

# Midwives' decision making during normal labour and birth

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## **Abstract**

### **Aim and research question**

The aim of this thesis is to explore midwifery decision making during normal labour and birth. The research question posed is: What influences midwives' decision making during normal labour and birth?

### **Background**

Normal physiological birth leads to improved health outcomes in every possible aspect: physiologically, mentally, emotionally and socially yet it is extremely well documented that rates of medical intervention in childbirth are increasing. How midwives make decisions and what influences those decisions during normal labour and birth might illuminate why this is happening. There is a dearth of research exploring midwifery decision making in clinical practice more widely but in particular decision making during normal labour and birth.

### **Methods and methodology**

An Interpretivist epistemology was chosen and a case-study approach selected which included data collection at 2 case-sites. Three focus group interviews were conducted at each case site labour suite. Eleven observational visits were made at case site 1 (total 92 hours) and ten observational visits (total 84 hours) were made at case site 2. In addition two midwives at case site 1 completed a decision making diary. A documentary review was also conducted. Ethical principles of conducting

research were adhered to, including gaining ethical approval. Data was analysed using thematic and cross-case analysis.

## **Findings and discussion**

There were five main themes identified: 'Woman focussed determinants', 'Midwifery specific influences', 'environmental and organisational factors', and 'intra and inter-professional influences'. The overarching, central theme was the 'hybrid midwife'. Each theme contained categories. Within the overarching theme, midwives in the case study environments were operating in dualistic belief systems in effect being 'hybrid midwives'. Some functioning as 'being with' midwives, embracing a social model of childbirth and some operating as 'doing to' midwives, embracing a biomedical model. In normal, straightforward labour and birth, intuitive- humanistic, phenomenological decision making processes tend to be utilised. However, this study also revealed that in busy labour suite settings, there appeared to be, at times, a dominance of women with complex needs. In higher risk situations hypothetic-deductive, rationalistic decision making models were reported to be used. It was apparent that some midwives struggled to function in this way, in that some 'being with' midwives were under organisational pressure to work as 'doing to' midwives, even when caring for women in normal childbirth. In addition, 'low risk' women's choices and decisions were sometimes not supported due to the sheer busyness of the labour suite.

Arising from the theme of 'the hybrid midwife' I proposed the more constructive concept of the dynamic midwife, who could balance the challenges of decision making when caring for both low risk and high risk childbearing women. Consequently the situated, dynamic midwifery decision making framework: Focus on straightforward labour and birth was developed as a result of this study. The model consists of two figures, the first based on empirical findings from this study, the second based on a continuum of existing decision making theories, models and influencing factors. This model could be utilised by midwives to enhance their knowledge regarding different types of clinical decision making approaches that can be used in normal childbirth.

## **Conclusions**

Decision making in normal labour and birth is an extremely complex phenomenon, influenced by a multitude of factors as exemplified by the themes identified in the findings. Midwives have to frequently balance decision making strategies that are appropriate for childbearing women in all risk categories.

Further recommendations have been made for research, practice and education to improve knowledge of midwives' decision making. The situated, dynamic midwifery decision making framework: Focus on straightforward labour and birth would benefit from evaluation in educational settings.

## **Publications and presentations**

Jackson K B (2011) Philosophy of mixed methods research. Conference presentation. Normal birth conference. Grange-Over Sands.

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Jackson K B, Marshall J, Brydon S (2014) Care during the first stage of labour. In: Marshall J, Raynor M (eds) Myles Textbook for Midwives. Churchill Livingstone. 16<sup>th</sup> Edition. London.

Jackson K B (2014) Abstract accepted for and presentation given on 'Decision Making'. At the International Confederation of Midwives Conference (ICM). Prague. June 2014.

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## **Glossary of terms and abbreviations**

ARM - Artificial rupture of membranes. This involves an amnihook being used by a doctor or a midwife to break the amniotic membrane (bag of fluid surrounding the baby), which is inserted up through the vagina and is similar to a crochet hook.

C/S - Caesarean section delivery

CTG - Cardiotocograph. This is a machine used to monitor women's contractions and her baby's heartbeat over a continuous period. It provides a continuous graph of both readings on paper.

EBP - Evidence based practice

G1P0 - A woman who is pregnant for the first time and has not given birth to any children.

G2P1 - A woman who is pregnant for the second time and has given birth to one child

HCPs - Health care professionals

L/S - Labour suite

MLC - Midwifery led care. Women experiencing care led by a midwife. She does not need to have contact with a doctor unless any problems occur.

MLU - Midwife-led Unit: a unit where midwives take the primary professional responsibility for labour care, usually for women with straightforward pregnancies

Multip / Multigravida. This is a woman who has had more than one pregnancy.

NHS - National Health Service

NMC - Nursing and Midwifery Council

PPH - Post partum haemorrhage

Primip - Primigravida. This is a woman who is in her first pregnancy.

Syntometrine – a combination of ergometrine and oxytocin, prophylactically used to prevent post-partum haemorrhage

Syntocinon - synthetic form of oxytocin, prophylactically used to prevent post-partum haemorrhage and for induction of labour

VE - Vaginal examination

WHO - World Health Organisation



## **CHAPTER 1 INTRODUCTION**

This introductory chapter will provide an initial rationale for exploring midwives' decision making during normal labour and birth. It is therefore imperative that the importance of normal birth to women's health is discussed. This chapter includes: normal childbirth in focus, the philosophy of midwifery more broadly, the various philosophical views of childbirth, why normal childbirth is important, variations in birth rates in 'normal', 'low risk' childbirth. A rationale for exploring midwives' decision making during normal labour and birth is also given. The use of personal pronouns in academic writing will be included and an overview of the thesis will be provided

### **1.1 Normal childbirth in focus**

In many cultures throughout history, birth has been viewed as a highly significant event, marked by particular rites and rituals which often have spiritual and cultural meanings (Kitzinger 2000). Narratives around childbirth include descriptions of it being a profound, transformative and powerful human experience (Lavender et al, 2012). Women often recount "feelings of empowerment, elation and achievement, although other women's experiences include trauma, fear, pain, and loss of control" (Lavender et al, 2012:2). According to Kitzinger (2005), the change from women giving birth in a familiar home environment surrounded by female attendants, to women giving birth in an institutionalised setting surrounded by technology has contributed to this alternative discourse of trauma and fear. The net result of this change, according to a number of authors (Downe, 2008, McCourt 2010,

Walsh 2018, Walsh et al, 2020) is a reduction in the occurrence and experience of normal birth. Thus normal childbirth over at least the last twenty years has become the focus of political, social and economic debate (Institute for Innovation and Improvement 2007, Healthcare Commission 2008, DH 2010a, NHS England 2017, NMPA 2019, Walsh et al, 2020).

## **1.2 The philosophy of midwifery**

Midwifery as well as nursing, has become embroiled in the 'art or science debate' (Silverton 1993). Both of these professions are identified as caring and supportive, traits that are associated with 'art', but both have become more recently grounded in the 'scientific', which philosophically aligns itself with a positivist approach. Some will argue most vehemently against midwifery becoming increasingly synonymous with science (Anderson and Davis 2004, Walsh 2011, 2012). Davis-Floyd (2009) described this as the super-valuation of the technocratic, rational, medical model, claiming supremacy over the heuristic, intuitive and humanistic model of childbirth.

In the literature review and background chapter, table 2.3 highlights the fundamental differences between the medical and the social models of childbirth. These characteristics are dichotomous but it is worth emphasising the point that most midwives and obstetricians would place themselves somewhere along a continuum of technological and humanistic approaches to childbirth and not firmly in one camp or the other (Walsh 2012).

Though medicine is often criticised for its dominance over other professional and non-professional groups, there is another viewpoint that organisations such as those that endorse natural childbirth can be equally responsible for promoting a particular version of natural birth as normative and authoritative (Walsh 2004). Midwifery is often portrayed as being at odds with obstetrics but, in putting forward an alternative model of childbirth, care needs to be taken not to attempt to replace one doctrine (or social construction of childbirth) with another. Fleming (1998) in her small qualitative study, discusses the midwives' mantra of being the guardians and the promoters of normality, working towards this end in partnership with women. However childbearing women in Flemings' (1998) study did not feel that they were in partnership with their midwives. They felt that midwives were the ones with the 'power', their own agency being suppressed. In exploring midwives' decision making, the issue of 'perceived' or 'real' power holders will be crucial.

Birth is a highly emotive experience for those involved. According to Miller (2008) birth is a powerful transformative process that can ensure women have the most positive initiation to becoming a mother at one end of the scale, or at the other extreme, it can be a devastating experience affecting every aspect of 'self' for many years. The rites of passage particularly in the first birth, changes the mother (and father/partner) fundamentally in terms of the social role that they will adopt, and for the woman has the potential to affect every aspect of her health (Downe 2010a, Downe and Finlayson 2016). Miller (2008) states that a woman's experience of birth can affect her

future maternity care, her physical and emotional health and her ability to mother her infant. This supposition is supported by available evidence (Glazener et al, 1994, Green et al, 1998, Hall and Bewley 1999, Lydon-Rochelle et al, 2000, Green et al, 2003, Clement 2001, Institute for innovation and improvement 2006, Lavender et al, 2012). It follows then that decisions made during childbirth can greatly affect a woman's experience of labour and birth and subsequent health and wellbeing. The chapter on 'Decision making' highlights the complexity and multi-dimensional aspects of the decision making process. It is therefore imperative that the most appropriate approach to conducting this study is chosen.

### **1.3 Philosophical views of childbirth**

As stated in the previous section, the philosophical world views of childbirth are often described in quite starkly opposing terms (see table 2.3).

The technocratic or biomedical model being on one side and the social or midwifery model of childbirth on the other (see table 2.3).

Childbirth from a social model point of view is physiological, with an inherent expectation that childbirth will be a safe and satisfying experience. It is based on holism, not just on biophysical processes, and embraces innate intuitive forces emanating from within women themselves. From a technocratic / biomedical model viewpoint, childbirth is pathological and risky until proven otherwise in retrospect. This approach requires adopting a

low threshold for intervening in labour and birth as it has a highly sceptical view of labour physiology. There is focus and monitoring on what can potentially go wrong (Walsh 2017). Models of childbirth will be discussed further in the literature review chapter.

Much of the dominance of the technocratic / biomedical model in maternity care has been reinforced by the very powerful presence of the risk discourse and this will be further explored later in the literature review chapter.

#### **1.4 Why is normal childbirth important?**

To answer the question, it is essential to explore what 'normal childbirth' is. Within itself this is fraught with difficulties as there is no one accepted definition of what normal childbirth is, for instance normal birth rates have historically been reported as spontaneous vaginal birth, regardless of what other interventions may have occurred (Downe et al, 2001, Downe and Finlayson 2016). This issue will be more thoroughly discussed within the literature review section. Evidence supports that childbearing women generally appear to recover more quickly, have less pain, have an easier breastfeeding experience, bond more quickly with their babies and report higher levels of psychological wellbeing, to name just a few benefits, when their labours and birth have been normal and straightforward (Johanson et al, 1993, Glazener et al, 1995, Odent 1999, Ferguson et al, 2002, Fisher et al, 1997, Green et al, 2003). A higher number of adverse outcomes are associated with interventionist, assisted or operative births and are

significantly related to negative experiences of childbirth (Green et al, 1998, Green et al, 2003, Baston et al, 2008).

### **1.5 Variations in birth rates in 'normal', 'low risk' childbirth**

Many of these tensions, highlighted previously, are played out in current maternity services across the world, especially in high income/resource countries. In the UK there have been wide variations in normal birth rates among 'low risk' populations of childbearing women (Dodwell and Gibson 2012, NMPA 2019) which is still apparent in the most recent maternity statistics (NHS maternity statistics 2019) and it is not clear why this is the case. Some maternity Units that report high intervention and caesarean section rates claim that this is due to serving a 'higher risk' population of childbearing women. Dodwell (2013) examined these assertions through detailed statistical analysis of NHS Trusts and the surrounding childbearing populations they serve and, after controlling for confounding factors, found that there was no evidence to support these claims.

### **1.6 A rationale for exploring midwives' decision making during normal labour and birth**

Research has tended to investigate the 'macro elements' contributing to increasing birth interventions, like place of birth and organisational models of care (Andrews et al, 2006, McCourt 2010, The Birthplace in England Collaborative Group 2011, Walsh et al, 2020), but there has been very little research at the 'micro level' of individual midwifery decision-making and its

impact on normal birth rates. The literature review and background chapter will examine the significance of normal childbirth and why midwives endeavour to promote it in the clinical, social and wider political arenas. The decision making chapter, will demonstrate a dearth of research in this specific area and will build a considerable rationale for conducting a study on midwives' decision making during normal labour and birth. The research will investigate this in two geographically close birth settings that have contrasting rates of normal birth, using case study methodology.

### **1.7 Use of personal pronouns in academic writing**

I am aware that the use of personal pronouns in academic works is a controversial one (Harwood 2006). Hyland (2001) argues that using personal pronouns in social sciences research emphasises that it is their own unique way of seeing and doing things. MacDonald (1992) also talks about how pronouns are connected to agency and researchers taking responsibility for their claims.

Having read literature on this issue and reading many other midwives' and other health professionals' PhD theses, I arrived at the conclusion that I will only use the personal pronouns 'I', 'me' and 'my' when and where I feel it is appropriate.

## **1.8 Overview of the thesis**

The literature review and background in chapter two, will explore the recent history of maternity services in the UK, the phenomenon of rising intervention rates, definitions of normal birth, organisational models of midwifery care and other factors that support normal childbirth, normal birth versus technological labour and delivery and normal birth versus caesarean section. Chapter three will then examine decision making as the pivotal point where these influences are enacted and may impact on childbirth outcomes. Decision making theory and models will be explored in depth. This will include hypothetico-deductive, evidence based practice, intuitive-humanistic, the dual processing theory, cognitive continuum theory, shared decision making, 'mindlines' and decision making related specifically to midwifery. The research aim and research question will then be postulated. Methods and methodology will then be discussed in chapter four, including an exploration of positivist and interpretive research approaches, a rationale for choosing case study research, use of focus groups, diaries and observations, data analysis and ethical considerations. The next two chapters have been divided into two to provide more manageable reporting of the substantial findings. Chapter five introduces the reader to the findings and reports the first two themes arising from the research and chapter six reports on the next three themes. Chapter seven discusses in detail the main salient points that emerged from the data including some of the original, novel contributions that the thesis offers to the arena of midwifery decision making during normal labour and birth. The final chapter, chapter eight, will make



concluding comments, outline the strengths and limitations of the study and provide recommendations for practice, education and research.

## **CHAPTER 2 LITERATURE REVIEW AND BACKGROUND**

### **2.1 Introduction**

The introductory chapter has illuminated the motivations behind the drive for normal physiological birth and thus a rationale for conducting this study on midwives' decision making during normal labour and birth. This literature review and background chapter will provide justification to stem the ever increasing rise in interventions in normal birth. The chapter will further explore the reasoning for midwives to continue promoting the normal birth agenda as a precursor to discussing decision making theories and models in the next chapter.

This chapter will include the literature searching process and explore the various definitions of 'normal birth'. It will discuss different organisational models of care, the rising tide of intervention in normal childbirth, birth environment, place of birth and different models of childbirth. A brief history of midwifery and maternity care in the United Kingdom (UK) and the Royal College of Midwives' (RCM) campaign for normal birth will be included.

The chapter will also examine technological childbirth and the relative advantages and limitations of caesarean section (C/S) delivery and normal birth. The risk discourse and its impact on labour and birth care will also be discussed.

## **2.2 Searching the literature**

Intervention rates are clearly increasing in normal births and there is also a wide variation in reported normal birth rates between maternity units (NHS maternity statistics 2019, NMPA 2019). The reasons for these phenomena are unclear. Midwives in the UK are the lead health professionals caring for women during normal childbirth. Even in normal straightforward labour and birth, challenges can arise, such as women becoming distressed with painful contractions or labour slowing or stopping. How midwives support women and the decisions they make could potentially have an impact on whether labour and birth remains 'normal', or whether it takes a more technological, interventionist route. Little research appears to have been conducted on midwives' decision making in relation to its impact on normality.

The literature was explored in detail in order to find appropriate literature and research articles on midwives' decision making during normal labour and birth. The key words and phrases used were: healthcare, midwifery, maternity care, normal childbirth, normal birth, normal labour and birth, natural childbirth, physiological childbirth, vaginal birth, spontaneous birth, normality in childbirth, normalising childbirth. The following terms were also searched for and were combined with the previous search terms: decision making, shared decision making, clinical judgement, professional judgement, diagnostic reasoning and clinical reasoning were also included. Boolean logic using AND (+ sign used in appendix 1) to link these key concepts were used to identify specific relevant articles.

The following databases were accessed: CINAHL, Maternity and Infant care (OVID), British Nursing Index (BNI OVID), MEDLINE, ASSIA, Psycinfo, Web of science and Embase (see appendix 1). The Cochrane Library was also searched but only generated sources of literature that had already been uncovered in other databases. General internet sources using search engines, such as 'Google scholar' were also accessed, online journals and hand searches of relevant health professional journals, journals allied to health professionals and consumer journals. This search rendered articles and information from a whole range of professions directly involved in childbirth and decision making such as midwifery and obstetrical journals. It also uncovered literature from professions indirectly involved in maternity care such as physiotherapy and psychology and from those who have experienced maternity care such as research generated from the National Childbirth Trust. Text books, conference abstracts and 'grey' literature such as unpublished PhD theses were also used as sources to retrieve relevant information. The literature search was regularly updated throughout the PhD process.

Sources of research and evidence were mainly drawn from the UK where maternity care is delivered through the National Health Service (NHS), abiding by guidance from bodies such as National Institute for Clinical Care and Excellence (NICE), the Royal College of Midwives (RCM) and the Royal College of Obstetrics and Gynaecology (RCOG) and have models of care that are therefore similar. However high income/resource rich countries that have access to the same obstetric technology as the UK such as Australia, New

Zealand, United States of America, Canada, The Netherlands, Scandinavia and other European countries were also included in the literature review although it is acknowledged that there may be cultural, geographical and demographic differences. No restriction was given to time frame as some older seminal and relevant articles, in relation to decision making and normal birth practices, make a legitimate contribution to the discussion.

### **2.3 Definitions of 'Normal birth'**

What is considered normal childbirth in high income, well-resourced westernised cultures is problematic. This is because in the current context of maternity care, technological interventions are commonplace and have themselves been absorbed into routine care. Taylor (2001) describes this as the customary everyday practices becoming the 'normal'. The boundaries between normal birth and medicalised birth have become blurred. This is supported by Downe et al's (2001) study where one third of 956 women who gave birth in a consultant led unit, had their births recorded as being normal or spontaneous, had in fact experienced induction or augmentation of labour. This could perhaps be explained by a socio-cultural construction of normal childbirth, the meaning of which can vary greatly for maternity organisations, midwives and childbearing women (Behruzi, Hatem et al, 2013). Downe et al, (2001) question the provenance of the terms 'normality' and 'normal birth'. This centres on whether 'normal' is the birth of the baby vaginally without the assistance of instruments (despite interventions that may have occurred during labour), an entirely natural physiological process,

or the common experience of women, where the notion of 'normal' really means 'usual'.

Health Episode Statistics (2012) reported statistics for 2011-2012 when approximately 61.2% of women in England, had a 'spontaneous vaginal birth'. When using the MCWP definition of 'normal birth', the rate was 41.8% (highest rate 54% and lowest rate 28.8%) (Dodwell and Gibson 2012).

More recently Downe and Finlayson (2016), in a study involving seven maternity units, found normal birth rates still being reported as relatively high, an average of 65.5%, but when adjusted to utilise the study protocol definition (see table 2.1, Birthchoice UK 2015) excluding many medical interventions, the average normal birth rate was 22%.

The 'Maternity Care Working Party' in the UK (MCWP 2007:1) defines a 'normal delivery' as one: "without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery". This document elaborates further by including in the 'normal delivery' category, women who experience augmentation of labour, artificial rupture of membranes, use of entonox, use of opioids, electronic fetal monitoring, managed third stage of labour, antenatal or postnatal complications such as post-partum haemorrhage, perineal tear, repair of perineal trauma and a baby's admission to neonatal unit. This definition was a compromise of the different professional groups (MCWP 2007).

The MCWP did stipulate that some members wished to have a tightened definition in future, to exclude procedures like augmentation of labour or use of opioids. Or alternatively, to establish a separate definition of 'physiological' or 'natural' birth. Beech (2008) would consider the inclusion of many of the factors above as an 'obstetric delivery' rather than a 'normal' birth. The Healthcare Commission (2008) endorsed the consensus statement by the MCWP (2007) and recommended that the normal birth rate should increase to 60% by 2011. This has clearly not been achieved, even when reviewing the latest statistics which show a spontaneous vaginal delivery rate of 56.8% (NHS maternity statistics 2019).

There are a whole range of definitions of normal birth / delivery from different professional and non-professional organisations (see table 2.1). There is still not a standardised definition of normal birth, as some of the published statistics still use 'spontaneous vaginal birth/delivery rates',<sup>1</sup> which as previously discussed can be quite misleading.

A consensus on definitions of normal childbirth would be useful and desirable so that audit, research and comparisons can be made with confidence (MCWP 2007). A consensus definition would also assist in correlating women's authentic experiences of different modes of birth.

The following terms (see table 2.1) will be used throughout this thesis in order to reflect the different definitions of childbirth. Unless otherwise

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<sup>1</sup> In response to the issue of 'normal birth rates' being reported inconsistently, Dodwell (who developed the Birthchoice UK web-site) and Gibson (2012) reported normal birth rates as per the MCWPs' definition and now reports them as per the Birthchoice UK (2015) definition.

stipulated, where 'normal birth' is used, it will relate to the MCWPs (2007) definition. Due to the contentious nature of the definition of 'normal birth', 'physiological childbirth' and 'straightforward labour and birth' will also be referred to (see table 2.1), as the ultimate goal of midwifery care is where childbirth occurs completely naturally without any assistance.



**Table 2.1: Summary of definitions of normal birth, normal delivery, spontaneous vaginal birth/delivery, physiological childbirth**

**Normal birth/delivery:** “one where a woman commences, continues and completes labour physiologically at term” (RCM, 2008: 1).

**Normal birth/delivery:** “without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery” (MCWP, 2007: 1).

**Normal birth/delivery:** “a birth without induction of labour (with prostaglandins, oxytocics or ARM), epidural or spinal or general anaesthetic, forceps or ventouse, caesarean section, or episiotomy” (Birth Choice UK 2015:1).

**Spontaneous vaginal birth/delivery:** “not assisted by forceps, vacuum, or caesarean section and not a malpresentation”. This definition relates only to the mode of delivery of the infant and therefore includes any unassisted vaginal delivery, regardless of any interventions during labour and birth (Joint policy statement, 2008: 1163). This is what has been generally reported historically in national statistics as the normal birth rate, unless the MCWP’s or other definition has been stipulated.

**Physiological childbirth:** “is characterized by spontaneous onset and progression of labour; includes biological and psychological conditions that promote effective labour; results in the vaginal birth of the infant and placenta; results in physiological blood loss” (International Childbirth Education Association, ICEA, 2015:1).

**Straightforward labour and birth:** “..... means giving birth vaginally, without any procedures or interventions. Some people call it a natural birth” (National Childbirth Trust, 2007:1).

The terms 'high risk', which relates to women with complex needs, due to pathology and/or social issues and 'low risk' related to women without complex needs are also contentious (Martlew 2015, Hill 2015). They categorise childbearing women according to presence or absence of risk, which some consider to be narrow, simplistic, pathologised labels (Martlew 2015, Hill 2015). However, I will deliberately use these terms that are in common use to highlight the largely binary nature of maternity care with the aim of rethinking classifications used ubiquitously in perinatal practice.

In addition to the challenges surrounding definitions of childbirth, it is also crucial to examine other factors that can influence normal birth rates.

#### **2.4 Normal childbirth and organisational models of care, birth environment and place of birth**

When conducting the literature search on normal birth or interchangeable terms, organisational models of care, birth environment and place of birth were frequently identified as being influential to straightforward childbirth.

Caseholding midwifery models, where the same midwife or small group of midwives care for a pregnant woman throughout the childbearing continuum, are thought to provide a more woman centred approach to maternity care (McCourt 2010). Sandall et al, (2016) in a Cochrane review, examined midwife-led continuity models versus other models of care during pregnancy, birth and early parenting. In the midwife-led models, they found less interventions in childbirth, such as epidurals, episiotomies and

instrumental deliveries. There was a higher rate of spontaneous vaginal births, a decrease in pre-term births and lower risk of neo-natal loss. In addition women were also more likely to know the midwife who cared for them during labour. No differences were found between the different models of care in relation to caesarean section rates.

A number of trials examining continuity of carer models in the UK and Australia previously reported that caseholding maternity care increased vaginal / normal birth rates (Bejamin et al, 2001, Nelson 2010, McLachlan et al, 2012), meant women were more likely to know their carer during labour and birth (Page et al, 1999, The North Staffordshire Changing Childbirth Research Team 2000, Benjamin et al, 2001) lowered epidural use (Page et al's 1999, The North Staffordshire Changing Childbirth Research Team 2000, McLachlan et al, 2012) lowered C/S rates (Nelson 2010, McLachlan et al, 2012), increased breastfeeding rates (Nelson 2010) and improved satisfaction rates for women, compared with 'traditional' or 'usual' care (Andrews et al, 2006, McCourt 2010). In addition there were lower preterm rates, lower smoking rates (Nelson 2010) fewer episiotomies and perineal lacerations and a shorter second stage of labour (Page et al, 1999).

However, in the The North Staffordshire Changing Childbirth Research Team (2000) study and in Benjamin et al's, (2001) study there were no differences in normal birth rates. But this needs to be balanced with the many beneficial aspects of continuity of carer as previously reported.

Darlington (2019) recently presented the latest statistics for the 1-2-1 midwives case-holding practice in Cheshire. Home birth 30%, normal birth 93%, C/S rate 3%, continuity of carer 93%, BF initiation rate 98%, stillbirth rate 2.3 per 1000 all of which compare extremely favourably to statistics in traditional models of maternity care. Year on year women who access the service rate it highly, again compared to traditional maternity care (Darlington 2019).

Continuous care in labour (Bohren et al, 2017), having a known midwife during care in labour (Page et al, 1999), non-supine positions during labour (Lawrence et al, 2009) and a shared philosophy of normal birth (Kennedy et al, 2004) have all been shown to increase normal birth rates and reduce unnecessary interventions. All of which are more likely in midwife-led units or at home.

NHS England (2017) have published guidelines for local maternity systems to implement innovations included in 'Better Births' specifically continuity of carer. The NHS is committed to introducing continuity of carer to all new mothers by 2020/21.

Given the known benefits and improved outcomes from caseholding models of maternity care it could be argued that, when women are given this option, the potential for normalised labour and birth are maximised. The stark reality is that most women give birth in acute health care settings, and receive care from a midwife unknown to them (The Birthplace in England Collaborative Group 2011) and is still the case in the latest published

statistics (NHS Maternity statistics 2019). This influenced the researcher to conduct the study on midwives' decision making within hospital contexts.

Other factors that are known to impact on normal birth rates and intervention rates are birth environments and place of birth. Hodnett et al, (2012), in a Cochrane review, concluded that alternative birth environments, specifically along-side midwife-led units (note the reviewers found no trials of freestanding birth settings), increased the likelihood of a spontaneous vaginal birth, decreased medical interventions and increased maternal satisfaction without any adverse maternal or neonatal health outcomes. Other systematic reviews and studies have reached similar conclusions in terms of improved physical and psychological outcomes for mothers and babies for freestanding midwife-led birth centres (Walsh and Downe 2004, Walsh 2005, The Birthplace in England Collaborative Group 2011, Scarf, Rossiter et al, 2018, Walsh et al, 2020). A study in the Netherlands examined planned home birth versus hospital birth for 529 668 low risk women. They also found reduced interventions and no adverse perinatal outcomes (de Jonge et al, 2009). Canadian and Swedish studies which also compared planned home birth with hospital birth reached the same conclusions as de Jonge et al, (Janssen et al, 2009, Lindgren et al, 2008) but both studies reviewed less than 20 000 women and were therefore considered to be underpowered (Hollowell 2011). More appropriately powered research is patently needed in this area.

A comprehensive review of 64 538 low risk women, planning to give birth in either a stand-alone or an along-side midwife-led unit, in an obstetric unit or at home, was completed by 'The Birthplace in England Collaborative Group' (2011). Women giving birth at home, or in either type of midwife-led units compared to women giving birth in an obstetric unit, were significantly more likely to have a normal birth and significantly less likely to have an instrumental or operative delivery, or to receive a range of medical interventions such as augmentation, epidural, spinal or general anaesthesia and episiotomy (The Birthplace in England Collaborative Group 2011). Overall there were no statistical differences for perinatal health outcomes for any planned birth setting. However, for nulliparous women, there were poorer perinatal outcomes associated with planned home birth, although the authors stress that adverse outcomes are rare in all settings (The Birthplace in England Collaborative Group 2011).

The normal birth rates vary even between midwife-led units (Mead 2008, Dodwell and Gibson 2012, NHS Maternity Statistics 2019, NMPA 2019) and therefore it may be asserted that there are a multitude of factors influencing 'normal childbirth' even within a population of 'low risk' women. Midwives' decision making maybe one of those influences. If these factors are affecting normal birth rates then it could be reasoned, they are also influencing intervention rates.

## **2.5 Rising intervention rates**

At policy level, one of the dominant drivers around childbirth is a concern about rising C/S rates and the multifaceted reasons for this trend, rather than examining factors which support normal birth. Normal childbirth has historically been the midwife's domain (Donnison 1988, McIntosh 2012). The concepts of 'normality' in childbearing and 'normalising' childbirth have only been used more recently. Prior to 1990 (see table 2.2) normal vaginal birth was by far the majority group and therefore 'normality' and spontaneous vaginal birth was the accepted 'norm' (Institute for Innovation and Improvement 2006). It is clear from tables 2.2 and 2.4 that normal birth rates in childbearing are reducing. In 1985 spontaneous vaginal birth rate in England was 75.4%, and the C/S rate was 10.4% and in 2017/2018 the spontaneous vaginal birth rate was 57.9% and the C/S rate was 28.8% (NHS maternity statistics 2019). Since the 1980s, as the C/S rate has steadily risen and the normal birth rate correspondingly declined, there has been a renewed interest for midwives and other health professionals in the UK and other developed countries to promote, achieve and maintain normality for childbearing women (Institute for Innovation and Improvement 2006, Institute for Innovation and Improvement 2007, Healthcare Commission 2008, Mead 2008, Davis-Floyd et al, 2009, Davis-Floyd 2011). Arguably, when women are provided with good quality information, continuity of carer and one-to-one support in labour, they tend to choose and follow a more normality focussed labour and birth experience, rather

than rely on technology (McCourt et al, 2006, Lawrence Beech and Phipps 2008, Hodnett et al, 2012).



**Table 2.2 Known method of delivery 1980-2017/2018 NHS Hospitals England – Source: NHS maternity statistics (2019)**

	Spontaneous			Forceps		Ventouse	Breech	Breech ext	Caesarean	Other
	Total									
Year	Total deliveries	Vertex	Other	Low	Other					
1985	605 100	75.4	2.5	5.3	3.8	0.7	0.9	0.9	10.4	0.1
1989-1990	633 500	76.7	1.4	3.9	3.9	1.6	0.8	0.3	11.3	0.2
1996-1997	594 500	70.6	1.1	2.4	2.1	5.9	0.7	0.1	17.0	0.3
1997-1998	585 000	69.2	1.0	2.2	1.7	6.5	0.5	0.1	18.2	0.5
2001-2002	541 700	65.6	0.9	2.0	1.5	7.2	0.3	0.1	22.0	0.3
2002-2003	548 000	65.9	1.0	1.9	1.5	7.1	0.3	0.1	22.0	0.2
2005-2006	593 400	64.2	0.7	2.0	1.9	7.2	0.3	0.1	23.5	0.2
2006-2007	629 207	63.5	0.4	2.2	2.3	7.0	0.4	0.0	24.3	0.0
2009-2010	652 377	62.0	0.4	2.5	3.5	6.3	0.4	0.1	24.8	0.0
2010-2011	668 195	61.8	0.4	2.6	3.6	6.3	0.4	0.0	24.9	0.0
2013-2014	646 904	60.3	0.3	3.5	3.5	5.8	0.4	0.0	26.2	0.0
2014-2015	636 643	59.7	0.3	3.6	3.6	5.9	0.4	0.0	26.5	0.0
2017-2018	626 203	57.9	0.3	3.3	4.0	5.2	0.4	0.0	28.8	0.0
2018-2019	603 766	56.8	0.3	3.5	3.8	5.1	0.3	0.0	30.1	0.0

\*\*\* Data from 2012-13 is not comparable with previous years due to a change in methodology. Figures for 2011-12 have been reproduced for comparison purposes. Please see the Maternity Summary Report for OPCS method of delivery codes and further details of methodology changes.

## **2.6 Models of childbirth**

Accompanying the shift to hospital birth, starting from the 1970s, there has been a philosophical shift from a social model of childbirth, to a biomedical model and this has had a major impact on the experience of childbearing for women (van Teijlingen 2005, Walsh 2012). The most often quoted difference between these philosophical viewpoints is that the medical model only sees pregnancy and childbirth as normal in retrospect, whereas the social model of childbirth sees pregnancy and childbirth as a normal physiological event (van Teijlingen 2005, Walsh 2012).

Table 2.3 extends and expands on some of the fundamental differences between the two dichotomous paradigms but Walsh (2012) makes the point that in modern maternity practice, few obstetricians would be seen as exclusively adopting a biomedical ethos and not all midwives embrace a social model of care. There is overlapping and blurring of the divisions, however the model remains a valuable heuristic tool in illustrating the core variations in approaches to childbirth.

**Table 2.3** - Medical model and social / midwifery model of childbirth

Medical model	Social / Midwifery model
<p>Doctor centred</p> <p>Objective</p> <p>Male</p> <p>Body mind dualism</p> <p>Pregnancy and childbirth: only normal in retrospect</p> <p>Statistical /biological approach</p> <p>Biomedical focus</p> <p>Medical knowledge is exclusionary</p> <p>Intervention</p> <p>Public</p> <p>Outcome: aims at live, healthy mother and baby</p>	<p>Woman centred</p> <p>Subjective</p> <p>Female</p> <p>Holistic</p> <p>Pregnancy and childbirth: normal physiological process</p> <p>Individual psycho-social approach</p> <p>Psycho-social focus</p> <p>Knowledge is not exclusionary</p> <p>Observation</p> <p>Private</p> <p>Outcome: aims at live, healthy mother and baby and satisfaction of individual needs of mother/couple</p>
Source: van Teijlingen E (2005)	
<p>Control and subjugate</p> <p>Homogenisation</p> <p>Technology as master</p> <p>Evidence</p> <p>Safety</p>	<p>Respect and empower</p> <p>Celebrate difference</p> <p>Technology as servant</p> <p>Intuition</p> <p>Self-actualisation</p>
Sources: Mackenzie Bryers and van Teijlingen E (2010)	

The hegemony of a biomedical model can be illustrated by the continual rise in intervention during childbirth (see tables 2.2 and 2.4), including rates of induction of labour, epidurals, instrumental deliveries and C/S rates in the UK (NHS maternity statistics 2019). In contrast Davis-Floyd and Davis (1996) describe medical interventions in maternity care as the 'technocratization' of birth. They propose that the medical profession views women's bodies as defective and that their pregnant bodies will become more efficient when attached to more perfect diagnostic machinery. They suggest that there appears to be a cultural super-valuation of machines over bodies and technology over nature (Davis-Floyd and Davis 1996).

The deconstruction of birth and the subsequent debates surrounding hospital versus home (Wax et al, 2010, Gyte et al, 2010), abdominal versus vaginal birth (Lavender et al, 2012), medicalisation versus holism (Walsh 2012), are all relatively recent developments, with some claiming that technological childbirth makes birth safer (Royal College of Obstetricians and Gynaecologists (RCOG) 2008, 2016a). Conversely, there is good evidence from well conducted research studies and Cochrane systematic reviews, that technocratic birth is only appropriate for women at risk of complications or experiencing them where the intervention(s) would benefit mother, fetus or both. It has been suggested that technocratic childbirth may be associated with women feeling deprived of power and control over their own bodies (Davis-Floyd and Davis 1996, Green et al, 2003, Stewart 2004, Stewart

et al, 2004, Walsh and Downe 2010, Hodnett et al, 2012, The Birthplace in England Collaborative Group 2011). However it must also be acknowledged that some 'low risk' childbearing women make informed choices to embrace technology during labour and birth (McIntosh 2012), and that some do choose to bypass vaginal birth altogether and make an informed decision to have a C/S delivery. Although it must be recognised that the actual numbers of women requesting C/S for non-medical reasons are very small (Bertran et al, 2016). Equally, some childbearing women in the 'high risk' category, make informed decisions to have little or no medical intervention. The motivation for this appears, in some cases, to be past negative experiences of maternity services (Holten et al, 2016). In order to have some understanding of the current status of maternity care in the UK it is necessary to explore the historical context and developments of the maternity services.

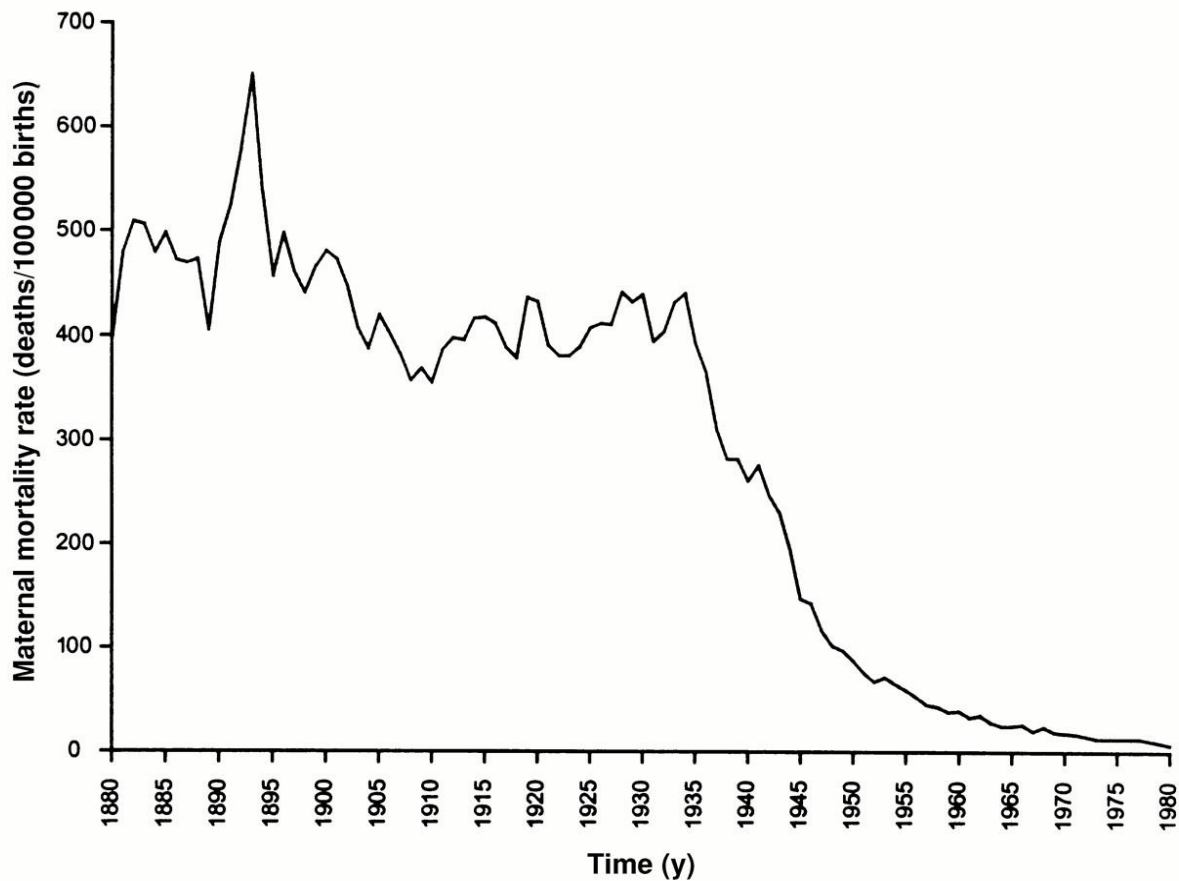
## **2.7 A recent history of midwifery and maternity care in the UK**

Midwifery has been in existence for thousands of years but did not become particularly visible as a profession in England and Wales until the Midwives Act of 1902. This marked the start of the regulation, certification, supervision and structured education and training of midwives. One of the aims of the Midwives Act of 1932 was a first step towards the comprehensive organisation of a national maternity service.

Early interventions in childbirth mainly related to pain relief during labour. Queen Victoria famously used chloroform during the birth of her eighth child in 1853. In the early 19<sup>th</sup> century, 'twilight sleep' induced by a combination of morphine and scopolamine, could be administered to labouring women (Skowronski 2015). There were organisations such as the 'Twilight sleep association' that lobbied for all childbearing women to have access to such pain relieving methods, demonstrating women's own demand for intervention in childbirth. However concerns about the true efficiency and safety of 'twilight sleep' ended their campaign in 1915 (Skowronski 2015).

The introduction of the National Health Service in 1948 was a significant landmark in British history and is associated with improvements in maternal and neonatal health (Louden 2000). However there were dramatic changes occurring in terms of reducing maternal mortality, prior to the introduction of the NHS, which Louden (2000) (see figure 2.1) attributes to a multitude of factors. At this time highly trained, experienced midwives cared for pregnant women with uncomplicated pregnancies largely at home, hospital care by obstetricians, was reserved for women with complicated pregnancies.

Figure 2.1 Maternal mortality (Source: Louden 2000).



From 1950, maternal and neonatal mortality continued to decrease. In 1954 the neonatal mortality rate was 18 per 1000 live births, by 2009 neonatal mortality was 3.2 per 1000 live births (CEMACH 2011). The latest neonatal mortality rate was 1.72 per 1000 live births (MBRRACE 2018). Maternal mortality also decreased dramatically<sup>2</sup> (see figure 2.1) (Louden 2000) with many obstetricians stating that the move to hospitalised birth was a dominant reason (Beech 2006). This could

<sup>2</sup> In 2014-2016, the maternal mortality rate was 9.8 women per 100 000 who died during pregnancy or up to 6 weeks after childbirth or the end of pregnancy (Knight et al, 2018).

indeed have been a contributing factor, for women with complex needs. However, women's general health was improving, they were having fewer babies because of contraception, housing conditions were improving and overcrowding was becoming less of a problem (Tew 1998, Campbell and Macfarlane 1994). In addition, from the 1930s, antibiotics were being used to treat puerperal sepsis, and infection control was becoming more prominent (Humphries and Bystrianyk 2013). In other words, improvements in public health could, in part, explain the decreases in mortality. Louden (2000) also cites the use of ergometrine, blood transfusions, better training, better anaesthesia, improved organisation of maternity services and less interference in normal labours as reasons contributing to the overall decline in maternal mortality rates.

During the 1960s, midwifery had been viewed as an 'art' based profession, (Silverton 1993) contrasting with obstetrics which positioned itself very much as a 'science'. This coincided with technological advancements such as ultrasound scanning. During this and the subsequent decade emerged the concept of 'scientific birth', where science was seen as capable of controlling nature including childbirth (McIntosh 2012). Indeed Hunter (2012) observed that despite continued improvements in maternal and neonatal health outcomes, childbirth was increasingly viewed as being 'risky', requiring medical surveillance, scientific regulation and management.



In 1970, The Peel Report recommended that the resources of modern medicine should be available to all mothers and babies, and that sufficient facilities should be provided to allow for 100% hospital delivery (Ministry of Health 1970). This recommendation was for 100% 'availability' of resources, nonetheless hospital birth rates soared without any evidence to support this fundamental change in health policy. In addition, no one asked mothers if they wanted to give birth in hospitals (Beech 2006). There was an alternating impetus from pressure groups (and indeed from midwives) initially campaigning for hospital birth and access to pain relief, and then back again to home and natural birth. This apparent paradox is comprehensively discussed by McIntosh (2012) who asserts that it was largely middle class, well educated women who initially lobbied for change, for access to hospital birth as an example, not necessarily taking account of the wishes of the invisible group of working class, childbearing women.

The 1980s signified an attempted backlash, by consumer groups, such as the Natural Childbirth Trust (NCT) and midwives, to the increasing use of technology in childbirth, the domination of obstetrics in maternity care and the marginalisation of midwives, often seen as 'hand maidens' to their medical counterparts (McIntosh 2012).

Discourses around woman-centred care, team midwifery, continuity of care, informed choice, the reassertion of midwifery as a profession and research based practice were starting to emerge (Alison 1996).

A third wave of feminists during the 1990s, reasserted a woman's right to choose a technological, pain free birth, asserting this as a legitimate feminist stance (Skowronski 2015).

As the rates of women giving birth in acute hospital settings continued to increase, so did medicalisation of the childbearing process.

Interventions such as induction, epidurals and assisted births have all risen substantially over the last 50-60 years as illustrated by tables 2.2 and 2.4 (Dodwell and Gibson 2012, ONS 2017, NHS maternity statistics 2019, NMPA 2019).

**Table 2.4 – Mode and place of birth, instrumental and epidural rates. Source: Dodwell and Gibson (2012, ONS 2017, NHS maternity statistics 2019, NMPA 2019)**

	1955	1990	2009	2016
Home birth rate (England and Wales)	33.4%	1.0%	2.9%	2.1%
NHS Hospital birth rate (England and Wales)	60.2%	97.9%	96.5%	97.64%
Induction rate (England)	13%	18.4%	20.2%	29.4%
Caesarean rate (England)	2.2%	11.3%	24.6%	27.8%
Instrumental rate (England)	4.4%	9.4%	12.1%	12.7%
Epidural rate (England)	-	17%	33%	35%

These interventions are associated with higher morbidity such as increased perineal pain, dyspareunia and mental health issues and/or lower levels of satisfaction, when compared to labours and births without intervention, in relation to the overall childbearing experience (Glazener et al, 1995, Green et al, 1998, 2003, Baston et al, 2008).

The Changing Childbirth report (DoH 1993) with its recommendation for more choice, control and continuity for childbearing women, was welcomed by all involved in maternity services (McIntosh 2012).

Despite this groundbreaking report and numerous government health reports endorsing the recommendations made in 1993 (DH 2004, DH 2007a 2007b, Healthcare Commission 2008, DH 2010a 2010b, DH 2017), including the most recent National Maternity Review (2016) 'Better Births', the maternity services have not demonstrated lower intervention rates and an increase in normal births (NHS Maternity Statistics 2019). Paradoxically, intervention rates have increased (see tables 2.2 and 2.4).

Continuing the historical review of midwifery and maternity care, in the early to mid 1990s the first students entered into a diploma in midwifery program, prior to this midwifery training was delivered at certificate level. The new millennium marked midwifery as an all graduate profession. In diploma and degree based programmes, students were formally encouraged to question conventional practices, to be analytical and to use evidence to underpin and reflect on practice

(Power 2015), all with the intention of continually improving clinical care. The importance of autonomy of both women and midwives', accountability and decision making are much more prominent in these curricula than in previous certificate level programmes. The ability to justify midwifery decisions, even when these may not follow 'guidelines', are crucial skills to prepare students midwives for contemporary practice. Arguably midwives have never received such a high calibre education and training, but the challenges and pressures on maternity services have developed in parallel such as: increasing complexity, increasing use of unnecessary technology and a culture pre-occupied with risk (Jackson 2017b). Midwifery is dealing with the withdrawal of statutory supervision following damning criticism of maternity and neonatal health care services at the University Hospitals of Morecambe Bay NHS Foundation Trust (Parliamentary Health Service Ombudsman 2013, NMC 2015a, Kirkup 2015, The Kings Fund 2015). Statutory midwifery supervision has since been replaced by an employer led model of clinical supervision (DH 2016).

## **2.8 The RCM's campaign for normal birth**

The RCM launched its campaign for normal birth in 2008 in reaction to rising interventionist practices in childbirth (RCM 2008). The RCM came under increasing pressure mainly from the Morcambe Bay investigation (Kirkup 2015) over its promotion of normal birth, over and above other modes of birth/delivery. Kirkup (2015:13) reported that there were a

group of midwives within the Trust: “whose overzealous pursuit of the natural childbirth approach led at times to inappropriate and unsafe care”. The report also found an embedded culture of normal birth “at any cost” (Kirkup 2015:64).

Hundley and van Teijlingen (2017) assert that it is the problematic cases that garner most publicity rather than the numerous cases of high quality NHS maternity care where normal birth is encouraged. The focus on single cases that are unrepresentative of wider practices in the NHS is extremely unhelpful and furthermore damaging to societal trust in midwives (Hundley and van Teijlingen 2017).

The term ‘normal’ also came under scrutiny, as it was felt that for some women this might translate into a sense of failure if normal birth is not ‘achieved’. It also poses the proposition if you are not ‘normal’ then you must be ‘abnormal’ (Hundley and van Teijlingen 2017).

