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Place of Birth and Concepts of Wellbeing

An Analysis from Two Ethnographic Studies of Midwifery Units in England

Christine McCourt, Juliet Rayment, Susanna Rance and Jane Sandall

Abstract

This article is based on analysis of a series of ethnographic case studies of midwifery Units in England. Midwifery units¹ are spaces that were developed to provide more home-like and less medically oriented care for birth that would support physiological processes of labour, women's comfort and a positive experience of birth for women and their families. They are run by midwives, either on a hospital site alongside an obstetric unit (Alongside Midwifery Unit – AMU) or a freestanding unit away from an obstetric unit (Freestanding Midwifery Unit – FMU). Midwifery units have been designed and intended specifically as locations of wellbeing and although the meaning of the term is used very loosely in public discourse, this claim is supported by a large epidemiological study, which found that they provide safe care for babies while reducing use of medical interventions and with better health outcomes for the women. Our research indicated that midwifery units function as a protected space, one which uses domestic features as metaphors of home in order to promote a sense of wellbeing and to re-normalise concepts of birth, which had become inhabited by medical models and a preoccupation with risk. However, we argue that this protected space has a function for midwives as well as for birthing women. Midwifery units are intended to support midwives' wellbeing following decades of professional struggles to maintain autonomy, midwife-led care² and a professional identity founded on supporting normal, healthy birth. This development, which is focused on place of birth rather than other aspects of maternity care such as continuity, shows potential for restoring wellbeing on individual, professional and

community levels, through improving rates of normal physiological birth and improving experiences of providing and receiving care. Nevertheless, this very focus also poses challenges for health service providers attempting to provide a ‘social model of care’ within an institutional context.

Keywords: birth centre, birthplace, childbirth, England, maternity care, midwife-led care, midwifery units, organisational ethnography, place, wellbeing

Introduction and Background

In 2007, a key Department of Health document proposed that all pregnant women in England should be offered the choice of having their babies in a range of settings (Department of Health 2007). Since the ‘Changing Childbirth’ report in 1993, greater choice, continuity and control for women had been recommended, but the issue of choice of place of birth had not been specifically addressed (Department of Health 1993). The 2007 policy implied a radical change from an earlier history of promotion of universal hospital birth in Britain, as in many other countries with well-resourced health systems. The shift to hospital birth, which has been well-documented historically (Borsay and Hunter 2012), was predicated on assumptions that birth in a hospital setting would confer greater safety for mothers and babies (Department of Health, 1970). It was also aligned with a strong focus on equity of access to health care in post-war Britain that cast access to hospital beds and to medical care as a moral right. Successive critics have argued that this moral right was transformed over time into a moral duty, as hospital birth became normalised (Viisainen 2000).

Under the NHS, England retained quite a diverse system of care provision, with midwives being the primary providers of care, working in collaboration with general practitioners (family doctors) and with obstetricians. Although the number of maternity

hospital beds increased steadily in the twentieth century, and accelerated after 1970, maternity homes run by midwives and general practitioners continued to provide labour and birth care for many women (Leap and Hunter 2013). These units continued for a longer period in rural areas where access to a hospital obstetric unit was geographically difficult. Previously called Maternity Homes, they were commonly known as ‘isolated GP units’ (Macfarlane and Mugford 2000 and under recent policies were reconstituted as freestanding midwifery units.

As care became more medicalised, a movement critical of certain aspects of hospital-based maternity care in hospitals developed, characterised by the development of organisations such as the ‘Natural Child Birth Trust’ (now called the NCT) and the Association for Improvements in the Maternity Services (AIMS). Parallel movements developed in other countries, such as Lamaze in the U.S. and ReHuNa in Brazil. Campaigns by women, their partners and families and midwives to restore a more social and health-oriented model of birth led to a House of Commons enquiry into maternity services (House of Commons Select Committee 1992) and the subsequent Changing Childbirth report (DoH 1993). These campaigns coincided with wider movements that impacted on health policy, initially the development of feminism and patients’ rights movements (McCourt 1998) and subsequently consumerism (Ritzer 2008). Arguably, all three factors contributed to the new climate of choice in maternity care but in a technocratic society it is not surprising that safety in childbirth would be associated in many people’s worldviews with hospital care (Davis-Floyd 2004). The analysis of epidemiological evidence on which the 1970s policy of universal hospital birth had been based was subject to detailed critiques (Macfarlane and Mugford 2000). However, the evidence base to underpin a policy of choice was limited and a large-scale programme of research was commissioned to provide more robust evidence on quality and safety of birth in different settings. The Birthplace in England Programme cohort

study found significant reductions in obstetric interventions, but no significant differences in neonatal outcomes between births planned in hospital obstetric units and those planned in midwifery units. In addition, *freestanding* midwifery units were found to have safety benefits for mothers in terms of lower rates of some serious complications (Birthplace in England Collaborative Group 2011).³

