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**CITY UNIVERSITY
LONDON**

**An ethnographic study of the philosophy, culture and practice in
an urban freestanding midwifery unit**

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**A thesis submitted in partial fulfilment of the requirement for the degree
of Doctor of Philosophy in Midwifery**

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Table 1-List of abbreviations

AMU	Alongside Midwifery Unit
CNST	Clinical Negligence Scheme for Trust
CQC	Care Quality Commission
DH	Department of Health
FMU	Freestanding Midwifery Unit
GP	General Practitioner
HCC	Healthcare Commission
MCA	Maternity Care Assistant
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NPEU	National Perinatal Epidemiology Unit
OU	Obstetric Unit
PFI	Private Finance Initiative
PPI	Patient and Public Involvement
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
SHA	Strategic Health Authority
WTE	Whole Time Equivalent

DEDICATION



To my husband Austin for the continuous encouragement and to my daughter Ofelia, who was born the day after I completed my data collection.

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DECLARATION

This written thesis is my own unaided work. I declare that the work in this thesis was carried out in accordance with the Regulations of the City University London and the School of Health Science on plagiarism. The work is original except where indicated by special reference in the text and no part of the thesis has been submitted for any other degree. Any views expressed in the thesis are those of the author and in no way represent those of the City University London and the School of Health Science. The thesis has not been presented to any other University for examination either in the United Kingdom or overseas.

Signed.....

Date.....

ABSTRACT

Introduction

The Barkantine Birth Centre, opened in 2008, is a well-established urban Freestanding Midwifery Unit (FMU) with a target number of 600 births/year. It is consistently achieving about 82% of spontaneous vaginal births and a similar percentage of normal births, keeping caesarean section rates at 9% and instrumental birth rates at about 8%. High rates of normal birth within FMUs have also been reported nationally by the *Birthplace in England Research Programme*. However, to date there is a knowledge gap regarding key elements in midwifery practice, environment, and organisation of care, which may potentially affect the care outcomes in FMUs as well as staff job satisfaction and wellbeing. This ethnographic study aimed at contributing to knowledge and theory-generation in the arena of midwifery-led birth settings and particularly midwifery units.

Funding

The study was funded by a National Institute for Health Research Doctoral Clinical Academic Training Fellowship awarded in 2009.

Ethics approval

Final ethics approval was granted in February 2011

Methodology

This is a post-critical ethnographic study carried out by an insider researcher, who carried out fieldwork in a FMU from April 2011 to June 2012. Participants included birth centre service users and staff as well as stakeholders at the referral hospital. A total of 82 participants were recruited. The

participants included all FMU staff as well as service users, who reflected the characteristics of the local multi-ethnic population. The fieldwork included participant observation, semi-structured interviews, analysis of local operational procedures and guidelines. Audio recordings were transcribed and anonymised in order to maintain confidentiality. Analysis was conducted alongside data collection using a modified constructionist Grounded Theory approach, in two intensive waves of analysis in August 2013 and in October 2015. The software package Atlas.ti was used in order to manage the large amount of data but some manual analysis was still included particularly for mapping categories, subcategories and codes. Constant comparative methods were used throughout the analytic process. Participants' involvement with the study was systematic. Two service users helped writing the protocol, developing the information sheets and both service users and midwives participated with the interpretation of the findings. Two FMU midwives also functioned as 'key informants'.

Findings

The analysis generated 152 codes, which were organised into categories and subcategories. Eventually the categories were organised into three key categories: key aspects for midwives', the organisational perspective of the FMU and service users' expressed needs and views. These were visualised in three models which function as maps, representing the landmarks of well-functioning FMUs: the midwives' dimension, the organisational dimension and the woman's dimension.

Conclusion

On the basis of both my ethnographic study and the findings of the meta-synthesis conducted as part of the work, I argue that well-functioning FMUs offer effective care focused on the needs of the woman and her family and facilitate the transition to parenthood by tailoring care around individual needs and wishes rather than being focused on an 'industrial' highly regulated model of care. The environment and organisation of work in the FMU not only generated health (salutogenesis) in the women but also created a positive climate among staff who felt that their basic needs of autonomy, competence and relatedness were met. The positive climate at work and the establishment of relationships at work led to the creation of a sort of social capital, which created a positive feedback loop of self-maintenance of the philosophy, culture, knowledge and skills at the FMU.

When the basic needs of the midwives were not met, women could notice a deterioration of the care that they received.

A balanced workload, team values and the wider organisational culture were identified as key aspects to be considered for a well-functioning FMU.

Strengths and Limitations

During the planning phase of my ethnographic study, the conduct of data collection and analysis I have always referred to the quality criteria described by Walsh and Downe (2005) as a framework for guiding my study and ensuring good quality.

There were however some limitations. Being an insider researcher led to both limitations (not having a 'fresh eye approach' and challenges in representation) as well as advantages ('verstehen' and access to the 'backstage' dynamics). Another limitation was not being able to use photographs as a data collection tool as originally planned.

Recommendations

This study highlights the need for the FMU to be considered as an integral part of the maternity services rather than treated as an 'isolated midwifery unit'. Fostering a culture of interdisciplinary collaboration and positive relations between the FMU and the obstetric unit (OU) also emerged as important aspects.

Mindfulness emerged as a key finding for the midwives and needs to be further explored. Being able to be fully present physically, mentally and emotionally to care for the woman was highlighted as essential both by the midwives and by service users. Mindfulness was also linked to a reduction of stress and increased sense of wellbeing for the midwives.

Evidence-based standards for midwifery units need to be developed in order to define how care should be organised and delivered in MU birth settings. Further research is needed on the relationship between environment, workload, practices and care outcomes.

SECTION ONE: HISTORICAL AND POLICY

BACKGROUND

Introduction to section

In this section I introduce the study by identifying the issue which is the focus of my ethnographic study. I report the aim, objectives as well as the research questions. I also provide a historical background to place of birth as well as exploring the key contemporary policy issues with maternity services and midwifery related to my topic.

Chapter 1- Introducing the study

Background

Childbirth is currently the single most common reason for hospital admission, yet we currently have strong evidence suggesting that Obstetric Unit (OU) care is not appropriate for low risk women (Hollowell et al., 2011). The Peel Report in 1970 recommended that provision should be made for all births to take place in OUs in the absence of supporting evidence for the assumption that obstetric units were the safest birthplace (Campbell and Macfarlane, 1994). This was met with criticism from the epidemiologist Archie Cochrane who pointed out that an opportunity had been missed in the sixties when many women still birthed at home, to conduct randomised controlled trials to compare places of birth for low-risk pregnant women (Cochrane, 1972).

A range of evidence from more recent research strongly suggests that, compared to OU care, midwifery units are associated with a reduction in obstetric intervention and maternal morbidity, with similar perinatal outcomes and improved cost-effectiveness (Walsh and Downe, 2004; Steward et al., 2005; Brocklehurst et al., 2011; Rocca-Ihenacho et al., 2014a; 2014b, Schroeder et al., 2012). On the basis of this strong evidence base, the NICE guideline 'Intrapartum care: care of healthy women with uncomplicated pregnancies and their babies during childbirth' (2014) provided clear recommendations to health professionals about the information and options to be provided to women with uncomplicated pregnancies regarding place of birth. The Nice Quality Standards (2015) recommend commissioners and providers to ensure that the four birth settings (home, AMU, FMU and OU) are available to all women (NICE, 2014). The recommendations were strongly influenced by findings of the Birthplace in England Study (Brocklehurst et al., 2011), its economic evaluation (Schroeder et al., 2012) and its related case studies (McCourt, et al., 2011 and 2014). Given the overwhelming evidence on maternal and perinatal outcomes, it could be argued that it is unethical not to offer midwifery-led birth settings as the mainstream place of birth for women with uncomplicated pregnancies (NICE, 2014).

Implementation and de-implementation

One of the greatest challenges facing the global health community of researchers and practitioners is not only how to implement new interventions which have been proven effective in real care settings and scale up the use of evidence-based practices (Peters et al., 2013) but also how to withdraw from use ineffective interventions that have become established in structures and everyday practices (Prasad and Ioannidis, 2014:1). This has been challenging in practice even though 'divesting from ineffective and harmful medical practices has the potential to improve outcomes for patients, and mitigate the unsustainable rise in healthcare costs' (Prasad and Ioannidis, 2014:1).

A range of recent studies have addressed the challenges for evidence implementation for complex interventions (Dixon-Woods et al., 2009; Greenhalgh et al., 2009; Raycroft-Malone and Bucknall, 2010), but fewer have addressed the additional complexity of changes involving divestment alongside implementation (Cheyne et al., 2013).

The most recent policies guiding the organisation and delivery of maternity care in England Maternity Matters and Better Births (DH, 2007; NHS England, 2016) highlight that the priority for modern maternity services is to provide safe, high quality care to all women and their partners. The aim is to offer safe, high quality services, which also engender positive experiences and support transition to parenthood and family life. The latest NICE Intrapartum Guidelines (2014) recommend that clinical intervention should not be offered when labour is progressing normally and both the woman and the baby are well (NICE, 2014). This suggests the question of what are the necessary interventions. Scammell and Alaszewski (2012) highlight that we are living in an era of an 'ever-narrowing window of normality during childbirth' (Scammell and Alaszewski, 2012:207).

Rates of intervention in childbirth have increased steadily in the past few decades. In England, despite successive government initiatives designed to support normal birth, the caesarean section (CS) rate rose from 11.3% in 1989-90 to 26.5% in 2014-15 (NHS Maternity Statistics, 2015) with wide variations in CS rates (NHS Maternity Statistics, 2015; Carroll et al., 2016). Data analyses adjusted for characteristics of mothers and clinical factors indicate that only a small proportion of variation is based on characteristics of patients (Lilford et al., 1990; Paranjothy et al., 2005; Bragg, et al., 2010, Carroll et al., 2016).

Focusing on low risk women at national level (Hollowell et al., 2011) a wide variation in normal birth rates was also associated with the type of unit: Obstetric Units (OU) had the lowest rate of normal birth with 62.2%, Alongside Midwifery Units 77.1% and Freestanding Midwifery Units 84.1%. These percentages were related to women who had a spontaneous onset of labour and did not have any complications on admission (Hollowell et al., 2011).

Clinically unnecessary interventions can increase service costs (Petrou and Glazener, 2002) and divert resources from other areas of care that are supported by evidence (Carroll et al., 2016). Strategies such as access to a pool (Cluett et al., 2009) and mobilisation in labour (Lawrence et al., 2009) have been shown to reduce intervention rates safely, but their use in obstetric units is still limited. The way care is organised can also have an impact on pregnancy, labour and birth outcomes. Models of care focused on continuity of carer models and continuous support during labour are strongly supported by the available evidence but still not offered as mainstream practice (Hodnett et al., 2013; Sandal et al., 2015).

A Birthplace follow-on study report (Hollowell et al., 2015) concluded that expansion in the capacity of midwifery-led birth settings could reduce intervention rates in low risk women and provide cost-saving opportunities. The NHS 5-year Forward Plan in 2014 also recommended expansion of midwifery units (DH, 2014). Rowe et al. (2014) found that 45% of women giving birth in NHS settings are at low risk of complications. Therefore, around 315,000 women in England could potentially benefit from midwifery-led settings. However, in 2013 the majority of women (97%) still gave birth in hospital settings (Health and Social Care Information Centre, 2014).

The first report from the National Independent Review of Maternity Services Think Tank, held in London in July 2015, voiced serious concerns about the 'over-use of obstetric units as the place for the delivery of low risk births'. The suggestion was that too often this had become an almost unthinking 'default option' rather than an informed choice by women based on expert professional advice' (Harvey and McMahon, 2015:3).

Rationale for this study

The Barkantine Birth Centre, which opened in 2008, was the first purpose built freestanding midwifery unit (FMU) opened in an inner-city area. It was created following the guidance of Government policies advocating more choice of place of birth (DH, 2007).

FMUs in England are more common in rural areas and are generally smaller than alongside midwifery units (AMUs), usually providing care for an average of 150-200 birth per year (Walsh, 2004). On the other hand, the Barkantine provides maternity care to approximately 1000 women with uncomplicated pregnancies in Tower Hamlets and has a target of 600 births per year. Furthermore, the Barkantine provides care to a population from a variety of ethnic, cultural and socio-economic backgrounds.

In parallel with planning for the Barkantine Birth Centre, a group was established, including midwifery practitioners, researchers, service users, primary care representatives and myself as a new researcher, to develop plans for evaluating the work of the Birth Centre. My MSc dissertation (Rocca, 2006), which consisted of a 'Systematic literature review of clinical outcomes of FMUs', looked at quantitative clinical outcomes and also included a non-systematic review of qualitative research.

Between 2006 and 2010 a research team led by Professor Macfarlane, including myself as a young researcher, worked on the "Evaluation of the Barkantine Birth Centre Project". We were granted several research awards including the 'Innovations fund' by Barts and the London NHS Trust to start developing the questionnaire to be used for the 'Survey of women's expectations, choices and experiences of maternity care in Tower Hamlets'. In 2007 we were granted funding from the Research for Patient Benefit Programme by The National Institute for Health Research for an evaluation with three components: analysis of routine local community and hospital data, a survey of women's views and experiences and an economic evaluation to compare costs of care between the consultant-led unit and the Barkantine Birth Centre. The study was linked to the national Birthplace in England programme. At the end of the survey of women's experiences of care at the FMU and the linked OU, further research questions arose, particularly on the reasons for the wide differences in women's experiences across birth settings (Macfarlane et al., 2014a; 2014b).

Hollowell et al. (2011) reported the clinical outcomes of births in midwifery-led settings and in obstetric units. McCourt et al. (2011) explored some of the features of maternity care systems that

may affect the provision of high quality and safe care in different birth settings. The study by McCourt et al. (2011) examined four birth settings focusing on high achieving services at a systems level and with a primary focus on management issues, while the follow-on study focused on AMUs (Mccourt et al., 2014). Therefore, more research was needed to explore in depth the landmarks of FMUs from the perspectives of the midwives providing care and the women receiving care as well as organisational perspectives.

My study focuses specifically on a FMU in order to investigate in depth what are the key landmarks of a high achieving FMU. It therefore complements previous research on this topic.

Motivation to undertake the study

I trained in Italy where lithotomy birth and routine episiotomy without local anaesthetic was the norm. In my last year of training I was at risk of being expelled because I started refusing to practice this 'obstetric violence'. I also wanted to become a researcher and was told that that was the doctor's remit. I therefore decided to move to London.

As a clinical midwife in London I struggled to align my loyalty for women and their families with the way my professional role was seen by the NHS and how my work was conceived by NHS managers. I attempted for years to be the best midwife I possibly could in very difficult circumstances. Often, when facilitating antenatal education, I felt terribly guilty about the couple as I felt as I was setting them up for a fight or disappointment.

The only time in my career when all the elements felt aligned in a positive way was when I worked at the Barkantine Birth Centre. Of course it was far from perfect, but I truly experienced from a personal perspective how a FMU can benefit women, their families, the staff involved and society as a whole.

I believe midwifery units, when functioning well, are a fantastic resource. My experience as a Consultant Midwife has taught me that not all MUs follow a social model of care, however. We have started to learn about some key features of FMU and AMUs thanks to fantastic researchers who have dedicated time to explore MUs culture, practices and outcomes. My motivation in this study was to build on that knowledge to contribute to the establishment of MUs as the mainstream model of care for healthy women with uncomplicated pregnancies and indeed those who opt for MUs even if not

eligible: 'out-of-guidelines' or to learn about improving care practices for higher-risk women labouring in obstetric units.

Aim

The aim of this study is to shed light on the philosophy, organisational culture and practices within a FMU model of care, by highlighting the key landmarks, which describe a well-functioning FMU.

Objectives

- To investigate the FMU philosophy and culture focusing on the experiences of service users and providers.
- To explore the relationship between the environment, the organisation of the service, culture and midwifery practice.
- To shed light on how midwifery skills are enacted and care is provided in a FMU.
- To explore how low rates of interventions for women with uncomplicated pregnancies are achieved within a FMU.
- To investigate the relationship between the FMU and the OU to which is linked.

The research questions

1. What are the key landmarks, which describe a well-functioning FMU?
2. How do service users, midwives and other staff experience maternity care within a freestanding midwifery unit?
3. How are midwifery philosophy, culture and practice enacted within a freestanding midwifery unit?

Ethics approval

Ethics approval was applied for in August 2010 and obtained from the South East **Medical Research and Ethics Committee** in December 2010. A favorable opinion from the Local NHS R&D was also given in February 2011 after applying for and obtaining Service Support Costs from the Comprehensive Local Research Network.

Definition of Midwifery Unit

A midwifery unit is a maternity unit which offers midwifery-led care to women with uncomplicated pregnancies in spontaneous labour (Rowe, 2011).

A distinction is usually made between Freestanding (FMU) and Alongside (AMU). The first is geographically separated from the hospital and needs transfer by car or ambulance to the Obstetric Unit if required, while the AMU is located within or on the same site as a hospital with a consultant led unit, either on the same floor or on a different location, requiring transfer only on foot, chair or trolley (Rowe, 2011).

Below the definitions by Rowe (2011) are reported in full.

Table 1-Definitions of types of maternity unit used in Birthplace in England Research Programme (Rowe, 2011).

Definitions of types of maternity unit used in Birthplace in England Research Programme
Obstetric unit (OU): an NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day.
Alongside midwifery unit (AMU): an NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair.
Freestanding midwifery unit (FMU): an NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance.

Eligibility criteria

Women are eligible to give birth in midwifery units if they do not have any relevant medical conditions, had a straightforward pregnancy and have started labour at term and spontaneously (RCM, 2009). Specific guidelines and operational procedures are developed at Trust level and women with borderline clinical situations can be reviewed by both a Consultant midwife and an obstetrician in order to agree a plan of care with the woman.

Type of midwifery care offered by midwifery units

Government policies (DH 2004a, DH 2007, NHS England, 2016) acknowledge the importance of midwifery led community services in the contribution towards more primary care based services, which focus on accessibility, particularly for 'hard to reach' groups and a reduction in interventions in labour (RCM, 2009).

Midwifery Units (MUs) are expected to reflect a philosophy focused on family centred care in a relaxed, comfortable and friendly environment. In MUs healthy women experiencing a physiological pregnancy are cared for by experienced midwives. The facilities are intended to foster a non-intrusive, non-interventionist approach to birth (RCM, 2009). MUs are typically based on a social model of care which views birth not as an isolated clinical episode, but as a transformative life experience, enhancing the long term physical and emotional wellbeing of women and their families (RCM, 2009).

A document which sets the standards for MU recommends that they offer antenatal, intrapartum and postnatal services in order to provide full care to women who are eligible for midwifery-led care (RCM, 2009).

Mapping of maternity services in England

Redshaw et al. (2011) in 'Mapping maternity care: the configuration of maternity care in England' described, as part of the Birthplace Study, how maternity care was configured, by whom and where care was provided at the time of the study. This study filled a gap in the knowledge of current configuration of Maternity Services in England and provided a context for the Birthplace national prospective cohort study.

The study collected data on the configuration of the maternity services in England in 2007 and 2010. This enabled a prospective picture of how the configuration has changed over the three-year period.

The report (Redshaw et al, 2011) of the Maternity Services configuration in 2007 showed that 66% of NHS Trusts had only one or more obstetric units (OUs), with fewer than a fifth of Trusts containing at least one Alongside Midwifery Unit (AMU) and only 18% of Trusts containing a Freestanding Midwifery Unit (FMU). There were 180 OUs, 26 AMUs and 56 FMUs.

By 2010 the overall number of maternity units had increased by 11%, with 49% of Trusts having only OUs, 35% having an AMU with twice as many AMUs as in 2007 (53 compared with 26) and a stable number of FMUs (53 in 2007 and 59 in 2010). Even if the overall number of FMUs was stable the configuration shows some FMUs closing and new FMUs opening (Redshaw et al., 2011; Walsh, 2004).

The configuration of the maternity services reflected regional characteristics. FMUs were most common in the South West and AMUs were more likely in London and South Central Strategic Health Authority regions.

In 2007 the majority of women gave birth in hospital (95%). The median number of women giving birth nationally by type of unit was 192 in FMUs, 613 in AMUs and 3217 in OUs. There was, however, a large variation of number of births depending on the type of maternity unit with 29% reporting having fewer than 2500 women giving birth and a similar proportion (26%) delivering more than 4000 women (Redshaw et al., 2011). Planned and unplanned homebirth had a median proportion of 2.5% in 2007.

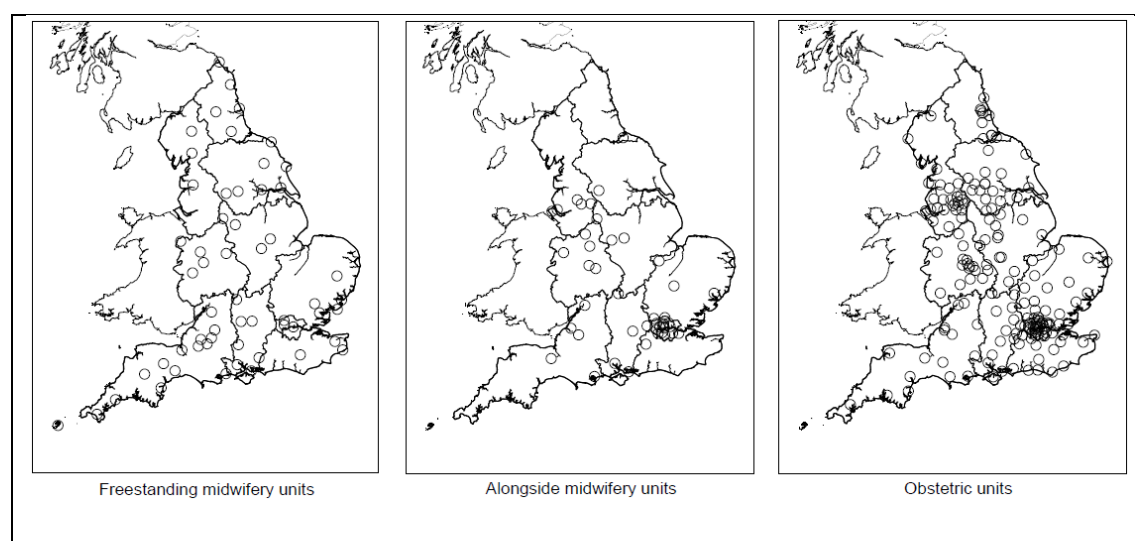


Figure 1- Distribution of FMUs, AMUs and OUs in England (SHA) in 2007

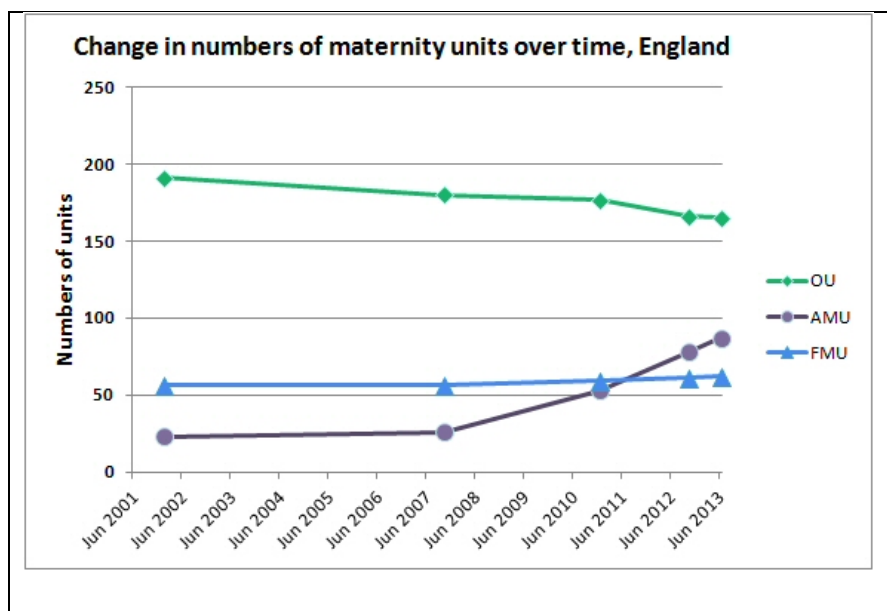


Figure 2- Change in numbers of maternity units over time. Source: Birth Choice, 2013 by permission of Miranda Dodwell.

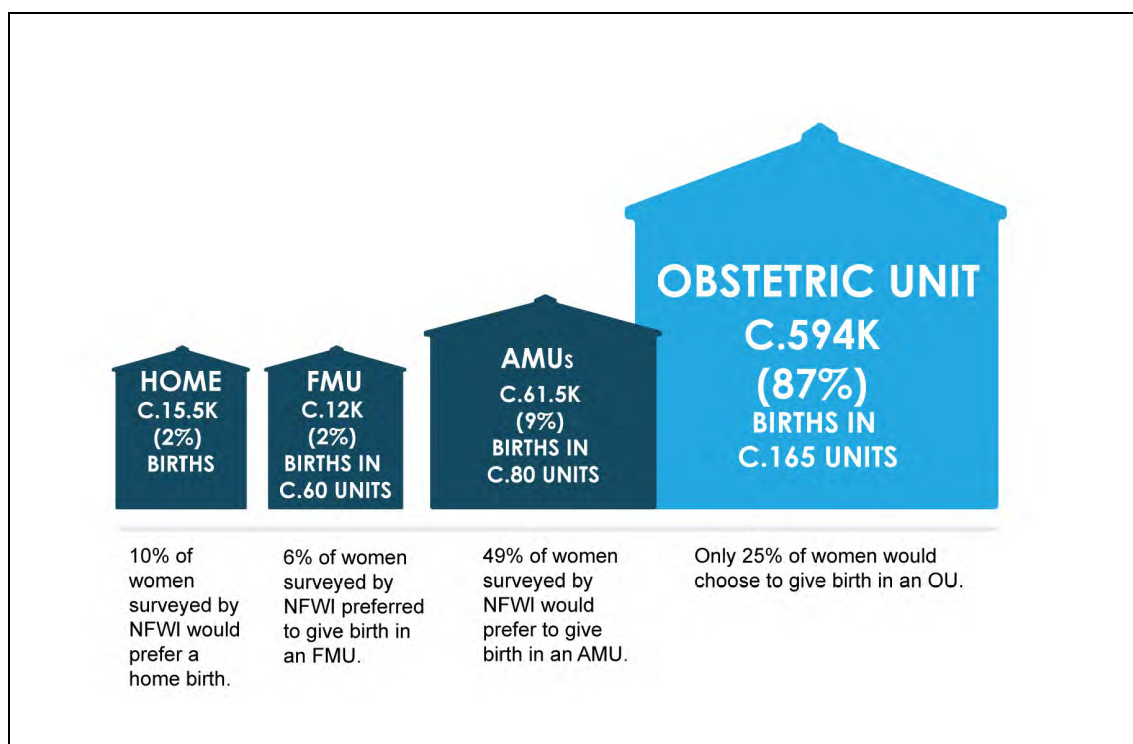


Figure 3- Births by type of maternity unit in 2012 (NHS England, 2016).

Outcomes by type of maternity unit

The Birthplace in England research programme used a range of methodological approaches to address gaps in the evidence relating to processes, outcomes and costs associated with different settings for birth in the NHS for woman with straightforward pregnancies (Hollowell et al., 2011). The cohort study aimed to compare outcomes by planned place of birth at the start of care in labour in obstetric unit (OU), home, freestanding midwifery unit (FMU), alongside midwifery unit (AMU). The primary objective was to 'compare intrapartum and early neonatal mortality and serious morbidity by planned place of birth at the start of care in labour in women judged to be at low risk of complications according to current national clinical guidelines. The study also compared a range of secondary outcomes (neonatal morbidities, normal birth, maternal interventions and maternal morbidities) by planned place of birth' (Hollowell et al., 2011, p.14).

The incidence of adverse perinatal outcomes was low in all settings. There were however differences depending on parity. After adjusting for differences in the characteristics of women planning birth in different settings, for multiparous women there were no statistically significant differences between settings in the incidence of the primary outcome. For nulliparous women, birth in midwifery units and OUs had similar perinatal outcomes, but adverse perinatal outcomes were more common in the planned home birth group (weighted incidence 9.3 per 1000 births, vs. 5.3 per 1000 births in planned OU births) (Hollowell et al., 2011, p.21).

For both nulliparous and multiparous women, all intrapartum obstetric interventions were significantly less frequent in non-obstetric units. Women giving birth at home, in AMUs or AMUs were significantly more likely to have a normal birth, defined as a spontaneous vaginal birth without induction of labour, an epidural or spinal anaesthetic or episiotomy, compared with women in the planned OU group. Transfers during labour or immediately after birth occurred in over 20% of births in the three non-OU groups but transfer rates were markedly higher in nulliparous women. For nulliparous women, rates varied from 36% in planned FMU births to 42% in planned home births compared with rates of 9-13% in multiparous women.

Women's experiences of MLU care

The Birthplace Study (Hollowell et al., 2011) did not include a component focused on women's experiences. However, the linked evaluation of the Barkantine Birth Centre (Macfarlane et al., 2014a, 2014b), focused on women's expectations, choices and experiences of care depending on intended place of birth. This survey in an inner-city area showed that women who chose birth centre care had positive experiences to report. The women's views highlighted the profound impact of staff attitudes and communication skills on their birth experiences. This issue was also highlighted in the Birthplace Organisational Case Studies (McCourt et al., 2011).

In the Barkantine study, women's experiences varied considerably depending whether they gave birth at the birth centre or at the hospital. Even though the two groups were not homogeneous, the women expressed very similar views about factors that influenced their experiences. Women reported positive views of feeling listened to, supported and cared for by the midwife. Negative experiences were directly linked to staff attitudes and lack of communication skills. Women reported dissatisfaction with their birth experience if they felt they were not listened to, nor involved with decision-making, or informed and if the midwife was rushing. Women, who transferred from the birth centre still expressed a positive experience if the communication between staff was smooth, they felt involved in the decision-making and were kept informed as well as feeling reassured about safety (Macfarlane et al., 2014a, 2014b).

Definition of Normal Birth

Historically there has been some debate on the definition of 'normal labour and birth' (Sandall, 2003). For instance the data reported in a Department of Health Statistical Bulletin (2002) included "episiotomies" and "augmentations of labour" in normal births, whereas Birth Choice UK (2002) defined a normal birth as 'starting naturally and does not involve any medical or technological intervention'. On the other hand, the Association for Improvements in Maternity Services (AIMS) defined what is not considered a normal birth. Namely: induction or acceleration of labour, artificial rupture of membranes, use of epidural analgesia and episiotomy (Downe et al, 2001). As Downe and McCourt (2004) noted, most definitions of normal birth focused on the absence of obstetric interventions. Most of the outcomes measures to evaluate maternity care were focused on morbidity

or the absence of it rather than on wellbeing. They suggested that the maternity services should be framed instead by the concept of 'salutogenesis' or generation of well-being (Downe and Mc Court, 2004).

The Maternity Care Working Party (MCWP) is an independent, multi-disciplinary group, which campaigns for improvements in maternity care, especially to promote awareness of the public health implications of the rising caesarean rate (MCWP, 2007). In 2007 the MCWP published a consensus statement, which defines 'Normal Birth'. The MCWP definition of normal birth was supported by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists and was adopted by the Information Centre in England in order to audit 'normal deliveries' in England. Normal birth was defined as a labour, which starts and progresses spontaneously without '...induction of labour (with prostaglandins, oxytocics or ARM), epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy' (MCWP, 2007:3). The MCWP agreed that a rate of 60% of normal births should be a realistic objective for all maternity services (MCWP, 2007).

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Limitations with the MCWP definition of normal birth:

The main advantage of this definition is creating a pragmatic instrument, which can extrapolate routinely rates on normal birth nationally and by NHS Trust. There are however several issues with the definition of normal birth by the MCWP. Firstly, the name per se 'normal' meaning 'average, usual' has been an ill choice as in Italy, for example, normal birth would be caesarean section. Secondly it creates a dichotomy of normal vs abnormal in which women who had interventions are made to feel 'abnormal'. Finally, this definition, being based only on the lack of certain clinical interventions, does

not acknowledge the importance of experience and emotional wellbeing as part of the definition. A woman could have a completely physiological birth and still have post-traumatic stress disorder as a result of lack of support.

A definition, therefore, more focused on what should be present in a normal birth rather than what should be absent would help shaping a better understanding of what normal birth is (Downe and McCourt, 2010).

Normal physiological childbirth

The US Midwifery Organisations including the American College of Nurse-Midwife (ACNM) developed a consensus statement: 'Supporting Healthy and Normal Physiologic Childbirth' (2012). They defined a normal physiological labour and birth as 'one that is powered by the innate human capacity of the woman and fetus. This birth is more likely to be safe and healthy because there is no unnecessary intervention that disrupts normal physiologic processes' (ACNM et al, 2012).

This document advocates for an approach in which interventions need to be justified rather than adopted routinely and it highlights that 'Supporting the normal physiologic processes of labour and birth, even in the presence of such complications, has the potential to enhance best outcomes for the mother and infant (ACNM et al., 2012).

According to the US Midwifery Organisations including the American College of Nurse-Midwife (ACNM) **the definition of normal physiological childbirth is as follows:**

- Characterised 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.
- Facilitates optimal newborn transition through skin-to-skin contact and keeping the mother and infant together during the postpartum period.
- Supports early initiation of breastfeeding'.

(ACNM et al., 2012, p. 2)

Based on the above definition the ethos seems to be on maximizing the possibilities for the most physiological labour, depending on the circumstances, and having to justify interventions.

Optimal birth

Building on previous definitions Donna (2010) suggested the name Optimal Birth as ‘a birth which is as good as it possibly can be, for both mother and baby and hopefully for caregivers too’ (Donna, 2010, p. 6). This simple definition captures the dimension of ‘being good’ for the mother and the baby as well as adding the importance of the dimension of the experience of the health professional as well, which is a novelty.

What works in achieving Physiological birth?

Recent research has focused on identifying which elements are key in maximising the opportunity for physiological birth in midwifery units (McCourt et al., 2011). Key elements include the culture of the maternity services, organisational features and clinical skills (Biringer et al., 2000). Among cultural features, a positive attitude towards birth as a normal physiological process, empowering leadership, commitment to evidence-based practice, and an ability to manage change appear to be of paramount importance (Biringer et al., 2000, Commission for Healthcare Audit and Inspections, 2005). The service organisation can influence good practice by being able to adapt to the needs of both women and staff, by integrating the different parts of the service, offering women choice regarding place of birth (DH, 2004, 2007; NHS England, 2016) and ensuring continuous senior support in clinical practice for both obstetricians and midwives (NICE, 2014).

The practice elements identified are numerous but include: continuous support in labour and one-to-one care by a midwife (Hodnett et al., 20013; Hatem et al., 2008), being able to mobilise and change position (Lawrence et al., 2009), access to a pool for hydrotherapy (Cluett et al., 2009), position in the second stage of labour (Gupta et al., 2012), skin to skin at birth with the baby (Moore et al., 2012), support with bonding and avoiding interrupting the bonding process (Moore et al., 2012), delayed cord clamping (McDonald et al., 2013) and early breastfeeding (Moor et al., 2012).

Cultural, organisational and clinical elements have not only been associated with normal birth, but also with improved outcomes for mother and babies as well as increased staff morale (Commission for Healthcare Audit and Inspections, 2005; Lewis, 2004).

One way of understanding how to increase normal birth is by studying interventions such as hydrotherapy, position in first and second stage of labour and so on. On the other hand, research on place of birth for healthy women with uncomplicated pregnancies has demonstrated that midwifery units as place of birth achieve the best outcomes for both mother and their babies (Hollowell et al., 2011). If we consider place of birth as a complex intervention, we could study how to implement it and how to scale up the use of midwifery units using the support of Implementation Science.

In order to progress in this approach, we need to define the complex intervention and to date there is little evidence on what the key characteristics of midwifery units are, particularly from an organisational and midwifery perspective (Macfarlane et al., 2014 a; 2014b)

The Birthplace in England study (Hollowell et al., 2011) identified that midwifery units are safe and cost-effective, but in order to scale up this complex intervention we need to follow several steps:

- Define the complex intervention (midwifery unit).
- Develop a theoretically informed strategy on how to implement the well-defined complex intervention in practice and pilot it.
- Develop a pragmatic trial to test the intervention and - if effective -
- Design a strategy for the implementation and dissemination in maternity services.

My PhD study aims at contributing to the body of knowledge on what are the key active ingredients and landmarks which make a FMU well-functioning.

Structure of the thesis

This thesis is structured in five sections. Table 1 provides a visual overview of the structure.

Table 2- structure of the thesis by section and chapters

SECTION	CHAPTER	CONTENT
Abstract		
SECTION 1	1- Introduction	Introduction
	2- Background	Historical and policy background
SECTION 2	3- Methodology	Theoretical Underpinning and Methodology
	4- Methods	Methods
SECTION 3	5- Literature reviews	Systematic review of clinical outcomes for FMUs
	6- Literature reviews	Meta-synthesis of qualitative studies on FMUs
SECTION 4	7- Findings	The context to the ethnographic study
	8- Findings	The individual dimension of the staff working in the FMU
	9- Findings	The organisational dimension
	10- Findings	The dimension of the woman
SECTION 5	11- Discussion	
	12- Conclusions	
Appendices		

Section One

In this section I introduce the study by identifying the focus of my ethnography. I report the aim, objectives as well as the research question. I also provide an historical background to place of birth as well as exploring key policies, which have direct relevance to the organisation and practice within midwifery units.

Section Two

In this section I consider the theoretical underpinning of the ethnographic study and I discuss the chosen methodology as well as methods, including positionality, reflexivity and authenticity.

Section Three

In Section Three I report the systematic review of quantitative studies, which examine the clinical outcomes for healthy women with uncomplicated pregnancies, who opted for FMU care as well as perinatal outcomes.

Section Four

In section four I present the findings divided in four chapters: in chapter 7 I present the context to the ethnographic study; in chapter 8 I present the individual dimension of the staff working in the FMU; in chapter 9 I present the organisational dimension; and in chapter 10 I present the findings relative to the dimension of the woman and the service users.

Section Five

In section five I include the discussion (chapter 11) and the conclusions (chapter 12).

Chapter 2- Historical and policy background

Introduction

In this chapter I will describe the historical background to my ethnographic study. I will provide a brief outline of the history of place of birth in the 20th Century England to highlight the non-evidence based shift from birth in domiciliary settings to in-hospital birth and some of the consequences.

I will describe concepts such as the institutionalisation, industrialisation and medicalisation of birth and their consequences and examine the consequences for midwives. I will also explore the response to medicalisation, the publication of Government policies and the existence of a policy-implementation gap.

Where to be born? A brief history of place of birth in England

There is a long tradition in England of freestanding midwifery-led units providing care for women with uncomplicated pregnancies, although the terms used to describe them have changed over the years (Tew, 1990; Campbell and Macfarlane, 1994; Stewart et al. 2005; Hollowell et al., 2011).

In the nineteenth century, a very small number of women gave birth in voluntarily run lying-in hospitals (Loudon, 1992). The major shift from birth in domestic settings to birth in institutions occurred during the 20th century. In much of Europe, with the exception of the Netherlands, it happened on a widespread level after the First World War. It followed the urbanisation and industrialisation of society and the major shift was after the Second World War, from the 1960s onwards (Loudon, 1992). This was a complex phenomenon, which was accepted by society within a relatively short period of time (Tew, 1990; Chamberlain et al, 1987; Campbell and Macfarlane, 1994). Maternal mortality remained very high between 1900 and 1935, when it was around 4 per 1000 births (Loudon, 1992). It fluctuated in time as well as having geographical variations. This period was also characterised by very inconsistent practices and standards of midwifery as well as obstetric care (Loudon, 1992). In Europe the Scandinavian countries and the Netherlands offered the safest care to mothers, which was mainly provided by well-trained and organised midwives, who assisted births in domiciliary settings (Romlid,

1997). The United States, where by this time most care was provided by obstetricians in hospital settings and with extensive routine use of obstetric intervention had the highest maternal mortality, which reached 7 deaths per 1000 births in 1920 (Loudon, 1992). In England, as well as in most western countries, maternal mortality decreased dramatically between 1935 and 1980, when, due to multiple causes such as introduction of sulphonamides, blood transfusion and legalisation of abortion, it reached less than 0.09 deaths per 1000 births (Loudon, 1992).

In England hospitals were an unusual place of birth until well after the Second World War. In 1927 only 15 % of births took place in institutions, which included hospitals, maternity and nursing homes as well as Poor Law institutions (Campbell and Macfarlane, 1994). The remaining 85% of women would give birth at home attended by a midwife employed by their local authority (Peretz, 1990). In 1950, however, 65 % of births already took place in hospital (Campbell and Macfarlane, 1994). In their book 'Where to be born? The debate and the evidence' Campbell and Macfarlane (1994) gathered historical and statistical evidence on the events which led to the centralisation of birth in hospitals.

The idea of very small midwife-led units for working class women with straightforward pregnancies had already appeared in the nineteenth century in response to concerns about the high levels of mortality from puerperal sepsis in lying-in hospitals (Loudon, 1992) and was suggested by Florence Nightingale (Nightingale, 1871) and supported by William Farr in 1872 (Loudon, 1990).

In 1904 William Williams also highlighted the high rates of maternal mortality in hospital and the need for an alternative to both hospital or homebirth for deprived women (Loudon, 1990).

After the First World War, some doctors were calling for a major move to hospital birth. For example, in 1919 the Lancet published an article by Victor Bonney making a case for hospitalising birth without providing any supporting evidence of the improved safety (Bonney, 1919). Others, notably the Women's Co-operative Guild, campaigned for maternity homes for women living in poor housing and obstetric hospitals for 'abnormal cases'. This was the policy adopted by the Ministry of Health in 1919 (HMSO, 1920) and many maternity homes were opened (Campbell and Macfarlane, 1994).

In 1920, a 'Memorandum in regard to maternity hospitals and homes' by the Ministry of Health provided detailed plans and descriptions of the characteristics of both types of maternity units also including eligibility criteria (HMSO, 1920). Maternity homes were envisaged as simple houses in the community, especially on the outskirts of towns, which provided midwifery-led care in a clean

environment. They could offer different capacities from 8 to 20 beds and focus on care for women in labour without complications but also miscarriages and 'minor cases' (HMSO, 1920).

In the 1930s the number of beds both in maternity homes and hospitals increased steadily and the percentage of births in institutions rose to 24 % in 1932 (Campbell and Macfarlane, 1994). Maternity homes were renamed 'Isolated GP Units' after the inception of the NHS in 1948, which started providing healthcare free at the point of use for all citizens and made the availability of hospital care more accessible.

In the 1950s successive Ministry of Health reports reported increasing maternal requests for hospital birth (HMSO, 1952). The Ministry of Health started developing eligibility criteria for admission to hospital in order to prioritise women who were believed to benefit from hospital admission (Campbell and Macfarlane, 1994). During that decade, the rate of homebirth had fallen to 35% but it decreased even more dramatically during the 1960s and 1970s (Campbell and Macfarlane, 1994). By the 1960s the idea of 'safer' hospital births under the lead of consultant obstetricians had spread among both professionals and the public. Additionally, the availability of pharmacological pain relief in hospital made it appealing for some women.