Whilst I have seen anecdotal accounts reported in the popular press, that this is how women may feel, I have yet to find any research evidence that this is indeed the case for the majority of actual childbearing women. Regardless of semantics, midwives celebrate the achievement and success of women having babies through all modes of births and deliveries (Jackson 2017b).

In 2017, it was widely reported in the media that the RCM had dropped the campaign. Far from abandoning the RCMs support for normal birth,

they state that the normal birth agenda is now part of the 'Better Births' initiative (RCM 2017).

The following sections will explore comparisons between normal birth and technological, medicalised childbirth.

## **2.9 Normal birth versus technological birth**

The use of appropriate technology in childbirth where there are complications are clearly necessary to reduce morbidity and mortality. Conversely, in normal straightforward childbirth, the justifications for the promotion of normality are numerous. Birth without medical intervention is associated with; much less pain during the post-natal period (Johanson et al, 1993, Glazener et al, 1995), quicker physical recovery from the birth (Johanson et al, 1993, Glazener et al, 1995), increase in self-esteem (Llewelyn and Osborne 1990), enhanced bonding with the baby (Odent 1999, Ferguson et al, 2002), reduced likelihood of post-natal depression (Fisher et al, 1997, Green et al, 2003), a calmer more settled baby (Kitzinger 1989) and an easier breastfeeding experience (Odent 1999), when compared to medicalised births. Glazener et al, (1995) in their study concluded that the optimal mode of delivery in terms of health outcomes is usually a normal vaginal birth, with both C/S and instrumental delivery more likely to be associated with residual maternal morbidity at one year. Moreover Green et al, (1998, 2003) and Baston et al, (2008) found that higher levels of obstetric interventions were an important

factor in predicting negative experiences of childbirth. The relative merits and disadvantages of normal versus C/S also need discussion.

## **2.10 Caesarean section versus normal birth**

The debate concerning 'normality' cannot be conducted without an exploration of the phenomenon of rising C/S rates in the UK. In 1980 the C/S rate was 9% (Thomas and Paranjothy 2001). In 1989/90 it was 12%, rising to 24% in 2005/06 (Institute for Innovation and Improvement 2006). This doubling of operative deliveries in 15 years was not accompanied by any measurable improvement in outcomes for babies e.g. hypoxic ischaemic encephalopathy (Institute for Innovation and Improvement 2006, NICE 2019). The most recent rate for C/S recorded for 2018/2019 is just over 30% (NHS Maternity Statistics 2019).

There is no question that operative deliveries are necessary and life saving for women (and their babies) with certain conditions such as placenta praevia. It is also clear that, even in the knowledge of some of the disadvantages of C/S, some women still choose this mode of birth. There is the obvious convenience of knowing when and where a baby is going to be born, the relative short time frame for delivery by C/S and avoidance of genital trauma. These seem to be the main advantages of C/S delivery reported by women (NICE 2011, NICE 2018a). Lavender et al, (2012) attempted to conduct a review but found no trial data to reach any conclusions regarding the superiority

of either mode of birth in terms of outcomes. However Lavender et al, (2012) also requested an urgent need for a review of observational and qualitative studies to assess normal vaginal birth compared to C/S in terms of health outcomes for mothers and babies.

The literature reviewed, from well resourced, high income countries, would appear to support that compared to vaginal birth, C/S delivery has higher maternal morbidity rates (Institute for Innovation and Improvement 2006, NICE 2011) and higher maternal mortality rates (Hall and Bewley 1999, Wen et al, 2004) although NICE (2011) do state that the evidence surrounding maternal mortality is complex and equivocal. Some studies cite higher neonatal morbidity rates (Fogelson et al, 2005, Gupta and Saini 2018, Peters et al, 2018) and mortality rates (MacDorman 2008, Gupta and Saini 2018) associated with C/S. MacDorman et al, (2008) found for low risk women having a primary C/S, the risk of neonatal mortality was 69% higher compared with women having a planned vaginal birth. In addition, consultant led care culminating in C/S is more expensive than midwife-led care leading to normal or vaginal birth (NICE 2011, DH 2013, NICE 2014b). The inference of these findings is, therefore, that this intervention should be reserved for maternal and/or fetal conditions that really warrant this mode of birth. Finally, there is a concern that some childbearing women are not making informed choices about their labours and births, and are not being involved in decisions regarding the use of technology in their childbirth experience, which may make them more



likely to have an instrumental or caesarean mode of delivery (Baston et al, 2008).

### **2.11 The risk discourse**

The risk agenda has been blamed as being one of the main reasons for a rise in defensive practice and interventions, even in normal straightforward childbirth (Sandall et al, 2010, Scamell 2016).

Evidence-based medicine claims to reduce or eradicate risk completely by the implementation of diagnostic aids and effective treatments (Walsh 2017). However these scientific processes are based on the positivist paradigm according to Proctor and Renfrew (2000), relegating interpretative, more contextualised approaches to the sidelines. The quantitative evidence based medical model supports an ostensibly rational, coherent, objective construct of the risk discourse according to Walsh (2017).

Coxon et al, (2016) describe an 'organisational culture of fear' within maternity care. Dahlen (2016) discusses the political value of fear, suggesting that fear inevitably leads to anxiety about safety during birth, which consequently rationalises a range of actions and arguably unwarranted interventions.

However, Pasupathy et al, (2010) in their epidemiological study, demonstrated a higher rate of neonatal deaths in Scotland, when births took place out-of-hours, outside of Monday to Friday 09.00-

17.00. This finding does not seem to have permeated into the risk averse conscience, the focus staying on women's lifestyle behaviours such as smoking, obesity, age and also place of birth (Sandall et al, 2010). However, other risks to optimal childbirth such as deprivation, patriarchy, social and structural inequalities do not appear to garner the same consideration from health providers (Sandall et al, 2010). Indeed Scamell (2016) posits that certain potential 'hazards' (over and above other potential 'hazards' such as those previously mentioned) in childbirth are problematized and open to clinical governance and risk management surveillance and are always socially mediated.

In 2016, Scamell authored an illuminating paper based on her ethnographic study on risk and clinical governance in midwifery. She states in her discussion section: "The data presented here suggests that midwives manage to work within two dissentient models of care, 'managing' risk while promoting 'normality' because those models have a disproportionate coexistence. That is to say, one model overwhelms the other: the midwifery rhetoric of normal birth is devitalised by the hegemonic, prioritisation of risk management and sensitivity" (Scamell 2016: 19). These findings serve to exemplify the immense challenges, in a risk obsessed and risk averse culture that midwives are facing in their decision making during women's normal, straightforward childbirth experiences.

## **2.12 Summary**

It is clear that intervention rates in normal childbirth are rising (Health Episode Statistics 2012, Dodwell and Gibson 2012, ONS 2017, NHS maternity statistics 2019, NMPA 2019). The evidence to promote normal birth in a technological, intervention dominant era is compelling. Factors highlighted earlier in this chapter show that normal straightforward birth is associated with potentially far reaching beneficial effects for mothers and babies when compared to medicalised labour and birth (Glazener et al, 1995, Glazener 1997, Lydon-Rochelle et al, 2000, Institute for Innovation and Improvement 2006, Dodwell and Newburn 2010, NICE 2011, Llewelyn and Osborne 1990, Kitzinger 2000, Birthchoice UK 2013, Lobel and DeLuca 2007, NICE 2018b).

In light of acknowledging the benefits of normal childbirth, there is also an abundance of evidence to suggest that normal birth rates vary greatly in different maternity units and many women in normal labour are somehow not realising normal straightforward birth (Andrews et al, 2006, Mead 2008, McCourt 2010, Dodwell and Gibson 2012, Walsh et al, 2020). A number of factors operating at a macro level are influencing this phenomenon including models of care, midwifery organisational models and different places of birth (Hodnett et al, 2012, The Birthplace in England Collaborative Group 2011, Hollowell 2011, Janssen et al, 2009, Lindgren et al, 2008, McLachlan et al, 2012,

Walsh et al, 2020). However, there is a dearth of research at the 'micro' level of midwifery decision-making with individual midwives and women (Cioffi and Markham 1997, Lankshear 2005, Mead and Sullivan 2005, Jefford et al, 2010, Everley 2012). This is the rationale for exploring midwives' decision making in normal labour and birth for this study.

This chapter has explored how the literature was reviewed, definitions of 'normal birth', organisational models of care, birth environment and place of birth, rising intervention rates and models of childbirth. It has elaborated on a recent history of midwifery and maternity care in the UK, the RCMs campaign for normal birth, normal birth versus technological birth, C/S versus normal birth, the risk discourse and a summary of the chapter.

Exploration of decision making theory is essential in a thesis dedicated to this topic. The next chapter will provide an in depth examination of decision making models and theories. The aim of the research and research question will be outlined at the end of the decision making chapter.

## **Chapter 3 DECISION MAKING**

### **3.1 Introduction**

The title of this thesis is 'Midwives' decision making during normal labour and birth'. A robust literature review was conducted to elicit relevant sources of information (see section 2.2: 'Searching the literature' for detail regarding the search process). This chapter will firstly conduct an in-depth exploration of the dominant decision making models and theories used in health care more generally, for example in medicine, psychology, nursing and midwifery. It will then examine some decision making studies that were specific to midwifery.

The chapter will therefore include: a critical analysis of decision making, decision making in health care, models that are dominated by rationalistic cognitive decision making such as the hypothetico-deductive decision making model and evidence-based practice. In contrast, the intuitive-Humanistic / phenomenological model is then explored. There follows theories that include both hypothetic-deductive and intuitive processes these being: the dual processing model and the cognitive continuum of decision making. Finally the following will be discussed: the shared decision making model, 'mindlines', situated clinical decision making in midwifery, seminal decision making studies in midwifery, culminating in the research aim and research questions.

### **3.2 A critical analysis of decision making**

Decisions are commonplace in everyday life, but particularly crucial are the decisions made that can potentially affect health. Bauman and Deber (1989) defined health care decision making as a situation in which a number of alternatives exist and the clinician must make a choice from these alternatives. This often involves a trade-off between the values placed on the possible outcomes. Heller and Hindle (1998) describe a decision as being a judgement or choice between two or more alternatives, arising from an infinite number of clinical situations, through stages of resolution of problems or challenges, culminating in implementation of the decision. Decision making is the process involving the collection of information, followed by analysis and evaluation of this information. Taking the decision is the final stage of the whole process (Lund and Robinson 1993). These early definitions are 'professional centred', meaning they focus on the clinician making the final health decision, rather than the patient or woman. More recent alternative patient / woman centred approaches, where non-experts are involved in the final decision being made, such as informed decision making and shared decision making, will be discussed later in this chapter.

Historically, nurses, midwives and other health care professionals decide what information to collect about the patient or childbearing woman, make a diagnosis or judgement about their condition,

subsequently deciding what intervention or treatment to administer and for how long (Dalglish 2006). According to Dalglish (2006) the quality of client care is unequivocally linked to the quality of the initial decision making processes. A number of researchers (Cooke 2005, Karnieli-Miller and Eisikovits 2009, Greenhalgh et al, 2014, Stacey et al, 2017) have found that patients and childbearing women, wish to make informed choices and share decision making when engaged with health services, rather than have decisions made for them.

Substantial evidence exists demonstrating that health professionals can and do make poor decisions and make serious errors of judgment (Weingart et al, 2000, Mead and Sullivan 2005, Dalglish 2006). A number of health researchers (Thomas et al, 1991, Nieuwenhuijze et al, 2014, Shay and Lefata 2015, Menage 2016a, Krishnan 2018, Jefford 2019) believe that by studying clinical decision making, significant improvements can be made to the quality of care delivered to clients with corresponding improvement in outcomes. Greenhalgh et al, (2014) also identify that research on decision making is crucial in terms of high quality patient centred care and effective evidence based shared decision making.

### **3.3 Decision making in health care**

Over fifty years ago, Polanyi (1966) wrote about tacit knowledge, a dimension where we know more than we can explain. Carper (1978) wrote about two contrasting types of knowledge, 'empirics' or

'scientific knowledge' and 'aesthetic' or 'non scientific knowledge'.

Benner's (1984) work highlighted the difference in propositional and non-propositional knowledge, often termed the 'knowing that' (based on science) and 'knowing how' (based on experience). These authors' writings and theories have been augmented and added to in the fields of psychology, philosophy and nursing, and are intimately related to theories of decision making processes (Paley et al, 2007) as will become apparent in this chapter. In naive terms, ways of knowing and decision making can be divided into rational or intuitive dimensions, or in some instances a combination of both (Paley et al, 2007, Nieuwenhuijze et al, 2014, Menage 2016b, Jefford 2019). Each of the principal decision making dimensions, which have emerged from the literature search, will be discussed and critiqued in this chapter. A wider inclusion of medical, nursing and other health literature and research will be included where it is felt to be relevant and transferable to decision making in midwifery.

In relation to midwifery decision making, there are a number of critical differences to decision making compared to other contexts of healthcare. For example, most childbearing women are healthy, fit and well when they enter maternity services and are considered as having agency to make decisions or share in decisions with HCPs (Birthrights 2017). Whereas in an acute nursing context, patients have a physical and / or mental health condition which could potentially complicate the decision making process, if for example a patients' condition



deteriorates rapidly (Nibbelink 2018), although this could arise in maternity care too, but much less commonly. Currently in the UK, the rights of the childbearing woman always override the rights of the fetus (Meredith 2007, Birthrights 2017) and therefore women's choices and decisions must be respected, even if those decisions could adversely affect the health of the mother and / or fetus.

### **3.4 Decision making models and theories**

As a result of the literature review, there appears to be an abundance of decision making models and theories. The following were most hegemonic and often cited in health care: the hypothetico-deductive model, evidence based practice, the intuitive–humanistic model, dual processing theory, the cognitive continuum of decision making and shared decision making (Mok and Stevens 2005) are just a few of these models. These models and theories will be explored in more detail in this chapter. Clinical judgement, professional judgement, diagnostic reasoning and clinical reasoning are often used interchangeably in the literature and are closely related to decision making (Raynor and Bluff 2005). These terminologies will be incorporated into the discussion as appropriate.

### **3.5 Hypothetico-deductive model (systematic-positivistic, rationalistic, analytical, conscious, rule-based, deliberative)**

The model that appeared to be the most influential in the health decision making literature, up until the 1980s was the hypothetico-deductive, also known as the systematic-positivistic, rationalist, analytical, conscious, rule based or deliberative models (Krishnan 2018). These interchangeable terms will be used in accordance with how researchers have referred to the hypothetico-deductive model. As the name might suggest, this model is considered to be logical, rational, coherent and judicial (Krishnan 2018). Reed (2004) describes hypothetico-deductive logic as making vertical links between the theoretical and empirical. In the modernist, post-enlightenment period of science, theory and research were connected through specialised systems of inquiry which were designed to ensure that research was value free and untarnished from the religious and philosophical teachings of the time (Reed 2004).

The basic tenet of the hypothetico-deductive decision making model is that all clinical decision making can be separated into two discrete categories.

Short term memory accommodates the stimuli responsible to release factual (semantic) knowledge and long term memory accommodates the stimuli responsible for the release of experimental (episodic) knowledge (Carnevali et al, 1984). The foundation of this cognitive

process is represented in four stages as described by Radwin (1990) and Hamers (1994). The practitioner engages with the patient/client for initial clinical data collection. It is possible for this data collection to occur prior to patient/client contact. Following this encounter the clinician formulates a preliminary provisional hypotheses. These are associated with short term memory cues. At this stage there are normally four to six hypotheses generated. Following this the clinician interprets the gathered data, categorising them as either supporting or rejecting the original hypotheses generated. The final stage (associated with long term memory cues) evaluates all the evidence, weighing up the pros and cons of each decision alternative. The ultimate decision chosen will be based on the amount and quality of the available evidence (Thompson 1999). This is a basic description of the four stage hypothetico-deductive process. Other authors use this as the basis for more sophisticated models. For example Carnevali et al, (1984) used the same principles to develop a seven stage process of diagnostic reasoning making model:

1. Exposure to pre-encounter data (e.g. from clients' notes).
2. Entry to the data search field and shaping the direction of data gathering.
3. Coalescing of cues into clusters or 'chunks'.
4. Activating possible diagnostic explanations (hypotheses).
5. Hypothesis and data directed search of the data field.
6. Testing diagnostic hypothesis for goodness of fit.

## 7. Diagnosis.

(cited in Thompson 1999).

Although it is recognised as an efficient system, the main criticism of the hypothetico-deductive model is that it can be open to cognitive biases, often termed 'anchoring' and the model does not appear to take into account these biases. 'Anchoring', is where the decision maker is often tempted to remain faithful to their initial hypotheses, even when new evidence emerges to the contrary (Harbison 2001). There is also the issue of initial hypotheses being generated on the basis of previous encounters with similar situations, thereby introducing further bias (Mok and Stevens 2005). For example a midwife is involved in the care of a woman in the first trimester of pregnancy with eczema, whose initial complaint is severe itching. She then subsequently encounters another pregnant woman in the third trimester of pregnancy who complains of severe itching, and makes an initial diagnosis of eczema, but the woman in reality suffers from intra-hepatic cholestasis of pregnancy. The first condition is treatable and does not have an adverse effect on mother or fetus, the second has potentially serious consequences for the fetus (Hillman et al, 2016).

Nonetheless, the hypothetico-deductive, rationalistic model is thought to be at the core of most evidence based national and local guidelines in the UK, attempting to unify health care treatment and management on the basis that there is sound, high quality clinical research on which

to base those guidelines (Jefford 2019). Thus, the hypothetico-deductive model is a fundamental component of evidence based practice (EBP) and clinical decision making (Carter 2019). A more detailed discussion of EBP occurs in the next section of this chapter.

### **3.6 Evidence based practice**

Historically, clinicians based their decisions on individual preference, choice and quite often on custom and practice (Mackey and Bassendowski 2017). When systematic research began to emerge, such clinical judgements were sometimes exposed as being based on unfounded assumptions, in addition a huge disparity in treatments were discovered for managing the same patient condition (Mackey and Bassendowski 2017). In the early 1970s, Cochrane (founder of the Cochrane library of systematic reviews) proffered that clinicians should strive to utilize only those procedures that have evidential support, mainly research, to be the most effective (Cochrane Collection 2013). Thus attempting to mediate a more uniform approach to healthcare.

Sackett et al, (1996:71) first defined the term evidence based medicine (EBM) as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”.

Evidence based practice (EBP) evolved from medicine and has been implemented into general health care since the late 1990s (Mackey

and Bassendowski 2017). The development of good quality evidence based clinical guidelines has been a consequence of the EBP movement. EBP in contemporary health care reflects that decision making is multi-factorial (Hunter 2008, Greenhalgh et al, 2014, Power 2015, Daemers et al, 2017). EBP can be conceptualized as clinical decision-making that considers the feasibility, appropriateness, meaningfulness and effectiveness of health-care practices (WHO 2017). This may be informed by the best available evidence (hypothetico-deductive and intuitive-humanistic models), the context in which care is delivered, the individual patient or childbearing woman, and the professional judgement (intuitive-humanistic and hypothetico-deductive models) and expertise of the health professional (Jordan et al, 2016).

As long as all of these factors are utilised, then EBP can be an effective tool in decision making. However, if one of these elements dominates, for example purely clinical experience (essentially constructivist), it could lead to outdated ritualistic practices. If research evidence alone (essentially positivist) was utilised, this could lead to prescriptive, non-individualised care (Sackett et al, 1996, Thornton 2006).

Systematic reviews and randomised controlled trials have clearly contributed significantly to EBP, and are appropriate to answer certain questions regarding health (Mackey and Bassendowski 2017). However, a limitation of EBP and clinical guidelines is often cited as the

continuing hegemony of positivistic evidence compared to the apparently inferior nature of more qualitative, interpretative forms of knowledge (Goldenberg 2009, Parkhurst 2016). (See table 3.1).

Table 3.1 NICE grading scheme Source: Brun (2013), National Institute for Health and Clinical Excellence (2014c)	
Recommendation grade	Evidence
A	Directly based on category I evidence
B	Directly based on <ul style="list-style-type: none"> <li>•category II evidence or</li> <li>•extrapolated recommendation from category I evidence</li> </ul>
C	Directly based on <ul style="list-style-type: none"> <li>•category III evidence or</li> <li>•extrapolated recommendation from category I or II evidence</li> </ul>
D	Directly based on <ul style="list-style-type: none"> <li>•Category IV evidence or</li> <li>•extrapolated recommendation from category I, II or III evidence</li> </ul>
Evidence category	Source
Ia	Systematic review and meta-analysis of randomised controlled trials
Ib	At least one randomised controlled trial / Critically appraised topics and articles, point of care decision-making tools
IIa	At least one well-designed controlled study without randomisation
IIb	At least one other type of well-designed quasi-experimental study
III	Well-designed non-experimental descriptive studies, such as: comparative studies, correlation studies or case studies
IV	Expert committee reports or opinions and/or clinical experience of respected authorities

Evidence hierarchies used in healthcare have been severely criticised as they marginalise other forms of evidence such as qualitative research (McCourt 2005, Lambert et al, 2006, Petticrew and Roberts 2008, Goldenberg 2009, Parkhurst 2016). Affective and emotional (intuitive) aspects of health care, such as those impacting on childbearing women (thoughts, feelings, values, expectations) are clearly paramount. Therefore minimising more interpretive, naturalistic types of evidence is seriously problematic within this context (Goldenberg 2009, Daemers et al, 2017). This issue is discussed in further detail within 'Midwives' decision making and evidence based practice' (see chapter 7, section 7.3.2).

Overall, despite the potential limitations of EBP (and its corresponding hypothetico-deductive dominant component), it is considered to be the cornerstone of good clinical decision making for all health care disciplines. Good quality clinical guidelines are an essential element of EBP and form a vital part of decision making processes, whilst also including patients and childbearing women's choices and preferences (NICE 2014b, Weber and Rajendran 2018).

### **3.7 The Intuitive-Humanistic model (phenomenological, affective, non-rational, non-conscious, unconscious, emotional models)**

The intuitive-humanistic decision making model is also known as the phenomenological, affective, non-rational, non-conscious, unconscious



or emotional models (Krishnan 2018) and these interchangeable terms will be used when authors refer to them as such.

The term intuition in this context is defined in the following ways:

“understanding without a rationale” (Benner and Tanner 1987:23),  
“immediate knowing of something without the conscious use of reason”  
(Schrader and Fischer 1987:63), “a perception of possibilities,  
meanings and relationships by way of insight” (Gerrity 1987: 63).

The general principle of the intuitive-humanistic model is that intuitive judgement replaces analytical thinking and is utilised by experts (as opposed to novices) to make appropriate judgements and decisions according to Thompson (1999). Supporters of the intuitive-humanistic model would argue that the rational logical forms of decision making that analyse or compartmentalise situations into the sum of its parts, reduces sensitivity resulting in important information cues being lost and decision making is therefore rendered less effective (Thompson 1999). Alternatively, experienced practitioners utilise recognition of similar situations to operationalise intuitive knowledge (Mok and Stevens 2005). Unlike the cognitive bias (anchoring) inherent in the hypothetico-deductive model, theorists claim that clinicians use of intuition enables them to visualise ‘the whole picture’ as a basis for more holistic decision making (Mok and Stevens 2005). Polanyi (1966) drew on the psychological theories of Gestalt. This relates to seeing a ‘completeness’ or ‘wholeness’ in a situation and is closely related to

experience. Polyani (1966) called this way of knowing 'tacit knowledge' but highlighted that tacit awareness relies on a personal, localised context which cannot be assumed to have universal validity.

The intuitive-humanistic decision making model has been subject to criticism for being less rational and structured than decisions made using system (or peer) aided judgement or based on scientific evidence such as randomised controlled trials or quasi experimental studies (Mead and Sullivan 2005, Vlassova et al, 2014, Krishnan 2018). Siddiqui (2005) discusses the historical epistemological reliance on positivism, and particularly empiricism as legitimate ways of acquiring knowledge. Intuition is not easily studied or articulated. Practitioners often refer to it as having a 'gut feeling' but such feelings are difficult or even impossible to measure, and are therefore not highly valued or endorsed by the logical positivists, who highlight the primacy of observation as being the only way to assess 'truth' (Siddiqui 2005, Mok and Stevens 2005).

In the wider health literature, more empirical research is emerging on the phenomenon of intuition (Vlassova et al, 2014, Mikels et al, 2011 Lufitynato et al, 2016) but most researchers studying this concept do so by garnering individuals' feelings and perceptions rather than the "actual existence of a testable mechanism involving emotionally charged, rapid, unconscious processes" (Lufitynato et al, 2016: 622). Additionally, even if the presence of intuition is acknowledged, there is

little scientifically rigorous evidence, at least in the positivistic sense, that it contributes to what might be termed, sound, erudite judgements and decisions (Vlassova et al, 2014). Some may contend that intuition is simply a prosaic accumulation of experience, knowledge acquisition and pattern recognition (Mattson 2014). Finally, some researchers feel that intuition is not consistently and repeatedly reliable in making important decisions (Dawes 2001, Greer 2005) which, in the context of healthcare, could be potentially problematic even catastrophic, in high risk situations. Nibbelink (2018) suggests that poor outcomes can occur regardless of the decision making approach adopted.

It was the work of Benner (1984), which was highly influential in nurse education and training, that provided an intuition based model to counter the systematic-rational approach. She presented a five-stage model: novice, advanced beginner, competent, proficient, and expert. The expert does not use general guiding rules on which to make decisions, but instead has an intuitive grasp of situations. Hypothetico-deductive processes are only used with unexpected or unfamiliar challenges (Thompson 1999). The very nature of intuition renders this theory problematic in terms of communicability, because, as already discussed, by definition it is intangible, difficult to record or measure. According to Davis-Floyd and Davis (1996) in western society, only highly linear inductive and deductive reasoning processes are considered to be trustworthy. They state that the inner knowledge that

constitutes a primary source of authoritative knowledge is granted no authority in the realm of technomedicine (Davis-Floyd and Davis 1996). Intuitive models such as that advocated by Benner (1984) were adopted widely in nursing practice, but according to Hargreaves (2001) the model paid little attention to the crucial influence of context.

In psychology, a number of researchers have added to the decision making discourse, by supporting claims that emotional, affective, intuitive processes can and do effectively enhance decision making processes (Mikels et al, 2011, Lufityanto et al, 2016). Mikels et al's, (2011) study aim was to examine whether affective (intuitive) versus deliberative (hypothetico-deductive) processing may be more effective for making complex decisions. They conducted four systematic controlled, psychological (laboratory based) experiments on a total of 238 participants. The researchers state the experiments had been previously validated. The sample group of undergraduate students in America were exposed to simple and complex decision making options. The researchers concluded that basing decisions on affective (intuitive-humanistic) impressions can be superior to deliberative (hypothetico-deductive, rationalistic) processes for particular complex decisions. There was no mention of which University or what the students were studying in the article, which could be relevant when critiquing the study. The author's report that these findings were contrary to traditional thinking that emotions impede effective decision making (Vohs et al, 2007).

Similarly Lufityanto et al's, (2016) research aim was to find evidence of an unconscious, emotionally based, rapid decision making process that might correspond with the concept of intuition. They conducted a series of six systematic, controlled, psychological (laboratory based) experiments, using a validated computational model, on a total of 81 participants (72 undergraduate students at the University of New South Wales and nine participants who were not university students). They reported that nonconscious, intuitive, emotional information can boost accuracy and confidence in a decision task, while also speeding up response times.

Researchers in the previous studies (Mikels et al, 2011, Lufityanto et al, 2016) acknowledge that use of university students as participants could bias the studies due to their educational status (none of the researchers discuss this in any detail), although Lufityanto et al, (2016) did use a small control group of non-university students. It is important to note that both researchers state that they are not claiming supremacy of affective, intuitive decision making processes over rational, hypothetico-deductive based decision making (Mikels et al, 2011, Lufityanto et al, 2016). Rather they are supporting that intuition can be used effectively under certain conditions. Mikels et al, (2011) also caution that intuition can lead to flawed, biased decisions that can be corrected or moderated by deliberation (hypothetico-deduction). Thereby concluding that both intuitive and rational forms of decision making are essential in health care, having a kind of

symbiotic relationship. Nonetheless the two discrete models of decision making do not take place in a vacuum. There are a whole raft of contextual, socio-political, professional issues that further frustrate and complicate decision making. I will return to this point later in the chapter.

Overall, that there is emerging robust, empirical evidence that non-rational, intuitive, non-conscious decision making strategies (often referred to as S1 thinking in the dual processing theory), do have a scientifically verifiable basis and indeed should contribute to evidence based practice (Goel et al, 2000, Kahneman and Frederick 2002, Stanovich and West 2002, Paley et al, 2007, Koenig et al, 2007, Mikels et al, 2011, Lufityanto et al's, 2016) and be balanced with hypothetico-deductive based thinking.

This evidence of different, contrasting cognitive processes enhancing decision making will be explored further in the dual processing theory and cognitive continuum sections.

### **3.8 Dual processing model**

One of the most well established models of decision making, developed in the field of psychology, is the 'dual processing model'. This theory postulates that there are two discrete systems of reasoning and rationality. The first is intuitive, unconscious, experiential and fast. The second is analytical, rule based, conscious, and slow. The two

processes are frequently referred to as generic labels, system one (S1) and system two (S2) (Stanovich and West 2002, Paley et al, 2007). S1 is thought to be an evolutionary process that developed and adapted to solve specific problems and S2 is thought to be learned, flexible and responsive to rational norms. According to Kahneman and Frederick (2002) it is generally accepted that S2 evolved more recently than S1. S1 is a rapid, simplistic and a relatively efficient means of addressing issues in complex situations. However, S1 utilises heuristic problem solving strategies and is open to error and bias and requires repeated correction by the second system which relies on deductive reasoning (Koenig et al, 2007). In neuropsychological decision making research, utilising neurological tracking systems (n=11) within the brain via magnetic resonance imaging (MRI), it was observed that S1 and S2 have differentiated neural pathways (Goel et al, 2000), supporting the inference that different processes are at work depending on the engagement with S1 or S2 thinking.

Theoretically, S1, though more primeval than S2, is in many ways just as capable and effective in cognitive decision making processes as S2. Indeed, psychologists Kahneman and Frederick (2002) hypothesize that complex cognitive processes eventually transfer from S1 to S2 as competency and skills are mastered.

The hypothetico-deductive and intuitive-humanistic decision making models have been previously discussed as discrete and separate. The

dual processing model amalgamates these two binary systems, lending further support to the theory that far from being competing forces, they work in tune, in balance with each other, as reported in psychologists later experimental research (as discussed previously in this chapter - Mikels et al, 2011, Lufityanto et al, 2016).

The characteristics of intuitive versus analytical decision making processes are summarised in table 3.2:

Table 3.2: Characteristics of intuitive versus analytical approaches in decision making. Source: Croskerry P (2005) The theory and practice of clinical decision-making.		
	Intuitive	Analytical
Cognitive style	Heuristic	Systematic
Cognitive awareness	Low	High
Conscious control	Low	High
Automaticity	High	Low
Rate	Fast	Slow
Reliability	Low	High
Errors	Normative distribution	Few but large
Compliance	High for answer Low for method	Low for answer High for method
Effort	Low	High
Predictive power	Low	High
Emotional valence	High	Low
Detail on judgement process	Low	High
Scientific rigour	Low	High



The dual processing model has gradually gained credence, especially amongst social and cognitive psychologists (Kahneman and Frederick 2002, Koenig et al, 2007). Conversely, in a critical review of research into dual processing theory, Evans (2008) suggests that there are numerous types of inherent processes offered by different theorists and that not all of the proposed attributes of the two kinds of processing can be discretely categorised into two systems as currently understood. Evans (2008:255) states "while some dual-process theories are concerned with parallel competing processes involving explicit and implicit knowledge systems, others are concerned with the influence of preconscious processes which contextualize and shape deliberative reasoning and decision making".

The dual processing theory strikes me metaphorically as a decision making piston engine. Only one of the pistons can be in operation at any one time, either intuitive or rationalistic thinking but never both at the same time. The cognitive continuum model presents an alternative cognitive process, discussed in the next section.

### **3.9 The cognitive continuum of decision making**

According to Cheyne et al, (2006) the systems of analytical and intuitive decision making were historically and traditionally considered to be mutually exclusive. However Hammond (1988) proposed an alternative view, where different modes of thinking could be based on a cognitive continuum, with intuition at one end of the continuum and

analysis at the other. The theory being that the type of thinking required was dependent entirely on the nature of the decision to be made.

Hammond (1988) theorises that the effectiveness of the judgement or decision should be highest when the induced cognitive process corresponds to that part of the continuum that is appropriate for the task system: analysis (or calculation), intuition or sometimes a combination of both (Dawson 1995). For example, in times when information cues are plentiful but time is not, the clinician may draw on the intuitive part of the continuum. This is often utilised by experienced health professionals faced with familiar tasks. This is also known as pattern recognition, recovering experiential stored knowledge. If information is limited, (and more remarkable) and time is increased, then more analytical types of judgements will be used. Inexperienced health professionals, or experienced clinicians faced with unfamiliar or complex tasks will use hypothetico-deductive reasoning (Cheyne et al, 2008a, Elstein and Schwarz 2002).

Paley et al, (2007) discuss that evidence based (analytical, scientific) knowledge tends to have epistemological priority over other forms of nursing knowledge. Many authors and researchers argue that other forms of knowledge should be included in evidence based care: experiential, intuitive, professional craft knowledge and reasoning for example (Rycroft-Malone 2004, Fawcett et al, 2001, Paley et al, 2007),

which could all impact on and influence where on the cognitive continuum, midwives would be executing their decision making. The authors (Rycroft-Malone 2004, Fawcett et al, 2001, Paley et al, 2007) do not discuss what happens if the contributing forms of knowledge conflict with each other.

Thompson (1999) White et al, (1992) and Eraut et al, (1995) argue that solely rational, analytical processes do not explain highly developed, sophisticated levels of clinical activity, providing support for Hamm's (1988) 'cognitive continuum theory'. Initially grounded in medicine this theory could be legitimately transferable to nursing and midwifery practice (Thompson 1999). Hamm (1988) speculated that cognitive processes are neither purely analytical nor purely intuitive, rather they are positioned on a continuum at a point between the two, at times working concurrently, synergistically unlike in the dual processing theory. The cognitive continuum could therefore be more practical and applicable to the complexities of health care decision making.

Hamm (1988) theorises that the degree of analytical and intuitive thinking and where on the cognitive continuum the task will lie, is dependent on three dimensions of the task; complexity of the task structure, ambiguity of the task and the nature and presentation of the task (see appendix 2). Hamm (1988) also acknowledges that other

influences and variables are in action during clinical decision making such as power, social structure and individual professional knowledge.

In addition to those previously mentioned, Mok and Stevens (2005) highlight associating factors that can influence decision making. These include environment (home, hospital), culture of organisations, maternity units and individuals (including custom and practice), spiritual leanings (religious ideologies), professional (junior, senior), philosophy of childbirth (social, medical model), level of experience (novice or expert) and clinical governance issues (risk management, guidelines). So for example, if a midwife adopts a medical model of childbirth, she may be more likely to encourage an interventionist, technocratic decision making approach to labour and birth (McKenzie Briars and van Teijlingen 2010, Walsh 2017). These influential factors discussed previously are related to midwives but many of these could just as easily be applied to women themselves, in addition to stage of labour (early labour, transition), level of pain experienced (personal perception), previous experiences (types of birth, good or bad) partners / husbands views (witnessing partner in pain)(Jackson et al, 2014). So for example if a woman had a bad experience of a medicalised birth previously she may want a physiological birth this time around (Walsh 2012, Walsh 2017), or vice versa. In nursing contexts, acutely ill patients have been found to have a preference for more passive decision making (Wilkinson et al, 2008), but this does not seem to be the case for most childbearing women, the vast

majority of whom, are healthy and wish to be engaged in decisions concerning their care (Green et al, 1998, Houghton et al, 2008, Jefford 2019). The clinical reality (or realities) suggests drawing on rational or intuitive forces separately or indeed exclusively, is far too simplistic. The theories and models drawing on both cognitive decision making processes may therefore be much more applicable, reliable and efficient in health care settings.

### **3.10 Shared decision making model**

In addition to models exploring the cognitive processes involved in decision making, the shared decision making model focuses on the individuals, such as consumers of health care and HCPs, who are involved in health care decisions and to what extent (Karnieli-Miller and Eisikovits 2009, DH 2010a, Nieuwenhuijze et al, 2014, Joseph-Williams 2017, NICE 2019).

According to Briss et al, (2004) shared decision making is a collaborative decision making process shared jointly by clients and their health care providers. This model of decision making aims to encompass client centred care to its highest degree, involving and engaging clients in all health care decisions. Shared decision making is a form of client-provider communication where both parties are acknowledged to bring their own particular expertise to the process and work in partnership to make a decision. This is advocated on the basis that clients have a right to self-determination and also, according

to Duncan et al, (2010), if a decision has been agreed by a patient (or childbearing woman), the expectation is that it will enhance clients' co-operation.

In 2001, Elwyn and Charles described three decision making approaches used in medical decision making. The first approach is 'paternalistic': all the information comes from the professional. The information is limited in nature. The decision is reached by the professional alone or following discussion and debate with professional colleagues. The client's views and preferences are either not elicited or ignored.

In the 'shared decision' making approach, information is shared from professional to client and vice versa. The professional imparts information that is appropriate and relevant, for example choices available, risks and benefits. The client shares information about themselves, such as health status, lifestyle, their own values and preferences. The client engages in debate and discussion regarding health choices and partners, other family members, or friends may also be included in such discussions. The ensuing decision is reached through mutual negotiation (Elwyn and Charles 2001).

In the 'informed approach', the information exchange is largely one directional from professional to client, the professional acting as an agent to transfer research and evidence to inform the client of their options and also convey risks and benefits. The client formulates

decisions either on their own or with the help of family and friends. In the 'informed approach' model, the professional does not offer any opinion or advice (Elwyn and Charles 2001).

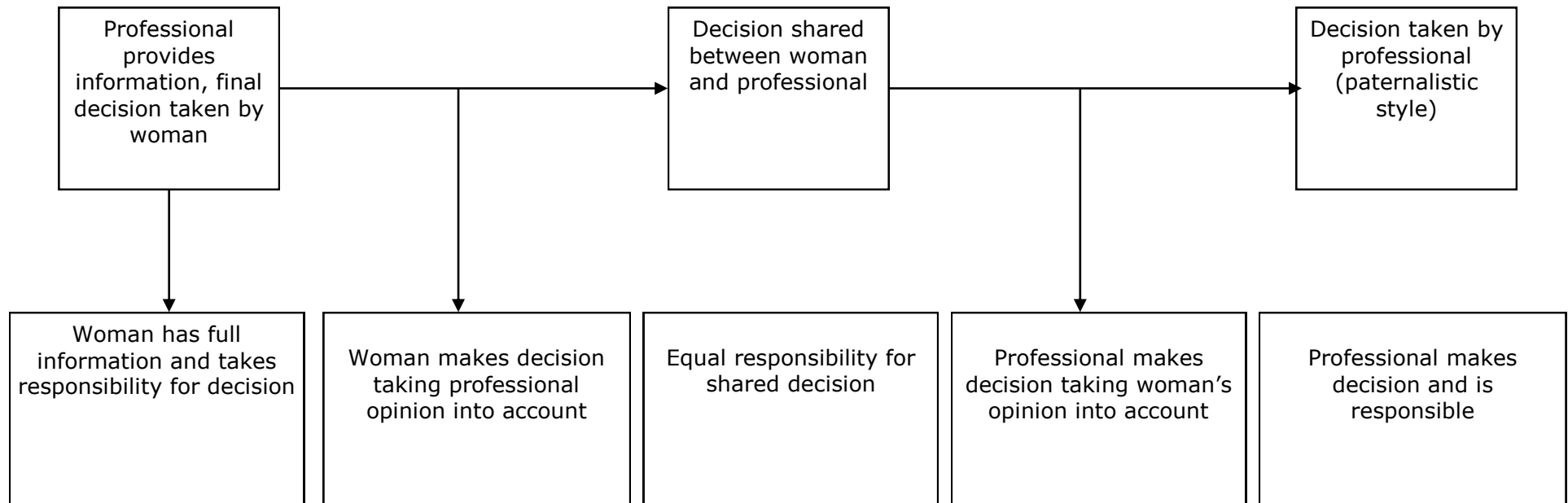
As discussed earlier, in maternity care, women tend to favour shared decision making models, but small numbers prefer to make decisions themselves or for health professionals to make decisions for them (Wykes et al, 2001, O'Cathain et al, 2002, Cooke 2005). (See figure 3.1: an 'at a glance' schematic representation of the decision making continuum).

These decision making approaches, used primarily within the medical model, have utility for nursing and midwifery practice. At the one extreme of a continuum is the paternalistic model where the physician will make and impose all decisions (Karnieli-Miller and Eisikovits 2009), at the other extreme is the informed model, sometimes described as the 'laissez faire model' (Emanuel and Emanuel 1992, Quill and Brody 1996), where information is provided to the patient and they make a decision without further input from the medical professional. In the middle of the continuum are the enhanced autonomy, shared decision making and the hybrid intermediate models (Quill and Brody 1996, Charles et al, 1999). The type of model is dependent on the extent of involvement of each of the participants (physician, client, family/friends) in the decision making process. Nursing and midwifery have echoed the continuum of medical decision making and adapted

them for use within their own fields. Cooke's (2005) model (see figure 3.1), illustrates a decision making continuum within midwifery and was not designed to include any of the contextual influences on decision making.



Figure 3.1: Decision making continuum. Source: Cooke (2005)



A systematic review was conducted by Stacey et al, (2017) on the use of decision aids in health care, including the effect of shared decision making on health outcomes. The review consisted of 115 trials that evaluated the efficacy of decision aids where patients or clients had to make difficult treatment or screening decisions. This compared usual care (not using decision aids) with utilisation of decision aids, models or programs. This review showed that for health care consumers, shared decision making: improved knowledge base, made them feel informed and more clear about what matters most to them, have more accurate expectations of possible benefits and harms of their options, participate more in decision making, lowered decisional conflict (related to feeling uninformed), increased the proportion of clients active in decision making (and related reduction in passivity in decision making), reduced the number of people who remained undecided and produced greater agreement between values and choice. Conversely, overall there were no significant benefits to general health outcomes or disease-specific health outcomes, which tend to be the focus of health stakeholder's interest (Stacey et al, 2017). However, a number of authors suggest that the many psychological benefits of shared decision making to health, should be of equal value to bio-physical benefits (Powell et al, 2010, Shallow 2016, Walsh 2017)

Shared decision making and involvement of patients, clients or women, in their own care, appears to be considered good practice in modern day health care services (Cooke 2005, Karnieli-Miller and Eisikovits 2009, DH 2010a,

Nieuwenhuijze et al, 2014, Joseph-Williams 2017, Stacey et al, 2017, NICE 2019). Indeed health policy now encompasses shared decision making, with the notion of 'No decision about me without me' being the pre-eminent component of the policy documents (Department of Health and Social Care 2010a, Health and Social Care Act 2012).

A number of population, clinical based surveys and reviews have demonstrated that significant numbers of consumers would like to be actively involved in decisions concerning their health (Chamot et al, 2004, Haskard and DeMatteo 2009, Coulter 2010, Begley 2019). In midwifery, studies and reviews repeatedly demonstrate that generally, involving women in decisions during pregnancy and childbearing, in an empowering and collaborative way, enables them to achieve a more positive birth experience and improves psychological outcomes (Green et al, 2003, Hardin and Buckner 2004, Porter et al, 2007, Nieuwenhuijze et al, 2014, Healey et al, 2015).

In UK based studies, using postal questionnaires, Wykes et al, (2001) and O'Cathain et al, (2002) elicited that the vast majority of women, over 80%, of their sample groups, want to share in decisions made during the whole of the childbearing continuum. Nonetheless they found that just under half of their sample groups (n=1957 and n=31270 respectively) felt that they had not exercised informed choice and thereby did not feel that they had shared in decisions made whilst receiving maternity care. These studies then demonstrate dissonance between what most women want and value, and

what was actually happening in the maternity services. Of the remaining women in O’Cathain’s (2002) study, most (approximately 14%) wanted to make the final decision themselves with a minority (approximately 3%) wanted the HCP to take responsibility for decision making. HCPs therefore need to be adaptable in specific circumstances when this is the case (Wykes et al, 2001, O’Cathain et al, 2002).

In spite of the evidence, Joseph-Williams et al, (2017) review of barriers to implementing collaborative (shared) decision making in the NHS, found that this model has yet to be widely adopted by health care professionals.

Joseph-Williams et al, (2017) reported on the ‘The MAGIC’ (Making Good decisions in Collaboration) programme. ‘The MAGIC’ programme was commissioned by the Health Foundation (2013) programme to design, test, and identify the best ways to implement shared decision making into primary and secondary care settings using quality improvement methods.

Ways in which shared decision making can be effectively implemented into the NHS, include examples such as clinical team interactive workshops and embedding a culture of shared decision making in nursing, medical and midwifery curricula. Joseph-Williams et al, (2017:3) state that

“Implementing shared decision making is challenging but possible. No one intervention will succeed in isolation. It requires interventions to support organisations, clinicians, and patients: a bundle of interventions working together holistically across all healthcare settings”.

Most of the literature on shared health care decision making, acknowledges its benefits to patients, clients and childbearing women (Sandman and Munthe 2009, Charles et al, 1999, Cooke 2005, Sullivan 2005, Moffatt et al, 2007, Porter et al, 2007, DH 2010a, Joseph-Williams 2017, Stacey et al, 2017, NICE 2019). However, there are critics of shared decision making. Coulter (1997) discusses that some clients do not want to be involved in making decisions and that it is unrealistic to provide comprehensive information on the potential risks and benefits of all available options. In addition, clients may demand unnecessary interventions or treatment options that are expensive or harmful and could have an inequitable effect on the allocation of resources (Coulter 1997). There may also be theoretical agreement about the value of shared decision making in health care settings but the rhetoric does not always translate well into the 'reality' of clinical contexts (Stevenson 2002). In maternity services, according to Menage (2016a: 44) "midwifery theory, and maternity service policy and rhetoric all promote egalitarian relationships with women and emphasise the importance of choice. However, too often these principles fail to transfer to real clinical situations". Menage (2016a) goes on to argue that any decisional making model must also be realistic. Environmental, organisational, professional, cultural and many other factors may conflict with women's decisions, making SDM a considerable challenge. How these challenges are managed will be a point of interest to this PhD study.

Trede and Higgs (2008) point out that the role of care providers and clients are dynamic and subject to change, for example if the health condition of

the client progresses from acute, to sub-acute, to chronic, the decision making preference of the client may also change.

In the majority of cases, midwives could feasibly use the shared decision making model with healthy, well, childbearing women who are competent to make decisions. In some circumstances however, shared decision making would be prohibitive. For example, in women who are unconscious and are experiencing emergency, sometimes life threatening conditions. In these situations, health professionals have to do what is in the woman's best interests (medically) and is immediately necessary to save life (GMC 2008, NHS 2016).

Wickham (2016) feels that shared decision making implies that the practitioner has a say in the choice being made, whereas the decision should be entirely down to the individual whose health care is under discussion. In addition King et al, (2018) states that to be meaningful, shared decision making must be free from implicit biases, prejudices and values and suggests that this cannot be guaranteed in midwifery practice. An interpretive perspective would argue that Kings et al's, (2018) beliefs are embedded within a positivistic world view. In social sciences, humans are 'meaning makers' and therefore value free, unbiased judgments are not possible in the context of the social world (Winch 1990). All involved in maternity care, including the woman herself, arrive at the maternity unit with their own unique embodied preconceived ideas, experiences and beliefs which will all impact on decision making (Shallow 2016, Walsh 2017).

Stapleton et al, (2002) assert that the informed choice and shared decision making rhetoric, does not translate seamlessly into practice. In clinical practice normative patterns of care are often sustained, those of 'informed compliance' rather than 'informed consent'. HCPs are seen as the 'trusted experts', hence an unequal relationship is mediated in decision making situations. Walsh (2010a, 2017) discusses the 'illusion of choice' in maternity care, as women are often gently steered towards the HCPs preferred option, whilst ostensibly claiming that it is the woman's decision.

In addition to the issues discussed previously, there are complex discourses surrounding the issue of informed consent as advocated by the Nursing and Midwifery Council (NMC 2015b). In medicine, and more recently in nursing and midwifery, the ethical principle of beneficence balanced with client autonomy may cause professional conflict. As stated at the beginning of this chapter, in the UK the rights of the mother always outweigh those of the fetus (Meredith 2007, Birthrights 2017). Health care providers may find themselves in ethical dissonance, supporting a woman who is making a decision that they know in the balance of probabilities will confer harm to her and / or her fetus (Mann 2004).

Non-maleficence (*primum non-nocere*), first do no harm, is a fundamental tenet of health care provision (Mann 2004) and therefore in certain medical and health care settings the health provider feels justified in adopting the 'doctor/ professional knows best' approach. This however is contrary to the Nurses and Midwives code of conduct (NMC 2015b), where it is implicit that

clients have the right to be involved and share in all decisions concerning their health care, including the right to refuse advice or treatment.