These clinical findings challenged the commonly accepted view that quality of experience in childbirth was distinct from, rather than related to safety. They also challenged the view that hospitals, with provision of potentially life-saving high-technology equipment and a concentration of professional expertise, would automatically provide greater clinical safety; additionally, that a midwifery unit provided on hospital premises would by its proximity to an obstetric unit provide safer care than the more geographically isolated, small midwifery units, many of which had continued with a marginal status in rural areas since their development in the twentieth century. At the time of the Birthplace in England research programme, around 2 per cent of births in England took place at home, 2 per cent in freestanding midwifery units (FMUs) and 3 per cent in alongside midwifery units (AMUs) (Redshaw et al. 2011).

AMUs were a relatively novel form of care, developed with the intention of providing a homely and comfortable birth environment that supported physiological processes of labour and birth. They were modelled on the older FMUs but promoted as a compromise between the assumed therapeutic benefits of this distinct setting and the assumed greater clinical safety of a hospital environment. By 2015, the number of AMUs in England had increased considerably, while the number of FMUs had remained around the same,⁴ despite the recent evidence of their safety and benefits (Birthchoice 2013, 2015).

This article draws on one component of the Birthplace programme: a set of ethnographic case studies of four well-performing maternity services in England (McCourt et

al. 2011), and a follow-up organisational ethnography that focused on a further four services providing Alongside Midwifery Units (McCourt et al. 2014). Midwifery units were specifically designed to support physiological labour and also a more social, rather than medical, model of birth. We discuss how both these features were considered by midwives and by women and families using midwifery units to underpin their own wellbeing, in terms of specific clinical outcomes and the social and emotional aspects of giving and receiving care. We also examine some of the challenges to this sense of wellbeing that were experienced within a system of care that continues to be medical in orientation and profoundly influenced by systems of risk management and an assumption that medical care confers safety.

The Literature on Place and Therapeutic Spaces

Midwifery scholars and social scientists have addressed issues of space and place in birth in relation to wellbeing. Some work in this area has focused on midwives rather than women (Hunter 2002, Rayment 2011) and explored the effects on midwives of working in different settings (Hunter and Deery 2009; Hunter 2003; Ledward 1996; Sandall 1996). Shaw and Kitzinger (2005) and Davis-Floyd and Davis (1996) are among a number of writers who have suggested that women feel more in control of their birth at home or in home-like settings such as free-standing birth centres. One reason given for this feeling of control is that the woman has the higher status of ‘resident’ at home and the midwife is constructed as a ‘visitor’, whereas in hospital these roles are reversed (Halford and Leonard 2003). This writing also echoed the critical literature on residential care, where those in need of care attempt to live ‘private lives in public places’ (Willcocks et al. 1986). However, while Gilmour (2006) claimed that making hospital spaces more home-like challenges the dominance of biomedical values, Fannin (2003) argued that it is presumptive to assume that

making a hospital space more like a home will in itself fend off the controlling influence of biomedicine. Our analysis illuminates the tension between these two positions, suggesting that transforming spaces *can* achieve substantial change, but that changes may also be constrained by the challenges of working within an institutional environment that still treats the medical model of care as the norm.

Other authors have been critical of the discourse that ‘home equals control’, as this seems to assume that women have agency in their own homes, which is not always the case: ‘home does not signify autonomy and bodily control for all women, nor is domestic space always the safest place for women’ (Mitchie 1998). However, midwifery units do not rely on assumptions about women having homes where they would want to give birth so much as supporting a more general view that a ‘home-like’ space may be therapeutic in supporting normal physiological birth and both physical and emotional comfort (see for example Walsh 2006). It has also been suggested that midwifery units support a more social model of birth, which recognises birth as a major life transition for women and families (Kirkham 2003).

