It wasn't kind of anything practical or discussion	they felt like very much pressured for time, in the post and pre-meetings, yeah. Uh, you kind of feel like, right I don't wanna, you know luckily I've no complications but you wouldn't wanna bother them with kinda like, 'ok you're obviously on a clock here', you know, 'better get going'.		In the health industry things do tend to work very differently, the regimentation is a lot different, but a two o'clock appointment you think, well its two o'clock and there are like three people with two o'clock appointments and two midwives and you think...what is different in doing midwifery work rather than in doing admin Yesterday I had another appointment, I got there a couple of minutes late and there were still five people in front of me I went in and they were almost like phew, your quite straight forward, you've got no complications, you're blood pressure's okay, so I think they'd had a bit of a morning of it.
Ava	I think we went over the appointments I would have at the surgery and the frequency of those, but I think that was pretty much it.	I could have accessed the central number and left a message for her, but I didn't really feel that I should, I didn't feel that it was an emergency if I could see my GP. I had to	Just part of the system really, it feels a bit like a conveyor belt, you have these appointments and you have these tests and that's what you do, you just go along with it. it was	they do ask if you have any questions, but particularly when I've been at work I'm like, I've been sat in the waiting room for half an hour, I haven't got time, just do it and I can		I don't know if that's people before me have taken a lot of time, by the time I get in I'm frustrated, late, I just want to get out again. So I have just been sat there

		travel to the hospital for a BP check. Yes that was frustrating, I was quite annoyed about that, but that was the only option because no midwife could see me on the Friday	perfunctory, test the urine, measure the bump, off you go kind of appointment. I imagined that there would be more information, a bit more discussion, and again it's probably not helped by my frustration by the late appointments	leave, so they give you the opportunity but it's all so rushed and late		getting more and more irate, and I think that may have influenced how I felt the appointments have gone. At times they are on time, but because it's a constant thing, I think, make the appointments longer. I've had the first appointment of the day and been seen half an hour late, it's a bit frustrating
	Knowing the System		Experience of midwife: woman interaction			
Participants	Schedule of Visits	Access to the midwife	In and out	Not asking questions	Insufficient staff	Long waiting times
Megan			So I turned up and it was very hustle, bustle, push you into a chair, 'right the blood man's coming in twenty minutes, we're going to do this, this, this, this, this'. I understand people have got forms to process and things like that but there was a limited amount of information, I don't know whether it's a pressure for time.	if you don't get the information that you want, there and then, or you feel under pressure for time or, you can't really think fast enough when you're there because you don't know what's going to come up because you don't know what to expect; you go and you look it up on the internet and then you frighten yourself to death.		They over-run all the time. The appointment setting seems to be fairly, um, they don't seem to be supported very well in that. I don't know whether it's their own knowledge of the IT systems that causes problems, whether their case load is just too great for them to be in more control of things
Lucy			it is very non-individual because it's a case of you have urine done, you have your blood pressure done, you have your measured bump thing and then if there's nothing else that you want to talk about or ask about you're out the door again. So it is literally getting the stats done and that's about it, I think impersonal sometimes. PN I know you have to ask certain questions to be able to	nobody has discussed anything with me unless I have really asked them about it, apart from the breast feeding, um and yeah I don't think, I've not felt comfortable bringing up, bringing up some stuff, like a birthing plan	I think it just depended on what kind of day people were having really rather than what people it was, because there might have been a day when they were short staffed and so their focus was on getting the job done rather than sort of like being more relaxed about it	

			find out the information that you need, but sometimes it did seem very clock workey, ten o'clock here they come, it was literally a case of you were put on a blood pressure monitor, your temperature was taken, your notes were written and then they were gone.			
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Appendix 15: Acronyms and Glossary