Although in 1958 the British Perinatal Mortality Survey reported mortality for planned in and out of hospital birth to be similar (Butler and Bonham, 1963), the Minister of Health set a target of providing availability for 70% of births to take place in hospital. The Cranbrook Committee had considered 30% of women to be eligible for out of hospital births (HMSO, 1959). The target of 70 % of births in hospital was achieved in 1964 (Campbell and Macfarlane, 1994).

In 1970 the Peel Report argued "that sufficient facilities should be provided to allow for 100% hospital delivery. The greatest safety in hospital confinement for mother and child justifies this objective" (Standing Maternity and Midwifery Advisory Committee, 1970, p.60). The Peel Report recommended that women should give birth in hospital even if they did not have any medical complications, applying a concept which has been summarised by the "Maximin Strategy" as 'choosing the alternative that makes the best of the worst possible outcome, regardless of the probability that that outcome will occur' (Brody and Thompson, 1981, p.997).

Again, there was no statistical justification for this recommendation (Tew, 1978; Campbell and Macfarlane, 1994). As a consequence of policies set out in the 'Peel Report' and Priorities for Health

and Social Services in England (HMSO, 1976) many GP units were closed during the 1970s and 1980s, due to claims that they were unsafe and not cost effective (House of Commons, 1980). The number fell from 226 in 1973 to 151 in 1978 (Campbell and Macfarlane, 1994).

In 1980 a report by the House of Commons Social Services Committee (1980), chaired by Renee Short MP and so also known as the 'Short Committee' recommended for an increase in obstetric-led hospital births, a better selection for isolated GP units and the further reduction of home birth. The 1980s saw the concept of 'birth being normal only in retrospect' becoming a reality, overriding the idea of birth as a physiological event (Tew, 1990; Kirkham, 1996; Oakley, 1984). This was to become a pillar in the medicalisation of childbirth and arguing for the need for specialised medical services, notably obstetrics, neonatology and anaesthetics for all birthing women (Tew, 1990). It was argued that the advances in medical care provided in hospital settings had played a major role in making birth safer for mothers and babies (McKeown, 1979). Archie Cochrane commented that: 'It is surprising how successive committees have been content to accept trends as something God-given which must be followed, instead of demanding a more rigorous analysis of causality (Cochrane, 1972). A number of factors seem to have contributed to the spectacular decrease in maternal and perinatal mortality since the 1930s (Tew, 1990; Campbell and Macfarlane, 1994). Better nutrition, hygiene, the advent of sulphonamide drugs and antibiotics as well as better knowledge and attention to asepsis and anti-sepsis seem to have played a key role (McKeown, 1979). However puerperal sepsis, a substantial proportion of maternal deaths up to the mid 1930s, was often an iatrogenic consequence of poor aseptic and anti-septic procedures by health professionals, especially when carrying out instrumental births, many of which were unnecessary (Loudon, 1992). In countries such as the Netherlands, where the main care provider had remained the highly educated and trained midwife, the maternal mortality rate in 1920 was less than 2.5 in 1000 births compared to 6.9 in the United States (Loudon, 1992; Tew, 1990; Campbell and Macfarlane, 1994). Loudon (1992) reports an account published by DeLee of Chicago, in which Dr DeLee describes how he would deliver every single woman under full anaesthesia, with forceps and manual removal of placenta (DeLee, 1920). In England, the standards of care varied enormously. Most general practitioners and obstetricians were skilled and conscientious, but as Dr Finer in Essex documented, some would use chloroform and forceps in order to expedite deliveries and free the bed for the next labouring woman. These accounts highlight the use of medical authority and techniques in order to serve the industrialised approach to care. This focused on getting the baby

out as soon as possible rather than on the use of interventions on the basis of clinical judgment and necessity (Loudon, 1992; Kirkham, 1996; Davies-Floyd, 1997).

If on one hand the availability of hospital care to women with obstetric complications has contributed to the improved outcomes, on the other hand we now have careful statistical analysis which has demonstrated that the centralisation of all births in hospital was not justified and that the Peel report was partly based on a statistical analysis that failed to control for the inclusion of unplanned and unattended home births in the outcome data (Tew, 1978; Campbell and Macfarlane, 1994).

In 1974 The National Health Service (Re-organisation) Act moved the management of community midwives from the local authorities to come under hospital authorities. This move effectively disempowered community midwives, who until then had been able to maintain a certain degree of autonomy. The work of the hospital midwife was perceived as superior and more essential. As the industrial approach was extended to the community services, clinics became rushed and impersonal (Kirkham, 1999). Since the decrease of births at home and in maternity homes, General Practitioners slowly lost involvement with intrapartum care, maintaining instead their role for antenatal care (Tew, 1990; Campbell and Macfarlane, 1994). Some General Practitioners maintained their role in midwifery in the maternity homes, renamed isolated GP units after the creation of the NHS in 1948. In all effects GP units were birth centres, where most care was provided by midwives, who would only involve the GP in case of complications (Tew, 1990; Campbell and Macfarlane, 1994).

In 1991 the Thatcher government introduced the 'Purchaser - provider split' (commissioning principle) and maternity services became part of acute trusts, with only a few exceptions mainly as a result of campaigning by the Association for Community-Based Maternity Care made up of GPs, midwives and obstetricians working together.

The percentage of births at home reached a minimum of 0.9% in 1987, then started to rise slightly (Campbell and Macfarlane, 1994). In less than a century the childbirth culture in England had radically transformed.

Institutionalisation, industrialisation and medicalisation of birth.

The move to hospital was intertwined with a major shift in the philosophy and care offered to women in childbirth creating a complex interconnection between institutionalisation, industrialisation and medicalisation. Once birth moved into large institutions an industrial model of care was adopted in order to maximise perceived efficiency. The changes were warranted by the authoritative knowledge of obstetricians (Martin, 1987; Kirkham, 1999; Perkins, 2004). The concept of authoritative knowledge was described by Jordan as signifying knowledge which has power, and makes claims to authority in terms of reason or nature (Jordan, 1992).

Birth turned from being seen as primarily a natural/social event, supported in a domestic setting to a medical event managed in an obstetric-led institution (Tew, 1990; Campbell and Macfarlane, 1994). Birth in an institutional setting meant 'serving the needs of many rather than the individual' (Stevens, 2009). The industrial model conceived the woman's body as a machine and the baby as its product, influenced by Fordism and Taylorism (Oakley, 1984; Martin, 1987). Fordism, named after Henry Ford, is a notion of a modern economic and social system based on an industrialised and standardised form of mass production (Antonio et al., 2000). Taylorism, also called scientific management, was a theory of management that analysed and synthesised workflows. Its main objective was improving economic efficiency, especially productivity (Aitken, 1985).

Following Taylorist and Fordist models of production and management the aim became the improvement of efficiency in order to maximise production and minimise time consumption (Oakley, 1984; Martin, 1987; Arms, 1994; Wagner, 1994).

Medicalisation of childbirth has been defined as the pathologisation of pregnancy and childbirth, which mirrored the normalisation of the routine use of medical procedures during childbirth (Oakley, 1984). The term 'Medicalisation' was developed by sociologists in the 1970s to describe the process by which human conditions become part of the medical domain by being defined and treated as medical conditions. Illich's 'Limits to medicine: Medical nemesis' (Illich, 1975), exemplifies one of the earliest uses of the term 'medicalisation'. He introduced the term 'iatrogenesis' to define harm caused by medical treatment (Illich, 1975).

More recently the post-modern concept of technocratic birth (Davis-Floyd, 1997) also associates the woman's body with an imperfect machine, which could fail. The clinician's duty is to strictly monitor

progress and to intervene if progress is delayed (Davis-Floyd, 1997). O'Driscoll (1980) eloquently described it as "the degrading scenes that occasionally result from the failure of a woman to fulfil her part of the contract". Arbitrary time limits, not scientifically justified and which changed over time, started being applied to labour and birth (Wagner, 1994; Downe, 2004, Downe and Dykes, 2009). The definition of labour dystocia shifted from a mechanical failure to a time-bounded failure to progress (Rothman, 1993). In 1992 a WHO study revealed enormous variation in the diagnosis of dystocia (Stephenson, 1992). Over the years the definition of established labour as well as what is considered normal progress in labour have changed and in fact at present there is a lack of evidence regarding time limits for labour (Downe, 2004; Downe and Dykes, 2009, Walsh and Downe, 2010). The industrial model of birth uses the authoritative status of medical knowledge to justify interventions to expedite labour in order to maximise the efficiency of the 'assembly line' (Davis-Floyd, 1997). As Jordan (1997) pointed out 'the power of authoritative knowledge is not that it is (necessarily) correct, but that it counts' (Jordan, 1997, p.58).

Since the 1970s the advances in technological development made the use of technologies such as ultrasound and electronic fetal monitoring readily available (Wagner, 1994; Odent, 2008). The percentage of women giving birth without any medical intervention decreased dramatically and the rates of induction, augmentation, instrumental birth and caesarean section rose significantly over time without significant health benefits (Tew, 1990; Campbell and Macfarlane, 1994).

The application of Taylorist and Fordist principles to the management of birth in hospital had significant consequences for both women and midwives (Martin, 1987; Kirkham, 1999; Perkins, 2004). The woman had to adapt to the 'assembly line' type of care, which demanded standardisation of practices and procedures. In this type of environment there was no space for women's wishes or preferences (Oakley, 1984; Martin, 1987; Arms, 1994; Wagner, 1994). The woman had to behave like a 'good patient' and move through the conveyor belt in order to produce its product: the baby (Martin, 1987). Midwives had also to adapt to become like skilled factory workers: to be efficient and under constant scrutiny (Kirkham, 1999). The NHS employed midwives had to choose whether to be 'with woman' or 'with institution', which created ethical dilemmas within midwives who wanted to support women's choices as well as resulting in internal professional conflict between the two groups of midwives (Kirkham, 1999).

Consequences for midwives

The regulation of midwifery under medical scrutiny reached its epitome during the 20th century. The 1902 Midwives Act, after a long debated campaign for controlling the registration of the profession, finally formalised the regulation of midwives (Heagarty, 1996). The Central Midwives Board, created to implement the objectives of the Midwives Act, counted mainly doctors as its members (Donnison, 1988; Kirkham, 2010). It was not until the 1920s that the Board was expected to include midwives as members, and even then they were statutorily precluded from becoming a majority (Donnison, 1988). It was only in 1973 that a midwife was elected as a Chairman of the Board (Donnison, 1988).

On the other hand the British College of Obstetricians, which was created in 1929, became crucial for the fast developing hegemony of obstetricians in maternity care (Donnison, 1988; Tew, 1990). Before then obstetricians had struggled to be recognised by their medical colleagues (Donnison, 1988).

As Kirkham summarised: 'in less than a century midwifery became regulated, professionalised and medically controlled' (Kirkham, 2000, p.465). If on one hand midwifery training and practice became more consistent, homogeneous and organised under supervision, on the other hand, the role of the midwife became increasingly more regulated under the obstetric control and shifted towards becoming an obstetric nurse (Donnison, 1988). This has changed the identity of midwives to the present time, and the establishment of the Nursing and Midwifery Council as the regulating body for both nurses and midwives is a manifestation of this long-lasting effect (Kirkham, 1999).

The centralisation of birth in consultant-led units had significant effects on midwifery practice. In a medically dominated environment the midwife became subordinate to the obstetrician (Donnison, 1988). The institutionalisation of birth saw the development among midwives of a culture of 'with institution' rather than 'with woman' (Kirkham, 2000a). Becoming a subordinate and oppressed group, midwifery developed a culture of 'horizontal violence' (Fanon, 1963; Leap, 1997; Kirkham, 1999). In hospital midwives became institutionalised and their practice processed and task focused (Hunter, 2006; Kirkham, 2000a). For the midwives, relationships with peers and managers became more significant than those with the women (Hunter, 2006). In this context of task focused midwifery work, midwives who attempted to be 'with woman', to personalise care and listen to women's wishes were perceived increasingly as deviant (Hunter, 2006; Kirkham, 2000a) and many became victimised by peers who remained 'with institution' (Kirkham, 2000a). This concept defined as 'horizontal violence'

has been introduced in midwifery to explain the observations and reports of hostile behaviour among midwives towards colleagues (Leap, 1997a; Kirkham, 1999). It has been theorised that oppressed groups internalise the rules and values of the dominant group resulting in embracing the dominant culture, which oppresses them (Freire 1972; Duffy 1995, Roberts, 1983). The subservience to the dominant group and inability to challenge the status quo causes built up tension, which is inappropriately released within the oppressed group. Frequent victims of such horizontal violence are individuals within the group perceived to be deviating from the dominant cultural norms (Fanon, 1963; Leap, 1997).

Lipsky (1980) argued that submitting to horizontal violence 'discourages innovation and encourages mediocrity' (Lipsky, 1980, p.144). Ball et al. (2002) on the other hand highlighted the role played by institutionalisation of midwives and industrialisation of practice in the decision of leaving the midwifery profession. The industrial model of care resulted also in the fragmentation of practice, which prevented midwives from developing their full range of skills and knowledge (Walsh, 2004; Walsh and Downe, 2010). Many midwives left the profession because they felt they were prevented from being able to practice real midwifery (Ball et al., 2002).

Response to medicalisation: Government policies and the policy-implementation gap

Feminist movements of the 'first wave' until 1960 focused mainly on the right to free and accessible health care as a human right and on women's emancipation from 'biological chains' (Martin, 1987); At the time 'humanising childbirth' or fighting against medicalisation of birth was not perceived as a need by feminists, who felt on the other hand that fighting for contraception and abortion was a priority (Tew, 1990; Oakley, 1993). In 1921 Marie Stopes founded the first UK birth control clinic in London, at the time when birth control was only available to married women. In view of the fact that the evidence on safety of place of birth had been overlooked, it is not surprising that women's movements did not focus on responding to the centralisation of all births in hospitals (Campbell and Macfarlane, 1994; Tew, 1978).

The closure of both maternity homes and isolated GP units as well as the centralisation of virtually all births in hospitals in England during the 1970s was associated with a rapid increase in medicalisation

and birth interventions (Tew, 1990; Campbell and Macfarlane, 1994). This led to the organisation of movements by service users, professionals and researchers in the attempt to highlight the lack of evidence supporting hospital birth as well as the lack of evaluation of birth interventions and technologies. As early as 1930, even before the systematic medicalisation of childbirth, the obstetrician and supporter of natural childbirth Grantly Dick-Read (1942) stressed that most women did not need medical intervention to give birth safely. The Natural Childbirth Association of Great Britain was founded in 1957 to promote Dick-Read's teaching. It became the National Childbirth Trust (NCT) in 1961. It campaigned for an improvement in hospital environment and for fathers or other birth supporters to be allowed to support the labouring woman. It also later started lobbying for women's right to be assisted at home if they choose to have a homebirth.

Sally Willington's letter published by The Observer in 1960 (Laurence Beech and Willington, 2007) about her inhumane treatment in hospital while giving birth created a reaction which resulted in the foundation of the Society for the Prevention of Cruelty to Pregnant Women, renamed in 1960 as the Association for Improvements in the Maternity Services (AIMS). AIMS originally focused mainly on fighting for better care within the hospital and increasing the numbers of hospital beds rather than challenging the medicalisation of childbirth per se. Only a year after the creation of AIMS, the government report Human Relations in Obstetrics (Ministry of Health, 1961) highlighted the need for addressing some of the issues highlighted by both the NCT and AIMS (Mander and Fleming, 2002). The lobbying by NCT and AIMS led to an improvement in childbearing women's condition in hospital (Tew, 1990).

The natural childbirth activists grew in strength during the 1970s gradually involving researchers and politicians. In 1974 the Society for the Support of Home Deliveries was set up in the UK with the aim to highlight the lack of evidence supporting the idea of all births to be safer in hospital.

Against the background of accumulating evidence of inappropriate use of obstetric interventions, in the 1980s the World Health Organisation started a campaign to support the use of appropriate technology for birth, stressing the iatrogenic risks of unnecessary birth interventions, (WHO, 1985). The World Health Organisation report "Having a baby in Europe" (WHO, 1986) highlighted the high level of fragmented care and interventionism since the Peel Report.

A turn in the trend of government policies was finally catalysed by the House of Commons Health Committee's report on Maternity Services (1992). The committee heard evidence and views from a

wide range of organisations and individuals representing women's views as well as professionals and academics who could help to shed light into the issue of in and out of hospital birth and experiences of care. The work of Tew (1990) and Campbell and Macfarlane (1994) played a crucial role in reinforcing the argument that the trend towards the centralisation of hospital birth and medicalisation were not evidence based. The Committee advocated women-centred care and a re-evaluation of midwives' role. This set the base for the convening of an expert committee, whose report in 1993 "Changing Childbirth" (DH, 1993), embraced the Winterton's Committee's philosophy of woman-centred care, which was summarised in the concepts of 'Choice, Continuity and Control'. This policy was later reinforced by the National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004) and the guidance Maternity Matters: Choice, access and continuity in a safe service (DH, 2007) which was the guidance document intended to enact the maternity component of the NSF. These advocated promoting normality, choice and improving women's experience of maternity care. They also supported and advocated for more choice for women about place of birth, including midwife-led units both in hospital and in the community.

The UK's Maternity Care Working Party consensus statement, published in 2007, provided an agreed working definition of normal birth. It aimed to enable better monitoring and analysis of birth intervention rates and highlighted why focusing on normal birth can improve outcomes as well as service users' satisfaction (Maternity Care Working Party, 2007). The consensus statement was embraced by the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists and the National Childbirth Trust. In the same year the National Institute for Clinical Excellence (NICE, 2007) published the guidelines 'Intrapartum care: Care of healthy women and their babies during childbirth', which reinforced the need for a clinical justification for interventions and the importance of sensitive and effective communication with the labouring women as well as the importance of keeping women's choices at the centre of decision making.

These concepts are echoed and reinforced by the RCM Campaign for Normal Birth and the publication by the NCT of a report 'Normal Birth as a measure of quality of care' (Dodwell and Newburn, 2010).

However, despite the government policies and normal birth initiatives supported by professional bodies, service users lobbies and clinical guidelines which have been developed since 1993, birth interventions keep rising (HSCIC, 2015).

Consequences of hospital industrialised birth for women, health and costs

A consequence of birth based mainly in institutions has been the fragmentation of midwifery care, the isolation of women from their loved ones and the routine introduction of intrapartum interventions (Tew, 1990; Kirkham, 1999; Loudon, 1990). The hospital was not 'culturally' prepared to assist births. Hence the norm became to 'manage' labouring women who were to 'be delivered' rather than 'giving birth' (Kirkham, 1999). Women's experiences of birth have been, and still are greatly affected by the care they receive (Green and Baston, 2003; Lavender et al., 1999; Kirkham, 2010).

Walker et al. (1995) summarised what women value as important for their pregnancy and birth as:

- To be informed
- To have options
- To be involved in decision making
- To make informed choices

In a survey on 'Better Birth Environment' organised by the National Childbirth Trust (NCT, 2003) almost all women reported that the surroundings could affect how a woman gives birth. Half of them agreed strongly that the environment could influence the extent to which a birth is considered easy or difficult. Factors mentioned as 'facilitating' were: space for walking, a pool or a bath, en-suite toilet, an adjustable bed, low lights, a private room. All these factors contribute to make sure the woman feels in control over the birth environment, which is not experienced as a disturbing element (NCT, 2003). To be in control has also been defined as being a fundamental aspect of good care. For a woman, it is important to be able to take her own decisions on the different aspects of labour and birth contrarily to professionals making those choices for her (Oakley, 1984).

After the spectacular decline in maternal and perinatal mortality since the 1930s, (Loudon) 1992, more attention was paid on how to reduce both physical and emotional morbidity (Tew, 1990; Campbell and Macfarlane, 1994). It was believed that obstetric intervention played an important role in improving outcomes (Wagner, 1994). Procedures such as induction of labour, artificial rupture of membrane, augmentation of labour, continuous fetal monitoring and episiotomy became common practice, if not routine (Wagner, 1994). The rate of induction of labour, which was 13 % in 1958,

doubled by 1970 to 26% and rose to 39.4% in 1974 (Tew, 1990). Electronic fetal monitoring also became routine practice for all women giving birth in hospital (Wagner, 1994).

Many obstetric interventions came into widespread use before adequate scientific evaluation sometimes with tragic consequences: for example, prenatal X-ray pelvimetry in the 1930s, diethylstilbestrol (DES) for pregnant women in the 1950s and thalidomide in the 1970s are examples (Wagner, 1994). Routine electronic fetal monitoring during labour became widespread and yet scientific evaluation showed that it did not lower perinatal mortality but increased the rate of caesarean sections (Wagner, 1994; 1998; NICE 2007).

The epitome of the idea of technocratic birth was the development and introduction of the package of interventions defined as 'active management of labour' in the 1980s following a randomised controlled trial in Dublin (O'Driscoll, 1980). It was later demonstrated that it was not effective in reducing caesarean sections rates (Thornton, 1996). The continual presence of a midwife in the intervention arm of the trial was identified as a confounder that had not been considered at the time and there were examples of 'low-tech' practice, which obtained better outcomes (Rockenshaub, 1990; Hodnett et al., 2007).

Since then numerous other publications demonstrated the link between intervention and iatrogenic harm as well as increasing costs and dissatisfaction with birth experience (Johanson et al., 1993; Lydon-Rochelle et al., 2000; Petrou et al., 2002; Thompson et al., 2002; Paranjothy et al., 2005; Williams et al., 2007; Bragg et al., 2010).

Ironically the only element of the active management of labour package, one-to-one care in labour by a midwife, which was later found to be effective in decreasing caesarean sections and instrumental delivery rates (Hodnett et al., 2003; Hatem et al., 2008) is still not systematically offered to labouring woman (Kirkham, 1996; Downe and McCourt, 2008; Walsh and Downe, 2010).

Reconfiguration and centralisation of services

Centralisation of services has been a key feature of the reorganisation of maternity care since the turn of the 21st century as well as other aspects of healthcare in recent years (Deery, 2010). This financially-led move risks contradicting recent government policies about women's right to choose the place of

birth if not accompanied with an increase of FMUs (DH, 2004, 2007; Macfarlane, 2008). Unfortunately, despite the links between centralisation, closure of OUs and the creation of some new FMUs in their place, the history of FMUs is a cause for concern, with many FMUs being closed within five years of opening (Deery, 2010).

Macfarlane stressed that the argument for centralisation of obstetric units to improve safety, as argued by the document 'Safer childbirth: minimum standards for the organisation and delivery of care in labour' (RCOG, 2007) was not based on evidence (Macfarlane, 2008). This document was published jointly in 2007 by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health. 'Safer childbirth' is based on an earlier document, 'The future role of the consultant' which recommends a reconfiguration of maternity units in order to enable consultant obstetrician cover 24/7 (Macfarlane, 2008).

Macfarlane (2008) continued by highlighting that 'The question of whether there is any association between the size of maternity units and the quality of their clinical care and their users' experiences has never been systematically evaluated' (p.81). Macfarlane stressed that the findings of the Healthcare Commission's enquiries into Northwick Park Hospital challenge assumptions relating to the safety and quality of care in very large units (Macfarlane, 2008).

Market values and Private Finance Initiatives

Many new NHS sites, including purpose built FMUs such as the Barkantine Birth Centre, have been built under the Private Finance Initiative (PFI) or LIFT, a similar initiative for community care buildings. This is very relevant for the strategic level of maternity services because the cost of PFIs has a dramatic impact on the distribution of NHS funding, redirecting vital funding which should be dedicated to the purchase of staff and services to the payment for the PFI. This is very relevant for purpose built FMUs which are not able to dilute costs of PFI over different services.

Allyson Pollock in her book 'NHS plc' (2004) described how privatisation was introduced in the NHS since the 1980s. She argued that Thatcher's governments systematically and radically changed the structure of the NHS opening a new market in healthcare for private companies, at the expense of patients' choice and public finances (Pollock, 2004). From 1980 onwards NHS hospitals were required

to outsource services such as cleaning, laundry and catering to supposedly more efficient private companies. Services for the elderly were also transferred out of hospital, managed by private contractors. In the same period two more structural changes introduced were the introduction of general management of hospitals and a reduction of the type of services the NHS would offer free of charge. The NHS's founding principle of 'comprehensiveness' of care was drastically revisited (Pollock, 2004).

In 1991 the internal market principle was introduced and the link between allocation of funding and local communities' needs was broken (Pollock, 2004). Hospitals were re-conceptualised as financially independent corporations. The NHS was required to provide income via contracts by the NHS purchasers. Private practice and other income generation were also encouraged.

Pollock argued that the fragmentation of the NHS services into small corporations and the 'purchaser-provider split' eroded the capacity of the NHS to plan and distribute resources on the basis of the health needs of the communities (Pollock, 2004).

Under the Private Finance Initiative (PFI) funding for a new hospital is raised by private capital on the behalf of the government. In return the private contractors build and manage the services in the new hospital for 30 or more years (Pollock, 2004). The responsibility to pay the debt and the interest will lie with the hospital, via lease arrangements which they then have to pay out of the annual budget for patient care (Pollock, 2004).

The debt created by PFI has been shown to have had a significant impact on the finances of public bodies (Hellowell, 2007).

The Treasury Seventeenth Report (HC, 2011) concluded that the substantial increase in private finance costs means that the PFI financing method has been extremely inefficient (HC, 2011, Paragraph 30). The financial cost of repaying the capital investment of PFI investors has been considerably greater than the equivalent repayment of direct government investment (HC, 2011, Paragraph 71). PFI would only provide value for money if this differential in the cost of finance, which has significantly increased, was outweighed by savings and efficiencies during the life of a PFI project (HC, 2011, Paragraph 30).

In the past, in order to save money, hospitals preferred to retain doctors and nurses and kept services running by spending less on building maintenance. Nowadays, under PFI, hospitals are forced to prioritise the contractual payments for their buildings over healthcare staffing and, according to

figures published by the Department of Health, these committed payments can account for up to 20% of operating budget (Timmins, 2010; 2011). If a NHS Trust cannot save on building maintenance, the only other options are cutting in staffing levels and the costs of health care services by lowering the quality of the services.

‘Payment by Results’ tariffs in England: why is it crucial to maternity services?

Payment systems for maternity care are key as inappropriate systems may create perverse incentives or lead to unintended consequences. Maternity services need well thought through systems, which focus on reducing unnecessary interventions and are equal across the country including remote geographical areas as well as focusing on equity of access to care for the most vulnerable.

The Payment by Results tariff system, first introduced in 2003, was intended to bring more transparency to NHS funding by specifically linking payment levels to the care which patients receive. This system established that NHS providers are due a payment each time they provide care (every episode or item of care). The NHS care provider would be paid £3,626 for a cesarean section with complications but only £1,174 for a spontaneous vaginal birth. This created a perverse financial incentive to increase interventions, or at least a disincentive from working to reduce them. This was cited as a key deterrent from focusing on midwifery unit development and increasing normal birth in McCourt et al.’s (2104) study of MUs. While such a system may be effective for certain aspects of healthcare, such as elective operations, NHS Trusts which kept low interventions were effectively penalised financially. Since 2003 many health professionals and researchers have called for a revision of Payment by Results tariffs in England, as a matter of urgency, to remove the perverse incentive to maintain high intervention rates (Maternity Care Working Party, 2007, p.2). Consequently, in 2013 the New Payment System in maternity was introduced.

The New Payment System aimed at encouraging a more proactive woman-focused approach to Maternity Services and was tested as a shadow system in 2012 (Commissioning Board, 2012).

Under the new system, a commissioner would pay a single lead provider for all the pregnancy related care a woman may need, via three payments in total: one for antenatal care, one for the birth and one for postnatal care (Henderson, 2016) with different tariff levels for women assessed at being at different risk levels.

The aim was to create incentives for providers to deliver the best, proactive care to prevent avoidable complications and interventions. The rationale was that the more proactive services are, the fewer interventions will be necessary and the fewer expensive interventions services undertake, the more money providers will save. (Commissioning Board, 2012, p.17).

In theory, this new payment system should provide a more supportive context for the development of midwifery units and midwife-led care. However, in a consultation notice for 2015/16 National tariff payment system the maternity pathway was used as an example of a rushed policy as engagement did not happen early enough. Both commissioners and providers sought clearer definitions and better guidance. Providers' comments focused on the level of the tariff that they say underfunded the cost of the service and on cross provider charging (Henderson, 2016). In addition, professional concerns have been raised (although not yet tested) about creation of a new perverse incentive to assess women as being at higher risk, owing to the higher tariff payment this attracts. This has the potential to create a new and unintended counterpoint to midwifery unit development or sustainability, but has not yet been evaluated.

National Maternity Review, 2016

The National Maternity Review (NHS England, 2016) has recommended movement towards a new payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission services for personalisation, safety and choice (NHS England, 2016).

The review recommends that the new payment system should:

- Consider the different cost structures services have
- Ensure women's choices drive the flow of money.
- Incentivise the delivery of high quality of care for all women, in particular, continuity of carer;
- Consider the challenges of providing sustainable services in certain remote and rural areas.
- Support providers to work together across a local maternity system, where care can be transferred between providers at any point.
- Incentivise community deliveries where clinically appropriate.
- Ensure access to perinatal mental health services.

The Maternity Review advocated for two main goals: for providers to undertake a bottom-up costing exercise and to test a Personal Maternity Care Budget System.

The first goal would lead to suggesting adjustments to the existing tariff to more accurately reflect relative costs. This could potentially lead to the introduction of different prices for home births, freestanding and alongside midwifery units, as well as obstetric units (NHS England, 2016).

The Personal Maternity Care Budget System was expected to force a real focus on choice by giving a woman control of the money used to buy her care. Several NHS Trusts in England have volunteered to function as test sites and they will partially adopt this new system to identify effects and possible unintended consequences (NHS England, 2016).

Litigation in maternity care

Maternity care is already notoriously litigious and accounts for nearly 50% of the value of all NHS negligence claims (NHS Litigation Authority, 2012). Clinical negligence claims have been steadily increasing worldwide and these can pose a serious threat to the financial viability of healthcare organisations.

The Clinical Negligence Scheme for Trusts (CNST), established in 1995 and extended in 2003 to maternity, provided NHS trusts with a set of risk management standards (NHS Litigation Authority, 2006a). These were designed to act as a framework, bringing focus to the clinical risk management procedures adopted by maternity services, and to contribute to the development and implementation of clinical governance, thereby potentially improving patient care (NHS Litigation Authority, 2006a). Both the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) endorsed the standards because of their perceived potential to benefit clinical care (O'Neill, 2008). By improving clinical risk management procedures within maternity units, the standards were ultimately intended to reduce the level of clinical negligence claims. Assessments against the CNST Maternity Clinical Risk Management Standards were conducted by Det Norske Veritas Ltd (DNV) on behalf of the NHS Litigation Authority (NHSLA) to ensure that members' contributions reflect their standards of clinical risk management.

However, it is unclear whether the CNST had a substantial positive effect on clinical care and outcomes or whether it simply helped in reducing viable claims, through adoption of more defensive processes (O'Neill, 2008). It has been argued that the CNST Scheme might even have had an adverse effect by diverting management resources into complying with CNST standards, rather than focusing on safety per se (O'Neill, 2008).

There is growing concern that a 'tick box' approach to risk management could affect women's experiences by trying to increase compliance with risk management protocols (O'Neill, 2008). The Report by the King's Fund 'Safe Births: everybody's business' (O'Neill, 2008) stated that 'Concern was also raised in some submissions that the CNST standards were not necessarily the right ones. We also heard from many respondents that it was possible to achieve CNST standards by means of a 'paper exercise', without investing in genuine safety improvements (O'Neill, 2008, p.89). The Report highlighted the importance of positive team culture and effective teamwork, which can increase

patient safety. The inquiry found a number of recurrent difficulties in teamwork, leadership and management as well as communication between clinicians (O'Neill, 2008).

Conclusions

Following a period of 'blind enthusiasm' for technocratic birth (Davis-Floyd and Sargent, 1997) strong evidence is now leading to reconsideration of the role of medicalisation of birth. Recent reviews of rates of birth interventions in developed countries and in England show large variations of rates not justified by population variations (Paranjothy et al., 2005; Bragg et al., 2010; Macfarlane et al., 2015). Thus, the variations seem to be due to organisational factors, culture of the maternity units and due to practitioners' practice rather than based on clinical necessity (Paranjothy et al., 2005; Bragg et al., 2010; Macfarlane et al., 2015).

There is a growing body of evidence in support of the fact that the increased use of obstetric intervention is not clinically justified, is associated with both maternal and neonatal morbidity and mortality and can cause iatrogenic harm (Cochrane, 1972; Petitti, 1985; Johanson, 1993; Glazener et al, 1995; Thompson et al, 2002; Allen et al, 2003; Liu, 2005; Williams et al, 2007). The NICE Intrapartum Guideline 2014 states that 'clinical intervention should not be offered or advised when labour is progressing normally and the woman and baby are well.' (NICE, 2014, p.7).

There is still uncertainty regarding the long-term consequences of many labour and birth interventions. The advancement of scientific knowledge, especially epigenetics poses serious ethical dilemmas about the iatrogenic effects of interventions such as labour augmentation and elective caesarean section (Dahlen et al., 2013; 2014).

Birth experiences have a long-lasting impact on the woman and its hospitalisation can have serious consequences on women's birth experiences (Green and Baston, 2003; Lavender et al., 1999; Kirkham, 2010). Together with clinical outcomes, assessing users' views of maternity care should be of paramount importance (DH 2004). Unfortunately, only a few of the evaluation studies regarding outcomes of different models of maternity care consider this dimension.

Some insights on women's expectations and experiences of maternity care are provided by Green et al. (1998; 2003). *Great Expectations* (1998) overcame two preconceived ideas: first that information

was less important for lower socioeconomic groups, and second that having greater expectations had a negative influence on birth experience.

The NICE Intrapartum guidelines states that 'Birth is a life-changing event and the care given to women has the potential to affect them both physically and emotionally in the short and longer term' (NICE, 2014, p.1). A positive birth experience can increase self-esteem, empowerment and easier transaction to motherhood (Simkin, 1991). The concept of women's centred care has been developed in order to stress the importance of partnership in decision making regarding all aspects of maternity care (Gerteis et al., 1993; DH, 1993; 2004; 2007; 2016).

Four key elements have been identified as essential in determining a positive birth experience: perception of intrapartum support, partnership in decision-making, information and control (Seguin et al., 1989; Lavander et al., 1999; Green and Baston, 2003; Waldenstrom et al., 2006).

This Chapter has critically explored the historical background to the centralisation of birth in hospital settings and identified several negative consequences to this non-evidence based shift, which had and still bear consequences for women, their families as well as for midwives and the maternity services.

SECTION TWO: THEORETICAL UNDERPINNING, METHODOLOGY AND METHODS

Introduction to section

In this section I consider the theoretical underpinning of the ethnographic study and I discuss the chosen methodology as well as methods.

Chapter 3- Theoretical underpinning

Introduction

In this Chapter the step-by-step decision-making behind the philosophical and theoretical stance of the study will be described. I will discuss the rationale for the chosen ontological and epistemological approaches. I will also discuss the methodological background starting from the rationale for using an inductive methodology and why ethnography was chosen.

Theoretical Underpinning

While writing this Chapter I had to reflect on the use of the terminology, since in the literature terms such as epistemology, ontology and paradigm were used in a quite ambiguous and confusing manner (Crotty, 1998). The understanding of ontological and epistemological positions is of paramount importance for discussing the theoretical underpinning of a research project. They are the two pillars on which a theoretical perspective is based. I will start from the basics to describe the ontological and epistemological positions informing the theoretical perspective which guided my ethnographic study.

Ontology and epistemology

Ontology and epistemology are two separate branches of philosophy: the first deals with the nature of existence, the second is concerned with the nature of knowledge. Both ontology and epistemology inform and shape a theoretical perspective, rooted in a philosophical paradigm. Unfortunately, there often seems to be confusion in the way the two terms are used.

Ontology deals with questions such as: 'What can be said to exist?' Epistemology asks questions such as: What is knowledge? How is knowledge acquired of what exists? How do we know what we know? And in this sense, ontology precedes epistemology (Crotty, 1998).

A key ontological division lies between the paradigm of Realism, the belief that reality exists independently from the mind, and Idealism, which is the belief that reality exists as mental activity; essentially does not exist without a mind (Crotty, 1998).

Philosophers such as Plato discussed the problems of knowing the external world. His opposition between objective knowledge and 'doxa' (opinions) would become the basis for later philosophies' intent on resolving the problem of reality, knowledge and human existence.

Key epistemological paradigms include Objectivism, Constructivism and Subjectivism (Crotty, 1998).

Objectivism posits that the reality we observe has truth and meaning 'per se'. As a consequence, the mind can discover the 'absolute truth' about reality. The researcher can investigate and discover objective truth about an object by conducting enquiry in an impartial manner, by remaining external to the field studied and can thereby create knowledge which directly reflects reality. Constructivism on the other hand, which emerges as a critique of the objectivist epistemology, stresses a socially constructed knowledge of reality. While positivists view validity as being directly linked to the researchers' objectivity, constructivists, acknowledging the impossibility of complete objectivity, stress the importance of using reflexivity. Constructivists and Subjectivists share the belief that, instead of aiming for an abstract and impossible 'absolute objectivity', researchers aim to be reflexive and acknowledge their beliefs and dynamics in the field.

Both Idealism or Realism in ontology are compatible with Constructivism: as Crotty (1998) stressed, to theories that the knowledge of the world is the result of interaction between the 'knower' and the 'known', does not exclude an independent existence of the world. On the contrary, as Crotty (1998) eloquently explains, Realism in ontology and constructivism in epistemology are compatible. 'The existence of a world without a mind is conceivable. Meaning without a mind is not.' (Crotty, 1998, p.11).

Constructivism's epistemology is embedded in interpretivist enquiry, which will be described in the next paragraph.

Most ethnographic methodology adopts an interpretivist approach, although ethnography could be objectivist or subjectivist. This highlights the importance of defining the ontological and epistemological positions of an ethnographic study as well as the theoretical perspective, as these cannot be assumed *a priori*.

Theoretical perspectives

Crotty argued that a theoretical perspective is 'the philosophical stance informing a methodology' (Crotty, 1998, p.3). Positivism, which had great success from the beginning of the 19th until the mid 20th century, is an example of a theoretical perspective informed by Realism in ontology and Objectivism in epistemology. Reality is considered to exist and hold meaning independently from the mind: we can learn about it in an objective manner in order to discover 'absolute truth'. It is based on the principle that objective knowledge is possible and based on empirical experience (through the senses) and positive verification.

Denzin (2001) summarised the underpinning assumptions of positivism as follows:

- There is a reality, which can be objectively studied.
- The researcher (subject) must keep the researched object as a separate entity.
- The knowledge discovered should be universal and not linked to time or situation.
- The researcher must seek to discover causality.

Kuhn, an American physicist, who wrote extensively on the history of science, forced the positivists to a less dominant position. Kuhn's 'Structure of Scientific Revolutions' (1962), based on analysis of how science works in practice, stressed that scientists could never divorce their subjective perspective from their work; thus, the comprehension of science can never rely on full "objectivity". Instead of claiming an impossible objectivity the scientist must rely on reflection and honesty in order to acknowledge bias, and to identify confounding factors, which may have influenced a study. Feyerabend, who considered scientific findings at the same level of any other cultural beliefs, called for a 'pluralistic methodology'. He argued that 'rationalists clamoring for objectivity and rationality are just trying to sell a tribal creed of their own' (Feyerabend 1987, p.301). Biomedicine has traditionally embraced a positivistic approach and tended to view its position as objective and outside the domain of cultural systems, although this is increasingly challenged within medicine (McCourt, 2009).

Interpretivism developed in an opposite direction to positivism in trying to explain the reality of human and social world. It 'looks for culturally derived and historically constructed interpretation of the social life' (Crotty, 1998, p.67). Interpretivism is often linked to the thought of Max Weber and has historically divided into three main streams: hermeneutics, phenomenology and symbolic

interactionism. The latter is a theoretical perspective that has informed ethnomethodology, a variation of ethnographic methodology.

Blumer (1969) described its three assumptions as that:

1. Humans behave towards things and events according to the meanings that these have for them.
2. Individual meanings of things and events derive from interaction with other human beings.
3. Meanings are controlled and modified via an interpretive process through interaction.

Interpretivism has been criticised as being an uncritical form of study (Crotty, 1998). In response to such critiques, Critical Theorists and Feminist researchers aimed to highlight power relationships within the field and injustice. Critical Theory is often associated with the work of Karl Marx, even if not all Critical Theorists are Marxists. Critical theorists are characterised by a political engagement. Their aim is not only to investigate and describe the 'status quo', but also for research to change it. Another prominent trait defining Critical Theorists and Feminists is to read social reality as determined by conflict and oppression, rather than simply by interaction, as understood by Interpretivists. Feminist researchers have a commitment to unmask the oppression of women in society. Feminist writers such as Ann Oakley have greatly contributed to the development of theory and knowledge about childbirth. However feminism is not a homogeneous movement and feminist research can be informed by different ontological and epistemological positions. One aspect of some feminists, which I always felt uncomfortable with, was the claim that only women can be feminists. Stanley and Wise (1983) argued that 'We reject the idea that men can be feminists because we argue that what is essential to 'being feminist' is the possession of a 'feminist consciousness' (Stanley and Wise, 1983, p.18). Crotty (1989) argued that this is the same as claiming that only a black person can embrace civil rights and anti-racist movements because a white person does not have a 'black consciousness'.

Critical theory and Feminism are very relevant to midwifery research: it is women who are pregnant and give birth and midwifery is a mainly female occupation (in a biological and gendered sense). Reading midwifery through the 'lens' of power struggles provide new insight into the field. Key concepts such as horizontal violence, as defined by feminist scholars like Kirkham (1986) offer very convincing explanations for the dynamics observed by many researchers and practitioners in organisations such as the NHS.

Methodology

Methodology is a strategy, which guides data collection using specific research methods (such as participant observation and interviews) and analysis. A study's methodology is informed by its theoretical underpinning (Crotty, 1998).

Rationale for using ethnography

The workplace culture is of paramount importance in trying to understand the context of midwifery practice (Kirkham, 1999). The best-suited method to study 'culture' is ethnography. Ethnography is a research methodology derived from anthropology, which aims to gain an insider's or 'emic' perspective, to make sense of 'why people do what they do' and the way the group functions (O'Reilly, 2009), within its context. Understanding the worldview and soft (tacit) 'rules of the group' is very important for comprehending why 'midwives do what they do', therefore opening the possibility of theory generation. This could enable the development of a theoretical framework on the way a MLU functions and midwifery skills are enacted.