Beyond maternity care, the development of new hospitals in the U.K. in the 1990s prompted consideration of the need to design hospital environments that promote the healing and wellbeing of patients through considering staff and patient wellbeing alongside clinical efficiency (Gesler et al. 2004). Aside from the architecture of the hospital building itself, the introduction of visual art into hospitals (Lankston et al. 2010) is one example of the way in which designers have attempted to mould hospitals into more therapeutic landscapes. These interior designs have particularly focused on integrating ‘nature’ (Conradson 2005) and ‘home’ (Gilmour 2006) into the institutional space because they are two arenas strongly imbued in the public imagination with the qualities of a ‘therapeutic landscape’ (Gesler 1992).

Contemporary interest in the design of hospitals has applied the principle that a

therapeutic landscape is not only one that is outside but one that may also be brought into an institution, and that ‘the hospital, rather than being a place of scientific inquiry removed from everyday life, can be conceptualised as the home place for its inhabitants’ (Gilmour 2006). Arguably, the ‘hybrid space’ of the alongside midwifery unit is a manifestation of a wider cultural conception of childbirth as both a normal life event (Foureur et al. 2010) and inherently risky and in need of medical assistance (Hausman 2005; Mackenzie Bryars and van Teijlingen 2010).

Douglas argued that social forms are inscribed on the body: ‘Every culture naturalises a certain view of the human body to make it carry social meanings’ (Douglas 1996: Preface). In Douglas’s theory, social institutions cultivate certain styles of thought, often via ritual practices, which shape meaning and risk perception (Douglas 1992). This is reflected in risk management approaches in health: what we fear and how much is driven by social organisation (Lane 1995). This provides a theoretical lens for thinking about why birth in midwifery units may be perceived as both risky and therapeutic, and for exploring the contradictions this poses in practice. In a similar vein, discussing the politics of place, Dirlik suggested that ‘places are not given, but produced by human activity’ (1999: 181). Our study presents a case in which place-making is actively used in order to put a certain philosophy of birth into everyday practice and to achieve certain therapeutic goals. Parallels might be drawn with the assertion of localism as opposed to globalism through concepts or projects of place as discussed by Dirlik (1999) and Escobar (2001). In the case we shall describe, the work to develop desired social relationships and philosophy as well as healthy physical outcomes in relation to childbirth is not only expressed and symbolised but also physically enacted through the development and design of midwifery units and their everyday practices.

Methods

The analysis in this article is mainly based on an organisational ethnographic study of alongside midwifery units that aimed to explore professionals' experiences of working in or alongside these units, and women's and their birth partners' experiences of planning and giving birth in them (McCourt et al. 2014). We also draw on the findings of our earlier ethnographic case studies of how services seek to provide good quality and safe care across different birth settings, conducted as part of the Birthplace in England Programme (McCourt et al. 2011). Both studies used an ethnographic design which was modified to take account of time and resources available for data collection, and the more limited scope for participant observation by a team of researchers who were not health professionals (Long et al. 2008).

The Birthplace ethnographic case studies took place in four 'best-' or 'better-performing' NHS Trusts (as identified by the Health Care Commission Review of Maternity Services in England in 2007) in different health regions in urban and rural locations, with varying socio-demographic populations and configurations of services. Interviews were conducted with service providers, managers and other key stakeholders including user-group representatives (86 in total), service users and their birth partners (72 in total). Other methods included documentary analysis (approximately 200 documents such as guidelines and protocols and service redesign briefs) and observation of key 'nodes' in the service (50 transcripts). We used the term nodes to denote key points where we could observe relations, communication and practices, to get a sense of how decisions were made and what kind of issues influenced structures and practices and experiences of giving or receiving care.

In the follow-up study focusing on alongside midwifery units we replicated the design and methods. Although in this study we focused on a particular type of space within the service, our aim was still to understand the 'case' as being the whole local maternity service, which in itself formed part of a wider local and then national health system.

Data from both studies were analysed thematically, starting with open coding of transcripts, gradually merging these to form a smaller number of general themes. Coding was undertaken independently by different members of the research team using NVivo10 software to support the process, and then compared and discussed to identify our key themes.

Study Findings

Here we discuss the themes from the studies relating particularly to how a sense of place was related by participants to a sense of wellbeing. Findings included use of the metaphor of ‘home’ to represent a social philosophy of birth. However, creating a protected space to support a physiological and social model of birth also presented challenges around professional territories and the management of boundaries. Our analysis indicated that midwifery units aligned three types of boundaries: philosophical, physical and professional, with each type of boundary referencing and overlaying the other. Other themes arising from the work will be discussed elsewhere.