Furthermore, religious and cultural beliefs must be respected by nurses and midwives (NMC 2015b).

Nonetheless, on balance shared decision making has been found to have many more benefits to healthcare than limitations (Green et al, 2003, Hardin and Buckner 2004, Nieuwenhuijze et al, 2014, Healey et al, 2015, Stacey et al, 2017, Department of Health and Social Care 2010a, Health and Social Care Act 2012, Health and Social Care Act 2012). The degree of shared decision making reported between midwives and labouring women may be an important aspect of this PhD study.

### **3.11 A brief history of decision making influences in healthcare**

The NHS has a long history of encouraging or mandating for patient, and childbearing women's involvement in their own health care (DoH 1989, 1991, House of Commons 1992, DH 1993, DH 2007a, 2007b, DH 2007c), usually focusing on 'choice' and 'control' as the cornerstones of good decision making for consumers. Thereby signalling a shift in the power dynamic in decision making, from health professional towards consumer.

Informed decision making, leading to informed consent, was a framework introduced in the late 1980s (Bekker et al, 1999). Designed to give NHS consumers sufficient information so that they could make a choice in relation to their health care and be responsible for their decisions. It was initially



enshrined in government policy in the National Framework for Children, Young People and Maternity Services (DH 2004).

The notion of informed choice has more recently been recognised as part of a wider shared decision making framework. Unlike informed choice which ultimately means the consumer is responsible for their own health decisions, shared decision making promotes an egalitarian relationship in the health decision making dyad, between HCP and consumer (Jefford 2019).

Childbearing women's and patient's involvement in decisions in their care using the shared decision making model, has become health policy in the UK (DH 2010a, Health and Social Care Act 2012, NHS England 2017a, NHS England 2017b). As with all decision making models, there are merits and disadvantages to both informed choice and shared decision making approaches and these have been discussed in detail previously within this chapter. Overall, shared decision making has been endorsed as a model to aspire to in the NHS (DH 2010a, Health and Social Care Act 2012, NHS England 2017a, NHS England 2017b, NICE 2019), however there are considerable barriers to achieve the implementation of the shared decision making model. Again this has been discussed earlier in this chapter (see section 3.10).

The views, comments, strengths and limitations of shared decision making are highly relevant to my own PhD study. The challenges of midwives engaging with SDM and to what extent, will be a consideration when

developing the research methodology, and throughout the writing of this thesis.

The next section in this chapter will explore some theories of contextualised, situated clinical decision making. More recent empirical situated decision making studies will also be discussed.

### **3.12 Situated clinical decision making theories**

A number of situated decision making models and frameworks have been proposed in health care. To explore what can be learnt from various health professionals' decision theoretical tools, including the complexity of decision making within these contexts, for this section I have selected three situated decision making models. The situated clinical decision making framework (used to assess novice nurses decision making theoretically and clinically - Gillespie 2010), 'mindlines' (a medical decision making model which has been the subject of a systematic review - Gabbay and Le May 2004) and the model for evidence based decision making in midwifery care (used in clinical practice by midwives - Menage 2016b).

A crucial aspect of healthcare is situated clinical decision making. Situated clinical decision making is embedded in situated learning theory, which posits that learners mainly acquire knowledge through real world social interactions (Lave and Wenger 2003). Lave and Wenger (2003) propose that novices, when in the clinical context, have 'legitimate peripheral participation' (learn about clinical care and decision making on the side lines)

until they develop more professional skills when they can fully engage in what they call a 'community of practice' (participate in clinical care and situated decision making).

Lave and Wenger's (2003) theory has resonance with Benner's (1984) 'novice to expert' theory of how contextualised, practice based learning takes place in nursing (see section 3.6). Indeed Benner's (1984) and Lave and Wenger's (2003) theories are based on the benefits of apprenticeship styles of learning in contrast to largely classroom based learning.

Furthermore, nursing situated learning theory (Lave and Wenger 2003) has formed the basis of the situated clinical decision making framework, placing the phenomenon of decision making in the immediate and broader context of nursing (Gillespie and Peterson 2009, Gillespie 2010).

The situated clinical decision making framework is comprised of: context, foundational knowledge, the clinical decision making process and thinking. The context includes (for example at micro level) the nurses experience, confidence and consideration of any moral or ethical issues. At the meso level examples could include the unit culture, workloads and staffing patterns and at macro level influences include: the profession, society and government policies. Foundational knowledge relates to nurses knowing the profession, knowing the self and knowing the patient. The framework examines clinical decision making, where nurses gather cues, then make judgements and decisions based on those cues. This aspect also describes a reflective aspect, where the practitioner should evaluate their performance

in terms of the outcomes of the decision. Finally, the framework considers nurses ability to think and consider their own assumptions, values and beliefs on decision making processes (see appendix 3, Gillespie and Peterson 2009, Gillespie 2010).

Many of the theories and models of decision making are polarized and binary such as the hypothetico-deductive (rational) (Reed 2004) and intuitive-humanistic (phenomenological) (Thompson 1999) models. The cognitive continuum (Hammond 1988) and the dual processing theory (Stanovich and West 2002) are also based on the same binary cognitive processes at work during decision making and do not consider the multitude of factors influencing those cognitive processes. In contrast, the multi-dimensional aspects of nurses' judgements are incorporated into the situated clinical decision making framework and reflects the multi-layered, deeply complex, arguably real life influences on nurses' decision making. As such this model offers a more comprehensive, broader reflection of clinical decision making. The framework was not designed to account for expert nurse practitioners decision making. Therefore its application is to novice nurses, it is not known if it could apply to any other HCP.

Gabbay and Le May (2004) appear to be the first researchers to have coined the term 'Mindlines'. They conducted an in-depth and extensive ethnographic study within two highly regarded areas of primary care in the UK. One was an inner city GP practice in the north of England serving a community where there is high unemployment and a large number of

immigrants and students. The GP practice in the south treats a largely middle class population. Gabbay and Le May (2004) found that practitioners, mainly GPs and nurses, only rarely referred to research findings, clinical guidelines or other types of formalised knowledge. The clinicians were more inclined to use 'mindlines' described as "internalised and collectively reinforced tacit guidelines rather than consulting written guidelines. These were informed by brief reading but mainly by their own and their colleagues' experience, their interactions with each other and with opinion leaders, patients, and pharmaceutical representatives, and other sources of largely tacit knowledge..... resulting in socially constructed knowledge in practice" (Gabbay and Le May 2004:329).

'Mindlines' differs to other models and theories of decision making as it is the construction of both intuitive-humanistic, tacit forms of decision making and to a lesser extent hypothetico-deductive (or rational) forms of decision making. In addition, 'Mindlines' also highlights clinicians valuing colleagues views and experience when making decisions, a factor that is rarely mentioned in other theories (Gabbay and Le May 2004). 'Mindlines' also includes patients in a shared decision making process.

Examining 'mindlines' through a reflexive lens (Polit and Tanto-Beck 2014), as a nurse and a midwifery practitioner, this model particularly resonates with my own and my experience of colleagues decision making behaviour. For example, in some clinical areas, HCPs often ask their colleagues advice or support concerning a decision about a patient / childbearing woman's

management, rather than immediately referring to local guidelines. This is because guidelines are sometimes difficult (IT issues) or time consuming (finding the correct guideline) to access. This of course is my own interpretation of decision making behaviours in clinical practice.

It could be argued that 'Mindlines' when being compared to using solely intuitive or hypothetico-deductive models of decision making, better reflects the realities of clinicians' decision making influences and represents a more context based, holistic approach to this complex phenomenon.

Wieringa and Greenhalgh (2015) conducted a systematic review using the concept of 'mindlines' within medicine. They synthesized 340 publications on the notion of 'mindlines' in real world (clinical) settings. The aim of the review according to the authors, was that they wanted to discuss whether and how 'mindlines' have influenced (or should influence) the EBM movement. They wanted to explore the impact of 'mindlines' on EBM and how the concept of 'mindlines' was interpreted and applied by researchers and practitioners following Gabbay and Le May's (2004) seminal paper.

The reviewers found that theoretical articles have contested the rationalist assumptions of evidence-based medicine (EBM). Traditionally, EBM, as with positivism, is predicated on the view that there is a knowable reality, unrelated to context, that is predictable and can be subject to rules. Conversely, 'mindlines' possess a more flexible, embodied and subjective view of knowledge, where context is key and multiple realities exist. They concluded that 'mindlines' provide the potential for EBM to develop its

conceptual toolkit to produce deeper more resonant (with practitioners and consumers) forms of evidence-based knowledge (Wieringa and Greenhalgh 2015). Wieringa and Greenhalghs (2015) also concluded that patients use their own 'mindlines' when making health decisions, they state that their findings need further exploration to see if patients and clients use 'mindlines' in other healthcare settings and what implications this has for collaborative decision making.

The findings of this review could, I feel, have applicability and utility to EBP in other health disciplines, such as midwifery that use the same principles of knowledge acquisition and decision making.

An evidence based decision making model for midwifery care has been proposed by Menage (2016b)(see appendix 4). It takes account of the following, the woman, her psychological and social individual needs, preferences, hopes and fears and risk factors, whilst establishing a reciprocal, equitable woman / midwife partnership: the midwife, her knowledge and skills, experience and judgement: research, quantitative and qualitative, evidence based guidelines, user feedback systems: resources available: midwives' knowledge of boundaries and scope of practice (of all the multi-professional team): facilities, information, equipment, managerial support and the environment: culture, political and professional influences, the law, physical environment.

It could be argued that a significant strength of Menage's (2016b) model is that the influence of 'risk' is explicitly visible in the framework. Risk and risk

perception has been shown to have a profound impact on midwives' decision making in numerous studies, in terms of them making defensive and often medicalised decisions, even when caring for 'low risk' women (Sandal et al, 2010, Blaaka and Schauer 2008, Scamell 2016, Rattray et al, 2011, Young's 2012). Jefford (2019: 7) comment that another strength of Menage's model is that it "sits within the physical, legal, political, cultural and societal boundaries within which women and midwives live and work", thereby reflecting genuine situated decision making.

Cultural considerations are present in Menage's model (Menage 2016b), for example the meaning of normal birth within a maternity unit, along with a multitude of influencing socio-cultural decision making factors. However, I feel that the impact of power dynamics, could have been a more overt presence within it. For example the impact of the continuing dominance of the medical profession, in 'all risk' (and at times in 'low risk') categories of maternity care (Donnison 1988, Allison 1996, Reiger 2005, McIntosh 2012). As discovered in Kirkham's (1999) study, midwives' decision making included 'doing good by stealth', that is midwives subverting their clinical findings by reporting and recording inaccurate information. The reasoning behind this practice is that they fear their more powerful obstetric colleagues will interfere and impose unnecessary intervention, so they distort the truth to ostensibly 'protect' the woman. The substantial influence of power differentials, between doctors and midwives' decision making has been found by a number of authors and researchers (Davis-Floyd 2003, Walsh 2010a,



Rudolphsdottir 2000, Stewart 2010, McIntosh 2012), thus may be informing for the development of this thesis.

### **3.13 Empirical situated clinical decision making in midwifery**

Following a generic exploration of the literature, situated decision making per se is not particularly visible in wider professional arenas. Situated decision making in mathematics and education, for example, did not, in my opinion, have any utility or applicability for healthcare. Despite the apparent importance of situated clinical decision making, little empirical evidence on this area of practice is currently available in health literature. Having conducted a thorough literature search (see chapter 2), no midwifery studies had 'situated' in the title. Studies had to have 'decision' in the title, be focussed on intrapartum, contextualised decision making, conducted in the last 10 years and be in similar health systems to the UK. Many midwifery studies used individual interviews, focus group interviews and vignettes to elicit situated clinical decision making (Styles et al, 2011, Rattray et al, 2011, Weltens et al, 2019). Only one of the studies discussed in this section conducted observations of midwives in practice (Young 2012).

In the context of midwifery, Young (2012) conducted an ethnographic study on how students and newly qualified midwives, practicing in the East of England, learnt to make clinical decisions. She undertook 15 observations in practice, 27 individual semi-structured interviews (with students and newly qualified midwives) and three focus group interviews (students only).

Young's (2012) study reported that the intuitive-humanistic model (pattern recognition) was used by the participants in some situations. When midwives appraised the similarities and differences between previous cases (Mok and Stevens 2005, Mattson 2014), learners found it beneficial to develop their decision making skills. Young (2012) also reported that hypothetico-deductive processes (assessment, collecting clues and interpretation) (Thompson and Dowding 2009) were used by midwives in other situations (the specifics of the situations were not expanded on). Learners also found hypothetico-deductive approaches useful in advancing their information processing, decision making skills. These findings provide support to the cognitive continuum (Hammond 1988, Hamm 1988) and dual processing models (Stanovich and West 2002, Paley et al, 2007) being utilised by midwives. Either intuitive-humanistic or hypothetico-deductive cognitive processes can be used effectively in clinical practice, depending on the task which presents itself (Young 2012).

In Young's (2012) study, she reports that the actual logistics of learning effective situated decision making was supported and hampered by a multitude of factors. Young (2012) reported that learners found midwives clinical decision making confusing. Students found that they needed to negotiate the workplace culture and the accepted custom and practices of a clinical area to understand midwives' decision making. This demonstrates the wider cultural and socio-political context within which decisions about health are made (Noseworthy et al, 2013). "The particular etiquette and routines of a clinical area had to be known in order to know what was

acceptable and what was not in relation to midwifery practice and therefore decision-making” (Young 2012: 828).

In addition they found that practices were shared by some midwives and not others, there were covert rules of practice and midwives varied in their perception of risk. Institutional authoritarianism and organisational constraints also impeded decision making. Learners and newly qualified midwives commonly learn decision making through role modelling and environmental norms which can be potentially facilitative or provide a hindrance to good decision making (Young 2012). Many of these factors are specifically accounted for in the model for evidence based decision making in midwifery care (Menage 2016b). Which shows that the model may be useful in authentically identifying midwifery decision making influences within this context.

Young (2012) acknowledged some limitations to her study. It was small scale, only including 2 NHS maternity units, midwives did not appear to be included in focus group interviews, which could have added to the richness and wholeness of the study. Finally the researcher was known to many of the participants as their lecturer with the potential for perceived power imbalance (Raheim et al, 2016). Nonetheless, the study has highlighted some important aspects of student and novice midwives’ decision making, such as workplace culture and the potential influence of positive and negative role-modelling on midwives’ development of decision making skills.

Styles et al, (2011) conducted the Scottish Trial of Refer or Keep (the STORK study). There were 102 midwife participants from four different Scottish Health Boards. They were given five fictitious case study vignettes, via a computerised program, presenting 5 staged slightly worsening clinical scenarios. At each stage they were asked if they would refer, to obstetric care or keep in midwifery care. They examined the association between the midwife's personal risk tendency, their place of work (consultant led unit CLU or Community maternity unit CMU), their years of experience and the timing of their decision to refer.

Although midwives were presented with identical information in the vignettes, there was wide variability in the range of referral decisions. There was no evidence that such inconsistencies were due to personality factors, risk propensity, level of experience or whether the midwife worked in a CLU or CMU. Midwives from one of the four boards were significantly more likely to refer earlier than the other three boards.

There had been some high profile adverse events that had occurred in this one Health Board just prior to the Style et al's, (2011) study being conducted, which the authors claimed could have influenced their earlier referral pattern. In these cases the only application of any decision making theory was that the midwives may have used availability heuristics.

Availability heuristics is where memories of profound clinical events that have recently occurred can have an impact on clinical judgements, regardless of how likely it is for the event to recur (Sox et al, 2013). It is

associated more with intuitive decision making processes via the use of mental shortcuts. Midwives use of availability heuristics in Styles et al's, (2011) study could be viewed as a link to their perception of risk, despite the researchers stating that there was no evidence of a correlation between decision making and midwives' risk propensity.

The use of vignettes in health research is often criticised as being textual descriptions of hypothetical situations that may not be representative of 'real world' phenomenon (Evans et al, 2015). This issue can be ameliorated by robust development and testing of the vignette, increasing internal, external and construct validity (Finger and Rand 2005). The researchers state the vignettes were subject to rigorous pilot testing, with 50 midwifery participants, thereby increasing validity of the research instrument (Styles et al, 2011).

In two hospitals in Queensland Australia, Rattray et al, (2011) used a grounded theory approach to examine, in detail, five midwives' decision making processes related to using continuous electronic fetal monitoring on low risk women. Various factors impacted on these decisions including staff workloads, practicing within a context of risk management, fear of adverse events and litigation and pressure from medical colleagues. Most of the factors mentioned are included in the situated clinical decision making framework (Gillespie and Peterson 2009) and the model for evidence based decision making in midwifery care (Manage 2016b), demonstrating that they are capturing influences on situated decision making.

Midwives' perception of risk once again played a critical role in decision making. Childbearing women were largely not involved in the decision making process about fetal monitoring and only limited information was provided to them prior to cardiotocography (CTG). This is in direct contrast to the majority of research, policy and literature related to health, which states that shared decision making with women and patients is imperative in health care settings (Sandman and Munthe 2009, Charles, Gafini et al, 1999, Mok and Stevens 2005, Sullivan 2005, Moffatt et al, 2007, Porter et al, 2007, DH 2010a, Health and Social Care Act 2012, NHS England 2017a, Stacey et al, 2017, NICE 2019).

Midwives in Rattray et al's (2011) study, regularly conducted admission CTGs which conflicted with clinical (hypothetico-deductive based) guidelines. This aspect of decision making behaviour appears to align with the concept of 'mindlines' (Gabbay and LeMay 2004). As discussed previously Gabbay and Le May (2004) postulate that health practitioners often use internalised tacit knowledge (intuitive based decision making) over and above use of hypothetico-deductive (evidence based) formal guidelines. This may highlight a distinct limitation of using 'mindlines', if, for example, well established evidence-based guidelines are being ignored in favour of intuitive decision making processes, another important consideration for this PhD study.

The purpose of Rattray et al's, (2011) study was to develop a woman-centred, evidence based, fetal monitoring decision-making pathway and as

such did not include any detailed discussion of underpinning decision making strategies. It would be useful to see if midwives' decision making was similar if Rattray et al's, (2011) study was carried out in other contexts within the Australian maternity system.

A small qualitative study carried out in the Netherlands, conducted 10 in depth interviews with midwives, exploring the influences on their decision making during childbirth (Weltens et al, 2019). Theoretical knowledge, experiential knowledge and the influences of women's needs and wishes were cited as important influences. All of the midwives in the study stated that shared decision making with childbearing women was important when decisions were being made regarding their childbearing experience. This finding was contrary to the other situated midwifery studies discussed in this section (Styles et al, 2011, Rattray et al, 2011, Young 2012), which may indicate that childbearing women's choices were not a major consideration within these contexts. The difference in utilisation of shared decision making could be due to national, cultural differences in philosophies of childbirth. The Dutch maternity system is based on the philosophy that pregnancy, labour and birth are physiological events until proven otherwise, which is generally a different outlook to that in many high income countries (De Vries et al, 2013, Thompson et al, 2019).

Fear of being held accountable for professional decisions (risk perception) also emerged. Similar to Styles et al's, findings (2011), the midwives in Weltens et al's, (2019) study felt that a recent adverse clinical event had

impacted on their decision making (availability heuristics). Availability heuristics could be a considerable influence on clinicians decision making, and perhaps this phenomenon should be accounted for in the 'mindlines' decision making model (Gabbay and Le may 2004) in the evidence based decision making model in midwifery care (Menage 2016b) and in the clinical situated decision making framework (Gillespie and Peterson 2009).

Both hypothetico-deductive (guidelines used in more acute situations) and intuitive-humanistic (feelings and senses used in straightforward childbirth) decision making approaches were mentioned by the midwives (Weltens et al, 2019).

Weltens et al, (2019) acknowledge the limitations of the participants possibly relating socially desirable accounts (known as social desirability bias) in an interview situation (Althubaiti 2016).

### **3.14 Examples of seminal research on decision making in midwifery**

Two seminal midwifery research studies have been selected to demonstrate intuitive and hypothetico-deductive decision making respectively. The purpose is to elucidate the relevance of these binary approaches to midwifery decision making and to this PhD thesis more specifically.

Although the two studies included in this section might be considered to be 'outdated', my rationale for including them are as follows. In my literature search, both studies were strongly visible, that is, appeared frequently when searching for midwives' decision making, or decision making in childbirth and



any of the permutations of these terms (see literature search, chapter 2). They were also referenced very frequently by other midwifery authors as seminal or germinal pieces of research. One is an exploratory qualitative study representing intuitive decision making in midwifery practice (Davis-Floyd and Davis 1996) and the second a randomised controlled trial (RCT), an example of hypothetico-deductive midwifery decision making (Cheyne et al, 2008b). More recent midwifery research is explored under the heading: empirical situated clinical decision making in midwifery.

Davis-Floyd and Davis (1996) in a study examining 'intuition as authoritative knowledge', conducted interviews with 22 white middle class midwives practicing in the United States (U.S). Nineteen of these midwives were experienced and considered by the authors to be highly competent in technological skills, being qualified between three and 16 years. Three had been qualified less than a year. They were fully aware that they would have to be prepared to justify their actions if they strayed from the prevailing medicalised and risk averse culture present in most maternity care in the US. Nonetheless, these midwives placed a profound value on the notion of 'connectedness', within the context of their holistic model of childbirth. This drives them to listen to and trust their 'inner voice' during birth rather than following the standard protocols and medically defined parameters of 'normal birth'.

Davis-Floyd and Davis (1996:3) observed that: "the level of tension between the technocratic and holistic paradigms with which homebirth midwives must

constantly cope, make their occasional willingness to rely solely on intuition, sanctioned by the holistic model and condemned by the technocratic model, a strong marker of their commitment to holism and its underlying principle of connection". This study, according to Davis Floyd and Davis (1996), illustrates well the pressures that midwives in highly technicalised, medicalised cultures have in drawing on and justifying use of intuitive skills, overcoming these pressures by their embedded trust in women in their care and in themselves. The midwives did relate many experiences where their intuitive knowing was in fact correct and the clinical outcome in very high risk situations was good. There appeared to be an implicit view from the participants that intuition was a superior form of 'knowing' when compared to rational ways of knowing, within this particular professional context.

Limitations of the study are that the participants consisted of midwives from similar socio-economic backgrounds. The majority of the sample group (n=17) of midwives primarily facilitated home births and a further three midwives facilitated both home and hospital births. It could be argued that these particular midwives leant more towards a social model of childbirth and therefore held a pre-existing positive view of intuitive decision making, privileging this approach over other cognitive processes. The participants all attended one of two 'Midwives Alliance of North America' (MANA) conferences. They self-selected to provide narratives to the interviewers about the 'role of intuition in their behaviour at births'. At the second conference this was during a workshop on 'intuition'. The researchers themselves (Davis Floyd and Davis 1996) state that these were highly

subjective accounts from midwives in an interview situation, which were being conducted by credible figures (one a prolific childbirth researcher and the other a midwife with 30 years experience) who would validate their experiences and views on intuition as an authoritative form of knowledge. The researchers do say that this was a deliberative strategy to enable midwives to 'open' up about intuition but could be seen as influencing participants' narratives about the importance, nature and power of intuitive decision making. There were no accounts from midwives where their reliance on intuition led to poor outcomes. One midwife did say "there are no guarantees even with intuition" (Davis Floyd and Davis 1996: 257). This was the only comment which illustrated that intuition may not be the most appropriate decision making strategy in all situations.

As debated in the earlier sections of this chapter, there is empirical support for intuition as a legitimate form of decision making. However, also discussed earlier, using either intuitive-humanistic or hypothetico-deductive decision making approaches in isolation may not lead to optimal decision making.

Cheyne et al, (2008a) recognised the importance of decision making in diagnosing active labour. Ball and Washbrook (1996, 2015) had previously discovered that up to 30% of women who are admitted to hospital labour suites were subsequently found to not be in labour, increasing the risk of unnecessary medical intervention. Cheyne et al, (2008b) drew on the analytical, hypothetico-deductive model to develop an algorithm to diagnose

active labour in primiparous women. The researchers hypothesised that improving the accurate diagnosis of labour in primiparous women using this algorithm would result in decreased use of oxytocin for augmentation of labour and other labour interventions compared with usual care. The algorithm was developed following a rigorous literature review, focus group interviews (n=6, n=7), and inter-rater reliability testing, (of what constitutes active labour), via vignette analysis in two sites (n=19, n=17). Following data analysis, a high level of agreement was found from the midwifery participants in relation to what factors 'diagnose' active labour.

A cluster randomised controlled trial (RCT) was then conducted at various sites with intervention groups that used the algorithm to diagnose labour and control groups that continued with normal care. Baseline data were collected for 200 women who gave birth before and 200 after the start of the study in each unit. The algorithm was used to distinguish between women in early, latent phase of labour and those in established, active labour.

However use of the algorithm did not reduce intervention in labour including use of oxytocin, electronic fetal monitoring and pain relief. This is despite the fact that more women who appeared to be accurately diagnosed as being in the latent phase of labour were discharged home. Further research by the same research team who developed the early labour algorithm, revealed that women in early labour who are sent home in the latent phase of labour actually reported an increase in anxiety levels and this may account for no difference in intervention levels once labour is established (Barnett et al,

2008). A later systematic review echoed these findings that women often feel unsupported and frightened when discharged home in early labour (Beake et al, 2018). The conclusions from these studies and review represents discordance with midwives' decisions concerning management of women in early labour (whether these are based on intuitive or rationalistic decision making approaches) and what support and care many women actually want. My own study will include midwives' decision making for women in 'latent' phase of labour, and therefore the previous study findings will be highly relevant.

The researchers appeared to use a rigorous methodology to develop the tool. This analytical, logical intervention should have improved care for women by accurately diagnosing active labour, thereby reducing intervention, but in the study, it did not. The researchers state that "diagnosis of labour may be straightforward on paper but is frequently problematic in practice. This may be because the diagnosis of labour is made in a high pressured environment where conflicting pressures of workload, limited resources and emotional pressures add to the complexity of the judgement" (Cheyne et al, 2008a: 211).

Cheyne et al, (2008b) concede that rational, analytical means of diagnosing 'active labour', may not account for the unpredictability and complexity of decision making in the real world of clinical practice. This study illustrates the complex and multifactorial dimensions in relation to clinical decision making. Highlighting that as with intuition, hypothetico-deductive decision

making processes alone may not be reliable or accurate for all circumstances.

### **3.15 Summary**

This chapter has reviewed the prominent decision making theories and models present in health literature. In the UK there is an acknowledgement of the value of shared decision making and health policy supports its implementation in modern day health care (DH 2010a, Department of Health and Social Care 2010a, Health and Social Care Act 2012, Sanderson et al, 2019). Shared decision making will inevitably be used in conjunction with other more cognitively and contextually focussed decision making models and processes such as hypothetico-deductive, EBP, intuitive-humanistic, cognitive continuum and dual processing models in the clinical setting. Researchers generally agree that both hypothetico-deductive and intuitive-humanistic cognitive processes have their place in clinical decision making (Cheyne et al, 2008b, Gabbay and Le May 2004, Menage 2016b, Mikels et al, 2011, Lufityanto et al, 2016, Jefford 2019).

Many of the decision making theories and studies in this section, evidence the extreme complexity of clinical decision making. This is best demonstrated by the comprehensive, but not exhaustive, list of influences on clinical decision making, highlighted in the various situated clinical decision making frameworks, models and studies (Gillespie and Peterson 2009, Gillespie 2010 [see appendix 3] Gabbay and Le May 2004, Menage 2016b [see appendix 4], Styles et al, 2011, Rattray et al, 2011, Weltens et

al, 2019, Young 2012). In addition midwives, during intrapartum care are required to make optimal decisions impacting on both mother and fetus, in busy, time limited, chaotic, noisy, highly stressed environments against a backdrop of these sometimes competing influences (Mok and Stevens 2005, Croskerry 2005, Cheyne et al, 2008a, Karnieli-Miller and Eisikovits 2009, Jefford 2019).

Given the potentially profound effect on midwifery care provision, midwifery decision making remains under researched. A gap in the area of situated clinical midwifery decision making, especially utilising real world, real time observations has been identified. This PhD study will add to the limited body of knowledge in this sphere of midwifery practice.

An in-depth exploration of the essence of the thesis, that is, decision making, has been essential in this PhD study. Decision making theory will be integrated into the thesis throughout.

The previous literature review and background chapter and the current chapter on decision making have led to the development of the research aim and research question of this PhD thesis.

### **3.16 Research aim and question**

The literature review chapter and the chapter on decision making theory, have highlighted the limited amount of research surrounding midwives' decision making in normal childbirth. The research aim and question have evolved as a result of a thorough review of the literature in these areas.

### **3.17 Research Aim**

To explore midwifery decision making during normal labour and birth.

### **3.18 Research Question**

What influences midwives' decision making during normal labour and birth?

The next chapter will discuss the methodology and methods that were used in the execution of this PhD study.



## **Chapter 4 METHODOLOGY AND METHODS**

### **4.1 Introduction**

The aim of this study is to explore midwifery decision making during normal labour and birth and the research question is: What influences midwives' decision making during normal labour and birth? This chapter will discuss the process in deciding the best methodological approach to address the research aim and answer the research question. It will examine the ontological and epistemological assumptions of positivism and interpretivism. Then all stages of the research process will be outlined and developed leading to a summary of the chapter.

### **4.2 Epistemology, ontology and methodology**

According to Crossan (2003), exploration of the philosophical assumptions underpinning research approaches is important because: it enables evaluation of different methodologies to ensure the appropriate one is eventually selected, helps the researcher to specify the research methods to be used at an early stage and may assist the researcher to become more innovative in the adoption or adaptation of research methods.

Three dimensions are often cited in philosophy in terms of research: epistemology, ontology and methodology. Epistemology is a branch of philosophy concerned with the theory of knowledge which is entrenched within the theoretical perspective, underpinning a research project and consequently embedded in the research methodology (Crotty 1998). Benton

and Craib (2011) describe epistemology as a philosophical enquiry into the character and range of human knowledge where theorists try to illuminate the differences between knowledge, beliefs and values. In social sciences, epistemology may refer to the underlying assumptions about how it is possible to acquire knowledge about the reality of the social world.

Ontology is the theory and questioning of 'existence', it entails the pursuit of what it is to be human and what the core components of existence are (Benton and Craib 2011). Ontological perspectives differ radically and may even be contradictory depending on the chosen philosophical standpoint, it is therefore imperative to know writers ontological and philosophical roots (Rawnsley 1998).

Finally, methodology relates to the whole process of coming to know. This final term is open to misuse as it is often used in the context of the process and methods or tools utilised in performing research (Avis 2003). Whilst these are important aspects of methodology, Crotty (1998:3) describes methodology as "the strategy, plan of action, process or design lying behind the choice of particular methods and linking the choice and use of methods to the desired outcomes". Lincoln et al, (2018) define methodology as how the inquirer goes about exploring and finding out whatever he or she believes can be known. None of these philosophical assumptions are entities on their own, and are often reliant or influenced by the other.

### 4.3 Positivism

Giddings (2006) suggests that there is a continuing hegemony of positivism. Positivism may be described as the traditional approach to gaining scientific knowledge. It assumes that certain aspects of the world exist independently of the knower (Breachin and Siddell 2000). The 19<sup>th</sup> century philosopher Comte (1853 Cited by Crossan 2003) suggested that all authentic knowledge should be ascertained from human observation of objective 'reality'. Murphy et al, (1998) state that in science there is an ontological assumption that there is a reality out there that can be studied and known. Data collected in a scientific and systematic fashion is therefore objective, measurable, and can be used to explain and predict certain events and phenomena. It is also described as being deductive, systematic, reductionist and controlled. The 'hard' data generated from positivist research is subjected to statistical analysis (Gerrish et al, 2015). Establishment of cause and effect or correlations between variables i.e. the dependent and independent variables, are key features of many quantitative studies (Punch 2013). Thus, according to Brechin and Siddell (2000), the focus of the positivist epistemology is on causal relationships and generalisability.

Positivism has had a major impact on the development of health care in all its disciplines, including medicine, nursing and midwifery (Arney 1982, Walsh 2004). Narratives surrounding quantitative research in the field of health care claim bias free, impartial and generalizable knowledge creation. In addition more recent approaches such as systematic reviews and meta-

analysis, which combine single studies into a more robust review of collected studies to affirm an irrefutable 'truth' (Walsh 2004).

The main criticism of a positivist philosophy is that it cannot account for the behaviour of human beings in any meaningful or in-depth way (Crossan 2003). This critical notion in itself can be and is contested probably most ardently by psychologists, studying human behaviour, generally drawing on quantitative methods. As Tolman postulates (2013) positivism remains the bedrock of main stream psychology.

#### **4.4 Interpretivism**

Interpretivism essentially arose as a reaction to and as a critique of positivism in the social sciences. The interpretative model has its roots in the late 19<sup>th</sup> century, although a philosophical opposition to positivism has existed for much longer (Chowdhury 2014) and has links to Weber's (Tucker 1965) and Simmel's (Suber 2009) 'Verstehen': the contextual nature of understanding. This view assumed a systematic process in which an external observer attempts to relate to a particular cultural group, or indigenous people, on their own terms and from their own perspective (Fadul and Estoque 2011).

There are a number of notions of interpretivism that embrace the interpretative tradition. These include: empathic identification and phenomenological sociology. Empathic identification first appears in the early work of Dilthey, who argued that to make sense of the meaning of human

action and behaviour requires acquisition of the subjective consciousness or intent of the actor from the inside (Schwandt 2000). Geertz (1979) questions whether this is realistically possible. Phenomenological sociology was initially based on the work of Schutz (1967), who later influenced sociologists and phenomenologists Cicourel and Garfinkel (Schwandt 2000). They discuss that the aim of this approach is to understand how we come to interpret our own and others' actions as meaningful in the "intersubjective communication of individuals in the social-life world" (Outhwaite 1975:91 cited in Schwandt 2000).

An interpretivist philosopher would argue that 'reality' is not a fixed entity, instead it is constructed by individuals and is always context bound. According to Hughes and Sharrock (2016) multiple 'realities' are possible. From this perspective, the voices and interpretations of those under study are the key to understanding the phenomenon of interest and their subjective interactions are the primary way to access them (Cresswell 2009). Interpretivist research is said to be: holistic, inductive, subjective and unique. The 'soft' data from interpretative research is subject to qualitative analysis of data that is usually in narrative form (Benton and Craib 2011, Cresswell 2009). Data collected using an interpretative philosophy will be individualistic and in-depth, the focus being on relativism and understanding (Brechtin and Siddell 2000).

Interpretivists attempt to derive their constructs from the field by a comprehensive and in-depth examination of the phenomenon of interest.

According to Gephart (1999) interpretivists assume that knowledge and meaning are acts of interpretation, hence there is an absence of objective knowledge. Myers (2009) argues that the premise of interpretive researchers is that access to reality (whether assigned or socially ascribed) is only through socially mediated constructs such as language, consciousness and shared meanings. Collins (2010:38) asserts that interpretivism is "associated with the philosophical position of idealism, and is used to group together diverse approaches, including social constructivism, phenomenology and hermeneutics; approaches that reject the objectivist view that meaning resides within the world independently of consciousness".

The main criticism of interpretive research is that it cannot be generalised or applied to the 'real' world outside of the context of the particular research setting (Gray et al, 2018). Another criticism of interpretivism is that its ontological standpoint, by its very nature, tends to be subjective rather than objective. For this reason, research findings and interpretation of the data are unavoidably influenced by the researcher's own belief system, values and cultural preference which can lead to bias, according to Gray et al, (2018).

However, instead of generalisability, to assess robustness, criteria such as credibility, dependability and transferability are used instead (Ryan et al, 2007). Therefore, interpretive research can still be explanatory and informing to other similar contexts. To address the second criticism,

interpretivist research is transparent about the notion of the researcher being an active participant in the whole research process (Denscombe 2007). Through openness and reflexivity, trustworthiness is enhanced (Korstjens and Moser 2018).

There is an inevitable affiliation between use of interpretivism in qualitative research and maintaining reflexivity during the whole research journey (Denscombe's 2007) (see section 4.18 on reflexivity). Interpretation is not about the uncovering of the intentions of 'others', it is an encounter in which a fusion of horizons occurs, embracing the meaning held by 'other' (Gadamer 1975).

The research aim and question posed earlier do not lend themselves to quantitative investigation. There is no intention to test or measure aspects of decision making in normal childbirth. It is rather to explore the phenomena of decision making in the context of two labour suites in order to gain more insight and understanding of this concept and how it is enacted in regards to normal childbirth. It is therefore appropriate that a qualitative, interpretative approach has been chosen.

#### **4.5 Case study research**

Decision making is a highly complex phenomena, and therefore if it is to be studied, it requires in depth scrutiny, by being examined through differing 'lenses'.

Ethnography alludes to the situated empirical description of people, culture and races (Rock 2007). Whereas case study aims to contextualise and understand a bounded and specific phenomenon (Creswell et al, 2009), in this study the phenomenon of decision making. Therefore phenomenology, which is concerned with capturing the 'lived experience' of study participants (Munhall 2012), was not considered to be appropriate to the research aim or question.

Grounded theory is an inductive technique where the findings are grounded in 'reality' as experienced by the participants and are interpreted at a more abstract theoretical level (Polit and Tantano Beck 2014). There was no intention to generate theory through this study, therefore a grounded theory approach was rejected.

Having considered the alternatives that could be used in interpretive research, case study research appears to fulfil the role for this particular project.

A case study design involves a detailed exploration of a single unit of study (Gray et al, 2018). Laws and McLeod (2004:6) define case study as the "examination of an instance in action" whereby focusing on the interchange between factors that are indicative of the phenomenon, can be uncovered and understood. Heale and Twycross (2018:7) cite the following definition of case study research: "A case study has also been described as an intensive, systematic investigation of a single individual, group, community or some



other unit in which the researcher examines in-depth data relating to several variables”.

Case studies tend to focus on understanding ‘why’ an individual thinks, behaves and acts in a particular manner rather than ‘what’ his or her actions are (Polit and Tanco Beck 2014). Yin (2013) also suggests that case study methodology resonates with exploratory and explanatory research based on ‘Why’ and ‘How’ questions.

Case study research relies on triangulation of data collection methods to enhance rigour and credibility (Gibbert et al, 2008, Swanborn, 2010).

Triangulation is discussed in more detail in section 4.7.

According to Gibbert et al, (2008) and Swanborn (2010) a case study approach is ideal for investigating phenomenon in an holistic and in depth fashion. Therefore adopting a case study methodology will gain detailed, in-depth insights into midwives’ decision making in normal birth across two sites. Nonetheless, as with all research methods, there are advantages and limitations to selecting a case study approach.

The advantages of case study research are that it provides context dependent (practical) knowledge as opposed to context independent (theoretical) knowledge. It is less restrictive and more flexible than other methods, the emphasis is on ‘learning’ rather than ‘proof’ and it provides a rich and holistic account of a particular phenomenon (Flyvbjerg, 2006, Thomas 2011, Yin 2013).

The proposed limitations of case study are that the data are unique to the individuals, process, event or phenomena (but can be explanatory for other similar settings), it is difficult to establish validity or reliability and it may be open to case selection bias for example which 'cases' the researcher selects may influence the outcomes of the study (Flyvbjerg, 2006, Thomas 2011, Yin 2013). The conclusions drawn may be highly subjective and case study is generally not predictive (George and Bennett 2005). The researcher does not subscribe to some of these issues and agrees with Thomas (2011) who argues that case study method, by its very nature does not seek to generalise. In addition, interpretive researchers may also argue that terms such as 'validity' and 'reliability' are positivist constructs that have no place in interpretive research (Polit and Tantano Beck 2014). Nonetheless, it is important in any research methodology to acknowledge proposed limitations as well as strengths, however many of the limitations can be minimised by employing multiple data collection methods and robust data analysis.

#### **4.6 Multiple case study research**

The literature review and decision making chapters make it clear that the issue of midwives' decision making during normal labour and birth is a highly complex, multifaceted phenomenon. Including more than one case study site was an intentional strategy to improve the robustness of the study. Yin (2013) would concur with this point, arguing that wherever possible, a multiple case study is preferable to a single case, as it increases the probability of offering results and theories. Furthermore, this standpoint is

affirmed when cases are purposefully chosen for their contrasting features, as findings might contribute to the strengthening of theories by distinguishing relevant cross-case characteristics (Yin 2013, Swanborn, 2010, Thomas 2011). Another advantage of multiple case study research is that the researcher is able to analyse the data both within each situation and across situations (Yin 2013). According to Baxter and Jack (2008), evidence developed from a multiple case study is considered to be strong and reliable. Thus, multiple cases enables broader exploration of research questions and theoretical evolution (Eisenhardt and Graebner 2007).

There are, nonetheless, drawbacks to multiple case study research. They can be inordinately expensive and time consuming (Baxter & Jack, 2008).

According to Siggelkow (2007), the existence of certain phenomenon can be effectively described by single case studies. Also, the more case studies, the less observation time the researcher has to study each of the cases (Gerring 2004). The ontological assumptions underpinning interpretivism (Fadul and Estoque 2011) (see section 4.4) led me to the conclusion that the many advantages of case study, in particular multiple case studies, outweigh the limitations and is the best 'fit' for the research aim and question.

The two case sites were chosen for very specific reasons (see selection of 'cases' section 4.8). It was thought that analysing and making comparisons of the data, between two case sites, searching for similarities and dissimilarities would be more illuminating and result in greater

understanding of the phenomenon under review (Stake 2006, Baxter and Jack 2008, Vannoni 2015).

#### **4.7 Triangulation**

Case study typically utilises a triangulation strategy in pursuit of explaining complex phenomenon. Although this term is often associated with positivist approaches, it can also refer to interpretive research and involves the use of a variety of research approaches and data collection tools (Stake 2006, Yin 2013).

Many different forms of triangulation exist. Patton (1999) identified four types of triangulation: (a) checking out the consistency of findings through methods triangulation, (b) examining the consistency of different data sources within the same method, is called data collection triangulation (c) using multiple perspectives or theories to interpret the data, that is theory / perspective triangulation, and (d) using multiple analysts to review findings, is analyst / investigator triangulation. This particular study incorporates data collection triangulation (Creswell 2009), as there is more than one method of gathering data (see figure 4.1). Bogdan and Bicklen (2006) confirm that triangulation can be effectively applied to qualitative research methods. Within this multiple case study, triangulation was used to enrich and verify different data. For example if the same or similar types of decision making approaches were used for pain in labour, as reported by midwives during observations, focus group interviews and diaries, then this would lead to development of categories

and eventually the emergent themes (Stake 2006, Cresswell 2009, Yin 2013)(see table 5.11 in the findings chapter to demonstrate corroboration between data sources). Acknowledgement has to be given that the triangulated data sources are mainly accounts by midwives from their own particular perspectives, though observational data and documentary analysis also contributed to the triangulation process.

Bryman (2009) states that triangulation offers the prospect of enhanced confidence and trustworthiness. He states that once a proposition has been confirmed by two or more independent processes, the uncertainty of its interpretation is significantly reduced. Cresswell (2009) asserts that using multiple data collection methods in qualitative research increases internal validity. Yin (2013) proposes that the most important advantage of using multiple sources of evidence and thus triangulation is the development of converging lines of enquiry.

#### **4.8 Selection of the 'cases'**

Case study research may be about a person, a group, an institution, a country, an event or a period of time (Thomas 2011). Yin (2013) refers to the case as a unit of analysis and concurs with Thomas, adding that a case study can be about decisions, programs, implementing a process, or organisational change. Arguably, the identification of the 'case' is considered the most problematic, yet crucial element in case study research (Swanborn, 2010; Thomas, 2011; Yin, 2009). Much thought went into deciding what the actual 'cases' in this case study were going to be. Initially it was debated

that the actual phenomenon of decision making in normal birth would be the 'cases'. However as the researcher was not directly observing the moment of decision making episodes, this would not be appropriate. Finally it was decided that the labour suites in the two different maternity units would be the 'cases' referred to as case site 1 and case site 2 throughout the thesis.

Data collected from different case sites enabled the phenomena to be viewed through different perspectives, comparing and contrasting data to strengthen the overall robustness and completeness of the research (Stake 2006, Thomas 2011).

The sites chosen to collect data were selected for important reasons. The two sites are geographically close but each has a different normal birth rate and, by definition, varying intervention rates (see table 4.1).

The Trusts included in this study performed average or above average in terms of normal birth rates when compared to national rates at the time the study was carried out (see table 4.1).

**Table 4.1 Comparing mode of birth with place of birth, case site 1 and case site 2 (Source: Dodwell and Gibson 2012, The Health and Social Care Information Centre 2012)**

	Caesarean section	Instrumental	Normal birth	Vaginal birth
England	24.8%	12.5%	41.8%	62.7%
Labour suite, case site 1	22.5%	15.2%	42.9%	62.3%
Labour suite, case site 2	17.1%	14.4%	-	68.5%

Labour suite 1 had an average spontaneous vaginal birth and lower than average caesarean section rate in the UK (Dodwell and Gibson 2012, The Health and Social Care Information Centre 2012). Labour suite 2 had one of the highest spontaneous vaginal birth rates nationally and much lower than average caesarean section rates for hospitals in the UK at the time (see table 4.1)(Dodwell and Gibson 2012, The Health and Social Care Information Centre 2012). The differences in modes of birth made the maternity units suitable for this study in terms of making observations and comparisons in aspects of 'decision making in normal birth'. The study may illuminate some of the possible reasons for these differences.

In addition, the maternity units and labour suites are known to the researcher therefore access was easier on this basis. (I will return to this

issue under section 4.10 'Access to the labour suites' and under section 4.18 Reflexivity').

#### **4.9 Data collection methods**

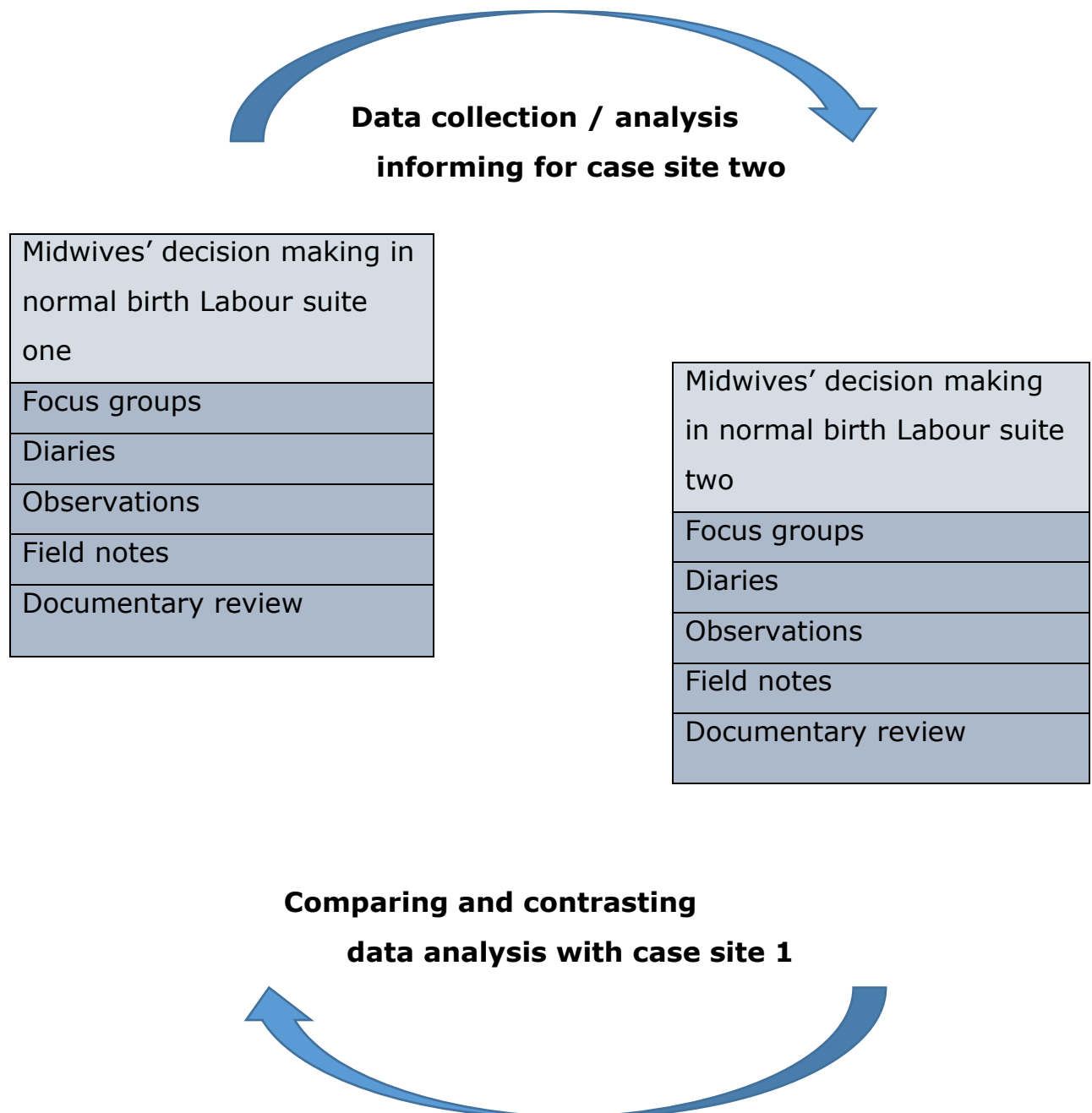
Multiple methods of collecting data were employed to examine the phenomenon of midwives' decision making (Schneider and Whitehead 2013). The data collection methods were observational visits to two labour suites, focus group interviews, decision making diaries, field notes and documentary review (see figure 4.1). This was to establish the factors that impact on and influence midwives' decision making and their subsequent impact on normal birth. Each of these collection methods will be discussed more thoroughly in this chapter. As stated, triangulation was used to access different sources of data to investigate varying perspectives, examining relationships, developing possible links between emerging influential factors, in pursuit of converging and diverging evidence (Stake 2006, Yin 2013).