Although each ethnographic study is unique in terms of researcher, participants and location and cannot simply be generalised to a wider population or context, the body of knowledge it produces is useful more widely in generating new theoretical ideas and in modifying pre-existing theories (Bryar and Sinclair, 2011; May, 2001; Rifkin and Pridmore, 2001). The term 'theory' is defined by Bryar and Sinclair (2011) as 'a mental construct, which seeks to clarify the relationship between facts and phenomena' (Bryar and Sinclair, 2011, p.28). Theories attempt to build an explanation for events and actions (Bryar, 1995). Theory can therefore be used to build experimental research in order to influence outcomes (Lavender et al., 2004). Using ethnography for theory generation followed by research with experimental design to test hypothesis, which emerged from the ethnography, seems a good combination of inductive and deductive methodologies (Lavender et al., 2004).

Ethnography

Ethnography has its roots in British social anthropology and American cultural anthropology (O'Reilly, 2009). It has evolved as a multi-method research methodology (including qualitative and quantitative

methods), which includes several ways of collecting data or considering data: observation (traditionally participant observation), interviewing, photographing, using texts, articles and official documents but also survey or statistics. There are different types of ethnographies depending on the theoretical paradigm which stands behind the methodology. Its aim is to gain an insider's or 'emic' perspective, to make sense of 'why people do what they do' and the way the group functions (O'Reilly, 2009). Conventionally this task was considered possible only for an outsider, who starts making sense of a specific community from zero and 'hangs around' asking 'naive' questions about the significance of what people do and say (O'Reilly, 2009). Classic ethnography highlights the importance of the 'initial cultural shock' as a source of rich data. The ethnographer in a new field will pay attention to the unusual, new and strange. Once she/he gets socialised in to the new group this will make her/him 'blind' towards the significant details, which provide meaning. The saying 'fish don't see water' is sometimes used to illustrate this argument (Wagner, 2001). This somehow implies that the members of the group studied are necessarily unaware of the hidden meanings and group dynamics. It also takes for granted that outsiders are 'objective' observers, while being part of the group instead biases insiders.

Conventional ethnography in the early twentieth century was mostly conducted by white, male, European ethnographers travelling to 'exotic' lands. They studied the native 'primitive' populations investigating the local culture (Goodall, 2000). The product of ethnography was typically a positivistic descriptive account of local customs and beliefs as well as explanatory theories, with the aim of uncovering universal laws of human nature and society.

Three different disciplinary crises redefined traditional ethnography, leading to a 'reflexive turn' in anthropology. These crises were all linked to power relations: the first was the result of the claim of complicity between Anthropology and colonialism (Asad, 1973; Hymes, 1999), the second, brought forward by feminist scholars, relates to the problematization of the concept of 'objective observer' and to the allegation of 'androcentric bias' perpetrated by the 'male white ethnographers'. This resulted in an emphasis on the concept of 'positionality' (Marcus, 1998). The third crisis was the result of a challenge of the traditional distinction between subjective and objective styles of writing, which resulted in experimentations in ethnographic writing where dialogue and memoir were used (Clifford 1998, Marcus and Fisher, 1998).

In addition to the rejection of positivism in ethnography, the fading distinction between the subject/self and the object/other resulting from such challenges has led to an interesting 'democratic turn'. The inspiring work of 'halfie' scholars (researchers who belong to two or more cultures simultaneously (Fox, 1991) has shed light into the hidden biases of traditional ethnography. Not only is the meaning created by interaction between the ethnographer/subject with the participant/object but also the boundaries between subject and object are somehow removed since the presence of insider ethnographers has blurred the distinction between insider/outsider.

Ethnography and Grounded Theory

In my original proposal for funding, I planned to use some principles of Grounded Theory (GT) merged with the ethnographic methodology.

Glaser and Strauss challenge qualitative analysis as non-systematic, separated from data collection, as an addition or precursor for quantitative research and disjoint from theory-generation (Glaser and Strauss, 1967).

I decided to include the following elements of GT in my research:

- Simultaneous data collection and analysis.
- Coding close to the data.
- Using constant comparative method.
- Moving towards theory generation from the data.
- Memo-writing to define categories.
- Sampling aimed towards theory construction, not for representativeness.
- Conducting a literature review after the analysis.

(Charmaz, 2006)

After reading the Discovery of Grounded Theory (Glaser and Strauss, 1967), I however became more aware of the philosophical differences with my research approach. For me knowledge is 'constructed' and not 'discovered' (Charmaz, 2006). Glaser and Strauss's approach felt quite positivistic (Clarke, 2005) and, if on one hand I was looking for some step-by step guide, on the other hand I soon realised

that the ontology and epistemology on which Glaser and Strauss based their methodology was not compatible with the theoretical underpinning in my study.

In ethnography, context and historical background hold a profound importance (Emerson et al., 1995). Glaser and Strauss (1967) however stress that in their methodology, historical context and background are irrelevant. On the other hand, Clarke (2005) advocates for a Postmodern Turn in Grounded Theory with a focus on situational analysis. I decided to follow this new tradition, which merges well with ethnography.

Another important issue for me was the advice of trying to make ‘tabula rasa’ of my knowledge of the literature as advised by Glaser and Strauss (1967). I found this a non-realistic expectation, as most researchers who approach a study would have conducted a literature review to some extent or some preparatory work. Additionally, as a practitioner with experience of working in the setting to be studied, I would inevitably have prior knowledge and ideas about it. Robert Loescher says that ‘there is something ludicrous about pretending to be a “theoretical virgin” (Elkins, 2003, p.31).

So although I had decided to conduct a formal systematic review and meta-synthesis *after* my first round of formal analysis, I had pre-existing knowledge of research on FMUs, including having conducted a systematic review of clinical outcomes in 2006, and did not want to pretend not to have such knowledge.

I found that once I undertook the meta-synthesis it then proved challenging to keep the findings of the meta-synthesis separated from the ongoing analysis of my ethnographic study data. With my co-reviewer (see chapter 7 for an account of the process) we often had to go back to clarify which findings were emerging from the case study and which from the meta-synthesis.

Positionality, reflexivity and authenticity

Since the attack on positivistic epistemology, led by Kuhn (1962) and Feyerabend (1987), as well as the ‘reflexive turn’ in ethnography, led among others by James Clifford and George Marcus (1986), it is impossible to deny that we are part of the world we study (O’Reilly, 2009). As a consequence, a researcher is required to declare her/his positionality in the study. Positionality refers to the ‘need for

finding a serviceable and responsible way of situating oneself in 'the field', and is a threshold issue in all ethnography' (Gould and Marcussen, 2004, p.6).

Very strongly connected to positionality is the concept of Reflexivity, another fundamental ethnographic tool. Reflexivity is defined as the constant analysis of the researcher's own values, views and emotions in the field and how these can influence the perception of the fieldwork (O'Reilly, 2009).

Reflexivity is the requirement to think critically about research, writing and the effect of the research on the group studied, the group studied on the researcher as well as the effect of the researcher's own worldview on data collection and interpretation of the data (O'Reilly, 2009).

O'Reilly (2009) emphasised the importance of reflexivity as a fundamental ethnographic tool that makes clear the researcher's own beliefs and objectives and the need to think critically about research and writing. In the case of my study reflexivity was particularly crucial because I had been part of the group studied.

As mentioned before, instead of claiming an impossible objective truth, the researcher is open and honest about field dynamics. The effect on the field could depend on the researcher's pre-existing beliefs, making the researcher focus or note specific things but also because of her/his impact on the participants (Jordan, 1993). The 'Hawthorne effect' could exemplify how the researcher can have an effect on participants. The concept of 'Hawthorne effect' was coined in 1950 by Landsberger (1958) based on the observation study at the Hawthorne factory. It described how research subjects increased productivity as an effect of being observed.

Another related concept is authenticity, which was developed in ethnography to describe the extent to which the ethnographer's representation of the fieldwork dynamics and their significance match the views of the research participants (Yanow and Schwartz-Shea, 2006). Authenticity is linked to credibility and involves the representation of the world studied in a manner that reflects the meanings and experiences of participants (Sandelowski, 1986). This involves capturing the subtle different nuances of voices from participants (Lincoln, 1995). Multiple, sometimes conflicting, socially constructed realities can be exposed via attention to authenticity (Bailey, 1996).

Insider, outsider and in-between

An increasing number of healthcare researchers use ethnography to study their own workplace. This has raised issues regarding the trustworthiness of the findings as 'insider researchers' are characterised as being over-involved and biased (O'Reilly, 2009). On the other hand it has been argued that 'outsiders' may not have the 'verstehen', a German word that translates into English as 'understand'. This means that they may not be able to fully comprehend or be able to access the 'backstage' dynamics (O'Reilly, 2009). In this section the problematisation of the relationship between insider and outsider will be critically explored.

Over the past decade a growing number of researchers from a migrant background started to study their own communities. It is estimated that in the USA almost half of the academics studying immigration issues are themselves from migrant background (Rumbaut, 1999). Classic 'orthodox' ethnography has traditionally been carried out by outsiders, considered as being 'objective' external observers. In other terms 'male and pale', mostly. On the other hand, the presence of 'insider' researchers such as indigenous ethnographers, feminist researchers studying women's lives, ethnographers from lesbian, gay communities, also called '*halfies*' ('people whose national or cultural identity is mixed by virtue of migration, overseas education or parentage' (Fox, 1991, p.137) has challenged conventional ethnographic tradition and the distinction between the 'self' and the 'other' (Abu-Lughod, 2008).

Murrillo, for example, calls himself 'mojado', which means 'wet', a term originally used in a deprecating way to describe the way illegal Mexican immigrants were getting to the USA crossing a river (Murrillo, 1997). He argued that a 'mojado ethnographer' is breaking these boundaries by being part of two worlds (Murrillo, 1997).

The special dilemmas introduced by belonging to two or more different cultures present a challenge to traditional anthropology by not being easily able to label the researcher as 'self' or 'other'. The attribution to either category has been challenged as relative to the context. The 'Insider/ outsider roles are products of the particular situation, in which a given fieldwork takes place, and not from the status or per se characteristics of the researcher' (Kusow, 2003, p.1). Merton stressed that individuals do not belong to a single social status (1972); as Kusow synthesised, citing Merton, 'they occupy a set

of social statuses such that one individual can occupy the status of outsider in one moment and of insider in another' (Kusow, 2003, p.592).

Kusow concluded that 'the relationship between researcher and participants cannot be defined 'a priori' such that a researcher can be categorically designated either as outsider or insider. Rather, the researcher status is something that research participants continuously negotiate. The researcher can be an insider in a particular local situation but an outsider in another' (Kusow, 2003, p.597). The key in the modification of the status depends on the interaction with the participants.

As Kusow explains, if we methodologically include all the categories, which may come into play at any moment, we will have to create scales or degrees of 'outsiderness' and 'insiderness'. This process of interaction and definition between the researcher and participants results in a collaborative process of meaning making, which is central to constructivism (Kusow, 2003).

I embrace the argument, originally raised by African American scholars and later proposed by feminist and critical theorists, which stresses that the distinction between insider and outsider is situational. The researcher's status and position is continuously negotiated within the field and never established a priori (Merton, 1972; Kusow, 2003).

In addition, I embrace the line of reasoning highlighted by Abu-Lughod (2008), who stresses the importance of acknowledging the political implications of the division of self/other, ultimately raising issues of power and oppression. For many of the 'halfie' scholars the role of the ethnographer traditionally carries connotations of the colonial or hegemonic appearance and raises ethical questions (Hume and Mulcock, 2004).

Feminist research and the dichotomy: male/female

The lessons learned from the reflexive exercises of 'halfie' scholars offer the possibility for a more 'democratic' ethnography with a 'humanistic turn' (Abu-Lughod, 1988; 2008).

Abu-Lughod (2008) stressed the importance of acknowledging the political implications of the division of self/other, ultimately raising issues of power and oppression. Quoting Abu-Lughod's own words: 'Women have been other to men's self. Feminism has been a movement devoted to helping women

become selves and subjects rather than objects of men's others' (Abu-Lughod, 2008, p.467). On the other hand defining the self as opposite to men/other is problematic.

Feminist researchers have approached the issue of women's oppression by highlighting the dichotomy female/ male, reaffirming the division of self/other. This approach has eventually led to the crisis of feminist movement because there were many feminist 'selves' and ultimately the dichotomised approach created a fracture within different type of feminisms.

I don't accept or embrace the dichotomist opposition women/ men. Patriarchy has oppressed and still oppresses everybody, men included.

Paulo Freire and the "Pedagogy of the Oppressed"

Paulo Freire was a Brazilian educationalist, who launched literacy programmes for the poorest people of north-east Brazil in the early 1960s. He believed that oppressed people were kept in poverty by being rendered unaware of their condition and disempowered (Freire, 1972). Poor people were oppressed by the culture of silence. By this he meant that they could not participate in the socio-historical transformation of society because they lacked means or instruments to engage and make their voice heard (Freire, 1972). Freire's method proved very successful not only in achieving literacy but also in creating critical awareness. Not surprisingly he met strong opposition by the upper and middle classes in Brazil and was forced into exile.

Freire's philosophy is very relevant to midwifery, as historically midwives have been an oppressed category and kept in silence by not being academically developed. Also Freire's work resonates with reflections on which type of training is most appropriate for midwives: being trained to keep the status quo, to fit the industrial maternity services or trained to think critically and have the best interests of women and their children at heart. This ultimately raises the political question of how much is women and children's' health worth?

Critical and post-critical ethnography

Abu-Lughod (2008) stressed the importance of acknowledging the political implications of the division between self and other and to 'reconsider the value of the concept of culture, on which it depends'

(Abu-Lughod, 2008, p.466). She claimed that culture 'operates in an anthropological discourse to enforce separation that inevitably carries a sense of hierarchy' (Abu-Lughod, 2008, p.467). She concluded by advocating for anthropologists to 'write against culture' as against division and oppression (Abu-Lughod, 2008).

Madison emphasised that the principal characteristic of Critical Ethnography is the ethical stance, the 'moral obligation to make a contribution' ... toward greater freedom and equity' (Madison, 2000, p.5). The term 'Critical' therefore highlights the intention. The research process aims not only to investigate 'what is going on' and to describe it but has the intention to change the 'status quo'.

Post-critical ethnography (Noblit et al., 2004) however includes in the equation the researcher's power as well. It not only aims to highlight power relations in the social context studied, but also stresses the importance of positionality in the context of research: it leads us to acknowledge our own power and influence as researchers, taking responsibility for the way we represent and interpret the world in which we are immersed to study (Madison, 2004). It is about contextualising our own position, thereby making it accessible, transparent and open to judgment and evaluation (Madison, 2004, p.7). This approach seeks to make research more 'democratic' by the ethnographer explicitly taking ownership of and responsibility for the ideas expressed and the way he/she represents the social world studied and the researcher's own effect on it. This brings us back to Reflexivity.

Philosophical stance informing this ethnographic study

My ontological position as a researcher is that there is an external reality independent from us. Humans are not essential to the world. Nonetheless, the knowledge that we can achieve is always dependent on our position and socially constructed. This project will therefore embrace Critical Realism.

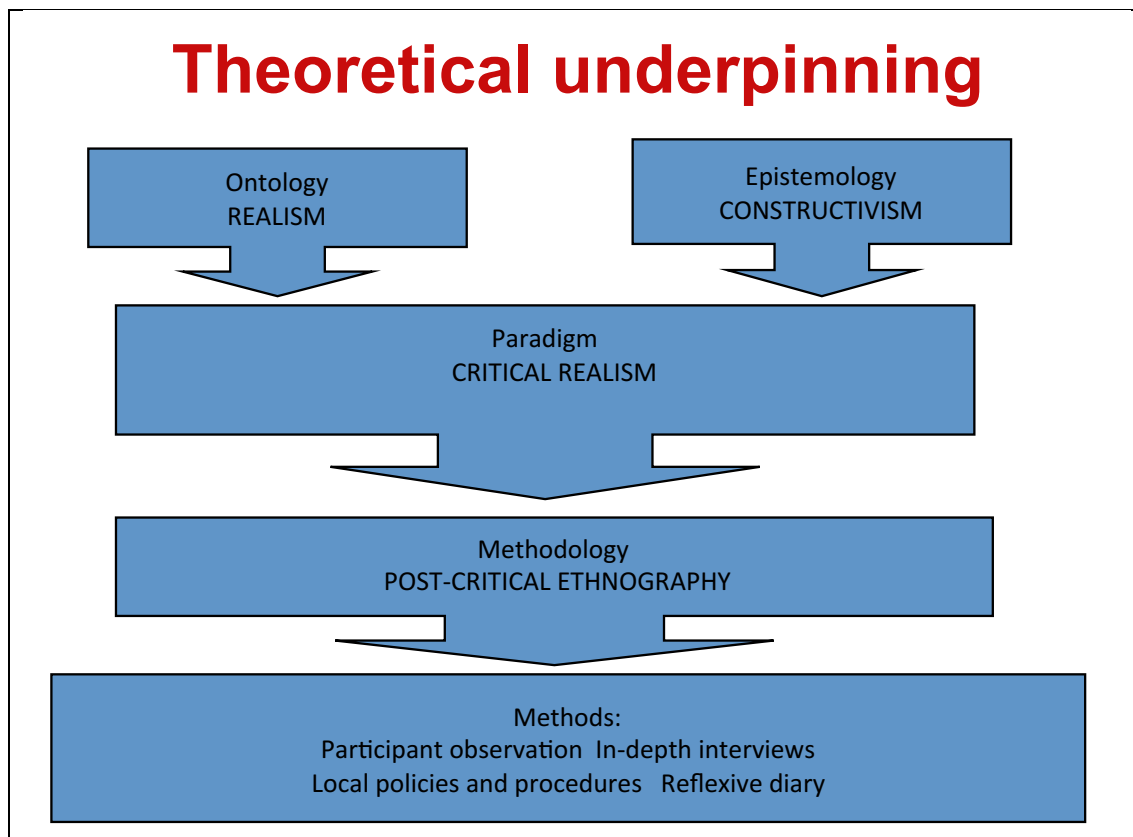


Figure 4- The theoretical underpinning of the thesis

How the philosophical stance has shaped my ethnographic study:

By embracing a constructivist epistemology, I aim at engaging with the current discourses around FMUs and at contributing to the construction of knowledge. As a feminist, I not only aim to study the reality as it is but I also strive to change the status quo by lobbying for women's rights and a salutogenic approach to maternity care.

My study will therefore be defined as post-critical feminist ethnography.

Before starting the fieldwork, I undertook an exercise in positionality by reflecting on my different positions in the field depending on the participants I engaged with. I also reflected on my positionality at every step of my data collection and analysis.

As a tool to enhance my reflexivity I kept a diary and analysed the field experience from my own perspective during the course of my study, thus helping me to identify possible unwanted dynamics. I often used the time driving to or from my field site to record voice messages with free flow of thoughts.

Particularly at the beginning of the fieldwork, these reflections really helped me with thinking about my position and role in the field.

Insider researcher and the construction of knowledge

During the planning phase of the ethnographic study I presented an outline of the project at the City University 'Doctoral Student Colloquium', led by Dr McKeown. An interesting question raised was how the theoretical underpinning of the study would be reflected in the data collection and analysis. I found the question very fascinating and I reflected on it for a while as well as discussed with my supervisors. Two concepts were clear for me: firstly, dissociating myself from a positivistic approach, in which being an insider would have been considered a disadvantage only, I wanted my knowledge and experience of the field to be included in the study. In order to elicit this, another researcher Dr Rayment (a sociologist who had studied midwives) interviewed me about my own experiences of working in the birth centre and the interview was transcribed and analysed as part of all the other data collected. Secondly I wanted to be able to construct the findings with my research participants. In order to obtain that I have discussed the emerging findings of the analysis with both staff from the Barkantine, service users and my wider PPI group supporting this project.

Overall being an insider researcher has been a 'double-edged sword', presenting both benefits and risks. The advantageous side was having in depth knowledge of the context, history and organisation. Additionally, being known from staff meant being able to 'blend in' more easily. There were also some disadvantages or challenges. Firstly, it was sometimes unclear whether the knowledge on certain aspects of the context was arising from my ethnography or whether they pre-existed the data collection period, drawn from my 'local knowledge'. Secondly, I did not have the advantage of a 'fresh-eye' approach. Thirdly, my personal feelings and history have influenced the way I have represented and interpreted the data. Although this may apply to all researchers, it is particularly the case when analysing a setting with which the researcher has had prior associations. Applying reflexivity in such situations is important to the quality of the analysis. In this case, applying reflexivity to my own emotional dynamics has helped, even if at times it proved difficult.

In chapter 11 (page 271) I will further reflect on the fieldwork, representation and writing this thesis.

Researching your own workplace and ‘not going home’

Insider researchers deal with a particularly challenging dilemma: ‘at the end of the study they do not go home’ (O’Reilly, 2009). This means that insider researchers carry the consequences of their own research not just ‘symbolically’, but quite tangibly because they will ‘stay in the field’ and continue to have relationships with the research participants. This highlights the ‘responsibility of representation’ even further (O’Reilly, 2009). Representation may constitute a problem if ‘negative dynamics’ emerged during the study. In order to overcome this potential issue I explained to the research participants that the research was not focused on single individuals but on the service provided and the relationship between service contexts and practices. The aim of the research was to explore the culture, practice and philosophy of the care in birth centre settings without pointing or focusing on any specific individual.

Conclusion

In this Chapter I have examined the theoretical underpinning to my ethnographic study. I have discussed the ontological and epistemological foundation for the chosen paradigm, critical realism, which has informed the methodology, post-critical ethnography. I have also explored key concepts such as positionality, reflexivity and authenticity as well as reflecting how the theoretical underpinning of the ethnography has informed my approach to the field and data collection.

In the next Chapter I will describe the recruitment procedures and the methods for data collection.

Chapter 4- Methods

Introduction

In this Chapter the methods of data collection, procedures for recruitment, management of the data and analysis are described.

Population studied

Following the ethnographic tradition, the intended participants were all people who were part of the natural setting being studied. In this case, this included pregnant women and those accompanying them, staff and students at the Barkantine.

Some staff were also recruited from the obstetric unit, where women were transferred if needed.

Methods and data collection

In ethnography, the researcher is the major research tool. As the study develops the methods may be modified to adapt to the 'real situation' (Spradley, 1979; 1980; May, 2001; 2002). Qualitative methods encourage flexibility in the data collection and openness to findings. This is a significant advantage when carrying out an exploratory study because it does not impose a preconceived fixed structure (Glaser and Strauss, 1967; Walsh, 2004; Silverman, 2006). I found that the flexibility of data collection significantly helped to collect rich data.

The main methods used were participant observation and semi-structured interviews with FMU staff and FMU service users as well as stakeholders such as members of the FMU steering group, hospital midwives, doctors and managers. I also used relevant local guidelines and procedures as background information in order to understand better the wider organisational culture. Originally, I also planned to include focus groups and Internet forums but after starting the fieldwork and following discussions with my supervisors we agreed to exclude them. The focus groups would not have added to the richness of data as I was attending team meetings, in which I was able to observe the team dynamics,

as part of the participant observation. Additionally, having only two midwives per shift it would have been difficult to ensure attendance. We decided instead to discuss preliminary findings and get group validation of the analysis by ad hoc presentations of the emerging findings to the birth centre staff during their monthly team meetings.

Recruitment

The fieldwork was divided in 'two waves': February 2011 to August 2011 and November 2011 to mid-June 2012.

Recruitment started as soon Ethics and NHS approvals were obtained. The recruitment of participants was purposive (Hammersley and Atkinson, 1995). For service users the aim was to reflect the diversity of women using the birth centre, in terms of ethnicity, age, parity and social class.

The recruitment followed three stages:

1. The provision of information to the potential participant by verbal explanation of the information sheet.
2. A period of at least 24 hours would be given to the potential participant to decide whether to take part.
3. Agreement about the form of participation and completion of the consent form.

The Barkantine staff were recruited systematically during the beginning of the field-work and within one month all staff had consented. This was of paramount importance because I needed staff consent before being able to observe clinical practice or even the 'everyday life at the Barkantine', since it would have been difficult to conduct observation without inadvertently or incidentally 'overlooking' some activities where the people had not given their consent.

I started by presenting the study at a team meeting and provided information sheets and consent forms to all staff. I also created some posters and displayed them in the midwives' office at the FMU. While recruiting, I have always been aware of not pressurising the staff in giving consent and reminded them that they could withdraw from the study at any time.

Table 3- Management of staff recruitment

Research Number Name	Info Leaflet	Consent From	Consent Interview	Consent Observe Everyday	Consent Observe Labour	Consent Pictures
1.	✓	✓	✓			
2.	✓	✓	✓	✓	✓	✓
3.	✓	✓	✓	x	x	x
4.	✓	✓	✓	✓	✓	✓
5.	✓	✓	✓	✓	✓	✓
6.	✓	✓	✓	✓	✓	✓
7.	✓	✓	✓	✓	✓	✓
8.	✓	✓	✓	✓	✓	✓
9.	✓	✓	✓	✓	✓	✓

Service users were recruited at first antenatally, in order to be able to interview them before and after giving birth. Some women agreed for me to be present at their birth as a participant observer. Later on, I recruited some women and their birth supporters postnatally in order to interview them retrospectively about their experience at the Barkantine. If a woman agreed for me to be present at their birth, I would be on call for them and they would inform me when the labour started. Only on one occasion I had to drop my researcher role and attend the birth as the midwife was busy attending another birth and the birth was imminent. I examine this further in chapter 12 when discussing reflexivity.

In order to invite women to participate, I sought consent to observe an antenatal appointment at the FMU while the woman was in the waiting area. I would explain the aim and objectives of the study and if she agreed I would arrange to observe her next antenatal appointment. During this appointment, I would already collect observation notes. At the end of the appointment I would ask the woman if she would be keen for me to interview her antenatally. I would also ask her if her birth supporter would be keen on being interviewed. I would then agree a convenient time and day for her to be interviewed. When calling her to confirm the interview appointment I would ask her if she was still keen on being interviewed. The antenatal interviews with the women and their birth supporters were focused on their expectations and decision making regarding place of birth; postnatally on their experience and perception of care.

At the end of the interview I would ask her if she would allow me to observe the birth. Most women, whom I approached, were very keen on taking part. When the woman agreed for me to observe the labour and birth she would have a sticker on her notes with my mobile number next to the Barkantine number and when calling in labour to inform the midwives of her arrival she would also call me.

The midwives, students and maternity care assistants showed great enthusiasm towards the project and helped in any possible way. In the hospital, I planned to recruit several obstetricians and midwives. Also, the hospital staff were keen to share their views and experiences. I eventually only interviewed a few members of hospital staff because of time constraints (I gave birth on the 18th June 2012, two days after completing data collection).

The service users generally expressed strong support and willingness to be involved with the project. As public perception of research is linked to experimental drugs or tests, I had to spend extra time explaining the nature of the project and the fact that I would only observe the care they would receive.

Rationale for participant IDs

The research ID was designed to help categorise the participants to aid analysis. This allowed comparison of data depending on specific characteristics such as place of birth, gender or profession.

Table 4- The abbreviations used as IDs for research participants

BC= birth centre	CP= clinical placement
H= hospital	SU= service user
MW= midwife	W= woman
SM= student midwife	BS= birth supporter
SS= support staff	F= female
SH= stakeholder	M= male
SG= steering group	

A total of 82 participants were recruited and provided written consent. This is a large number for an ethnographic study but in reality the number of participants actively engaged in interviews and participant observation was around 60. The rest were participants recruited only to observe group activities.

Table 5- The research participants

Participants	Subcategories	Number
Barkantine staff	Midwives	23
	Maternity care assistant	6
	Admin	1
Hospital	Midwives	2
	Obstetricians	1
Students	Student mw	3
	Mw placement	2
Stake holders	Managers	2
	Consultants	2
	Steering group	2
	Commissioners	1
Service users	Women	18
	Fathers	15
	Other birth supporters	4
		Total participants = 82

Barkantine staff

All Barkantine staff consented to be part of the study. I recruited 23 midwives and six maternity care assistants. During the fieldwork period the integration of the local community midwives also took place. After discussing with my supervisors, it was decided to particularly focus on interviewing the FMU midwives who were part of the original team but also to include a few midwives from the community team which was integrated with the birth centre during the course of the study.

During the 15 months of data collection the turnover of midwives was very significant.

Of the 11 midwives who originally opened the birth centre only two are currently still working there. I will discuss this further in the findings.

Table 6- The age profile of the midwives working at the FMU

Staff Age	25-34	35-44	45-54	Over 54
Midwives	13	7	3	0
MCA	3	2	2	0

Table 7- Ethnicity profile of the midwives working at the FMU

Ethnicity	African	British Asian	White UK	Mixed British	White EU
Midwives	3	2	10	1	7
MCA	0	4	1	0	1

Table 8- Profile of the midwives working at the FMU: midwives' years of experience

<5 years	>5 <10	>10 <15	>15
9	9	3	2

Table 9- Profile of midwives working at the FMU: Direct entry/ nurse-mw

Direct entry	Nurse/MW
9	14

Service users

Eighteen women, fifteen partners and four other birth supporters agreed to participate. Some of these only participated by letting me observe the antenatal group; others let me follow them from 36 weeks until the postnatal period, others just at a certain time of their maternity journey. A few had to transfer their care to the hospital before giving birth because they did not meet the eligibility criteria any longer. Nonetheless, I interviewed them postnatally.

Table 10- Service users' ethnicity

Ethnicity	Bangladeshi	White British	White other	Other Asian	Japanese
Women	11	2	1	1	1
Birth partners/family	6	4	1	2	1

Public and Patient Involvement (PPI)

In 2010 I set up a service users group to provide PPI to my research project.

Several service users engaged with my research project at different times (by nature in maternity services PPI members do not stay engaged for long periods). Two service users have remained engaged for the whole duration of the project. Since joining City University London I had access to the City University Advisory Group for Maternal and Child Health Research. This group led by Dr Olander is very active and has advised me on interpretation of the data as well as being engaged with dissemination plans.

Participant observation and field-notes

The participant observation covered the shifts at different times and days of the week over a period of twelve months. I observed the birth centre activities for a total of 30 shifts. This included team meetings, active birth workshops, breastfeeding support groups and other birth centre activities. I was also 'on call' for the women who had agreed for me to observe their labour and birth. I could only start the observation if the Barkantine staff in the shift had consented.

Following the tradition of the Chicago School, I immersed myself in the 'day-to-day activities of the people whom I was attempting to understand' (May, 2001, p.148). As an 'insider' participant observer I was able to blend well with the everyday activities of the group because I shared the 'group language' and culture. At first not having a clinical role resulted in some awkwardness but this improved with time. I discuss further the ethical implication of being an insider observer later in this Chapter.

In my field notes I aimed to generate a 'thick description', which aims to give a sense of environment, events, emotions and perceptions of people involved in the set (observer included) (Geertz, 1973). Four points guided my observation and field notes: physical setting and persons involved in the scene, events, timing, observer's feelings and impressions. Spradley (1980) stated that observation progresses in three steps: descriptive, focused and selective. At the beginning of the process the

observer records almost everything. As time goes by, the researcher will only focus on certain important aspects of the setting. Eventually the observer selects only very specific and relevant issues (Spradley, 1980).

My feelings and impressions were captured in the reflexive diary, which I kept separated from my observational field notes.

A dynamic process interconnected my participant observation and the semi-structured interviews: the observation guided the development of the questions for the interviews and the findings of the interviews, on the other hand, have guided the observation (May, 2001). This approach also offered the opportunity of checking for consistency between what participants said in the interviews and were doing in practice. For instance, by observing the practice of one midwife I could confirm whether what the person said at the interview was consistent with what she/he did, observing any differences and exploring these in the analysis. Similarly, for the women I could check consistency between antenatal and postnatal interviews and observation notes.

Semi-structured interviews

In keeping with a constructionist philosophy in the research, I decided that the interviews would take the form of a conversation in which both researcher and participant would share and benefit from each other. This type of 'democratic' interviewing has also been described by researchers such as Oakley (1981) and Agar (1980). While approaching FMU staff I had a general thematic guide and I always started the interview by asking the person to introduce him or herself, how they got to the Barkantine and asked them to 'tell me your experience of the Barkantine birth centre'. The interviewee would choose in which direction the conversation would go, although I also followed up with some focused questions. These included asking midwives to describe a good day and a bad day, in order to elicit a range of feelings and reflections about their work.

Table 11- Topics explored during the interviews with FMU staff

Topics explored during the interviews

- Midwives' background
- Motivation for working at the Barkantine
- First impressions when started working there
- Challenges
- The team
- If and how practice changed
- What keeps birth normal
- A 'good day' and a 'bad day' at the birth centre
- Current issues

In most cases, I interviewed women antenatally and postnatally, which enabled me to observe and explore their experiences at different stages of their maternity journey. Some additional women and birth supporters were only interviewed postnatally. Interviews were carried out both at the Barkantine and/or at the woman's home.

For both staff and service users the length of the interviews varied, but they never exceeded one hour. Confidentiality was ensured at every stage of the research by using participants' IDs instead of their names. The interviews were tape-recorded and later transcribed 'verbatim' professionally. I checked every transcript against the audio recording in order to correct any mistake in transcription. This also enabled me to reflect on the interviews.

Guidelines and operational procedures

Guidelines and operational procedures can be key documents for an ethnographer. If on one hand most maternity units write on their websites that they provide women-centered care and active birth and are keen on non-pharmacological pain relief, often the rhetoric can be unmasked by looking at key guidelines and operational procedures. For example, the local NHS Trust guideline on pain relief included 3 pages on non-pharmacological pain relief and 20 on pharmacological, demonstrating a fairly medicalised approach to pain relief. In addition, the NHS Trust guideline on water birth focused

primarily on when water birth was contraindicated. The language used in the guidelines can also provide a very interesting insight in the culture of a service. Of great interest were also guidelines on 'how to deal with women, who refuse treatment' or fall outside the guidelines. Even if I didn't do a full discourse analysis, nonetheless, the analysis informed my thinking in the analysis overall.

Use of bilingual research interpreter

As for previous studies in Tower Hamlets a large proportion of the research participants did not have English as their first language. Most of the participants felt confident in carrying out the interview in English. However, in case a participant needed a translator arrangements were made. Four interviews were conducted with the help of a bilingual English/ Bengali interpreter. By coordinating the survey of women's experience of maternity care in Tower Hamlets, I had gained sound experience in organising interviews for women whose first language is not English (Only 11% of the women interviewed for the Barkantine Birth Centre Evaluation Study had English as first language) (Macfarlane et al., 2014). This previous experience significantly helped in this study. If conducting an interview with the bilingual interpreter I would read the question in English and the interpreter would translate the question and the answer. The verbatim transcripts of the interviews were later sent to the interpreter for validation.

Transcription of interviews

I transcribed the first few interviews and then used a professional transcriber in order to improve time management. The transcripts were then reviewed by checking them against the audio file and corrections were made.

Data management

Special frameworks were created in order to help the data collection and keep up to date with the tasks to be done. As shown in Table 14 this framework helped having an overview of the progress of data collection activities and to plan the fieldwork.

Table 12- Recruitment and data collection summary for service users

Name	Res Id Number	Consent	Int	Obs An App	Obs Abw	Obs Other	Obs Birth	Trans	Atlas.Ti
1.		✓	✓	x	x	x	✓	✓	
2.		✓ ✓	✓ ✓	x	✓	x	x	✓	
3.		✓ ✓	✓ ✓	✓	X	X	X	✓	
4.		✓ ✓	✓ ✓	✓	X	X	X	✓	
5.		✓	✓	✓	X	X	X		

Analysis

In my analysis, I adopted a constructionist approach to grounded theory via the approach of Charmaz (2006) and eventually across towards thematic analysis. I also made extensive use of ‘mapping’ concepts and categories as described by Clarke (2005). In effect, my approach has also followed the pragmatist tradition (Patton, 2002) of using ‘the right tool for the right job’ (Saldana, 2009). Saldana’s (2009) ‘coding manual for qualitative researchers’ proved a very useful tool since on one hand it is well grounded in the ontology and epistemology, while on the other hand it is very pragmatic.

The pathway of data analysis

As a researcher, my job is to unpick the different layers of meanings and to be as transparent about the analytic trail as possible.

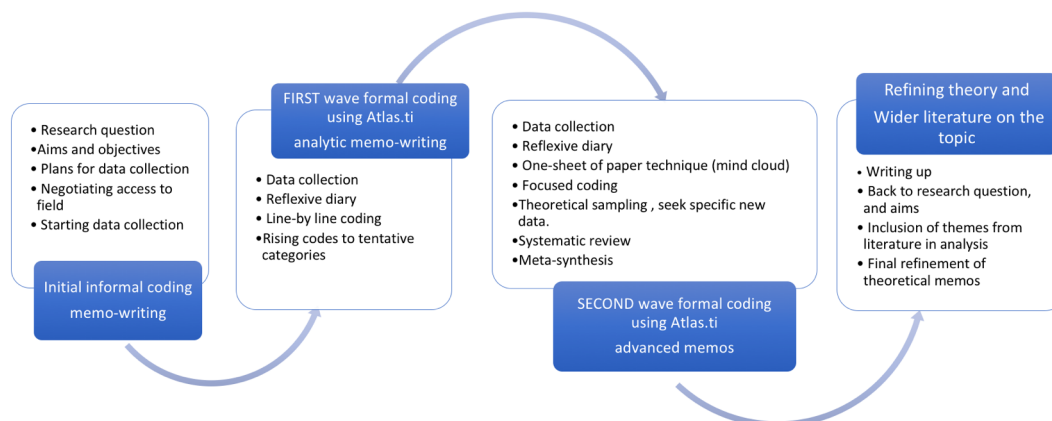


Figure 5- The step-by-step research process for the ethnographic study

Audit trail

I started some tentative coding and writing some analytical memos simultaneously with data collection. At the end of each observational shift or interview I audio-recorded some analytical reflections (while driving home from the FMU) and started unpicking some of the key potential themes through my reflections. As soon as I finished transcribing an interview, I also started writing some analytical memos and tentative codes emerging from the data while reading and re-reading the transcripts. I also kept a reflexive diary of my feelings and dynamics in the field.

FIRST wave formal coding using Atlas.ti

After reading the transcripts several times and making analytical memos on the margin throughout the data collection period, in August 2013 I started the first wave of formal coding directly on Atlas.ti. I started by coding word-by-word and line-by-line as described by Charmaz (2006). I micro-coded ten interviews, which created more than 100 codes. I realised at that point that the system of micro coding without any structure was getting confusing as it was impossible to code managing a big number of codes. I was getting lost in the codes and blurring the boundaries between codes. By

using directly Atlas.ti, I also felt I had lost all the creativity needed for the process. The micro-coding however gave me the opportunity of getting very close with the data.

BC6: Okay I think from working in the labour ward I was probably kind of tool in the labour that when the woman comes in you know you assess her and the assessment is really like temperature, blood pressure, pulse and then a VE to see if she is in labour or not in labour either stay in the labour ward or home. Whilst here I think I have learnt more to not necessarily need to do that examination in order to know whether the woman is in labour. I know that is still part of here but I think that is a big part of what I have learnt is to look at the woman rather than to looking at the paper work to see how far dilated she is, that is a big part of learning. And I think also just literally birthing in different positions, pool birth before I came here I have only seen a water birth and that's you know only one and since I have been here it's very much normal really to have a water birth. So that is something else that is you know is coming to more practice since I have been working here.

Int: and how do you think that benefit the woman? Do you think that is kind of our flushing or is something within it?

BC6: I don't think so; I think it kind of gives her more of one to one care rather than feeling like she is one of many. It means that hopefully she feels like she is being looked after, she is that way looking at her rather than just seeing her as a woman giving birth and that we are looking at her as a whole and have progress is a good thing.

Int: And in the cases that may be you have one may be a multipara who somehow she has been imprinted for lying down on her back and then we kind of almost force them to get off of the bed and how do you feel about that?

BC6: Because here at the birth centre we don't have labour beds as such so I think they don't really do that you know because it's not available to them. May be if the bed was the sole centre of the room it might be different but here you can't really lie on the bed I means it's just a normal double bed. And women that I have seen that come here they generally want to walk, they want to mobilize, they want to do anything that feels natural to them. And feeling natural to them is very rarely because they kind of lie on their back when they have a contraction.

Int: So do you think they are educated before-hand or the environment helps them or both?

MW-holistic care
 MW-having to justify interve...

MW-active birth skills

MW-supporting women
 MW-holistic care

FMU-environment supports n...

Figure 6- Example of coding using Atlas.ti

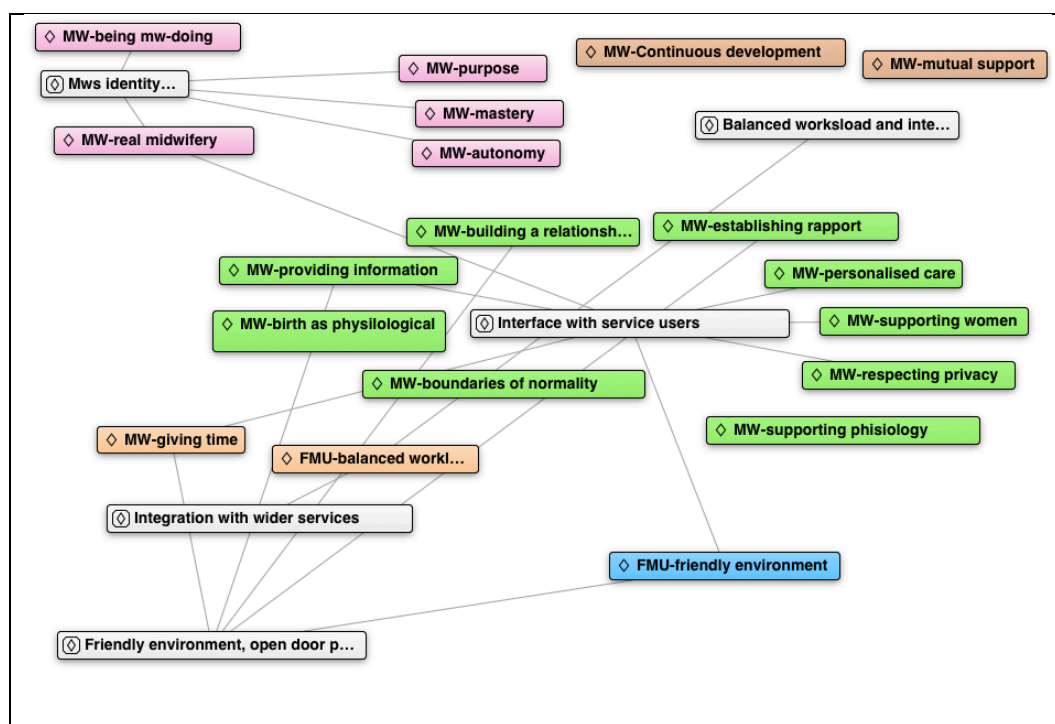


Figure 7- A web of codes showing the networks among codes and categories

Once I had coded ten interviews I, therefore stopped the formal coding and started creating 'clouds' of codes (figure 8 and 9), which then were organised into categories and subcategories (Figure 10 and 11). At this point I also wrote down my research question and aims, in order to focus my analysis on that.