Philosophy of Birth: A Biopsychosocial Model

Alongside midwifery units had been developed for various reasons, often opportunistically as part of service reconfigurations driven by external factors. However, all shared a common core philosophy of restoring and supporting birth as being both a normal physiological process and a major social and life transition – what Jordan, in her study of birth in four cultures, called a biopsychosocial model (Jordan 1993) that could be contrasted with a medical-industrial model (Martin 1989). Thus, the midwifery units were designed to facilitate and to represent this model of birth in a physical form. One of the units we studied had a wall placard which read, ‘Your birth in our home’. This motto signified some of the contradictions of attempting to provide a homely environment for birth in a public healthcare institution. It

suggested an ideal of birth in the home, referring implicitly to the history and anthropology of birth as having been managed in private, domestic spaces (Wilson 1995). Yet the ‘home’ to which it referred was in fact within a hospital and was nobody’s real home.

Figure 1. Wall placard ‘Your Birth in Our Home’⁵



The underlying theory of this social model is that birth is a physiological process that is deeply affected by psychological states and by the social environment. It also regards birth as an inherently social matter, culturally shaped. This philosophy is contrasted with a biomedical model that rests on a more mechanical view of the body and a linear rather than complex-systems model of the mechanisms of birth (Davis-Floyd 2001; Downe and McCourt 2005). The philosophy was summed up by one service manager as follows:

... if people are relaxed and in a relaxed environment their hormones and their body can work better than if they're tense and they feel that they're being imposed on in here. You know, we say to women as they come in, 'Make yourself at home, go where you like, move things around, whatever you want to do', and it's their area to do what they want in. And it's been shown to improve outcomes and ... I would say, I can't say shorten labours but not prolong them by that fear aspect of changing, you know, if you've been at home and you've been relaxed and calm and then you come in and all of a sudden contractions go off, and that's what we're trying to avoid really. So they can relax and [pause] get on with their business. (Northdale Manager 2)⁶

The philosophy of birth was materialised in physical aspects of design such as décor, which typically included domestic features – 'homely touches' – but also references to 'nature' and to comfort. Choice of colours, for example, was influenced by notions of calmness, as were the names chosen for some of the units, and they often featured murals or paintings depicting pastoral scenes. Where possible, windows were utilised to provide a view of natural outside space such as trees or gardens.

Choice of furnishings was designed to be domestic in feel but also to facilitate active physiological birth, with features such as birth balls, ropes, rocking chairs (comfort and movement combined), so that rooms sometimes looked like a combination of bedroom, gym and hotel room. Water immersion was commonly used to provide buoyancy and comfort in labour and to help women to cope with labour pain, and the rate of using water immersion and births in water was high. Rooms were designed where possible to conceal clinical equipment, and some equipment such as resuscitation trolleys was usually kept in a nearby storage area rather than being visible in the room. Hence, the physical design 'embodied' a certain philosophy of birth.

Figures 2 and 3: Features of the designed environment:

2a&b. Mix of domestic comfort, pastoral and active birth imagery



3. Birth room like a hotel room with Jacuzzi



Midwives working on the units explained the connection, as they saw it, between the environment and the physiology of birth:

Everyone who walks into this room is like ‘Oh my gosh, it’s really nice’, and they’re relaxed and there’s music and it’s calm and there’s no noise and ... you know, there’s like normal furniture and normal pillows and a rocking chair, just normal stuff (...).

Interviewer: This is going to sound like a really silly question: why is that important?

Your oxytocin is what you need, you know, it’s your labour hormone, brings you on contractions, everything like that, and your oxytocin is hugely inhibited by your fear hormone, your cortisol and your stress hormones and all that. (Westhaven AMU Midwife 1)

The space did not only *look* different, but those who designed it also hoped that it would promote different kinds of practice, both by the women and the midwives. The distinctive ‘low-intervention look’ of the midwifery units in each Trust contrasted with more conventional obstetric unit environments, despite moves to introduce some elements such as birthing balls or murals into the obstetric unit. Such moves were generally quite tentative, but decorative changes were sometimes followed through in the context of changing practices. There were some suggestions that this philosophy could perhaps be brought back onto hospital labour wards to help them to become a more therapeutic type of space:

And also, things like CTGs⁷ were done quite routinely on women when they came in. ... slowly we've started to move away from that now. Not doing traces on ladies that don't need it or you know strapping them to the bed, um, encouraging mobilisation. Let, giving them a chance, you know, let them try and do it themselves, I think that's come across as well, you know, giving them a couple of hours, let them walk around and if they're not doing anything, take it from there. (Midburn OU midwife 8)

This difference in environment not only demarcated the two types of physical spaces of the midwifery unit and labour ward but also – as the environment was created to mirror and promote a certain kind of birth 'philosophy' – it worked to reflect the ideological differences at work in each space:

It really helps to have the toys to encourage women and make it comfortable. It's also a sign for the doctors.