The observations would be described by Cresswell (2009) as studying the 'actors' within the context of their actions and behaviours. The organisational, environmental and contextual nature of the 'case(s)' (in this instance two labour suites) under investigation are of paramount importance because of the apparent differences in birth outcomes. The range of data collection techniques facilitates understanding of the complexities and influences of the phenomena being studied.



Figure 4.1 illustrates the multiple data collection methods that were carried out. All data collection was conducted at case site 1 before collecting data at case site 2. Data collection from case site 2 could then iteratively be compared and contrasted with data from case site 1.

**Figure 4.1 – Diagrammatic schema of research design. Multiple data collection methods on two labour suites with different Normal Birth Rates.**



#### **4.10 Access to the labour suites and preparation for the data collection**

As previously alluded to, the researcher was known to many of the staff employed at the two sites within this study, making access easier, although it was acknowledged that there were downsides to having this status (see section 4.18 on reflexivity). The managers of the Trusts had given permission for the research to take place in the labour suites.

Staff meetings and labour suite forums were accessed to outline the purposes of the study and the role that the researcher would adopt during observations. This gave the opportunity to explain that it was not in any way a critical review of midwives' practice, rather to illuminate midwives' decision making processes during normal labour and birth.

Posters (see appendix 5) were displayed in labour suite areas to highlight the purpose of the research and presence of the researcher where appropriate. Contact details were included so that any member of staff could clarify any issues related to the study. It was important to stress that midwives were the focus of the study and women were not to be accessed at all. Information about the study was sent to prospective participants in an e-mail (see appendix 6). Participant information sheets for the observations (see appendix 7) and the focus group interviews were also sent by e-mail to midwives who were eligible for inclusion in the study. That is those who worked regularly providing care to women during normal labour and birth. It is worth noting that the title and overview of the study was included in the

participant's information sheet. This could have had an influence on midwives during the data collection periods. For example reporting their views and decision making behaviour during normal childbirth more favourably in relation to maintaining normality.

The focus group interviews were initially planned to be conducted prior to the observational visits, although this did not happen because of the challenges of gathering groups of midwives together during busy shifts.

There were 11 observational visits to labour suite one (total hours 92, April-August 2014) and 10 observational visits to labour suite two (total 84 hours, October 2014-February 2015). The period of data collection was 10-12 weeks per labour suite. All data collection took place in one labour suite before rotating to the next. It was hoped that this would include data from the diaries, this did not prove to be possible, as the participating midwives did not complete the diaries until other data collection was complete.

However it was not essential for these to be completed prior to moving to the next labour suite.

#### **4.11 Focus groups**

Focus groups can be an effective way of gathering data (Schneider and Whitehead 2012) as they facilitate interactions between individuals and can help to express and clarify their views which may not happen in one-to-one interviews (Gray 2009). In addition, cultural groups that share common characteristics may feel safer and less threatened when discussing issues in a focus group forum (Gray et al, 2018). The dynamics of a group with

individuals who are in the same profession may spark off debate, discussion and tangential perspectives unlikely to be raised in an interview.

The limitations of focus groups are that some members of the group may be inhibited by the more vociferous members, and that some individuals may not feel comfortable sharing their views in a group situation (Polit and Tatano Beck 2014). These issues can however be ameliorated by careful planning, ensuring the group have common social, cultural and, in this case, professional backgrounds facilitating a more homogenous and equitable group (Liamputtong and Ezzy 2005).

An interview schedule was used so that there was parity between the facilitation of the focus groups, the same questions were asked of all focus group participants (see appendix 8). The prompt questions in the interview schedule were based on some challenging, but essentially normal, aspects of labour and birth care that emerged during the literature review. These were: latent phase of labour (Cheyne et al, 2008b, Spiby et al, 2008, Zhang et al, 2010, Jackson et al, 2014, Spiby 2017), pain in labour (Leap and Anderson 2008, Walsh 2007, Walsh 2009, Mander 2011), transitional phase of labour (Walsh 2010b, Larsen et al, 2001, Hosseini et al, 2013, Downe and Marshall 2014), when labour stops or slows (Duff 2005, Davis 2011, Simkin and Ancheta 2011, Jackson 2017a) and third stage of labour (Dixon et al, 2009, Fahy et al, 2010, NICE 2014a, Mousa et al, 2014, Begley et al, 2015). As the focus of this study is midwives' decision making during normal labour and birth, these aspects of practice will not be analysed in detail. However, in the

findings and discussion chapters, where relevant and appropriate (to decision making and normal labour and birth), brief discussion regarding some of the practices will be further explored to illustrate some contextual and cultural influences on midwives' decision making.

Written signed consent was gained from all midwives taking part in the focus group interviews (see appendix 9) in line with good practice guidelines (Royal College of Nursing (RCN) 2011, Ryen 2016).

The groups were also split into band 5 and 6 midwives, or purely band 6 midwives, or band 7 and above midwives (there were three, two and five midwives who participated in the focus group interviews at case site 1 and two, three and four midwives in the focus group interviews at case site 2). This was to ensure that less experienced midwives did not feel apprehensive and unable to express themselves with their more experienced senior colleagues present, although it is acknowledged that midwives may feel intimidated by their peer group (Jayasekara 2012). To help address these issues, a skilled facilitator, sometimes referred to as a moderator, is essential. They should broadly reflect the characteristics of the focus group, have a thorough understanding of the aims of the focus session, be able to communicate these aims to the group and ensure that all participants are informed that their views are equally valid (Gray et al, 2018). As an experienced facilitator of focus group interviews and as the researcher, I was able to fulfil all of these requirements and acted as moderator.

Careful thought also must be given to recruiting appropriate participants. In this study midwives who were directly involved in labour and birth care of women in each of the labour suites were invited to take part in a focus group interview. Ideal numbers tend to be between five and seven, but it soon became clear that expecting this number of time constrained midwives was not realistic. Timing of the sessions was between 45 minutes and 1½ hours, the setting was as relaxed and accessible as possible (this was discussed with midwives and managers) and refreshments were provided. All the focus groups were audio-recorded. The recordings were transcribed verbatim, the transcripts of discussions were clearly and accurately documented (Gray et al, 2018).

From these meetings, midwives attending were asked if they would be willing to complete a diary, for a short period of time i.e. 10 days or 10 shifts, noting decisions made during normal labours and births, how these decisions were made and what influenced these decisions. This data was analysed and triangulated with the other data collection methods. Though data from diaries was limited due to only two midwives participating in keeping a diary.

#### **4.12 Use of diaries in health care research**

As with all approaches to data collection there are advantages and limitations to the use of diaries in health care research. Offredy and Vickers (2010) propose the following advantages: they minimise the issue of recollection as the phenomenon are written close to the time the event

occurred, they are useful when collecting data on sensitive topics which may be embarrassing for the participant in interviews, they are extremely useful when observation is impossible or difficult. Limitations of diary use include: the use of a diary means that most of the responsibility for data collection lies with the participant, completion of the diary may be incomplete or haphazard, the accuracy of the data contained in diaries is difficult to ratify, the diary entries can be edited in a way to construct a positive narrative around themselves as a practitioner (Offredy and Vickers 2010, Snowden 2015).

Diary keeping in research is often viewed as burdensome, particularly if given to busy, time restricted professionals such as midwives and nurses, or childbearing women. Bedwell et al, (2012) used diaries to collect data from midwives regarding their experiences in intrapartum care. They evaluated the use and acceptability of diaries in this professional group. They found that the "use of diaries for qualitative data collection is feasible and well received by health professionals. Individuals completing diaries were engaged in a reflective process enabling them to address significant events. Hence diaries may provide benefits to both the researcher and the participant" (Bedwell et al, 2012:154). Way (2011) also found that use of diaries and indeed follow up with interviews, was a useful way of collecting data in order to seek a more insightful understanding of individuals' experiences in a health care setting. It is acknowledged that diary keeping may be problematic for some individuals.



Instructions were given verbally and in written format to participants on how to complete the decision making diaries (see appendix 10). It was expected that one-two midwives per focus group would volunteer to keep a diary. However once again this proved to be unrealistic as only two midwives from case site 1 (one band 6 midwife and one band 7 midwife) volunteered to complete decision making diaries.

#### **4.13 Observations and field notes**

Observations are defined by Marshall and Rossman (1989:79) as "the systematic description of events, behaviours, and artefacts in the social setting chosen for study".

An epistemological stance is assumed that suggests observation is fundamental to generate meaningful knowledge of the social world, as Mason claims (2002:85) information is not always "articulable, recountable or constructable in an interview" (Mason 2002a:85). Observations are therefore advantageous for triangulating with other data collection methods such as interviews and diaries (Stake 2006, Yin 2013).

Aspects of LeCompte and Schensul's (2010) approach to observational ethnographic research were adopted in this study. These encompassed similar systems and approaches to observational data collection as described later in this section by Morse (2003) and Mulhall (2003).

There are four main ways that observations are carried out in research ranging from complete participation to complete observation (Kawulich

2005). In this particular study, three of these roles were ruled out for practical and ethical reasons. The observer as participant appeared to be the most appropriate role for the researcher (Gray et al, 2018). This is because in a labour suite setting, in certain situations, it would be problematic and unethical for the observer to remain completely passive. Kawulich (2005:21) proposes that: "The observer as participant stance enables the researcher to participate in the group activities as desired, yet the main role of the researcher in this stance is to collect data, and the group being studied is aware of the researcher's observation activities". This observer type is considered to be the most ethical because of its transparency to research participants (Kawulich 2005).

The intention was to conduct the focus group interviews prior to the observations to inform the researcher of possible areas of interest to focus on. Organisation of the focus group interviews was problematic, and therefore some observational visits took place before the focus group interviews. Observations were made, in the context of the two labour suites, to capture environment, context, staffing, use of guidelines, actions of co-ordinating midwives and doctors. Informal conversations took place with midwives of all grades on duty, capturing their experiences in relation to decisions made during normal childbirth, following handovers between shifts (care from one midwife to another) and following ward rounds with doctors, as and when appropriate. Direct observations of care of women did not take place (see section 4.20).

Because of the personal, intimate nature of labour and birth, the observations were conducted during times outside of the women's birthing rooms through informal interactions (Lauzon Clabo 2008). These included descriptions of social dynamics for example relationships with obstetric staff (Mulhall 2003). Prospective and retrospective accounts of decision making episodes were recorded on an i-pad. The observer was generally positioned at the midwives station and did not observe or interact directly with childbearing women. It is acknowledged that this stance was limiting in terms of capturing actual 'in-the-moment' decision making. From a reflexive standpoint, this was a personal ethical choice, most likely influenced by me being a midwife. It was more important to me to not disrupt the delicate dynamics of labour and birth.

Different days of the week, different times of the day and different shifts were included to capture the contextual nature of decision making in normal childbirth. The total number of shifts attended depended on the emerging data but was initially set at a minimum of 10 for each labour suite setting. No new data were forthcoming (Polit and Tatano Beck 2014) following the 21 observational sessions, that is 11 (total 92 hours) at case site 1 and 10 (total 84 hours) at case site 2. Therefore field work ceased at this point.

Field notes were used to collect data whilst undertaking observations. This enabled the researcher to make notes regarding contextual information. Morse and Field (1996) describe field notes as jottings of salient points

which are reformulated into more detail later in the same day, and may consist of reconstructions of interactions, short conversational excerpts and description of events. Note taking was sensitive to the field setting and was not undertaken in environments where participants would consider it inappropriate, distracting or intimidating (Hammersley and Atkinson, 2007).

Mulhall (2003: 311) includes a summary of what appears to be a very practical schema of what to document in field notes:

- Structural and organisational features – what the actual buildings and environment look like and how they are used
- People – how they behave, interact, dress, move
- The daily process of activities
- Special events – in a hospital ward this might be the consultant's round or the multidisciplinary team meeting
- Dialogue
- An everyday diary of events as they occur chronologically – both in the field and before entering the field
- A personal/reflective diary – this included both my thoughts about going into the field and being there, and reflections on my own life experiences that might influence the way in which I filtered what I observed. Some of

these notes are included in the findings and discussion chapters, to add meaning and context to the discussion.

This guidance on field note writing, was adopted as they appeared to be appropriate for this study.

#### **4.14 Documentary review**

Whilst on the labour suites, the activities occurring in real time dictated what would be observed, reviewed and documented at any particular time.

Therefore recording of documentary data took place simultaneously to other data collection. The purpose of including reviews of these documents was to add to, corroborate and triangulate with the other data collection methods (Yin 2013, McCourt et al, 2011) to achieve a more complete, view of the organisational cultures within which midwives operate. For example to examine if midwives report that they comply with local evidence based guidelines or if they veer away from guidelines in some circumstances. The collection and analysis of documentary evidence at both case sites was an iterative process guided by all data sources collected during observational fieldwork (McCourt et al, 2011).

Documentary analysis can be an efficient and cost effective aspect of qualitative research (Bowen 2009). Soy (1997) states that good investigators are searching for relevant information but should also be able to 'read between the lines' and pursue collaborative evidence elsewhere. Some limitations to document review are that they may not provide

sufficient detail about the phenomenon being studied, they may not be accessible or there may be some subjective preference in what documentation is selected and analysed (Bowen 2009).

I accessed and thematically analysed all documentation that I thought might add value and meaning to the study. The documents reviewed included: obstetric guidelines, midwife led-guidelines. In particular local and national guidelines and pathways (current at the time of carrying out the study) for labour that may require decisions to be made by midwives regarding 'management', for example when a woman's labour slows down or stops.

Other documents reviewed were, agendas and minutes of interdisciplinary meetings, for example: labour suite forum minutes, caesarean section meeting minutes, perinatal mortality / morbidity meeting minutes.

Communications from managers and matrons for example, were reviewed. Evidence based leaflets for women, monthly clinical news magazines. The meanings and substance of documents are important in case study research according to Thomas (2011).

It was imperative that all data was methodically and systematically stored to enable easy retrieval. Data from document review can be stored in a database (Soy 1997). In some cases the documents such as guidelines may be in electronic form which assisted with the analysis stage (Thomas 2011). All data storage complied with the University of Nottingham code of research conduct and ethics (2013).

#### **4.15 Issues of transferability, credibility and trustworthiness in qualitative research**

Initially, the researcher was of the opinion that member checking would be utilised as a way of strengthening credibility, trustworthiness and rigour of the study, and has been considered to be good practice when using certain qualitative data collection methods (Lincoln and Guba 1985). Member checking is where participants read the transcripts of interviews and verify the authenticity of those transcripts or results are returned to check for resonance with the member's experience (Cohen and Crabtree 2008, Birt et al, 2016).

The advantages of member checking are that it can provides an opportunity to understand and assess what the participant intended to do through his or her comments and interactions during the interview (Lincoln and Guba 1985). Participants are afforded the opportunity to amend errors and contest what are perceived as wrong interpretations (Lincoln and Guba 1985).

However the drawbacks may be that member checking assumes that there is a fixed truth of reality that can be accounted for by a researcher and ratified by a respondent (Cheek 2000). From an interpretive philosophical standpoint, understanding is co-created, in this case between researcher and participant, and there is no objective absolute 'truth' or 'reality' to which the results of a study can be compared (Angen 2000). The researcher and participant may have different views of what is an accurate account

(Sandelowski 1993). Study participants may not recall what they said or did and would have difficulty verifying data (Cohen and Crabtree 2008).

Overall I decided that member checking, for this study provided more negative than positive aspects (see appendix 11) and was therefore not used.

Trustworthiness was achieved in other ways by: prolonged engagement and observation in the field, triangulation of data collection methods, providing rich descriptions and accounts of the two case sites and of the participants, and transparency through reflexivity (Korstjens and Moser 2018).

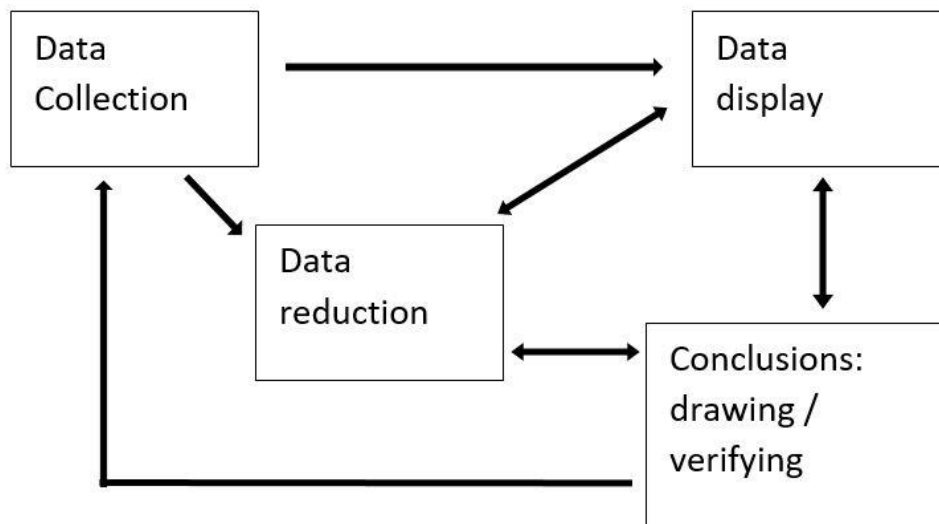
In a small qualitative study, claims of generalisability cannot be made. Indeed it is not the intention of interpretive research to generalise to other populations or settings. However it may be possible to state that there are findings that could feasibly be transferred and have relevance to other similar populations and contexts (Lincoln and Guba 1985).

#### **4.16 Within case data analysis**

Miles and Huberman (1994) suggest that data analysis consists of the three stages following data collection, as shown in figure 4.2.



Figure 4.2 - Overview of qualitative data analysis



(Miles & Huberman 1994)

The first stage was data reduction, as the mass of data from field notes and the document review, for example, needed to be organised, initially coded and non-relevant data set aside. They suggest that displaying the narrative data in graphical format, such as tables, charts and networks, is essential and is not just reserved for the end of data collection. This process facilitated an inductive process of interrogating the data, iteratively searching for similarities and dissimilarities. Finally the analysis should enable the development of conclusions regarding the study. These initial conclusions were then verified or supported, by comparing to existing field notes and any further data collection.

This iterative process eventually led to a point where no new themes or categories were emerging (Polit and Tatano-Beck 2014).

It is acknowledged that in any qualitative research, case study included, the amount of data is likely to be prolific (Yin 2013, Thomas 2011, Morse and Field 1996). Qualitative data analysis is therefore challenging and time consuming (Polit and Tanto-Beck 2014). Braun and Clarke (2006) define thematic analysis as a method that identifies, analyses and reports patterns or themes within data. It organises and describes the data set in rich detail. However, frequently it goes further than this by providing interpretations of various aspects of the research topic.

Thematic analysis, examining text from all data sources line by line, was conducted concurrent with data collection (initially at case site 1, followed by case site 2) throughout the whole period of data collection. This enabled the researcher to engage with emerging themes, which then allowed more focussed enquiry when examining subsequent cases (Yin 2013). For example intra-professional influences, such as the pivotal role of the co-ordinator, emerged strongly in case site 1 and was reported as equally influential in case site 2. Rapley (2016) concurs with this stating that writing to meaningfully simplify and reduce data is essential at all phases of the analytical trajectory. Bendassolli (2013) discusses how emerging themes and categories can inductively develop (see appendix 12).

However Braun and Clarke (2006:2) state that “thematic analysis is a poorly demarcated, rarely-acknowledged, yet widely-used qualitative analytic method...”. The specifics of how thematic analysis is carried out is surprisingly difficult to find in health care literature. Braun and Clarke (2006)

provide a step-by-step guide on how to 'deliberately' and 'rigorously' use thematic analysis for qualitative data and has been utilised for this study (see table 4.2).

Table 4.2 Guide to thematic analysis
<p>Phase 1: Familiarising yourself with your data</p> <p>Transcription of verbal data</p> <p>Phase 2: Generating initial codes</p> <p>Phase 3: Searching for themes</p> <p>Phase 4: Reviewing themes</p> <p>Phase 5: Defining and naming themes</p> <p>Phase 6: Producing the report</p>
Source: Braun and Clarke (2006)

There are numerous computer assisted tools for analysing qualitative data for example Atlas, HyperRESEARCH, Nvivo and The Ethnograph. These are commonly referred to as computer assisted qualitative data analysis (CAQDAS) programs (Silverman 2017). Although Yin (2013) cautions, despite the inference, that these tools are useful for coding and categorising large amounts of narrative text, they cannot analyse data. Rapley (2016) suggests manually coding to allow for 'scrawling', crossing out and underlining which cannot reasonably be accomplished by electronic packages. In this study, due to the copious amount of qualitative data

generated from the observations, focus group interviews, diaries, document review and field notes, NVivo 10 and 11 were used to manage and code the data, but the actual analysis can only be carried out by the researcher.

Appendix 13 illustrates the initial codes, identifying preliminary themes and patterns. The text was read and reread within NVivo numerous times to enable next level codes, categories and finally main themes to arise from the data.

#### **4.17 Cross case data analysis: Identifying the 'quintain'**

Once the data analysis was complete for both case sites, a cross-case comparative analysis was conducted (Stake 2006, Thomas 2011). Elements of the guidance offered by Stake (2006) on cross case analysis was followed but not fully, as some of the suggested tools (the analytical worksheet for researchers) did not fit with the type of data generated from this study.

Therefore, thematic analysis continued to be used and adapted for comparing and contrasting across case sites in addition to within them. The process used was what Stake specified as 'Track I and track II' for the analysis of multiple case studies (Stake 2006). Track I analysis highlights case findings whilst preserving situationality. Track II analysis combines similar findings across cases. Findings that are prominent across multiple cases will be presented in the report (Stake 2006).

Associations between themes and categories were sought between the two data sets. Stake (2006) asserts that the cases are grouped and viewed as

one entity, called the 'quintain'. He continues that the researcher seeks to understand better how this whole or 'quintain,' operates in different situations within different contexts. In this study the 'quintain' is the essential factor or factors which underpin the phenomenon of midwives' decision making during normal birth (see section 7.2 for an example).

An initial first level of understanding of the 'quintain' originated from grouping the themes from both cases whilst maintaining their situatedness. Stake (2006) maintains that this is how we come to know the 'quintain' better.

Whilst making comparisons between the qualitative data sets, the researcher made further notes, memos, schematic drawings and anything that would help concentrate on the cases as a 'quintain', whilst also maintaining focus on context. Stake (2006:64) offers the following guidance: "A Theme or a finding, as used here, is a central idea having importance related to its situation. It is at least somewhat context-bound.....".

Data collected and stored electronically, in NVivo software package and in field and reflexive notes were all reviewed many times over to enhance confidence in the data analysis and to check for disconfirming data.

The findings from the cross-case data analysis were compared with the most relevant up-to-date literature, searching for verification or alternative explanations than those offered by the researcher. Finally, the interpretations presented were those, I as the researcher, felt most

authentically corresponded to the data (Gillham 2000, Yin 2013). Stake (2006) proposes the development of persuasive assertions based on the evidence that has emerged from the data. This appeared to be the continuous engagement of a 'case-quintain dialectic' that is "a rhetorical, adversarial procedure wherein attention to the local situations and attention to the phenomenon as a whole" is made (Stake 2006:46).

Because there was high concordance between the themes that emerged during the cross-case analysis, it is this analysis that will be presented in the findings and discussion chapters. The assertions arising from the cross case analysis will be expressed at the beginning of each of the presented themes within the discussion chapter. These encapsulate the essence of the key findings from the study.

#### **4.18 Reflexivity**

Slembrouck (2004:3) describes reflexivity as "the inward looking dimension of the research process". It is a concept that is normally associated with qualitative or social research. Findlay (2003) asserts that reflexivity is the process of examining how the researcher and intersubjective elements impact on and transform research. It means that when carrying out a study, the researcher is aware of and explores his or her personal feelings, experiences and values and how these may impact on the research. These influences are recognised and integrated into the study (Polit and Tanco-Beck 2014). This process according to Gray et al, (2018) requires a degree of consciousness of 'self'.

I was fully aware that my primary role, whilst conducting this study, was as researcher. However, I am also a midwife, a woman and a mother, (which I consider offer important resources to enhance reflexivity whilst simultaneously providing potential limitations to the study). I acknowledge that these factors must influence the various stages of the study. These stages being: the preparatory stage, (knowledge of the research area and development of the research questions), to data collection methods (focus group interviews, observations, questions asked) and data analysis (interpretation of the data). According to Ibrahim and Edgley (2015) qualitative data analysis is unavoidably impacted on by a researcher's personal and professional background, cultural dogmas, institutional influences, pre-conceptions and pre-suppositions.

Reflexivity assists the researcher to have an awareness of 'self' and to integrate their own personal involvement in a reciprocal process of interpretation of those being studied (Spence 2001).

Throughout data collection, I had a constant appreciation of my own experiences, prejudices, biases and pre-existing feelings and values concerning the topic under review. For example my own profound beliefs in the midwifery/social model of childbirth and these beliefs were continually reflected upon and included in the text of the thesis when felt to be significant. My own positionality was tested when for example, midwives' decision making processes were medicalised and interventionist when caring for women in normal labour and birth. Data collection is co-constructed and

inevitably embodies interpretation. Reflexivity is about making this explicit. This concurs with Denscombe's (2007) view of reflexivity.

As stated earlier, the researcher is also a clinical midwife, therefore considered an 'insider' within the group being studied. An insider, as opposed to an outsider, is a member of the group sharing a language, identity and experiential base with the participants (Asselin 2003). As an insider, the researcher may be clouded by their own personal experience (Dwyer and Buckle 2009) and may not be able to see 'what is in front of them'. Conversely being an insider enhances access, legitimacy and acceptability (Dwyer and Buckle 2009). Asselin (2003) counsels that insiders must ensure they keep their 'eyes open' during data collection, approaching from a stance of having no or little knowledge of the phenomenon under study.

According to Gadamer (1975), interpretation is not about the uncovering of the intentions of another person. It is rather an encounter in which a fusion of horizons occurs, embracing the meaning held by the other.

The intensive viewing and reviewing of the research approach, the data collection methods, the data analysis and the interpretations of the data addressed the notion of reflexivity via a reflexive journal. This enabled insights both within the 'field' and outside of it. It assisted with the iterative process, as I had the opportunity to make slight amendments to the research method from one case to the next (Swanborn 2010), such as questioning midwives more in subsequent observational visits. Some of the



reflexive notes have been included in the findings and discussion chapters, where I feel they will add context and understanding for the reader and to demonstrate awareness of my 'situatedness' within the study.

Supervisors, who are experts in the arena of normal childbirth, and/or experts in qualitative research, reviewed and commented on all stages of the research process, so that perspectives other than my own were sought. The aim was not to eradicate bias but to be explicit about the researcher's impact on each phase of the study. Part of the reflexive process is recognising the researchers' history to explore how they 'came to be' in the place they are now and how this has impacted on the rationale for the study.

#### **4.19 The researcher in context**

It is important in qualitative research to acknowledge the researcher's positionality within context, in order to understand the reasons for carrying out the study and the stance that the researcher takes.

I started my professional life as a nurse. After two years post qualification I became a midwife, I realised I had found my niche. I loved being a clinical midwife. When I look back, I realised, to my shame, that I was very compliant, and took on many of the practices that I saw and experienced, not always good ones. During my time as a clinical full time midwife, my experiences of childbirth were very medicalised, CTGs were routinely used and episiotomies conducted frequently.

It gradually dawned on me that there must be a different way, a more woman centred approach to pregnancy, labour and birth. I commenced the Advanced Diploma in Midwifery (ADM) in 1991, and it was this course that awakened in me the true meaning of normality in childbirth. I was exposed to a completely alternative view that I had previously not realised existed. Childbirth could actually be an empowering, positively transforming, even an enjoyable experience for women.

In 1993, I commenced my first degree, which was in education, to enable me to become a midwife teacher. My first piece of personally conducted research was 'The role of the lecturer / practitioner in midwifery', because I felt very strongly that educationalists should have a grounding in clinical practice, this role seemed to me to be the ideal.

I started my career as a 'Graduate midwife teacher' in 1994, at the University of Nottingham. I became a mother the following year, and started an MPhil in 1996. My research this time was 'Midwives' knowledge and attitudes towards aspects of sexuality', a reaction to sex and sexuality in childbirth being firmly 'kept in the closet' at that time. Normal childbirth and normality were really not such an issue in the mid-nineties although it was becoming apparent this was changing. By the time I commenced my PhD, normality in childbirth was becoming recognised as a public health issue. Intervention, instrumental and operative deliveries were fast becoming the norm.

I have to declare that I commenced this PhD study because I have a profound belief in women's ability to labour and birth physiologically and little research has examined the role of decision making in supporting normal childbirth. I acknowledge, therefore, that I am not coming from a place of neutrality and being reflexive throughout this journey, from the planning stages, data collection and analysis through to interpretation, is absolutely imperative.

#### **4.20 Ethical considerations**

All ethical requirements, approvals and permissions were addressed or obtained as appropriate (see appendix 15). Ethical approval was required from the Faculty Research Ethics Committee and from the NHS Research and Development departments for the Trusts involved. The Heads of Midwifery in the Trusts involved gave permission for the study to be carried out. The 'University of Nottingham Code of Research Conduct and Research Ethics' (2013) was rigorously adhered to at all stages of the case study research.

Written consent was obtained from midwives for the focus group interviews and from midwives who consented to keep diaries in line with good practice guidelines (Royal College of Nursing (RCN) 2011, Ryen 2016). Thank you posters were distributed across the two case sites, following completion of the study (see appendix 14).

The decision to exclude childbearing women from the study was not taken lightly. It was eventually concluded that direct observations of midwives interacting with women in labour would prove to be an ethical quagmire, in terms of obtaining consent and the possible influence of researcher presence causing disruption to the progress of labour. In addition potentially causing a change in behaviour by midwives. The researcher also did not feel entirely comfortable being an observer at such an intimate, private time. The decision was therefore taken that the sample group were qualified midwives and were therefore viewed as being responsible and autonomous professionals and would not be classed as 'vulnerable'. However the researcher had to acknowledge the potential causes of 'harm' in addition to 'benefits' (RCN 2011). At the time of data collection, the researcher was a midwife lecturer and a practicing midwife. Participants may perceive that the researcher was there to criticise their practices. In the preparatory stages of the research, it was made very clear that the purpose of the research was to explore and illuminate decision making processes in normal birth, with the potential benefit of reporting the decision making processes that appeared to maximise the physiology of normal birth.

Clarity was also given in relation to the role that the researcher adopted, that of observer as participant (see section 4.13). I was there solely as a researcher and was not there to engage in any clinical practice. The exception to this would be if an emergency occurred, where ethically I would be required to act within my professional capacity. Moreover, I did

not act as an advisor to midwives when caring for women in normal labour. Every effort was made to ensure that the presence of the researcher and the interactions with all levels of staff was non-threatening, relaxed and informal. Reflexivity and my own positionality were key aspects of the study at all stages of the research process.

Many authors have discussed the difficult issue of informed consent when conducting observational research (RCN 2011, Thomas 2011, Silverman 2017, Ryen 2016). This includes non-intervention, observational research where it would be impossible to gain written consent of all those who came into view (RCN 2011). Therefore Thomas (2011) discusses the approach of implied consent, whereby participants are made aware of the research and the researcher assumes that they have given their consent to be included, unless the participants informs to the contrary. In this research, which was conducted in two different labour suites (see section 5.4 in Findings chapter (1) for descriptions) where many different health professionals come and go, the implied consent was the preferred option. However, it was made clear to the participants, prior to and during the research period that they may choose to 'opt out' at any given time.

In the event of an ethical issue arising in the field, the researcher would be able to discuss the issue with the appropriate individual(s), this could have been a senior midwife, a supervisor of midwives or the research supervisors. No such issue arose.

All information contained in focus interview transcripts, diaries, field notes, personal diary was treated with the strictest confidence. Locations and names were substituted with codes to protect anonymity. This data was stored in accordance with 'The University of Nottingham Code of Research Conduct and Research Ethics' (2013).

#### **4.21 Summary**

The research aim is: To explore midwifery decision making during normal labour and birth. The research question is: What influences midwives' decision making during normal labour and birth?

The broad paradigm of interpretivism underpins the study, with a case study approach chosen to best facilitate the aim of the study and answer the research question.

Ethical approval was granted for the study by the Research Ethics Committee and from the NHS Research and Development departments for the Trusts involved. Midwives gave written consent for the focus group interviews and decision making diaries. Implied consent was used for the observations, after midwives had been fully informed about the study. Midwives were informed that they did not have to participate and they could withdraw from the study at any time.

Two labour suites in the East Midlands were identified as the case sites. The only inclusion criteria was that participants had to be regularly involved with direct labour and birth care of childbearing women. In total

there were six focus group interviews conducted, twenty one observational visits, and two decision making diaries completed. Documentation was also reviewed at both case sites.

Reflexivity is a key aspect of qualitative research and has been recognised throughout the thesis journey. Field notes and a reflexive diary have been kept by the researcher. Such a robust triangulation of methods adds to the completeness of the study.

Transcription was mainly conducted by the researcher but a professional transcription service was also employed due to timing constraints. However, all transcriptions were read and reread many times during the analytical process. NVivo versions 10 and 11 were used for data management. A thematic analysis was adopted to first identify codes, then categories, leading to the emergence of the main five themes. A cross-case analysis was then conducted.

The next chapter will introduce and report some of the findings of the study and will discuss those findings in detail.

## **CHAPTER 5 FINDINGS (1)**

### **5.1 Introduction and overview of findings**

The research aim was: To explore midwifery decision making during normal labour and birth. The research question for this study was: What influences midwives' decision making during normal labour and birth?

Reporting of the findings has been divided between chapter five and chapter six. This is to provide manageable sized chapters. In this chapter, a within case analysis will be included, an overview of case site 1 will be described, the characteristics of the midwives who participated in the various data collection processes will be presented in tabular format. The within case themes and categories will be illustrated. A within case analysis will then be described for case site 2. A cross case analysis will then outline the five main themes arising from all forms of data collection from case site 1 and case site 2. The chapter will then be dedicated to presenting in detail, the findings of the study related to the first two themes: Woman focussed determinants (Theme one) and Midwifery specific influences (Theme two).

### **5.2 Within case analysis**

#### **5.2.1 Overview of the characteristics of case site 1**

Case site 1 is a large teaching hospital within the region of the East Midlands (see table 5.10). Within the labour suite there are 4 500 births a year. It has a co-located (to the main obstetric unit) midwifery led care unit (MLC). Case site 1 has neonatal intensive care facilities that can accommodate very



premature and ill babies. This site has four birthing pools (two plumbed in pools and two inflatable pools). Water immersion and water birth are readily facilitated, particularly on the MLC unit. All midwives and student midwives at this site are educated and trained in the use of aromatherapy during labour and birth and this service has been well established for over 10 years. Case site 1 serves a large (35%) black and ethnic minority population (Census 2011). The site serves geographical areas of significant deprivation but in contrast, also serves areas of great affluence (English Indices of deprivation 2015).

The significance of some of these features are integrated into the findings and discussion chapters.

### **5.2.2 Overview of participants - case site one**

### **5.2.3 Observations**

There were a total of 33 midwives who were observed at case site 1 during 11 different observational visits (Total number of hours 92). The midwives were band 5, 6 or 7 and varied from being qualified between six months and 30 years.

### **5.2.4 Focus group interviews**

The intention, during data collection, was to have focus group interview groups of between four-seven ideally, in practice this was not possible due to clinical pressures therefore focus group interviews were conducted as and when staff could be excused and with smaller numbers than I had planned

(see tables 5.1-5.3). This could potentially affect the interaction between the group members, however I feel that being in groups of the same or similar grade band may have helped ameliorate any difficulties. The focus group interviews lasted between 56-95 minutes. The band 6 focus group interviews at case site 1, took place at a participant's house, who had volunteered for her house to be used for this purpose. All members attended of their own free will in their own time. This made the interview much easier to facilitate in a less stressed and time constrained environment. In each focus group interview, I supplied refreshments for the midwives attending.

<b>Table 5.1 Focus group interview Band 7s Interview 1 case site 1</b>	
<b>Midwives code</b>	<b>Approximate years qualified</b>
<b>MWQ5</b>	<b>15 years</b>
<b>MWQ21</b>	<b>9 years</b>
<b>MWQ29</b>	<b>20 years</b>

<b>Table 5.2 Focus group interview Band 7s Interview 2 Case site 1</b>	
<b>Midwives code</b>	<b>Approximate years qualified</b>
<b>MWQ13</b>	<b>30 years</b>
<b>MWQ15</b>	<b>26 years</b>

<b>Table 5.3 Focus group interview Band 6s Interview 3 Case site 1</b>	
<b>Midwives code</b>	<b>Approximate years qualified</b>
<b>MWQ14</b>	<b>15 years</b>
<b>MWQ30</b>	<b>15 years</b>
<b>MWQ31</b>	<b>11 years</b>
<b>MWQ32</b>	<b>6 years</b>
<b>MWQ33</b>	<b>2 years</b>

### 5.2.5 Decision making diaries

There were two midwives, from two different focus group interviews, who agreed to keep decision making diaries at case site 1 (see table 5.4). This was for 10 shifts or equivalent (see appendix 10, for full instructions).

**Table 5.4 Midwives completing decision making diaries – case site 1**

<b>Midwives code</b>	<b>Band</b>	<b>Approximate years qualified</b>
<b>MWQ13</b>	<b>Band 7</b>	<b>30 years</b>
<b>MWQ14</b>	<b>Band 6</b>	<b>15 years</b>

### 5.2.6 Documentary review

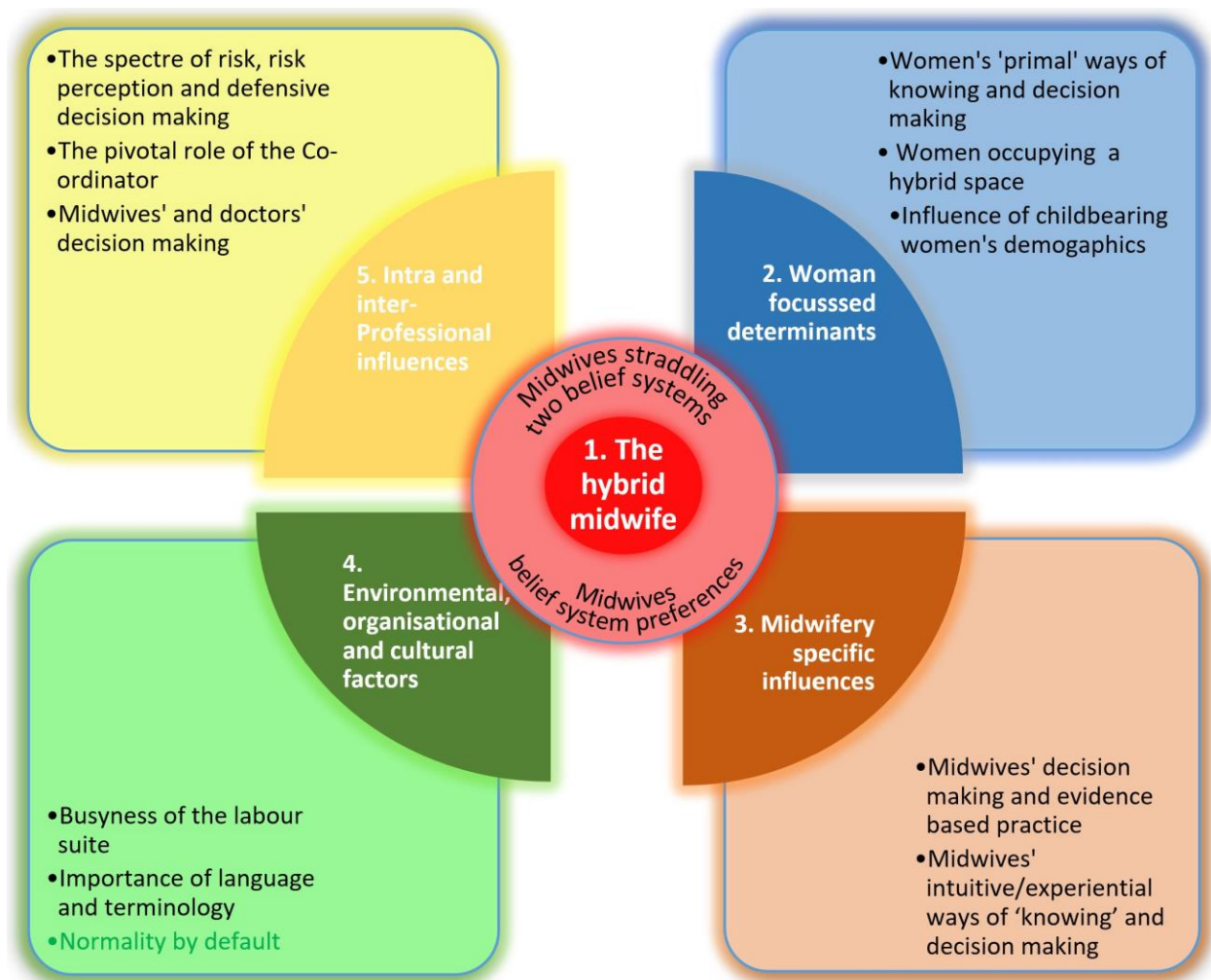
Documentary review was conducted as part of the field research (see table 5.5). Monthly labour suite magazines, leaflets / pamphlets - information for women, local guidelines and minutes of meetings (see section 4.16 of the methods / methodology chapter). The documentary review did not add as much value to the study as I was expecting, for example minutes of multi-professional group meetings examined did not contain any content related to decision making during normal labour and birth (e.g. labour suite forum meetings). The most relevant documents to midwives' decision making were local guidelines, monthly labour suite clinical news magazines and evidence based leaflets for women as these most closely related to normal labour and birth. Any pertinent data will be incorporated into the findings and discussion chapters where appropriate.

<b>Table 5.5 Documentary review case site 1</b>	
<b>Type of document</b>	<b>Number</b>
<b>Local Guidelines</b>	<b>5</b>
<b>Monthly labour suite News journal</b>	<b>3</b>
<b>Leaflets /pamphlets for women</b>	<b>4</b>
<b>Minutes of meetings</b>	<b>2</b>
<b>Communications from managers</b>	<b>1</b>
<b>Field notes</b>	<b>1</b>

### **5.2.7 Within case analysis case site 1: Emergent themes and categories**

There were 5 emergent themes at case site 1. These were: 'Woman focussed determinants', 'Midwifery specific influences', 'Environmental, organisational and cultural influences', 'Intra and inter-professional influences' and 'The Hybrid midwife'. See figure 5.1 for themes and categories related to each theme.

Figure 5.1 Influences on and exploration of midwives' decision making – data collection case site one



\*Text in black demonstrates shared categories between case site one and case site two.

\*Text in green signifies category only found at case site one.

### **5.3 Overview of the characteristics of case site two**

Case site 2 is a large teaching hospital within the East Midlands (see table 5.10). Case site 2 provides care for all risk categories in one labour suite location, however, certain rooms are allocated to lower risk and higher risk cases. Case site 2 has a neonatal care unit. Any very premature neonates or those requiring intensive care facilities would need to be transferred out to a unit with appropriate facilities. Case site 2 has one plumbed in pool. Water immersion and water birth were not frequently facilitated. Approximately 70% of the midwives and all of the student midwives have received education and training in aromatherapy use during labour and birth. This service has therefore been partially established for around 10 years. There is not much diversity with only 6.8% of the population being from black and ethnic minority groups (Census 2011). The site serves geographical areas of significant deprivation but in contrast, also serves areas of great affluence (English Indices of deprivation 2015).

#### **5.3.1 Overview of participants case site two**

#### **5.3.2 Observations**

There were a total of 34 midwives who were observed at case site 2 over 10 observational visits (total number of hours 84). The midwives were band 5, 6, 7 and 8 and varied from being qualified three months to over 30 years.

### 5.3.3 Focus group interviews

Similarly, as with case site 1, I found that I could not conduct the focus group interviews with the numbers of staff that I had anticipated due to clinical constraints. I therefore had to facilitate focus group interviews with midwives in smaller numbers, as and when they were available (see tables 5.6-5.8). The focus group interviews lasted between 52-87 minutes. Please note in the band 7 focus group interviews, there was one band 8, but I have not identified individual grade bands, when reporting on findings of this particular focus group interview, to preserve confidentiality.

**Table 5.6 Focus group interview band 5 and band 6 Interview 1 case site 2**

Midwives code	Band	Approximate time/years qualified
MWM31	Band 5	5 months
MWM33	Band 6	19 years

**Table 5.7 Focus group interview Band 6s Interview 2 case site 2**

Midwives code	Band	Approximate time/years qualified
MWM2	Band 6	10 years
MWM30	Band 6	5 years
MWM32	Band 6	2 years

**Table 5.8 Focus group interview Band 7s and 8 Interview 3 case site 2**

Midwives code	Approximate time/years qualified
MWM3	15 years
MWM7	23 years
MWM26	30+ years
MWM34	10 + years

### 5.3.4 Decision making diaries

No midwives agreed to complete decision making diaries at case site 2.

### 5.3.5 Documentary review

Similar to case site 1, the most relevant documents to midwives' decision making were local guidelines, monthly labour suite clinical news magazines and evidence based leaflets for women as these most closely related to normal labour and birth (see table 5.9). Any pertinent data will be incorporated into the findings and discussion chapters where appropriate.

<b>Table 5.9 Documentary review case site 2</b>	
<b>Type of document</b>	<b>Number</b>
<b>Local Guidelines</b>	<b>4</b>
<b>Monthly labour suite clinical news magazines</b>	<b>2</b>
<b>Leaflets /pamphlets for women</b>	<b>3</b>
<b>Minutes of meetings</b>	<b>3</b>
<b>Communications from managers</b>	<b>1</b>
<b>Field notes</b>	<b>1</b>
<b>Evidence of learning (written by Student/MW)</b>	<b>1</b>

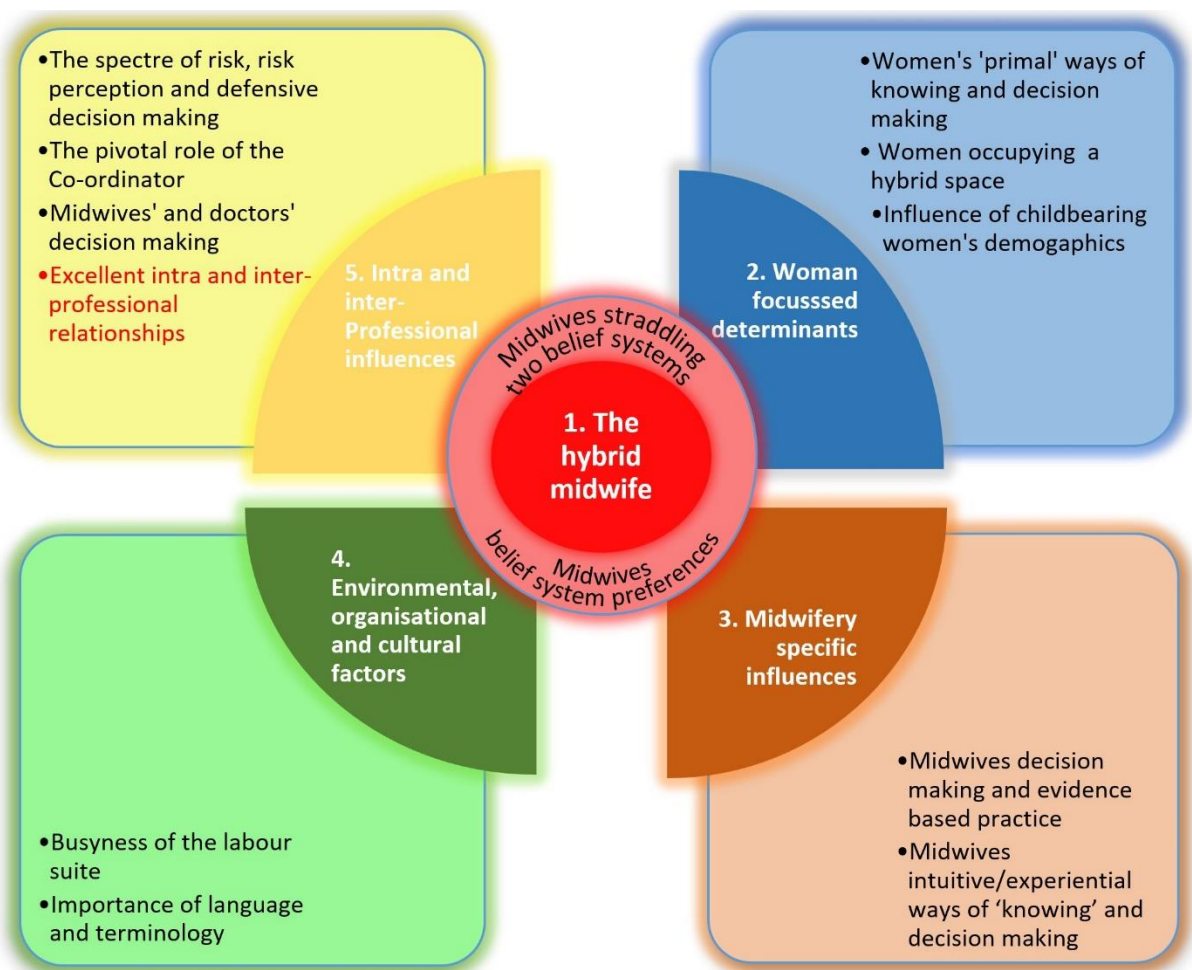
### 5.3.6 Within case analysis case site two: Emergent themes and categories

The same five emergent themes arose from case site 2 as arose from case site 1. These were: 'Woman focussed determinants', 'Midwifery specific



influences', 'Environmental, organisational and cultural influences' , 'Intra and inter-professional influences' and 'The Hybrid midwife'. See figure 5.2 for themes and categories related to each theme.