Figure 8- The Clouds of codes, categories and subcategories by manual mapping exercise



Figure 9- Clouds of codes, sub-categories and categories being organised by relations among them

Eventually from the creation of several clouds and the progress in the coding of the FMU's staff and stakeholders' interviews as well as referring to the field notes, a preliminary descriptive set of categories and subcategories emerged. At this point of the analysis I did not feel confident to move to a more abstract level but I started getting a feel of the core themes emerging, for instance, the importance of the culture of the team, the power relations with the women and the importance of ownership. This was very different from what I had imagined. I was expecting the midwives to focus more on clinical aspects or practice related issues. Another interesting element was the importance of shared leadership within the first year of opening the FMU, which had been highlighted by all the original midwives working in the team from the beginning. The shared leadership had been possible because of a 'vacuum of management' from the main unit.

Once I rearranged the codes under a more systematic tentative structure I moved on to finish coding the other interviews and field-notes.

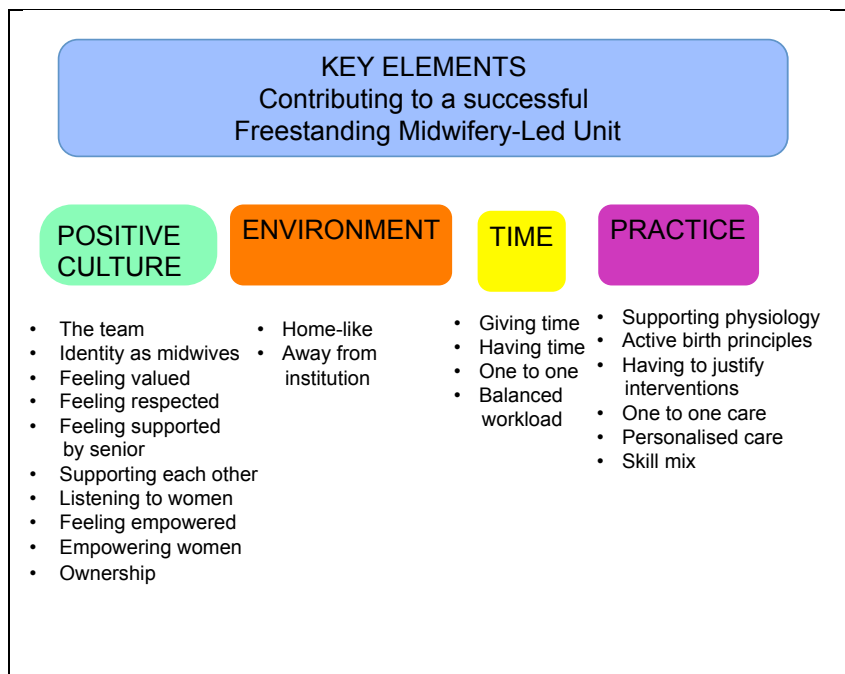


Figure 10- Emerging categories and subcategories: 'Key elements for a successful midwifery unit'

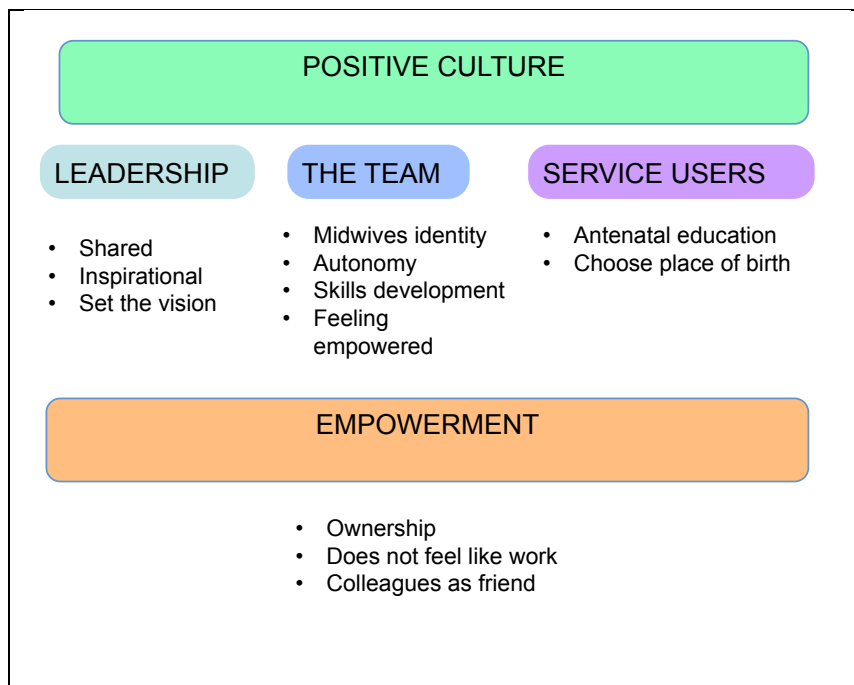


Figure 11- Categories and subcategories relative to organisational culture

The meta-synthesis and the second wave of coding

In late 2014 I started conducting the Systematic Review of clinical outcomes of FMUs (originally conducted in 2006 as my MSc dissertation) and also conducted a meta-synthesis of qualitative research on FMUs. Findings are reported in chapters 6 and 7.

After completing the meta-synthesis I conducted a second wave of coding from October 2015 to February 2016 with the aim of integrating the findings from my ethnography with the findings from the meta-synthesis.

There were many similarities in the themes emerging in my study and the meta-synthesis. There were however some differences particularly related to whether the service was offered as part of a public service or independent midwifery practice.

The aim of the second wave of analysis was to integrate what had already emerged from previous research with my findings focusing on my research question and the aims of my study. For me reflecting on my findings in view of the meta-synthesis felt meaningful and productive. If on one hand I was able to conduct the first wave of analysis with only a partial knowledge of the concepts developed by other researchers, conducting the meta-synthesis offered me the opportunity of looking at my findings in relation to the other studies.

The result was the creation of three models, which attempt to capture key concepts on FMU for the midwives, the FMU as an organisation and the women. These models are described in chapters 8-9-10.

This is an early sketch of the model focused on women's experiences and expressed needs.

confidentiality and data protection have been guaranteed. I have also respected the principle of beneficence and justice.

By reflecting before, during and after the recruitment and data collection I have identified some important ethical considerations for this study:

1. Making sure that during the recruitment and the data collection none of my potential participants felt compelled to participate because of 'friendship' or power dynamics. I have always highlighted the fact that participation was voluntary and that they could withdraw at any time.
2. Clearly defining to others and myself the distinction between my clinical role and my role as a researcher.
3. What I would do in the case of observing malpractice.
4. Reflecting on how to report in my study any negative aspect observed during the fieldwork.

Ethical dilemmas

While starting the fieldwork, I had to reflect on several possible challenges. How was I going to deal with the hypothetical case of midwives providing information to the women that as a midwife I considered to be inaccurate or wrong, not offering choices to women or frankly practising outside the guidelines, without women's consent?

How was I going to report possible data highlighting problematic leadership in the birth centre or wider organisation?

Before starting the fieldwork, it was agreed with management that in any case where I observed practice that I perceived as not conforming to professional standards I would discuss the issue with a manager only if I considered this posed a risk to women and their babies. This proved stressful in practice.

Regarding the issue with reporting negative data, I found it particularly challenging and had to review my thesis eventually to ensure authenticity was guaranteed.

Reflexivity

A reflexive diary was kept, in which I documented my experience of conducting this project, of the fieldwork as well as any ethical issue or dilemma. The diary was not coded but used as a wider point of reference for my analysis.

Table 13- Reflexive exercise

Reflexive exercise and positionality: I am a midwife but also a woman, Italo-Spanish living in the UK, married to an Englishman of West African ethnic origin. All these attributes have influenced my position in the field and the way research participants perceive me. I have been a 'halfie' (person, who belongs to two or more cultures simultaneously as defined by Fox, 1991) all my life. As a child of a Spanish mother and Italian father I got used to belonging to different cultures since very young. Being simultaneously an insider and outsider is a very familiar situation for me. I studied midwifery in Italy, where obstetric violence is common and women have little say about what happens to their bodies during childbirth. I worked as an independent midwife for a year before moving to England. I loved providing full caseloading care for women and I learned greatly from the women I assisted. I learned about the 'boundaries of normality' and how different women will make different decisions as they all perceived risks and benefits of a given situation differently. I feel that I truly learned the meaning of partnership in decision-making through this experience, despite working in very difficult settings. I felt, however, very isolated as midwife and very vulnerable. I also realised that I wanted to fight against the status quo and I had to broaden my horizons in order to achieve that. I moved to England in 2004 to pursue a clinical-academic career, which was impossible in my native country. In England, I started working for the NHS and to develop academically. I have been offered incredible opportunities and substantial academic support to develop. I had access to funding for starting a research career and to fantastic supervisors such as Professors Macfarlane, McCourt and Walsh. I worked for the same NHS Trust for 11 years before moving on to a Consultant Midwife position elsewhere. During my 11 years in Barts Health NHS Trust I had great opportunities of getting involved in setting up innovative services such as a caseloading team for vulnerable women and creating the Barkantine Birth Centre. I have learned substantially about organizational culture, collaboration but also about obstruction, horizontal violence and discrimination. Since I arrived in the UK I was considered and felt an outsider. The most interesting point is that I felt 'other' by both the white English midwives, as I speak with an accent, and by the black African midwives, who included me in the category of the 'white midwives'. I felt more 'at home' with the Spanish midwives as we share the same culture but being half Italian made me somehow 'other' to them too. For instance, I forgot how to dance 'Sevillanas'. Things have changed since I married an English man of West African origin raised in a white English family. I have noted a change in attitude from both the English and the African midwives. It is difficult to provide clear explanation for that and I can only formulate hypothesis: I have been introduced more into the English culture and custom by my husband, which makes me interact 'more appropriately' with English people. My communications skills have improved not only because my English improved but also because I am more aware of the English 'rules' of interaction; e.g. lower the tone of my voice, wait for natural pauses of the conversation before replying, and do not contradict others (most of the time!).

In chapter 11 I further reflect on the experience of fieldwork and the implications of being an insider researcher.

Conclusions

In this Chapter I have described the methods of data collection adopted for my ethnographic study. I have described the population studied, recruitment procedures, data collection and analysis. I have also discussed how positionality, reflexivity and authenticity applied to my study.

SECTION THREE: THE SYSTEMATIC REVIEWS

Introduction to the Section

A literature review prior data collection and analysis is conducted in order to help the researcher to contextualise the research within existing knowledge (Cluett and Bluff, 2006).

In order to contextualise my ethnographic study of an urban freestanding midwifery unit, I conducted both a systematic review of maternal and perinatal clinical outcomes for women choosing to give birth in a FMU as well as a meta-synthesis of qualitative research on FMS.

I conducted a first systematic review on FMUs in 2006 as my MSc dissertation. This also included a non-systematic review of qualitative research as well. As a result of my MSc dissertation I was familiar with the literature on the topic.

The plan for my PhD was originally to update the systematic review from 2006, but I eventually conducted a new systematic review entirely.

The reviews were conducted after data collection and the first cycle of analysis in year 3 of my part time 4 years PhD. Further explanation on the chosen timing for the reviews is provided below.

Reasons for the timing of the literature reviews

As discussed in the previous Chapter, when I started my PhD I originally planned to use Grounded Theory for analyzing the data. Very soon I realised that Glaser and Strauss (1967) adopted a theoretical underpinning which was incompatible with the philosophical approach of my ethnographic study.

I however reflected on their approach and found interesting that they would discourage researchers using classical grounded theory to conduct the literature review prior to having conducted the fieldwork and the analysis. The aim argued by Glaser and Strauss was to avoid bias arising from the ideas and concepts read from the literature.

In their 'Discovery of Grounded Theory' Glaser and Strauss (1967) adopted a positivistic paradigm and in their view an objective theory is 'discovered' within the data and the aim of grounded theory is to unveil it (Glaser and Strauss, 1967). This notion of emergence or discovery of a theory implicitly assumes that such theory exists independently from its discovery or perception (Ramalho et al., 2015). The researcher is therefore advised to avoid 'contamination' of the analysis by ignoring pre-existing literature on the topic (Glaser and Strauss, 1967). On the other hand, Strauss and Corbin (1990) clarify that researchers always have prior knowledge of the literature when approaching a new project. Dey (1999) and Layder (1998) argue that Glaser and Strauss naively expect researchers to be a 'tabula rasa'.

On the other hand, Henwood and Pidgeon (2003) created the term 'theoretical agnosticism' advocating for a cautious and critical approach towards previous work conducted on the topic at hand and to stay close to the data. Charmaz (2006) advocates for a brief literature review before the data collection and a more systematic review later.

After discussion with my supervisors it was agreed to follow the latter argument (Charmaz, 2006) for the conduct of the literature reviews. I therefore conducted the systematic review and the meta-synthesis after the data collection and the first cycle of analysis. This allowed me to approach the analysis of my data with a 'fresh eye' approach, even if I recognise that I certainly had previous knowledge on the topic.

After completing the literature reviews I conducted a further cycle of analysis and integrated some of the concepts from the literature reviews, if relevant to my study, in the discussion chapter. Some brief discussion, when relevant has been integrated at the beginning of the findings chapters.

The other advantage of conducting the systematic reviews later in the process of my PhD was to ensure that the reviews were up to date (we started the review in 2014 and updated the search in 2016), towards the end of my PhD avoiding having to integrate many new studies later.

The review teams

Lia Brigante a caseload midwife working at St Thomas' NHS Trust functioned as my second reviewer for both the systematic review and the meta-synthesis. Professor Macfarlane functioned as a third reviewer for the systematic review and particularly helped with the tables. Professor McCourt functioned as third reviewer for the meta-synthesis.

The third author functioned as a third reviewer particularly in case of doubts whether to include a paper or not. Professors Macfarlane, McCourt and Walsh have of course also been my supervisors for the whole PhD.

Chapter 5- Systematic review

Title

What are the maternal and neonatal clinical outcomes for healthy women experiencing an uncomplicated pregnancy, who opt for freestanding midwifery unit care? A systematic review.

Objective

This systematic review was undertaken to compare the maternal and neonatal clinical outcomes for low risk women who receive freestanding midwifery unit care with those for women who receive care in consultant obstetric units.

Background

Rates of interventions in childbirth have steadily increased over the years at a time when the care of most women has taken place in hospitals. In England, the caesarean section rate has risen from 11.3% in 1989-90 to 26.5% in 2014-2015 and the wide variation in intervention rates is also a cause for concern. In 2014-2015, the caesarean section rate in England ranged from 15.8% to 34.7% (HSCIC, 2015). Data analyses adjusting for characteristics of mothers and clinical factors failed to explain the extent of this variation (Alves, 2002; Carroll et al., 2016). Even wider differences are seen internationally (Macfarlane, 2015).

Methods

Definitions

Definitions of terminology, eligibility criteria and the types of care provided in midwifery and consultant led units have been far from consistent nationally as well as internationally. For this reason, this review used the Birthplace in England Research Programme definition, as the programme included a consensus process to propose definitions of terminology and care provided in midwifery units in the National Health in England (Rowe, 2011- See Figure 1).

In the UK, women are eligible to give birth in midwifery units if they have no relevant medical conditions, had a straightforward pregnancy and have started labour spontaneously at term (MCWP, 2007; NICE, 2014).

In New Zealand midwifery units are called primary units and obstetric units can be described as secondary or tertiary units. Since the 1990s, the term 'birth centre', originating in the United States has also been used in the UK for midwifery units, while in the United States birth centres may also have obstetricians involved in care.

Framework for the systematic review

The framework used to conduct this systematic review was based on the Cochrane Handbook for Systematic Reviews of Interventions, version 5.1.0 (Green, 2011) and on the manual 'Systematic Reviews: to support evidence-based medicine' (Khan et al., 2011).

Table 14- Steps of a systematic review proposed by Khan et al., 2011

Steps of a systematic review proposed by Khan et al., 2011
Step 1: Framing questions for a review
Step 2: Identifying relevant literature
Step 3: Assessing the quality of the literature
Step 4: Summarizing the evidence
Step 5: Interpreting the findings

Step one: The research question

The research question for the systematic review was formulated with the aid of PICO, which is a structured approach using four components: population, intervention, comparison group/control and outcomes. For this review the population were women at low risk of obstetric interventions, eligible for FMU care; the intervention was FMU care; the control was OU care and the clinical outcomes were key maternal and perinatal clinical outcomes.

The research question: What are the maternal and neonatal clinical outcomes for low risk women who receive care in freestanding midwifery units and in consultant obstetric units?

Step two: Identifying relevant literature

Once the research question was identified, a strategy to retrieve and identify all relevant studies was developed. In order to identify relevant studies, inclusion and exclusion criteria were developed, based on the objective of the systematic review. An electronic search strategy was developed and relevant citations identified. The selection of citations was conducted on the basis of the title, abstract and full text. If the abstract suggested the study was relevant or if this was still unclear, the full text was retrieved. Further clarification was elicited from the article authors in case needed.

Table 15- Inclusion and exclusion criteria

Inclusion criteria

The following inclusion criteria were applied:

- Articles examining clinical interventions and outcomes of care in FMUs compared with those achieved in OUs
- Cohort studies with controls matching the socio-economic characteristics
- Studies of cases that used modelling or adjusted odds ratios to control for these
- Case control studies
- Articles were included if the control group met the eligibility criteria for admission to the midwifery unit
- Studies analysed on the basis of 'intention to treat'
- Studies which passed the quality assessment

Exclusion criteria

The following exclusion criteria were applied:

- Studies not meeting the inclusion criteria
- Studies of FMUs with an on-site obstetrician
- Studies undertaking only economic analysis studies of midwifery units
- Studies carried out in low-income countries
- Studies published in languages other than English
- Articles which failed the quality assessment

A systematic electronic search was carried out in two platforms: ebsco-host and OVID. The search was conducted with MeSH terms, key words and word variation.

A first attempt was made to search for studies looking at clinical outcomes in FMUs compared to OUs. The key variations of the terms for midwifery unit were combined using 'and' with the following group of key words: Hospital-birth, hospital delivery, consultant-led birth, consultant-led delivery, obstetric unit (all combined with 'or'). This combined search did not retrieve relevant studies. In view of my previous knowledge of the fact that studies on FMU were not numerous, after discussion with my co-investigator, the university librarian and my supervisors we decided to change the search strategy.

We decided to conduct a search based on the key terms including variations of freestanding midwifery unit excluding the comparison group with the OU. This new strategy, not focusing on identifying studies with a control group, or methodology, included also qualitative studies. We decided therefore

to use the same search strategy followed by two separate selections based on the inclusion and exclusions criteria for the systematic review and the meta-synthesis.

Table 16- Key Words for search electronic search

Key Words for search electronic search
midwifery-led unit
free-standing birth cent*
free-standing midwifery unit
freestanding midwifery unit
stand-alone birth cent*
standalone birth cent*
stand-alone midwifery unit
midwife-led unit
home-like birth cent*
home-to-home

Table 17- The search strategy

The search strategy

A systematic electronic search was carried out in two platforms: ebsco-host and OVID

Journals from OVID

EMBASE 1980 to 2016 week 3

Maternity and Infant Care 1971 to 2016

Cochrane Central Register

Cochrane Systematic Reviews

OVID Nursing Full Text Plus

In ebsco-host we searched the following databases:

Academic Search Complete—1967- WEEK 3 2016

CINHAL Plus with Full Text

MEDLINE with Full Text

PsycINFO

Cross-reference with other literature reviews and studies was performed to check if any important study was missed. The cross-reference did not identify any further study for the systematic review.

The selection process was peer reviewed and a third opinion included for any discordance on the selection in order to reach a final agreement with co-authors. After removing duplicates, we obtained 541 citations from Ebsco-host and 245 from OVID for a total of 786 citations. A first selection was conducted by reading the titles. Non-relevant citations were removed. The second selection was performed on the base of the abstract, removing articles which did not meet the inclusion criteria. We reviewed the full text of 25 articles and 17 articles were excluded. Of these, 10 articles were excluded because they focused on AMUs or demonstrated routine medical input (Eide et al., 2009; Gaudineau et al., 2013; Schmidt et al., 2002; Cheung et al., 2011; Suzuki et al., 2011; Begley et al., 2011; Law and Lam, 1999; Eakins et al., 1989; Creasy, 1997; Fahy and Colyvas, 2005). Another article evaluated a freestanding unit which could call on a medical registrar working on the hospital's gynaecology ward (Campbell et al., 1999). Five papers reported clinical outcomes of FMUs without an obstetric comparison group (Rogers et al., 2010; Scupholme and Kamons, 1987; Stapleton et al., 2013; Royds-

Jones, 2006; Muthu and Fischbacher, 2004). One paper was a pilot study and was therefore excluded (Monk et al., 2013).

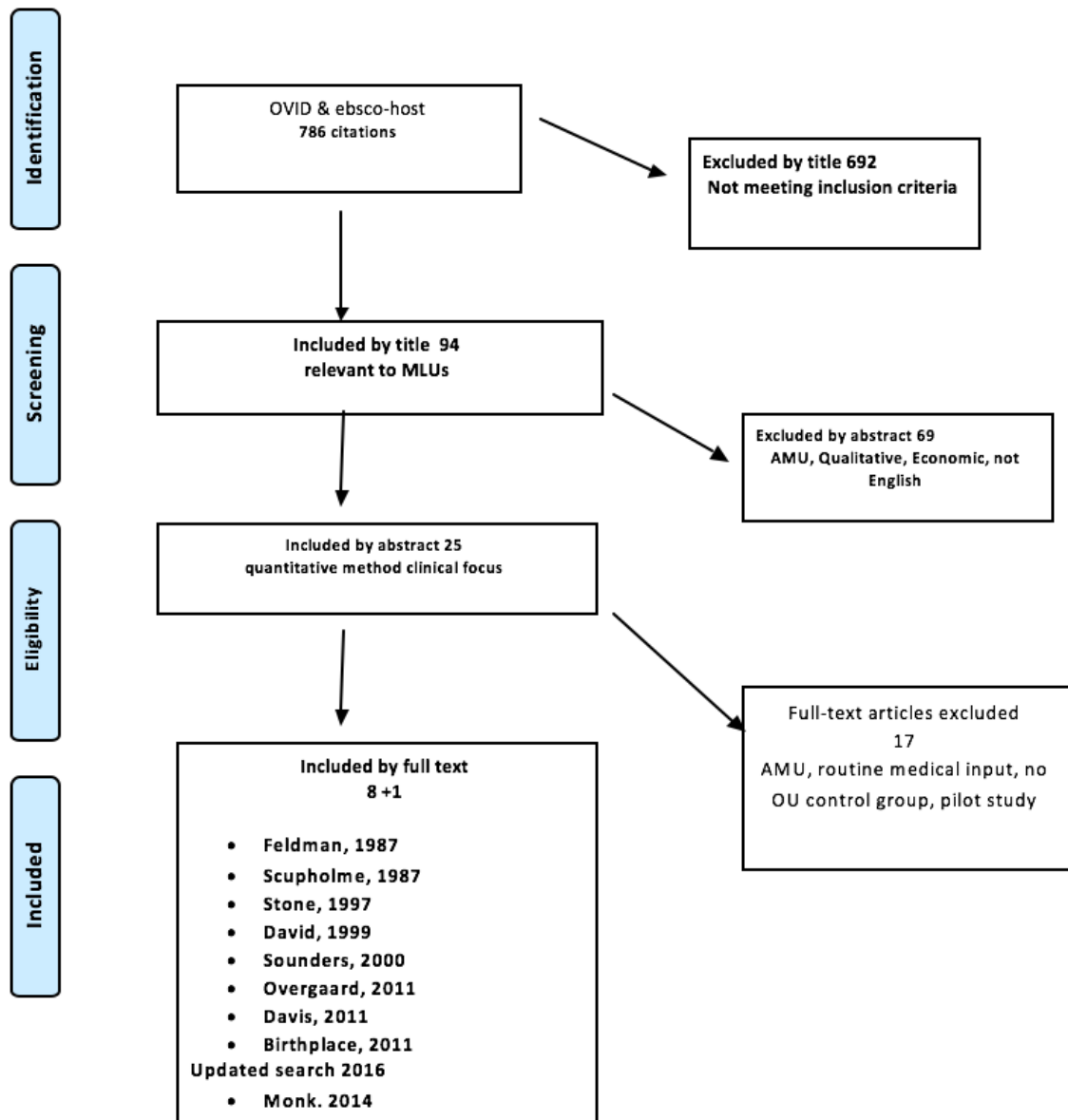
The search did not identify any randomised controlled trials comparing FMU care outcomes with those of obstetric units. In January 2015, after conducting an updated search, we found one newly published article, which met the inclusion criteria (Monk et al., 2014). A final update of the search in January 2016 did not identify any further papers. The process is illustrated in Figure 13.

We had to contact one author (Davis) to clarify if the study reported in the article was focused on FMUs and to ask for access to the original data as some relevant information was missing from the article. She replied and provided us all the necessary information.

The nine selected studies (Scupholme et al., 1986; Feldman and Hurst, 1987; Stone, 1997; David et al., 1999; Saunders et al., 2000; Brocklehurst et al., 2011; Overgaard et al., 2011; Davis et al., 2011; Monk et al., 2014) were compared in Tables 21 and 22 in terms of research design, entry point, selection of participants and outcomes used. They were then submitted to a quality assessment.



PRISMA 2009 Flow Diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed.1000097

For more information, visit www.prisma-statement.org.

Figure 13- The study flowchart

Table 18- The full text articles excluded

Exclusion of full texts articles	
Studies excluded because AMUs, or despite being FMU demonstrated routine or potential medical input	
	1. Begley et al. (2011) 2. Campbell and McFarlane (1999) 3. Cheung et al. (2010) 4. Eakins et al. (1989) 5. Eide et al. (2009) 6. Fahy et al. (2005) 7. Gaudineau et al. (2013) 8. Gottvall et al. (2004) 9. Lieberman and Ryan (1990) 10. Rooks et al. (1989) 11. Suzuki et al. (2011)
Studies excluded because of lack of comparison group	
	1. Rogers et al. (2010) 2. Royds-Jones (2006) 3. Stapleton et al. (2013) 4. Schmidt et al. (2002) 5. Scupholme and Kamons (1987)
Study excluded because pilot design	
	1. Monk et al. (2012)

Step Three: Assessing the quality of the literature

A quality assessment checklist was developed, based on the Critical Appraisal Skills Programme's tool '11 questions to help you make sense of cohort study' (CASP, 2013) and following the recommendations of Khan et al. (2011). The tool was developed in order to serve the aims and objectives of this systematic review and the research question. The two reviewers independently rated the nine studies using the 'study quality assessment checklist' developed by the reviewers. The quality assessment used a 'gate system'. If a study did not score over four on questions 1 to 4 it was excluded. Studies were also excluded if their total score was under 15. The scores are shown in Table 21.

Two studies (Stone, 1997; Saunders et al., 2000) were rated as of low quality and were excluded from the systematic review.

Table 19- Characteristics of studies included by electronic search before quality assessment

	Study	Country	Design	Evaluation period	Women in sample	Women in comparison group	Control method	Exclusion criteria	Point of entry
1	Scupholme et al, 1986	USA	Cohort study	Nov 1982-Jan 1984	250 women arriving at one FMU in labour	250 women meeting admission criteria for FMU but delivering in OU up to two weeks after a woman in sample	Matched control group selected from OU delivery book retrospectively.		Antenatal booking with FMU
2	Feldman and Hurst, 1987	USA	Cohort study	May-July 1981	77 women delivering in one FMU	77 women eligible for FMU care at 37 weeks delivering in one tertiary centre	Matched control group	Women with incomplete records or on Medicare	37 weeks
3	Stone, 1997	USA	Cohort study	Mid 1990s	69 women eligible for FMU care at 37 weeks planning to give birth in one FMU	77 women eligible for FMU care at 37 weeks planning to give birth in one mixed staff women's clinic or one FMU	Eligibility for FMU care at 34-36 weeks	Women who could not speak, read and write English	37 weeks
4	David et al, 1999	Germany	Cohort study	August 1992-July 1994	801 women who started labour care at two FMUs	3,271 women who met the criteria for the FMU but chose birth obstetric units in Berlin hospitals, 1993-4	Eligibility for FMU care	Women from countries other than Germany, the US or northern and central Europe, , incomplete records	Admission in labour
5	Saunders et al, 2000	England	Cohort study	1997-1998	589 women who delivered in one FMU	19,529 women who delivered in 14 OUs plus home births	Comparison group selected from delivery book retrospectively		20-37 weeks
6	Brocklehurst et al., 2011	England	Prospective cohort study	1 April 2008 – 30 April 2010	11,666 women in spontaneous labour at term who started labour care in 53 FMUs	32,257 women who met criteria for FMU care but chose delivery in a stratified random sample of 36 OUs	Adjusted odds ratios	Women known to have risk factors listed in NICE intrapartum care guideline. Gestational age under 37	Start of care in labour

								weeks , elective caesarean, caesarean before onset of labour, induction of labour.	
7	Overgaard et al, 2011	Denmark	Prospective cohort study	Between 2004 and 2008.	839 women in spontaneous labour who started care in two FMUs	839 women in spontaneous labour eligible for FMU care who chose to deliver in one secondary and one tertiary OUs	Prospectively matched control group.	Not meeting inclusion criteria for FMU.	Admission in labour
8	Davis et al 2011	New Zealand	Cohort study	Births in 2006 and 2007	2,877 women eligible for FMU care at 37 weeks planning to give birth in 57 FMU-type primary units	11,503 women eligible for primary care but who chose to deliver in six tertiary and eighteen secondary OUs	Adjusted odds ratios	Not meeting criteria for planning to give birth at primary units.	Admission in labour
9	Monk et al, 2014	Australia	Prospective cohort study	1 April 2010 – 31 August 2011	494 eligible women planning to deliver in two FMUs	3,157 eligible women planning to deliver in two OUs	Adjusted odds ratios	Women with an Australian College of Midwives B/C or C risk factor. Previous section not classified as ACM B/C or C, so they were included.	Antenatally at booking

Table 20- Socio-demographic variables, Matching criteria, outcomes assessed

Study	Design	Socio-demographic variables recorded	Matching criteria	Outcomes assessed
1 Scupholme et al, 1986	Cohort study	Age, ethnicity, parity, financial status, highest education level completed	Admission criteria for FMU. Matched within 2 weeks of delivery on age, parity, ethnicity, financial status.	Dietary intake in labour, use of analgesia, method of delivery, dilatation on admission, length of labour, neonatal outcomes: weight, Apgar, resuscitation needed, admission to intensive care, complications: augmentation, second stage longer than 2 hours, shoulder dystocia, PPH. Transfer rates
2 Feldman and Hurst, 1987	Cohort study	No Medicare, age, parity, marital status, education, ethnicity	Admission criteria for FMU	Antenatal, intrapartum and postpartum transfer rates, artificial rupture of membranes, augmentation, use of CTG, analgesia, length of labour, fetal heart rate abnormalities, meconium stained liquor, position for birth, complications III stage, mode of delivery, episiotomy, lacerations, intravenous infusion, Apgar scores, resuscitation of newborn, transfer to intensive care, birthweight
3 Stone, 1997	Cohort study	Ethnicity, marital status, payment method. Multiparae only	Eligibility for FMU	State of perineum, feeding at six weeks, cost, satisfaction
4 David et al, 1999	Cohort study	Age, employment, education, marital status, gravidity, parity (no table provided)	Admission criteria for FMU and maternal employment.	Method of delivery, Indications for instrumental delivery, episiotomy, perineal tear, transfer rates, maternal complications, Infant outcomes: birthweight, Apgar scores, resuscitation needed, admission to intensive care
5 Saunders et al, 2000	Cohort study	Ethnicity, age, parity	Admission criteria for FMU	Antenatal, intrapartum, and postpartum transfer rates and reasons, induction of labour, analgesia, mode of delivery and reasons for intervention, meconium staining, perineal tear, episiotomy, postpartum haemorrhage, , transfer to neonatal intensive care and reasons, stillbirth, birthweight, Apgar scores, postnatal stay, women's experiences of care received.
6 Brocklehurst et al, 2011	Prospective cohort study	Ethnicity, parity, BMI, age, smoking,	Adjusted for maternal age, ethnic group, parity,	Primary outcome was a composite of perinatal mortality and specific neonatal morbidities (see discussion).

		understanding of English, educational level, occupational status and marital/cohabitation status, index of multiple deprivation score .	understanding of English, marital status, body mass index, index of multiple deprivation score.	Secondary outcomes: maternal interventions, maternal and neonatal morbidity, mode of birth.
7	Overgaard, 2011	Matched cohort study	Ethnicity, parity, BMI, age, smoking, education, occupational status and cohabitation status.	Prospective individual matching on low risk status, parity, smoking, body mass index, age, ethnicity, education, occupation and cohabitation status.
				Primary outcomes: Apgar scores under 7 at 5 minutes and caesarean section. Secondary outcomes: Maternal: type of birth, perineal outcomes, epidural analgesia, use of birthing pool, abnormal fetal heart rate leading to action, dystocia, shoulder dystocia, state of perineum, postpartum haemorrhage over 500 ml, maternal readmission 0-28 days postnatally. Neonatal: Apgar under 9 at 5 minutes, neonatal asphyxia, admittance to NICU, admittance to NICU for over 48 hrs, neonatal readmission 0-28 days postnatally
8	Davis et al 2011	P Cohort study	Age, parity, ethnicity and smoking.	Analysis planned in advance with multinomial logistic regression controlling for maternal age, parity, ethnicity and smoking
				Primary outcomes: mode of birth. Secondary outcomes: augmentation of labour, artificial rupture of the membranes, pharmacological pain relief including epidural or spinal anaesthesia, nitrous oxide and narcotics, episiotomy, perineal trauma, blood loss over 1000ml, 5 minute Apgar score under 7 and admission to NICU.
9	Monk et al 2014	Prospective cohort study	Ethnicity, parity, body mass index, age, smoking.	Adjustment for maternal age, smoking status, parity, risk at the onset of labour, previous caesarean section, gestation at the time of birth, induction and augmentation of labour.
				Primary outcomes: mode of birth, \Apgar score less than 7 at 5 min and admission to the neonatal intensive care unit. Secondary outcomes: onset of labour, analgesia, blood loss, management of third stage of labour, perineal trauma, transfer, neonatal resuscitation, breastfeeding, gestational age at birth, birth weight, severe morbidity and mortality.

Table 21- Study Quality Assessment Checklist (Rocca-Ihenacho and Brigante, 2014) -Grading of quality: Low: Under 15, Medium: 15-17, High: 18-20

	Scupholm e et al., 1986	Feldman et al., 1987	Stone et al.,1997	David et al., 1999	Saunders et al., 2000	Brocklehur st et al., 2011	Overgaard et al., 2011	Monk et al., 2014	Davis et al. 2011
Population: (selection bias)									
1. Was the selection of participants clearly explained?	2	2	1	2	1	2	2	2	2
2. Are the eligibility criteria for the FMU described?	1	1	1	1	2	1	1	2	2
3. Was the control group matched to the intervention group or adjusted?	2	2	1	2	0	2	2	2	2
SUBTOTAL If score less than 4 exclude at this point	5	5	3 Excluded	5	3 Excluded	5	5	6	6
Intervention: (perfromance bias)									
4.a What was the entry point in the study?-In labour (2 points)	2	-		2		2	2	2	2
4.b What was the entry point in the study?-37/40 (0 point)	-	0		-		-	-	-	
5. Was the model of care offered by the FMU described?	2	2		0		2	2	1	1
Outcomes: (measurement and attrition biases)									
6. Were the data analysed following intention to treat principle?	2	2		2		2	2	2	2
7. Are the outcomes described comprehensive/appropriate?	2	2		2		2	2	2	
8. Is the follow up of participants complete?	2	2		2		2	2	2	
9. Study design									
Prospective (2 points)	-	-		-		2	2	2	-
Partial prospective (1 point)	1	-		-		-	-	-	
Retrospective (0 point)	-	0		0		-	-	-	0
Overall:									
10. Did the cohort study address a clearly focused issue?	2	2		2		2	2	2	2
11. Was the cohort recruited in an acceptable way?	2	2		2		2	2	2	
Total score	20	17		17		22	22	21	19

Step four: Summarizing the evidence

The studies differed in their design and statistical analysis, with some using matched control groups (Scupholme et al., 1986; Feldman and Hurst, 1987; Overgaard et al., 2011) and others using statistical adjustment to compare unmatched cohorts (David et al., 1999; Brocklehurst et al., 2011; Davis et al., 2011; Monk et al., 2014). Because of the significant clinical and methodological heterogeneity between the included studies, it was decided not to attempt a meta-analysis.

One of the included studies compared primary units in New Zealand with secondary and tertiary units as well as births at home (Davis et al., 2011). In each case, primary units were used as the reference group, in contrast to the other articles, which used consultant units as the reference group. In order to compare this article with the others in the review, we contacted the lead author for additional aggregated data, which had not been included in the published article. We then combined data for secondary and tertiary units and used them as the reference group and calculated unadjusted relative risks. As we did not have access to the authors' full dataset of individual level records, we were unable to calculate adjusted relative risks. The outcome variables included in each study were summarised and compared in Table 22.

Table 22 - Outcomes considered by included studies

	Scupholme et al. (1986)	Feldman et al. (1987)	David et al. (1999)	Brocklehurst et al. 2011	Overgaard et al. (2011)	Monk A. et al. 2014	Davis D. et al. 2011
AN transfer rates	-	√	-	NA	NA	√	√
Intrapartum transfer	√	√	√	√	√	√	-
Post partum transfer rates	√	-	√	√	√	√	-
Neonatal transfer	√	√	√	-	√	√	√
Mode of birth	√	√	√	√	√	√	√
Immersion in water	√	√	-	√	√	-	-
Epidural analgesia	-	√	-	√	√	√	√
Augmentation	√	√	-	√	√	√	√
Shoulder dystocia	√	-	-	√	√	-	-
PPH	√	√	-	√	√	√	√
Blood transfusion	-	-	-	√	-	-	-
Perineal outcomes	-	√	√	√	√	√	√
Episiotomy	-	√	√	√	-	√	√
Apgar scores	√	√	√	√	√	√	√

Results

The findings of the seven studies reporting clinical outcomes of care are presented in the following order: primary outcomes, including mode of delivery, postpartum haemorrhage and neonatal outcomes, secondary outcomes including transfer rates, intrapartum analgesia, state of the perineum and breastfeeding rates.

Primary outcomes

Mode of birth and obstetric interventions (Table 23)

Planning to give birth in a FMU was associated with higher rates of spontaneous vaginal birth and lower rates of caesarean section and instrumental birth.

Post-partum haemorrhage (Table 24)

Planning to give birth in a FMU was associated with a lower risk of post-partum haemorrhage of 500-999ml. No differences were detected in rates of massive post-partum haemorrhage of more than 1000 ml but the Birthplace Study showed a significantly higher rate of blood transfusion for women planning to birth in OUs, however (Brocklehurst et al., 2011).

Perinatal outcomes (Table 25)

The only study which had sufficient statistical power to detect differences in neonatal outcomes was the Birthplace in England study (2011). In the other studies the sample size was too small. In the Birthplace study, a composite outcome was chosen to increase the statistical power to detect differences in adverse outcome. The composite perinatal outcome included: stillbirth after the start of labour care; early neonatal death (within 7 days), neonatal encephalopathy defined as either clinical diagnosis of neonatal encephalopathy or 'signs of neonatal encephalopathy'; meconium aspiration syndrome; brachial plexus injury; fractured humerus or clavicle. No differences between FMUs and OUs were detected in this composite outcome.

Two studies reported a higher rate of neonatal admission to neonatal intensive care for babies of women planning OU birth (Brocklehurst et al., 2011; Monk et al., 2014) while another did not (Overgaard et al., 2011) and adjusted comparisons were not available for two further studies (David et al., 1999; Davis et al., 2011).