Interviewer: What kind of a sign do you mean?

I think it, I think it's a ... well they wouldn't come down unless it's an emergency, would they. That it's not their normal territory. (Southcity AMU Midwife 2)

Some midwives described the alongside midwifery unit as a place that helped to soften the sharp contrast between a woman being at home and being in the obstetric unit, by bringing elements of the home into the hospital. As the home was a space within which women were assumed to have more control over their environment, then a 'home-like' space within the

hospital would promote the same feelings of control over their labours. One midwifery manager at Midburn explained:

When I walk in there I see partners walking through the unit and it feels as if I'm walking into their home. It's quite weird. (...) The funny thing about when you go into the midwifery-led unit is you walk in there and the women and the partners have almost, walking around as if, they don't know you, and they shouldn't know me. I'm walking into their environment. And it's lovely. They go into the kitchen and they make their drinks and ... they don't, very often the partners aren't wearing shoes. It's a very, very relaxed feel about that unit, quite unlike any other unit I've been in.

(Midburn Manager 1)

Whilst supporting the principles of alongside midwifery units, a few midwives questioned how far this idea could be implemented in practice within an institutional building. However, these challenges were few and far between, particularly at Midburn, which had the clearest commitment to the idea of the 'home within the hospital':

We call it 'homelike', I suppose, because we expect that the woman will feel most comfortable in her home, but of course it isn't anything like her home. [Laughs] So perhaps it's a misnomer. Perhaps we should find it something else to call it. Because I don't think it's anything like her home (...). I don't know, I think it's just a name, and what we really mean is a comfortable place. A little nest, really, where she'd feel at home but not in her own home. (Westhaven AMU Manager 1)

So, for me, a home-like space would not for example have Entonox on the wall. But it does in a hospital, it does in a birth centre because it's an easy way of doing it um... and there's nothing wrong with that you know. A home-like space does not have a birthing pool in the middle um, it probably doesn't have this kind of floor so you know it's the it's the little things but I think you know, it is actually the little things that do make a difference because um, for a woman, wherever, when she walks into that room it is inevitably going to be a medicalised space unless, you can do some sort of magic to it (...). I'm always telling people that they need they can bring whatever they want in but realistically you can't, you know. (Southcity AMU Midwife 4)

This was illustrated by somewhat contradictory views around the use of beds and what the bed symbolised. In some rooms, the beds were removed or hidden (by folding up to the wall or behind curtains), the aim being that women would be encouraged, just by the space they were in, to be more active in labour:

If you're on delivery suite you've got, it is quite clinical, you've got your bed, you've got your resuscitaire and you've got all your equipment and, you know, everything's there, whereas on the birth centre there's no bed, you know, there's a mat on the floor, a ball and a wedge and, you know, it's all very dimly lit and all very homely looking. Um, so you're more likely to say, 'Right, you know, move around more, get on your hands and knees, try standing'. (Westhaven AMU Midwife 2)

There was a tendency among midwives to reject the bed as a symbol of medical intervention and passive birth, yet the use of domestic-style double beds also responded to the philosophy of a home-like space, and the desire for the environment to provide comfort and relaxation.

4. The bed as obstetric instrument – a place of clinical safety



5. The bed as home and family – a place of social and emotional safety



This arrangement was met with some surprise on the part of women, who had come to expect labour and birth to be ‘on a bed’ but they quickly adapted to the idea:

... we couldn’t find a bed anywhere [laughter] but it’s in one of the cupboards folded up and I was thinking, where’s the bed? [laughs] (...) in nearly every room there was a

birthing pool and I was quite, Oh OK, they have sort of everything in one room.