Figure 5.2 Influences on and exploration of midwives' decision making, data collection case site two



\*Text in black demonstrates shared categories between case site one and case site two.

\*Text in red signifies category only found at case site one

## **5.4 Cross case analysis - comparison of the characteristics of case site one and case site two**

The main differences and similarities of case site 1 and case site 2 are as follows (see table 5.10). Health care students, including student midwives, attending the same University are placed for their clinical experience at both of these case site hospitals. The main differences between the two case sites are that case site 1 has a co-located (to the main obstetric unit) midwifery led unit. Case site 2 provides care for all risk categories in one labour suite location. Case site 1 has 1000 more births than case site 2 per year. There are more birthing pools available to women at case site 1 compared to case site 2. Water immersion and birth is frequently accommodated at case site 1. The aromatherapy service is well established at case site 1 compared to case site 2 where the service is partially established. Case site 1 serves a much larger black and ethnic minority population than case site 2 (Census 2011).

Table 5.10 Comparisons of case site 1 and case site 2

Case site 1	Case site 2
Large teaching hospital in the East Midlands	Large teaching hospital in the East Midlands
4 500 births per annum (approx)	3 500 birth per annum (approx)
Obstetric unit and alongside midwifery led unit (MLU)	Integrated obstetric and midwifery unit
2 (+ 1 being plumbed in) birthing pools plus blow up pools	1 birthing pool
9 rooms on obstetric unit, 4 on MLU	12 birthing rooms
Well established aromatherapy service	Part established aromatherapy service
2 high dependent care rooms	2 intensive monitoring rooms
Triage room off main labour site	Triage room on labour suite
2 theatres	2 theatres
Neonatal intensive care facilities	Neonatal unit care facilities
Indices of deprivation score 8 <sup>th</sup> (out of 326) with some areas of very low deprivation scores. Contrasted with some very affluent area.	Indices of deprivation score 56 <sup>th</sup> (out of 326) with some areas of very low deprivation scores. Contrasted with some very affluent areas.
35% of population BME	6.8% of population BME
Census (2011), English Indices of deprivation (2015), Which? Birth Choice (2018), Information supplied to researcher by case sites.	

## **5.5 Cross case analysis: Identifying the themes and categories**

Following the within-case analysis, a cross-case analysis then took place (see section 4.17 in methodology and methods chapter). It quickly became apparent that there was a high degree of parity between the themes and categories (apart from two categories) from both case sites. Therefore the decision was made to provide a detailed report on the cross-case analysis, otherwise there would be much repetition. However there were some nuanced differences between the two case sites within some of the themes and categories, for example the degree to which evidence based practice was adhered to varied. These will be examined in the discussion chapter. Table 5.11 illustrates the themes arising from the cross case-analysis and the data sources which contributed to identifying the themes.

Table 5.11 Contribution of each data source to identify themes and categories					
Data sources (both case sites)					
Theme	Category	Observations	Focus group	Document	Diaries (Case site 1 only)
The hybrid midwife	M/Ws straddling two belief system	✓	✓		✓
	M/Ws belief system preferences	✓	✓		✓
Woman focussed determinants	Women's primal ways.	✓	✓		✓
	Women occupying a hybrid space	✓	✓	✓	
	Women's demographics	✓	✓		
Midwife specific influences	M/Ws decision making and EBP	✓	✓	✓	✓
	M/Ws intuitive /experiential ways of knowing and of DM	✓	✓		✓
Environmental, organisational and cultural factors	Busyness of the labour suite	✓	✓	✓	✓
	Importance of language and terminology	✓	✓		✓
	Normality by default (Case site 1)	✓	✓		
Intra and inter-professional influences	The spectre of risk, risk perception and defensive DM	✓	✓		✓
	The pivotal role of the co-ordinator	✓	✓		✓
	Midwives' and doctors' DM	✓	✓		✓
	Excellent intra and inter-professional Relationships (Case site 2)	✓	✓	✓	

As stated, all the themes were the same for case site 1 and case site 2.

Figures 5.1 and 5.2 encapsulate original findings from this study, or aspects of midwifery decision making that have had little coverage or exposure in midwifery research. The themes were: woman focussed determinants, intra and inter-professional influences, midwifery specific influences and environmental, organisational and cultural factors. The final main central theme from the five identified was 'The hybrid midwife' because the midwife working between dualistic belief systems and therefore decision making approaches, impinges on each of the preceding themes and vice-versa. All the themes inter-relate to each other to a degree and also connect to the overarching theme of 'the hybrid midwife'. These relationships and connections will be further explored within the discussion chapter.

There are also categories related to each theme (also illustrated in figures 5.1, 5.2 and table 5.11). The subsequent discussion chapter will explore how these themes and categories are situated within the wider multi-professional literature as well as in the midwifery decision making literature. However, whilst most of the categories were found at both case sites, two categories were only found at one of the case sites (one at case site 1 and one at case site 2), as highlighted in different coloured text in figures 5.1 and 5.2. It is acknowledged that some of the categories could 'fit' into several of the main themes. There were some findings in this study that have been the subject of much midwifery literature and research. For example the influence of birth partners (Brown et al, 2009, Bäckström and Hertfelt Wahn 2011, Page and McCandlish 2006, Simkin and Ancheta, 2017, Walsh 2011, Johansson et al,

2015) and birth plans (Berg et al, 2003, Lundgren et al, 2003, Doherty 2010, Cook and Loomis 2012, RCM 2012c), as both adversarial and empowering impacts on midwives' and women's decision making. These are included in the findings and discussion chapters. However the main focus is on original or little explored phenomenon related to midwives' decision making as illustrated in the themes and categories (see figures 5.1 and 5.2).

The categories within the themes reported on here, and within the following sections were those which emerged from the data following reading and re-reading of the data multiple times. There was one category: 'normality by default' which was only found at case site 1 and one category 'excellent intra and inter-professional relationships' which was only found at case site 2, which highlights that there were some fundamental differences between the two case sites.

In discussing decision making with midwives during the focus group interviews and during informal conversations with midwives whilst undertaking observational visits, the conversation often swayed towards their practices such as how the fetal heart is monitored, or use of interventions such as artificial rupture of membranes (ARM). Arguably this may have been because midwives found articulating their decision making processes, which could be seen as quite abstract, somewhat challenging. The subjective, unpredictable, flexible and reflexive nature of qualitative research (Silverman 2017) lends itself to legitimately report on what participants, in this case midwives, found important to them. Therefore,

whilst this thesis focusses on the core aspect of midwives' decision making, some clinical practices, (for example conducting VEs, ARMs and admission CTGs) are explored briefly to 'make sense' of and to contextualise midwifery decisions. Including specific practices also elucidates what midwives report as influencing their decision making in particular clinical circumstances.

It was not possible to 'follow through' the same midwife and the labouring woman they were caring for during entire observational episodes. This was because of midwives changing shifts, co-ordinators reallocating workload during busy periods and also midwives being allocated several women at a time. Therefore during the observations, informal conversations with different midwives on shift took place in the clinical settings when they were outside of the labour room. Thus, these informal conversations are reported frequently, in addition to citations from the focus group interviews and excerpts from midwives diaries.

General field and reflexive notes were made at the time of data collection and therefore provide important contextual information and thoughts. Some of these notes have been inserted in consequent sections and chapters, if it was thought that these add meaning and understanding to the discussion. The document review also provided some additional data.



## **5.6 WOMAN FOCUSSED DETERMINANTS (THEME 1)**

### **5.6.1 Introduction**

Recognition must be given to women not being directly involved in this research and the reasons for this decision (see chapter 4, section 4.20). Nonetheless I wanted childbearing women to be visible within this study and therefore asked midwives about women's views, actions and behaviours in relation to decisions that were made during their childbearing journey. I acknowledge therefore that these were reported through the lens of the midwives and not directly by the labouring women themselves.

### **5.6.2 Women's primal ways of knowing and decision making**

Under the broad theme of 'women's primal ways of knowing and decision making', as to be expected in normal childbirth, there were a number of instances reported where women laboured and gave birth, physiologically, without intervention. For example:

MWQ11: (Band 6) caring for woman admitted in spontaneous labour.

Primigravida (first baby). Cervix 4cms, in pool, woman feels like pushing. Eventual normal birth. (Observations case site 1).

Primigravida (first baby) continuing to mobilise, had aromatherapy, bed up high for her to lean against.....VE... cervix now 5cms.

Continued making slow progress. (Observations case site 1).

On L/S G2P1. Cervix 6cms. No issues progressed well. (Observations case site 2).

These women's labours seemingly progressed physiologically, but midwives did state that in some of these and other cases, prior to the birth, women's labours may have slowed down or their contractions may have stopped altogether. In such instances it was reported that women themselves instigated decisions. For example wanting to be more active, requesting water immersion, changing position or requesting massage. There was one account where the labouring woman and her female birth companions appeared to instinctively know what to do:

Primigravida (first baby) labouring well, but contractions were spacing out and finally stopped. The woman was distressed that nothing seemed to be happening, she became restless and changed her position frequently from upright to sitting to lying down. The female birth companions started massaging her back, shoulders and abdomen and within about 20 minutes her contractions slowly returned. She gave birth normally a few hours later. (Informal conversation with midwife, Observations case site 1).

There were also reports of midwives encouraging women to use their primal instincts, to 'go with the flow'. A midwife talks through the process:

As cited by MWQ14 (Band 6):..... "I explained about letting it happen: let baby press, let it be strong, feel everything as it is....."  
(excerpt from decision making diary two, case site 1).

Midwife MWQ32 described how a 15 year old had a 'go with the flow' approach to decision making and instinctively laboured and birthed using tactile 'hug's and 'stomping' to help her through labour:

MWQ32: Yeah.... I remember a 15 year old stomping around the room during the contraction or in between contractions, then she'd grab you and hug you really, really, really, really tight and then she'd let go keep walking and then she got on the bed on all fours and she was 'right I'm pushing now, I'm pushing now'.

MWQ14: Primitiveness

MWQ32: it was beautiful to watch it, it was yeah... just instinctual. (Focus group interview, band 6s, case site 1).

Many midwives stated the importance of building a rapport and a relationship with women in order for them to trust what they were saying. They encouraged women to embrace their inner physiology rather than make choices and decisions to resort to medication, for example.

Several midwives alluded to their perception that the birth partner may have a negative effect on the progress of labour, disrupting the 'go with the flow' approach to decision making that they had encouraged in the labouring woman. They would therefore send the partner for a coffee or a walk in order to change the environmental ambience for the woman:

MWM31 (Band 5)".....Do you want to get a coffee and just have a break away? I'm with her. You're fine. And just give that person some time away, and give the woman some space to be able to kind of let

the oxytocin come and let the adrenaline calm down. Again, making her a nest.....turn the light down, put some music on.....". (Focus group interviews, Band 5 and 6, Case site 2).

This tactic was reported by midwives to enable a 'go with the flow', physiological labour to progress effectively.

Women's instinctive, embodied, primal ways of knowing and decision making were alluded to in the following excerpt, which appeared in the focus group interviews at case site 1:

MWQ30 (Band 6): ".....and there's something called the inner chimp or something and that really rang true with me cos I thought we are so cerebral now we're so gadgets and technology that labour and birth are one of the only times we allow our bodies to be taken over that way. I think I even said it to this couple and they laughed at me....but she actually understood...."

MWQ14 (Band 6): "When they get what you're saying it's awesome..."

MWQ14 (Band 6): "...Be....just be..."

MWQ30 (Band 6): "...chimp inside you that is happy to make this noise and it doesn't mind if it poos on itself and it doesn't mind if there's a bit of blood and screaming and swearing cos that chimp...that's what that chimp does and they thought it was quite funny but..." (Focus group interviews, band 6s, case site 1).

This midwife and others in the focus group interview talked about women having this inner strength, inner voice that they can tap into and listen to, even when it is not comfortable or even if it hurts. To make decisions based on that inner strength. These midwives suggested if women can do that, they are more likely to have a normal labour and birth. Women's belief in their own physiology, embracing a 'go with the flow' approach to decision making, was reported by a number of midwives as being key to a normal labour and birth experience.

Here is an account of a woman who would be considered high risk but wanted to share in decision making during a home birth for her third child:

MWM 26 (Band 7/8) Told me about a woman who had two sections, had reached 8cms but then didn't progress any further. In her third pregnancy she employed an independent midwife and wanted to have a VBAC at home. Very well informed woman, knew that she would need to transfer into hospital if any problems, knew the implications of her decision. She went into labour, called the midwife who came and examined her. Her cervix was 8-9cms. Progressed and gave birth, with a shoulder dystocia (which was quickly resolved), to a baby that was almost 11lbs. Was able to overcome this 'block' by being in her own environment with a midwife that she completely trusted. (Informal conversation with midwife, observations case site 2).

The senior midwife reported how the woman had an implicit trust in her body to labour and birth normally at home, in her own familiar environment

the woman was in control, making all the decisions or sharing decision making with the midwife throughout labour.

In another account a woman relayed to a midwife her first childbirth experience:

Her baby was OP [occipito-posterior] position, she knew that she needed to get up and mobilise to get her labour going. But was told the fetal heart rate needed to be monitored continuously, she had no idea why, so was strapped to the bed and indeed her labour did not progress.....so with her subsequent labour (also with an OP positioned baby) she made the decision to be active and as mobile as possible....labour progressed normally (Informal conversation with midwife, observations case site 1).

The midwife's view was that an OP position of a baby is challenging but is still normal. The labouring woman apparently instinctively knew that she needed to get up and be active but was not 'allowed' to do so with her first child as the midwife was in control and made all the decisions. The account from this midwife proffers that the philosophy of the midwife (relates to the 'hybrid' midwife) and her subsequent decision making can work with a woman's primal instincts or contrast with them.

### **5.6.3 Midwives' decision making and influence of childbearing women's demographics**

Health Care Professionals (HCPs) at both case sites, but much more explicitly at case site 2, repeatedly told me that the type of childbearing women had an influence on decision making and childbirth outcomes. The women at case site 2 attending the hospital were described by HCPs as being of low socio-economic status, had low expectations, low educational achievement and came from quite disadvantaged back grounds, but when it came to labouring they 'just get on with it', a phrase that was used numerous times. Here is one such account:

In coffee room, I asked a senior obstetrician why this unit has a high normal birth rate. Doctor said it's probably multi factorial. Women are not very well educated, low expectations, happy to be told what to do! But these are obviously massive generalisations. (Informal conversation during observations with senior obstetrician, case site 2).

I had a discussion with the Head of Midwifery at case site 2:

I said that a number of individuals have told me that because of the demographics of the women at case site 2, (low expectations, low educational achievement) they come in to labour suite and just get on with labour and birth without any fuss and without intervention. She [the Head of Midwifery] felt that there may be some truth in that.

(Discussion with Head of Midwifery, in her office during observations, case site 2).

And a discussion with another senior midwife at case site 2:

"MWM26 (Band 7/8)".....in [case site 2] a less affluent area, women are largely surrounded by family, have that social support, their mothers and sisters have given birth normally and it's just an attitude of 'yes it hurts but just get on with it". (Informal conversation during observations, case site 2).

And reported in a focus group interview:

MWM32 (Band 6):".....some women from certain [affluent] areas want more input [from midwives]. Whereas other women from certain [non affluent] areas, they don't expect anything hardly, do they?" (Focus group interview, band 6s, case site 2).

The opinions given previously were echoed by this co-ordinating midwife at case site 2:

Asked MWM17 (Band 7).....why the unit has such a high normal birth rate, she said that the women of [case site 2] are very different to the women of [case site 1]...she said that there are a lot of young women that do just come in and get on with it. (Informal conversation, observations case site 2).



There appeared to be a strong belief from some midwifery and obstetric staff, particularly at case site 2, that women's demographics did affect decision making and birth outcome. The perception appeared to be that generally, women at case site 2 were younger, more passive, didn't make decisions to have intervention, they didn't question anything too deeply, they just got on with the business of giving birth.

#### **5.6.4 Women occupying a hybrid space**

The 'grey' area of childbirth between normality and pathology was observed on a number of occasions at both case sites. The category of 'women occupying a hybrid space' arose that highlighted some labouring women's situations were viewed as potentially pathological by some (usually medical staff) and low risk or 'normal' by others (usually midwives) and that this could potentially affect midwives' decision making:

MWQ1 (Band 6) was caring for a woman who had a complex obstetric history. Currently 37 weeks. As the fetus is now term, technically could be a normal labour and birth. Consultant A has requested a low threshold for C/S. Co-ordinator MWQ18 (Band 7) stated that Consultant 'A' had had a discussion antenatally with woman to have continuous fetal heart rate monitoring when established in labour. It is not known how this conversation was framed or whether the options available to monitor the fetus were explored. (Observations case site 1).

The woman's care continued in early labour:

Woman given aromatherapy, lavender, camomile and frankincense.

Out on birthing ball. Consultant 'A' asked again for continuous monitoring once labour established (Observations case site 1).

The midwives caring for this woman and the co-ordinating midwife stated that they felt they had to comply with Consultant A's management but did not think that the woman or the attending midwives had any part in the decisions being made regarding her labour.

I also observed instances at case site 2 of women occupying a hybrid space. A woman having her second baby was on the labour suite. Her waters had broken over 24 hours ago, which means that she was under consultant care and that the decision to induce labour had been made. However the woman appeared to be spontaneously labouring and therefore was being 'managed' as 'low' risk.

MWM15 (Band 6)..... woman on continuous CTG. Midwife said that if she had been up and mobile would have intermittently monitored fetal heart rate, but as she is on the bed anyway will keep CTG on as doctors will probably want her fetus continuously monitored. I asked if that was because she was now considered to be in established labour, she said that it was because she was for augmentation (even though she was not having a syntocinon infusion to induce contractions). (Observations case site 2).

The account by MWM15 signifies decisions for labour that are both a 'low risk' and a 'high risk' approach. If the case is considered 'low risk' then the decision (shared with the woman) to monitor the fetal heart rate is usually intermittent monitoring. If it is considered 'high risk' then the decision (should also be shared with the woman) is usually to continuously monitor the fetal heart rate throughout labour. The case cited previously shows a confused, hybrid approach to decision making. In addition, the midwife's account did not allude to the woman's involvement in decision making.

There were quite a few instances, particularly at case site 2, where women in the 'grey zone' were under consultant led care, but being cared for by midwives and categorized as 'low risk', leading to a lack of clarity in relation to which professional was responsible for making decisions.

Another woman at case site 2 who was in the 'grey zone' due to her slightly raised BMI:

Asked MWM16 (Band 6).... Women with only slightly raised BMI will be under consultant care. Consultants will see them on the rounds, some will be happy with intermittent monitoring, others will want continuous monitoring. There wasn't any reference to women being involved in these decisions. She said that this [continuous monitoring via CTG] can often lead to other interventions like a Fetal Scalp Electrode (attached internally to fetal head to monitor heartbeat) for example if CTG cannot continuously pick up fetal heart. Asked if midwives challenge this. She said yes, all the consultants are approachable and

you can negotiate with them. She said you can have good professional debates with them, and sometimes meet in the middle [regarding decisions]. (Informal conversation with midwife, observations case site 2).

Labouring women with a marginal raised BMI were often reported to be in the 'grey zone' if they did not present with any co-morbidity. Technically, according to local guidelines (document review) they had to be placed under consultant led care, but they did not present with any pathology and therefore could also be classified as 'low risk'. The problem was perceived to be which obstetrician was on duty, whether these women were classified as 'low risk' or 'high risk'. Therefore at times conservative decision making (watch and wait) could be delegated to the midwife or interventionist obstetric decision making (induce or augment labour) could ensue. Consequently, there could be the potential for a decision making and childbirth experience 'lottery'.

## **5.7 MIDWIFERY SPECIFIC INFLUENCES (THEME 2)**

### **5.7.1 Introduction**

This theme includes midwives' decision making and evidence based practice, and midwives' intuitive, experiential and situated ways of knowing and decision making.

### **5.7.2 Midwives' decision making and evidence based practice**

Although, during the observational visits and the focus group interviews, I explicitly asked about 'decision making' strategies, midwives frequently defaulted to discussing 'practices'. This often related to evidence based guidelines and practices during childbirth. Midwives often gave accounts of their decision making approaches when these connected to care and 'management' during labour and birth. Thus it was felt important to report how midwives articulated their decision making approaches. Therefore the practices discussed in this section will include advice regarding latent phase of labour, artificial rupture of membranes (ARM), vaginal examinations (VEs), active management of the third stage of labour and admission cardiotocographs (CTGs).

Midwives, almost universally, at both case sites advised women in the latent phase of labour (early labour), to stay at home for as long as possible as this was better for them. Midwives stated that this was evidence based as reflected in the local guidelines. Here is a quote from an experienced midwife:

MWQ7 (Band 7): " ..... in latent phase, I tell them that the evidence around latent phase is that you're better in your own home....."

(Focus group interview, band 7s, case site 1).

Both the local guidelines and evidence based leaflets (current at the time - document review), designed for women, encouraged women to stay at home in early labour.

Sometimes midwives stated that they made the decision to admit women in early labour to the labour suite to 'see how they go' but other midwives discussed the organisational, environmental impact of having women in early labour stay on the labour suite in terms of 'blocking' a bed:

MWQ29 (Band 7): "It's catch 22... I came onto one the other day like that and I thought...it's very nice of the midwife at the time to yeah.... I'll let you have a sleep but she still woke up at 1-2 [1-2 cms cervical dilation] you know eight hours later and what have we done..... blocked a bed and given the impression that you can stay now" (Focus group interview, band 7s, case site 1).

Most midwives views were that admitting women to the labour suite in early labour is more likely to lead to unnecessary intervention.

Midwives' decisions in early labour (for women to stay at home or be sent home) therefore could be related to a genuine concern for women who wished to pursue a normal childbirth pathway. Or midwives using 'local guidelines' to mask a concern for the maternity unit with women not established in labour taking up precious bed space.

During the observations at both case sites, decisions were made to conduct ARMs very frequently to augment ('speed up') labour even in

straightforward, normal labour, which did not comply with local guidelines (document review) for normal labour. This appeared to be a cultural 'custom and practice' based approach to decision making.

Routine vaginal examinations were performed ubiquitously at both case site, which again did not comply with local guidelines (document review).

Sometimes junior midwives' accounts were that they complied with the co-ordinating midwife's decision preferences in carrying out routine VEs. Some more experienced midwives, often on MLC (case site 1) made decisions based on their own clinical judgement for example, not offering or carrying out routine VEs during normal labour and birth:

MWQ5 (Band 7): rarely conducts vaginal examinations, as she felt that this supported keeping labour and birth 'normal'. She felt that doing VEs can lead to further intervention. (If for example the cervix is not dilating as quickly as would be expected, but still in the parameters of normal, doctors can still get involved and make decisions to augment labour). She does discuss her reasoning with women she is caring for. (Informal conversation during observations case site 1).

Another midwife also does not adhere to local 'norms' of routine VEs. Here is an example of her non-interventionist decision making approach and her reasons for not conducting a four hourly VE:

MWQ14 (Band 6):.....Another co-ordinator would have pushed (or tried to) me into a VE and/or questioned why I hadn't. My rationale

.....she had only just been contracting regularly.....so there wouldn't have been much change and even if there had been change, that it's all good as all was normal. (Decision making diary, case site 1).

MWQ5, MWQ14 and other midwives' accounts were that they felt confident in their decisions and provide justification to veer away from local guidelines, co-ordinating midwife's preferences and the cultural norms of the labour suite but this was not the case for all midwives.

During observations and focus group interviews at case site 2, there were many references to the routine use of active management (use of a set process including drug administration to expel the placenta) of the third stage of labour, as opposed to physiological third stage (natural expulsion of the placenta). Midwives' views were that the evidence shows that active management reduces post-partum blood loss. This particular midwife (see subsequent citation) stated how her experience of post-partum haemorrhages (PPHs) influenced her decision making. Whereas the much less experienced band 5 midwife was very clear that women should always be given the choice of type of management of the third stage and be involved in the decision making process:

MWM33 (Band 6): "I must admit, I don't tend to sort of go into the physiological [only discusses active management of the third stage of labour]. And again, that's my training, that's my issue...."



MWM31 (Band 5): "..... Complete opposite " [meaning that she always gives choice to women of physiological or active management of third stage of labour].

MWM33 (Band 6): "I've had so much experience with PPH's and things like that that it wouldn't...I wouldn't be...it wouldn't enter my head to talk someone out of active management of the third stage" (Focus group interview, band 5 and 6, case site 2).

Whilst there were accounts of midwives educating women about or offering women both types of management of third stage, it became evident that active management was the default position.

MWM34 (Band 7) ".....to be honest, the default is active management and that's being honest. And that probably, hopefully, will change. But, hand on my heart, that's what they get, isn't it?" (Focus group interview, band 7s, case site 2).

Therefore according to many midwives at both case sites, most women will not be informed about the decision to have a physiological third stage of labour.

In addition to being heralded as the safest option (due to the 'evidence' showing reduced blood loss during the third stage of labour), midwives often cited that active management was attractive to women because it was the quickest:

MWM30 (Band 6): "Well, I'll always ask them if they've spoke to the community midwife about third stage and are they happy to have the injection. And generally the ladies want it because they want the placenta...they want it all to be over quick".

MWM32 (Band 6) "As quick as possible. So whatever's the quickest, that's normally what they say a lot of the time". (Focus group interview, band 6s, case site 2).

The nuanced implication here was that, generally, the default position was active management of the third stage of labour and that there was little if any shared decision making with labouring women in relation to this stage of labour. The main exception to this was on the MLC unit at case site 1, where both management approaches were reported to be offered to women. In addition, midwives again were making decisions ostensibly in the woman's best interests but there is an organisational advantage to active management as it tends to speed up expulsion of the placenta and women can be processed through the system more quickly.

The local evidence based guidelines, at both case sites, do not support the practice of admission cardiotocograph (CTGs) recordings, in normal labour. It has been associated with increased intervention in normal childbirth. However admission CTGs on some normal labouring women was noted as still being performed at case site 2.

In the observations at case site 2, Midwife MWM24 discussed the practice of midwives conducting admission CTGs of the fetal heart rate:

MWM24 (Band 6):.....said that some midwives are losing faith in normality for example still doing admission CTGs, and then once on [the CTG monitor].. they tend to be kept on continuous monitoring. (Informal conversation with midwife, observations case site 2).

Reflexively, I had made the assumption that some practices which have been found to have deleterious effects on normal childbirth would not be conducted, however I was surprised to find that this was not the case. I felt compelled to critically discuss this practice with midwives but again felt that I had to refrain from this for several reasons. Firstly, I had to step back from my role and identity as a midwife and be consciously aware that I was present on the labour suite as a researcher. I did not want to affect my relationship with midwives or affect the authenticity of my data collection. Secondly, my assumption was that midwives are aware of the research, it is very well known and long established and present in both NICE and local guidelines.

Previously some midwives report that conducting admission CTGs are a form of defensive decision making. This practice contradicts EBP and also did not seem to include any shared decision making with women.

### **5.7.3 Midwives' intuitive, experiential and situated ways of knowing and decision making**

Midwives reported that decisions were sometimes made without recourse to evidence or evidence based guidelines. I was informed about intuitive, experiential (based on experience and observation) and situated (context dependent) decision making by midwives.

As stated earlier in this theme, some midwives cited 'knowing', 'feeling' something, or having a 'sense' of something, which fits more with an intuitive model of decision making.

Midwife MWM2 was discussing that she knew what normality based strategies would work for an individual labouring woman, purely by watching her and observing her behaviour:

MWM2 (Band 6): "I think as well, you know [what supportive strategies she will need]..... when you look at a lady [intuitive cues]....." (Focus group interviews, band 6s, case site 2).

Similarly, midwife MWQ30 stated that she had a sense of what particular strategy would facilitate physiological labour for an individual woman, because she had observed how the woman behaved during labour:

MWQ30 (Band 6): "I think it would be a really good idea if this lady sits out on the birth stool for a little while because I feel like the head needs to come down and just really small things, not big whole labour

things but it could be the difference between asking a woman to stand up or squat or get onto all fours or to say would you want to go in the pool just tiny little things sometimes because you've got this knowledge you can...you've watched how she's laboured..." (Focus group interview, band 6s, case site 1).

Midwives' intuitive ways of knowing and making decisions, were often relied upon without resorting to clinical, physical confirmatory examinations. This citation is in relation to assessing a labouring woman's progress in labour, without use of vaginal examinations:

MWQ15 (Band 7):....."but you know that whether their accelerating [progressing in labour] nicely or not..... you just have a sense of it...." (Focus group interviews, band 7s, case site 1).

Two midwives provided an account of a case they were involved in where labour progress was unusually slow:

MWQ22 and MWQ23 A primigravida (first baby) had previously been sent home to establish in labour. Readmitted to labour suite distressed. In advanced labour but continued to progress very slowly. Once the cervix was fully dilated, the woman was given a passive hour (to enable the fetal head to descend further). Then commenced pushing. In second stage for over two hours. Normal birth. (Informal conversation with midwives, observations, case site 1).

Some midwives would have referred to the doctors because of 'slow progress', however midwives MWQ22 and MWQ23 made the decision that all was normal with the fetal heart and maternal condition and for a physiological labour to continue. The midwives gave huge amounts of emotional support to the woman. They made intuitive / experiential non-invasive suggestions to mobilise, change position, try aromatherapy or even just to rest, based on what they thought would support this individual woman through a difficult longer labour.

Some midwives cited that they used like-minded colleagues to support normality and their intuitive / experiential type of decision making:

MWQ32 (Band 6): ".....when we're on MLC, I really value having the chance to kind of talk about decisions and how you make them.....how you're going to keep it normal, or what you can try to do something different.....if I meet someone like MWQ14 on duty (laughter) , who's like 'Oh great, we're doing great, get some aromatherapy', and you're thinking, yeah this is good, we're doing the right thing...." (Focus group interview, band 6s, case site 1).

MWQ32 and MWQ14 reported themselves to be very pro-normality midwives, using normality driven, experiential decision making when labour is straightforward. They found it easier to facilitate this type of approach when they had the support of other pro-normality midwives.

This particular labouring primigravida (first baby) had been examined and found to be in very early labour, cervix 1cm dilated. However both the attendant midwife and the co-ordinating midwife 'felt' that the woman would progress quickly. They made the decision for the woman to remain on labour suite and administered diamorphine, as requested, for pain relief:

Discussed with midwife the challenge of latent phase of labour and early labour, very difficult when women are so distressed. Both co-ordinator and midwife caring for woman 'felt' that she would progress.(Observations, case site 2).

Yet in other situations, when women were in early labour, midwives either encouraged women to go home or discouraged pain relief. Here is one such example:

MWM10 (Band 6):....said that woman had mentioned gas and air but that she [the midwife] veered her away from this at this point.  
(Observations, case site 2).

The varied approach to midwives' decision making, related to women in early labour appears to support that midwives on some level use individualised intuitive / experiential knowledge and decision making.

### **5.7.31 Midwives using 'inaction' in decision making**

Midwives in this study often cited that they were passive when labour was physiological and straightforward, they were essentially using 'inaction' as a

decision making approach. Generally, midwives perceived that inaction culminated in reduced or no intervention (despite midwives reporting that sometimes, there were subtle pressures and input from the medical staff to intervene in labours) and enabled physiological, normal births.

This particular midwife encourages women to go with their physiological urges. She, as the midwife, adopts a passive role:

MWQ14 (Band 6): ".....But the body knows how to do this and how amazing is that and to surrender completely and let everything happen: let the baby press, let it be strong, sing, hum, vocalise, drum, be anxious, weep and think 'loose'.....I encouraged her to listen to her body and do exactly what it was telling her to do and that it knows what to do" (Decision making diary, case site 1).

Midwives who largely used 'inaction' claimed to not readily resort to medical intervention during challenging moments in normal labour. They reported being inert, purely encouraging women to 'go with the flow':

MWM7 (Band 7): "So if everything is just spontaneous and normal, .....we just watch and wait for a little bit so that nature takes its course and time stops. I think we are sometimes struck on how many centimetres per hour when actually it's just letting individuals body, just go with the flow really....." (Focus group interview, Band 7s, case site 2).



MWM14 (Band 6): "..... encourage them to become primitive and do whatever their body is telling them to do...yeah, if your body is saying lift your leg up ...do it....if your bodies saying...noise is fine everything is fine...the pressing is fine it has to be strong you don't have to like it and when they get you, they just do it don't they." (Focus group interview, Band 6s, case site 1).

Midwife MWM31 said that making decisions very much depended on the childbirth philosophy of colleagues on duty. If they are like minded and believe in childbirth as physiological, making decisions to support normal labour and birth was much easier. This same view was expressed by a number of midwives.

MWM31 (Band 5): "But if you know they're going.... 'Oh, yeah, get [her] in the pool, that's really good' you're more likely to want to go with the flow". (Focus group interview, Band 5 and 6, case site 2).

A community midwife reported that midwives generally use 'inaction' when women are labouring at home.

MWQ33 (Band 6): "...suggested that women just know what they need to do when they are labouring at home, they don't need to be told (Informal conversation with midwife, case site 1)

When all is well, and progressing normally, 'inaction' is apparently a decision making option which seems to be used quite frequently by midwives.

### **5.7.32 Woman using 'inaction' in decision making**

This is an account from focus group interviews at Case site 1, regarding a woman who was in labour and found to have an undiagnosed breech:

MWQ14 (Band 6): ".....This woman just completely shut down she was a primip (first baby) and would not make any decision and she kept saying to me, 'what would you do...what would you do?' and I said 'it's not what I would do these are the facts'.. and the doctors were quite good at giving the facts, I was quite pleased with how they did it but one of the registrars was like 'oh ??? make her go for a section just make her.... just tell her, and I thought .....I had a brilliant co-ordinator, going back to the co-ordinator point, if I'd had a different co-ordinator, she would have been in that theatre, she really supported me and they all kept laughing every time I opened the door they'd go 'yes, and?'. This woman went into her shell would not make a decision at all and this particular co-ordinator was clever and she said well she's made a decision by not making a decision....."

(Focus group interviews, case site 1).

The midwife's perception was that the doctors continued to put considerable pressure on her [to persuade the woman to have a C/S]:

"she needs to go for section now....can't you just make her...make her...tell her ' and I thought with one tiny fraction I could have said I think it's best, come on it will be over and done with, she would have

gone....and that was the decision making for me and I was scared and thought no I can't do this and when they said that outside in front of everybody with these faces looking at me I was so scared, and I thought I cannot tell her to go, I'm not going to force her to go, I'm not doing it and the co-ordinator [said] exactly she has made her decision by not making a decision, I'm so glad she was there, she was a beacon for me.....and the woman had a vaginal breech and it was just awesome....that was awesome..... but it could have been so [different]....I could have influenced that...my decision.... I'm getting stressed in here they're all looking at me I'll just tell her to go [and have a C/S] and I could have said that, I probably have in the past, you know to placate them, when you're frightened and new and....." (Focus group interviews, case site 1).

The account by this midwife provides her view of the influence on decision making by obstetricians, to try and make the woman agree to having a C/S in this particular situation. Conversely it also demonstrates the support of the particular co-ordinating midwife (see section 6.3.3 the pivotal role of the co-ordinator) to the attending midwife to facilitate a vaginal breech birth.

### **5.7.33 Fast and slow midwifery decision making**

Many midwives felt that at times the extreme workloads, pressures of the labour suite and the imposed time limits on stages of labour for example, led them to make 'fast', in the moment decisions. An example of perceived pressurised, 'fast', decision making is captured by this band 6 midwife:

MWQ30 (Band 6): "I mean I...I've done it before I've kind of when it's been really busy and people are pressuring to get things....ARMs things like that, I've managed to kind of persuade a woman to have her waters broken when I knew really actually I should be leaving well alone but the pressure has been on there to accelerate her labour and my own decision would have been to have left it... but the same scenario people knocking on the door, has she progressed?... she doesn't want to be examined, are you going to examine?.... and it's just the drip, drip, drip from outside that eventually....[wears you down]" (Focus group interview, band 6, case site1).

Such perceived pressure meant that midwives sometimes made decisions that didn't comply with guidelines and best practice, nor did it take into account the woman's wishes. MWQ30 felt that under different, non-pressurised circumstances, she would make different decisions.

Two midwives in this focus group interview cited the heavy workloads of the labour suite and the pressure of time constraints influencing their decisions, even when they felt the decisions were not appropriate. The midwives reported that pressure was usually conveyed via the co-ordinating midwife who would have concerns regarding time limits on first stage of labour (Local guidelines – document review) for example:

MWQ30 (Band 6): "Eventually you get to the point where you...you break at some point and you have to .....you have to kind of phrase it

[to the woman] 'well I think maybe you know it's been a long time and we maybe should think about doing' ...[intervention]"

MWQ14 (Band 6): "It feels terrible though..."

MWQ30 (Band 6): "Well it does it make me feel terrible because I know....in my heart..... I shouldn't really be doing this because ...the fetal heart rate is fine there's nothing actually untoward in this room....."

MW14 (Band 6): "And the clock!" [reminder of the time constraints]

MWQ30 (Band 6): " .....and the clock" (Focus group interview, band 6s, case site 1).

This community midwife is discussing advocating for childbearing women who are clear on what they want for their labour and birth experience. She described a very different environment in which decisions are made:

MWQ33 (Band 6): "We get that in the community because they know exactly what they want to have in their home birth, and you haven't got that pressure of someone hovering... [to make certain decisions].... because she's not [managed] as a primip or a multip, not done [by cervical] dilatation, by the guideline or the protocol, and she's adamant she's going to have her home birth....." (Focus group interview, band 6s, case site 1, community midwife).

This midwife is illustrating a 'slow', considered, non-pressured approach to decision making in childbirth, in the home environment.

### **5.7.34 Shared decision making**

Shared decision making was not frequently reported in the observations and only implied by midwives in the focus group interviews. Here is one of those quotes:

MWQ21 (Band 7): ".....I think it's again her wishes isn't it and sort of keep as best as you can to what she would like and wouldn't like, you might have to tweak that and guide her in another direction..." (Focus group interview, band 7s, case site 1).

An example that MWQ21 cited as 'guiding her in another direction' was if there was meconium stained liquor (which may warrant the fetal heart rate to be continuously monitored, according to local guidelines) and the woman might not want continuous monitoring, she might want to stay mobile:

MWQ21 (Band 7): ".....you might have to say well actually we would recommend that you're monitored now but let's keep you mobile and still do this [monitor the fetus intermittently] so I think her wishes do .....influence ... You know you would still try and facilitate what she wanted to do..." (Focus group interview, band 7s, case site 1).

Midwife MWQ27s account demonstrates a commitment to getting the balance right between women's choices and clinically orientated decisions.

## **CHAPTER 6 FINDINGS (2)**

### **6.1 Introduction to Findings (2)**

The following 3 themes will be reported in this chapter: Environmental, organisational and cultural factors (Theme 3): Intra and inter-professional influences (Theme 4) and the 'hybrid' midwife (Theme 5).

### **6.2 ENVIRONMENTAL, ORGANISATIONAL AND CULTURAL FACTORS (THEME 3)**

#### **6.2.1 Introduction**

This section of the chapter will explore the theme of environmental, organisational and cultural influences on midwives' decision making during normal labour and birth. The categories under this theme are: the busyness of the labour suite environment, the importance of language, terminology and information giving and normality by default (only found at case site 1).

#### **6.2.2 The busyness of the labour suite**

The consequences of the labour suite being extremely busy on midwives' decisions is reported in this section. From my perspective, during the observational visits, both sites had their busy shifts, but it was at case site 1 that this situation was much more frequent and considerably more noticeable. Here is one example of what seemed to me to be a remarkably busy night shift at case site 1:

Night shift: Handover full of women with significant risk factors, only one woman on obstetric side 'normal'. One woman in possible preterm

labour may need transferring out. Transpired later that other units within 50 miles were also full to capacity. Two women in high dependency care. Not enough staff. Because of the labour suite being extremely busy, I offered to stop conducting the observations and help out for a while. The midwife co-ordinator agreed that I would help out with some tasks (note that I have an honorary contract at this trust). I did some observations, made drinks and transferred women to the wards (Observations case site 1).

The impact of the labour suite being so busy meant that, at times, 'normal', low risk labouring women's choices and decisions could not be facilitated (see following text). The report on the extremely busy night shift at case site 1, as highlighted in the previous section, continues to be related here:

The labour suite was full of childbearing women with pathology or potential pathology, one of the midwives said that this can affect decision making for normal straightforward labouring women. She gave the example of not 'allowing' (a power laden word in itself, see section 6.2.3 on importance of language, terminology and information giving) water immersion / birth when the labour suite was extremely busy, as actually happened on this shift. This was mainly because the local guidelines (document review) state women have to have one-to-one care when immersed in water. Having witnessed this night shift first hand, from a researcher's perspective, I could absolutely see and understand why this decision might be made. There were some very



'high risk' cases on the LS, and as soon as one woman gave birth another would arrive, or a complication or emergency would occur (APH, retained placenta, PPH, shoulder dystocia). There were barely enough midwives to cope with all these situations, and therefore the priority was to support women to give birth, ensure mother and baby were safe and well, before they moved onto the next 'case'. The pool was on the 'midwife led side' which is a short distance away from the main labour suite. In addition, as mentioned, the guidelines meant that women who were using the birthing pool had to have one-to-one care at all times. (Observations, case site 1).

The busy status of the labour suite meant on this occasion and reportedly on other occasions, midwives had to make decisions not to facilitate water immersion / birth for low risk women.

The labour suite environment being busy or excessively busy was expressed many times by midwives in all but one of the focus group interviews and was also observed by me as the researcher on a number of occasions at both case sites. Some of these midwives stated that they did their best not to let the status of the labour suite dictate their decision making, but some midwives admitted that it did affect decision making at times, including introducing intervention in women's labours:

MWQ5 (Band 7): " .....I wouldn't say they're ever compromised [women's wishes] unless it's dire...direly busy....." (Focus group interview, band 7s, Case site 1).

MWQ15 (Band 7): "Yes I think it can sometimes I think that em possibly some people get pushed into doing things like ARMs sooner than they should be...." (Focus group interview, band 7s, Case site 1).

Some co-ordinating band 7 midwives at both case sites cited environmental issues, over and above women's choices and preferences, as influencing their decision making. Here is a citation from a band 7 midwife at case site 2:

MWM7 (Band 7): "Environmental influence is your staffing, how many ladies..... whether you're on a 1:1 ratio. So it's the whole environment really, possibly will influence your decisions. And certainly, you'd have to take into consideration the skill mix as well". (Focus group interview, band 7s, case site 1).

Midwives therefore appeared to reluctantly agree that in some circumstances the busy environment did influence their decision making for women in normal labour and birth.

#### **6.2.21 The dominance of women with complex needs**

There was a dominance of women with complex needs, compared to 'low' risk' labouring women observed at both case sites. This was both in relation to numbers of women with complex needs and also degrees of obstetric complexity. For example some women with diabetes were also obese and vice versa. Women with complexity and multiple co-morbidities resulted in more resources and time allocation of staff than their 'low risk' counterparts.

My observations during data collection patently illustrate the real life, real time challenges for midwives when considering making decisions for women during normal labour and birth when there were so many women with complex needs that midwives deal with on a daily basis. This appeared to be the main reason adding to the busy workloads for midwives on labour suites. Here are 2 such cases recorded at case site 1:

2 women on MLC 'normal', all women on obstetric side complex.

(Observations case site 1)

Handover, nine women - six complex cases, three normal have all given birth. Interesting to note that three women are diabetics (two on insulin one on metformin) and two more for induction of labour, one on metformin (medication) and one diet controlled. (Observations case site 1).

And at case site 2:

Only one 'low risk' straightforward woman. A few more complex cases..... (Observations case site 2).

No women in black (midwife-led, low risk) on the board. (Observations case site 2)

On the board - eight women only two in black (midwife led, low risk).

Midwife said Tuesday was busy with 'normal births'. (Observations case site 2).

The dominance of women with complex needs was apparent during the whole period of observational data collection, not just on a few occasions. Therefore decision making for women in normal labour and birth against a backdrop of midwives dealing with obstetric complexity appeared to be a common occurrence within these contexts. Under the 'busyness of the labour suite', I reported that midwives' decision making during normal labour and birth is sometimes compromised.

In my reflexive notes, I expressed a pre-conceived idea that I would encounter large numbers of 'normal' labouring women. I think this was because of my experience as a practicing midwife, largely caring for low risk women, perhaps not being aware of the 'bigger picture' of the labour suite environment outside. This turned out not to be the case at all.

#### **6.2.22 Safe staffing levels and adequate skill mix**

In relation to a question on what affects your decision making during normal labour and birth, some midwives reported that they were well aware of placing the 'right' midwife with the 'right' woman in order to enhance care and decision making by both midwives and women (also see midwives' belief system preferences, section 6.4.3). This was expressed a number of times by band 7 midwives, here is one such quote:

MWQ5 (Band 7): ".....even for the most normal of women never mind the abnormal you try and get the right member of staff in, into the

right place and be available.....”(Focus group interviews, band 7s, case site 1).

Equally there were numerous comments about not having adequate staffing levels at times and also not having appropriate skill mix of staff:

MWM34 (Band 7): “.....but not always do you have that mix of staff.....” (Focus group interviews, band 7s, case site 2).

MWM30 (Band 6): “Yeah, I think as well when we’re short-staffed. That has massive impact on everyone” (Focus group interview, band 6s, case site 2).

MWQ29 (Band 7): “..but they’re all quite you know needing one on one and I haven't really got the staff so I have to really match up who can manage what really” (Focus group interviews, band 7s, case site 1).

Midwives appeared to report that not being able to match up the ‘right’ midwife with the ‘right’ woman will not fully optimize care and decision making (see section 6.4.3). The implication being that a woman wanting a straight forward normal labour and birth, allocated the ‘wrong’ midwife (one that does not embrace a social / midwifery model of childbirth), may not have her choices and decisions fully supported.

### **6.2.23 Pain relief as a form of organisational control**

When the labour suite environment was busy, MWM32 reported that some midwives make decisions to administer analgesia, before more non-invasive strategies for pain are used. This quote was in relation to a labouring woman being given diamorphine in very early labour:

MWM32 (Band 6): ".....when it's really busy.....she's not had the chance to have the gas, no, she's not had the chance to have hydrotherapy, she's not had the chance to mobilise and have the aromatherapy. It just started off with diamorphine just almost to calm her down and keep her quiet. And I think that it's awful when that happens. And to be fair I've known that to happen for a while.....

(Focus group interview, Band 6s, case site 2).

In stressful, busy situations, midwife MWM32 alluded to midwives making 'in-the-moment' decisions, in the first instance, to give labouring women who are distressed, pain relieving injections. She appeared to imply that sometimes midwives default to administering injections, rather than discussing other options, in order to control and quieten women, to enable them to manage their work load.

### **6.2.24 Midwives' decision making in context**

There were a number of midwives who intimated that the current system in the UK, of women giving birth in hospital settings, was not always the best place for them. The citation below was in relation to labour slowing down:

MWM31 (Band 6): ".....whereas in a hospital, where you know there's doctors there, you've a coordinator..... waiting for room and you've got the pressure, you may be a lot more inclined to act in a medicalised situation to try and increase the contractions, get some syntocinon running or other things. Whereas at home, you have to say, right...make a cup of tea....." (Focus group interview, band 6s, case site 2).

The environment within which women were labouring, for example, home, hospital and MLC unit, was mentioned a number of times by midwives as having a significant influence on midwives' and women's decision making. Home and MLC environments appeared to support more autonomous, normality focussed and shared decision making for midwives and women.