Table 23 - Mode of birth and interventions

Study	Planned birth in:		Planned birth in:		Absolute difference		Adjusted comparison
	Freestanding midwifery unit		Obstetric unit				
	Numbers	Percentage	Numbers	Percentage	Difference	95% CI or p value	
Spontaneous Vaginal Birth							
Scupholme et al., 1986 (USA)		92.0		83.0	9.0	p= 0.005 to 0.01	NA
Feldman and Hurst 1987 (USA)		87.9		45.0	42.9		NA
David et al., 1999 (Germany)		91.4		84.3	7.1	p <0.001	NA
Brocklehurst et al., 2011 (UK)*	10150/11280	90.0	14645/19688	74.4	15.6	14.8 to 16.4	Freestanding compared with obstetric, adjusted OR=3.38, 99%CI=2.70 to 4.25
Overgaard, 2011 (Denmark)	796/839	94.9	751/839	89.5	5.4	2.8 to 8.0	
Monk et al., 2014 (Australia)	400/494	81.0	2044/3157	64.7	16.3	12.2 to 19.9	Freestanding compared with tertiary, adjusted OR=1.57, 95%CI=1.20 to 2.06
Davis et al., 2011 (New Zealand)	2722/ 2875	94.7	9195/11773	78.1	16.6	15.4 to 17.6	NA
Instrumental Birth							
Scupholme et al., 1986 (USA)		2.0		3.0	-1.0	P=0.005 -0.01	NA
Feldman and Hurst 1987 (USA)		5.6		43.7	-38.1	P <0.0001	NA
David et al., 1999 (Germany)		5.0		11.0	-6.0	P <0.001	NA
Birthplace, 2011 (England)	686/11280	6.1	2842/19688	14.4	-8.3	-7.7 to -9.0	Freestanding compared with obstetric, adjusted OR, ventouse=0.32, 99%CI=0.22 to 0.47. forceps= 0.45, 99%CI=0.32 to 0.63
Overgaard, 2011 (Denmark)	25/839	3.0	61/839	7.3	-4.3	-2.2 to -6.5	Freestanding compared to obstetric, RR=0.4, 95%CI= 0.3 to 0,6
Monk et al., 2014 (Australia)	34/494	6.9	331/3157	10.5	-3.6	-5.8 to -0.8	Freestanding compared with tertiary, adjusted OR=0.79, 95%CI=0.53 to 1.17
Davis et al., 2011 (New Zealand)	60/2873	2.1	1022/11773	8.7	-6.6	-7.3 to -5.8	NA
Intrapartum caesarean section							
Scupholme et al., 1986 (USA)	15/250	6.0	35/250	14.0	-8.0	-13.4 to -2.8	Freestanding compared with obstetric, RR=0.43 95%CI= 0.24 to 0.76
Feldman and Hurst 1987 (USA)	5/77	6.5	8/71	11.3	-4.8	-14.9 to 4.8	Freestanding compared with obstetric, RR=0.58, 95%CI=0.2 to 1.68
David et al., 1999 (Germany)		3.0		4.6	-1.6	P= 0.057	NA
Birthplace, 2011 (England)	405/11280	3.6	2158/19688	11.0	-7.4	-6.8 to -7.9	Freestanding compared with obstetric, adjusted OR=0.32, 99%CI=0.24 to 0.42

Overgaard, 2011 (Denmark)	19/839	2.3	34/839	4.0	-1.7	-0.1 to -3.5	Freestanding compared with obstetric, RR=0.6, 95%CI=0.3 to 0.9
Monk et al., 2014 (Australia)	60/494	12.1	782/3157	24.8	-12.7	-1.6 to -0.9	Freestanding compared with tertiary, adjusted OR=0.65, 95%CI=0.48 to 0.88
Davis et al., 2011 (New Zealand), secondary unit compared with primary	91/2873	3.2	1232/11773	10.5	-7.3	-8.1 to -6.4	NA

* Spontaneous vertex birth

Table 24- Post partum haemorrhage

Study	Planned birth in:		Planned birth in:		Absolute difference		Adjusted comparison
	Freestanding midwifery unit		Obstetric unit		Difference	99% CI or p value	
	Numbers	Percentage	Numbers	Percentage			
PPH not specified							
Scupholme et al., 1986 (USA)	-	5.0	-	1.4	-	-	-
Feldman and Hurst 1987 (USA)	2/72	2.9	1/63	1.6	1.2	-6.0 to 8.1	Freestanding compared with obstetric, RR=1.75, 95%CI= 0.16 to 18.84
PPH -500ml to 999ml							
Overgaard, 2011 (Denmark)	18/839	2,1	54/839	6.4	-4.3	-6.3 to -2.4	Freestanding compared with obsteric, RR=0.3, 95%CI= 0.2 to 0.6
Monk A. et al., 2014	48/494	9.7	485/3157	15.4	-5.6	-8.3 to -2.5	Freestanding compared with tertiary, adjusted OR=0.70, 95%CI=0.51to 0.97
Massive PPH (>1000ml)							
Overgaard, 2011 (Denmark)	11/839	1.3	14/839	Table	0.4	-1.6 to 0.9	Freestanding compared with obstetric, RR=0.8, 95%CI=0.4 to 1.7
Monk A. et al., 2014	18/494	3.6	139/3157	4.4	-0.8	-2.3 to 1.4	Freestanding compared with tertiary, adjusted OR=0.88, 95%CI=0.52 to 1.47
Davis et al., 2011 (New Zealand)	34/2877	0.12	192/11503	0.17	-0.05	-0.09 to 0.00	NA
Need for blood transfusion							
Brocklehurst et al., 2011 (England)	67/11230	0.6	241/19579	1.2	-0.6	-0.8 to -0.4	Freestanding compared with obstetric, adjusted OR=0.48, 99%CI=0.32 to 0.73

Table 25- Perinatal outcomes

Study	Planned birth in: Freestanding midwifery unit		Planned birth in: Obstetric unit		Absolute difference		Adjusted comparison
	Numbers	Percentage	Numbers	Percentage	Difference	95% CI or p value	
Stillbirth							
Brocklehurst et al., 2011 (England)	4/11282	0.0	3/19706	0.0	0.0	0.0 to 0.1	Not calculated
Early neonatal Death							
Birthplace, 2011 (England)	5/11263	0.0	5/19637	0.0	0.0	0.0 to 0.1	Not calculated
Overgaard, 2011 (Denmark)	1/839	0.1	0/839	0.0	0.1	-0.3 to 0.7	Freestanding compared to obstetric, RR=1.05, 95%CI,= 1.03 to 1.09
Admission to Neonatal Intensive Care Unit (NICU)							
David et al., 1999 (Germany)		2.6		2.0	0.6	p=0.39	-
Brocklehurst et al., 2011 (England)	194/11257	1.7	543/19642	2.8	-1.0	-1.4 to -0.7	Adjusted OR freestanding compared with obstetric=0.61, 95%CI=0.40 to 0.91
Overgaard, 2011 (Denmark)	28/839	3.3	42/839	5.0	-1.7	-3.6 to 0.3	Comparison of freestanding with obstetric, RR=0.7, 95%CI=0.4 to 1.1
Monk A. et al., 2014	33/490	6.7	432/3145	13.7	-7.0	-9.3 to -4.2	Adjusted OR freestanding compared with tertiary=0.60, 95%CI=0,39 to 0.91
Davis et al., 2011 (New Zealand)	61/2877	2.1	384/11503	3.3	-1.2	-1.8 to -0.5	NA
Composite Perinatal Mortality and Morbidity*							
Brocklehurst et al., 2011 (England)	41/11199	0.4	81/19551	0.4	0.0	-0.2 to 0.1	Adjusted OR freestanding compared with obstetric=0.92, 99%CI=0.58 to 1.46
Nulliparous women	24/5158	0.5	52/10541	0.5	0.0	-0.2 to 0.2	Adjusted OR freestanding compared with obstetric=0.91, 99%CI= 0.52 to 1.60
Multiparous women	17/6025	0.3	29/8980	0.3	0.0	-0.2 to 0.2	Adjusted OR freestanding compared with obstetric=0.91, 99%CI, 0.46 to 1.80
Brocklehurst et al., 2011 (England), all women without complicating conditions	35/10571	0.3	48/15676	0.3	0.0	-0.1 to 0.2	Adjusted OR freestanding compared with obstetric=1.22, 99%CI=0.76 to 1.96
Neonatal Encephalopathy (clinical diagnosis)							
Brocklehurst et al., 2011 (England)	21/16569	0.2	42/19587	0.2	0.0	-0.1 to 0.1	Not calculated

Secondary outcomes

Transfer rates (Table 26)

All the included studies used intention to treat analysis from their baseline but these baselines were at different points in pregnancy or at the onset of labour care. It has been estimated that in England within a group only 50% of women in England eligible for FMU care at 36 gestational weeks would actually give birth in a FMU (Hollowell et al., 2011). For studies with a baseline at 37 gestational weeks, therefore, any observed effect of FMU care would be greatly 'diluted' by transfers to OUs before the start of labour care.

Parity has been highlighted as a major factor associated with the risk of transfer in labour, with nulliparous women needing to transfer more often than multiparae. This was highlighted as an important topic of discussion at the time the woman chooses the place of birth. In the study in Denmark 36.7% of nulliparae and 7.2% of multiparae transferred intrapartum or up to 2 hours after birth (Overgaard et al., 2011). Brocklehurst et al., (2011) reported that 29.6% of nulliparous women transferred compared with 5.3% of multiparae.

Use of analgesia (Table 27)

There were significant differences in the use of epidural analgesia with women planning to give birth in OUs being more likely to use epidurals compared to those planning to birth in FMUs. Data on non-pharmacological pain relief were available for only two studies (Brocklehurst et al., 2011; Overgaard et al., 2011), however, and these both showed that FMUs were associated with a greater use of the birthing pool for analgesia.

Perineal outcomes (Table 28)

There were significant differences in perineal outcomes with higher rates of intact perineum in FMUs and higher rates of episiotomy in OUs. Incidences of third and fourth degree tears were significantly different only in the Birthplace study (Brocklehurst et al., 2011) with higher rates associated with OU care.

Breastfeeding

Babies born from mothers intending to give birth in FMU were significantly more likely to being breastfed at birth (Brocklehurst et al., 2011; Monk, 2014) and at discharge (Monk, 2014).

Table 26- Transfer rates from freestanding midwifery units to obstetric units

Study	Baseline	Timing of transfer	Total women	Number transferred	Percentage transferred
Antenatal transfer					
Scupholme et al., 1986 (USA)	Booking with the midwifery unit				17.0
Feldman and Hurst 1987 (USA)	37/40 weeks				8.0
Overgaard, 2011 (Denmark)	Beginning of labour before admission	Gave birth before admission	839	9	1.1
Monk A. et al., 2014	Planned birth in freestanding unit	Antenatal	494	168	34.0
Antenatal + intrapartum					
Feldman and Hurst 1987 (USA)	37/40 weeks				22.0
Overgaard, 2011 (Denmark)	Beginning of labour before admission	Gave birth before admission or transferred in labour	839	108	12.7
Intrapartum Transfer					
Feldman and Hurst 1987 (USA)	Admission in labour				14.0
Scupholme et al., 1986 (USA)	Admission in labour				21.6
David et al., 1999 (Germany)	Admission in labour	Transferred before delivery	801	146	18.2
Brocklehurst et al., 2011 (England)	Admission in labour	Transferred before delivery	11282	1863	16.5
Overgaard, 2011 (Denmark)	Beginning of labour before admission	Transferred before delivery	839	99	11.6
Monk A. et al., 2014	Planned birth in freestanding unit	Intrapartum	494	65	13.2
Intrapartum + immediate postpartum					
Brocklehurst et al., 2011 (England)	Admission in labour	During labour or immediately after birth	11282	2468	21.0*
Overgaard, 2011 (Denmark)	Beginning of labour before admission	Transferred intrapartum or up to two hours postpartum	839	126	14.8**
Monk A. et al., 2014	Planned birth in freestanding unit	Intrapartum or immediately after birth	494	83	16.8 ***
Postnatal transfer					
Scupholme et al., 1986 (USA)	From birth to discharge				17.5
David et al., 1999 (Germany)	From birth to discharge				3.6
Overgaard, 2011 (Denmark)	Beginning of labour before admission	From two hours after birth to discharge	839	13	1.5
Monk A. et al., 2014	Planned birth in freestanding unit	From birth to discharge	494	18	3.6

* Transferred postpartum or immediately after birth. Includes 545 transfers after birth and 60 where timing of transfer was missing

** Transferred intrapartum or up to two hours postpartum

***Transferred postpartum or immediately after birth. N

Table 27- Analgesia

Study	Planned birth in: Freestanding midwifery unit		Planned birth in: Obstetric unit		Absolute difference		Adjusted comparisons
	Numbers	Percentage	Numbers	Percentage	Difference	95% CI or p value	
Epidural							
Feldman and Hurst 1987 (USA)	4/77	5.2	40/71	56.3	-51.1	-62.5 to -37.4	Freestanding compared to 0.24 95%CI=0.03 to 0.24
Brocklehurst et al., 2011 (England)	1251/11251	11.1	5817/19576	29.7	-18.6	-17.7 to -19.5	Freestanding compared to 0.34 99%CI=0.22 to 0.34
Overgaard, 2011 (Denmark)	35/839	4.2	86/839	10.3	-6.1	-3.6 to -8.6	Freestanding compared to 0.6
Monk et al., 2014 (Australia)	62/494	12.6	577/3157	18.3	-5.7	-8.7 to -2.3	Freestanding compared to 1.19 95% CI=0.63 to 1.19
Pool for pain relief							
Brocklehurst et al., 2011 (England)	5253/11270	46.6	1836/19680	9.3	37.3	36.3 to 38.3	Freestanding compared to 14.69 99%CI=4.76 to 14.69
Overgaard, 2011 (Denmark)	269/839	32.1	197/839	23.5	1.4	1.2 to 1.6	Freestanding compared to 1.6

Table 28- Perineal outcomes

Study	Planned birth in: Freestanding midwifery unit		Planned birth in: Obstetric unit		Absolute difference		Adjusted comparison
	Numbers	Percentage	Numbers	Percentage	Difference	95% CI or p value	
Intact Perineum							
Feldman and Hurst 1987 (USA)	18/77	23.4	4/72	5.6	17.8	6.6 to 28.9	Freestanding compared with obstetric, RR=95%CI=1.50 to 11.84
David et al., 1999 (Germany)	-	30.0	-	22.0	-	P <0.001	-
Overgaard, 2011 (Denmark)	514/839	61.3	466/839	55.5	5.7	1.0 to 10.4	Freestanding compared with obstetric, RR=95%CI=1.02 to 1.2
Monk A. et al., 2014	241/494	48.8	1752/3157	55.5	-6.7	-11.4 to -2.0	Freestanding compared with tertiary, adjusted OR=0.88, 95%CI=0.71 to 1.10
Episiotomy							
Feldman and Hurst 1987 (USA)	-	47.2	-	78.1	-	P <0.0001	-
David et al., 1999 (Germany)	-	15.7	-	54.8	-	P <0.001	-
Brocklehurst et al., 2011 (England)	995/11275	8.8	3780/19678	19.2	-10.4	-11.1 to -9.6	Freestanding compared with obstetric, adjusted OR=0.27, 99%CI=0.22 to 0.34
Monk A. et al., 2014*	38/494	7.7	315/3157	10.0	-2.3	-4.6 to 0.6	Freestanding compared with tertiary, adjusted OR 0.81, 95%CI 0.55 to 1.19
Davis et al., 2011 (New Zealand)	125/2571	4.9	1242/10075	12.3	-7.4	-8.5 to -6.4	NA
Third and forth degree tear							
Feldman and Hurst 1987 (USA)	7/77	9.1	6/72	8.3	0.8	-9.1 to 10.4	Freestanding compared with obstetric, RR=95%CI=0.38 to 3.09
David et al., 1999 (Germany)	-	0.9	-	1.1	-	P =0.24	NA
Brocklehurst et al., 2011 (England)	259/11262	2.3	625/19638	3.2	-0.9	-0.5 to -0.2	Freestanding compared with obstetric, adjusted OR=0.78, 99%CI=0.58 to 1.05
Overgaard, 2011 (Denmark)	19/839	2.3	24/839	2.9	-0.6	-2.2 to 1.0	Freestanding compared with obstetric, RR=95%CI=0.4 to 1.4
Monk et al., 2014 (Australia)	24/494 (?)	4.9	132/3157	4.2	0.7	-1.1 to 3.0	Freestanding compared with tertiary, adjusted OR=0.90, 95%CI=0.56 TO 1.45

Monk et al., 2014 (Australia) extended from episiotomy	7/494	1.4	37/3157	1.2	0.2	-0.6 to 1.8	Freestanding compared with tertiary, 95%CI=0.67 to 3.77
Davis et al., 2011 (New Zealand)	57/2718	2.1	417/10720	3.9	-1.8	-2.4 to -1.1	NA

Step five: Discussion and interpretation of findings

This systematic review suggests that, for women with uncomplicated pregnancies, planning to give birth in FMU is associated with better maternal outcomes with similar perinatal outcomes.

It is impossible to establish causality in cohort studies, but experimental studies on this topic would not be ethical or feasible. In addition, it would be impossible to use blinding in trials on this subject and there would be considerable problems of bias and crossover in response to study allocation. Therefore, well-controlled cohort studies are the optimum design for a question of this type. Lower rates of birth interventions could hypothetically be linked to a difference in the characteristics of the women choosing to give birth in FMUs. These are difficult to measure and control for. Differences in the birth settings including the environment may play a part as could differences in the midwives' attitudes and practices or a combination of all the above elements.

FMUs not only seem to be associated with lower intervention rates and better maternal outcomes but additional studies, not included in this systematic review, also suggest lower costs (Schroeder et al., 2011) and better birth experiences (Overgaard et al., 2012; Macfarlane et al., 2014).

This systematic review demonstrates the lack of well-designed and conducted research on the clinical outcomes of FMUs compared to OUs. As in the case of home birth, evaluating outcomes of FMUs is a particularly complex task as randomised controlled trials are impossible to conduct because of ethical issues related to women's right to choose place of birth in the UK. Well-conducted cohort studies are limited in numbers, however. In addition, there are differences between countries in criteria for eligibility and the types of care offered. Research studies on FMUs have not used consistent outcome measures, making systematic reviews and other comparison problematic. All these elements add layers of complexity to the task of evaluating FMUs.

Maternal and neonatal outcomes of care in FMUs however seem to be safe and effective. It could be argued that due to the lower rates of maternal intervention FMUs have the potential to improve maternal health. FMUs could be seen as an opportunity for building primary care services, nested in the community and which offer public health benefits to mother, babies and their families as advocated by the new Maternity Review (NHS England, 2016).

Strengths and limitations

We conducted a thorough search of the available databases as well as a systematic selection of the articles, using a clear and systematic methodology. This review was limited to articles published in peer-reviewed journals and to the English language. We did not explore the grey literature. The heterogeneity of studies described above makes it impossible to do meta-analysis.

Conclusion

The systematic review identified 432 articles. Seven articles were included after applying inclusion and exclusion criteria as well as using a quality assessment tool. The review suggests that similar perinatal outcomes are achieved in FMUs and OUs but maternal outcomes in FMUs are better, with lower levels of intervention.

More research is needed on FMUs and this should be well designed and address the limitations of previous research. We strongly suggest the creation of a set of outcome measures to be adopted when evaluating FMUs. Prof Khan and other journal editors, have already created the Core Outcomes in Women's health (CROWN) to harmonise outcome reporting in women's health research. The aim of the CROWN is to address the widespread, unwarranted variation in reporting of outcomes. This problem makes comparison between and combination of results across studies difficult, if not impossible.

Additionally, the outcomes collected are focused on the absence of pathology only and do not include any indicators of wellbeing (salutogenetic outcome measures). It would be important to determine which salutogenic outcome measure would be important to include by engaging with scholars who work on this field as well as service users.

Chapter 6- Meta-synthesis

Introduction

The systematic review of maternal and neonatal clinical outcomes for healthy women experiencing an uncomplicated pregnancy, who opt for freestanding midwifery unit care, which was presented in the previous Chapter, suggested that FMUs achieve better maternal outcomes and similar neonatal outcomes than OUs. In this Chapter I report the findings of a meta-synthesis of qualitative studies on FMUs, including studies which focused on the views and experiences of those involved with providing midwifery care as well as service users.

Background

Walsh and Downe (2005) refer to Stern and Harris (1985) as the first to coin the term meta-synthesis. Since the 1980s the methodologies for synthesizing qualitative research findings have developed and multiplied. While in 2003 Finfgeld (2003) reported five methodologies for qualitative synthesis, in 2014 more than a dozen methodologies can be found (Campbell et al., 2011). Meta-synthesis approaches may differ on the basis of four attributes: epistemology, aggregative or interpretative approach, the degree of iteration and whether the overall aim is theory generation or a descriptive summary. Nonetheless, all meta-syntheses share some commonalities and can sit within a continuum of available methodologies, from more aggregative to more interpretive, depending on the theoretical underpinning of the review.

Aggregative methodologies such as meta-summary, thematic synthesis or qualitative comparative analysis maintain a more descriptive approach whereas interpretive methodologies such as meta-ethnography, meta-study and grounded theory aim to elaborate the data and provide an interpretation of the phenomenon under scrutiny (Hannes and Lockwood, 2012).

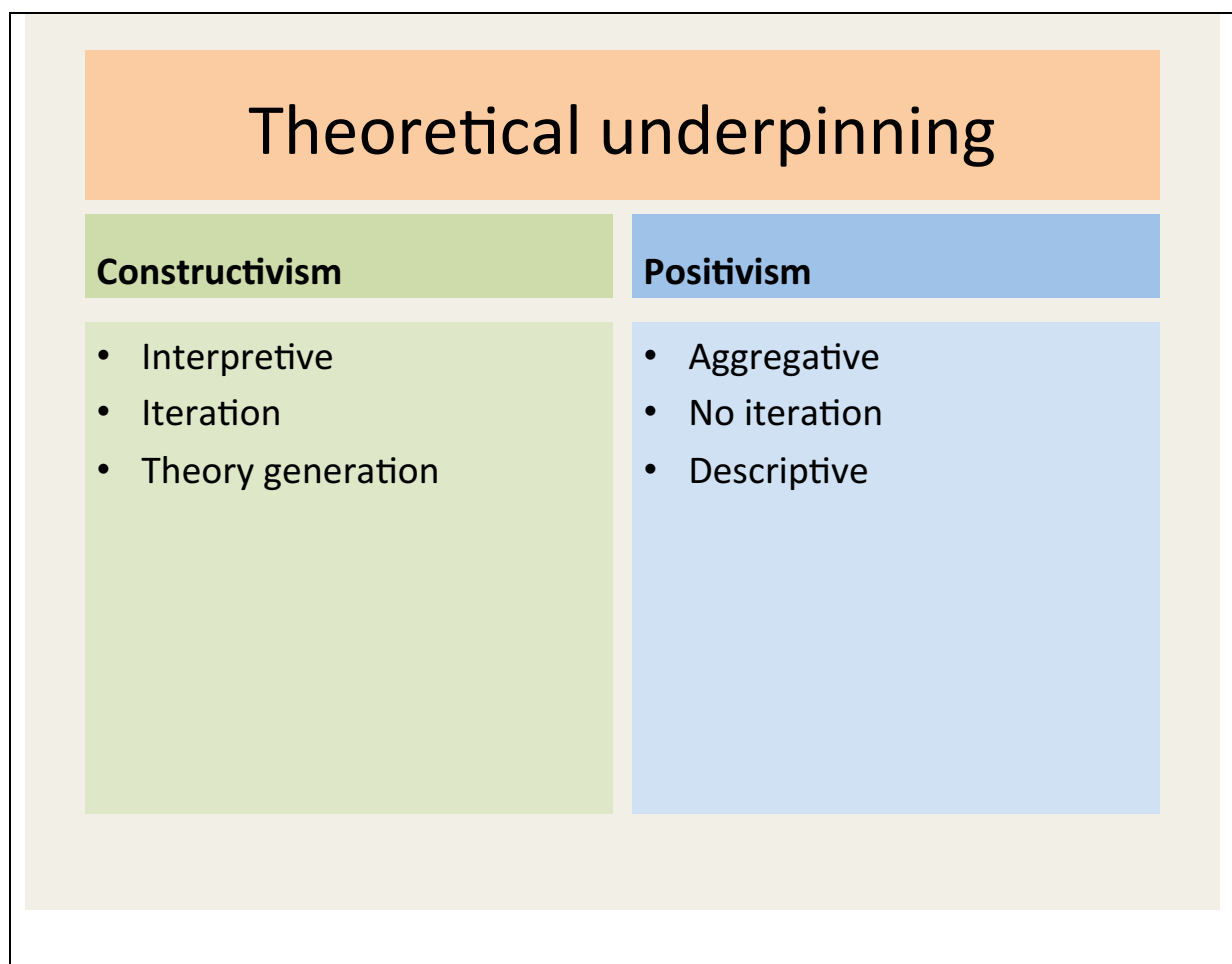


Figure 14- The theoretical underpinning for meta-synthesis

Sherwood (1999) stressed that methodologies for guiding the synthesis of qualitative research are important since the synthesis can modify our understanding of a phenomenon or widening it by a higher level of abstraction. Qualitative research synthesis can therefore contribute to theory generation and underpin experimental research as well as informing policy and practice (Garrett and Thomas, 2004; MRC, 2008).

Interpretive approaches to meta-synthesis involve further interpretation of data arising from several qualitative studies on the same topic with the purpose of theory generation.

This meta-synthesis aimed to adopt an interpretive approach and to contribute to theory generation and therefore used a modified meta-ethnography methodology based on that developed by Noblit and Hare (1988). This was also considered to be consistent with the overall theoretical perspective of the study.

Aim

The aim of this meta-synthesis was to explore the current evidence arising from qualitative studies on FMUs.

Objectives:

1. To explore culture and philosophy of care within FMUs.
2. To investigate how practice is enacted within FMU settings.
3. To highlight staff and service users' experiences.
4. To explore possible explanations on how FMUs achieve low rates of interventions and high service users' satisfaction.

The review team

Lucia Rocca-Ihenacho and Lia Brigante were the two principal reviewers, who conducted the electronic searches, the selection, the tabulation of the articles and the synthesis. The City University London librarian Catherine Radbourne supported us in developing the search strategy and helped refining the electronic searches. Professors Christine McCourt and Denis Walsh functioned as supervisors. They provided ad hoc support when questions arose or decisions had to be made regarding crucial issues such as inclusion and exclusion criteria, whether to include specific articles as well as interpretation of the findings.

Theoretical underpinning of this review

The theoretical perspective underpinning this meta-synthesis is constructivism, which is in line with the wider theoretical underpinning of the whole thesis.

Methodology

The methodology for this meta-synthesis was a modified version of the framework proposed by Noblit and Hare (1988), who aimed to develop interpretive explanations and understanding of the phenomena under study and described their methodology following seven steps:

- 1. Identify a topic.
- 2. Search and select the relevant qualitative studies.
- 3. Read the articles several times.
- 4. Determine how the studies relate to each other by tabulating key themes/concepts and how they relate to each other.
- 5. Translating the studies into one another.
- 6. Syntheses.
- 7. Expressing the synthesis.

We have used a modified version of the seven steps in the attempt to address some of the limitations of the methods described by Noblit and Hare (1988). Mainly we aimed at increasing clarity about the steps, but also including a quality assessment of the literature, which was not included in the original framework. Our framework excludes Noblit and Hare’s step 7, which is expressing the synthesis because we consider it as part of the dissemination process.

Table 29- The modified steps based on Noblit and Hare (1988)

Modified steps:

Step 1: Framing the research question for a review

Step 2: Identifying relevant literature

Step 3: Assessing the quality of the literature

Step 4: Summarizing the evidence:

A) Read the articles several times

B) Determine how the studies relate to each other by tabulating key themes/concepts

C) Translating the studies into one another

D) Synthesis

Step 5: Interpreting the findings, line of argument

Step one: the research question

The research question for this review was framed on the basis of the research question for my ethnographic study in order to be able to relate the findings from the two:

What are the philosophies, culture, practices, and experiences of staff and service users providing or receiving care in FMUs?

Step two: search and select the relevant qualitative studies

A strategy to retrieve and identify all relevant studies was developed. Inclusion and exclusion criteria were developed on the basis of the research question and the aim and objectives of the meta-synthesis.

Search strategy and selection process

As already discussed in the introduction to the previous Chapter, after several attempts a common search strategy for both the systematic review and the meta-synthesis was adopted. This was possible because the final search only included midwifery-unit and its word variations as search terms.

A selection strategy specific to the inclusion and exclusion criteria for the meta-synthesis was developed however.

Table 30- Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Peer-reviewed primary research reports	Not peer reviewed, not primary research data
Focus on Freestanding Midwifery Units (FMUs)	Alongside Midwifery Units (AMUs)
Midwifery-led service	Not midwifery-led
Any observational study using qualitative methods	Studies that include data from AMUs or home birth unless the data are reported discretely
Focus on processes, practices, experiences or views of care	Trials, cohort studies, surveys except where the article reports on a qualitative component.
	Focus on clinical or economic outcomes of FMUs

After removal of duplicates, selection was conducted on the base of title, abstract and full text (figure 15). Non-relevant citations were removed as follows: 761 citations were excluded by title and 25 papers were included; of these three were excluded on the basis of the abstract, as clearly not meeting the inclusion criteria. Full text was therefore retrieved for 22 articles plus three new articles that were identified by cross-reference. After reading the 28 full articles, 11 were excluded because they focused on alongside rather than freestanding midwifery units (Thorgen et al., 2009; McNelis et al., 2013; Stine et al., 2012; Eide et al., 2009; Gaudineau et al., 2012; Newburn, 2010; Pewitt, 2008; Rowe et al., 2012; Stapleton et al., 2013; Tucker et al., 2013; Howell et al., 2010), one did not include primary research (Rowe, 2010), one was not midwifery-led (Chambliss et al., 1992) and one included homebirth or AMU settings with the data analysis for each setting not distinct (Gepshtein et al., 2007).

Ultimately 14 articles were selected from 10 primary studies (Annandale, 1987; 1988; Walker, 1995; 2000; Esposito, 1999; Hunter, 2003; Walsh, 2005; 2006; 2006a; 2007; Schuster, 2006; Deery et al., 2008; 2010; Stone, 2012). The selected articles were then subjected to quality assessment before confirming inclusion.

**OVID
& ebsco-host searches**
786
Citations

Excluded by title
758
Not meeting inclusion criteria

Included by title
28
Relevant to MLUs
Qualitative research method

Excluded by abstract
3
Conference abstract, PhD Thesis

Included by abstract
25
Qualitative method, FMU

**Added
after cross-
reference**
3
Hunter, 2003
Gepshtein, 2007
Pewitt, 2008

Included by abstract
28
Qualitative method, FMU

Excluded by full text
14
AMU, not primary findings, not
midwifery-led, including homebirth



Included by full text and quality assessment
14 articles
from 10 studies

Annandale, 1987,1988
Walker, 1995
Esposito, 1999
Walker, 2000
Hunter, 2003
Walsh, 2005,2006, 2006, 2007
Schuster, 2006
Deery et al, 2008
Deery, 2010
Stone, 2012

Step 3: Assessing the quality of the literature

The need for quality assessment in qualitative research synthesis has been debated (Dixon-Woods et al., 2006a, Walsh and Downe, 2006). There are two opposite approaches to the issue, the first supports the argument that the content and the relevance of the data is more important than the methodological aspects, the second that there must be a threshold of methodological quality to be considered (Walsh and Downe, 2006).

In this meta-synthesis the second position was adopted, considering a quality assessment to be important when evaluating the inclusion of articles. The quality assessment tool by Walsh and Downe (2006) was adapted and modified in order to apply a consistent screening for desirable quality standards.

The quality criteria included: statement of scope and purpose of the study, contextualization of study within existing literature, thorough description of the study design, including statement of the theoretical perspective, study methodology, description of the sampling strategy, justification of sampling, description of data collection, clear description of the process of analysis, interpretation grounded in the data, indication of the use of reflexive approach, indication of ethical approach (see table 31).

A numerical grading was added for this review, in order to mirror the quality assessment of the systematic review of the clinical outcomes of FMUs conducted in parallel with this meta-synthesis. Each article was graded by the two primary reviewers (LRI and LB) independently and before rejection on the basis of quality a third opinion by the third reviewer (CMc) was agreed. The possible score ranged from 0 to 42 and it was decided to assign a quality assessment of high, medium, low or poor quality. Articles scoring less than 20 would be considered of poor quality and excluded. This was consistent with the principle that all studies that can add data of value to the review should be included (Campbell et al., 2011). All the articles examined in this review scored between 20 to 39, demonstrating a wide variation in quality. As a result of the scoring, however, no further exclusions were made.

Table 31- Grading System applied

Classification of quality	Score	Description	Outcome
High Quality	34-42	No, or few flaws. The study credibility, transferability, dependability and confirmability is high.	INCLUDED
Intermediate quality	27-33	Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.	INCLUDED
Low quality	20-26	Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study.	INCLUDED
Poor quality	Less than 20	Significant flaws, which are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.	NOT INCLUDED

Table 32- Quality assessment based on Walsh and Downe (2005) and modified by Rocca-Ihenacho and Brigante

Stages	Specific elements	Essential criteria	Points	Score
Rationale	Scope and purpose	Contextualization with literature Aims Research question stated	0-3	
Design	Methodology	Rationale for using qualitative design Description of theoretical background Description of methodology Methodology appropriate for research question	0-4	
	Methods	Description of methods Methods appropriate for research question	0-2	
	Sampling strategy	Rationale for sampling strategy explained Selection criteria described Thickness of description likely to be achieved from sampling Any disparity between planned and actual sample explained	0-4	
	Data collection	Description of data collection Data collection strategy appropriate to capture complexity of events and illuminate context Was triangulation of data sources used if appropriate?	0-3	
	Analysis	Analytic approach explicit Analytic approach appropriate for methodology Analysis grounded in the data Evidence of participants' involvement in analysis Saturation addressed Inclusion and discussion of 'deviant data'	0-6	
Interpretation	Clear audit trail given	Demonstration of thorough interpretative pathway and 'decision trail'	0-1	
	Description of context	Description of social, physical and interpersonal contexts of data collection	0-1	
	Interpretation grounded in the data	Extensive use of field notes entries/verbatim interview quotes in discussion of findings Provides new insights and increases understanding	0-2	
Discussion	Discussion of findings in view of literature	Findings compared and contrasted with other literature	0-1	
	Relevance and transferability	Interpretation interwoven with existing theories and other relevant literature drawn from similar settings Discussion of how explanatory proposition/emergent theory may fit other contexts Limitations and weaknesses of study clearly outlined Significance for current policy and practice outlined Outlines further directions for investigation Comment on whether aims/purposes of research were achieved	0-6	
Reflexivity	Researcher reflexivity demonstrated	Discussion of relationship between researcher and participants during fieldwork Evidence of self-awareness, insight Discussion of effects of research on the researcher Discussion about how issues/complications met were dealt with	0-4	
Ethical dimensions	Ethical committee approval granted	Evidence of ethical approval	0-1	
	Sensitivity to ethical concerns	Clear commitment to integrity, honesty, transparency, quality and mutual respect in relationships with participants Recording of dilemmas met and how resolved in relation to ethical issues Evidence of fair dealing with all research participants Documentation of how autonomy, consent, confidentiality, anonymity were managed	0-4	

Table 33- Quality assessment of the included articles

Article	Author	Rationale	Design	Interpretation	Discussion	Reflexivity	Ethical dimensions	Total score
1.	Annandale	2	9	3	6	0	2	22
2.	Annandale	2	9	3	6	0	2	22
3.	Walker, 1995	2	15	4	6	0	4	31
4.	Esposito, 1999	2	10	3	5	0	3	23
5.	Walker, 2000	2	15	4	6	0	4	31
6.	Hunter, 2003	3	9	3	3	0	4	22
7.	Walsh , 2005	2	18	4	7	4	4	39
8.	Walsh, 2006 a	2	18	4	7	4	4	39
9.	Walsh, 2006 b	2	17	4	7	4	4	38
10.	Schuster, 2006	2	9	3	4	0	2	20
11.	Walsh, 2007	2	17	4	6	4	4	37
12.	Deery, 2007	2	13	4	7	1	5	32
13.	Deery, 2010	2	15	4	7	4	4	36
14.	Stone, 2012	3	16	4	6	4	4	37

Step 4: Summarizing the evidence

- A) Read the articles several times
- B) Determine how the studies relate to each other by tabulating key themes/concepts
- C) Translating the studies into one another (reciprocal translation)

A) Read the articles several times

Following the steps of the meta-ethnographic approach adopted for this review, the two main reviewers read the papers several times, made independent and wrote analytical memos about the first impressions on each paper.

A table was created summarising the characteristics of the 14 studies in terms of theoretical perspective, methodology, methods, context, sampling and analytical approach (see table 34).

B) Determine how the studies relate to each other by tabulating themes/concepts:

A tabulation of key concepts and ideas from of each study was then developed including the second order concepts set out by the original article author/s, the final iterations of the article author/s and the core findings (Noblit and Hare, 1988; Walsh and Downe, 2005) (see table 35).

Table 34- Characteristics of studies

Author Year Country	Quality Rating	Aims	Theoretical perspective Explicit (inferred)	Methodology	Methods	Setting context	Sampling	Analytic approach
Annandale, 1987 US	Low	Phenomenon of patient control in a midwife-run FMU.	Not stated. Feminist	Not stated (Ethnography)	Participant observation, interviews, document review, review of notes. Repeated focused-interviews.	One FMU located on the campus of a community hospital.	46 patients. 1000 medical records.	Triangulation of data and findings.
Annandale, 1988 US	Low	Identify how midwives accomplish natural birth in a FMU.	Not stated Feminist	Not stated (Ethnography)	Focused-interviews, participant observation. Thematic analysis of 900 medical records.	One FMU located on the campus of a community hospital.	38 women.	Not stated. (Content analysis).
Walker, 1995 UK	Intermediate	To elucidate the experience of labour for those receiving any aspect of care in a FMU	Not stated	Grounded theory	In-depth focused interviews.	One NHS FMU in a community hospital in an English City	Purposive sampling of 32 women and 6 partners.	Grounded theory. Constant comparative analysis.
Esposito, 1999 US	Low	To describe and interpret the culture of a FMU	Not stated	Ethnography	Participant observation (14 months), interviews.	Private FMU in New York city.	Purposive sampling of: 29 women, 5 midwives, 6 staff	Thematic analysis.
Walker, 2000 UK	Intermediate	To explore the experiences of women who were transferred from the FMU before or during labour.	Not stated	Grounded theory	Focused interviews.	NHS FMU in an English city	18 women.	Grounded theory.
Hunter, 2003 NZ	Low	To describe the experience of independent midwives providing intrapartum care in FMUs	Not stated	Not stated	Focused interviews.	Three small FMUs in Auckland area, funded by the government	Convenience sample of 10 independent midwives.	Thematic comparative analysis.
Walsh, 2005,2006 2006a, 2007 UK	High	To explore the culture, beliefs, values, customs and practices around the birth process within a FMU	Constructionist approach.	Ethnography	Participant observation (9 months), in-depth unstructured interviews of staff and women.	One rural NHS FMU in England.	Purposive sample of: 15 midwives, 10 MCAs and 30 women	Thematic analysis.
Schuster, 2006 US	Low	To understand the consequences of the FMU on the bodies and minds of clients seeking an ideal birth.	Not stated.	Ethnographic case study	Participant observation, interviews.	One rural private FMU	1 lead midwife. 18 women.	Not stated.
Deery et al., 2007 UK	Intermediate	To evaluate the implementation of a new FMU	Not stated	Qualitative pilot study	Focus group with midwives and interviews.	One urban NHS FMU in England.	9 midwives. 15 women.	Thematic content analysis.
Deery et al., 2010 UK	High	To investigate midwives' and managers' experiences of the FMU	Not stated	Grounded theory approach	In-depth interviews.	One NHS FMU in England.	13 midwives, 5 midwifery managers Key stakeholders	Thematic content analysis.
Stone, 2012 Germany	High	To investigate and describe midwives' approach practicing in a FMU	Not stated	Grounded theory	Semi-structured interview Participant observation of intrapartum care	One FMU in Berlin	5 midwives 9 women and birth supporters	Grounded theory

Table 35- Second order concepts by the original article author/s, final iterations of the article author/s and the core findings

ID	Author year country	Second order concepts by article author	Final iteration by article author	Core findings
1-2	Annandale 1987, 1988 US	Patient taking control Provider status and gender Consumerist behavior Societal control over birth Societal view birth centre as risky Mws low status in society Women selfish for wanting good birth. Patient ambivalence Negative interaction with hospital Constrained by protocols Patient control as health maintenance Control of self Information exchange Woman-directed 'Natural' childbirth Threat of professional control Constrained by protocols Timing of labour: a medical norm of risk Women's concerns: risk and safety Precarious childbirth Reducing ambivalence, securing a clientele Building commitment Striking a balance, courting contradiction The compromise on second stage of labour: standardization Shaping 'natural' birth Resistance to 'natural' interventions	Dimensions of patient control in a freestanding birth centre Clash of two paradigms: risk and salutogenesis. It determines who has ownership and power in decision-making. Both mediated by perception of safety and trust. Power dynamics Women empowerment Resisting the dominant paradigm and power Women and MWs oppressed by society and imposed risk paradigm Trust = able to let it go There would seem to be an ironic sense in which a trusting relationship between patient and midwife is similar in outcome to a relationship between patient and obstetrician where the patient's cooperation is gained on the basis of obstetrical dominance: both inhibit the patient's decision making role through the restriction of information exchange. How midwives accomplish natural birth: managing risk and balancing expectations With women-constrained by protocols Necessary -Not necessary intervention Lack of trust by society and hospital, lack of respect, regulation Boundaries of normality Keeping within boundaries of 'normal' MWs tricks to avoid transfer	How midwives manage risk and balance expectations in an oppressive society. Boundaries of normality Normative control of mws attitude of 'everything is ok' With women-constrained by protocols Trust = able to let it go
3-4	Walker 1995 2000 UK	Feeling informed Having choices and making decisions Being involved in decision-making Having options A supportive environment Someone to give confidence Knowing someone is always there Transfer as loss of choice and control Transfer as loss of continuity and support	The balance of perceived personal control and perceived support Transfer as loss Interaction between need of control and need of support MEDIATED BY TRUST Physical and emotional safety Trust Continuity of carer appreciated only by those who had it.	Interaction between need of control and need of support MEDIATED BY TRUST

5	Esposito, 1999 US	Birth centre accessible Struggling to maintain control: searching for connections Being relaxed, able to “go with the birth” Hospital: lack of privacy, lack of emotional support, impersonal, lack of control, struggle to be listened , bureaucracy, lack of respect, discrimination	Intimate connections with MWs and peers Control over care and environment Support of physiology Building rapport =Trust = feel safe= able to let it go Control: Accessibility, Personalized care ,Over environment , privacy, Over own body, Over care Support: Empowerment, Feeling respected, Building rapport with mws, Peer support	Interaction between need of control and need of support MEDIATED BY TRUST Ethnic discrimination
6	Hunter, 2003 NZ	Real midwifery: practising autonomously, having time, giving time, tolerating noise. MWs carrying the can Real Midwifery ‘tuning in’ (Siddiqui, 1999) ‘in her own time’ Watching and waiting , With woman with institution Assembly line production personalized care	Real midwifery: practising autonomously, having time, giving time, tolerating noise. MWs empowered, ownership of work Being mw, doing mw, being with machines Empowering women, Women-centred care Supporting physiology, Trusting physiology ‘Watch, listen and respond’ Leap (2000) Full holistic presence = safety, 1-2-1 care MWs knowledge and skills of physiology Having to justify interventions Tricks of the trade: using your eyes and hands Physical and Emotional labour (Kirkham, 2000) MWs carrying the can Negative relationships with OBs unit, feeling a lack of respect for BC work.	Real midwifery as: practicing autonomously, having time, giving time, tolerating noise and full holistic presence. causes mws to ‘carry the can’
7-8-9-11	Walsh, 2005, 2006a, 2006b, 2007 UK	Fordist maternity care Taylorist management style Social model of maternity care Non-industrial time management Positive environment Welcoming attitude Psychosocial safety, salutogenesis Personalized care Having time, giving time Building rapport Trust Nesting , Vicarious nesting Nurture the transition to parenthood Can do attitude Everybody’s business Being vs doing Social capital Power relations Job satisfaction	Social model of maternity care MWs Empowerment: Ownership Vicarious nesting Psychosocial safety, salutogenesis	Social model of maternity care and social capital. MWs Empowerment: Ownership Vicarious nesting. Psychosocial safety, salutogenesis

		Family friendly Deconstructing the life-family split Mutual support Leading with a clear vision Team ownership of the vision Bottom-up approach to change Non-hierarchical management structure Focus on positive		
10	Schuster, 2006 US	Birth as a risky process Mother and child interest in competition Resistance of the medical model Potency and agency ‘whole woman approach’ body as physical, body as cultural Birth centre = support = control to women = able to let it go Hospital = body in labour as out of control = needs to be controlled empowerment privacy and intimacy, staff attitude avoid fear AN education Inner resources vs delegation Birth centre as spiritual healing Feeling safe in birth centre familiarity with environment Physical environment, smells, lights, comfortable, quiet	Medical vs midwifery models of childbirth Birth centre as resistance to the hegemonic construction of their pregnant bodies as risky entities best managed by medical experts who may intervene. Birth centre as the physical environment which enables resistance Birth centre vulnerable Birth centre as salutogenesis and optimizing physiology of labour Trust +Control over the environment + decision-making = allows woman to feel emotionally safe and to let it go (to be out of control). Labour and birth as involuntary processes Giving time, info, AN education and holistic care. Hospital= labouring body as ‘out of control’ needs to be controlled.	Birth centre as resistance to the hegemonic construction of their pregnant bodies as risky entities. Trust +Control over the environment + decision-making = allows woman to feel emotionally safe and to let it go. Empowerment and holistic care = salutogenesis
12-13	Deery, 2008, 2010 UK	Social model of midwifery, family centred Personalized care Positive environment Building rapport: continuity of carer and trust Support Social support in labour Birth centre as healing previous negative experiences Real midwifery, good midwife Autonomy: owning the birth centre MW Open and welcoming ‘working in a goldfish bowl’ threat of closure	Social model of midwifery Conducive environment Continuity of carer, trust and Rapport-support Mws ownership of the birth centre Negative culture in referral unit.	Social model of midwifery Environment , Continuity of carer, trust and Rapport-support Mws ownership of the birth centre Negative culture in referral unit.
14	Stone	Natural birth as against the norm, marginal in society Negotiating normality at the birth centre	Society unsupportive of women’s empowerment Birth centre as an intervention of salutogenesis	Society unsupportive of women’s empowerment

	2012 Germany	Understanding and supporting physiology Mws tricks Justify interventions Care based on the individual needs Baby as a competent member of the birthing team Concerns taken seriously Reassurance Positive language MWs need to learn the language of the medical discourse and of the birthing body	Personalized care 'hospital takes the humanness out of being born' language of the medical discourse and language of the birthing body	Birth centre as an intervention of salutogenesis
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C) Reciprocal translation

Despite some differences in nuances, due to the specific setting and the context, a strong consistency of the concepts expressed by the different study authors was noted. A main issue was identified, however, in relation to the degree in abstraction within the included studies: some studies such as Walsh (2005; 2006a; 2006b; 2007), Walker (1995; 2000), Deery (2007; 2010) and Stone (2012) had a higher level of abstraction and included an exhaustive analysis, whereas studies such as Annandale (1987), Esposito (1999), Hunter and Shuster (2003; 2006) had a lower level of abstraction, in which the analysis remained very descriptive. Possibly as Downe and Walsh (2005) suggested, some authors resisted interpreting the data for fear of imposing a meaning on it.