Acronyms

ACOG	American College of Obstetricians and Gynaecologists
AMP	Albany Midwifery Practice
APEC	Action on Pre-Eclampsia
BM	Blood sugar monitoring – BM actually stands for Boehringer Mannheim, a German pharmaceutical company (now called Roche).
CPM	Certified Professional Midwife
CMACE	Centre for Maternal and Child Enquiries
DH	Department of Health
FG	Focus Group
FW8	Form for maternity exemption certificate
FBC	Full blood count
GP	General Practitioner
HIP	Health in Pregnancy
ICM	International Confederation of Midwives
LMC	Lead Maternity Carer
Mat B1	Maternity Certificate
MLU	Midwifery Led Unit
MORI	Ipsos MORI are a large research company that undertakes surveys
NCC-PC	National Collaborating Centre for Primary Care
NCC-WCH	National Collaborating Centre for Women's and Children's Health
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for (Health) and Clinical Excellence
NPEU	National Perinatal Epidemiology Unit

NSF	National Service Framework
PCT	Primary Care Trust
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians
REC	Research Ethics Committee
SACN	Scientific Advisory Committee on Nutrition
SOGC	Society of Obstetricians and Gynaecologists of Canada
SSMG	Sure Start Maternity Grant

Glossary

Antenatal care	Care offered during pregnancy by doctors and midwives to identify normal progress and to predict any problems with the mother and baby. Advice, support and education are provided to prepare the woman for birth and early parenthood.
Birth centre	Stand alone or alongside unit where women are supported by midwives to give birth in a home from home environment.
Birth plan	A written record of a woman's preferences for her care during childbirth which is held in the maternity records.
Breech presentation	Where the baby is presenting with the buttocks first
Caesarean Section	An operation where the baby is delivered through an incision in the abdominal wall and uterus.
Cervix	The lower third of the uterus. A fibro-muscular structure which dilates to facilitate childbirth
Clary Sage	An essential oil which is used by some midwives during childbirth to strengthen the contractions.
Continuity of Carer	Where care is provided during pregnancy, birth and the postnatal period by one to two midwives who are able to form a relationship with the woman.
Continuity of care	Where the philosophy of care is consistently applied by a small team of midwives to a woman during pregnancy and childbirth.
Day assessment unit	A part of the maternity unit where woman can attend for day case admissions to enable the pregnancy to be more closely monitored.
Down's Syndrome	A chromosomal abnormality which is associated with physical and intellectual challenges.
Epidural Analgesia	A local anaesthetic injected around the lumbar spine, in the epidural space, which numbs the nerves and provides effective pain relief during labour.
Expected date of delivery	The date that birth is anticipated normally between 37 and 42 completed weeks of pregnancy.
Fetus	The unborn child
'Gas and Air' (Entonox)	An inhalational analgesic which provides pain relief during labour

Induction of labour	When labour is artificially induced by using hormones to stimulate cervical ripening and uterine contractions.
Intrapartum	The period of time during labour and birth
Multigravidae	A woman who has been pregnant at least once before
Nuchal fold	A fold at the back of the fetal neck which is measured to determine a baby's risk of carrying a chromosomal abnormality.
Oxytocin infusion	A synthetic hormone infusion which initiates and maintains uterine contractions during labour.
Parity	The number of times a woman has been pregnant
Postnatal care	Care that is provided in the first few weeks following childbirth
Pre-eclampsia	A medical condition of pregnancy associated with raised blood pressure, proteinuria and generalise oedema.
Preterm	A baby born before the thirty seventh completed week of pregnancy
Primigravidae	A woman pregnant for the first time
Prostaglandin pessary	A hormone tablet or gel which is administered vaginally and acts to soften the cervix in preparation of induction of labour.
Show	The release of a mucus plug from the neck of the cervix when it starts to dilate. It is a sign of labour.
Supervisor of Midwives	A midwife who has undergone further education to equip her to provide support and guidance to a group of midwives on professional practice issues.
Trimester	Pregnancy is divided into three trimesters which equate to approximately thirteen weeks.
Ultrasound scan	An antenatal investigation to view the fetus and determine normal growth and development.
Vitamin K	A vitamin injection administered to newborn babies to reduce the risk of bleeding in the first week of life.
Waterbirth	Where birth takes place under water, usually in a birthing pool, maintained at body temperature.