### **6.2.3 Importance of language and terminology and information giving**

Both normalised and medicalised language and terminology was captured during data collection, which could have consequences for decision making. The terminology that was used by midwives to describe the maternity services consumer was noticeably 'normality' focussed. Overwhelmingly the terms: woman/women or labouring woman/women were used. However some midwives at both case sites used the terminology of 'patient' (related to illness). The use of 'deliver' (midwife focussed) was also commonly used rather than 'given birth' (woman focussed). The phrase 'failure to progress'

(the woman's body is faulty) was also used to signify when a woman's labour had slowed down or stopped.

Some midwives were aware of the use of medicalised language having a negative impact on decision making and on women's confidence in their ability to labour without intervention. This was most noticeable in relation to how they referred to pain in labour.

### **6.2.31 The framing of language used in relation to pain in labour**

The data from both case sites showed that midwives were aware of the power of language related to labour pain and how this might affect their own and women's decision making. Many midwives stated that they did not use the terms pain or pain relief, recognising the negative connotations that pain has in most other human conditions. There were numerous mentions of banning the word 'pain':

MWQ14 (Band 6): "I don't say pain ever..". (Focus group interview, band 6s, case site 1).

MWQ30 (Band 6): "I don't talk about it..". (Focus group interview, band 6s, case site 1).

In favour of 'contractions' or 'surges':



MWM26: “.....We talked about contractions because contractions are part of the normal physiological process.....” (Focus group interview, band 7s, case site 2).

Most midwives within this study did not use the phrase ‘pain relief’:

MWQ14 (Band 6): “....and don’t talk about options of pain relief at all”.  
(Focus group interview, band 6s, case site 1).

Most midwives attempted to educate women about viewing the physiological pain of childbirth differently to other pathological forms of pain, describing it as a ‘positive pain’ and ‘pain with a purpose’. Some midwives talked about the natural endorphins that are released during normal labour:

MWM32 (Band 6): “I always talk about the special pain relief, the endorphins, the magic stuff. I always call them magic endorphins, I do”. (Focus group interview, band 6s, Case site 2).

The view from midwives appeared to be that the decisions they made in relation to how they framed the pain of childbirth could influence the woman’s decision regarding what strategies she used to negotiate her labour. The accounts from most midwives would support presenting pain in a physiological way which would then influence women’s decisions to use non-invasive approaches.

### **6.2.32 Language, communication and information giving**

Concealment of the accurate clinical picture was reported at both case sites in this study. This was usually at a point in the labour that was at risk of having doctors involved, potentially changing to a more interventionist decision making approach, if for example progress in labour was slower than expected. This is an account from an experienced band 6 midwife:

MWQ14: (Band 6)....."In view of progress since contracting 1cm - 8.5cm [cervical dilatation] very fast, I made the choice to be economical [with the true clinical findings] as all was normal and she had rapidly progressed. So I said 7-8cm, as that was still very rapid progress and I was very mindful of the clock restrictions [Local guidelines] in dilating and only having certain time to push the baby out....." (Diary entry, band 6, case site 1).

From a reflexive stance, I did not expect midwives to still be reporting 'doing good by stealth'. There seems to be an acceptance of this covert behaviour, in that there was no attempt for surreptitious activities being covered up. This could be that midwives trusted me and saw me as 'part of the gang' and/or the covert behaviour is seen entirely as 'the norm' in everyday labour suite practice.

The actual finding from the woman's VE was that the cervix was 8-9cm dilated (almost full dilatation therefore almost in second stage of labour),

effaced with a thick anterior cervical lip (which can slow the last part of first stage of labour down). The midwife reported that all was 'normal' but that she was aware of the time restrictions placed on second stage of labour (and on first stage of labour) according to local guidelines (document review). She therefore made the decision to manipulate the clinical findings to protect the woman from medical decision making and intervention.

In another account, MWM33 talks about the 'little tricks' that she uses so that obstetricians doing the doctors round cannot directly see or examine the woman in labour by ensuring they are mobilising away from the labour suite and providing quite vague information:

MWM33 (Band 6): "...but it's down to sort of like little tricks..... Don't tell them [the doctors] until they're [the labouring woman] off the unit' and say, 'Oh, I examined her. She wasn't really [cervical dilatation] much changed But she wants to mobilise around.....and when she comes back, you know, we'll [I'll] see what she's doing'..... there are little ways that you could be that barrier between medical and the woman, if you need to be". (Focus group interview, band 6s, case site 2).

The decision making by this midwife again appears to be to protect the woman from medical interference.

#### **6.2.4 Normality by default**

There were a number accounts where the woman and the midwife didn't really have the opportunity to make or share decisions, in relation to the labour and birth experience. This was usually related to the busyness of the labour suite and was only apparent during data collection at case site 1.

MWQ24 admitted a woman labouring with her second baby, to the labour suite early in the morning. She was found to be in the latent phase of labour. The woman had a birth plan in which she clearly stated she wanted an epidural early on in the labour:

MWQ24 (Band 6) .....Went to the ward, had diamorphine on the ward, came back to MLC this evening, wants epidural but labour suite too busy at present [epidurals can only be facilitated on labour suite]. Currently standing upright, using some entonox.....About four in the morning, the midwife did a vaginal examination, cervix fully dilated, the woman did not mention epidural again, gave birth squatting (Observations, case site 1).

This was a challenging situation for the midwife, as the woman did not want to go back home to establish her labour in the first instance. The woman had made the decision to have an epidural but she could not have an epidural administered as the labour suite was full. This was a 'normal birth' by default because of the extreme 'busyness' of the labour suite.

This following case is a situation where the woman had been experiencing contractions, had rung the labour suite for advice but had been told that the labour suite was currently full and could not admit any more women:

MLC Woman labouring with first baby, came in from home in established labour. Cx 8-9cms. Progressed quickly to a normal birth. (Observations case site 1).

No real decision making was apparent as labour was so advanced. Again this could be viewed as normality by default as this woman was told that the unit was closed, so delayed admission until she was in advanced labour.

There is, of course, no way of knowing what would have happened during this woman's labour if she had been admitted earlier. Nonetheless, there did not appear to be time for her to discuss her birth plan or to share decisions and choices for the labour and birth with the midwife.

## **6.3 INTRA AND INTER-PROFESSIONAL INFLUENCES (THEME 4)**

### **6.3.1 Introduction**

This section will discuss intra and inter-professional influences on midwives' decision making during normal labour and birth. Under this theme the category of the spectre of risk, risk perception and defensive decision making will be reported. The pivotal role of the co-ordinator and the notion of doctors' influence on midwives' decision making will be included. Excellent intra and inter-professional relationships was a category found at case site 2 only.

### **6.3.2 The spectre of risk, risk perception and defensive decision making**

Here is an account by a midwife who was on the verge of making the decision to conduct an episiotomy defensively, partly due to a pre-occupation with risk and partly due to what 'others' might say:

MWQ17 (Band 5): who normally works on MLC, cared for a woman who had a continuous CTG. During the second stage, the CTG did not 'look good' and although she was very happy with fetal wellbeing, she almost made the decision to do an episiotomy. She recognised that this was defensive practice, because of what the CTG trace would look like to an objective person. She stated that if she, as an experienced midwife felt that way, then more junior midwives might actually make decisions based on how they may be viewed by their colleagues. (Informal conversation with midwife, observations, case site 1).

This midwife appeared to be concerned about the status of defensive midwifery and that she, herself, would make defensive decisions in certain situations.

Defensive decision making was also observed and reported on at case site 2, as was evident in the following excerpt:

MWM24 (Band 6):.....in relation to midwives conducting admission CTGs on 'low risk' childbearing women, MW24 said that midwives 'look for problems' even in normal women. She feels that it

may be to 'cover their backs'. (Informal conversation with midwife, observations case site 2).

It is not known if the 'cover their backs' comment was related to litigation, complaints or to risk management processes, but any one of these appears to illustrate defensive decision making.

### **6.3.21 Midwives' compulsion to comply**

In a decision making diary by a very experienced midwife, she wrote candidly about feeling under pressure not only from the more senior co-ordinating midwife but from a student midwife and the woman too:

MWQ14 (Band 6): 'I felt under pressure strongly from the st/mw to do VE.....(she had never done a VE) although I knew these reasons were not a reason to VE.....I then updated my co-ordinator who was one who liked to move women through as quickly as possible ..... So pressure of knowing how the co-ordinator liked things, together with woman really wanting to know and my st/mw insisting she had been promised one (VE) led me to making the decision to do a VE.....I knew though it would make her [the co-ordinator] satisfied to write a number on the board!'. (Decision making diary, case site 1).

Midwife MWQ14 said that if she had not been under 'pressure', she would have discussed with the woman why a VE was unnecessary at that point and would have been confident to justify this decision to the co-ordinator.

### **6.3.3 The pivotal role of the co-ordinator**

In the observations, the focus group interviews and the decision making diaries, the pivotal role of the co-ordinating midwife was cited as a very dominant factor that influenced midwives' decision making. In the discussion below, the midwife reported feeling very unsupported in relation to making decisions during normal labour and birth as follows:

MWQ10 (Band 5)..caring for a primip whose cervix had dilated to 9cms, after several hours no progress, possibly head in an occipito-posterior position. Asked co-ordinator for advice, co-ordinator was reported to be very unsupportive. MWQ10s perception was that decisions were then taken out of her hands and that doctors started intervening...When MWQ10 returned on duty the next day, the woman had had a C/S, she felt that this could have been avoided as woman was not given sufficient time to push..... (Informal conversation with midwife, observations, Case site 1).

The midwife's perception in this case was that, had this situation been handled differently and different decisions had been made, a physiological outcome could have been achieved.

Some co-ordinating midwives reported that a number of more junior midwives make decisions to more readily resort to intervention in normal labour and birth and will suggest that they provide women with other



options first. Here is an excerpt from focus group interviews with band 7 midwives:

MWQ5 (Band 7): .....“but I think also being a band 7 as well like you’re different, I think when you are co-ordinating and you are trying to help people be normal, I personally as the co-ordinator and they comes out and say...oh she wants an epidural, I will often say have you tried...why don’t you just try...[something less invasive].....first .....” (Focus group interview, band 7s, case site 1).

This co-ordinator felt that some midwives will encourage requests for epidurals rather than suggesting to women other forms of support and comfort (water, aromatherapy), to keep the labour physiological, at least in the first instance.

In another focus group interview with band 6 midwives following the question: ‘How do you make decisions when you care for women during normal labour and birth?’ The first response was:

MWQ32 (Band 6): “Depends who’s co-ordinating. [laughter].....really does.....” (Focus group interview, band 6s, case site 1)

There followed many examples of both very positive and very negative comments concerning co-ordinators support of midwives’ decision making:

MWQ14 (Band 6): “I had it on MLC only a few days ago and all through the shift, it was awful. [The co-ordinator] questioned me and

at handover..... they said she's being mis-managed round there, this particular woman, which she was not... at all, and I've talked to somebody senior about it, and she was really shocked too. So that for me, it, it crushed my confidence, so then I had to go and discuss it with our normal birth lead... to make me feel better.....and to validate what I was doing was correct and it was, but that for me was not good and it makes me feel very [sigh]..... retreating into the room and not telling anyone anything, which I would if something was wrong....."

(Focus group interview, band 6s, case site 1).

In the previous scenario, MWQ14s perception was that one co-ordinator adversely affected her confidence and another co-ordinator really supported her in her original decision making.

This same midwife (MQM14) had highlighted how the support of the co-ordinating midwife stopped her from encouraging a woman with a breech presenting baby to go for C/S rather than give birth vaginally (reported earlier also under 'Midwives intuitive, experiential and situated ways of knowing and decision making', see section 5.7.3).

#### **6.3.4 Doctors influencing midwifery decision making**

Within this study, there were accounts from many midwives about them not agreeing with doctors in relation to management and decisions concerning women in normal labour. This was found mainly at case site 1:

Consultant A said woman must remain on continuous CTG because of her age. Challenged by co-ordinating midwife as NICE and local guidelines (document review) do not reflect this. Consultant insisted on continuous CTG. (Observations, case site 1).

The midwife reported that both she as a senior midwife and the woman were not considered in this decision and the 'low risk' woman was continuously monitored during her labour.

This midwife was responding to the question 'What influences your decision making when caring for a woman during normal labour and birth?'

MWQ13 (Band 7): " ....it does affect the decisions and that's sometimes the consultant whose on... em even though you know it might be someone completely normal you can try your hardest not to get them involved but that's sometimes very difficult". (Focus group interview, band 7s, case site 1).

This band 7 midwife recounted that certain consultants will review normal labouring women and make decisions about their labour management.

During an observational visit, a band 7, co-ordinating midwife related this encounter with a senior obstetrician:

MWQ19 (Band 7):..... a doctor was reviewing a labouring woman's CTG. The doctor said that the CTG was 'abnormal', co-ordinator said that it wasn't abnormal, that it was around 160 which is within normal

boundaries. After a few 'words' outside of the woman's room the doctor apologised and said that she [the midwife] was right about the trace. (Informal conversation with midwife, observations case site 1).

The midwife's view was that had she not challenged the doctor's assessment, then medicalised, interventionist decision making would have ensued. This would have been inappropriate as the labour was still essentially 'normal'.

#### **6.3.5 Excellent intra and inter-professional relationships (case site two only)**

There were some examples of good working relationships between midwives and obstetricians at case site 1. The relationships appeared to remain very formal and professional. Sometimes there were differences of opinion, in terms of normal labour management decisions between certain consultants and midwives and also between midwives and other midwives.

Excellent intra and inter-professional relationships were much more in evidence at case site 2. There were numerous occasions within the observations where the excellent relationships between all members of staff were reported which made for easier decision making both in normal labour and birth, where midwives were the lead decision makers and in more complex cases where collaborative decision making was evident:

Informal discussion with midwives about the inter professional relationships with the medical staff. They said the unit pretty much

runs as midwife led unit. Obstetricians are very pro normality and will often question for example, why normal low risk women are on a CTG. I was shown an Evidence of Learning (reflective account) from a student midwife, who had come from a different maternity unit to gain some experience. This was very positive, describing the welcoming calm nature of the unit (document review). Also how all staff work towards normalising labours and births (Observations case site 2).

On another observational visit, late evening, had a coffee break in the coffee room:

Midwives, doctors, theatre staff all use the same coffee room. Friendly informal chats taking place. Doctors catching up on writing up prescription charts. (Observations case site 2). I wondered if this sharing of social space helped with building positive, respectful, interpersonal relationships between all members of staff (Field notes, observations case site 2).

During my observational visits to case site 2, it was noticeable that there was a degree of 'banter' on the unit. Midwives, doctors, reception staff, students, domestics, all have light hearted repartee with each other.

Talked to a support worker who said that the unit was like one big happy family. All of the consultants are very approachable. Everyone from domestics to consultants are friendly and approachable. (Informal conversation with support worker, observations case site 2).

Talked to consultant about the unit, how friendly and relaxed it is. He said that it is down to the size of the maternity unit [smaller than case site 1]. Staff tend to be local, everyone knows each other (Informal conversation with consultant obstetrician, observations case site 2).

Arguably a very reasonable explanation for the close, friendly relationships found within this unit, but there may well be other reasons or factors for example, recruitment and selection policies.

The light hearted 'banter' that I reported many times during the observations, mediated a pleasant, comfortable and welcoming environment.

Still lots of banter. Light hearted joking between all members of staff.  
(Observations case site 2).

The staff of all levels and roles appeared to be very happy in their working lives. I also saw very friendly, supportive and professional interactions with childbearing women at all times.

Talking to a very senior registrar in the coffee room.....he said that he believes that low risk women should be left to midwives. Will not interfere in low risk cases. He will only make a plan [decisions] for consultant led women. He said that some new registrars will 'poke their nose in' [in straightforward childbirth]. He said that they will make inappropriate plans and that sometimes the midwives will negotiate care plans, even with higher risk cases. He said he thought

that it was a unique but good system here... (Informal conversation with obstetric senior registrar, observations case site 2).

The excellent working relationships were not just between midwives and obstetricians but between junior and more senior midwives;

MWM33 (Band 6): “..The coordinators will tend to support you [in decisions] if you want to.... you know...they are quite good. Probably the best here. I’ve worked in a few different places, you know, for supporting you”. (Focus group interview, case site 2).

The environment at case site 2 appeared to facilitate normality focussed decisions as doctors did not get involved with low risk women. Excellent collaborative working relationships were evident at every observational visit.

The next section will explore the central theme, found at both case site 1 and case site 2, ‘The hybrid midwife’.

## **6.4 THE ‘HYBRID’ MIDWIFE (CENTRAL THEME 5)**

### **6.4.1 Introduction**

Arising from the thematic analysis, within and cross case analysis, the overarching, central theme of ‘The hybrid midwife’ arose from the data, in particular midwives straddling two belief systems or having a belief system preference. Tensions and frustrations were apparent for both types of midwives in terms of their philosophy of childbirth and therefore which decision making strategies were enacted clinically. This section will explore these findings in depth.

#### **6.4.2 Midwives straddling two belief systems**

There were a number of reports from midwives of all grade bands and at both case sites, that there were differences in midwives' approach to childbirth, in that some midwives had a more technocratic, medicalised approach to childbirth than others:

MWM30 (Band 6):..."Some are more medicalised, aren't they  
.....Some midwives are more medicalised than others, aren't they?"  
(Focus group interviews, band 6s, case site 2).

Here is an example of a band 6 midwife, discussing the actions of a midwife who was more medicalised in her practice and decision making:

MWM30 (Band 6): "The lady was all low risk and then she's got everything out for an episiotomy and suturing and all of that's all laid down under the trolley 'just in case' whereas it's a low risk lady and there's no need for any of that. And I've put it all away as soon as I've taken over and thought, 'Oh, if you need, it you'll get it when you need it.'" (Focus group interview, band 6s, case site 2).

A supporting comment was made by another midwife in the same focus group interview:

MWM32 (Band 6): "And especially I think if the woman's going to see these things start being produced underneath the trolley she's going to



think, 'Well, what's this? What's that? Why?'" (Focus group interview, band 6s, case site 2).

MWM30 also reported that she removed the medical equipment when she took over the woman's care. This change of environment or the ambience was mentioned by a number of midwives. These midwives described how they made the labour suite context more conducive to normality by dimming the lights and keeping a calm, quiet atmosphere, where they felt that discussing options, choices and sharing decisions with women is optimized. However, some midwives reported that mediating a serene environment was not always respected by all midwives. Some midwives views were that others changed and controlled the ambience in the birthing room setting rather than focussing on and respecting the labouring woman and her decisions regarding the environment:

MWQ32 (Band 6): ".....You get that on labour suite don't you when they come in and they want the lights up and they start having really loud conversations when you've been talking really quietly....." (Focus group interview, band 6s, case site 1).

During the focus group interviews, several midwives expressed that in their opinion, such behaviour signified an organisational centred rather than woman centred approach to decision making.

#### **6.4.3 Midwives' belief system preferences**

Some midwives seemed to prefer to operate in one 'camp' or the other.

There were many instances in the observational visits and in the focus group interviews, when midwives confirmed their commitment to normality and making decisions based on a holistic, midwifery philosophy. Here is an excerpt from one midwife, who worked on a midwife-led unit caring for 'low risk' women:

MWQ27 (Band 6) .....says she normally encourages water immersion / water birth [for women]. Says she 'doesn't do epidurals'.  
(Informal conversation during observations, case site 1).

I did not get the chance to fully explore with this midwife what she meant by ..... 'doesn't do epidurals'. Some of the midwives on MLC described doing everything in their power to ensure a woman does not want / need an epidural? In part because if they do have an epidural, they have to move to the obstetric side of the unit and this may expose them to more medicalised decision making.

Alternatively there were a number of midwives who preferred the more high risk, high dependency care type of work, which follows a more biomedical, technological model of pregnancy and childbirth and a more rule based, rationalistic style of decision making:

I asked MWM12 (Band 6) if she was interested in doing a focus group interview. She said that she would but is more into 'high risk' care. Commenting further that she cannot fully embrace normality. The reason for her apparent lack of engagement with normality was due to

a previous bad experience, when she was caring for a woman who had a physiological third stage, who had a massive haemorrhage culminating in a hysterectomy. It was the woman's first baby.

(Informal conversation with midwife, observations, case site 2).

Reflexively, I would perhaps normally (if I'd been in clinical practice) have said something like 'we all have experiences like this but it shouldn't shake your belief in physiological birth'. This stance would clearly have highlighted my positionality, as a midwife, regarding normality in childbirth. Being in the role of a researcher I had to desist from this as (1) it could influence her feelings or beliefs (2) she may not want to engage with me and express her feelings honestly if she feels I'm being judgemental.

Some band 7 co-ordinating midwives continued with this theme of certain midwives preferring higher risk care.

MWQ5 (Band 7): ".....you hear midwives say....oh I'm happy with an epidural and synto...you know....junior midwives". (Focus group interview, band 7s, case site 1).

MWQ21 (Band 7): "They'd prefer to care for [woman with] an epidural than [a labouring woman] in the water". (Focus group interview, band 7s, case site 1).

These band 7 midwives stated that junior midwives were more used to caring for women who had syntocinon infusions in progress and epidurals in situ, that they like having clear guidelines to direct their care and decision

making. Midwives at both case sites frequently reported that they felt there were too many inappropriate inductions being conducted. MWQ5 asserted that feeling more comfortable with women whose labours were being induced was to do with the culture of induction being 'normalised' and used abundantly in childbirth. Also that inductions then lead to decisions to use a cascade of interventions:

MWQ5 (Band 7)...."it's the way we sort of do inductions..... she's started synto [syntocinon] now..... she probably needs an epidural".  
(Focus group interview, band 7s, case site 1).

Some midwife co-ordinators also acknowledged different midwives' preferences and skill sets which will inevitably impact on their decision making approaches. They recognised that staffing levels and skill mix is an important organisational factor but that you cannot always facilitate midwives' preferences. Here is a citation from a band 7 midwife:

MW34 (Band 7)....."You will have new midwives that are very interested and skilled in normal midwifery, but not always do you have that mix of staff [sometimes they have to care for 'high risk' women]....." (Focus group interview, band 7s, case site 2).

This midwife also discusses that she would, where possible, make decisions to allocate a very pro-normality midwife to a straightforward labouring woman. However the decisions surrounding allocation of midwife to woman are impacted on by a combination of factors, as mentioned previously: skill

mix and staffing levels in addition to characteristics of the women. MWQ34 makes the point that in her view, midwives should be able to care for and make decisions in relation to childbearing women with diverse needs.

MWM34 (Band 7):....."As a midwife, you should be able to look after a full range of women we all know, in practice. But that may be all well... but some people need more support looking after that type of women going down that pathway of care [high risk], than this pathway of care [low risk]. So it's not always possible....." (Focus group interviews, band 7s, case site 2).

Similarly , this senior midwife's view is that the role and decision making skills of the midwife should not be purely caring for 'low' or 'high' risk women but should range through the whole spectrum of 'risk' categories.

MWM26 (Band 7): "So therefore, for me, they've got to have [all practicing midwives] a real balance of having the knowledge of the absolute normal, right the way through to the incredibly high risk, which, for me, gives them that ability to firstly, confirm normal, recognise deviation from normal and act [make decisions] appropriately". (Focus group interviews, band 7s, case site 2).

MWM26 appeared to believe that all midwives should have the knowledge and skills to care for 'all risk' categories of childbearing women including the associated appropriate decision making skills.

Therefore some midwifery co-ordinators at both case sites tried to match 'low' risk or 'high' risk midwives with 'low' risk or 'high' risk women (also matching their decision making skills), but conceded that this was not always achievable.

A number of midwifery co-ordinators at case site 1 spoke about some midwives 'pulling out all the stops' to promote and maintain normality, utilising more normality focussed, non-interventionist decision making strategies (see following text) but others who make decisions to resort to intervention much sooner:

The co-ordinators know which midwives will make decisions and try many strategies to maintain normality, others will, say 'she's been pushing for an hour' [alluding to local guidelines: document review] or 'she needs an epidural', others you know will have tried everything [water, change of position, aromatherapy] before they come to you. You have to think about which midwife to put with which woman. (Observations case site 1).

In summary, some senior band 7 midwives reported that they attempted to allocate staff on the basis of their belief system preferences and the associated decision making strategies but this was often not possible because of the busy status of labour suite. Other senior midwives believed that all midwives should have the skills, knowledge and decision making skills to be a 'hybrid midwife'. Efficiently and seamlessly moving between all

risk categories of women and using appropriate decision making skills accordingly.

This section has reported the findings from the theme the 'hybrid midwife' and the two main categories of midwives straddling two belief systems and midwives' belief system preferences.

## **6.5 Overview of findings**

Chapters five and six have presented the five identified themes emerging from the data and their corresponding categories. These were: woman focussed determinants, midwifery specific influences, intra and inter-professional influences, environmental, organisational and cultural factors and the hybrid midwife. The next chapter will provide a summary of the findings and will discuss the findings in detail. It will integrate wider theories, research and literature related to the data.

## **CHAPTER 7 DISCUSSION**

### **7.1 Summary of findings**

The research aim was to explore midwifery decision making during normal labour and birth. The discussion chapter encompasses an analysis of the findings in light of existing theory, research and literature.

There were five main themes identified and within each theme, categories emerged (see figures 5.1 and 5.2). The first theme was: 'woman focussed determinants' (theme 1), which encompassed midwives' perceptions of women's primal ways of knowing and decision making. Midwives reported that women often laboured and birthed through innate, instinctual forces and that their own decision making in these circumstances was to use intuitive type approaches such as 'inaction' and 'go with the flow' which seemed to best support physiological childbirth. Midwives perceived that there was some conflict between who was the primary decision maker, and therefore the decision making approach, when women occupied a hybrid space, as women could be classified as low risk or medium to high risk depending on the attending HCP. Midwives reported that women's demographics could influence decision making. They perceived women who were of lower educational attainment and had low expectations 'just get on' with giving birth, thereby leading to less interventionist orientated decision making.



Under the theme of 'Midwifery specific influences' (theme 2), midwives reported that sometimes they used evidence based practice on which to base their decisions. This largely related to women whose labours were not entirely straightforward. When labour was 'normal', midwives often reported using intuitive/experiential ways of knowing and decision making, again preferring to 'go with the flow' and to use 'inaction' as a decision making strategy.

Under the theme of 'Environmental, organisational and cultural factors' (theme 3) midwives' decision making was often influenced by the busyness of the labour suite, inadequate staffing levels and unsatisfactory skill mix. This demonstrates the relationship between the themes and categories. For example if a woman is labouring physiologically (Woman focussed determinants - theme 1) and a midwife has an intuitive /experiential, 'go with the flow' approach to decision making (Midwifery specific influences – theme 2) such an approach may not be supported by the co-ordinating midwife (Intra and inter-professional relationships theme 4). This was because of reported organisational constraints, the need to process women through labour suite quickly and efficiently for example.

The importance of language and terminology (using medicalised or normality woman-centred language) was perceived as being key not only to midwives' decision making but also to women's decision making.

The theme of 'intra and inter-professional influences (theme 4) included risk, risk perception and defensive decision making. Midwives reported that

decisions were sometimes based on risk and risk perception rather than what was appropriate for the woman and the clinical situation. The pivotal role of the co-ordinator emerged as a strong influential factor in midwives' decision making, sometimes supporting intuitive, woman-centred decisions and sometimes supporting organisational based decisions. Midwives and doctors decision making sometimes conflicted, especially in the case of 'women occupying a hybrid space' (childbearing women whose labours could be considered normal or pathological - category in theme 1) for example.

The overarching theme, from the five identified was 'The hybrid midwife' because all themes related to midwives straddling two belief systems and midwives' belief systems could potentially impact on midwives' decision making in all of the other four themes. There were also two categories that were only found at case site 1 or case site 2. These were 'normality by default' (Organisational, environmental and cultural influences, theme 3) at case site 1 and excellent intra and inter-professional relationships (intra and inter-professional influences, theme 4) found at case site 2 (see figures 5.1 and 5.2).

Each of the themes will be discussed, debated and analysed within this chapter, commencing with 'woman focussed determinants'.

## **7.2 WOMAN FOCUSSED DETERMINANTS (THEME 1)**

### **7.2.1 Introduction**

The assertion adding to the 'quintain' (the essential factor or factors which underpin the phenomenon being investigated [Stake 2006] which in this study is midwives' decision making during normal childbirth) under this theme is that midwives' decision making during normal labour and birth was impacted on by the women themselves. For example their choices, views, values, characteristics and innate behaviours.

The overall aim was to explore midwifery decision making during normal labour and birth. The research question for this study was: What influences midwives' decision making during normal labour and birth? Although the focus was on midwives' decision making, as the researcher, I was extremely keen for childbearing women to be visible in this study. Even though women were not directly observed, the findings, as perceived by midwives, related to women's involvement, agency and autonomy in the decision making process.

This theme reflects childbearing women's primal ways of knowing and decision making as recounted through the lens of the midwife participants. It also shows how midwives' decision making may be shaped or influenced by labouring women's demographics.

Women occupying a 'hybrid space' is also discussed. Midwives related that women quite often fell into a 'blurred' area of categorisation, with arguments

on both sides for her clinical status remaining 'normal' but 'unusual' or for her transferring into medium/high risk obstetric territory. The decision making approaches could potentially be normality driven or interventionist depending on which risk category the woman was placed in and which HCP was the lead decision maker.

### **7.2.2 Childbearing women's primal ways of knowing and decision making**

At times, in addition to midwives using alternative discourses to the traditional, predominant positivistic and rationalistic approaches (Krishnan 2018) on which to base their decisions, midwives recounted that childbearing women used primal ways of knowing and decision making. Moreover midwives reported that they work harmoniously, in sync with women to support and achieve a physiological birth.

In many of the labours and births that occurred during data collection, a significant number of midwives' perceptions were that they often did not use any tangible decisions, other than to enable the physiological process of childbirth to run its course, to 'go with the flow', to embrace the natural forces of labour and birth. This could perhaps be seen to be making an unconscious decision in itself, for the woman to get into the zone and get on with the business of giving birth and for the midwife to facilitate and not to militate against this process. Indeed Menage's (2016b) decision making model emphasises the importance of reciprocal, equitable relationships

between midwife and woman. I propose that for the midwife this will encompass deciding when it is right to sit back and do nothing.

Women were reported to sometimes take the lead in making decisions in relation to what was going to help them negotiate labour and birth and did not need the midwife's input or advice on this. The concepts of 'inaction' (Feldman and Kutcher 2018), 'slow' midwifery (Browne and Chandra 2009) and masterly inactivity (Tew 1990) are factors that all relate to the decision making approach of the midwife. Arguably, the woman has to trust the attending midwife and also be comfortable with the midwife deciding to 'do nothing well' (Leap 2010), in order for this passive but powerful relationship to succeed.

As reported by community midwives facilitating home births, where the woman is much more likely to know her midwife and to have built up a relationship, decision making is shared and physiological birth appears to be optimized. Fahy (1998) and Walsh (2007), would concur, that woman centred, midwife led maternity services fosters normality driven shared decision making. Walsh (2012) calls this 'being with' women (intuitive, experiential, situated decision making), as opposed to 'doing to' women (hypothetico-deductive, rationalistic, technocratic based decision making). However, for the relationship to be symbiotic, arguably both parties have to be signed up to the 'being with' model. A childbearing woman who trusts biomedicine and technology over nature, would not embrace a 'being with'

midwife relying largely on intuition, preferring a 'doing to' midwife, who embraces rationalistic, technocratic decision making (Cooper 2011).

Some of the literature uncovered in the literature search implied that intuitive decision making in childbearing was something women did not connect with, distrusted or felt that others would distrust (Davis-Floyd and Davies 1996, Savage 2006). Perhaps the context of women giving birth in a hospitalised setting, with caregivers largely unknown to them, could impact on a midwife – woman relationship that fosters intuitive decision making. I will return to this point under section 7.3.3 on midwives' intuitive, experiential and situated ways of knowing and decision making.

Davis-Floyd and Davies (1996) refer to the holistic model or paradigm of health care which sees mind, body and spirit as one, not just in relation to the practitioner but also in relation to the patient, or in this case, childbearing women. The implication being that an alternative instinctive and innate energy is at work and forms a complex interaction and a powerful 'healing dance' between clinician and woman that is imperative for intuitive decision making.

Parratt and Fahy (2007), in their literature review, discuss 'non-rational' ways of knowing and decision making. In their paper they "expose the limitations of pure rationality in the context of childbirth" (Parratt and Fahy 2007: 37). They assert that the sole use of rational thinking severely restricts possibilities by disregarding both the midwife's and the woman's embodied (integrated body/soul/mind) ways of knowing and subsequent

approach to decision making. According to Parratt and Fahy (2007) the inclusion of non-rational, intuitive ways of knowing in the context of childbirth opens up alternative epistemologies that provide for a more comprehensive and optimal decision making process.

The work of Parratt and Fahy (2007) once again highlights the interplay between women's and midwives' unspoken and tacit knowledge that may have a powerful influence on decision making.

As highlighted in the findings chapters, there were many instances where I recorded women being admitted to the labour suite, and just getting on with labour and birth, instinctively knowing what to do, if for example their labours slowed or stopped. The midwives related their 'watchful waiting' (passive decision making or 'inaction') (Carlson and Lowe 2014) being in tune with the woman, seemingly knowing that all was well, supporting women to embrace this physiological process thus enabling normal birth to unfold. Midwives in hospital based labour suite settings have to work extremely hard and skilfully to build rapid, meaningful relationships with labouring women they have most likely never met before. Many midwives within this study did report building good relationships with women quickly, but through observations and reports from midwives, such close bonds were often not attainable, mainly due to sheer workload. This is why I would suggest connectedness (close physical and emotional relationships) is a key aspect of intuitive, normality driven decision making which appears to be

associated with physiological childbirth (see section 3.14). There is little in the midwifery literature related to this concept (Davis-Floyd and Davis 1996).

To achieve ontological or epistemological congruence between women's and midwives' decision making preferences in physiological labour is not something that can be based tangibly on scientific evidence. This is wholly in line with the concept of 'situatedness' as Chalmers et al, (1989) said, what really counts cannot be counted. Thus there are some aspects of midwifery care (such as connectedness) that are generally undervalued, unexplored or considered unmeasurable that could have significant impact on midwives' and women's situated knowledge, decision making and consequent birth outcomes (Davis-Floyd and Davies 1996, Walsh 2012). As a result of conducting this study, I would suggest that the woman-midwife relationship, in regard to the level of 'connectedness' (the degree of a close social, emotional and physical bond that can be achieved), needs further qualitative exploration to highlight if this impacts on decision making and normal birth.

### **7.2.3 Midwives' decision making and influence of childbearing women's demographics**

As Cooper (2011) asserts, neither woman nor midwife come together in a labour suite setting without 'situated knowledge'. A multitude of factors culminate to arrive at women's and midwives' ways of knowing and decision making (Haraway 1988, Stoetzler, Yuvual-Davies 2002). The demographics



of childbearing women was something that came through strongly at one of the case sites.

At case site 2, I was repeatedly told that childbearing women who used the maternity unit, just got on with labour and birth, decision making by midwives was therefore largely passive. It was proffered that this was because of women's limited educational achievements and low expectations. There is no real empirical evidence to support this supposition but a study of birth plan use by Burke et al, (2016) which included 2336 nulliparous women, found that older, more educated women who made the decision to write a birth plan actually had more adverse outcomes in terms of longer labour and higher caesarean section rates. The statistics on birth outcomes actually support a correlation between older, educated women having higher levels of intervention (NHS maternity statistics 2019) but the emphasis is arguably to do with them being 'older', than to do with their educational attainment, as complex risk factors increase along with increasing maternal age (Jackson and Wightman 2017, NHS maternity statistics 2019). Moreover, although the perception of the clientele being of lower socio-economic status and lower educational achievement, was much more prevalent at case site 2, there are significant pockets of deprivation and affluence in the cities where both case site 1 and case site 2 are located (see chapter 5, table 5.10). But midwives at case site 1 did not report the same perceptions of their clientele or of the associated passive decision making. Midwives' perceptions of the demographics of childbearing women and the relationships with their own decision making approaches has not been the

subject of any empirical research and is therefore an original finding from this study and is worthy of further investigation.

#### **7.2.4 Women occupying a hybrid space**

In the findings section, there were a number of women who were reported by midwives as occupying a 'hybrid space', a grey area between normality and pathology. Most women occupying a 'hybrid space' were reported by midwives to have paternalistic, interventionist decision making by the duty obstetrician. Midwives perceived that they and the women they were caring for were largely excluded from sharing in decisions (Porter et al, 2007, Stacey et al, 2017) made in these circumstances, or there was a 'hybrid', approach to decision making where women were neither managed as 'low risk' or 'high risk'. Accounts by midwives demonstrate a confused, muddled approach to decision making which can potentially lead to varied childbearing experiences for women. Women could be essentially 'normal' (for example a woman having one recording of raised blood pressure, when all other readings were within normal parameters) but be managed and have decisions (potentially interventionist) made by an obstetrician.

Some midwives felt that the power differential between obstetricians and midwives was responsible for doctors taking control of decision making (see section 6.3.4) when women occupied a 'hybrid space'.

Whilst the duality of theoretical discourses surrounding the nature of childbirth (technocratic versus humanistic, medicine versus midwifery) are

fairly abundant in the literature (Davis-Floyd 2001, Davis-Floyd 2003, Walsh 2010a, Jackson 2017b), little can be found regarding the phenomenon of this 'grey' area in the real world of clinical midwifery, obstetrics and associated decision making. Dahlen, in a research presentation in 2012, did allude to the challenge of hybridity as: 'dancing in the grey zone between normality and risk'. Dahlen and Gutteridge (2015) go on to say that if midwives are being really honest, most maternity care is grey. They typically frame 'dancing in the grey zone' as enhancing vigilance, responsiveness and use of normality driven decision making, with a view to open up the possibility of physiological birth. Women should be seen as "full of capacity not full of catastrophe" (Dahlen and Gutteridge 2015:100).

Walsh (2010a) argues that managing this dichotomous space is best accomplished where there is trust, respect and collaborative decision making between midwives and obstetricians and where robust clinical governance systems are in place.

## **7.3 MIDWIFERY SPECIFIC INFLUENCES (THEME 2)**

### **7.3.1 Introduction**

The next assertion and addition to the 'quintain', is that within this study midwives at times used evidence based practice (EBP) to influence their decisions, but there were also a myriad of other influences on midwives decision making during normal labour and birth.

This chapter explores midwives' decision making in relation to reported use or non- use of evidence based practice. Where EBP appears not to be used, there will be a section on midwives reportedly using intuitive, experiential and situated ways of knowing to inform their decision making.

### **7.3.2 Midwives' decision making and evidence-based practice**

Midwives in this study who worked in community practice, MLC or self-identified as being normality focussed, (the 'being with' midwives) generally reported using more individualised, woman centred, intuitive types of decision making (Mok and Stevens 2005). These midwives reported, at times, making decisions to veer away from local evidence based guidelines, even though some of these guidelines and practices were deeply entrenched within the culture of the labour suite.

Midwives who worked on obstetric labour suites and worked with 'high' risk women or those who reported that they enjoyed working with women with complex needs (the 'doing to' midwives) tended to use more guideline based, hypothetico-deductive forms of decision making (Reed 2004, Krishnan 2018). It could be argued therefore that those midwives, who worked with both 'low risk' and 'high risk' childbearing women were adopting a cognitive continuum (Hammond 1988, Hamm 1988 - on a scale between intuitive-humanistic and hypothetico-deductive processes) or dual processing (Stanovich and West 2002, Paley et al, 2007 - use of intuitive-humanistic or hypothetico-deductive processes or both concurrently) approach to decision making. Some of these midwives did comment that

they struggled to operate and make decisions when working between these two dualistic belief systems, potentially this could be due to a lack of decision making preparedness for some midwives working in the reality of all risk categories of maternity care.

The reported motivations for the different decision making approaches could demonstrate a woman centred, intuitive based approach to decision making (when some women in early labour are kept on the labour suite, do not have routine ARMs or VEs conducted). Or alternatively an organisation centred, hypothetico-deductive approach to decision making (when all or most women in early labour are encouraged to stay at home or to be discharged home, when ARMs are conducted to speed up labour, without a clear clinical indication and VEs are performed routinely).

'Being with' midwives often reported that they used their intuition and clinical judgement based on their own knowledge and experience of progress in labour, rather than basing it on guidelines or under direction from the co-ordinating midwife. Cioffi et al, (2008) would support this process of clinical judgement, as they concluded that midwives use heuristics (use of mental short cuts, or based on probabilities), originating mostly from their own clinical experiences, in an attempt to save cognitive energy and to facilitate reasonably accurate decision making processes. This use of internalised tacit guidelines (as opposed to formal guidelines) also concurs with the concept of 'mindlines' (Gabbay and Le May 2004). 'Being with' midwives often reported using like-minded colleagues to support their intuitive decision making

processes which also aligns with the 'mindlines' model of situated decision making (see section 3.12).

There is some evidence that senior colleagues influence more junior midwives' decision making and that the junior midwives dare not deviate from the cultural and organisational decision making norms (Parsons and Griffiths 2007, Hollins Martin and Bull 2010, Kirkham 2011, Russell 2016). However as mentioned previously, some midwives reported decision making which deviated away from the evidence based guidelines. Parsons and Griffiths (2007) would call this 'rule bending', by being non-conformist to practice convention. The findings in this study show that some midwives decision making was reported as being influenced by (usually senior) professional colleagues but other midwives' decision making appears not to be influenced by colleagues. It could be argued that some student and qualified midwives need further support in developing assertiveness so that they are confident of their autonomy and decision making processes.

It is proposed that when midwives' epistemological beliefs align with an evidence-based guideline, they are more likely to adhere to it (Polanyi 1966, Church and Raynor 2000, Clews 2013). Therefore conversely, where midwives' beliefs do not 'fit' with a guideline, they are more likely to veer away from it and use their own tacit knowledge (Polanyi 1966, Church and Raynor 2000, Clews 2013) on which to base their decisions.

Midwives at both case sites reported embracing some evidence based practice, basing their decision making on EBP, whilst others are rejecting

certain EBP, seemingly basing their decisions on their intuition, experience, custom and practice.

Other forms of midwives' decision making rather than EBP were reported. The next category will explore some of these decision making approaches.

### **7.3.3 Midwives' intuitive, experiential and situated ways of knowing and decision making**

Under the broad theme of 'midwifery specific influences', arose a number of instances where midwives appeared to use intuitive, experiential and situated ways of knowing to inform their decision making. Examples were given in the findings chapters where intuitive, experiential and situated decision making processes were apparent, as no evidence based (hypothetico-deductive based) guidelines were reportedly used to navigate decision making.

Decision making based on the scientific paradigm of positivism appears to retain its hegemony within the spheres of medicine, nursing and midwifery and other health disciplines (Davis-Floyd and Davis 1996, Siddiqui 2005, Mead and Sullivan 2005, Mok and Stevens 2005, Reilly 2015). As a direct result of positivism, the hypothetico-deductive decision making model (also known as the systematic- positivistic model) remains dominant in health care including maternity services (Reed 2004, Mok and Stevens 2005). However, as discussed in the decision making chapter, many researchers and authors are challenging the notion of the supremacy of scientific

knowledge as the only source of authoritative knowledge (Davis-Floyd and Davis 1996, Siddiqui 2005, Mead and Sullivan 2005, Mok and Stevens 2005, Reilly 2015). The concept of intuitive, experiential, situated (context based) knowledge, a feminist response to the masculinist, positivistic paradigm is emerging as a credible alternative to rationalistic ways of 'knowing' and decision making (Haraway 1988, Stoetzler and Yuvual-Davies 2002).

### **7.3.31 Midwives expressing intuitive decision making**

As stated previously, there were a number of accounts when midwives commented on using intuitive types of decision making when caring for labouring women, when midwives expressed that they just 'knew' or 'sensed' something, seemingly without any conscious rational use of reason (Schrader and Fischer 1987). There were situations in women's labours and births that were not covered by evidence (hypothetico-deductive) based guidelines. This would also fit with the notion of situated knowledge and decision making, where the midwife and the woman do not come from a place free of experience and knowledge. Both parties are laden with a profound history of influences on their belief systems, culture, ethnicity, class and gender to name but a few, blending together to arrive at a situated knowledge standpoint (Haraway 1988, Stoetzler, Yuvual-Davies 2002, Menage 2016b). Situated knowledge accounts for non-rational, intuitive type decision making processes (Wieringa and Greenhalghs 2015). Use of tacit, situated knowledges is also reflective of the decision making model of



'mindlines' (Wieringa and Greenhalghs 2015), because it is largely reliant on intuitive processes.

Arguably it could be contended that these expressions of 'knowing' and decision making were from experienced midwives, making intelligent, academic deductions. Equally it could be argued that childbirth is notoriously unpredictable and is therefore impossible to make these kinds of judgements and decisions, from a rationalist perspective at least.

Intuitive forms of decision making, such as 'inaction' and 'going with the flow' based on experiential, situated knowledge were reported by many midwives. However the actual terminologies 'intuition' or 'intuitive decision making' (which in terms of reflexivity, I was expecting to be used – Ibrahim, Edgley 2015) were not widely cited by midwives. However, midwives did not refer to the technical terminology of using deductive or rational forms of decision making either, therefore it could purely be due to using semantics midwives were comfortable with.

As alluded to in the decision making chapter, intuition, especially its use in decision making, is a problematic and contested phenomenon (Siddiqui 2005, Mok and Stevens 2005) and midwives may not have felt that it was a legitimate decision making strategy. It is not tangible, it cannot be seen, some would argue it cannot be measured, it is therefore understandable that some scientists and researchers at best have a scepticism around intuition and at worst dismiss its existence altogether (Davis-Floyd and Davis 1996).

It is suggested that in order for midwives and childbearing women to use optimal intuitive types of decision making, connectedness (a close social, emotional and physical bond) should be evident (Walsh 2010a). Almost 98% of childbearing women in the UK currently give birth in a hospitalised or birth centre setting (ONS 2017). Choice in maternity care givers tends to be severely restricted (Shaw et al, 2016) and the close, connected relationship building with for example, an independent midwife, is not possible. Within this particular study this was evidenced by the busy labour suites where midwives were caring for several labouring women, or being swapped around to care for different women, depending on skill mix. Therefore, at times, effective use of an intuitive decision making model, may not have been viable. In effect there was no temporal space for intuition and this could be reflective of UK hospital based labour care (which tends to be organisationally similar – Walsh 2018) more generally.

In the decision making chapter (chapter 3), there is an in depth discussion surrounding empirical psychology research which supports the existence of intuition as a sound, efficient decision making process in certain circumstances (Mikels et al, 2011, Lufityanto et al, 2016). They and other researchers caution, however, that intuitive decision making should be balanced with hypothetico-deductive reasoning, depending on the situation, to be most effective (Mikels et al, 2011, Lufityanto et al, 2016, Paley et al, 2007, Koenig et al, 2007).

### **7.3.32 Midwives using 'inaction' in decision making**

Passivity or 'inaction' was often cited by midwives as something they adopted during normal labour and birth. I would suggest that 'inaction' was not explicitly seen by midwives as a decision making strategy. There is a distinct dearth of the phenomenon of 'inaction' in midwifery research. Guiver (2009), in her grounded theory based research, found that midwives used 'diligent inaction', in order not to disturb the process of giving birth.

Although this was seen as a behaviour rather than a decision making approach. The very notion of inaction (though the terminology may differ), is a skill that appears to resonate significantly in normal labour and birth care. Inaction could arguably be a profoundly important form of midwifery decision making in itself.

In the field of psychology the terms action and inaction have been the subject of decades of research with the intention to better understand action and inaction and their role in human psyche and decision making (Albarracín et al, 2011, Albarracín and Shavitt, 2018). Feldman and Kutcher (2018:2) describe inaction thus: "inaction has been used for capturing lack of action, a deliberate decision to not take action, reduction or inhibition of action, the avoidance or deference of a decision, or sticking with the status quo or the default". Whilst some view inaction as a non-decision, Feldman and Kutcher (2018) assert that inaction can be even more deliberate, conscious and intentional than action.

Kennedy (2000) discusses 'doing nothing well' and Leap (2000) coined the phrase 'the less we do the more we give'. Tew, back in 1990, espoused the virtues of 'masterly inactivity'<sup>3</sup> and the concept of 'presence' has been comprehensively explored by Kennedy et al, (2010). As stated earlier, these intuitive decision making strategies were reported frequently by midwives within this study. These notions do not literally mean that the midwife makes the decision to do nothing but be 'with woman', rather that they are skilfully, quietly and unobtrusively going about their business of supporting women in labour, they are constantly available and they are sensitive to women's needs. They are observing even the slightest nuanced change in women's behaviour to assess that all remains well. The noises women make, the way they move their bodies, even a shift in their breathing pattern can signal continued normality (or a deviation from normality and a need for a different decision making approach). In essence they are supporting the physiological processes of childbirth, enabling the woman and her body to take centre stage, to be in control and in charge during normal labour and birth. These skills are seen as profoundly important in keeping childbirth normal (Tew, 1990, Kennedy 2000, leap 2000). The reporting of inaction as a deliberate and potentially empowering form of midwifery decision making (for midwives and women) in normal labour and birth is a novel suggestion. It has not been the subject of research, therefore inaction as a legitimate decision making approach is worthy of further investigation within midwifery.