After discussion with supervisors, a decision was made, therefore, to adopt a highly interpretive approach and to re-analyse the first order concepts (the direct quotations reported in the paper). Despite the awareness that re-analysing only quotations chosen by the authors was quite different from analyzing a whole dataset, we still believed that there were advantages in trying to move the level of interpretation forward. We uploaded all the papers in Atlas.ti and coded the articles, respecting the original authors' interpretation, but also moving it one step forward. Once we had coded the first order concepts (direct quotations of the participants), we printed the codes and sorted them into groups of categories.

Attempting to stay grounded in the data, we found it meaningful to divide the analysis between implications for women and midwives as well as for organisations with some reference to the societal view of birth as referred to within the studies. We then conducted a reciprocal translation by matching key themes with the relevant articles (table 36).

Table 36- Reciprocal translations

Reciprocal translations	Synthesis
Women	- Building a rapport and trusting the MW are the foundations for a woman to feel safe and 'let it go' together with having control and support in a 'nesting' environment. - There is a dynamic relationship between women's need for control and the need of support mediated by a trusting relationship with the care provider
Building rapport and trusting the midwife Annandale (1987); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Feeling safe to let it go Annandale (1987); Walker (1995); Esposito (1999); Walsh (2005, 2006) Shuster (2006); Deery (2008, 2010)	
Feeling in control and Need for Support Annandale (1987); Walker (1995); Esposito (1999); Walsh (2005, 2006) Shuster (2006); Deery (2008, 2010)	
Having control: over the environment, decision-making, own body Annandale (1987); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Having support Annandale (1987); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Partnership in decision making Walker (1995); Hunter (2003); Shuster (2006); Walsh (2007); Deery (2008, 2010); Stone (2012)	
Nesting environment Annandale (1987); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Birth centre as salutogenesis Walker (1995); Esposito (1999); Hunter (2003); Walsh (2005), Shuster (2006); Deery (2008, 2010); Stone (2012)	-
Birth centre as social capital (for women) Esposito (1999)	
Midwives	- FMUs seem to foster an ideal hub for 'real midwifery' defined as: vicarious nesting, personalized care, having and giving time, using midwives' skills; - midwives' 'ownership' of the birth centre leading to compassionate personalized care. - FMUs as creation of salutogenesis and social capital
Philosophy, knowledge, skills and practice Annandale (1988); Esposito (1999); Walsh (2005); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Ownership	

Walsh (2005, 2006, 2006a, 2007); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Team Spirit	
Building rapport and building trust Annandale (1987, 1988); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Having time, making time, giving time Annandale (1988); Walker (1995); Esposito (1999); Hunter (2003); Walsh (2005, 2006); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Nesting environment, vicarious nesting Annandale (1987, 1988); Walker (1995); Esposito (1999); Hunter (2003); Walsh (2005, 2006); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Birth centre as Social capital Walsh (2006a)	
Salutogenesis Walker (1995); Esposito (1999); Walsh (2005, 2006); Shuster (2006); Deery (2008, 2010); Stone (2012)	
<i>Wider organisational culture</i>	Wider organisational culture based on an industrial model of care in which individual needs are disregarded. FMU midwives feel under scrutiny, unsupported and lack of respect by OU Transfer to the OU can result in loss of continuity, support, choice and control depending on women's expectations and negative relationship between BC and OU.
Clash of two paradigms: Annandale (1988); Walker (1995, 2000); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
Midwives feeling under scrutiny and oppressed Annandale (1988); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	
<i>Societal view of birth, birth centre and mws</i>	The extent to which midwives are able to support and empower women is determined by the societal view of birth and the midwives' role and status within that society.
Birth as risky Annandale (1987, 1998); Walker (1995); Esposito (1999); Hunter (2003); Shuster (2006); Deery (2008, 2010); Stone (2012)	

WOMEN

The findings focused on women's views and experiences led to the creation of eight core categories:

The eight categories of women's experiences and needs:

- Establishing rapport, building relationships and trusting the midwife
- Feeling safe 'to let go'
- Feeling in control and need for support
- Having control: over the environment, decision making, own body, having options
- Having personalised support
- Partnership in decision making
- Nesting environment
- MU as salutogenesis and social capital

Establishing rapport, building relationships and trusting the midwife

Women experiencing freestanding midwifery unit care talked about how the midwives made them feel safe and how they were able to relate positively to them.

The data suggests two distinct types of phenomena: *Building a relationship*, which is a bilateral meaningful bond built over time; and *establishing rapport and trust*, which is the midwifery skill of being able to gain trust and immediate bonding with the woman over a short period of time without having built a rapport over time. Both phenomena were reported as resulting in the woman feeling safe and trusting the midwife.

Building a relationship

Women highlighted the importance of being cared for by a midwife they were already familiar with:

'I was lucky because when I came in, the midwife who I'd seen most, all my antenatal sessions here and she booked me into (the Unit) as well, she was the one that actually did everything....it meant that I relaxed a lot more' (Walker, 1995).

'I wasn't planning on having children...and so it was a big shock (...). And so when I was pregnant, it took me almost those all nine months to get used to the idea...I think that Naomi helped me a lot in that the fact I could come to an appointment and she was willing to spend an hour with me. Doctors don't do that. She is so excited about... the baby and this birth and it's infectious' (Schuster, 2006).

On the other hand there was a feeling of loss for some by not being cared for by the midwife they built a relationship with:

'I would have liked (a particular midwife) to have stopped with me the whole time... I know it would have been impossible because she wouldn't have had any sleep, she would have been up the 24 hours with me, but... I had a lot of confidence in her... I would have liked that more than anything' (Walker, 1995).

Establishing rapport and trust

Some women also spoke about how the midwife was able to make them feel relaxed and able to establish rapport over a short period of time:

'The midwife who actually delivered him - she's fantastic... I didn't know her - I feel like I've known her for a lifetime 'cos she's so lovely' (Walker, 1995).

The relationally mediated benefits included a feeling of safety, which was facilitated by the relationship established between the midwife and the woman.

Feeling safe 'to let go'

Many women highlighted a feeling of emotional safety and relaxation, which led them to 'being able to let go'. Anderson (2010) wrote about the concept of 'Feeling safe enough to let go' (in Kirkham, 2010:116). Anderson described it as a sense of 'letting go' at psychological level, which allows the body to take over (2010).

A woman who received continuity of carer during pregnancy at the FMU said:

'I think that a big part, of just from what I have learned from Naomi especially, is that the more relaxed you are, the more easy it is going to be on your body, the less pain you are going to be in. I really felt that way. I felt much more relaxed here. It was just relaxing. It was really good experience' (Schuster, 2006).

'I wasn't nervous...because I was relaxed, the labour went faster . . . it was mostly me and the midwife, it was just her talking to me, just telling me what to do, just her listening to the baby's heart, it wasn't a midwife here, then a doctor, then another doctor. . . . I didn't feel like a rat in a cage, I felt like a woman about to give birth' (Esposito, 1999).

The effect of the support and the respect of the woman's privacy had a strong impact on the woman who felt relaxed and able to let go to the physiological process of labour.

Feeling in control and need for support

It was evident from both service users' and the midwives' words that there was a dynamic relationship between women's need for personal control and their need for support. Walker (1995) hypothesised that women may need more personal control or support depending on their personal characteristics and the relationship with their birth supporter. Some women will require more 'hands-on' presence and support by the midwife:

Woman: 'They didn't leave my side, they were there the whole time - talking, helping me, they were brilliant..., the balance was perfect for me, I wouldn't want to change it, I think they've got a good system going from what I can see. ... they treat you as if you're the only person there' (Walker, 1995).

The need for support was met by the care offered by the midwives:

Woman: 'She (midwife) was great afterwards because it was like having my Mum there. I remember having my head on her lap and she was just stroking the back of my head saying you will be all right. Just kind of nursing you, which was invaluable. It was like you were her daughter' (Walsh, 2005).

The support was both emotional and physical via non-pharmacological pain relief techniques:

Woman: 'At one point I thought I'd have to go over to the hospital; that I needed to go and get pain medications (...) it was a real good experience because when I got here the midwife and Mel (husband) ran a bath for me and at the contractions Mel poured water over my abdomen. And I had hot oil compresses and vitamin E oil that really helped with the pain' (Annandale, 1987).

Several studies highlighted that other women will prefer to labour autonomously and know instinctively what to do:

'They are just outside and you've got the buzzers which are right next to you and you just press and they are there..., it's quite nice because if somebody was there you might feel sort of pressured.., nice to have the choice whether you want someone there or not' (Walker, 1995).

'The woman was having her first baby and was obviously deep into herself not really wanting to talk. The midwife said that she did not say a word to her until an hour had passed. This surprised me because, although women are like that in consultant units, once they get into the second stage of labour, they usually require the continuous presence of the midwife. But this woman was in the second stage of labour and still did not want the midwife in the room most of the time' (Walsh, 2005).

The studies identified that the same woman may naturally fluctuate from the need for control to the need for 'hands-on' support by the midwife during stages of labour and the midwife's role entails an ability to detect this emotional shift in order to respond to the changing needs of the woman. In order to do so the presence of the midwife is key.

The meaning of presence in the reviewed studies seems to be a wide one: from being present in the room, but in a non-obtrusive manner, being present in the next room listening, or just available when asked. Sometimes the woman would require very intense support including hands on support like massage or hugs. This seems to be part of the plans of care and negotiation with the woman and her birth supporter.

As discussed by Annandale (1987) in some instances the complete trust in the mw resulted in a handover of the personal control over decision-making by the women to the midwife. This within midwifery unit settings was mediated via having discussed choices in the antenatal period, a trusting relationship and having built a rapport with the midwife over time.

Woman: 'I didn't need to worry about making decisions and could leave it all to (the midwives)...I felt utterly relaxed being at home and having complete faith in those around me' (Annandale, 1987).

The key element was the ability of the midwife to tailor the care to the different needs of the women and to the variations of needs that the same woman had during different phases of labour.

Having control: over the environment, options and decision-making, own body.

The category of 'having control' was present in all the studies. Freestanding midwifery units offered control to women and their birth supporters via a wide range of options: firstly the environment in terms of home-like décor but also as enabling privacy; choice of birth supporters was not limited in any way by rules or architectural constraints such as early labour/ postnatal bays with multiple beds and women could decide who they wanted with them.

Woman: 'It was just 'do whatever you want' and you can have as many people here and bring your mum... he [woman's partner] stayed overnight... I thought it was the nicest thing. You're very emotional afterwards and you need somebody there with you that you know' (Deery, 2008).

Woman: 'I think that the size of the place, it's not a very large building so the size and the privacy, it was all about birth, my birth, my birth experience' (Schuster, 2006).

Having control over decision-making and what happened to their body was also important to the women:

Woman: 'Erm, control means personal involvement; you can read your own chart and say what you think, which you may not feel like doing in a doctor's office if you're rushed in and out . . . I enjoy the philosophy of control over my pregnancy, well control is probably not the correct word ...

Int: What do you mean, control?

Debbie: As to knowing what's going on and being responsible for your own physiological well-being with exercise and nutrition' (Annandale, 1987).

Woman: 'Here [at the birthing center] it's different, there are no big spotlights, they don't strap you down. [Here], I was calm' (Esposito, 1999).

Having control was particularly important for women from a socially disadvantaged background who had little control over several aspects of their life (Esposito, 1999). In the FMU women found respect and support.

Having personalised support

Women refer to the availability of meaningful and personalised support as key for feeling reassured and calm:

Woman: 'They are friendly and they are talking you through it so you're not panicking.., they calm you down.., it makes the whole thing much easier' (Walker, 1995).

Support, positive communication skills and personalised care were key aspects of the care offered by the FMU midwives.

Woman: 'When I realised I was in labour I called the birthing center. . . I came in to be checked and I was only three centimeters. They told me [go home and] to call back . . . So it wasn't like they sent me home and I had to come back and go through the procedure of registering and everything, like [I] knew who was here. [It's] way different than the hospital. And . . . one time they even called me to see how I was doing' (Esposito, 1999).

Knowing the midwife was important to women as it meant having a relationship with the midwife who could personalise the care to the woman.

Partnership in decision-making

The women indicated the importance of the partnership with the midwife and the equal power-relation:

Woman: 'I prefer a nurse practitioner or a midwife, there's none of that patronizing air that there is between a doctor and a patient. They're a lot more willing to spend time and cover questions--doctors don't like to do that. I like my relationships with medical people to be a two-way street. With doctors if you ask more than two questions they shift in their seats' (Annandale, 1987).

The needs of the women were acknowledged and women were treated as adults, able to make informed-decisions rather than patronised:

Midwife:' It was the week before Christmas and I had one lady who was five centimetres when she came in. Actually she was really more six but she was desperate to get her Christmas shopping done—you know she had this little window of time to do it and now this! So because the labour wasn't that strong we decided she could go shopping and come back afterwards. She came back and delivered a couple of hours later. I was still here when she came back and she got her shopping done and then she went home that night after the baby was born. You have got to be flexible here. That's one of the nice things here, you can use common sense' (Walsh, 2006).

Midwife: 'In the birth center you are encouraged to take charge and follow your natural instincts. You decide to take responsibility. Most of you don't need us, you have the ability to take care of yourselves and the baby. (Annandale, 1988).

Birth partners felt more involved and their help was acknowledged in a non-patronising manner:

Birth Partner: 'She made me feel involved as well, you know, she was always asking me and she did really make me feel involved where really (my partner) was the important one ... she acknowledged me as well, that I was there...' (Walker, 1995).

In a social model of maternity care the focus was on the whole family.

Nesting environment

The importance of the environment and the role played in the immediate feeling of safety was reported in all studies:

Woman: 'As soon as we walked in we thought — yep! This is the sort of place' (Walsh, 2005).

Woman: 'I thought it was brilliant... I was as comfortable as I could be... silly little things like the fact that on the beds ...just by an electric switch the headboard comes up to adjust your position to make you more comfortable ... the bottom bit, here your knees are, kind of bends down from there so you've got all these different ways of helping you move position and help ease you in whatever way they can' (Walker, 1995).

Woman: 'It's more relaxed; it seemed to be more relaxed than in hospital where they're all running around and you see so many people at once...' (Deery, 2008).

'During labor the women's chosen friends or family cooked for them. The women ate, walked, used the shower or Jacuzzi, gave birth in a bed, and kept their babies with them after the birth (Esposito, 1999).

Having access to family and friends enhanced the sense of support and wellbeing.

Salutogenesis

The freestanding midwifery units were referred to as a birthplace which fostered health (salutogenesis) by supporting physiology and the transition to parenthood and empowerment:

Midwife: 'I am still amazed. I still always find it beautiful to observe- When they do everything for themselves. How introverted they become. Like a cocoon. That closes, yes, and does the work itself. Works and works until a butterfly flies out. So, the woman is, a brief moment before the baby is born, she is, or at the same time that the baby is born, poof, the cocoon is open. And then you have the woman again and then you have the baby again. But you have a different woman. So, I still find that observing this is the ultimate' (Stone, 2012).

This support was particularly crucial in the case of women who had previous traumas. In some circumstances the FMU facilitated a healing process:

Woman: 'Because of the nature of how he was conceived ... I regarded the pregnancy with very similar ways as women who have been raped regard them when they become pregnant. I wasn't happy about being pregnant...and to be honest I didn't really want the child.... I just feel that if it had been a very cold hospital setting...I don't think that I would have embraced the joy and privilege of having this little guy as much as I did once I finally did give birth to him because in this sort of setting with a midwife that becomes more part of the family (...) Hospitals aren't into healing your emotions and your soul. They are just there to get the baby out...you can come here for such healing and because of that this birth was such a healing birth for me' (Schuster, 2006).

The FMU offered the possibility of healing previous traumatic experiences by offering personalised care and building relationships.

Midwife: 'A teenage girl (Rachel) came in with her mother and sister. The girl became extremely distressed in the middle of the labour. She was thrashing around on the bed so we took the bed out. Bev (the midwife) wondered whether her distress was due to the awesome responsibility of parenthood that she felt she wasn't ready for so Bev asked her Mum and her sister to leave the room. Then she just sat with her for 2 hours on the floor and this girl was just sobbing into her lap, just sobbing, and then after 2 hours — almost as if it was out of her system — she was completely more focused and she went on and had a really good birth' (Walsh, 2005).

The care was adapted to the needs of the women and not focused on a medical model of care but on a social model of care, therefore mediating for social disadvantages.

Social capital

Social capital broadly refers to the resources accumulated through social relationships (Coleman, 1988). Walsh described how social capital was created by the alignment of FMU staff, service users and the wider community to jointly engage in a common battle against the closure of the FMU.

Within the dimension of the women's experiences and the creation of social capital, the family focus of FMUs and the attention to building relationships created additional resources for women. Particularly for vulnerable and disadvantaged women the FMU created an invaluable resource:

Woman: '[The birthing center] offers . . . it's like a place to have your baby, it's a place that you can come to for personal counselling, it's like everything wrapped up into one, and a lot of times mothers come and you think they are waiting for their prenatal visit. [But] they've already been seen, and they just sit around and just talk and it's really nice.

[At the hospital clinic] they're not set up for that [socialising]. . . . After you have your baby, you go home, and nine times out of ten you never see the midwife again. . . . I think that's important, that's one thing that stands out. (Lois)' (Esposito, 1999).

Woman: ' . . . It was an intimate thing to share my pregnancy with the ladies here, to get to know them; they're very special' (Esposito, 1999).

The figure below summarises the eight categories of the women's needs.

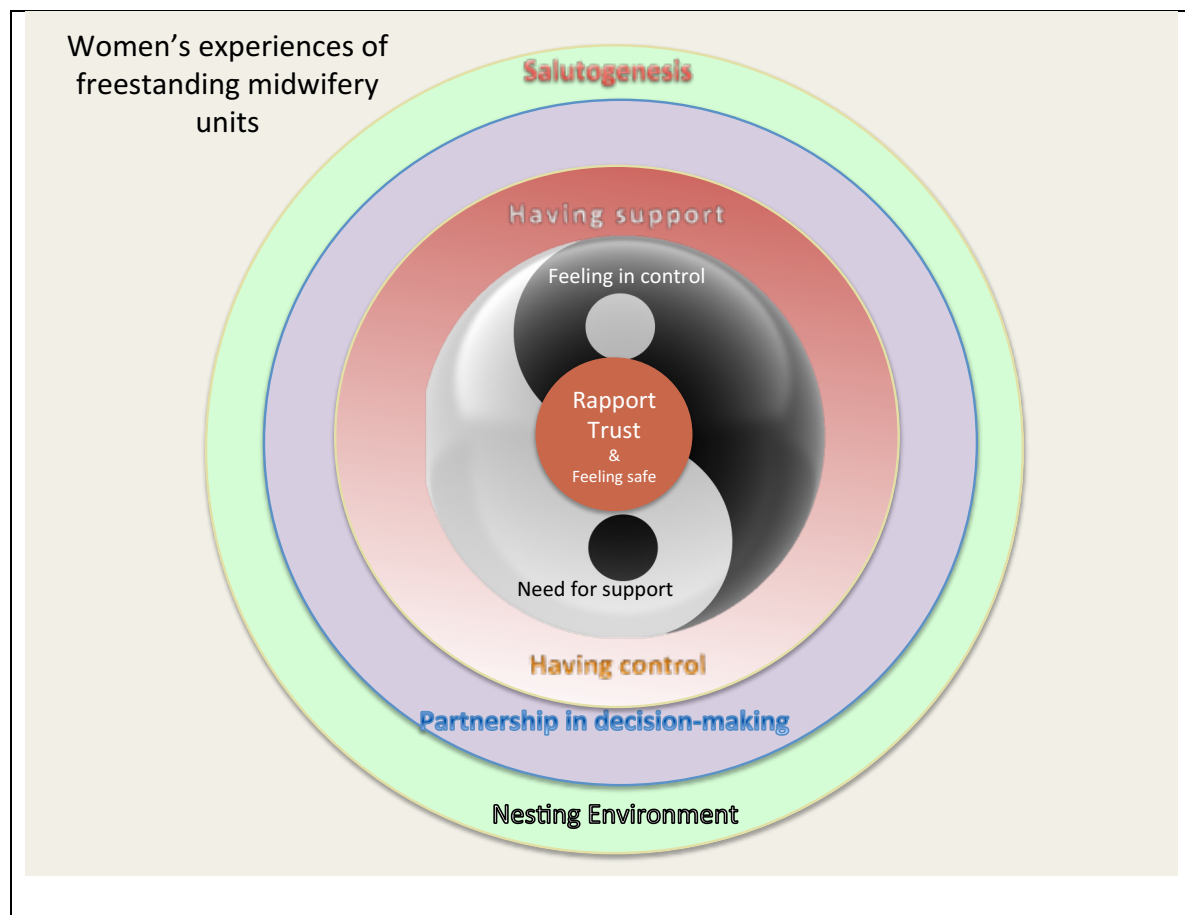


Figure 16- Women's experiences of FMU care

This model captures the eight categories relative to the women's needs and also visually reflects the dynamic interaction between the need of control and the need of support, with at the core the feeling of safety mediated through the rapport and trust.

MIDWIVES

The analysis of the article data on midwives led to the creation of four categories.

Midwives' views and experiences:

- Philosophy, knowledge, practice and skills
- Ownership
- Having time and giving time
- Vicarious nesting

Philosophy, knowledge, practice and skills

The FMU midwives expressed a consistent approach to care grounded on the concept of childbirth as a physiological event and on having to justify interventions:

Midwife: 'I think with real midwifery a lot of it is not doing, in a way letting it happen, being there, but you are still there and you still want to make sure that things are happening as they should (...) and I think real midwifery can be not being that overpowering person there' (Hunter, 2003).

Midwife: 'Uhm, a normal birth means that I don't actually have to do anything except serve here and there. Apart from showing my presence, my [pause], when she needs me, I'm there. The woman is doing; the woman is deciding when she is walking, when she is standing' (Stone, 2012).

In FMUs, interventions were described as needing to be justified rather than simply used routinely:

Midwife: '(...) and I started questioning myself: 'well is it just routine? Why am I doing it? Is it the place that's dictating to me?' (Hunter, 2003).

In FMUs the care was described by midwives as being based on supporting the woman and reading the signs that the woman gives rather than task oriented and based on technology (technocratic):

Midwife: '(...) Real midwifery is seen as normal midwifery and attending to women, as opposed to attending to machine' (Hunter, 2003).

Midwife: 'I guess in a situation where I was pretty sure of the presentation and the engagement. If the woman was contracting really well and hadn't been in labour too long...and had a good fetal heart, I wouldn't examine her right away unless she was really keen to know what dilatation she was. Maybe 3 or 4 hours later, if I didn't feel she made the progress I expected, I would ask her if she wanted to know' (Hunter, 2003).

The midwives' knowledge of the boundaries of normality guided the decision of transfer:

'Some problems happen in labour and you have to deal with them. You always have to be aware in those small places if you are going to transfer someone or things are not progressing, the transfer can take, like, three hours before you actually get the woman seen. You have to take that into consideration, so that is difficult' (Hunter, 2003).

The midwives stressed that the possibility of dedicating time to the women, the continuous presence and listening to the woman, provided them with extra knowledge and clues to inform their judgment:

'You've actually got to use gut feeling and perhaps just really listening to what the women are saying and adjusting your thoughts and practice to what the needs of women are. That's a huge shift to working in a big hospital where you got machine and technician interfering with that basic in-built knowledge that you've got. You turn off, I'm sure you switch off at the hospital because you are too busy watching all those other things instead of listening to the women (Hunter, 2003).

This possibility of being fully present and focused on the care of one woman provided midwives with a sense of safety.

Ownership

The midwives working in FMUs were quite aware of the personal responsibility and commitment of working in a FMU. On one hand they enjoyed the autonomy:

Midwife: 'Clinically it was just lovely. I enjoyed every moment because I'm happy without doctors, and I'm happy making my own decisions, and I'm perfectly happy with women who are birthing physiologically, and clinically it was my dream job' (Deery et al., 2010)

Midwife: 'I think working in a small unit your senses have to be a lot more acute, I suppose. You are solely responsible if something does happen. You have to know what you have to do then, just right there, like A B C.

I suppose you're usually totally aware of that all the time, even though it doesn't come to the fore all the time' (Hunter, 2003).

On the other hand they felt sometimes, if embedded in a wider negative organisational culture, as though they had responsibility without autonomy as described by Hunter (2003) as 'Carrying the can':

'It is quite lonely because you think well I've got another midwife here but maybe she's got no more experience than me, so really I'm going to carry the can if there is a problem. So you leave with that, but you balance that by believing that, in most cases, the outcome is going to be good' (Hunter, 2003).

The lack of support for the midwives and the concept of 'Carrying the can' were present in Hunter (2003), Deery (2008, 2010) and Stone (2012).

Having time and giving time

Midwives in several studies felt that the different way of organizing the workload, more focused on women's needs rather than tasks, as well as a smaller caseload, ensured that the midwives had time to dedicate to the women:

Midwife: 'I've never worked anywhere where I've just been able to give one person my undivided attention...where I worked before you'd have six or seven women...' (Deery et al., 2010).

Woman: '...They had all the time in the world to answer questions. You kind of get a sense that they want to help you rather than just a sense of you are just another person coming in the door and you have got to get in and out as quickly as possible'. (Walsh nest, 200)

Midwife: 'Well, I don't always do VEs on arrival (...) I give women the time to settle in... a vaginal examination is just one part of the whole picture.' (Hunte, 2003).

Many also perceived that this different management of the time had direct implications for clinical practice:

Midwife: 'She (the birthing woman) was lying in the lap of her husband. I didn't do anything; the second midwife checked the fetal heartbeats. It took several minutes; the head was at the pelvic floor. I didn't have to do anything. And I didn't do anything with the perineum. The woman put her own hand there, yes, I didn't have to guide her at all. She took the time she needed. I am only there to pay attention. If the heartbeats are low, then

I have to tell her to pushy otherwise, there is no reason to interfere. I let her do what she wants, when she wants.' (Stone, 2012).

Interventions had to be justified and the 'wait and see' approach had often to be learnt as the approach was quite different from the one at the labour ward:

Midwife: 'Coming to the birth centre, I found it...quite slow and I found that a little bit frustrating. I was used to be busy all the time. One of the reasons for wanting to go to the Birth Centre was to get better continuity, to see what childbirth is about when it is not medicalised. I found that It was really really nice, once I kind of wound down..I just found really fulfilling to me as a midwife and...from the feedback we've got from the women (they were) really enthusiastic about the experience that they were having' (Deery et al., 2010).

Many midwives would go through a transition to a relationally centred care after socialising with the FMU culture.

Vicarious nesting

Vicarious nesting was described by Walsh (2005) as the act of nesting for the woman. Midwives in the FMU he studied decorated the FMU and brought items to furnish the FMU from home. The environment was important in terms of an extension of the care provided by the midwives (vicarious nesting):

Woman: 'The next morning the tables were laid and there were lots of choices for breakfast. There were slices of melon and they had put cling film over — just lots of little things that you wouldn't expect. That evening they cooked us tea. There were only three of us so they gave us the attention there. You know when you get home, everything starts' (Walsh, 2005).

The category of vicarious nesting for midwives was also linked to ownership. The midwives described by Walsh had demonstrated a strong sense of ownership towards the FMU environment and was in a sense an extension of their homes. They cared for the FMU as they would for their own homes. This concept is also linked to the social model of maternity care.

The figure below illustrates the key elements for midwives working in a FMU and summarises the analysis of the data from the 14 included papers.

Key elements for midwives working in
freestanding midwifery units



Figure 17- Key elements for midwives working in FMUs

ORGANISATIONAL PERSPECTIVE

Organisational culture

- A 'them and us' culture: horizontal violence and poor inter-professional relationships.
- A big brother culture

Within the included studies there was limited reporting on organisational aspects and leadership: the studies from the US and NZ (Annandale et al., 1987; 1988; Esposito, 1999; Hunter, 2003; Shuster, 2006) reporting from FMUs privately owned by midwives did not refer to organisational issues. They reported however on often tense relationships with the referral obstetric unit.

Within the studies from the UK Walker (1995; 2000) only reported on service users' views, while Walsh (2005; 2006a; 2006b; 2007) reported the FMU as being quite independent from the obstetric unit. He explained that this FMU used to be a GP Unit and was later turned into a FMU, till owned by the Primary Care Trust. The only other study from Europe, Stone (2012) did not discuss relationships with the referral OU, but referred to 'extreme resistance' from the obstetricians (Stone, 2012, p. 569). From the UK, Deery et al. (2008; 2010) stressed the lack of positive leadership and support for the FMU in their study.

A 'them and us' culture

In the majority of articles the midwives reported a strong sense of 'them and us' culture. The midwives working in FMUs felt generally quite oppressed by the OUs and reported on two clearly distinct paradigms of reference: a midwifery- social model of maternity care and a medical-industrial model of care. This led to conflict and misunderstanding:

Manager: 'Birth centre midwives as well are often seen as different breed of midwife by the majority of the jobbing midwives, and I think that that's where the 'us and them' is bred from. The language is different that two groups of midwives speak. One talks about supporting the women giving birth, and one talks about delivering women and it's completely different. The philosophies are different...the cultures are different.' (Deery et al., 2010).

The clash of cultures was particularly evident in case of transfer of a woman to the OU:

FMU Midwife: 'I can honestly say I was nervous about the labour, there was a part of you that think what will happen when I get to the large obstetric hospital? I'm going to be told -you should have come 2 hours ago- or if you ring -Well does she really need to come?' (Hunter, 2003).

Many midwives felt a lack of trust and respect from the hospital staff:

FMU Midwife: 'You really lose something when you go over there. I don't feel like it's a peer relationship, I feel like I am one of the housekeeping staff...but you're there for the couple and that's the way you have to see it. (Annandale, 1988).

If not mediated via positive leadership the OU staff were under the false perception of the FMU as not performing clinically well:

FMU Midwife: '(...) they were always moaning that cases were been transferred. I did feel as though I was imposing in their territory' (Walker, 2000).

The issue with the 'them and us' culture did not only affect the midwives transferring the women but on the women themselves. Walker (2000) stressed how the negative relationships between sites exacerbated the feeling of loss of control and grief among women transferred from the FMU to the OU.

A Big Brother culture

The midwives often felt they were continuously being scrutinised in their practice:

FMU Midwife: 'There will always be sort of Big Brother looking down on what we do and why we do it.' (Deery et al., 2010).

FMU Midwife: 'You're working in a goldfish bowl and everything you do will be scrutinised...every single thing...' (Hunter, 2003).

This was more exaggerated than the usual level of scrutiny experienced by midwives working in more 'mainstream' environments like the OU.

Societal view of birth as risky

A striking picture of a patriarchal society, which sees birth as risky, was described by the participants, particularly from the US and Germany:

Woman: 'They are all opposed to it. My parents are still afraid because it is not a hospital birth, they think it is dangerous. My husband's father is a pediatrician and he is terribly opposed. The first time he said 'we want to help, we'll pay for a medical doctor' ...My colleagues think I should be in a hospital. They think it's not safe here.' (Annandale, 1987).

Esposito reported the stories of routine medical intervention that women described having experienced in their births before referring themselves to the FMU:

Woman: 'People don't realize how my privacy was invaded in the hospital...A whole bunch of lights, they put your legs up' (Esposito, 1999).

Stone described the extreme resistance that the first team of midwives at the FMU from obstetricians and the media 'who branded them as potential baby murderers' (Stone, 2012, p. 569).

Annandale (1987) quotes a paragraph from the Boston Globe Magazine, which builds on the discourse of 'birth as risky':

'To give birth is to take a monumental risk. Perhaps no other act in a woman's or a couple's life involves such a gamble The statistics say that in more than 9 cases out of 10, everything will turn out just fine, but when disaster strikes you or your baby, the tragedy is 100 percent yours (Boston Globe Magazine, quoted by Annandale, 1987).

As mentioned earlier the wider societal climate described by Annandale (1987) pictured birth as a 'monumental risk' and FMUs were perceived as 'against the norm'.

D) Synthesis

The findings of the included studies suggest that FMUs were the midwives' territory in which a physiological/social model of maternity care was cherished. Midwives working in FMUs felt a strong ownership of the FMU. Most midwives were empowered to support physiological birth, respond to women's needs and tailor their care around individual women's circumstances. This was not possible when midwives felt oppressed by the dominance of hospital policies and guidelines and perceived to be in a 'Big Brother' culture in which they felt under threat.

Having time and being able to offer one-to-one care offered midwives the possibility of developing knowledge and skills which they did not develop in hospital settings by learning the physiological processes of labour and birth.

Women's experiences and expressed needs were found to be quite consistent across the nine included studies and suggested a fundamental need for building trust with their midwives and feeling emotionally safe in order to be able to 'let go' during labour and birth. A dynamic interaction between the need of control (over the environment, decision-making, own body, having options) and the need of support was mediated via the trusting relationship with the midwives.

The experience of labour and birth in a FMU was described as an empowering one in which transition to parenthood was facilitated.

There was however evidence of a 'them and us' culture between the FMUs and their referral OUs. This was detrimental towards interdisciplinary work and particularly exacerbated in the case of transfers. This negative relationship between sites had a negative impact on women's experiences of transfer and contributed to a sense of loss of control by the women as described by Walker (2000).

Discussion

The 14 articles included in this meta-synthesis consistently described how physiological birth was valued and facilitated in FMU settings.

A previous meta-synthesis by Walsh and Devane, which focused on midwife-led care, included six of the articles which were also included in this study. The other studies excluded in this meta-synthesis were focused AMUs or a mixture of different units.

Walsh and Devane (2012) synthesised three central themes: relationally mediated benefits for women, greater agency for midwives and conflict between midwifery units and the OUs. This meta-synthesis had some overlaps with Walsh and Devane's study but also some differences determined by the different studies included.

In the included studies midwives described their philosophy as one of having to justify interventions rather than using interventions routinely. This demonstrated a trusting attitude towards physiology and women's bodies. The only study, in which dissonant data regarding the midwives' attitudes towards supporting women's choices emerged, was Annandale (1988). In this study midwives had to navigate between the expressed needs of the women, the women's ambiguity towards physiological birth, the control exerted by the referral OU and the wider societal perception of the FMU as 'against the norm'. Midwives therefore had to negotiate between opposite forces and often persuaded women into accepting 'necessary interventions'. These were described as 'ironic interventions' by Annandale (1988:105) since they were deemed necessary because of the oppressive relationship with the OU and a lack of acknowledgement of the women's autonomy and right to informed choice, ironically in order to avoid further intervention. In this culture women's needs and choices were distorted into compliance to the obstetrical norms.

A strong culture of midwives' ownership was evident in all nine studies. This ownership emerged in Walsh's study (2007) as the result of a battle to avoid the closure of the FMU. In Deery et al. (2008, 2010) however it arose as a 'them and us' culture. In this study a poorly managed transition from OU to FMU exacerbated by a continuous poor leadership led eventually to the closure of the FMU. Deery et al. (2010) exemplify perfectly how the wider organisational culture can negatively affect a FMU and instigate a detrimental 'them and us' culture. These issues recall the findings from the Kirkup Report (2015) which highlighted how a culture of mediocrity and negative interdisciplinary relations led to poor outcomes. Deery et al. (2010) demonstrate how such a culture could be developed via the wider

lack of positive leadership. In this case the threat of closure did not trigger the creation of a positive movement of resistance but simply damaging relations between clashing cultures.

Walsh (2007; 2006; 2006a) argued that the FMU in his study succeeded in avoiding closure because of the strong ownership by the FMU midwives who were able to take the initiative, re-decorate the FMU and make it their own (the building was owned by the Primary Care Trust which left total ownership of the place to the midwives). The FMU was also described as having a transformational lead midwife who managed to catalyse not only the FMU staff efforts but also to engage the community.

The opposite example was presented by Deery et al. (2010) in which FMU leadership was weak because of the serial resignation of any lead midwife appointed, which she argued was related to strong central control coupled with a severe lack of support by the NHS Trust.

These two opposite examples indicate how important the wider organisational culture is in creating and supporting well-functioning and striving FMUs. This suggests that the key should be on providing support and offer ownership to the FMU midwives as well as foster positive interdisciplinary and cross-site relationships.

Most of the included studies refer not only to the support of the physiological process of labour and birth within the FMUs, but also to the possibility of a healing process facilitated by a supportive and respectful care. Shuster (2006) reports how one of the women cared for by a FMU midwife who provided continuity of carer felt supported in her transition to motherhood despite a history of sexual abuse. Walsh (2005) also reported the story of Rachel, a teenage girl, who was 'mothered' by the midwife and supported in the transition to motherhood. These examples indicate the salutogenic potential of FMUs which may go well above and beyond the 'safe clinical care' offered by OUS.

Esposito (1999) highlighted the empowering experience that vulnerable and socially disadvantaged women had in the FMU. This hypothesis is supported by the findings of Overgaard et al. (2012) who argue that FMUs may compensate for social inequalities as in her cohort study with a matched control group the maternal clinical outcomes for women from socially disadvantaged groups were similar to those from more affluent social background. A previous survey of women's expectations and experiences of FMU care compared to those at the linked OU also demonstrated striking differences in women's' experiences of care and access to choice. This study also included a large sample of women from a diverse social and ethnic background (Macfarlane et al., 2014a, 2014b).

Limitations

Substantial effort was made to avoid bias. The search strategy was developed by the three authors with the help of Catherine Radbourne, City University Librarian, who also helped with the systematic electronic searches. We did not explore the grey literature and we only included articles written in English. The selection and quality assessment was conducted by Lucia Rocca-Ihenacho and Lia Brigante independently and a third reviewer was included when a need to reach consensus arose. The tabulation and reciprocal translation was conducted by Lucia Rocca-Ihenacho and Lia Brigante as well as the synthesis.

We could only identify 14 articles from eight studies. The articles covered a wide time gap (1987 to 2012) and the studies were conducted in countries in which health services were organised in very different ways. Additionally, the care offered by FMUs as well as the role and limitations of midwives were subject to cross-country and within country variability.

Despite these limitations in comparing the models of care, there was significant consistency in the key components of midwifery care offered by FMUs and women's experiences.

Further research is needed to further explore the relations between the different key characteristics of FMUs identified and explore further the concepts of salutogenesis and social capital as applied to FMU as a social model of maternity care.

Line of argument

FMUs offer a model of care in which physiology and transition to parenthood is facilitated maximising the creation of health (salutogenesis) rather than pathology. FMU needs to be considered an integral part of a whole maternity service in which positive interdisciplinary relations are nurtured and midwives empowered in providing physiological personalised care in a conducive environment.

Conclusions

The meta-synthesis suggests that FMUs could become the hub for maternity services focused on the creation of health (salutogenesis) as suggested by Downe (2010).

The data suggests that FMUs could especially offer support and the creation of social capital for women from socially disadvantaged backgrounds or in vulnerable conditions therefore compensating for the negative effects on health determined by social disadvantage.

The findings in relation to staff tensions suggest that particular attention needs to be paid in avoiding the creation of a 'them and us' culture, which can instead be nurtured as a positive organisational culture if FMUs are cherished and strongly integrated to the wider maternity services and the acute settings despite maintaining full ownership of the FMU itself. This integration holds the potential of also improving women's experiences of transfers which can be a traumatic experience, exacerbated by negative inter-professional or cross-site relationships.

SECTION FOUR: FINDINGS

Introduction to the Section

In this section of the thesis, I present the findings of the ethnographic study in four chapters. The main aim of the study was to shed light on the key landmarks which describe a well-functioning freestanding midwifery unit (FMU).

In Post-Critical Ethnography, the researcher attempts not only to unmask and discuss power dynamics within the field, but also to acknowledge the researcher's impact on the field and her own views. I have done this by keeping a reflexive diary as well as including my interview with Dr Rayment as part of the data. The interview was included in the analysis as any other staff interview. The interpretation of the data was also mediated via interaction and feedback with two 'key informants' from the midwifery team at the Barkantine and service users who were actively involved with the interpretation of the data and provided significant insights in the power dynamics within the unit.

Chapter 7 provides a descriptive account of the FMU that was the focus of this study, its origins and development, including staffing and management arrangements.

Chapter 8 focuses on the professional dimension of the staff working at the FMU. When interpreting the analysis of the data on the staff views and perception of working at the FMU, I have found particularly relevant the Self-Determination Theory (SDT) (Deci, 1971; Deci 1975; Ryan, 1982; Deci and Ryan, 1985), which offers a psychological reading of the individual dimension of the staff working at the Barkantine. This theory was not part of my initial review and consideration of possible theoretical perspectives for the study. However, as the data analysis proceeded, it emerged as a useful framework for developing further the analysis of the data captured in the three models, the model representing the staff dimension in particular.

The SDT helped in making sense of some of the categories which emerged through the data analysis and offers further understanding of the dynamics between the different elements of the model.

Chapter 9 focuses on the organisational dimension of the FMU and chapter 10 focuses on the dimension of the women, in terms of their experiences of midwifery unit care, the needs that women have expressed and whether they perceived the FMU met their needs.

On the basis of the findings I propose three models, which can be seen as 'maps' highlighting the essential 'landmarks' for a well-functioning FMU, from the perspectives of the individual midwife (figure 28), the FMU as an organization (figure 34) and the woman (figure 36). A fourth integrated model will then be presented in the following section at the end of Chapter 11 (figure 37) in order to integrate the different dimensions and crystallise the essence of a FMU. My hope is that the models can be used as a guide when setting up a new FMU, to improve the performance of existing services and to guide service evaluation.