(Midburn, Woman 1)

Some obstetricians were dismissive about what they saw as midwives' unnecessary preoccupation with interior design:

I believe, really believe that if a woman is a, for want of a better way of describing it, a midwifery-led labour and delivery, then that midwifery care should be able to be provided anywhere and if that lady happens to be in one of the rooms which is nominally in the [Labour Ward] at the moment because say the birth centre is full, then why should her care be any different from what it would be if she were 'round the corner? (...) Therefore the whole obsession with the curtains – having to have a curtain to put around any bit of machinery, all that sort of thing does seem a bit like nonsense to me. (Westhaven Obstetrician 3)

This obstetrician clearly felt that quality of care did not, and should not, depend on the environment of care per se and dismissed the impact of the environment on labour and birth, whether real or symbolic. This could be understood in terms of differing physiological theories of birth, or potentially in terms of gender, since midwifery has a predominantly female workforce. While a large proportion of obstetricians are now female, historically roles were divided along lines of both gender (female : male) and risk (normal : abnormal birth). The decoration of the midwifery units arguably reflected both gendered and classed dimensions of their culture. One midwife at Midburn said of her alongside midwifery unit that 'it's almost like a really white, middle-class concept, do you know what I mean? Put it in somewhere like [middle-class area] or [middle-class area] and people would be all over it'

(Midburn AMU Midwife 2). However, this belied the unit's inner-city location, and the fact that a socially and ethnically diverse range of women in this socio-economically deprived community were giving birth in the alongside midwifery unit. The midwifery unit environment was important to, and valued by, a diverse range of people. For example, women described the 'birth centre' as like a 'hotel' or 'spa' in such a way as to suggest they felt more cared for than they had done previously in healthcare environments:

... it's, um ... it's just, yeah ... I can't explain the smell it's just, it's like being in a spa, it's not like being in hospital with all that clinical smell, it's a ... completely change of atmosphere, not just visually but, you know, everything. (...) Um, well they've got the massive prints, um, which are in the corridor and in each room, which are like the flowers and things, um, which are lovely, again it's that kind of spa atmosphere. Um, and all of the medical equipment is, is kept away. (Midburn Woman 4)

Woman: ... it felt, and again going back to that image of a love... a lovely big room with a pool and a ball and a hammock. It felt kind of, it felt expensive in a way that it probably isn't compared to what actually goes on in the room but it felt like um...

Partner: It felt lush...

Woman: Yeah, it felt lush. That's what it is (...) and that's, that's available on the NHS. That's an NHS service. (Southcity Woman 9, & Partner 4)

The idea of hotel or spa indicated comfort and a relaxing or therapeutic environment, while the idea of the unit as 'home-like' also spoke to a social philosophy which sees birth as a major transition in the life of a woman, her partner and family. This was reflected not only in the choice of double beds for postnatal rest and allowing fathers to stay overnight but also in the way the units attempted to function as family-oriented environments:

this time they said, '[partner's name] do you want a drink, do you want some toast?' as well as me, whereas last time because we were on the proper ward [OU] where there's, he didn't get offered anything. Um, so this time, you know, it's more about you as a couple, I think. (Northdale Woman 3)

Boundaries of Place and Space

The midwifery units were designed as a distinct space, either within the hospital (AMUs) or geographically remote (FMUs). Therefore, a sense of place and the drawing of boundaries are inherent in their design and conceptualisation. This was particularly challenging for the AMUs, most of which had been converted from conventional hospital wards. Some were deliberately located on a different floor or area of the hospital, while others consisted of several rooms at one end of a labour ward, or an area separated by double doors. The less physically distinct units were more preoccupied with the issue of making and maintaining boundaries, as reflected by this manager:

I think location is really important, and it's becoming more obvious to me, just the last couple of weeks of this business of, this suggestion that we should go up there [the labour ward] for [handover]. If we were in another building, even on the site but in another building, even as close as the antenatal clinic which is just across the car

park, that would make a difference (...). I would advise anybody setting up an alongside midwife unit not to do it just down the corridor. We've kept it going for six years but I can feel it being swallowed up, and I know it happens and I'm really worried that it's going to happen here. (Westhaven AMU Manager 1)

Professional Space

On a second level of boundary, marking out a distinct territory signified different professional roles and hence also professional jurisdiction. In interviewing managers and professionals (obstetricians as well as midwives) we asked them why they could not simply have supported more 'normal' physiological birth on the labour ward. Many felt that attempts to do this had failed and so a distinct protected space needed to be created, both for midwives and for the labouring woman:

I kind of touched about midwifery performance, um, in the context of midwifery-led care it was virtually non-existent. Um ... [name] was one of our consultant midwives, had been slaving away here for a few years and had tried to make inroads into providing low risk/midwifery-led care, and at that point she had succeeded in having a couple of rooms assigned to that within the labour ward on [first hospital]: there was no such, I don't think there was any such practical arrangement at [the other hospital] at the time. Um, but despite her best intentions it hadn't really got anywhere because of the culture of the practice both by obstetricians and midwives ... (Midburn manager 3)