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<sup>3</sup> Masterly inactivity is a policy of deliberate **inactivity**, carried out with diplomatic skill, so as to preserve a predominant influence (Wiktionary 2019) (i.e. physiological labour). In midwifery it is seen as developing confidence in a woman's ability to labour and birth independently. A disposition towards compassionate companionship with labouring women (RCM 2008). Being comfortable when there is nothing to do. Doing nothing yet doing everything (Walsh 2011a).

### **7.3.33 'Mindlines' as more a 'real world' clinical decision making process**

This chapter has discussed midwives use of hypothetico-deductive forms of decision making and midwives' intuitive ways of knowing and of decision making. Citations have been given when midwives used these 'other' types of decision making (for example: 'inaction', experiential and situated forms of decision making section). I propose that the model of 'Mindlines', (discussed in the decision making chapter, chapter 3), as an emergent and innovative theory of decision making could encompass intuitive, experiential, situated forms of decision making. This is where tacit, non-conscious, intuitive, emotional thought processes are used in conjunction, often to a lesser extent, with hypothetico-deductive methods to make 'real world' decisions. Decisions are embodied within the situation and are always context bound (Wieringa and Greenhalghs 2015). As such this is the only decision making model that proposes both intuitive and rationalistic decision making processes are used in clinical practice, but that intuitive processes are often the most dominant.

Though Wieringa and Greenhalgh's (2015) review was largely related to EBM, the concept of 'mindlines' resonated with the data findings of this study into midwives' decision making. This was evident where midwives did not appear to adhere to any overt rationalist thinking in the examples reported within this category, instead tapping into their own internalised tacit guidelines and intuition. At times midwives reported using each other to

reiterate that their proposed decision making was correct which is also an important component of 'mindlines'. The theoretical construct of 'mindlines' seemed to align more closely with these midwives' decision making, rather than other well established theories and models of decision making and is an original finding within this study.

## **7.4 ENVIROMENTAL, ORGANISATIONAL AND CULTURAL FACTORS (THEME 3)**

### **7.4.1 Introduction**

The next assertion in relation to the 'quintain' is that midwives' decision making at both case sites, was hugely influenced by environmental, organisational and cultural factors, such as those identified in this theme and within the categories: the busyness of the labour suite, the importance of language and terminology and normality by default.

### **7.4.2 The busyness of the labour suite**

Busyness and extreme busyness were observed at both case sites. However overall case site 1 appeared to be the busier of the two.

#### **7.4.21 'Low risk' childbearing women's choices and decisions being compromised**

As reported in the findings chapters, there were busy times when women's choices could not be supported. A number of studies have highlighted that childbearing women not having their decisions respected or have control

over their own labour is strongly associated with a negative experience of childbirth (Hardin and Buckner 2004, Hauck et al, 2007, Cook and Loomis 2012). The overwhelming workload and the busyness of the labour suite was reported to have a definite influence on midwives' and women's decision making in normal labour and birth. This finding lends further support to 'normal', 'straightforward' labouring women being in a completely separate environment to acute labour suite settings as recommended in numerous reports and reviews (Walsh 2004, 2018, The Birthplace in England Collaborative Group 2011, Sandall et al, 2016, Walsh et al, 2020). Alternatively for maternity services to be provided by a case-holding model of care (Nelson 2010, McLachlan et al, 2012, McCourt 2010, Darlington 2019).

#### **7.4.22 Safe staffing levels and adequate skill mix**

It could be argued that staffing levels were not as they should be if women weren't being supported in their labour decisions. The Birthrate plus model (Birthrate plus 2015, Ball and Washbrook 2015) of determining safe staffing levels along with appropriate skill mix was in use at both case sites. Safe staffing levels are purported to enhance effective decision making by midwives in partnership with women (NICE 2015) and Birthrate plus is endorsed and supported by NICE (2015). Sandall et al, (2011) in a Kings fund study on staffing levels in maternity, found that the skill mix of staff on duty and the way that they were deployed was more important than absolute numbers. However it was clear from co-ordinating midwives'

reports and from the observations, focus group interviews and diary entries at both case sites, that both staffing levels and skill mix were sometimes not adequate to make woman centred decision or to meet the needs and facilitate the decisions and choices of all childbearing women.

The accounts from these and other midwives from the two case sites run counter to the establishment requirements for maternity labour suites and by implication could feasibly impact on effective, shared decision making with women (Sandall 2011, NICE 2015, Ball and Washbrook 2015).

#### **7.4.23 Extreme busyness of the labour suite facilitates a 'with organisation' rather than a 'with woman' approach**

A number of midwives within the study expressed that the organisation and the busyness of the labour suite dictated decision making and signalled a 'with organisation' approach to decision making rather than a 'with woman' approach (DH 2010, RCM 2017). This was particularly, but not exclusively, when the labour suite was busy. Senior co-ordinating midwives were making crucial clinical decisions whilst functioning in very busy, stressful, challenging circumstances. The issue then may be better framed at illuminating the organisation of maternity care and how best 'low risk' childbearing women can be served (DH 2010, RCM 2017), which is a point I will return to within this category.



#### **7.4.24 Pain relief as a form of organisational control**

One midwife implied that when the labour suite is extremely busy, diamorphine is given to women, sometimes inappropriately early in labour, as a form of control or delaying tactics until the environment becomes less busy. If this is indeed the case, then this type of decision making could be viewed as medicalised, unethical and paternalistic (Elwyn and Charles 2001) being based on the clinician's standpoint and seemingly ignoring women's agency entirely (O'Cathain 2002, Karnieli-Miller and Eisikovits 2009).

Complex clinical decisions (to augment labour, to conduct fetal blood sampling) and, more broadly, organisational decisions (closing labour suites, diverting women to other Trusts) have to be made as doctors and midwives in hospital settings generally have to work within an all risk category context, ensuring the safety of all women in their care (NICE 2015).

According to some of the midwives who participated in this study, this can be at the expense of woman centred decisions and choices.

Within this section, the examples cited by midwives of giving diamorphine to keep women 'quiet', not 'allowing' water immersion and reports of inadequate staffing levels and skill mix, highlight context, situated findings which provide a valuable and novel contribution to the place of birth debate. Arguably busy labour suites may not be the best environments for low risk, labouring women. This is because their needs, wishes and decisions may not be facilitated and decisions to intervene in normal labours is much more

likely (Walsh and Downe 2004, The Birthplace in England Collaborative Group 2011, Hodnett et al, 2012).

#### **7.4.25 The dominance of women with complex needs**

This category is very closely related to the category of 'The busyness of the labour suite' as it is the degree to which women with complex needs require the care and attention of health professionals which largely leads to this 'busyness'. I was well aware that maternity care was becoming more challenging, including decision making processes, due to the demands of women with more complex physical as well as psychological and social needs (RCOG 2007, 2016a, Raynor et al, 2012, Ball and Washbrook 2015). The data collection period, particularly the observations, brought this into sharp focus. There were many occasions at both case sites, when I was confronted with no, or very few straightforward, 'normal' cases on the labour suites.

Increasing complexity in childbearing women is well documented and is the result of a number of factors, including increasing maternal age, rising levels of obesity and related diabetes (Jackson and Wightman 2017). In addition, the ever-increasing trend towards more high-risk, complex cases and associated complex decision making and higher levels of dependency (monitoring, testing, screening), have placed extra demands on the staffing levels of acute labour suites (RCOG 2007, RCOG 2016a).

#### **7.4.3 Importance of language, terminology and information giving**

Within this category, the organisational and cultural use of language,

terminology and information giving are absolutely key when it comes to the pathway that a woman's labour can take and the decision making approach utilised (Phillips 2009, Mobbs 2018). Subtle nuances can skew the way that information is provided to women (Phillips 2009, Mobbs 2018). Use of medicalised language rather than the language of normality can also reinforce the idea of pregnancy, labour and birth belonging to the technocratic model of childbirth rather than the social model of childbirth. In turn leading to more rationalistic, hypothetico-deductive decision making when more intuitive, experiential approaches may be more appropriate.

Case site 2 referred to all childbearing women as 'patients' which seems counter-intuitive as the unit has a reputation for promoting and maintaining normality in childbirth. 'Patient' has the connotation of being ill or sick rather than healthy and well.

Medicalised language such as 'failure' to progress, 'incompetent' cervix and 'trial of labour' appeared at both case sites, highlighting the view of childbearing women's bodies fragility and propensity to 'go wrong' (Mobbs 2018). Such sayings and many more are still in common use today, serving to propagate and reinforce the notion of childbirth in need of intense surveillance, a high level of medical input and as ultimately dangerous (Walsh et al, 2015) and a tendency towards hypothetico-deductive based and/or interventionist decision making, even when all is 'normal'.

Within this study, some experienced and well respected midwives used negative language. In addition they presented themselves as great

advocates of promoting normality in labour and birth and of informed, shared decision making with women and yet used medicalised language, and patriarchal decision making in certain situations. This serves to demonstrate how deleterious, undesirable terminology has permeated the culture of labour suites (Borrelli 2015). Negative language was being used at both case sites, infiltrating the vocabulary of even the most normality committed midwives. The knock on effect to women making decisions about their own care could potentially be influential.

#### **7.4.31 The framing of language used in relation to pain in labour**

Some midwives within this study reported that they used, what would arguably be called the informed decision making approach, to tell women in labour about pain relief options, providing a type of menu of medications available. However, overwhelmingly midwives reported using a working 'with pain' approach (Leap and Anderson 2008) whereby they do not readily defer to pain relieving drugs. Rather they suggest non-invasive strategies (a 'go with the flow' decision making approach) such as water immersion, massage and aromatherapy.

In relation to language influencing decision making, the language used surrounding pain in childbirth is considered to be divisive (Leap and Anderson 2008, Walsh 2007, Mander 2011). Providing a menu of options of pain relieving drugs, as stated previously, could be seen as facilitating informed decision making (Mander 2011). Conversely, other midwives would

argue that the menu type approach to pain relief is well meant, but it undermines a woman's ability to feel in control of her body and her pain, by subtly (or sometimes not so subtly) saying she will not be able to cope with labour pain without help (Mander 2011). How midwives frame 'pain' in childbirth and how this is mediated through the language they use is linked to the ultimate decisions women will make on how to best manage labour (Walsh 2007).

Midwives' decision making power in offering labouring women drugs to potentially relieve pain during childbirth has been described as seductive (Leap and Anderson 2008). Epidural analgesia has repeatedly been found to disrupt the normal physiological processes in labour (Anim-Somuah et al, 2018). For some midwives within this study, there was a perceived necessity to make decisions to relieve women's 'suffering' in labour. It is important to note that use of pain relieving agents in labour is not necessarily associated with increased satisfaction with the experience of birth (Dickenson et al, 2003, Heinz and Sleigh 2003).

#### **7.4.32 Language, communication and information giving**

Linked to use of language is communication and information giving.

Kirkham's (1999) ethnographic study found that midwives subverted the obstetrics dominated systems by 'doing good by stealth'. This included making the decision to report and record the dilatation of the cervix being less than the actual authentic finding, thereby protecting the woman from

intervention if birth was not achieved by the guideline definition of second stage.

Several midwives in this current study openly reported 'doing good by stealth' decision strategies. They were clearly acting in good faith, in their perception of a woman's best interests. These were seen as an attempt to circumvent hypothetico-deductive, rationalist guidelines that would prompt interventionist decision making in a given timeframe. I suggest that this practice is not limited to a small number of midwives (Stewart 2010), as Walsh (2010b:71) asserted "Most of us have been there".

I suggest that there could be a link between making the decision to 'do good by stealth' and the next section, 'matriarchy in childbirth'.

#### **7.4.33 Matriarchy in childbirth**

Surreptitious behaviours reported by midwives in this study may be displaying matriarchy, in that the knowledge is concealed rather than shared with women. In these circumstances women cannot make genuinely informed, or share in, decisions. Care is not truly woman centred, as there is an imbalance of power. This is not in relation to doctor-midwife, or doctor-woman as may be claimed in a patriarchal belief system, but in relation to midwife-woman in what Stewart (2010) would call a matriarchal fashion. Midwives would defend covert practices as coming from a place of deep compassion and caring but the obscuring of information represents a power differential and goes against any of the classical or post-modern feminist

philosophies (Walsh 2007, Kirkham 2010). Stewart (2010) warns midwives against falling into the trap of matriarchy.

An alternative view of matriarchy is that it has benevolent connotations of nurturing, protecting and mothering. Marsden (2018) contends that in feminist theory, matriarchy is not the mirror image of patriarchy. Edsell (cited in Marsden 2018: 1) states that matriarchy is not a paradigm of oppression, describing it as “..... a society that values instinct as much as intellect, receptivity as much as assertiveness, collaboration as much as individualism and empathy as much as objectivity”. It could be contested therefore that matriarchy is an egalitarian philosophy (Daly 1978), centring on maternal wisdom, support, autonomous decision making and empowerment (Goettner-Abendrot 2010) and thus would not be used as a detrimental force against childbearing women. Whatever the underlying philosophy of matriarchy might be, replacing one orthodoxy (medicalised, interventionist, rationalistic decision making), with another (non-medicalised, non-interventionist, intuitive decision making) is not an acceptable resolution (Walsh 2007).

When midwives use covert behaviour, however well intentioned, it may be obfuscating the unique nature of women’s labour physiology. It is also severely restricting midwives’ ability to improve their situation, as autonomous, decision making professionals, according to some authors (Kirkham 1999, Davies 2012). Whilst the argument that covert practices may be damaging midwifery in the long term is completely valid, the counter

argument is that midwives' powerlessness, working in masculinised, oppressive, hierarchical organisations (Kirkham 2010) forces them to make decisions in clandestine ways. This is ostensibly for the good of a particular woman (avoiding unnecessary intervention) at a particular time and could be seen as a coping strategy to 'play the system'. The potential link between midwives' decision making to 'do good by stealth' and patriarchy is an original contribution to the midwifery decision making discourse.

#### **7.4.4 Normality by default**

In chapter six, I discussed that during extremely busy periods, midwives reported that, at times, women who wished to have a physiological labour and birth (using water for immersion for example) were not having their choices and decisions respected, albeit for very understandable reasons. Moreover, women who requested to have medicalised labours were also reported as not having their decisions facilitated in one busy labour suite environment (case site 1). This culminated in them having normal labours and births, when this was not the childbirth experienced they had wanted. Women not being involved in decision making processes and not feeling in control are powerful predictors of poor labour and birth experiences (Hardin and Buckner 2004, Hauck et al, 2007, Cook and Loomis 2012).



## **7.5 INTRA AND INTER-PROFESSIONAL INFLUENCES (THEME 4)**

### **7.5.1 Introduction**

The penultimate assertion and addition to the 'quintain' is that midwives' decision making during normal labour and birth was strongly influenced by intra and inter-professional relationships, either in a positive affirmative way or destructive, disempowering way.

### **7.5.2 The spectre of risk, risk perception and defensive decision making**

There were a number of midwives' accounts demonstrating risk averse, defensive decision making. For example, to potentially conduct an episiotomy when not clinically indicated and to conduct admission CTGs on low risk women.

Scammel (2016) in her ethnographic study, examined the spectre of risk in midwifery in detail. "The connection between fear and risk seemed to be deeply embedded into the imaginations of the midwives" (Scammel 2016:18). Though risk management and risk governance strategies are often proffered as 'non blame, learning opportunities', inevitably, if anything goes wrong, then someone has to be held accountable for their decisions (Alaszewski and Harvey 2002, Walsh 2017). Decision making in a punitive orientated organisation is perceived to be a perilous activity (Scammel 2016).

Walsh (2017) states that risk appears to be all pervasive in contemporary society, despite unprecedented levels of prosperity and technological advances in high income, high resource countries. The risk discourse is especially prevalent in maternity care, exemplified by women's choices and decisions of how (accepting of intervention) they give birth (Green and Baston 2007) and where (in hospital settings) the vast majority of them give birth (Mari 2009, Cooper 2011). It is also apparent that midwives can and do at times, base their clinical decision making on risk and risk perception (Sandal et al, 2010, Scamell 2016). Risk and risk perception was reported to be a significant influencer on midwives' decision making at both case sites, thereby potentially affecting women's experience of normal childbirth.

#### **7.5.21 Midwives' compulsion to comply**

In addition to a culture of risk influencing midwives veering towards defensive decision making a number of midwives reported having a compulsion to comply with the normative values present in their place of work (cultural macro influencing factors).

Some midwives' accounts in the findings chapters reported that the co-ordinating midwife sometimes pressurised them into making interventionist decisions they would not normally make, for example to conduct vaginal examinations or to artificially rupture membranes (breaking the waters).

This was reported to be because the co-ordinators wanted to get childbearing women 'processed' through the system quickly and efficiently.

This processing of women has been referred to as 'fast' midwifery by Browne

and Chandra (2009) and a 'Fordist', conveyer belt approach by Walsh (2015).

In their qualitative research where a sample group of 20 representative midwives were interviewed, Hollins Martin and Bull (2008) found that midwives tend to respond to social influence from more senior staff impacting on their decision making. The processes they described were obedience and conformity. "For midwives there is a fundamental conflict between government directives to work as autonomous evidence based practitioners and the demand for obedience that is a requisite of the hospital hierarchy" (Hollins Martin and Bull 2008: 504). The researchers explained the midwives' behaviour in terms of 'legitimacy', 'perceived obligation to the organisation' and 'social identification'. These pressures create conflict between the midwives' knowledge of how they would prefer to behave, to make shared decisions with women for example, and concern to please authority or fit into the social group, to comply with senior midwives' decision preferences. Consequently, it may be difficult for midwives to support decisions and choices negotiated with women that conflict with what a senior colleague proposes.

#### **7.5.22 A societal 'culture of fear'**

In the wider sociological literature, Furedi (2007) argues that fear has become politicized, institutionalized and is mediated through risk management policies. He describes a 'culture of fear' in society at large and

quips in his writings: 'The only thing we have to fear is the culture of fear itself' (Furedi 2007: 231), a play on a well-known saying.

Some midwives within this study reported that their decisions were influenced not just by actual risk factors (for example high BMI) but by perception of risk and how other practitioners might view their labour management decisions (for example decisions made during slower than expected labour). Walsh argues that purely the perception of risk is a powerful entity, profoundly influencing midwives' decision making (Walsh 2017). Within this study, certain influential risks were reported to be amplified, such as women's clinical characteristics, whilst other risks, such as organisational shortcomings were not even considered in decision making, which according to Walsh (2017) are present in maternity care in general.

#### **7.5.23 Organisational 'risk' factors**

'The busyness of the labour suite' and 'The dominance of women with complex needs' (see sections 6.2.2 and 6.2.21), were perceived by many midwives to greatly influence their decision making within this study.

Risk management tends to focus on pathology or potential pathology of pregnancy and childbirth (Walsh 2017). There are many other factors that could potentially pose risk to childbearing women, alter decision pathways and affect them being able to labour physiologically. Similar to the current study findings, Anderson (2004) highlights some of the organisational

maternity factors which constitute risk and arguably influences decision making (see table 10.1):

Table 10.1 Organisational maternity risk factors. Source: Anderson 2004

Lack of continuity of care and continuous support by midwives
Inexperienced doctors at the start of their rotation
Absence of expertise during the summer holidays, weekends, night shifts and bank holidays
Disagreements between midwife and obstetrician
Inadequate handovers because of fatigue, intimidation
12½ hour shifts when midwives are too busy to have the breaks they are entitled to.

However, as previously stated, these features do not tend to be part of risk management agendas (Anderson 2004). The same risk centric culture, focus on women's clinical characteristics and associated defensive decision making, was reported by a number of midwives at both case sites within this study. Some authors proffer an alternative discourse to 'risk' (and defensive decision making), that of salutogenesis, an emphasis on health and wellness (Downe and McCourt 2008, Downe 2010b, Jackson 2017c) and a propensity for more woman centred, shared, intuitive decision making.

### **7.5.3 The pivotal role of the co-ordinator**

Within this study, several co-ordinators gave accounts of attempting to influence midwife's decision making in not resorting immediately to invasive interventions like epidurals. These co-ordinators reported that they influence midwives' decisions to encourage women to use non-invasive strategies for labour and birth, thereby promoting normality. Some more junior midwives' accounts were that they feel certain co-ordinators can influence either physiological childbirth or technological, interventionist models of labour. Thus the decision making dynamic of junior and senior midwives would appear to work both ways.

In Russell's study (2016), she found that hospital based midwives, tended to obey and conform to the co-ordinators directives, even if this conflicted with evidence based practices, their own decisions or the woman's wishes. Other authors' works echoes Russell's findings (Hollins Martin and Bull 2010, Kirkham 2011).

### **7.5.4 Midwives' and doctors' decision making**

Although there were some reports of conflicts between doctors' and midwives' decision making (mainly at case site 1) it was mostly consultants or senior registrars that were cited as the main sources of differences of opinion in care of women, even in normal labour and birth.

Certain medical judgements and decisions such as classification of CTG tracings and intervening in longer labours that were essentially 'normal',

could have significant ramifications for the subsequent pathway labour takes (either physiological or technocratic). Some midwives at case site 2 reported challenging doctor's decisions successfully, thereby enabling normal labour to continue, but other midwives' perceptions were that they did not feel empowered to do so.

The narrative of doctors being in more powerful, authoritative, patriarchal positions and therefore the more dominant decision makers compared to nurses and midwives has been the subject of midwifery interest for many years (Donnison 1988, Allison 1996, Reiger 2005, McIntosh 2012) and has been discussed in other chapters (in particular see 'The importance of language, terminology and information giving' in chapter 7). In midwifery particularly, where midwives care for low risk childbearing women and ostensibly work autonomously within the arena of normality without recourse to doctors, frictions arise within the two distinct but overlapping professions. Reiger and Lane (2009: 315) state that "In maternity care especially, professional rivalries and deep-seated philosophical differences over childbirth generate significant tensions". The fundamental ideological differences that result in poor relationships between doctors and midwives and the domination of medicalised decision making may be explained, at least in part, by social identity theory (SIT) (Tajfel 1982). This will be discussed in detail in the next section.

### **7.5.41 Social identity theory**

Social identity theory could account for the perceived more powerful social groups' (doctors) decisions overriding those of the less powerful social group (midwives) as discussed further here.

Social identity is defined as "that part of the individuals' self-concept which derives from their knowledge of their membership of a social group (or groups) together with the value and emotional significance of that membership" (Tajfel 1981: 255).

In social identity theory, individuals form groups based on similar, congruent social factors such as status or race, or as is the case here, professional affiliation (Tajfel 1982, Braithwaite 2016). Hogg (2006) asserts that in social identity theory, a discrete group has self-perceived positive attributes superior to those of the out-groups and leads to behaviour intended to maintain a group's status, prestige, and social valence. Group identification and a strong collective sense of belonging influence individuals' self-concepts and manifest as in-group (solidarity) versus out-group (adversarial) assumptions (Tajfel 1982). This group cohesion in colloquial terms mediates an 'us and them' narrative. Thus a tribalist mentality emerges, a group with shared common social characteristics, displaying favour towards those in their own tribe and those outside the group are judged less favourably (Robbins and Krueger 2005). The 'in-group', the tribe, makes decisions to protect their clinical territories. The actual or perceived stronger, more powerful tribe, in this case the medical professionals, are ultimately



successful in securing or maintaining control, this will naturally encompass decision making.

It has to be acknowledged that this competitive tribalism is not just the preserve of obstetricians commanding power over midwives and subsequently of childbearing women, it can be reversed as in Kirkup's (2015) findings in the Morecombe Bay investigation (where midwives were reported to make inappropriate decisions and maintain 'ownership' of women's labours when they deviated away from the realm of normality - see section 2.8). Nonetheless, generally, medical practitioners still maintain overall power control and decision making during childbirth, mainly of obstetric cases but also, in many cases, of the low risk category of women (Pollard 2011, Murray-Davis et al, 2011) as has also been found in this study. The roles of midwives and obstetricians are historically gendered, regardless of the biological gender of individuals (Porter 2007). The obstetrician (masculinised traits) whatever the gender, has higher status than the midwife (feminised traits) and the childbearing woman is at the bottom of the hierarchy (Pollard 2011). Thus, ensuing power differentials, feelings of oppression, rivalries and insecurities can result in inter-professional working relationships being fraught. Midwives and ultimately women's agency and decision making are lost in the midst of the power struggle.

This category has highlighted that within this study, midwives often perceived that doctors, and in particular consultants and senior

obstetricians, had a significant impact on their decision making. This influence was present even when midwives were caring for women in low risk labour, the alleged sole remit of the midwife. A number of midwives, including co-ordinating midwives, reported that they often felt powerless to challenge doctor's decisions.

#### **7.5.5 Excellent intra and inter-professional relationships**

At case site 2, there were numerous reports of excellent intra-professional relationships. Midwives were the lead decision makers in the care and management of low risk childbearing women. Doctors did not appear to be involved in low risk care unless their advice was specifically solicited by the midwives. In moderate to 'high risk' cases midwives and obstetricians were often reported to make collaborative decisions regarding management and doctors respected midwives input. This may be because when childbirth is completely normal, only midwives are required, whereas in more complex childbirth both midwives and doctors are involved. Thus midwives do accumulate experience in care and decisions made for higher risk cases.

In Murray-Davis et al's (2011) qualitative study, of midwives thoughts about inter-professional working and learning, the sharing of informal social space such as coffee rooms, as was reported within this current study, was cited as being facilitative of good inter-professional relationships. Watson et al's, (2015) study found that both midwives and obstetricians felt that socialisation between groups was important to enhance information sharing, a positive working environment and respect for decision making skills.

Case site 2 was considerably smaller unit than case site 1 and this may have added to increased socialisation between HCPs. Murray-Davis et al's, study (2011) also highlighted a 'small is beautiful' concept in relation to the size of the maternity unit. Everyone knows everyone else, which fosters harmony, good relationships and arguably effective decision making.

The relevance of these apparent excellent working relationships appeared to be the collaborative nature of the decision making processes (Murray-Davis et al, 2011, Watson et al, 2015). There is mutual respect between midwives and obstetricians. Having respect, viewing each other as equals and negotiating decision making processes have been cited as the premise of healthy interpersonal relationships (Pollard 2011).

Numerous reports and guidelines have highlighted effective inter-professional relationships, including collaborative decision making as being key in improving safe care for mothers and babies (Health Care Commission (HCC) 2006, Health Care Commission (HCC) 2008, National Patient Safety Agency (NPSA) 2007, National Institute for Health and Clinical Excellence (NICE) 2014a, Centre for Maternal and Child Enquiries (CEMACE) 2011, Thomas and Dixon 2012, Kirkup 2015, Knight et al, 2018).

Where there is poor communication, discord and disrespect this can lead to dysfunctional team working. This not only affects the care of childbearing women and their babies, but can potentially increase morbidity and mortality rates too, and this can be related to poor decision making (CEMACE 2011, Thomas and Dixon 2012, Kirkup 2015, Knight et al, 2018). As midwives and

obstetricians will be all too aware, the devastating effects of dysfunctional team working and making inappropriate decisions concerning care of low risk childbearing women, has been starkly exemplified in the Kirkup report (2015) (see section 2.8).

As previously highlighted, safety is not the only consideration. There is increasing emphasis on the importance of equal and respectful collaborations, including negotiated decision making, within disciplines that are involved in maternity care (Downe 2010b). Where teams have mutual respect, trust and have friendly working relationships, the positive atmosphere is transmitted to women and their families and high quality care is enhanced (Ontario Women's Health Council 2006, cited in Downe 2010b). Such an environment also engenders job satisfaction. In the data collection period spent at case site 2, I would most definitely and unreservedly report that these positive relationships and negotiated decision making were observed by me as the researcher and verbalised by many members of staff of all disciplines.

Whether the excellent relationships between midwives and doctors had a direct impact on the high normal birth rates within the unit can only be speculated.

## **7.6 THE HYBRID MIDWIFE (CENTRAL THEME 5)**

### **7.6.1 Introduction**

The assertion arising from the cross case analysis, contributing to the final 'quintain', was that midwives in both case sites struggled, to a lesser or greater degree, with working within both the biomedical model and the social model of childbirth, depending on who they were caring for and where they were working. Some midwives reported wanting to operate as 'being with' midwives, drawing on intuitive 'go with the flow' types of decision making and some wanted to function as 'doing to' midwives, favouring the guideline based, rational, hypothetico-deductive model of decision making. However these midwives perceptions were that they were expected to be hybrid practitioners, utilising dualistic decision making strategies, in effect straddling two disparate epistemologies.

This theme is considered the overarching theme as each of the other themes influence the 'hybrid midwife' and vice versa. For example, environmental, organisational and cultural issues will inevitably impact on a midwife's belief system preference, if, for example, the labour suite is so busy and short staffed, that women's decisions (water immersion / birth, strategies for labour pain) cannot be facilitated. Woman focussed determinants such as their own feelings values and primal ways of knowing and decision making influence what type of decision making the 'hybrid midwife' will adopt. That of intuitive driven or hypothetico-deductive, guideline based decision making approaches, or combinations of both.

### **7.6.2 Midwives straddling two belief systems**

As reported in the findings chapters, many midwives favoured a more normality centred approach or a more technocratic based approach to care in labour and to associated decision making.

In the literature review, I provided a rationale for the promotion of normality in childbirth. The evidence shows that normal, straightforward childbirth leads to improved health outcomes for mothers and babies physiologically, psychosocially and emotionally (Lydon-Rochelle et al, 2000, Institute for Innovation and Improvement 2006, Lobel and DeLuca 2007, Baston et al, 2008, Dodwell and Newburn 2010, NICE 2011, McCourt et al, 2011). In addition, where continuity of carer, case-holding, normality focussed models of maternity care are available, women chose this model of care more readily, have better health outcomes and evaluate it more highly than traditional maternity care (Mccourt 2010, McLachlan et al, 2012, Darlington 2019).

Thus there is empirical evidence to justify the social model or midwifery model of childbirth which promotes, supports and maintains 'normality' in childbirth, and associated intuitive forms of decision making strategies, where ever possible (Walsh 2011, 2012, Cooper and Way 2016).

The word 'midwife' is widely known to mean 'with woman'. The International Confederation of Midwives' (ICM 2017:1) describes the scope of a midwife and includes:

“.....to conduct births on the midwife’s own responsibility ...care includes.....the promotion of normal birth.....”.

But the landscape is changing, as was explicitly noticeable within these two case sites. Midwives were observed and reported to be dealing with high levels of complexity (see section 6.2.21) as well as reporting increasing intervention in normal labour and birth, arguably leading to risk averse decision making approaches (Walsh et al, 2008, Downe 2010b, Walsh 2017, Jackson 2017b). A number of midwives recognised the impact that making decisions in a ‘what if’, ‘just in case’ manner can have on labouring women, potentially increasing their anxiety levels. The primary role of the midwife, as supporters of normal childbirth, as has been the case throughout history (Donnison 1988), could be compromised in such a risk conscious environment.

There does appear to be some recognition of the difficulties encompassed in social groups working in what Rouse (2002) terms a ‘contested space’. Within the context of this study, the reported contested space is between midwives and obstetricians, the ‘normal’ and the ‘abnormal’, the ‘low risk’ and ‘high risk’ and ‘intuitive’ and ‘hypothetico-deductive’ decision making processes. Martinez (2005) discusses ‘borderlands’ as metaphorically helpful for “understanding the concepts of health and disease (the physiological versus the pathological) as ‘referential codes’ standing in opposition to one another, and yet straddling a zone where clear delineations among them are problematized” (Martinez 2005: 799). Walsh (2010a) also highlights the

polarised views of birth and associated decision making, arguing that women are experiencing birth in the uneasy space between the two.

Blaaka and Schauer (2008) conducted a phenomenological study, using in-depth interviews of seven experienced (qualified over five years) labour suite midwives. Similar to this PhD study, they found that midwives were operating between two belief systems, those being: biomedical (focus on control, risk, monitoring, prediction) and phenomenological (focus on the organic body, holism, equity, mutual participation). The authors concluded that midwives articulated that they used special, wise midwifery judgement and decision making to manage the struggle. They state that: "doing wise midwifery means to find a good balance between closeness and distance and not intervene unnecessarily" (Blaaka and Schauer 2008: 350).

Vincifori and Molinar Min (2014) conducted a survey of 235 Italian midwives, practicing in all areas of midwifery within the Lombardia region. The emerging profile appeared to be the midwife occupying a hybrid space. They discussed that the hybrid midwife experiences the contradiction between what can actually be achieved in hospital based maternity care and the core values of midwifery (normality, holism, intuition), often drifting unintentionally toward interventionist methods. Zhang et al, (2015) in their grounded theory study of 15 midwives, also described a 'hybrid identity' of midwives working in an inner city hospital environment in Southeast China. Midwives described themselves as negotiating competing identities, one as 'obstetric nurses' focussing on risk management (obstetric guidelines,



hypothetico-deductive driven decision making), the other as 'professional midwives', advocating normal birth (midwifery intuition driven decision making). Lane (2002) conducted 22 unstructured interviews with midwives working in all areas of midwifery practice in Victoria, Australia. She also used similar terminology of 'hybrid' midwifery' which also elucidated the struggle between two competing belief systems and decision making strategies.

A number of midwives in this current study did report struggling to work between competing belief systems. However, I also found that a few midwives did appear to work fluidly between all risk cases of women and did not express to me any problems with decision making in these circumstances. That of course does not necessary mean that such tensions do not exist.

Darra and Murphy (2016) propose that dichotomous models of maternity care where midwives work in an entirely medicalised, technocratic or an entirely 'with woman' midwifery fashion is unrealistic in the current maternity care system. The working experience of midwives and the lived experience of birth in the UK is somewhere between the middle of these two extremes of biomedicine (hypothetico-deductive decision making) and holism (intuitive decision making) according to van Teijlingen (2005). However the way that hybrid midwifery decision making is enacted in the real world of UK labour suites and the impact of this on health outcomes, has not been the subject of research to date.

### **7.6.3 Midwives' belief system preferences**

Some midwives in this study did express that they preferred working with 'low risk' women and some midwives reported a preference for working with 'high risk' women.

One midwife, working on the MLC unit at case site 1, said she didn't 'do' epidurals. In the context of the discussion under this section, some would say that this midwife fully embraced the holistic, social paradigm of childbirth (Crabtree 2008, Walsh 2011, Walsh 2012). If, however, women are being denied requested pain relief (and I acknowledge that this is not necessarily the case), it could be argued that this approach is extreme, as this strategy might be seen to enforce normality and deny the woman the opportunity to share in decision making (Karnieli-Miller and Eisikovits 2009, DH 2010, Nieuwenhuijze et al, 2014). Achieving an acceptable balance between the midwife's, woman's and organisations' belief systems of childbirth are seemingly a challenge for midwives.

In the findings chapters, midwives at both case sites reported that the 'being with' and 'doing to' midwives (and related decision making strategies) are known to the co-ordinating midwives and they try and match these midwives according to risk status of labouring women. This could be viewed as a positive strategy matching preferences for low risk versus high risk cases. Alternatively, other co-ordinating midwives reported that the role of midwives is caring for the full spectrum of childbearing women (all risk categories) and therefore there should not be an element of choosing who

they do or do not care for. Co-ordinating midwives also reported that facilitating midwives' preferences was often not possible because of the busy status of the labour suite and not having an adequate skill mix on duty.

It is important to reiterate that some researchers have found midwives working in hospital labour suite settings, serving all categories of women, do often make decisions that inadvertently deliver higher risk intervention strategies to low risk women (Vincifori and Molinar Min 2014, Zhang 2015). Resorting more readily to use of syntocinon to augment labour or to epidurals for pain management assumes more regime, rule-based, hypothetico-deductive models of decision making.

Within this study, some band 7 midwives proffered that the casual use of induction of labour means that midwives are comfortable with interventionist and therefore more rational, hypothetico deductive forms of decision making. As the induction rate around the time of data collection was 25% (ONS 2017), this is arguably a reasonable assertion.

Some midwives who prefer more normality driven models of maternity care do self-select to work in midwife-led units (as was the case in this study), but in hospital based obstetric units, self-selection is normally prohibitive. Whilst the number of midwife-led units are increasing, the dominant model of maternity care in the UK is still obstetric centred, together with the associated hypothetico-deductive decision making model (Walsh 2018).

Similar to my own findings, Cooper (2011), recognises that 'being with' (intuitive driven decision making) midwives are often functioning as 'doing to' (hypothetico-deductive driven decision making) midwives, because of the organisational, cultural, hierarchical maternity systems in place. I would therefore suggest that the 'being with' midwives, within this study were, at times, not able to enact normality driven decisions because of a multitude of constraints.

#### **7.6.31 Intuitive-humanistic and 'inaction' as the prevailing decision making strategies in normal labour and birth**

Within this study, broadly speaking, in caring for women in normal straightforward labour, intuitive-humanistic approaches to decision making were reported to be used, adhering to 'go with the flow', 'watchful waiting' types of model (Thompson 1999, Mok and Stevens 2005, Mead and Sullivan 2005). I would also propose that 'inaction' can be categorized under the intuitive-humanistic realm of decision making (see section 7.3.3 on: 'Midwives' intuitive, experiential and situated ways of knowing and decision making') and was also reported by midwives to be used when everything was progressing physiologically.

However, I would also proffer that midwives have to be cognisant with and be able to utilise other decision making processes, as labour can of course be unpredictable.

### **7.6.32 The cognitive-continuum and dual processing theories when labour deviates from 'normal'**

When childbirth was not completely 'normal' (higher BMI, labour slowed or stopped), I suggest that the cognitive continuum (Hammond 1988, Hamm 1988) of decision making or the dual processing theory (Stanovich and West 2002, Paley et al, 2007) was used. These two models enable the critical thinker to switch seamlessly between two cognitive decision making processes (hypothetic-deductive, rationalistic and intuitive-humanistic).

Davis Floyd (2007) identifies 'post-modern midwives', working fluidly between the two paradigms of biomedicine and holism, which could indicate dual processing or cognitive continuum decision making approaches (using both hypothetico-deductive and intuitive driven decisions). The degree to which these decision making processes are used efficiently in the current UK maternity system is not known.

### **7.6.33 Shared decision making**

The literature on midwifery decision making emphasises the importance of shared decision making with women being fully involved in all clinical decisions (Davis-Floyd 2001, Duncan et al, 2010, O'Connor et al, 2009, Cooke 2005, Karnieli-Miller and Eisikovits 2009, DH 2010, Nieuwenhuijze et al, 2014). Despite this, shared decision making was not reported widely by midwives within this study.

Some midwives reported a commitment to getting the balance right between women's choices and clinically orientated decisions. Provided that the woman is in agreement and happy with the decision, then this is, in essence, shared decision making (Duncan et al, 2010, O'Connor et al, 2009, Cooke 2005). The relative absence of any mention of shared decision making within this study, does not mean that shared decision making does not take place in these case sites. Shared decision making approaches, especially in normal labour and birth is overwhelmingly considered to be good practice and is desired by most childbearing women (Duncan et al, 2010, O'Connor et al, 2009, Cooke 2005, Karnieli-Miller and Eisikovits 2009, DH 2010, Nieuwenhuijze et al, 2014).

#### **7.6.4 Development of the situated, dynamic midwifery decision making framework: Focus on straightforward labour and birth**

There was no initial intention to develop new theory or decision making tool during the execution of this PhD thesis. However, as a natural inductive process, a decision making framework has evolved as a result of this empirical study with input from relevant existing decision making research and literature.

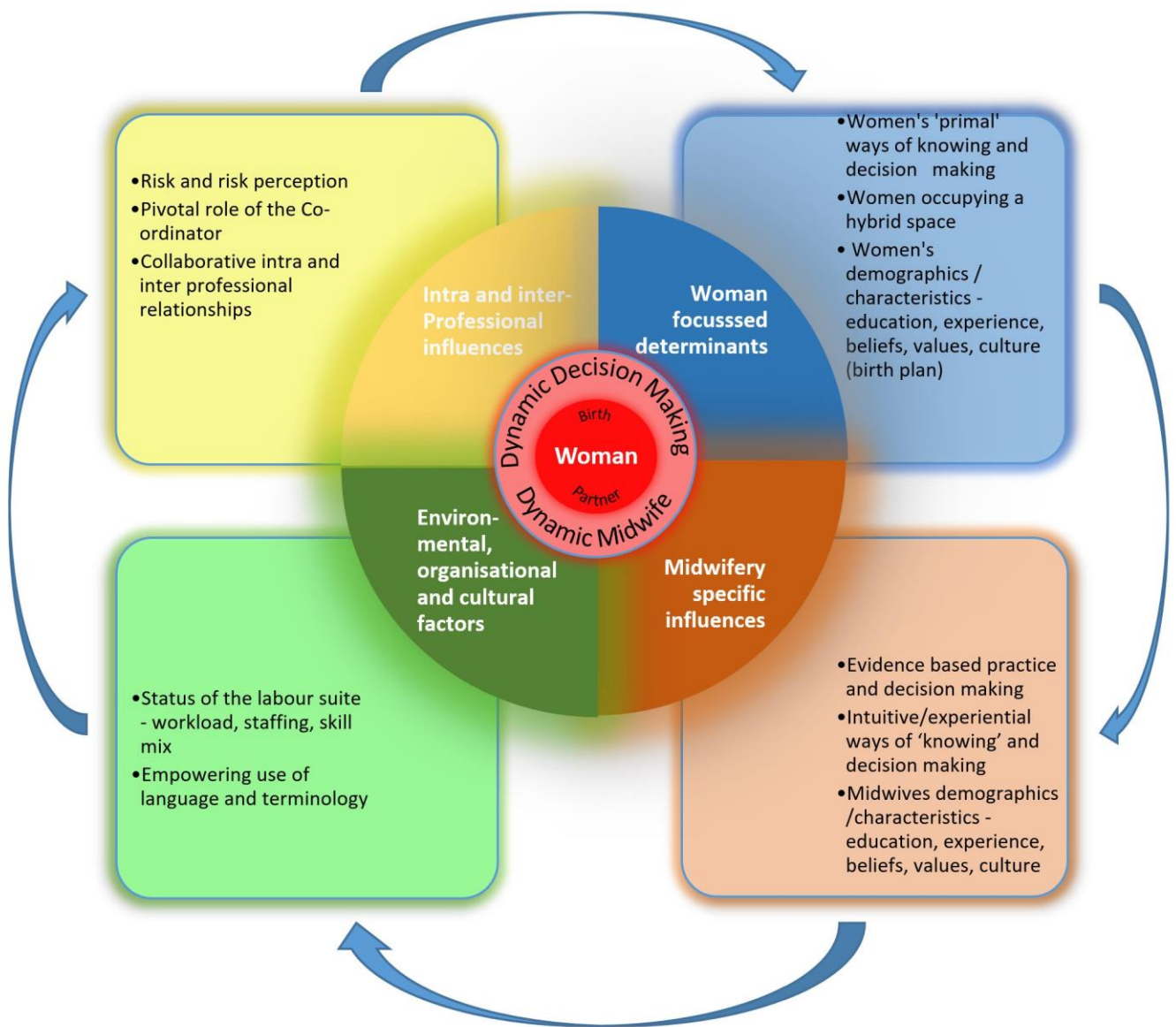
The themes and categories arising from the data demonstrate the multiple influences on midwifery decision making. This is the only model designed for the specific purpose of enhancing knowledge of midwifery decision making during straightforward childbirth, whereas Menage's (2016b) decision making model was designed for midwifery care more generally. Two figures

were needed to demonstrate two different aspects of the complexity of midwives' decision making. The first of the two figures for the situated, dynamic midwifery decision making framework illustrates the influential themes and categories arising from this empirical, situated, context based study. This figure has the woman as being central to the decision making process, with her partner and or birth partner(s) also featuring as being crucial influences on decision making. Regardless of midwives' preferences in relation to the type of risk category they work with, the reality of the role of the midwife in the UK is that most will be working between both low risk and high risk childbearing women.

#### **7.6.5 The Dynamic midwife**

The hybrid midwife, for some at least, is seemingly imbued with negative connotations as this term aligns with the notion of struggling with two belief systems, midwives operating with 'split' personalities (Walsh 2010a, Zhang et al, 2015). Instead I have used the term dynamic midwife. Dynamic is defined as being marked by continuous and productive activity or change (Merriam-Webster 2020). The dynamic midwife is required to make dynamic decisions which can change, depending on all of the other multiple influences (either individually or concurrently), moment by moment. This is illustrated by the blurring of the colours between each of the themes and categories in figure 7.1.

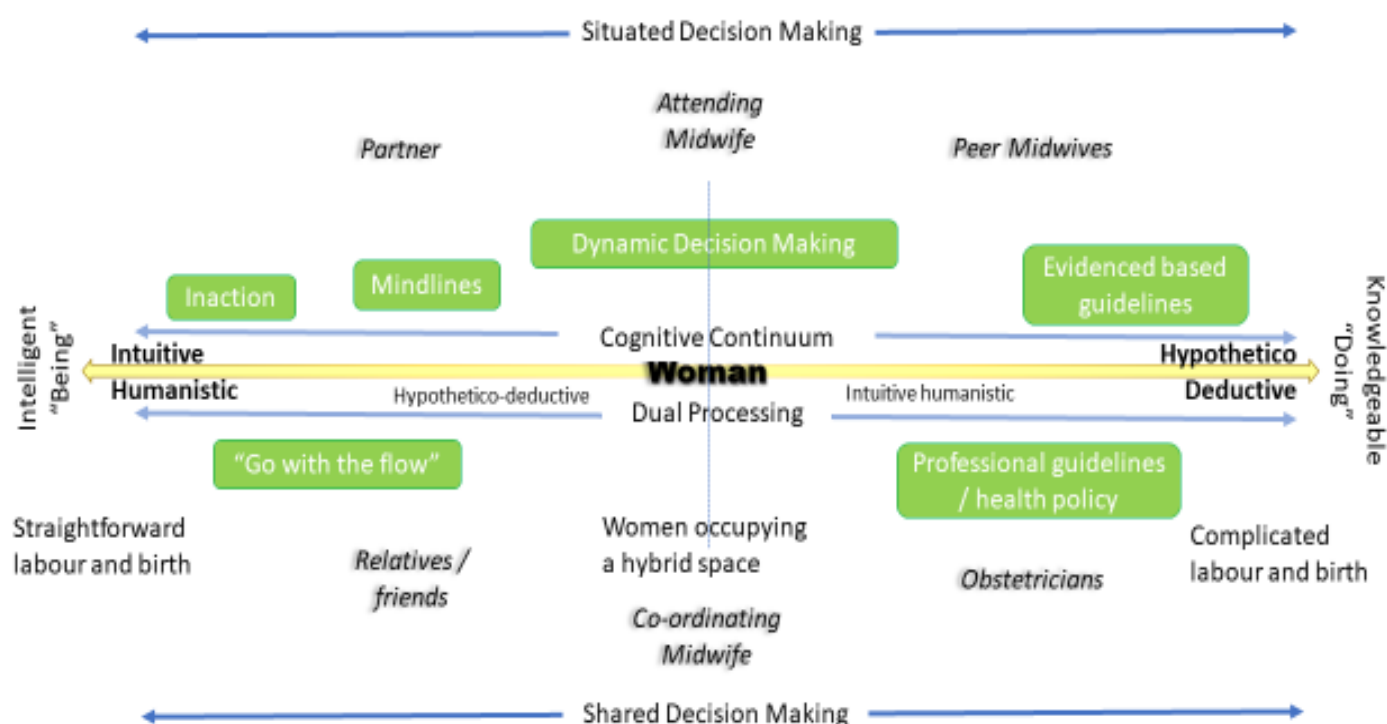
**Figure 7.1 The situated, dynamic midwifery decision making framework: Empirically supported influences on decision making during straightforward labour and birth**





**Figure 7.2 The situated, dynamic midwifery decision making framework.**

**Existing theories and models of decision making: Focus on straightforward labour and birth**



The second figure 7.2 shows a decision making continuum, where all of the traditional and more recent decision making models and theories are placed along a continuum. This ranges from the left where labour and birth is completely straightforward, where midwives will generally, but not exclusively (as illustrated by bold text for the dominant decision making approach, smaller non emboldened text for the less dominant decision making strategy), utilise intuitive decision making processes such as inaction, 'go with the flow' approach or possibly 'mindlines' (Internalised

tacit guidelines). Women who have an unusual but still essentially normal labours, midwives will also broadly draw on intuitive types of decision making. The middle of the figure illustrates dual processing theory and the cognitive continuum of decision making. Where dynamic midwives are working in dualistic belief systems environment and / or caring for 'women occupying a hybrid space' they may be moving between intuitive and hypothetico-deductive decision making approaches. They may even draw on both processes at the same time. Towards the right side of the continuum, mainly related to caring for women who are developing complications or women with more complex needs (complex needs can arise in women commencing normal labour), generally, but not exclusively, (as illustrated by bold text for the dominant decision making approach, smaller non emboldened text for the less dominant decision making strategy) use a hypothetico-deductive model of decision making often drawing on evidence based guidelines.

At the far left of the continuum is 'intelligent being'. This is to highlight that 'being with' midwives who are using intuitive, inactive types of decision making are not just passive onlookers, rather they are using highly developed, sophisticated skills in recognising physiological labour. Enacting such deliberate strategies could be viewed as 'masterly inactivity' (Tew 1990) or 'diligent inaction' Guiver (2009).