In chapters 8-9-10 all names used are pseudonyms in order to maintain the service users' anonymity and confidentiality.

Chapter 7- The context and development of the Barkantine Birth Centre

Introduction

In this chapter I describe the context in which the Barkantine Birth Centre was developed. I briefly describe the history of the FMU and the different models of care tried out since its opening in 2008. I describe the operational organisation of the team and the activities offered by the FMU.

The information presented here derives from local operational procedure documents, the NHS Trust website, from my field notes, from conversations with the team midwives and from interviews conducted particularly with the steering group and midwives who formed part of the initial team in 2008.

The pictures included in this chapter were provided by the Barkantine Team and consent was provided for their use by each member of staff via the consent form.

The local context for the ethnographic study

Tower Hamlets, the borough where the Barkantine Birth Centre is located, has a very diverse and multi-ethnic population. In 2011 Tower Hamlets had the third highest proportion of minority ethnic citizens in London (52.5%) with Bengali as first language (CIS, 2011).

Deprivation is widespread in Tower Hamlets and the borough remains one of the most deprived areas in the country. The borough was ranked third overall in the 2010 Index of Multiple Deprivation (Department for Communities and Local Government, 2010) out of 326 local authority districts in England. In 2015, although Tower Hamlets no longer appeared within the 20 most deprived local authorities, it is still the most deprived district in terms of income deprivation among both children and older people (Department for Communities and Local Government, 2015).



Figure 18- Tower Hamlets

The Royal London Hospital and Barts Health NHS Trust.

The Royal London Hospital is the referral obstetric unit, to which women booked at the Barkantine Birth Centre are transferred in case of need. It was founded in September 1740 and was originally named The London Infirmary. The name changed to The London Hospital in 1748 and then to The Royal London Hospital on its 250th anniversary in 1990. The first patients were treated at a house in Featherstone Street, Moorfields in November 1740. In May 1741, the hospital moved to Prescott Street, and remained there until 1757 when it moved to its current location on the south side of Whitechapel Road, Whitechapel, in the London Borough of Tower Hamlets.

The Royal London has merged to become part of Barts Health NHS Trust, the largest NHS Trust in the UK serving a population of over a million in east London and beyond. The Trust, established on 1 April 2012, consists of six local hospital sites: Mile End Hospital, The London Chest Hospital, The Royal London Hospital, Newham University Hospital, St Bartholomew's Hospital and Whipps Cross University Hospital. Barts Health is also part of UCL Partners, Europe's largest academic health science partnership.

The Royal London provides district general hospital services for the City and Tower Hamlets and specialist tertiary care services for patients from across London and elsewhere. It is also the base for the helicopter ambulance service, operating out of a specially built roof area. There are 675 beds at The Royal London Hospital. The new building is the largest hospital in Europe (Barts Health NHS Trust website, 2016).



Figure 19- The New Royal London Hospital PFI building

Maternity Services

Barts Health NHS Trust assists currently the birth of 17,500 babies a year in three obstetric units, three alongside midwifery units and two freestanding midwifery units (Barts Health NHS Trust website, 2016). These are the Barkantine Birth Centre, opened in 2008 and the Barking Birth Centre, opened in 2012.

Barts Health NHS Trust placed under special measures

Barts Health NHS Trust was placed in special measures in 2015 over the standard of its care following a report by the Care Quality Commission (CQC), which ruled the NHS Trust as 'Inadequate'. The report highlighted how organisational culture was poor and leadership weak at the time of the inspection (Care Quality Commission, 2015). The inspection found that Whipps cross hospital needed substantial improvement. The team of CQC inspectors found that many of the recommended improvements for Whipps Cross Hospital, which were made after visiting the hospital the previous year had not been made. Many of the 400 staff who spoke to the CQC during their visit were highly critical about working conditions, especially the lack of staff and a leadership culture which did not listen to staff's concerns and issues with bullying and poor staff morale.

The NHS Trust's entire leadership announced its resignation shortly after the publication of the 2015 CQC report (Campbell, 2015).

Another inspection took place in 2016, as a follow up over concerns around patient safety and the quality of care raised in 2014 and 2015. The 2016 inspection focused on eight core services: Urgent & Emergency Care, Medicine, Surgery, Critical Care, Maternity & Gynaecology, End of Life Care, Services for Children, and Outpatients & diagnostic services.

The CQC report showed that Whipps Cross still needed improvement and was rated overall as 'Inadequate' but its maternity services were rated 'Good'. On the other hand, the CQC published a very negative report for at the Royal London Hospital maternity services (CQC, 2016) which was rated overall as inadequate.

The report on the maternity services highlighted:

- A severe shortage of midwives
- Issues with midwives' attitudes towards patients
- Midwives not willing to adopt new processes
- Lack of care for its own staff (rosters late, delays with approval of AL)
- Low morale among midwives
- Midwives felt that their concerns were not listened to
- Issues with security tags for newborn babies
- A lack of consultant obstetricians cover of the labour ward
- Inconsistencies with record keeping

Barts Health Trust was also placed into financial special measures by the NHS in 2016 after it forecasted the largest budget deficit of any healthcare provider in the UK. The Trust was one of the first five providers placed into special measures under the new scheme, in order to bring about "swift improvement in finances".

In chapters 8 and 9 I will explore how the wider organisational culture within the maternity services and the NHS Trust as a whole have influenced the FMU.

Barkantine Practice and the Birth Centre

The Barkantine Practice, one of the first Polyclinics in London, builds on a very strong history of Primary Care and women's health rooted in the community in the East End with a long-standing passion or enthusiasm for investing energy in the community and the creation of social capital in one of the historically most deprived parts of the capital.

Dr. Wendy Savage, an obstetrician and gynaecologist who worked at the Royal London Hospital, has been an advocate for women's rights in fertility, abortion, and childbirth. In 1985 she was the victim of a miscarriage of justice and suspended from the London Hospital Medical College after allegations of incompetence. After a high-profile inquiry, which found the charges groundless, she won her job back (Savage, 1986). She is president of Keep Our NHS Public, a pressure group that opposes privatisation of the NHS (Savage, 2007).

Dr Sam Everington's Bromley by Bow Health Centre is another example. A general practice, which attracts nationwide interest for the innovative ways in which it engages talented people in this deprived part of London's East-end. Dr Everington's strong belief in involving patients in their health care prefigured a general movement to see patients into experts in their own health experiences, a concept which is promoted by the *Expert Patient* initiative (Corrie and Finch, 2015).

At a time when the number of births in Tower Hamlets was projected to increase by a third by 2021 (Tower Hamlets Primary Care Trust, 2006), the Barkantine GP Practice on the Isle of Dogs was redeveloped to become one of the first polyclinics in London and serve the health and social care needs of the local population. The Barkantine Birth Centre is exceptional in being the first purpose built FMU in England. As discussed in chapter 2, most of the other FMUs in England were originally maternity homes, then classified as isolated GP units or have been transformed into a FMU as a result of the closure of an OU.

The campaign to build a new birth centre for local women in Tower Hamlets began in 2003 and it took five years for the project to be implemented (Rocca-Ihenacho and Redfern, 2010).

A midwifery lecturer from City University who was also a local mother gathered together a steering group, which consisted of a well-connected GP, service user representatives, a consultant midwife from the local NHS Trust, a community midwife and the chair of the Birth Centre Network. A key

element of success was having influential and well-connected individuals within the steering group (Rocca-Ihenacho and Redfern, 2010).

The Barkantine Practice, one of the first polyclinics in London, opened in 2007 and includes: a general practice, occupational therapy, a pharmacy, a women and young people services, health visiting, dental and foot health services, mental health, school nursing, community district nursing and Children's Centre offices.



Figure 20- Isle of Dogs peninsula in Tower Hamlets



Figure 21- The Barkantine Practice

The Barkantine Birth Centre, situated on the third floor of the building, opened for births in January 2008. It is a freestanding midwifery unit, designed to provide care for women with straightforward pregnancies (Rowe et al., 2011; Rocca-Ihenacho and Herron, 2011). Women who start care at the birth centre but develop complications are transferred to the Royal London Hospital, the nearest obstetric unit, 2.6 miles away, which is approximately, door to door, 10 minutes by ambulance.

The Barkantine Birth Centre facilities include a common area, a clinic, a kitchen shared by staff and service users, five birthing rooms each with pool and a breastfeeding room. Since 2010, when integration of community midwifery teams was initiated, it also includes the riverside community midwives' office.



Figure 22- The Barkantine Birth Centre

The beginning of the Barkantine Birth Centre

The original agreement between the Royal London NHS Trust and the Primary Care Trust, which was funding the midwifery-led service, was for the birth centre to gradually increase the workload from 250 births in year one and to achieve 450 births in year three.

The team of midwives and maternity care assistants working at the FMU was selected from the existing staff within the Royal London Hospital maternity unit as well as advertising externally. Eight midwives already employed by the NHS Trust and three external midwives formed the first midwifery team.

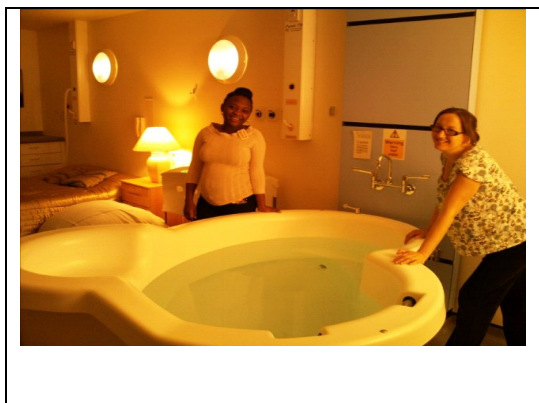


Figure 23- A room at the Barkantine Birth Centre

The Barkantine Birth centre steering group was very vocal and influential in setting the foundations for a freestanding midwifery unit focused on a social model for maternity care in which physiological birth could be supported (Rocca-Ihenacho and Redfern, 2010).

The steering group was involved with the recruitment of the staff working at the FMU and with the original organisation of the model of care. It was later dismantled, as the NHS Trust did not perceive it to be useful beyond the setting up of the FMU.

Models of care

The Barkantine Birth Centre has tried different ways of organising the workload and staffing models over the years. There have been tensions between organising a model which worked for the midwives, was financially viable and provided continuity of care to women.

When it first opened in 2008 the birth centre had 11 Whole Time Equivalent (WTE) midwives, five WTE Maternity Care Assistants (MCAs) covering 24/7 and an administrator working weekdays only. Every band 7 midwife was paired with a band 6, who had at least two years' experience. An MCA worked closely with the midwives on 12-hour shifts. There were two midwives and one MCA per shift and all staff worked 12 hours shifts.

Initially the labour ward manager was officially in charge of the FMU. This was changed later to a dedicated band 8a FMU lead midwife.

Women were booked at the beginning of pregnancy and followed through the pregnancy. This model offered a high level of continuity of care to women, but on the other hand it led to a high 'drop out' of

women from booking to birth (Keeler and Martin, 2011). This was due to several factors including women developing complications or risk factors, which made them not eligible for midwifery-led settings birth. Some personalised care plans were developed in consultation with the link consultant obstetrician. The consultant midwife did not have clinical input into the FMU.

At a time when the FMU was only seen as 'viable' on the basis of number of births and received funding 'by birth', this model (of providing antenatal as well as birth care) was not perceived as financially viable.



Figure 24- The Barkantine team 2011

In 2009, the team moved to booking women for birth centre care at 36 weeks' gestation after providing women with a tour at 20 weeks' gestation if women expressed the wish to birth at the FMU. This later booking approach was decided because the agreement with the Primary Care Trust, which was commissioning the service at that time, was based on the number of births rather than on a caseload model. By booking women for midwifery care at the beginning of pregnancy the midwives would have to care for approximately 500 women in order to achieve 250 births. Additionally, women expressed unhappiness about their care being moved to other community midwives when they developed complications, which made them not eligible to give birth in the midwifery unit. With the new model, women would be offered a screening appointment at 36 weeks gestation and if the pregnancy was uncomplicated, care would be taken over by the Barkantine midwives. This model increased the possibility of accepting more women but limited the level of continuity of care for the women in a different manner, as care would be taken over by the Barkantine midwives at 36 gestational weeks.

Women were also offered a two-hour active birth workshop as an integral part of the antenatal care, where the woman and her birth supporter would be able to learn and practise positions for labour and

birth, massage, interact with other women and ask questions. This was also an opportunity for the woman to get more familiar with the midwifery team and the environment.

Table 37- The Barkantine activities until 2010

FMU activities from 2008 until 2010:

- Tours of the unit
- Antenatal care from booking (later from 36 weeks)
- Active birth workshops
- Intrapartum care
- Postnatal care
- Examination of the newborn clinics
- Breastfeeding support group
- Baby café' (baby massage group)

Under this model of care, the midwives working at the Barkantine also had monthly team meetings and a six-monthly day away for team building. New midwives joining the birth centre team would also be offered a one-day workshop on active birth philosophy, knowledge and skills. This workshop was developed with the intention of building a common way of working and share skills.



Figure 25- The one-day workshop on active birth philosophy, knowledge and skills

The integrated team: ‘The Birth Centre and the community as one’

In 2010 the Barkantine team moved to another model of care, integrated with the local community midwives under the name of Riverside team. The new staffing model includes 19 midwives divided between birth centre core team and the community and 6.5 maternity care assistants (MCA). Two midwives and one MCA per shift staff the birth centre. During the working hours, an administrator is also working in the reception area.

This model provides community midwifery services to all the local women as well as 24/7 cover for homebirth and the FMU. There is always an extra midwife on call 24/7 in case of high clinical activity at the birth centre. This caseload includes the whole workload for the area, not only women with uncomplicated pregnancies.

This new model of organising the FMU offered flexibility to the team especially in organising an on-call system within the team to cover for periods when the activity was particularly intense. Certainly, the integration of the community midwives, who traditionally were not assisting births regularly, led to a re-assessment period for the team.

Table 38- FMU activities from 2010

FMU activities since integration of local community midwives:

- Booking around 140 women/month
- AN care for all local women
- 28 clinic sessions/month in 9 GP practices
- Antenatal care from booking (later from 36 weeks)
- Active birth workshops
- Tours of the unit
- On call for homebirth
- Intrapartum care
- Postnatal care to all local women
- Examination of the newborn clinics

The Audit of the Birth Centre outcomes

Since the opening of the Barkantine Birth Centre a detailed audit has been maintained. Findings have been presented yearly at the Barts and the London NHS Trust, now Barts Health Maternity Services Audit Meeting. A dedicated audit was needed as the NHS Trust maternity system was not equipped either to identify site of activity or record data relevant to birth centre care.

Presenting accurate data with positive clinical outcomes has played an important role in strengthening the image of the FMU within the NHS Trust (personal communication by a service manager). Several midwives from the Barkantine had allocated time dedicated to the audit activity. In Appendix 7, I provide some key findings for the three years (2008 to 2010) leading up to the period of data collection in order to provide a picture about clinical outcomes of the FMU in the years prior to commencing the fieldwork.

Midwives Miriam Martin, Michelle Keeler, Kirstie Savege, Kerry Mahoney and Jenny Haddon collected and analysed the data presented there. Professor Macfarlane, from City University London also provided some initial assistance for the data collection tool development and the analysis of the data. The audit of the Barkantine was also presented at the Sixth Normal Labour and Birth Research Conference in Grange over Sands (2010) in a plenary session by Midwives Michelle Keeler and Miriam Martin.

Workload and transfer rates

The FMU gradually increased its activity over the years. In the first year 622 women booked for care at the FMU. This included women at all gestations including booking at 10 gestational weeks. In 2010 the number increased to 948 women being booked. The number of births increased from 304 in 2008 to 438 in 2010. By the end of this study (June 2016, personal communication) however the number of births had dropped and the birth centre staff also struggled to complete the birth centre audit as time was no longer allocated in the rota to auditing activities.

Table 39- The Barkantine Birth Centre workload 2008-2010 (Barkantine Audit 2008-2010)

	2008	2009	2010	Total
Women booked at Birth Centre	622	848	948	2418
Antenatal change of plan	204 (33%)	329 (39%)	399 (42%)	932 (39%)
Started labour at Birth Centre	418	519	549	1486
Intrapartum transfers	114 (27%)	98 (19%)	111 (20%)	323 (22%)
Birthing at Birth Centre	304	421	438	1163
PN transfers (% of BC Births)	31 (7%)	37 (9%)	34 (8%)	102 (9%)

It is difficult to interpret the antenatal transfer rates because of the changes in the model of care. The antenatal transfer rates refer to the transfers before the onset of labour but the gestational week in which the audit was commenced varied from booking (before 12 weeks) in 2008 to 36 weeks in 2009. The integration of the community midwives from the local team also created a period of reassessment within the team in which there was variability of practices regarding recommendation for transfer (personal communication, Barkantine Midwife).

As with the Birthplace in England Study (2011) there was a significant difference between the intrapartum rate of transfer for nulliparous and multiparous women. The main reasons for intrapartum transfers were meconium-stained liquor and delayed 1st and 2nd stages. Only 2% of women who started labour at the FMU transferred for an epidural.

The Audit of the Barkantine Birth Centre is reported in Appendix 7.

The clinical outcomes of the Barkantine were consistent with the Birthplace in England Study (2011).

Previous research on the Barkantine Birth Centre

As part of a research team at City University, led by Professor Macfarlane, we have conducted research on women's experiences of care before and after the opening of the Barkantine Birth Centre. Between 2007 and 2010 we conducted telephone surveys of women who were eligible for FMU care in late pregnancy and about six weeks after birth. The two surveys were conducted at

separate time periods, Phase 1 before the birth centre opened (Macfarlane et al., 2014a) and Phase 2 after it had opened (Macfarlane et al., 2014b).

Phase 1 of the study was funded by Barts and the London Trust - R&D Innovations Fund Pilot Project Grant Scheme through a grant to Lucia Rocca-Ihenacho. The rest of the work forms part of a project funded by the National Institute for Health Research through a Research for Patient Benefit grant to Professor Macfarlane.

The findings suggested that, among a group of women eligible for midwifery-led care, those who opted for FMU care were more satisfied with their labour and birth care compared with those who opted for OU care. Women were more involved with choice around care options during labour and birth, were more informed about non-pharmacological techniques for dealing with labour and were exposed to fewer obstetric interventions compared to women who opted for OU care.

The research programme also included a component to compare the economic costs of intrapartum maternity care for women part of the survey depending whether they opted to give birth at the FMU compared with those who chose birth in the OU (Schroeder et al., 2017).

The study concluded that care at the FMU was associated with lower rates of interventions in labour/birth. Women who opted for FMU care received higher quality of care with significantly more continuous support in labour and during birth. Care for women who intended to give birth at the FMU and started labour at the Barkantine was cost-minimising. These findings were similar to those of the National Birthplace Research Programme, where freestanding midwifery units emerged as a safe and a cost-effective option (Schroeder et al., 2012).

Chapter 8- Perceptions and views of the staff working at the freestanding midwifery unit

Introduction

In this Chapter I present the findings related to the dimension of staff working at the FMU.

Motivation to move to the FMU

Most of the midwives interviewed expressed dissatisfaction with their previous work at the hospital and said that they wanted to be able to offer 'real midwifery care', to be autonomous and were ready for a 'challenge'. They wanted to be able to provide personalised midwifery care to women.

'I've got lots of experience but was involved with a lot of high-risk care. It was a bit busy and intense looking after two to three women and I felt that I was not providing the kind of care that I really wanted to. So I decided to look into working at a birth centre where I could hopefully provide one to one care' (BC1-MW-F-INT).

The obstetric unit labour ward was perceived as not allowing them to practise as midwives:

'...Whereas in the labour ward the opportunity to practise midwifery is actually taken away from midwives because the doctors are there, there is pressure of time, pressure to do things quickly so you don't think that far and you don't offer the choices that you know they are there, that's what you learned, and that's how you are trained to be' (BC3-MW-F-INT).

Moving to the FMU was therefore an opportunity to expand their midwifery skills and work autonomously.

Midwives' identity and becoming a 'being midwife'

Many of the midwives described the hospital labour ward as an industrial model of maternity care, where midwives focused on completing tasks rather than supporting labouring women.

'... Even just the atmosphere on the ward there is no relaxation at all, everyone is just you know, you need to do A B C and you know there's no time to sit down and relax you need to be up, going here there you know,

there's always something to do and it's not... I mean there is always something to do but it's how it's coming across so you know, it's so stressful. I hate it' (BC31-MW-F-INT).

Participants described the focus of the labour ward as on 'controlling bodies' and serving the assembly line production.

'For those midwives it's like working in an ICU (intensive care unit) you've got complete control over a body, you know you run, you've got your little charts you've got your drugs going in, your catheter going out you know. And they are completely aware of what's going to happen they're not going to have someone coming and disrupting their sort of flow of their day' (BC15-MW-F-INT).

Most of the participants described two distinct type of midwives: the 'doing midwife', which some described as being more like an obstetric nurse, or the 'being midwife'.

'The first, the obstetric nurse, doesn't have a professional identity (as midwife), doesn't own her or his own work, it's an assistant to the doctor; and a midwife is an independent practitioner that works with the tools of experience and evidence based literature and you try to use your brain to come up with sometimes creative solutions to problems that you face on the day to day running of the unit' (BC7-MW-M-INT).

A consultant obstetrician at the obstetric unit reinforced this dichotomy:

'Um, I think some midwives are... Well no, I think there is two groups... it's difficult because of course midwives who are interested in normal birth tend to not want to work in an obstetric labour ward and the midwives who like working the obstetric labour wards are the ones, who are quite happy for it to become a bit more medicalised. So it can... but you know. And the [hospital name removed] was a horrific case for that. The midwives just couldn't be bothered because they spent so many years just being obstetric nurses, to be very medical led so everyone was epidural, Synto you know, flat on their back on a bed because that's how the midwives preferred it because that was just... they became medicalised as well (SH1-OB-M-INT).

All the FMU staff interviewed expressed a clear view of what midwifery was and the possibility of really working as midwives at the FMU.

'Midwifery is staying with women. Midwifery if you look at the meaning of midwifery it means with the woman not with CTG, not with monitors.... (int: laughing) but staying with the woman and the birth centre gives us that opportunity of providing one to one care... ' (BC3-MW-F-INT).

Staff felt that the focus of being a midwife was 'being with woman, having time to explain options and building a rapport:

'I remember my first shift there I said to myself "Gosh this is nice" because I could practise midwifery here. Whereas in the labour ward the opportunity to practise midwifery is actually taken away from midwives because the doctors are there, there is pressure of time, pressure to do things quickly so you don't think that far and you don't offer the choices that you know they are there, that's what you learned, and that's how you are trained to be' (BC3-MW-F-INT).

Many of the midwives who arrived at the FMU had not experienced physiological labour and birth before. They had the motivation to experience FMU practice and they were supported by the team to transition to 'being with woman'. Many of the FMU staff described the shift in their perception of their role as midwives once they started working at the FMU:

'...For the first time I felt that I was truly being a midwife, I was learning how to be a midwife and as opposed to my previous experience on the labour ward and my previous student experience I could very clearly see quite soon that I was going through a transition from being an obstetric nurse to becoming a midwife' (BC7-MW-M-INT).

Another FMU midwife described the two types of midwives also reflected a dichotomy between motivated or 'burnout' midwives:

'There are those who are committed and they have these... they get this energy back by going the extra mile and there are others who... It feels more like they are just there you know, doing the job and they just want to... their brain and their heart is not in the job' (BC0-MW-F-PART1).

The being midwives were motivated to 'going the extra mile' and they invested in their job emotionally whereas the 'burnout' midwives were just doing the job.

Autonomy and ownership

The birth centre steering group was very influential in setting the basis for the FMU philosophy and culture, particularly by influencing the recruitment of staff based on a strong motivation to work there.

All the staff who worked at the FMU had a strong sense of ownership and autonomy. The term ownership in this study is conceived in the sense of 'being in control' and self-determination. Autonomy in Self Determination Theory is conceptualised as autonomous motivation. It refers to acting with volition, as when employees engage in their job for the inherent pleasure and satisfaction they experience (intrinsic motivation) and/or because they personally endorse the importance or value of their work (identified regulation) (Fernet, 2013).

'Owning your own work' was mentioned by several midwives as an important feature of their work at the FMU, which made them feel good and made for a positive experience of work. It meant being proud of the work done and wanting to ensure that the care of a woman was well organised even once the shift was finished:

'But naturally now I see that we finish handing over, you still want to hang around, there's still something about a woman that you know, you are not in a rush to go again because you know now I am enjoying the job because you know I think yeah, this is the job' (BC13-MW-F-INT).

The importance of creating a relationship and rapport with the woman was often mentioned by the Barkantine staff and I have also observed it via my participant observation. Having built a relationship with the woman, created a positive emotional response in the midwives, who obtained joy and job satisfaction by it. The FMU staff described a culture which created a virtuous cycle of empowerment:

'So I think that continuous feedback system in which you own your own work and there is a culture that allows you to get satisfaction from your work, to be responsible of what you do that's what keeps you going and makes you bigger as a midwife I think' (BC7-MW-M-INT).

This empowerment also enabled learning, which was part of the everyday activities of the FMU staff:

'I don't think I was skillful enough in looking at holistically at what was happening and trying to understand from a broader prospective why things are happening the way they are happening, whether they are positive or not. So I think all those skills freshen up or are growing when you are working in an environment where you own your work' (BC7-MW-M-INT).

The sense of being the alternative to the norm (the obstetric unit) and having to be proactive in order to secure the needed number of births also encouraged the midwives to adopt an entrepreneurial sense of ownership and 'can do' attitude:

'And then I think the resounding big difference is that the birth centre needs the number (of births) to be open you know, there has always been in the background this idea that – you don't reach the number, you are going to be closed, um, people go the extra mile. You know, when you see a woman coming through the door it's not like, 'Oh shit, another woman coming,' it's like, 'Oh, let's make sure she wants to give birth here' (BC0-MW-F-PART2).

One of the MCA recalled an episode when a woman came for her appointment on the wrong day:

'[laughter] It's a client you know, it's a potential client um so you know, it's normal... A woman comes for the wrong appointment, the wrong day and you don't just tell her off sending her away making her feel ashamed, you try to say, 'Look you know, if you are Ok to wait we will try to accommodate you,' so just really um, more personalised less bureaucratic approach' (BC23-SS-F-INT).

This sense of ownership and a less bureaucratic or depersonalised approach was also perceived by the service users, who experienced the FMU as an open and welcoming environment:

'...Yeah. And I went in on Sunday and um, one of the reception lady when I walked in she saw me on that day and she said, 'No, you're going to give birth soon [laughs] so we'll see you today.' Which was very nice of her, so yeah, so they saw me and um, they gave me an appointment for the same day (SU32-W-BC-INT-PN).

The midwives also described how the normal division between work and family life was blurred:

'... when I finished handing over or when I get home, I remember something I am happy to call, when it's my day off, I'm happy to come into the unit and see, oh, what can we do here, which is a big difference from what I used to' (BC13-MW-F-INT).

There seems to be a direct connection between having autonomy and ownership and the creation of social capital within the FMU which is both the cause and effect in creating a virtuous cycle which reinforces positive feedback systems. In a way once social capital is ignited it becomes like an organic system, which can be maintained if the conditions of autonomy and ownership are maintained. The concept of social capital will be discussed later in this chapter.

Struggling for ownership

The data suggest that since its inception there were issues around ownership of the FMU.

The birth centre steering group had a vision of the FMU being strongly connected with the local community and the senior midwifery leadership from the hospital did not share that vision.

The steering group had imagined the FMU being 'owned' by mothers:

SH2: 'Yeah I remember we talked a lot about ownership way back at the philosophy stage and the people there in that generating idea group wanted this place to be owned by the mothers'.

Int: 'Yes'

SH2: 'And I don't see mums just coming here popping in'.

Int: 'Yeah I remember that being the conception'.

SH2: 'I had the idea that after the baby was born may be the mums would just be coming in at the open space and have coffee and just come here not for care, not for an appointment, not to do anything but just to be until that visit' (SH2-BC-SG-F-INT).

If the steering group had imagined a strong service users and community involvement with the FMU, at the time of this study this was still not a reality. In 2010 the steering group was already in crisis, as it did not manage to assert its position with the NHS Trust and it later dissolved, after negotiations for its transition into an ongoing 'advisory group' with Barts Health NHS Trust failed. This severely limited service users' input to the FMU.

By 2012 the FMU had been under threat of closure a few times and the team felt under pressure to increase the number of births. This was due to increased financial scrutiny associated with the main hospital being rebuilt and opening in April 2012 under a Private Finance Initiative (PFI) which resulted in a catastrophic increase in estate and maintenance costs (Pollock and Roderick, 2015 and see chapters 2 and 8).

The FMU staff felt very vulnerable as it was perceived by managers as an 'expensive luxury' (personal communication, senior management). Senior management therefore decided that an integrated model, which included the FMU original staff and the local community midwifery team, would be more financially viable as the FMU would include more antenatal and postnatal activities:

The FMU struggled to have a voice and to feel empowered in developing a strategy to sustain and increase the number of births and the way of working:

'But in terms of my other roles within the Unit um for example, I mean (as band 7 midwives) we are all called managers aren't we? We are supposed to have certain roles in developing the unit, the birth centre ah, that I... I haven't felt that many of the things that we have raised as issues have always sort of been taken on board and acted upon... (BC9-MW-F-INT-PART1).

This senior midwife wanted the FMU to retain ownership of how to increase the workload but felt disempowered.

On other senior midwife complained about lack of ownership over philosophy and how to implement Trusts' objectives:

'...It's a bit like the objectives that the birth centre has got are not the birth centre objectives, but it's like they are the obstetric unit objectives. Like, this is how it needs to be done because otherwise it is not going to work and we just go with all that philosophy instead of birth centre philosophy' (BC10-MW-F-INT).

Staff complained that since the opening of the FMU in 2008 the leadership of the FMU had been unclear and unsupportive. From having the labour ward manager as leader for the FMU in 2008 when first opened, the leadership was changed for the consultant midwife for normality in 2009 and in 2010 (when the consultant midwife was on maternity leave) a team leader position was created. This latter development was perceived by staff as having had in many aspects a positive impact on the FMU:

'Eh... It's a change yeah, I mean the manager in the labour ward, I never seen her clinically working, and when I came here and I saw the manager doing a labour care and everything I was shocked. I thought I didn't know

managers could actually do that [laughs]. I was used to the manager in labour ward that she was in an office there forever and, never clinically doing anything' (BC2-MW-F-INT).

The presence of the team leader, which later became FMU manager, had a positive influence on the transition to integrating with the community midwifery team:

'...Then obviously because we were all passionate and because of some positive managerial efforts in organising the workload we have managed to orchestrate the workload in a more harmonious way. I think we are beginning to find a balance' (BC7-MW-M-INT).

The manager made an effort to maintain the feeling of shared leadership and in some extent she achieved that by continuing the idea of making decisions in a collegial manner in order to come up with the best solution:

'For instance we tried one model of a rota um, where on the community side they were working a sort of short day pattern and the Birth Centre was a long day pattern and the midwives all hated it because they felt like they were working all of the time and it was quite hard to fit night shifts into their um... So having to then go away and think about, ok how else could we do this? And changing to a system with long days in the community um, so it... just sort of being willing to sort of adapt in that way' (SH1-BC-F-INT).

If the sense of 'them and us' was alleviated by having a lead midwife well connected with the OU and in good terms with senior management, on the other hand however some staff felt that having an official manager meant that some of the ownership was lost:

'...That feels a bit like the manager that we have got at the moment I think she is very organised but she is too organised that doesn't allow you to develop yourself' (BC10-MW-F-INT).

The struggle for ownership was evident from the following accounts from two of the senior midwives, part of the original team:

'Now many of the ideas are coming from the hospital, the head of midwifery and now we have got the manager, the manager need to go there and we get feedback from the main unit' (BC10-MW-F-INT).

In the previous quote the midwife suggests a lack of empowerment of the FMU staff and highlights an issue about management style and whether managers have the kind of approach and philosophy that enables people and encourages a sense of ownership and shared decision-making.

The following senior midwives expanded on more issues:

'Yeah, but they are managers, they ultimately make the decision and um... And whistle blowing I think is a very [laughs] contentious sort of... issue. So these are some of the problems at the Birth Centre right now with all these things, mistrust you know, feeling unsafe working with certain people... um. As a team you know...anyway. That's how it is' (BC9-MW-F-PART2).

And with the lack of ownership the social capital was lost:

'Yah you just try to do your work, and come, do you work and finish and go and sometimes you have a great experience with a woman in labour, but that's it you don't really care as we did at the beginning of the birth centre' (BC10-MW-F-INT).

Both the midwives left towards the end of this study, as they felt that their role as leaders was not being valued.

Getting a FMU specific manager was perceived by staff as helping resolve this but there were some limitations as the management style it appears was still more in tune with that favoured in a hierarchical and protocolised service.

While on the one hand it may have protected the unit and its position within the service, on the other a 'tight-ship' management style was not really in tune with the philosophy and some of the midwives (who had applied as very motivated people and felt the environment gave them more autonomy) felt rather restricted from really building on this and making an active contribution to how the unit was run and could develop. This was demotivating and coupled with the increased workload and a feel of being under continuous scrutiny from the OU some cited these as reasons for leaving.

This lack of feeling involved with the wider strategy on how to develop the FMU and continuous improvement of the FMU was considered by many of the FMU staff as the cause for poor staff retention. To date only one midwife from the original team remains at the FMU.

The issue with staff retention resulted in a lack of skill-mix and what some midwives described as a struggle in keeping the culture of the FMU stable:

'Many of the very young midwives arriving there, they have all the good intentions; they you know, are very keen on being there but they are really need supervision' (BC9-MW-F-PART1).

These dynamics over the years and the conflicting relationship with the obstetric unit raise questions regarding the leadership structure of FMUs. The midwives at the FMU described feeling unable to negotiate with the obstetric unit senior management team. The FMU midwives argued that the leadership and philosophy at the main unit was strongly medically dominated and that the FMU instead wanted to refer to a social model of care. The struggle for ownership and consequent feeling of being disempowered had a strong impact on the team morale:

'You see the problem with us I mean, we can only, we can only take it to the, the channels and, and report it and once it comes to the managers or the supervisors then, then we cannot then get... I mean they have to be the one taking the right steps to manage the problem and if they don't, what can you do about it? I mean unless you want to whistle blow or whatever um... I really don't know' (BC9-MW-F-INT).

The FMU staff felt vulnerable in negotiating terms and fighting for maintaining a social model of midwifery, particularly because the model in hospital was, in their view, medical and industrial. It appears that in the process of appointing a birth centre manager the senior management nonetheless missed the opportunity of handing over greater ownership to the FMU team and the FMU midwives felt vulnerable and unable to negotiate as they were directly employed by the NHS Trust. The hierarchical structure of the NHS prevented them from being able to negotiate.

Team spirit

The midwives described how most of the staff at the FMU were good team players and this had a positive impact on them professionally but also at a personal level:

'...here people will make the time for you even if it is busy which is really lovely especially anything doing with normal birth' (BC4- MW-F-INT).

During the fieldwork, I could systematically observe how the team on shift would coordinate activities, check on each other regularly to ensure they could cope and offer help if a colleague was overloaded.

The following vignette with observational data exemplifies the team spirit that I have often noticed among staff during my participant observation:

Observational notes -Shift 7-7th March 2012- weekday 0800-2000

0800- Today is very busy. There are two senior midwives on shift and one maternity care assistant as well as the receptionist from 9 am. There are three women in labour and one postnatal woman. Two women are multiparous and one is a nulliparous woman in labour. As soon as I arrive one woman gives birth, the night shift midwife has stayed as the birth was imminent at handover and one of the day shift midwives has joined her. Also the other multipara is cracking on and the second senior midwife takes over her care after taking a quick handover from the nightshift midwife.

The environment is not as relaxed as usual but I can notice the connection between staff.

0900- The midwives are moving fast from a labouring woman to another, they do not smile as much as usual, they are just getting on with the work. The maternity care assistant is helping with the woman who has just given birth. Fortunately, there is no clinic in the morning.

1000- The two midwives touch base with each other often checking if the other one is ok or needs any help. They are coordinating well and in a smooth manner. The maternity care assistant is fetching equipment and whatever the midwife needs in the room. The receptionist is calling to postpone some of the appointments for the afternoon. Despite the exceptional workload it does not feel chaotic or out of control.

1130- The maternity care assistant brings a tea to the midwives who are now both in the rooms with labouring women and then checks on the two postnatal women to see if they need anything.

Figure 26- Vignette with observational data on 'team spirit'

The presence and role of the senior midwife on shift was described by staff as supportive rather than authoritative and staff felt that support was available when clinical plans needed to be developed:

'I think that you have a hierarchy in the hospital which you don't have here in the birth centre, we're midwives and um... we make decisions together whereas the doctor is still the top dog in the Hospital so you're always working far more by protocols and less by instinct' (BC15- MW-F-INT).

This following midwife firstly experienced the FMU as a student and described how the relaxing environment and support by the FMU staff made learning easier:

'...Opportunity for normal birth in a more relaxed environment definitely, because when you are learning and you are relaxed you actually learn more, you actually remember what you could do that is brilliant; the stress is a thing in the labour ward. To actually be able to trust your instinct as well because you could talk to the other midwives about what you are feeling and to actually make a plan together that was really useful' (BC4- MW-F-INT).

The relaxed ambiance and team spirit allowed staff and students to feel more comfortable to speak about 'instincts' and to work in partnership to develop care plans in a non-hierarchical manner which was conducive towards learning.

Philosophy, knowledge and skills

When speaking about philosophy I intend it as the term 'assumptions' described by Schein (1993): widely held, ingrained subconscious (and conscious) views of human nature and social relationships that are taken for granted. The category 'Philosophy' and its subcategories were also related to 'Knowledge and skills' with its sub-categories.

Table 40- The subcategories linked to 'Philosophy' and 'Knowledge and skills'

Philosophy (assumptions):

- Birth as physiological
- Midwife as an expert facilitator
- Having to justify interventions
- Woman's autonomy

Knowledge and skills:

- Communication
- Personalised care
- Giving information
- Physiology
- Active birth skills
- Skills and drills

All midwives said that midwifery practice at the FMU differed consistently from the hospital. They referred to the practice at the FMU as 'real midwifery'. Physiology was nurtured and understood as well as having to justify interventions rather than intervention being the norm. The role of the midwife was perceived as a 'guardian of physiology', a facilitator, who could create a nesting environment for the women and their families and interpret and support the needs of the women. All midwives agreed that one-to-one care in labour and having time to build rapport with the women were key to both safety and the success of a FMU.

Birth as physiological and midwife as an expert facilitator

It was very evident from all interviews and from the participant observation that staff at the FMU shared a philosophy of labour and birth being physiological processes and their role being facilitators, implying the concept of avoiding disruptions of the woman's physiology.

'.... empowering women to do what they are supposed to do when in labour Women are empowered to do it and we are just there to support, we are just there to encourage and we are there to see it happen really' (BC3-MW-F-INT).

Midwives cared about being part of a team which supported the natural progression of labour and birth:

'I also think this promotion of natural birth I think is the most important for people who work here' (BC1-MW-F-INT).

The staff also pointed to two concepts: Maximising opportunities for normal birth and having different 'boundaries of normality' compared to the obstetric unit.

A maternity care assistant commented:

'I think it's a combination of so many things. I think not coming in too early when the women are in labour because once people come in they start looking on the clock and they get distressed and so on. A lot of women when they come in they are 5 or 6 cm and it's not so long for them to go when they come in and they become so relaxed. I think is a calm relaxed environment, I think the midwives are friendly, approachable and they just make it easy' (BC28-SS-INT).

And a senior midwife added:

'... Reflecting on things all the time, I think that reflection has been a very important part of my learning um and to... sort of be laid back and say, 'Look this is normal, I know it's taking place a little bit differently but it is normal,' you know' (BC9-MW-F-PART1).

This concept of continuous development and learning was present throughout the data set and suggests that the FMU environment and work pattern facilitates staff's development.

Having to justify interventions

The shared philosophy of the FMU included the concept that interventions needed to be justified and were only used in cases where the benefits outweighed the risks:

'[at the FMU] I was just able to wait a little bit more and watch and I had a plan in my head to wait for 15-20 minutes and if I see anything, and if not may be examine her. But I was able to see the way she was acting she was transitional and the baby was on its way, I was happy and really quite sure that she is about to give birth' (BC5-MW-F-INT).

Internal examinations and anything interfering with the physiological progress of labour were perceived as an intervention:

'I actually found it to be quite an education to work here you know because I think I really found when I actually started here, I really learn about labour. I know it sound a little bit weird but I learnt about how to assess a woman in labour without actually having to do examinations just looking at her and how she is reacting and acting in an environment. And it really was a learning curve for me when I first came here that I could step back and just by watching a woman to kind of know what was going on rather than.... in the labour ward is very much like women coming in and you must assess them straight away and you must do an examination and see how far they are, are they in labour or not' (BC6-MW-F-INT).

The concept of having to justify interventions was often learnt once started practicing at the FMU and having socialised with the FMU culture as midwives referred to the OU practice as using interventions routinely and value given to 'doing' rather than 'being'. In the Vignette below I report an extract of my observational notes.

Shift 1-27th April 2011- Lucia Rocca-Ihenacho's observational notes

Jose's impression of the first birth observed at the FMU (all names are pseudonymous)

Jose is a student midwife in his first placement at the birth centre. He had previously spent 3 weeks on the labour ward at the main obstetric unit. He is working with Maria, a band 6 midwife, who has worked at the FMU for three years. The activity at the birth centre is moderate tonight with one postnatal woman and a multiparous woman who has just given birth. After attending the birth Maria, Jose and I sit in the birth centre common area and have a coffee while they are writing the notes. The maternity care assistant is in the room helping the mother who has just given birth to have a shower and tidying up the room.

Maria is reflecting on the birth, which they have just attended with Jose, discussing his impressions and comparing with his experiences of the obstetric unit.

Jose: 'I liked this so much more than a birth on the labour ward, there is no comparison possible, I like it so much more. The moment the baby was born, passing her the baby between her legs, the fact that she picked the baby and sat in the pool with the baby skin to skin. I would love to work here once I have finished my training. I would love it.'

Me: regarding midwifery practice have you noticed anything different from the hospital?

Jose: 'The fact that the midwives do not shout to the women as it happens on the labour ward! The environment was great: the lights, the music she brought with her, speaking softly to the woman, all these things influence the way the labour goes'.

Me: What about the clinical care, have you noticed anything different?

Jose: 'Yes, well everything went very quickly, but Maria did not do many clinical procedures, she did not do a VE at all'.

Maria 'Yes, but when I was on the labour ward, every woman coming in would have a VE'.

Jose: 'The VE is to assess progress in labour, so if the woman is not in labour, there is no need for VE'.

Maria: 'Yes, but the second time we went in the room Jane was in active labour, when she got in the pool she was in Labour'

Jose: 'Mmmm, that is right', 'So are we saying the we should not do VEs?'

Maria: 'No we are saying there should be a reason for it and we also look at other signs:

Jose: 'oh yes, the purple line, the rhombus of Michaelis....'.