These responses could be understood more easily by reference to the history of childbirth in the twentieth century, and the history of midwifery as a profession. In her critical history of

the Midwives Act, Heagerty (1997) argued that midwifery at the point of formal regulation in 1902 was subsumed under the authority of nursing and medicine, undermining its prior autonomy. Similarly, Witz (1992), in her analysis of gender and professionalisation strategies, argued that unlike medicine midwifery did not achieve full professional autonomy, in the sense of maintaining control over its own regulation. Professional roles between midwives and obstetricians were partitioned into care for 'normal' or 'abnormal' pregnancy and birth, but midwives did not establish self-regulation, instead being subsumed within the nursing regulatory body. In the course of the following century, with the expansion of medical technology and hospital birth, the sphere of normal had become increasingly confined. This could lead to defensiveness around professional territories, and the midwifery units represented a protected space for midwifery practice and for normal birth that was also seen as in need of protection:

At the base of it it's about trying to keep the birth centre different from delivery suite, because we need to have a different environment and a different ethos, and a different way of practising, otherwise we won't give the women a different service. And we now know from Birthplace that women get a good service from alongside midwife-led units; they get just as safe a service for themselves and the baby whether they're primips or multips, and they get less intervention if they're planning a birth in a midwife, and we know that now. So we have to ... protect, or ... what's the word, keep them going basically. (Westhaven AMU Manager 1)

Negotiating and managing boundaries could, however, be difficult for the midwives, and this was reflected in tensions between and within the professional groups working in different areas, particularly around workloads and transfers. Midwives working in AMUs in particular

were commonly stereotyped both as too quick to transfer women to the labour ward, and too willing to ‘hang onto them’ when there might be a clinical case for transfer. Many professionals’ accounts were preoccupied with an ‘us and them atmosphere’ and this was more often reflected in our observations of the alongside units than of those which were more geographically remote. The environment of the midwifery unit appeared to form a kind of enclave (Douglas 1992, 1996) in which midwives also felt more relaxed and able to attend to birth:

It’s just, just completely the sort of midwifery that I love, I love to ... to do, really, it’s how it should be. Unless it’s too busy that you can’t be with the woman, but you know, it’s such, so nice to strip it back and be in this sort of home environment, it’s really nice. (Westhaven AMU Midwife 5)

The common thread in midwives’ accounts was that the alongside unit was a protected space in which they could do ‘the sort of midwifery that I love’. The midwifery units provided such a space for the midwives working in them, and a break from a different kind of midwifery for those obstetric unit midwives who worked there occasionally. However, our observations and interviews with staff revealed that this was not without cost in terms of intra-professional relations. The few midwives who regularly worked across these boundaries – such those who practised caseload midwifery and followed the women they cared for across areas – appreciated this sense of place, but those who did not work across boundaries appeared to feel threatened by it. This factional tendency was increased by the lack of attention to continuity of care across the maternity system. MU managers were keen to see midwives staying with women who transferred across these boundaries, to support the women and also

to bridge different staff groups and increase flexibility of care. However, this arrangement was not supported by institutional staffing models.

According to Douglas's (1992, 1996) theory, enclaves have a strong internal coherence and integration with weak external regulation and may be inherently unstable, 'well devised for protest but poorly devised for the exercise of power' (1996: xxi). The midwifery units appeared to form enclaves in certain respects, as illustrated by a coherent philosophy of care, with midwives and women feeling well supported within them and describing them as a kind of protected space. Additionally, they are integrated within a shared national health system, unlike such units in countries like the U.S. (Davis-Floyd 2003). However, the preoccupation with boundary issues, particularly in the more proximate AMUs, intra-professional tensions, lack of trust and sense of threat indicate that their integration is fragile. Additionally, although the number of AMUs has increased, supported by national health policy, the number of FMUs (despite the scientific evidence of their safety) has not, and all our case study FMU services were described as being under threat of closure. Despite the tensions around boundary issues, midwifery units appeared to be predominantly isolated within the maternity services and wider healthcare system. They experienced high levels of external regulation, and their integrated status was undermined in some cases by intra-professional tensions and lack of trust.

Discussion: The Midwifery Unit as a Therapeutic Space?