The far right of the continuum is 'knowledgeable doing' (Cooper 2011, Borrelli 2015), a recognised term for midwives using evidence to inform their

practice and decision making. This draws on a mainly hypothetico-deductive model of decision making. It is important to note that midwives need to draw on the skills of 'intelligent being' and 'knowledgeable doing' to make optimal decisions regardless of the risk category of women they are caring for. This is because women in normal, straightforward labour can develop complications and women with complications or complex needs can experience straightforward, normal childbirth.

The continuum has 'situated decision making' (Lave and Wenger 2003, Gillespie 2010) at the top showing the embedded contextualised nature of decision making. At the bottom is 'shared decision making' which should be enacted by all midwives, according to health policy (Health and Social Care Act 2012, NHS England 2017, Stacey et al, 2017, NICE 2019). Surrounding the continuum are all the individuals who are involved or who may influence midwives' decision making. The woman is once again central to the whole process.

The two figures (figures 7.1 and 7.2) constituting the situated, dynamic midwifery decision making framework, with a focus on straightforward labour and birth, could be used for educational purposes. The framework could enhance understanding of clinical decision making processes, during normal labour and birth for both qualified midwives and student midwives. The framework demonstrates the multitude of influences on and complexity of midwifery decision making at any one time. A whole spectrum of labour and birth scenario's or vignettes could be used together with the decision

making framework, to prepare midwives and students to utilise optimal decision strategies. These could range from completely physiological, to women whose labours are challenging but still normal, to women occupying a hybrid space (between normal and pathological), through to women developing complications or having complex needs. Users of the framework could explore what factors are most likely to influence their decision making approach in each vignette. The first figure (figure 7.1) can be used to illustrate some possible influences on midwives' decisions. Users could also be asked to add in any local, contextualised influences on decision making that may not feature within this particular framework. Users would then refer to figure 7.2 to discuss which decision making approaches would most likely be utilised in each vignette scenario.

The strengths and limitations of each of the decision making models and theories (presented in figure 7.2) again related to each vignette, could be debated in a theoretical context. The framework would of course need to be evaluated. The situated, dynamic midwifery decision making framework is the only framework dedicated to normal labour and birth and is a unique contribution to the field of midwifery decision making.

#### **7.6.6 Concluding summary of discussion chapter**

The findings and discussion chapters have added to the decision making discourse, by demonstrating that midwives' clinical decision making is a multi-faceted, complex process (Cheyne et al, 2006, Porter et al, 2007, Daemers et al, 2017). Decision making theories such as the hypothetico-

deductive model of decision making (Radwin 1990, Hamers 1994, Mok and Reed 2004, Stevens 2005), intuitive-humanistic theory (Benner and Tanner 1987, Thompson 1999, Mok and Stevens 2005, Siddiqui 2005), 'Inaction' (Albarracín and Shavitt, 2018, Feldman and Kutcher 2018), cognitive continuum model of decision making (Hammond 1988, Hamm 1988), dual processing theory (Stanovich and West 2002, Paley et al, 2007), the shared decision making model (O'Connor et al, 2009, Duncan et al, 2010, Gravel et al, 2006) and 'Mindlines' (Gabbay and Le May 2004) have been discussed.

This chapter has examined some woman focussed determinants in influencing midwives' decision making during normal childbirth as recounted by the midwives themselves. There is evidence that both midwives and childbearing women use intuitive type forces (Davies-Floyd 2001, Parratt and Fahy 2007) to come to 'know' and to base decisions on.

This chapter has also discussed childbearing women who occupy a hybrid space. Similar to hybrid midwives, this 'grey area' is a contested space, however in relation to childbirth, midwives and obstetricians are vying for control and the power to make decisions (Davis-Floyd 2003). The woman is in this ethereal, no-woman's land. Walsh (2010a) asserts that the only way forward is to foster a multi-professional, collective, shared approach to care and decision making in these circumstances.

Under the theme of 'midwifery specific influences', midwives' decision making and evidence based practice has been explored (Hunter 2008, Power 2015, Daemers et al, 2017). Research and evidence appeared to influence

many midwives, mainly in the guise of adhering to evidence based guidelines (Cluett 2005, Munro and Spiby 2010). However, others veered away from EBP and cultural norms. This means there is no relatively standardised approach to care and decision making, even in straightforward labour and birth.

Midwives were generally using intuitive, experiential, situated approaches to decision making during normal labour and birth, as opposed to hypothetico-deductive, guidelines based decision making (Siddiqui 2005, Mead and Sullivan 2005, Mok and Stevens 2005, Reilly 2015). 'Inaction' (Albarracín et al, 2011, Albarracín and Shavitt, 2018, Feldman and Kutcher 2018) as a form of decision making was also examined.

A relatively new form of decision making model called 'Mindlines' (Wieringa and Greenhalghs 2015) was postulated as a possible approach that better reflects the complexity and influences on contemporary midwives. This thesis argues that the use of 'mindlines' is an original contribution to the field of decision making in midwifery and warrants further investigation.

The organisational, environmental and cultural influences theme has examined how extremes of busyness in labour suites, mostly because of the dominance of women with complex needs, does influence midwives' decision making when caring for women in normal, straightforward labour. Choices and decisions that women and midwives make can be compromised at busy times and/or when staffing is short or skill mix is not appropriate. It is now extremely well reported that 'low risk', childbearing women have better

outcomes physiologically, mentally, emotionally and socially in midwife led units or midwife led organisational models (Walsh and Downe 2004, The Birthplace in England Collaborative Group 2011, Hodnett et al, 2012, Sandall et al, 2016). Whilst the busyness of a labour suite is not in itself a hidden or unknown fact of life for midwives, this empirical study has demonstrated actual situations in which women's decisions have been compromised or not supported at all, adding to the discourse in favour of woman centred, not institution centred, maternity care.

The importance of language in maternity care has been explored. The use of medicalised language by midwives was still reported in this study (Hewison 1993, Wickham 2002, Davis-Floyd 2008, Mobbs et al, 2018). Such Language can frame the way information is perceived by labouring women and may affect both midwives' and women's decision making.

It has also highlighted that many years after Kirkham's (1999) work on 'doing good by stealth', the deliberate modification of information still appears to be present. In the context of maternity care, the potential link between midwifery decisions to 'do good by stealth' and patriarchy has not been the focus of any comprehensive research and as such should form the basis of future studies.

The intra and inter-professional influences theme has demonstrated that within this study, the spectre of risk, risk perception (Sandal et al, 2010, Scamell 2016), fear of being criticised by colleagues and fear of litigation

(Symon 2000, Hood et al, 2010), were reported as having an impact on midwives making defensive decisions.

The role of the co-ordinator was highlighted as a critical influence on midwives' decision making. They would either support midwives in decisions that maintain and promote normality or encourage a more technological approach. This is a key original finding and should be subjected to further interrogation.

Similarly doctors (mostly at case site 1), were reported to have an impact on midwives' decision making usually in terms of insisting on more interventionist management. Social identity theory (Tajfel 1982, Braithwaite 2016, Hogg 2006) was discussed as a possible explanation regarding the tensions between doctors' and midwives' decision making, each attempting to protect their tribe. In case site 2, excellent intra and inter-professional relationships were reported which meant that midwives' decision making was perceived to be respected by doctors.

The final theme examined the emergent struggle of the hybrid midwife, consistently having to negotiate two distinct belief systems (Rouse 2002, Martinez 2005, Walsh 2010a). It has given examples of some midwives who seemingly do have a preference for either 'high risk' or 'low risk' midwifery care, but has also demonstrated that midwives' preferences are often not facilitated because of organisational constraints.



The situated, dynamic midwifery decision making framework with a focus on straightforward labour and birth has been proposed as an educational tool to develop effective midwifery decision making.

This thesis centred on decision making during normal labour and birth and previously I described how the decision making framework could be used to highlight effective decision making in various scenarios of straight forward childbirth and when childbirth deviates from being completely 'normal'. A dynamic midwife making dynamic decisions may bridge the gap between 'being with' and 'doing to' styles of midwifery decision making (Walsh 2012, Cooper 2011) and between 'holistic' and 'technocratic' models of decision making (Davis-Floyd 2001).

Shared decision making was not reported widely by midwives within this study, even though it is considered to be essential for ensuring that women's voices, choices and decisions are respected during childbirth, at any particular time, in any context (Duncan et al, 2010, O'Connor et al, 2009, Cooke 2005, Karnieli-Miller and Eisikovits 2009, DH 2010, Nieuwenhuijze et al, 2014).

The concluding chapter will summarise the findings and discussion chapters, discuss the strengths and limitations of the study, highlight the novel contributions made to the area of midwifery decision making. The chapter will make recommendations for practice, education and research.

## **CHAPTER 8 CONCLUSIONS AND RECOMMENDATIONS**

### **8.1 Introduction**

The aim of this thesis was to explore midwifery decision making during normal labour and birth. The research question posed was: What influences midwives' decision making during normal labour and birth?

An interpretivist epistemology was adopted and a case-study approach selected for this research. Data collection was conducted at two labour suites which were the case-sites. Three focus group interviews were conducted at each case site labour suite. Eleven observational visits were made at case site 1 and ten observational visits were made at case site 2. In addition two midwives at case site 1 completed a decision making diary. Documentary evidence was also analysed at both case sites. Midwives reported their decision making influences and approaches to the researcher during the data collection period. Data was analysed using thematic and cross-case analysis.

Some of the findings from this case study research are reflective of existing study findings and midwifery literature. Other findings are original, novel or have had very little coverage from other midwifery researchers such as those summarised next.

Overall, this current study reported that midwives found being a 'hybrid' midwife (and facilitating associated hybrid decision making) challenging. A number of previous studies also found that midwives had a hybrid identity and struggled to operate between dualistic belief systems of normality and

medicalisation (Lane 2002, Vincifori and Molinar Min 2014, Zhang et al, 2015).

Terms such as 'the less we do the more we give' (Leap 2010) and 'masterly inactivity' (Tew 1990) have been proposed as desirable midwifery behaviours to support normal birth, however these have not previously been posited as serious decision making theories or models. Midwives reported using passive decision making strategies which I have termed 'inaction' whilst caring for women during completely physiological childbirth. I suggest that this was not recognised as a decision strategy in midwifery practice. However 'inaction' has been the subject of psychological studies and is acknowledged as a legitimate form of decision making (Albarracín and Shavitt 2018, Feldman and Kutcher 2018). I propose 'inaction' is a potentially powerful, deliberative midwifery decision making strategy, to keep childbirth 'normal'.

Cultural embeddedness of negative language (Phillips 2009, Mobbs 2018), was reported within this study which can compromise both midwives' and women's decision making. Midwives still making decisions to 'do good by stealth' and the possible link this may have with patriarchy (Kirkham 1999), were also reported in the study.

Shared decision making is recognised as essential in contemporary health care (Moffatt et al, 2007, Porter et al, 2007, DH 2010a, Joseph-Williams 2017, Stacey et al, 2017, NICE 2019). Despite this, Joseph-Williams et al, (2017) found that shared decision making was not widely implemented in

health care settings by HCPs. Aligned with Joseph-Williams et al's, (2017) findings, midwives in this current study reported shared decision making infrequently. Women were often perceived to use primal ways of knowing and decision making in straightforward labour, but even when women were in need of guidance during their labours, shared decision making did not feature strongly by the participating midwives. This could be due to midwives adopting paternalistic decision making and/or due to hierarchical, gendered organisation of maternity care, where obstetricians (at case site 1) still, at times, had dominance over decision making, even in normal childbirth (Porter 2007, Pollard 2011, Murray-Davis et al, 2011).

The central original contribution from this study has been the development of the situated, dynamic midwifery decision making framework. The decision making framework consists of two figures. The first based on empirical findings from this study, the second based on a continuum of existing decision making theories, models and influencing factors.

This chapter will discuss the strengths and limitations of the study.

Recommendations for midwifery practice, education and for future research will be offered, followed by final concluding comments.

## **8.2 Strengths and limitations of the study**

### **8.2.1 Strengths**

A complex phenomenon such as decision making, required a holistic, rich account, viewed through multiple lenses (Thomas 2011, Yin 2013). Case study research (Gray et al, 2018) encompassed real time, real world observations, focus group interviews, decision making diary accounts from midwives and documentary reviews on labour suites at two case sites. This research approach illuminated reported influences on midwives' decision making during normal labour and birth, many of which had not previously been the focus of midwifery research or literature, in relation to this topic. As such this case study makes a unique contribution to the arena of midwifery decision making.

There were many original, novel or little explored findings from this study, which have been highlighted in the introductory section of this chapter.

The researcher, as a registered midwife, had relatively easy access to the case sites and blended into the field with ease, as an 'insider' (Asselin 2003, Dwyer and Buckle 2009). I felt that midwives were very comfortable and relaxed in my presence. This was evidenced by quite candid expositions and disclosures, for example, one midwife felt intimidated by a student midwife, midwives also spoke openly about 'doing good by stealth' behaviours (Kirkham 1999).

### **8.2.2 Limitations**

Whilst it would have added a unique and illuminating dimension to the study, childbearing women were not directly included in the research, although they were represented through the eyes of the midwifery participants. My own personal beliefs based on over 30 years practice as a midwife were that the presence of an additional person within a birthing setting, could alter the course of the physiological processes of labour. Though I would have been fascinated to conduct observations of midwives' decision making processes with childbearing women and I acknowledge that this thesis would likely have been more rounded and holistic had I done so, I could not justify this approach due to my own ethical values. This was a very difficult but deliberate decision as I have discussed previously in this thesis (see section 4.20). The original intention was to examine midwives' perceptions of decision making and I maintain that I was able to capture the essence of what influences midwives' decision making during normal labour and birth, through the chosen data collection methods.

Whilst I was fully reflexively aware (Polit and Tanto-Beck 2014) and wholly prepared for taking on the role of researcher, I sometimes allowed the midwife to take centre stage. I needed to consciously force myself back into researcher mode (Dencombe 2007, Grove et al, 2013). I have inserted some of these 'role tensions' in the findings chapters, in line with demonstrating reflexivity.

A case study of this nature can only technically relate to the two case sites under scrutiny. However, I suggest that many of the findings could resonate, be relevant and have theoretical transferability (Lincoln and Guba 1985) to labour suite settings of comparable sizes, serving similar diverse populations across the UK. This is because the model of midwifery organisation and care in large teaching hospitals are generally analogous to those of the case sites within this particular study.

### **8.3 Recommendations for practice, education and research**

Recommendations for practice, education and research are presented in order of wider maternity organisational factors that need immediate review to better serve the needs of childbearing women. More abstract notions such as the impact of 'inaction' and 'matriarchy' on midwives' decision making will then be discussed.

#### **8.3.1 Recommendations for practice**

Stakeholders, governance bodies and management need to urgently review current organisation of maternity care, as the current system is not, at times, supporting childbearing women's decisions. In effect HCPs may be operating under a 'with organisation' rather than a 'with woman' model.

A fundamental role of the midwife is to promote normal, physiological childbirth. This study found a dominance of women with complex needs on the labour suites at the two case sites. Again maternity stakeholders, governance bodies and management needs to increase focus on humanising

and optimising care for all childbearing women. For example access to aromatherapy, mobilisation and water immersion where safe and appropriate.

It is recommended that the importance of shared decision making, is incorporated into practice via inter-professional updates. For example when labouring women are not using their primal ways of knowing and decision making and require guidance from the HCP.

Risk has been described as being all pervasive in health care and in particular within maternity provision. There are a number of adverse effects on women and in relation to midwives' decision making, when operating under the 'spectre of risk'. Practice stakeholders need to review discourses and emphasis on 'risk' including terminology of 'risk management'.

High quality maternity care is strongly linked to respectful, trustful, cohesive and collaborative inter-professional relationships. Practice strategies on improving inter-professional relationships leading to shared or negotiated decision making are imperative. It would also be helpful to know if positive inter-professional relationships improve normal birth rates and outcomes.

### **8.3.2 Recommendations for education**

Shared decision making is considered to be the cornerstone of good healthcare, albeit in conjunction with other decision making strategies.

Shared decision making strategies should be included into midwifery pre-registration and masters level curricula.



The situated, dynamic midwifery decision making framework, which focusses on straightforward labour and birth, could be used in higher education (in ways described in section 7.6.4) to enable student midwives and qualified midwives to have a greater understanding of decision making strategies that support physiological childbirth. Evaluation of the framework can be conducted each time it is used.

Intuition has been found by robust empirical research to be an effective decision making strategy. Analysis and debate on intuitive decision making approaches and its use in midwifery should be included in midwifery curricula.

There were a number of childbearing women in the study who I described as being in the 'grey' area between 'normal' and 'high risk'. There was some contention regarding decision making, in relation to which professional should take responsibility for these women, in terms of, should it be the doctor, the midwife or through negotiation between the two. Educational input on 'childbearing women occupying a hybrid space' is needed.

### **8.3.3 Recommendations for research**

This case study added to the argument concerning the current organisation of maternity care, in that, at times, it is not honouring childbearing women's choices and decisions. Systematic quantitative and qualitative reviews, on contemporary maternity care provision and influence on midwifery decision making would be beneficial.

In normal childbirth, as previously alluded to in this chapter, midwives are, or should be mindful that 'the less we do, the more we give' according to Leap (2010) to achieve a 'being with' midwifery philosophy. The environments included in this study did not lend themselves easily to this philosophy. An imperative to 'do' and a compulsion to act were reported by midwives at both case sites. A novel suggestion is that 'inaction' is a conscious decision making strategy, that supports physiological childbirth and is worthy of exploration through ethnographic research. This is with a view to elevating 'inaction' as a recognised, legitimate midwifery decision making approach, not something that midwives just 'do'.

The situated, dynamic midwifery decision making framework, would benefit by educational evaluation of its efficacy in enhancing understanding of decision making strategies (in ways outlined in section 7.6.4) that may support normal labour and birth.

'Mindlines' is a relatively new model of decision making. In this study I propose that 'mindlines' encompassed the diverse, complex challenges that midwives face on a daily basis, negotiating the maze of which path to take in a range of labour scenarios utilising largely intuitive decision making. Qualitative research into 'mindlines' as a feasible decision making strategy in midwifery is needed.

There is an increasing body of evidence from a diverse range of health professions that intuition, as a phenomenon, is an important and effective decision making strategy. Despite this, limited research exists in relation to

midwifery use of intuition, especially in the context of contemporary labour and birth care. More research is needed in this area which could be facilitated through an in depth phenomenological study.

There is a wealth of coverage concerning the adversarial effects of patriarchy on midwifery and childbirth. Surprisingly, little could be found on the impact of matriarchy (as opposed to patriarchy) on midwives' and women's decision making. The role of matriarchy, and the possible link to 'doing good by stealth', on midwifery decision making is an original proposition and I suggest that matriarchy should be the subject of qualitative empirical midwifery decision making research.

Research is also required in relation to 'Childbearing women occupying a hybrid space' in terms of who should be the lead health care professional in these circumstances or if it would be beneficial to negotiate and share decisions between midwives and obstetricians. Another case study approach would be suitable for exploration of this phenomenon.

## **8.5 Final concluding comments**

This case study research added to the discourse of midwives' decision making being extremely complex, multi-layered, with a multitude of factors influencing midwives' making decisions during normal labour and birth. The research has added to the body of knowledge concerning midwives' decision making processes during normal childbirth by exploring this phenomenon in two maternity units within the East Midlands.

With the aim of maximising care for childbearing women and their babies, factors found relating to midwives' decision making, may have a positive effect on promotion of normality. These factors will be highlighted and disseminated locally and nationally through publications, research conferences and study days.

This thesis has highlighted that a crucial component of normal childbirth, midwives' decision making processes, is relatively absent from midwifery literature (Cioffi and Markham 1997, Lankshear 2005, Mead and Sullivan 2005, Everley 2012, Jefford et al, 2010). Given that normal childbirth has potentially wide-ranging short and long term beneficial health outcomes for mothers and babies when compared to medicalised labour and birth (Lydon-Rochelle et al, 2000, Institute for Innovation and Improvement 2006, Lobel and DeLuca 2007, Dodwell and Newburn 2010, NICE 2011, Green et al, 1998, Green et al, 2003, Baston et al, 2008), this is a serious omission.

This case study is itself original, as no other case study has explored midwifery decision making during normal labour and birth. It has also illuminated some novel, unique or little explored findings in relation to midwives' decision making during normal labour and birth. It has made recommendations for practice, education and research based on these findings.

Midwives' decision making can potentially make a difference to women's experience of normal childbirth and moreover the health outcomes from their childbirth journey. Midwives having an awareness of what influences

their decision making and the potential impact of their decisions on women, may assist in them making more woman centred decisions, and shared decisions where appropriate. It may also make midwives conscious of decision making approaches that are more likely to support the physiological processes of childbirth.

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## Appendix 1: Literature searching, decision making and normal labour and birth

Literature searching, decision making and normal labour and birth								
Term / Concept	Med line	CINAHL	Maternity and infant care (OVID)	BNI (OVID) (2011) RCNi (2019)	ASSIA	PSYC-INFO	Web of science	Emb ase
Decision making <sup>4</sup>	91550	125032	4939	2338 (RCN)	85117	160245	504 240	409 292
+ (Healthcare)	10954	547	345	230	16180	2942	12633	18836
+ (Midwifery)	757	17	503	51	4172	149	457	679
+ (Maternity care)	228	485	215	4	1936	70	572	356
Normal childbirth + Decision making	151 9	5985 1564	830 17	4327 (BNI) 1	110 6	8628 2	492 20	36625 2
Normal birth + Decision making	2249 34	824 19	724 19	4299 1	309 9	8756 1	18246 108	41996 19
Normal labour and	70	1528	87	14	58	4	962	44

<sup>4</sup> Decision making includes terms such as: shared decision making, clinical judgement, professional judgement, diagnostic reasoning and clinical reasoning

<b>birth + Decision making</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>17</b>	<b>1</b>
<b>Natural childbirth + Decision making</b>	<b>2408</b> <b>128</b>	<b>6003</b> <b>0</b>	<b>472</b> <b>7</b>	<b>20</b> <b>3</b>	<b>63</b> <b>1</b>	<b>91</b> <b>3</b>	<b>332</b> <b>6</b>	<b>1903</b> <b>119</b>
<b>Physiological childbirth + Decision making</b>	<b>24</b> <b>1</b>	<b>15</b> <b>0</b>	<b>4</b> <b>0</b>	<b>7453</b> <b>0</b>	<b>17</b> <b>0</b>	<b>8615</b> <b>0</b>	<b>112</b> <b>3</b>	<b>35023</b> <b>0</b>
<b>Vaginal birth + Decision making</b>	<b>3551</b> <b>268</b>	<b>2554</b> <b>111</b>	<b>2545</b> <b>111</b>	<b>138</b> <b>16</b>	<b>203</b> <b>20</b>	<b>8627</b> <b>16</b>	<b>5057</b> <b>120</b>	<b>12432</b> <b>134</b>
<b>Spontaneous birth + Decision making</b>	<b>155</b> <b>2</b>	<b>344</b> <b>0</b>	<b>44</b> <b>0</b>	<b>0</b> <b>0</b>	<b>93</b> <b>2</b>	<b>8616</b> <b>0</b>	<b>6034</b> <b>35</b>	<b>57603</b> <b>4</b>
<b>Normality in childbirth + Decision making</b>	<b>2</b> <b>0</b>	<b>9276</b> <b>0</b>	<b>13</b> <b>0</b>	<b>4683</b> <b>0</b>	<b>12</b> <b>1</b>	<b>8624</b> <b>0</b>	<b>30</b> <b>0</b>	<b>47857</b> <b>0</b>
<b>Normalising childbirth + Decision making</b>	<b>2</b> <b>0</b>	<b>5944</b> <b>0</b>	<b>4</b> <b>0</b>	<b>2966</b> <b>0</b>	<b>5</b> <b>1</b>	<b>0</b> <b>0</b>	<b>19</b> <b>1</b>	<b>14967</b> <b>0</b>



## **Appendix 2 - The cognitive continuum theory**

Cognitive continuum theory: Determinants of utilisation of an intuitive to rational approach to decision making along a continuum which has three dimensions.

### **1. Complexity of task structure**

Number of cues – when presented with lots of information a practitioner will probably utilise an intuitive approach.

Redundancy of cues – the more cues help in the prediction of the presence of other cues then the more likely that intuitive cognition will be used.

The nature of an organising principle – if a simple averaging approach to combining information is known to be more accurate than intuitive thought is likely to be a feature. If it is known that a complicated approach to combining evidence produces more accurate answers then this will induce an analytical approach.

### **2. Ambiguity of the task**

Whether an organising principle exists – if an organising principle exists then the practitioner is more likely to be analytical.

Familiarity of the task – unfamiliarity induces an intuitive approach as the practitioner has not had time to develop more complicated ways of dealing with cue information.

The potential for accuracy – if a particular approach to assessment is known to be accurate (even if only perceived as such) then it is more likely to be used as the basis for analysis. For example, universal assessment scales for pressure sore assessment.

### 3. Nature of the presentation of the task.

Task decomposition – if the task leads to the need to address related sub tasks then analytic modes of thought will be used.

The ways in which information is presented – if visual information is used then intuition is induced. If the information is presented as objective and quantitative then analysis is commonly a feature.

Time available – the shorter the available time the more likely that intuitive approaches will be adopted.

(Hamm 1988).

## **Appendix 3 The situated clinical decision making framework (nursing)**

### **Context**

Is there evidence that clinical decision making is being influenced by

#### **Micro level**

Moral or ethical issues?

The nurse's experience level relative to the patient assignment?

The nurse's personal capacity for communication?

The nurse's confidence?

Patient complexity and acuity?

#### **Meso level**

Unit culture (e.g. nursing care priorities, collaborative practices)?

Nursing workloads and staffing patterns?

Availability of appropriate resources?

Lines of communication within the unit?

Physical layout of the unit?

#### **Macro level**

The profession

Society

Government policies

### **Foundational knowledge**

**Knowing the profession**

**Knowing the self**

**Knowing the case**

**Knowing the patient**

**Knowing the person**

### **Clinical decision making process**

#### **Cues**

Are cues and their associated significance recognised? (e.g. abnormal patient responses, absence of expected responses)

#### **Judgments**

Are a range of judgements considered?

Are cues considered to 'rule out' judgements?

#### **Decision(s)**

If present what does 'inaction' signify? (e.g. waiting and watching, uncertainty).

Are choices to 'try something' made thoughtfully and revised with new information?

#### **Evaluation**

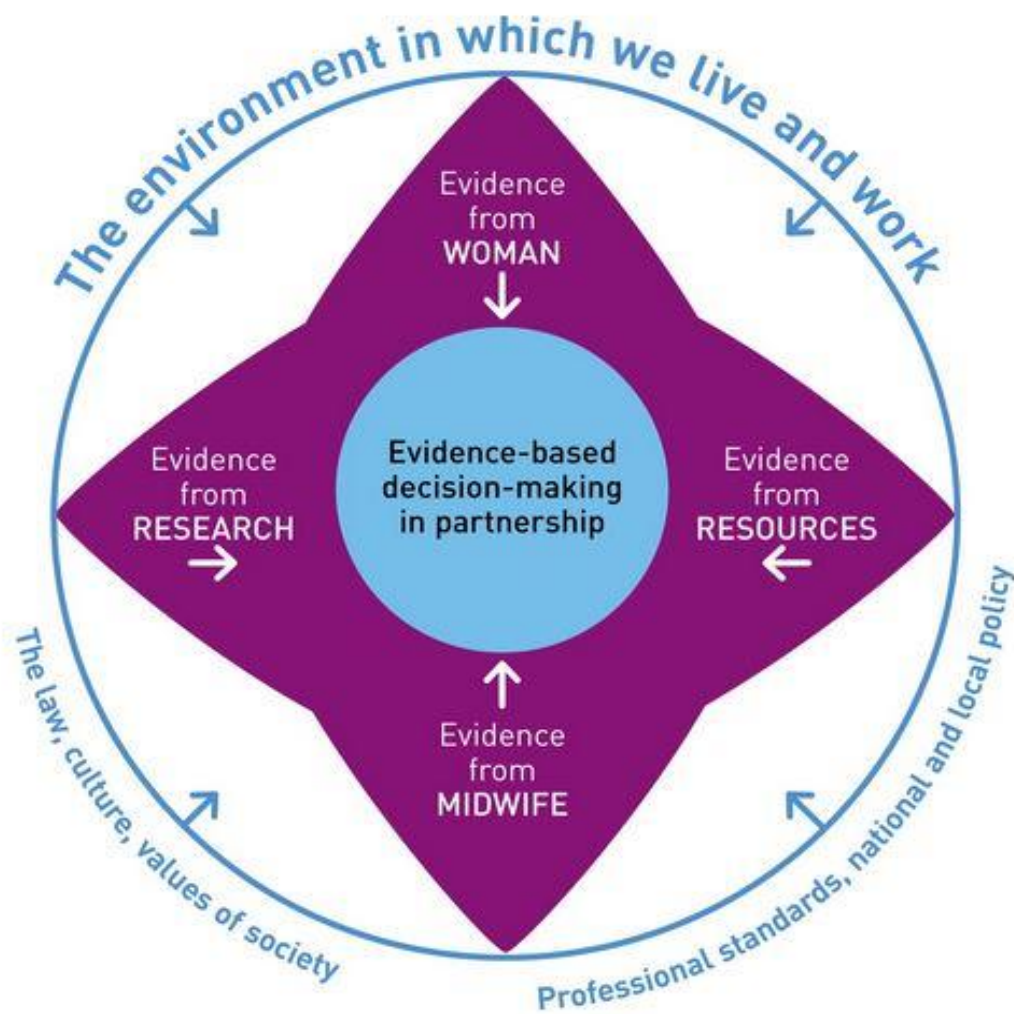
Are the outcomes of actions evaluated consistently?

### **Thinking**

Does the nurse consider the influence of personal assumptions, beliefs and values, and of context?

(Source: Gillespie and Peterson 2009, Gillespie 2010)

**Appendix 4 Model for decision making in midwifery care – (Menage 2016b)**



## Appendix 5 – Information poster: Midwives’ decision making during normal labour and birth



### Poster

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#### Title of Study: Midwives’ decision making in normal labour and birth

##### What is the purpose of the study?

There is an abundance of research demonstrating the benefits of a normal straightforward labour and birth, when compared to technological, interventionist labour and birth. Whilst many studies have explored organisational models of care, environment and philosophies that enhance normality in childbirth, little has been conducted on the impact that midwives decision making may have on normal labour and birth. This study has been designed to explore midwives’ decision making during normal childbirth.

##### How will the study be carried out?

The initial part of the study will involve focus group interviews of between 5-7 participants. These groups will be divided into Band 5 and 6 midwives and band 7 and 8 midwives. Two focus group interviews will take place at [REDACTED]

One or two midwives from the focus group interview will be asked to volunteer to complete a diary, related to their decision making approaches, whilst caring for women during normal labour and birth, for 10 shifts.

The final part of the study will consist of observations being conducted on the labour suite for a maximum of 10 shifts. The researcher will be based at the midwives station. Informal discussions will take place with midwives outside of the labour rooms. Childbearing women will not be included in the study.

##### What if I agree / do not agree to take part in the study

Anyone approached to take part in the study does not have to take part if they do not wish to. Or if you do decide to take part you can withdraw from the study at any time.

For further information please contact: Karen Jackson, Midwife Teacher / PhD student,  
Academic Division of Midwifery, School of Health Sciences,  
[REDACTED] Phone:  
0115 8230979 E-mail: [k.jackson@nottingham.ac.uk](mailto:k.jackson@nottingham.ac.uk)

## Appendix 6 – E-mail / letter to prospective participants



### E-mail / letter to prospective participants

Title of Study: Midwives' decision making during normal labour and birth

Dear Midwife,

My name is Karen Jackson, I am a midwife teacher and am currently conducting a study as part of a PhD on 'Midwives' decision making during normal birth'.

This study has been approved by the local 'Research and Development' department. I have been given permission to contact you directly through e-mail /letter by [REDACTED] Clinical lead for Midwifery NUH NHS Trust / [REDACTED] Head of Midwifery, [REDACTED] NHS Trust.

There is an abundance of research demonstrating the benefits of a normal straightforward labour and birth, when compared to technological, interventionist labour and birth. Whilst many studies have explored organisational models of care, environment and philosophies that enhance normality in childbirth, little has been conducted on the impact that midwives' decision making may have on normal labour and birth. This study has been designed to explore midwives' decision making during normal childbirth.

I would like to conduct 2 focus group interviews: one with band 5 and 6 midwives and one with band 7 and 8. Following these interviews, I will ask one or two midwives to complete 'decision making diaries' for ten shifts. I will also be conducting observations on the labour suite for a maximum of 10 shifts.

Please see the attached participant information sheets which contain more detail regarding the study. If you would be willing to take part, please contact me by responding to this e-mail / letter, or speak to me in person. You may decline to take part if you wish,

Kind regards,

Karen Jackson  
Midwife Teacher

## Appendix 7 – Participant information sheet – observations



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### Participant Information Sheet - Observations

Title of Study: Midwives' decision making during normal labour and birth

**Name of Researcher(s):** Karen Jackson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

#### **What is the purpose of the study?**

There is an abundance of research demonstrating the benefits of a normal straightforward labour and birth, when compared to technological, interventionist labour and birth. Whilst many studies have explored organisational models of care, environment and philosophies that enhance normality in childbirth, little has been conducted on the impact that midwives' decision making may have on normal labour and birth. This study has been designed to explore midwives' decision making during normal childbirth.

#### **Why have I been invited?**

You are being invited to take part because you are a practicing midwife who regularly cares for labouring women on the labour suite.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. Information about this stage of the study is provided in this information sheet, however it will not be possible to obtain written consent from all practitioners who may be observed. If you are on duty when the researcher is carrying out observations, you can inform her verbally if you wish to take part or if you do not wish to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

#### **What will happen to me if I take part?**

This part of the study will involve midwives and other health professionals working on a labour suite during a shift when the researcher is present. The researcher will be based at the midwives' station and will observe decision making activities outside of the labour rooms. Women will not be observed as part of this study. The researcher will have informal interactions and conversations with midwives and possibly other health professionals, regarding decisions made when caring for women during normal labour and birth. However, you may or may not be on duty when these observations occur. You also have the right not to be involved in this part of the research if you wish.

#### **Expenses and payments**

Participants will not be paid to participate in the study.

#### **What are the possible disadvantages and risks of taking part?**

Being observed may feel threatening to the participant.

Participants may feel that their practice is being criticised.  
Participants may feel uncomfortable being observed

### **What are the possible benefits of taking part?**

This aim of this study is not to criticise midwives' practices. The researcher is a midwife teacher but is also a practicing midwife and will endeavour to ensure that midwives and other health professionals do not feel threatened or uncomfortable during the observational stage of this study.

We cannot promise the study will help you but the information we get from this study may help explain how particular decision making approaches may help to enhance normality in childbirth.

### **What happens when the research study stops?**

The information collected will be analysed and used to address the aim of the study which is to explore midwives' decision making during normal labour and birth.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: PALs, Main Reception Area, [REDACTED] NHS Trust, [REDACTED].

### **Will my taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about you will be handled in confidence.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (e-mail address) will be kept for 6-12 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you do or say during the observational stage of the study will remain confidential, should anything arise or if you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

### **What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

### **What will happen to the results of the research study?**

The results of this study are likely to be published in 2016/2017. The PhD thesis will be available from Nottingham University library. The study may also be presented at study days, seminars and research conferences. Research articles or reports may also be published from the study. Participants will not be identified in any publication, article, report or presentation arising from this study.



**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and is being funded by the student/researcher.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee.

**Further information and contact details****Co-investigators:**

Karen Jackson, Midwife Teacher / PhD student,  
Academic Division of Midwifery,  
School of Health Sciences,  
[REDACTED]

Nottingham, NG7 2UH

Phone: 0115 8230979

E-mail: [k.jackson@nottingham.ac.uk](mailto:k.jackson@nottingham.ac.uk)

Studying for PhD in Health Studies

**Chief investigator:**

Denis Walsh, Associate Professor in Midwifery  
Academic Division of Midwifery,  
School of Health Sciences  
[REDACTED]

Nottingham

Phone: 0115 8230987

Email: [denis.walsh@nottingham.ac.uk](mailto:denis.walsh@nottingham.ac.uk)

## Appendix 8 – Focus group interview schedule



Focus group interview schedule  
Final version 1.0 14/01/14

### **Title of Study: Midwives' decision making during normal labour and birth**

The focus group interviews will commence with open ended questions:

How do you make decisions when caring for women during normal labour and birth?

How does midwifery decision-making influence normal labour and birth?

What influences your decision making when caring for a woman during normal labour and birth?

If prompt questions are required, these questions may be asked:

How do you make decisions when a woman is admitted in the latent phase of labour.

How do you approach the topic of pain in labour.

What do you do if a woman's labour slows down or stops.

If a woman becomes distressed during labour how do you approach this situation.

How do you approach the topic of third stage of labour?

## Appendix 9 – Consent form - Focus group interviews



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### CONSENT FORM – Focus group interviews Final version 1.0 14/01/14

Title of Study: Midwives' decision making during normal labour and birth  
REC ref: (to be added after approval given)

Name of Researcher: Karen Jackson

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number .....dated..... for the above study and have had the opportunity to ask questions. ☐
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 employment or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the focus group interview will be recorded and that anonymous direct quotes from the focus group may be used in the study reports. ☐
5. I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

2 copies: 1 for participant, 1 for the project notes

## Appendix 10 – Instructions on completing decision making diaries



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### Instructions on completing 'Decision making' diaries.

Final version 1.0 14/01/14

#### Title of Study: Midwives' decision making during normal labour and birth

Please make entries into your diary for 10 shifts (or equivalent) when you cared for women during normal labour and birth.

Please make entries as soon as possible after the events have taken place to enhance accuracy of recall.

Ensure that all names are changed in line with the NMC (2012) to protect women's confidentiality.

Do not record any personal details or information about childbearing women that may identify them.

Ensure that you only record decision making episodes that have taken place when caring for women during normal labour and birth.

Make entries into the diary on the dates that you cared for women in normal labour and birth.

If a woman's labour and birth that has previously been 'normal' but then deviates from normal, these cases can be included. However do not make detailed notes of decisions made after the case has become 'obstetric led'.

Include details on; what the circumstances were, what decisions were made and what influenced those decisions. Examples might be: how you approach and make decisions regarding pain in labour, how you approach and make decisions regarding transition, how you make decisions about perineal care (e.g. when to do an episiotomy).

Record any interactions with women, co-ordinating midwives, other midwives or medical staff related to decision making.

Your entries into the diary may be as detailed or as concise that you feel necessary.

If you wish to reflect on these cases within your diary, please feel free to do so.

For further information please contact:

Karen Jackson, Midwife Teacher / PhD student, Academic Division of  
Midwifery, School of Health Sciences, 'B' Floor East Block, QMC, Nottingham,  
NG7 2UH

Phone: 0115 8230979 E-mail: [k.jackson@nottingham.ac.uk](mailto:k.jackson@nottingham.ac.uk)

## Appendix 11 - The positive aspects and drawbacks of using member checking

<b>The positive aspects and drawbacks of using member checking</b>	
<b>The Positive Aspects of Member-checking</b>	<b>The Drawbacks and Problems with Member-checking</b>
<p>Provides an opportunity to understand and assess what the participant intended to do through his or her actions</p> <p>Gives participants opportunity to correct errors and challenge what are perceived as wrong interpretations</p> <p>Provides the opportunity to volunteer additional information which may be stimulated by the playing back process</p> <p>Gets the respondent on the record with his or her reports</p> <p>Provides an opportunity to summarize preliminary findings</p> <p>Provides respondents with the opportunity to assess adequacy of data and preliminary results as well as to confirm particular aspects of the data.</p>	<p>Whether participants can certify the truth of a text depends on what text they are shown.</p> <p>Participants may not necessarily be in a position even to verify data-near texts, such as transcripts or descriptive fieldnotes, derived from their own lives.</p> <p>Participants may have forgotten what they once said or did, regret having said or done it, and therefore see the member checking process as a way to erase the past.</p> <p>Seeing transcripts of what they said in the past may engender discomfort in participants. Yet, participants may also validate researchers' interpretations out of a desire not to offend researchers or be completely uninterested in such an exercise.</p> <p>Moreover, narrative accounts are themselves inherently revisionist as</p>

	<p>every telling of an experience leads to a retelling of it.</p> <p>Participants' accounts of an event offered at different times, and even within the same interview session, may be inconsistent as they are constantly being revised in the very act of telling.</p>
Source: Lincoln and Guba (1985:314)	Sandelowski (2008:502)

## **Appendix 12 – The generic analytic cycle**

The generic analytic cycle (Source: Bendassolli 2013: 8-9)

1. The process of analyzing qualitative data begins with researchers establishing initial contact with the material in their set by means of a general reading, followed by careful reading (and thick description; Geertz, 1979) of each piece of information—an interview, an image, excerpts from documents. In this process, researchers can (and in some cases must) take notes, in the form of memos (Strauss & Corbin, 1998), to record their impressions and insights, which can help them in later stages of the analysis. Some researchers refer to these records as "audit trails" (Lincoln & Guba, 1985).
2. As a result of the previous procedure, it is expected that certain themes and patterns will start to emerge from the data; that is, that they will inductively reveal themselves to the researchers in the data's interaction with the empirical tools as given above. Another alternative in attempting to discover themes would be to analyze data according to an existing framework, that is, deductively. Thus, when creating codebooks for qualitative analyses, in content analysis for example, researchers can be both inductive (allowing themes, patterns, and categories to emerge from the data) and deductive (relying on previous analytical categories, obtained from a theory of reference or even an interview guide), or both at the same

time (especially in mixed research designs; Cresswell, 2009). The coding procedure develops (see appendix 13) as researchers identify themes and patterns in their data.

3. The coding procedure is complemented by categorization and conceptualization. At this point, the purpose of analysis is to reduce the material even further, at the same time raising its level of abstraction. Classifying or clustering themes or codes into categories allows researchers to organize them and develop conceptualizations about them—that is, explain them. To achieve this, researchers can contextualize their findings (thick description), encompassing a wider picture in which they make sense; compare them to theories and other findings discussed in the relevant and extant literature; compare subgroups, observing whether explanations differ depending on the individuals involved; link and relate categories among themselves (in general, following the criterion of grouping them according to similar characteristics); and use typologies, conceptual models and data matrices. Researchers can also try to explain outliers, that is, units of empirical material that do not fit into the theory under construction.



## Appendix 13 - Example of initial coding, identifying preliminary themes and patterns – captured on Nvivo

The screenshot shows the Nvivo software interface with the 'Nodes' list displayed. The interface includes a menu bar (File, Home, Create, External Data, Analyze, Query, Explore, Layout, View), a toolbar with icons for workspace, item, clipboard, format, paragraph, styles, editing, and proofing, and a left sidebar with navigation options (Nodes, Relationships, Node Matrices, Sources, Nodes, Classifications, Collections, Queries, Reports, Models, Folders). The main area displays a table of nodes with columns for Name, Sources, References, Created On, Created By, Modified On, and Modified By.

Name	Sources	References	Created On	Created By	Modified On	Modified By
Barriers to normality	1	1	17/07/2015 17:14	KJ	17/07/2015 18:35	KJ
Funding	1	1	17/07/2015 17:15	KJ	17/07/2015 18:35	KJ
Birth environment	2	2	17/07/2015 16:05	KJ	24/07/2015 12:07	KJ
Birth partners	3	4	19/08/2015 12:24	KJ	20/08/2015 12:06	KJ
Birth plans	2	2	05/06/2015 14:55	KJ	01/10/2015 16:37	KJ
Attitudes of midwives to birth plans	1	1	05/06/2015 14:55	KJ	05/06/2015 14:56	KJ
'Busyness' of the labour suite	2	5	11/08/2014 21:10	KJ	19/08/2015 17:07	KJ
Coding - Skewing statistics	1	1	24/07/2015 10:43	KJ	24/07/2015 10:43	KJ
Complexity	2	3	11/08/2014 21:06	KJ	19/08/2015 12:10	KJ
Handover full of complex cases	0	0	21/08/2014 05:34	KJ	21/08/2014 17:45	KJ
Lack of 'normal cases'	7	9	17/07/2015 16:54	KJ	19/08/2015 13:59	KJ
Consultant obstetricians	3	3	11/08/2014 21:13	KJ	21/11/2015 18:15	KJ
Continuity of care - carer	1	1	05/06/2015 16:43	KJ	05/06/2015 16:43	KJ
Debriefing to prepare women for next pregnancy	1	1	17/07/2015 17:00	KJ	17/07/2015 17:00	KJ
Defensive practice	1	1	09/06/2015 13:32	KJ	09/06/2015 13:32	KJ
Demographics of women	3	4	17/07/2015 17:01	KJ	19/08/2015 14:12	KJ
Dissonance between women's and midwives perceptions	1	1	10/11/2015 12:14	KJ	10/11/2015 12:23	KJ
Enforced normality	2	3	09/06/2015 14:00	KJ	30/10/2015 14:14	KJ
Evidence based care	1	2	05/06/2015 14:51	KJ	05/06/2015 14:58	KJ
How do midwives make decisions	1	1	19/08/2015 16:24	KJ	19/08/2015 16:24	KJ
Birth plans	3	5	01/10/2015 16:38	KJ	21/11/2015 17:05	KJ
Clinical judgement	4	10	19/08/2015 16:29	KJ	20/11/2015 17:12	KJ
Consultant influence	2	5	06/11/2015 14:08	KJ	01/12/2015 14:04	KJ

## Appendix 14 – Thank you poster



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### Thank You

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#### **Title of Study: Midwives' decision making in normal labour and birth**

I have now completed my data collection from the labour suite and [REDACTED]

[REDACTED] I am currently  
Transcribing focus group interviews and analysing the data I have collected  
so far.

I just wanted to express my sincere gratitude and thanks for all the  
Midwives that participated in the study. All those involved in the  
observational part of the research, and a special thanks to those who  
attended the focus group interviews and who agreed to keep decision  
making diaries. I have been truly impressed and inspired by the sheer hard  
work and commitment that midwives have shown in keeping birth as normal  
as possible. Even in the face of the most difficult of circumstances. I believe  
that intervention rates would be much higher in this unit if it wasn't  
for your passion and dedication. I am genuinely proud to be a midwife.

If anyone would like any further information on the study please contact:  
Karen Jackson, Midwife Teacher / PhD student, Division of Midwifery, School of  
Health Sciences, [REDACTED]  
[REDACTED]

## Appendix 15 – Ethical approval letter

Direct line/e-mail  
+44 (0) 115 8232561  
Louise.Sabir@nottingham.ac.uk

1st March 2014

Ms Karen Jackson  
Academic Division of Midwifery  
School of Health Sciences  
[REDACTED]  
Nottingham University Hospitals  
NG7 2UH

Dear Karen

**Ethics Reference No:** S13022014 13134 SoHS Midwife  
**Study Title:** Midwives' decision making during normal labour and birth.  
**Chief Investigator/Academic Supervisor:** Dr Denis Walsh, Dr Alison Edgley,  
Associate Professors in Midwifery, School of Health Sciences.  
**Lead Investigators/Student:** Karen Jackson, PhD Student in Midwifery, School of  
Health Sciences.  
**Duration of Study:** 3/3/2014-04/5/2014 6-12mths **No of Subjects:** 38

Thank you for your recent application which was considered by the Committee at its meeting on 13<sup>th</sup> February 2014 and the following documents were received:

1. Full Set of Project data v1.5 Form IRAS Version 3.5, dated 28/2/2014
2. Midwives' decision making during normal labour and birth-Protocol final version 1.0 date 14.01.14
3. Midwives' decision making during normal labour and birth-Poster Final version 1.0 14/01/14.
4. Midwives' decision making during normal labour and birth-Participant Information Sheet – Observations Final Version 1.0 14/01/14.
5. Midwives' decision making during normal labour and birth-Participant Information Sheet – Focus groups and diaries final version 1.0 14/01/14.
6. Midwives' decision making during normal labour and birth-Instructions on completing 'Decision making' diaries final version 1.0 14/01/14.
7. Midwives' decision making during normal labour and birth-Focus Group Interview Schedule final version 1.0 14/01/14
8. Midwives' decision making during normal labour and birth-e-mail/letter to prospective participants final version 1.0 14/01/14
9. Midwives' decision making during normal labour and birth-Consent form –Focus group interviews final version 1.0 14/01/14
10. Letter of permission dated 3<sup>rd</sup> November 2013 from [REDACTED] Acting Head of Midwifery, [REDACTED] Hospitals NHS Trust.
11. Letter of permission dated 31<sup>st</sup> January 2014 from [REDACTED] Acting Divisional Matron-[REDACTED] Hospital Trust.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).



The University of  
Nottingham

Faculty of Medicine and  
Health Sciences

Research Ethics Committee  
Division of Respiratory Medicine  
D Floor, South Block  
Queen's Medical Centre  
Nottingham University Hospitals  
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NG7 2UH



2. You must notify the Chair of any serious or unexpected event.
3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

**Dr Caroline Chapman**  
**Acting Chair, Faculty of Medicine & Health Sciences Research Ethics**  
**Committee**