Our analysis showed that the midwifery unit is designed consciously, in contrast with a typical hospital environment, as a therapeutic space. This was signified and effectively embodied in the physical design, in professional territories and roles, through a philosophy of birth that interconnected all dimensions to support this. The midwives who worked in these units and the women and partners who gave birth in them all echoed the view of the unit as a

therapeutic space. The women felt more relaxed and comforted in labour, and those from less privileged backgrounds particularly felt more valued as mothers-to-be as they entered this environment for birth. The midwives, too, felt more valued as professionals, and described and were observed as being more able to relax and practice what they often described as ‘real midwifery’ to support physiological birth. In Douglas’s (1992, 1996) sense, the enclaved aspects of midwifery units enabled this kind of supporting philosophy and the sense of therapeutic space to develop in a way that – professionals and patients expressed – had not seemingly been possible on an obstetric labour ward.

The space also encompassed a more social model of birth, with deliberate references to family relationships, such as the pull-down double beds that were used for the parents to rest together with their baby after the birth. The social transition of birth was more fully acknowledged and accommodated in this environment. The contrast of public institution and home was consciously muted through features of the design and in some cases the built environment. It would be hard, and probably unhelpful, to try to disentangle *which* is most effective (care or environment) in reducing interventions and increasing wellbeing. This is because the ability to care and the approach to care are influenced by the environment in which care takes place, and also by staff wellbeing.

Creating a distinct therapeutic space that was different both from the women’s homes and from a hospital ward involved developing new borders and boundaries, however. These needed to be managed and negotiated, not least since any woman who developed medical complications or did not progress normally in their labour would need to transfer to an obstetric unit. The physical and symbolic boundaries were also crossed continually by staff who needed at times to work across areas. At the same time, there was a tangible reluctance on the part of many midwives working in the obstetric unit to do so, and staffing models did not enable the MU midwives to transfer to the OU with women when needed. In alongside

units, transfers also often occurred owing to space and staff pressures within the hospital. Women and midwives moved across the boundaries according to *organisational* as much as clinical imperatives, or choice, in an institution where continuity of care was not supported. Such pressures did not impact on freestanding units in the same way, because of their geographical separation, but staff interviews nonetheless revealed a continual sense of threat around their boundaries: the threat of professional criticism or of closure. Thus the sense of working or giving birth in a therapeutic space was continually challenged by the location of these ‘home-like’ spaces for birth within an institutional setting.

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¹ The term midwifery unit was adopted by the Birthplace research programme in place of the more popular term 'birth centre' to avoid ambiguity. In a midwifery unit care is not only provided by midwives but is also managed by midwives and does not normally include use of obstetric instruments or interventions. If a woman planning birth in a midwifery unit develops obstetric complications, or decides she wishes to have a medical intervention such as epidural pain relief, she is transferred for care to an obstetric unit. Some units called birth centres are not managed by midwives in this way.

² Midwife-led care refers to care where the midwife, rather than an obstetrician or other professional is the lead professional, who takes responsibility for a woman's maternity care through from pregnancy to postnatal. Following the Changing Childbirth report in 1993, this was re-established as the usual model for women classified as at low risk of pregnancy and birth complications.

³ The clinical component of the Programme was a prospective cohort study with the main analysis being of almost 65,000 births of women in England who were classified as low-risk and thus eligible to choose their birth setting. Findings were analysed by intention to treat, according to the woman's planned place of birth at the start of care in labour. Analyses were adjusted to account for any demographic and clinical differences between women planning their care in the different settings.

⁴ The number of FMUs in England increased from fifty-three in April 2001 to fifty-nine in February 2013, providing for 1.8 per cent of all maternities. This shift included opening of thirty units but closure of twenty-one. Three further units were temporarily closed, with the possibility that they would not re-open. In Wales, the number increased from eleven to thirteen, with six new units opened but four also closed (Birthchoice 2015).

⁵ Photographs are not necessarily from the services studied, in order to protect confidentiality.

⁶ Pseudonyms are used to protect confidentiality of services involved.

⁷ A CTG (cardiotocograph) is an electronic device used to monitor uterine contractions and the baby's heartbeat during labour. Clinical evidence shows that it is not beneficial if used routinely and in low-risk women during labour and may create additional risks through triggering other interventions. The U.K. NICE clinical guidelines recommend it should only be used selectively in situations of medical risk, but routine use spread rapidly across the U.K. and almost universally in obstetric hospitals in the 1980s and has been difficult to discontinue. CTGs are not used in midwifery units.