Maria: '...And the most important element is the behavior, it tells you everything, when she arrived she was chatty, smiling etc..., the second time we went in the room she was focused on her breathing... she was different'.

Jose: 'So if she had not progressed so quickly would you have done a VE at some point?'

Maria: 'yes, at some point maybe in a couple of hours, if there were no signs, no change'.

Figure 27- vignette with observational data on 'having to justify interventions'

During the field-work I have often observed midwives discussing progress together and midwives seeking what is commonly known in clinical practice as a 'fresh-eye approach' (Alfaro-LeFevre, 2015). This is when the case midwife asks another clinician to review progress with her and to discuss the possible care plans (Alfaro-LeFevre, 2015). This was done regularly at the FMU in a non-hierarchical

manner and also based on a philosophy of 'birth as physiological'. In the presence of deviation from normality there were discussions to understand whether this was a borderline or pathological situation (in which case the midwife would try to understand the underlying mechanisms of malposition).

Women's autonomy

The midwives and MCAs all shared the assumption that women were autonomous and able to make decisions:

'I think it's... To me, normality is about the woman being in control. It's not about me being in control you know if you like, I am the guide. I always feel it's the woman who is in control, she's the one who's actually leading, she's the one that's saying, 'This is what I want, this is what will make things easier for me, this is what will make me happy,' and my job is to actually do whatever she wants you know, obviously within reason, as long as it is safe and it's ok for the baby but I do feel quite strongly that it's about the woman' (BC20-MW-F-INT).

This involved a shift in the power balance compared to what most midwives experienced in the hospital setting:

'It's feeling lighter when you are working because you are not carrying the responsibility of making decisions for the women. So it is that present sensation of becoming more free when on your day to day running and not being so constantly worried and oppressed by this fake sense of "I need to encourage this woman to have syntometrine or she must do this or she must eat this." I think that is a good example of something that I have learnt here and it allows me to feel better as I am working' (BC7-MW-M-INT).

The acknowledgement of the woman's autonomy was linked to a sense of 'freedom' and being lighter, which had a positive impact on the level of stress the midwives experienced.

The midwives used their expertise, knowledge and communication skills in a non-patronising way to support the women making decisions about their pregnancies and in the labour process. This will be further discussed in Chapter 12.

Knowledge and skills:

Clinical knowledge and skills were perceived as very important by FMU midwives and coupled with communication skills, the ability of providing balanced information and being able to offer personalised care.

'I feel more, more confident um, talking to women when they are in labour um. I feel I can give women more suggestions about how to cope with the contractions' (BC16-MW-F-INT).

A MCA described the midwives' communication skills:

'The best thing is (Pause) the way women are approached by the midwives, the care that the midwives are giving women, and everything is explained to them. So I think the approach is one of the essential things between the midwives and the women that want to come to the birth centre to have their babies' (BC23-SS-F-INT).

The type of knowledge was relationally dependent and the midwife had more insight to inform decisions by understanding and knowing the individual woman:

'You kind see them as a whole person and the different kinds of things that are affecting them and you can get to know them and you can talk to them and understand their feelings and anxieties and try to work through that... So I guess I possibly listen and think about what is best for that particular woman more than I did at the hospital' (BC1-MW-F-INT).

Knowing physiology and being conversant with active birth skills were included by staff as key aspects of a midwife's professional profile:

'I always say women that I can't remember when I last delivered on a bed. Now I have forgotten all about that. Now I encourage women to deliver while standing. I feel confidence to deliver in standing position, on birthing stool with different positions. Whilst before it was "stay on the bed, lie on your back that's where you are going to have your baby' (BC3-MW-F-INT).

Many midwives also felt the freedom to implement new knowledge into practice and learn new skills because they were working in a conducive environment:

'...but now the biggest thing is the second stage because now I just allow women to tell me when they feel really the need to push. I don't encourage when to push or not to push, which is a new thing and before I would have a time limit and someone will tell me this and that whatever in the labour ward but here is different you can relax and let her get to that stage naturally. That's what I have learnt' (BC4-MW-F-INT).

'And one big thing is that I have actually experienced is physiological third stages, that I have never done until I come here... But here I have managed to do that and it just happens I can facilitate that now. It's a choice and I can actually facilitate that and its okay that. It has been a wonderful thing and now I feel confident to do' (BC4-MW-F-INT).

The FMU offered newly arrived midwives the opportunities to develop their skills and feel safe while expanding their 'boundaries of normality'.

Having, making and giving time

Hunter (2003) used the codes 'having time' and 'giving time' referring to the way midwives worked in a FMU in New Zealand. In my study the midwives referred to the importance of being able to be with the woman and dedicate her time.

Having time was perceived as an essential part of the FMU success. Having a balanced workload was critical for this. However even when the FMU became busy the priority of the FMU midwives was the woman rather than routine tasks or 'paperwork'. The philosophy of 'being with the woman' therefore influenced the time-management resulting in the midwives 'making time' for the woman even when under pressure. The midwife cited below joined the FMU after working for two years on a labour ward:

'The way the midwives work was very relaxed. They took their time to stay with their women and I found it very different from being in a high-risk unit because of that. Because in the high risk you, you keep rushing because we are short of beds because there is another labourer coming and you don't have the time to sit down and, and talk to them really. So I really like that' (BC2-MW-F-INT).

The midwife cited below did not originally apply for a job at the FMU because of fear but changed her mind after experiencing the FMU team spirit:

'So when going to the birth centre I saw that there was time to offer women choices, it was time to give women information that could actually assist them in making an informed choice. So I said to myself that ooh I would want to come and work in this kind of area' (BC3-MW-F-INT).

After spending a few shifts at the FMU to cover for sickness, she requested to stay at the Barkantine and applied for a job vacancy there. Two years later she had become one of the senior midwives coordinating the birth centre.

Dissonant data: Not having time

From 2010 the FMU became under pressure to increase the number of births and there were rumours that it was under threat of closure (several personal communications). Under this new sense of pressure only birth and clinics were perceived as meaningful activities for the senior management and this led to the discontinuation of antenatal and postnatal support groups run by the FMU midwives:

'We were offering ah the active birth workshop to women. We used to run it on Mondays and Fridays it was our session to explain about active birth so we give information about how to cope with the contractions at

home, how how... um, the labour ah progresses how to deal with um, the contractions once um, once they are here and when they are home. We talk about water birth about pain relief, about vitamin K about the third stage this is all our session and we, we used to run... We stopped it now because we are short of staff, so, we are doing clinics on this space on this ah, two hours' (BC16-MW-M-INT).

The lack of time and increase in workload led to a decline in positive experiences by service users:

'The third time around I felt a lot more anxious than the second time around um, mainly because the, the [B] was quite busy um. All the rooms were taken up I think there was only one room that wasn't but then they didn't have um, an extra midwife so all the midwives were, were busy with, with other ladies. So I did feel quite anxious then um, I thought I... I probably... I thought to myself that I probably would end up going to the hospital because there wasn't, there wasn't any midwives there' (SU8-W-and SU9-BS-M-INT-PN, part2).

The lack of time and excessive workload affected the way the midwives communicated to the women:

Int: 'So that's interesting. Somehow you're saying that when you go over capacity and if you are stressed automatically the communication goes?'

SU8: 'Yeah it does. Definitely because even when I went in and I saw her face, she looked very stressed out. She was... she wasn't being horrible or anything like that but the way she was talking to me was just like, 'Look you know, we don't have any more midwives, there can't be someone with you all the time,' So she was... the things that she was saying to me for a first time mum, that would have been scary you know and for, for a new Mum it would've been like, 'She doesn't have to talk to me like that,' and you know, it's not nice basically um...' (SU8-W-and SU9-BS-M-INT-PN, part2).

The major complaint staff had was a lack of time to dedicate meaningful attention to postnatal women:

'Yah I don't think we do have much time to dedicate to postnatal women any more where before you could come in spend some time, to see how the feeding is going. Now we can have clinic all day, we have got postnatal clinic, admin work it's just ridiculous that's not what we are assigned to do' (BC28-SS-INT).

Since the integration with the community team and the change of model of care many of the midwives felt that they had moved to a more industrialised model of care as they organised whole-day clinics with sometimes 30 women in a day.

Mindfulness

Barkantine midwives described how, having time to dedicate to the women, and being able to be in the room with the labouring woman, allowed them to be 'fully present' and grasp clues about progress in labour:

‘...the birth centre gives us that opportunity of providing one to one care where you sit in the room and you know when the first contraction come, you know when there is transition from first stage to second stage, you know when it all happens you pick up those clues. (BC3-MW-F-INT).

The opportunity at the FMU to being fully present while supporting a labouring woman was strikingly different from the obstetric unit, where midwives’ time, energy and attention were pulled in different directions.

The opportunity of ‘being there’ allowed the midwives to ascertain what the needs of the woman were and to offer care tailored around unspoken needs:

‘You need to listen to the woman and observe her. If you are just sitting with the woman you know what is happening I think that is the most important thing. If you are in a room with her and you are not coming in and out and that is your case, that is the woman and the baby and you are sitting there and you know what you need to do’ (BC10-MW-F-INT).

Brown and Ryan (2003) define mindfulness as an enhanced awareness and attention of the present reality or current activity. Midwives also described how this mindfulness helped detecting deviation from physiological situations and to predict risky complications:

‘A lot of skills and drills actually in midwifery when you work at a Birth Centre it’s just using your eyes. [laughs] It’s not about anything else and trusting that because we are working with women one to one and you can use your eyes to say things aren’t going as well’. (BC15-MW-F-INT).

Being fully present and focused on the woman offered the midwives the opportunity to read signs and pick up clues that were enabling them to determine early a deviation from normality:

‘Like you’re so much more involved, and as well you learn about... you have to... you can, you can watch a birth, like now I feel I can watch a birth and know how its progressing without even having to touch a woman. Like VEs are good for establishing... ‘cause sometimes people do seem to be more established then at other time and it’s good for that but if you watch a labour progress you can see things happening and you’re picking up on abnormalities long before it becomes a problem. And I think that’s a skill that you pick up from watching people without an epidural and that are just birthing completely, normally’ (BC18-MW-F-INT).

In contrast “mindlessness” was described as the relative absence of mindfulness by dividing attention with multiple tasks, being worried, distracted or by refusing to acknowledge a thought, emotion or motivation (Brown and Ryan, 2003).

Many of the FMU midwives described the working conditions in the hospital as forcing staff towards mindlessness:

'In a consultant unit there is no time to do that, there is too many things going on, the monitor is there and you rely on the monitor rather than your instinct as a midwife, rather than relying on your knowledge as a midwife to pick up those things' (BC3-MW-F-INT).

Midwives referred to the lack of time to dedicate to women as a major problem in busy obstetric units:

'You constantly rush through; you feel like you are rushing through the women and sometimes you don't want to engage too much in case they need to give you more information that's personal stuff as well as medical stuff. It is horrible but you don't have the time' (BC5-MW-F-INT).

The accounts of the midwives suggested that there was a direct link between being able to offer one-to-one care, mindfulness and safety.

Vicarious nesting

Walsh introduced the term nesting related to the midwifery unit he studied (Walsh, 2005) describing how women had an immediate and instinctive sense of emotional safety on entering in the FMU. He also described how the midwives looked after the environment 'preparing for a baby' (Walsh, 2005:6). My findings also point towards the creation of a 'nurturing environment'.

The midwives and MCAs in my ethnographic study would facilitate nesting for the women as part of the shared practice within the FMU:

'Well I was used to work in the labour ward and labour ward is completely different with here. Being here is like home to home because we always try to make the women feel welcome. While in the hospital environment everybody is running around and the care is not one to one and here we try our best for the women to have one to one care' (BC23-SS-F-INT).

'That doesn't mean staying in the room all the time, I don't believe that either, but creating a kind of sense of, wellbeing using essential oils if she feels, um she feels they help, running water even running water into a pool and to sort of put women at ease' (BC15-MW-F-INT).

While conducting participant observation I often observed midwives and support staff arranging the environment to be welcoming for women arriving in labour, for the arrival of service users for tours or for an active birth workshop:

'The MCA has set the room up for labour, which means that she has laid a large and thin mat on the floor, covered with linen and added a beanbag. She has also started running the pool, turned on the music and set the lights to be low. In the room there are also a gym ball and a birthing stool visible. The MCA has also

fetches extra towels, checked the clinical equipment and ensured that there is a torch available for the waterbirth as well as a sieve and a mirror. When asked about what she was doing she said that they always like to make the room as homely as possible when women arrive to ensure they feel welcome and that they do not go and lie down on the bed but that they have active birth equipment around and visible. She also said that she likes to ensure that the midwife has all the equipment needed at hand' (Observation Notes-26th April 2011).

The fact that women did not need to move to a postnatal ward also had a positive impact as the midwife could focus on supporting the transition to parenthood rather than being stressed about getting the woman ready to move to the postnatal ward:

'Here because the lady is just going to stay in the same room then there is no need to hurry her third stage because she is in her room she is not going to the ward and its fine. And now I have seen and I have actually been able to help women during the third stage and I have actually built confidence in that because now I know and I have experience, is great' (BC4-MW-F-INT).

The data suggests that the concept of vicarious nesting refers to a homely physical environment in which the woman feels relaxed but is also enhanced by an emotional environment which is created by the staff who express care and a nurturing behavior by preparing the birthing room for the woman's arrival.

Salutogenesis

Downe (2008) has proposed the shift from a maternity service culture based on risk management to one based on salutogenic factors (creation of well-being and health). She quotes the work of Antonovsky (1993) as extremely relevant to our field. Antonovsky suggested as we are all already familiar with the concept of a risk factor, perhaps we could also use the concept of a salutary factor (Antonovsky 1993).

The concept of 'coherence' is of particular interest for midwifery units is. It was coined by Antonovsky to explain how some people in stressful situations, maintained their health and even improved it. Individuals who saw their world as manageable, comprehensible, and meaningful could read their life as coherent and were more resilient in adversity.

Within FMUs salutogenic factors refer to both staff and service users' experiences.

Most of the staff in my study described how the environment, the team and the organisational culture made them feel well:

'I feel people are happy here and people are not happy there (in the hospital)' (BC5-MW-F-INT).

The following midwife recalled how he felt when first arrived at the FMU:

'The reality was better than the expectations. When I came I was very pleasantly surprised and the first thing that shocked me was the positive effect by the building itself, that the birth centre itself has, because this was fresh, it was new and it was nice and it felt like you were respected more, in a way like your work could become more valuable. I don't know it's weird. But it gave you this new steam to work in such a beautiful place. I think it was just the mood from day one' (BC7-MW-M-INT).

The accounts of the FMU staff point to the fact that happy staff worked better, which had a positive impact on service users:

'...You don't go home half as stressed and the other thing is that we probably smile a lot more, we're a lot more welcoming, we're a lot more relaxed...' (BC20-MW-F-INT).

The FMU environment was reported by staff as also having a strong impact on service users:

'...We were talking the other night that our primips seem to do very well, they seem to progress very quickly so why is that? You know, it's got to be that they come here... the atmosphere is a good atmosphere and everything that needs to get going, just gets going and, and they're active...' (BC20-MW-F-INT).

The data suggests that this sensation of wellbeing was linked to the environment as well as the team spirit and culture. A team culture which focused on building relations among staff and with women led to the creation of wellbeing for both in a reciprocal manner:

'...Birth Centre is a place where you can go into partnership with women, to get the best outcome for the woman, and actually best outcome for the midwife as well, you understand because when you are able to support the woman and the outcome is fantastic then you feel well in yourself as well' (BC13-MW-F-INT).

And this midwife summarised it as follows:

'The concept of the birth centre is a wonderful idea, which I fully support and I intend to use it if it's available to me when I have a child. I think it's beneficial for the women, beneficial for the partner and whoever is with the woman, beneficial for the baby, beneficial for the midwife, beneficial for the point of public health because we are really engendering health using very simple techniques and very economical techniques. I believe it will be a cost-effective way of achieving exceptionally competitive clinical and economic outcomes' (BC7-MW-M-INT).

This description of the FMU points towards a strong public health effect of the FMU care focused on the creation of wellbeing and health as well as cost-effective care.

Social capital

The very inception and creation of the Barkantine birth centre arose from a grass-roots movement of like-minded people who got together to lobby for the creation of a FMU in order to offer women choice and improve midwifery care (Rocca-Ihenacho and Redfern, 2010).

One of the steering group members said:

'So it stemmed from just a few people with a huge passion for midwifery care, for women led care, for making sure that women are getting the right care; that they sort of basically wanted it to happen and they're the ones that made it happen... but if you haven't got one or two individuals right at the beginning who have the belief that it can work, the belief that they are able to do this and that there are women out there who are wanting it, who are willing to give their time, their life, their blood supply, whatever you might want to say... to keep going and to keep chipping away at it despite adversity' (SH2-BC-SG-F-INT).

And she continued:

'Well I think it was the fact that the people involved in doing it because they honestly genuinely cared as people, it wasn't anybody's job to solve this problem. All of us were involved in a voluntary capacity because we had the passion and interest on the local people, you know people who have lived in the borough for many years or worked in the borough for many years and cared and wanted this to happen' (SH2-BC-SG-F-INT).

Bourdieu and Wacquant (1992) defined social capital as 'the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition' (Bourdieu and Wacquant, 1992, p. 14).

Social capital broadly refers to the resources accumulated through social relationships (Coleman, 1988) and it is conceived as a cause as well as an effect (Resnick, 2001; Williams, 2006). Social capital offers a person to draw on resources from other members of the networks or the community they are part of (Ellison et al, 2007) in the form of useful information, personal relationships, or the capacity to organize groups. It has been linked to a variety of positive social outcomes such as increased commitment to a community and the ability to mobilise collective actions (Ellison et al, 2007), improved public health and lower crime rates (Adler and Kwon, 2002).

Declining social capital on the other hand is associated with an increased level of social disorder, reduced participation in community activities, and potentially more distrust among members of the society (Ellison et al, 2007).

At individual level different forms of social capital such as relationship with friends and neighbours, are linked to indices of psychological wellbeing (Bargh and McKenna, 2004; Helliwell and Putnam, 2004).

Interpretation

The map below attempts to capture the key elements of a FMU from the individual perspective of the midwives working there.

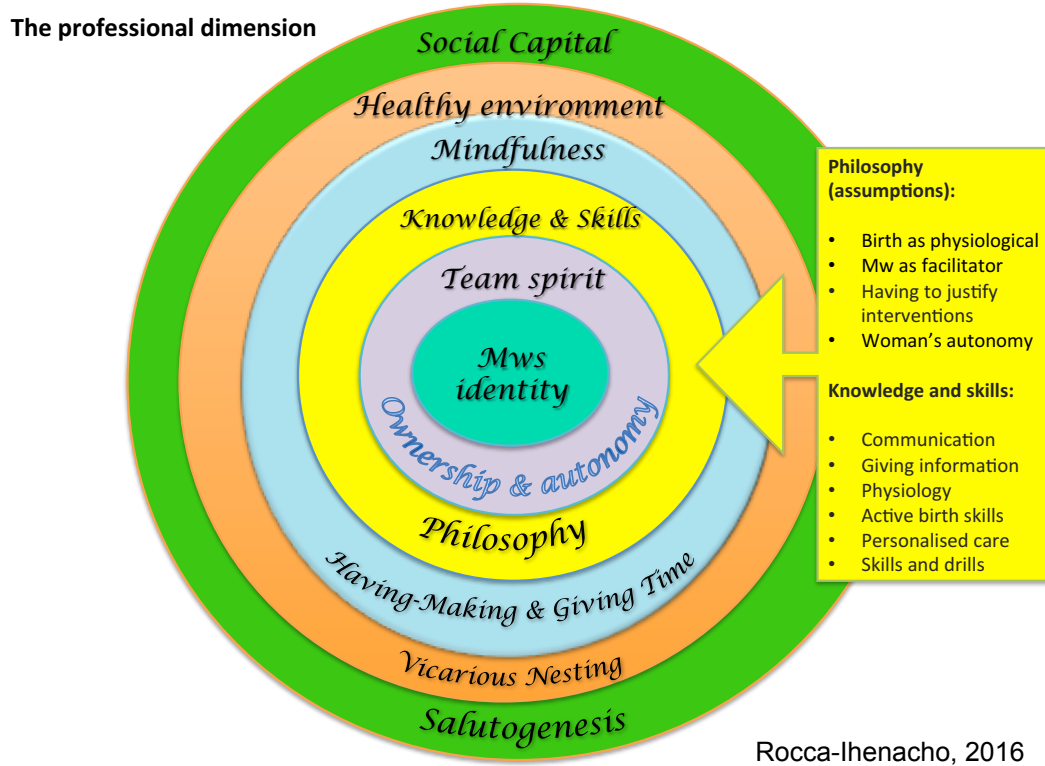


Figure 28- The midwives professional dimension

Midwives' identity emerged as an important theme in this study. Consistently with findings described in previous studies (Kirkham, 1996, 1999, 2010; Hunter, 2004; Hunter and Deery, 2009; Rayment, 2011; Cooper, 2011) midwives' identity seemed to be dichotomised into two main categories 'the being-midwives and the doing-midwives'. The first identity has a strong grounding on the relational role of midwives (with-women), whereas the second identity is grounded on an institutional role (with-institution). The midwives who participated in this study describe their previous experience of the obstetric unit as limiting their autonomy, competence-minimising and preventing the development of relations with other staff and the women they cared for.

Interestingly the findings suggest that the midwives' identities were not fixed. In fact, with support and a conducive environment and socialisation with FMU culture, midwives were helped in moving towards

a relational role rather than a task focused one. Both the interviews and the participant observation suggest that a supporting environment facilitated an identity shift from doing to being; from institutionalised to women centred. This could be a natural response to having met the fundamental psychological needs of autonomy, competence, and relatedness (Deci and Ryan, 2008).

Autonomy and ownership were other categories which emerged from the data analysis. In this context autonomy means to act volitionally, with a sense of choice (Deci and Ryan, 2008).

A supporting environment, a sense of ownership/autonomy and team spirit enhanced staff's motivation to create a birth environment in which labour and birth physiology was supported and nurtured.

I argue that the FMU not only offered a working place which had a positive impact on service users, but it was evident from what emerged from the analysis of the data, that the FMU had also a positive impact on the staff at a personal psychological level.

The way time and space were managed was described and this related to the concept of mindfulness, which Brown and Ryan (2003) define as an enhanced awareness and attention of the present reality or current activity.

Many of the emerging categories and concepts related and reinforce what are previously theorised by Downe (2004) as 'salutogenesis' and Walsh (2006) as 'social capital'. These concepts will be further discussed and elaborated in the Discussion section of this thesis.

While reading a wide range of literature in the attempt of making sense of my data on motivation, autonomy and ownership, I encountered the Self-Determination Theory (SDT), which offers a psychological reading of the individual dimension of the staff working at the Barkantine.

Self-determination theory helped in making sense of some of the categories which emerged through the data analysis. In my view despite conducting an ethnographic study, which focused on the group culture and took an anthropological approach, it seems meaningful to also use psychological theories when focusing on an individual dimension.

SDT represents a broad framework for the study of human motivation and personality. SDT specifically studies the interplay between the extrinsic forces and the intrinsic motives and needs inherent in human nature. It is concerned with supporting our natural or intrinsic tendencies to behave in effective

and healthy ways. The theory was initially developed by Deci and Ryan (Deci, 1971; Deci 1975; Ryan, 1982; Deci and Ryan, 1985) but has now received contribution from many academics internationally (Bidee et al., 2012; Gillet et al., 2013; Van den Broeck et al., 2010).

Deci and Ryan (2008) highlighted that SDT differentiates motivation between two broad categories: autonomous and controlled motivation. Autonomous motivation includes intrinsic motivation and well-internalised extrinsic motivation. Intrinsic motivation involves performing a behaviour because the activity itself is interesting and spontaneously satisfying. When intrinsically motivated, people perform activities because of the positive feelings arising from the activities themselves. This was linked with increased emotional wellbeing (Deci and Ryan, 2008). Extrinsic motivation, in contrast, involves engaging in an activity because it leads to some separate consequence. The clearest examples of extrinsically motivated behaviours are those performed to obtain a tangible reward or to avoid a punishment (Deci and Ryan, 2008).

Importantly the latest developments of SDT have focused on how social and cultural factors facilitate or undermine people's intrinsic motivation, in addition to their wellbeing and the quality of their performance (Ryan and Deci, 2006). Conditions supporting the individual's experience of autonomy, competence, and relatedness are argued to foster the most volitional and high quality forms of motivation and engagement for activities, including enhanced performance, persistence, and creativity (Ryan and Deci, 2000; Deci and Ryan, 2008).

Conclusions

In this chapter I presented the findings related to the individual dimension of staff working in the FMU. The findings have led me to explore how Self-Determination Theory (SDT) could shed light on some of the categories which emerged through the data analysis.

The philosophy embraced by the FMU staff was grounded on a physiological and social model of birth in which intervention had to be justified and the midwife was seen as an expert facilitator. There was also a clear understanding and recognition of the woman's autonomy and the principle of partnership in decision-making were followed.

Appropriate clinical skills in supporting physiological labour and birth, communication, providing information and being able to offer personalised care were cited by both midwives and MCAs as key skills for staff working in a FMU environment.

Having time to dedicate to women and one to one care was a precedent to the creation of mindfulness which midwives directly linked to safety and previous research has linked to psychological wellbeing (Brown and Ryan, 2003). This will be further discussed in chapter 11.

From what emerged from the analysis of the data it could be argued that the FMU had a positive impact on the staff at a personal psychological level.

Many of the categories and concepts which emerged were related and reinforced what has been theorised by Downe (2004) as 'salutogenesis' and Walsh (2006) as 'social capital'. I argue that the working environment created a positive feedback loop of salutogenesis and social capital which was self-sustaining if the pre-requisite conditions were sustained.

Chapter 9- The organisational dimension

Introduction

Schein (1985) has argued that organisational culture consists of three dimensions: assumptions, values and artefacts. Assumptions are widely held, ingrained subconscious views of human nature and social relationships that are taken for granted. Values constitute the basic foundations for making judgments and distinguishing “right” from “wrong” behaviour. Artefacts are the more concrete representation of an organisational culture and include rituals, slogans, and traditions as well as material objects.

In this study, I have analysed the FMU team culture following this structure, as it is pragmatic and simple to discuss with NHS staff.

When speaking about the team philosophy I refer to the system of assumptions shared by the team and taken for granted. I will refer to the team’s values, which guided the FMU’s staff behaviours and artefacts which were observed during the fieldwork.

Team values

Schein (1985) defined values as the basic foundations for making judgments and distinguishing “right” from “wrong” behaviour. The analysis of the data has revealed 11 core values, which guided the behaviour of the FMU staff. These team values would be shared and passed over to the new staff joining the team via a process of socialisation to the FMU ‘way of working’.

Table 41- The team values

The team values:

- *Shared vision*
- *Openness*
- *Power balance*
- *‘Work should be enjoyable’*
- *Mutual support*
- *Supporting learning*
- *Building relationships*
- *Listening to women*

- *Partnership in decision-making*
- *Family friendly*
- *Open door policy*

The FMU staff felt strongly a sense of contrast with the culture experienced at the obstetric unit, in which they felt they were victim of bullying and hierarchical relationships. This resulted in high levels of stress and a lack of wellbeing:

'I think the longer you are in Labour Ward, and I really am glad I left when I did, and I could have left much earlier, was that I think it's quite corrupting being on Labour Ward. It doesn't matter how lovely you are, [laughs] how nice you are how much you try... You're so tired and so physically stressed by, watching abuses or being abused or being spoken to in a way...' (BC15-MW-F-INT).

This participant stressed the opposite socialisation which occurred on the busy labour ward where she previously worked, where despite her willingness to be 'nice' she was pressurised to conform to the team philosophy and culture.

Shared vision

There was a strong sense of the need for a shared vision among the staff, particularly those, who joined the team when the FMU first opened:

'I think when we opened the birth centre all the midwives that we used to work here we had an approach like "this place need to work we need to offer good choice, opportunity for the women" and it was everyone working towards that goal' (BC10-MW-F-INT).

The sense of shared vision was still strong in 2011-2012 when the data was collected:

'We all sing from the same tune, we are not singing from a different tune ...' (BC3-MW-F-INT).

Another midwife said:

'...it was nice and for the first time as a midwife and everyone had like the same philosophy it was like "yah" even doing simple things like a tour for the women who wanted to have the baby at the birth centre and it was like "ooh yah lets show her the rooms." It was really nice at the beginning; really good team everyone thinking about the same. It was a bit chaotic because everything was new, paper work and it was tiresome, but very nice' (BC2-MW-F-INT).

The essence of the shared vision was to offer family-centred holistic care based on a social model of midwifery rather than a medical model:

'We are all different people but we all have a very similar feeling that labour is a natural part of life and that is not a medicalised thing and that does sort of... aah, aah what's the word am looking for? It does come out in your practice. So although we don't work the same here we do have a very similar attitude you know we are all very women focused in a way and not focused on the labour as much' (BC6-MW-F-INT).

All the midwives interviewed as well as the maternity care assistants consistently expressed a strong shared vision based on personalised care.

Openness and power balance

The midwives described 'openness' among the FMU staff and towards service users. This meant a lack of defensiveness among staff, who were open to discussing, learning and service user's views:

'...[At the hospital] here's that attitude of having to know everything and an unwillingness to learn new things whereas I think we're all very open to learning, well maybe not even all of us but, the majority of us are open to learning new things and are able to be told, not necessarily that we've done something wrong, but where we could improve on something and I feel comfortable...' (BC18-MW-F-INT).

This openness linked directly with the concepts of power balance and being 'against hierarchies' which had implications for the way the leadership of the FMU was enacted and the workload was shared:

'there's never... you know, well there's six jobs two midwives so you know, you take five I'm going to take one you know, cause I'm Band Seven and you're Band Six you know there's never... there's none of that its all um you know, I'll take half and you take half and you know we'll get through this together' (BC31-MW-F-INT).

The midwives could always count on having support from their FMU colleagues and I often observed during my fieldwork cases in which a midwife would return from a transfer frustrated because of the way she was treated at the obstetric unit during transfer as a result of interaction with ambulance staff or somebody at the obstetric unit. A newly qualified midwife commented:

'There is a good relationship with everyone who works together. It's very welcoming ... It's nice to know that I have got people that I can ask questions and people are approachable. I know I can approach anyone and that way I can learn and the things that occurred at the hospital I can share when I come back here. That's really nice. And there is less of such a hierarchy and I know that I can have a chance to speak to anyone that is really good' (BC4-MW-F-INT).

Within this power balance the concept of woman's autonomy was clear to staff:

'...Letting women know that it's their birth and that they don't have like um... and it's all the information we give at the beginning as well like, the 36 weeks appointment that give women a lot more um, information on what to expect, because we're telling women that we're expecting them to take control of their birth um... (BC32-MW-F-INT).

For many midwives working at the FMU consisted in a fundamental shift in the power relations with the women:

'Now I feel more satisfied because I now realise, you know the woman is actually she'll actually be the leader, because it's about her, it's about her pregnancy, but the fact that I am able to support that, if there is an agreement about her Birth Plan that gives me satisfaction' (BC13-MW-F-INT).

Student midwives were supported in perceiving the different approach to care and power relations by the midwives at the FMU. The following vignette exemplifies how this transition was managed in one of my participant observation notes:

Shift 1-27th April 2011- Lucia Rocca-Ihenacho's observational notes

Maria looking at Jose: 'does this look like a sound plan to you? we would not need to need anything medical for a while, we will let you move around and see what happened within a couple of hours.

Maria to Jane: 'At this point there isn't a reason to do an internal examination as contractions are not regular yet. Is that ok for you? If you prefer me to do an internal examination I can do it but I just don't think it is necessary right now ' Jane agrees to wait.

Jose asks: 'how do you know when is the right time for a woman to get in the pool as I was told she needs to be at least 5 cms?'

Maria replies: 'there isn't a rule about this, it is a matter of what is happening for the individual woman, if she is 3-4 cms and her contractions are irregular perhaps the pool could slow things down but if she has very strong contractions things will just keep happening. It is also a matter of how she feels, sometimes women will benefit from getting in the pool early just to relax and get some rest'.

Jane's husband Mark arrives. Maria and Jose introduce themselves to Mark, discuss the findings again in Mark's presence and answer Mark's questions.

Mary to Jane and Mark: 'We are now going to leave you for a while and go to the office to write the notes, if you need anything you can call us using the bell, but we will be back just in a few minutes anyway'.

I stay in the room as Maria and Jose leave the room.

I really like the way Maria has helped Jose to focus on relational elements and building rapport rather than only on clinical aspects. She is doing it in a very friendly and open manner. She has also demonstrated to Jose a great example of 'partnership in decision-making'.

Figure 29- vignette with observational data on 'openness and power balance'

This approach of 'openness' was also discordant with the practices in the obstetric unit described by several midwives:

'But here I find that you give information and then expect a response back from the woman you know. In situations like vaginal examination, when I was in the hospital you just meet the woman and that's that I have to examine you, there's you know there's no other way we really need to do it. You know the approach is the woman cannot even say no, because, generally I see people presenting it as if this has to be done. But then at the Birth Centre I realised, women still have options' (BC13-MW-F-INT).

The observational data mostly confirmed what emerged from the interviews in terms of a shared philosophy among the FMU team, which emphasised power balance and openness. This was certainly the case when I conducted the first cycle of data collection. During my data collection in 2012 the observational notes point towards inconsistencies in care as described in the vignette below:

Shift 11- April 2012- night shift- Lucia Rocca-Ihenacho's observational notes

2030- Polly is the senior midwife on shift. She is one of the community midwives who have joined the integrated team.

2100-Susan, a 'cockney' British woman having her second baby arrives back to the FMU after having been sent home during the day as in latent phase. Polly is not really engaging with the woman and offers a VE straight away without really building rapport, she simply tells Susan that she needs to examine her.

2130-Susan is 7 cm dilated and is cracking on but Polly keeps leaving me alone in the room with her, the birth centre is not busy, I am not sure what she is doing.

2230- Susan is clearly transitional, I call Polly and tell her that the birth is imminent. She comes in but leaves again to fetch equipment.

2245- Susan is pushing involuntarily and the midwife is still in and out all the time. She finally comes in as Susan is about to give birth. She then proposes active management of the third stage without any discussion. She has assisted the whole birth telling the woman what to do or not to do.

Figure 30- vignette with observational data on lack of 'openness and power balance'

During the second wave of data collection, I noticed several similar episodes in which the midwife's behavior was strikingly different from the typical behaviours which I had observed in early 2011. These approaches to care were particularly associated to midwives who joined the team after the integration and arrived after years of practice in the community. During interviews, some of those midwives disclosed a sense of fear and expressed the need for training. They explained that they felt particularly out of touch with intrapartum care as they did not have any intrapartum experience for several years while in the community.

Building relationships and enjoying work

It was common for staff to stay over their shift to chat if the workload allowed it and it was normal for midwives and MCAs to socialize outside work.

The environment also played an important role in facilitating socialisation between staff and service users:

'I found it more approachable and you come in the door and there is an area where staff sits and eat and talk as well as the women and their family, that was quite great and interesting and even when you come in everyone greets each other, lovely, and the women and midwives talking to the families and the women as well as they know them and they have already built that relationship. I think that was great' (BC4-MW-F-INT).

Many of the participants interviewed described the joy of working in a supportive environment and being among supportive colleagues:

Uh huh. Um... I think there is a strong culture about being nice to each other and wanting to enjoy the workplace. So it is quite common to stay way after you have handed over to chat about what happened before um, and that's, I would say, shared by everybody and the idea that you go to work and you want to create an environment which you enjoy and it's nice to work in as opposed to the hospital where it's a little bit the opposite. Um, there is almost this idea of having to be... you know, 'You have to be hard,' and you criticise each other etcetera. So I think that's one of the first things I would say that you, you, you know, it's normal, you go on shift, you hug and kiss everybody and you have a slice of cake together. That's, I would say, the first thing that you notice when you arrive there um' (BC0- MW-F-INT).

Several midwives expressed the joy they have found working at the FMU and the rediscovery of the passion for Midwifery:

'And I took up that opportunity and up until today I love working there, I love what I do. It gives me the chance of providing midwifery care. And seeing women taking up those, empowering women to do what they are supposed to do when in labour have actually given me lots of joy because you can see that this is proper midwifery' (BC3-MW-F-INT).

The extract below from my observational notes offers a snapshot about staff's relationships at the FMU. The dynamics described in the vignette below refer to a typical day at the FMU when it was quiet.

Shift 4- June 2011- SATURDAY 0800-1730- Lucia Rocca-Ihenacho's observational notes

It's 0800 on a Saturday, the birth centre is very quiet. The two midwives and the maternity care assistant from the night shift are about to go home and they are chatting in the reception area.

The day staff arrive. They are smiling and are greeted by the night staff with hugs and kisses.

Julie (midwife) says: 'we have kept it quiet for you guys' a mw says. But a riverside midwife is off sick and you will have to cover for her clinic.'

The day midwives are in the kitchen and the hand over happens over coffee and croissants brought in by a day shift midwife. There are two women in early labour, who are still at home (one of the midwives knows it all already as she was working also the previous day). Carol (midwife) says that one of the women in early labour has called earlier on during the night, but not for the last 6 hrs, maybe the contractions have stopped.

The night staff leave by greeting warmly everyone.

The day staff start organising the day: there is a clinic in the afternoon and in the morning, we have 2 bookings to cover for the midwife who is of sick. At 900 the riverside midwife arrives and greets everybody, a student mw arrives as well.

Figure 31- vignette with observational data on 'building relationships'

In other occasions when it was quiet I observed the whole team having lunch together, other times they would use the time to rehearse 'skills and drills' for obstetric emergencies or they used the time to catch up with data entry for the FMU audit.

Many of the midwives who worked on both the obstetric unit and at the FMU said that the approach to work among the FMU was strikingly different from the obstetric unit. They were making an effort to support each other and they did not show a concern if the workload permitted it to sit down and relax for a while.

Both students and new staff joining the team were visibly uncomfortable with this at the beginning as had been previously socialized in a very industrial model of care.

On the other hand, if a woman or a relative arrived at the FMU while on a break or having coffee, I witnessed personally how staff would immediately attend to offer help. The management of time was led by the workload rather than by organisational rules.

Rapport and continuity of care:

The data points to two separate concepts already discussed in Chapter 8: building a rapport, which implies the development over time and establishing rapport, as the communication skills of ‘tuning in with the woman’. The FMU included a combination of the two as the model would not guarantee building a rapport over time but most of the midwives were skilled at establishing rapport and moreover they shared philosophy and vision.

‘Aah I had one very nice night shift when I met a lady a night before and she was in very early labour and I sent her home and she was someone I had also met before at the clinic at 36 weeks and I managed to build something good and then she came back just before my shift started and I had to look after her and she had her baby very quickly in the water when I came... And the fact that I had met them before as well, it was really nice and she did not have any problems at all, she came out, she did not need any suturing and then I spend some few hours just helping her to breastfeed’ (BC4-MW-F-INT).

The midwives often acknowledged the benefits of having been able to build a rapport over time.

A few midwives in the interviews referred to some specific cases in which having known the woman from the antenatal period was particularly beneficial for them as midwives:

‘I think the woman can relax when she trusts you already hopefully. So well for example the woman who was hypno-birthing and her partner was telling her “don’t push don’t push” I have known her throughout her pregnancy and she wanted everything to be natural including physiological third stage but she bleed quite heavily and I said to her need to give you syntometrine and the partner said “no! No! We don’t want that. That’s not part of our birth plan.” And the woman said “I know (mw name) and if she says we need that then we need that.” Then I was just saying “okay thanks goodness (laughing)” (BC1-MW-F-INT).

In many cases there was a mixture of continuity of care and carer because, despite the fact that the FMU model was not a caseloading one, especially before the integration of the community midwives, the team was relatively small (11 midwives).

‘But they feel that well, the midwife is there to support because they have got lots of information. And midwives by the time the woman comes into labour, they go through their birth plan as well and the midwives know what the woman wanted. They all sing from the same tune, we are not singing from a different tune and most of our women we know them before they come in labour at the birth centre. So we make that relationship that makes you to say yes I feel comfortable with that person that is gonna look after me’ (BC3-MW-F-INT).

Staff perceived a model in which continuity of carer was possible as the ideal. Midwives already working in the birth centre expressed mixed feelings regarding the recent integration of the local community midwives with the FMU as for some women this facilitated continuity of carer, yet in other cases it made building a rapport more difficult because of the large team of 19 midwives.

Mutual support, sharing and supporting learning

Many of the midwives joining the team expressed very positive feelings regarding the way in which they felt supported in joining the FMU team, especially in the first wave of data collection in 2011:

‘So it was so nice that I was able to give her that sort of care that she wanted and I was supported by the other midwife as well...’ (BC4-MW-F-INT).

A midwife who first experienced the FMU as a student midwife highlighted the importance of learning in a relaxed environment:

‘Opportunity for normal birth in a more relaxed environment definitely, because when you are learning and you are relaxed you actually learn more, you actually remember what you could do, that is brilliant’ (BC4-MW-F-INT).

Surprisingly, when asked about what had been the most challenging aspect of the FMU practice when they joined the team, the midwives almost unanimously said ‘the way birth centre midwives talk to the women’. They explained that the approach to information giving was completely different from the hospital as there was a lot of information to give and the pros and cons and alternatives to treatment needed to be explained.

Sharing top tips of the midwifery tricks that worked was usual and the midwives would get really excited about that:

‘Ah, you know what I’ve done? I’ve used this trick and it worked,’ and you have somebody who actually sits there and listens and is excited as much as you are. So the idea of sharing knowledge and what worked was key...’ (BC0-MW-F-PART2).

Many midwives felt they had to not only to develop their knowledge in order to be able to provide the information, but also had to improve their communication skills.

‘My first impression is, I felt to be honest a little bit out of my depth because I was so used to high risk care. Although this is what I wanted to do I did not have a lot of experience to talk to women in the kind of ways that the midwives did here. So I felt that I have to learn a lot and I worked alongside the [established] midwives to start with. I was just listening to the way they were with women and I felt that I learned a lot from them. But to start with I find it was a big change because there was a lot more choice for women and information giving than what I have seen in the other hospitals before’ (BC1-MW-F-INT).

Some midwives explained that they had previously practised without really thinking about the potential iatrogenic harm caused by interventions, but since arriving at the birth centre they had become more aware. In summary, many midwives believed that:

'At the Birth Centre this is when I really learned how to be a midwife' (BC16-MW-M-INT).

Unanimously the midwives referred to the learning that had characterised their practice at the FMU:

'I am really happy that I came here to work because I feel like I learnt so much about midwifery from being here you know and midwifery not in a medicalised way but in a 'with woman kind of way'. Here it is a bit more relaxed and a bit more you know we are able to actually observe things rather than I think just going and get it done' (BC6-MW-F-INT).

The midwives shared a 'wait and see' approach in which the woman's wishes were at the centre of the care.

The following table summarises what midwives mentioned during the interviews as the key areas in which their practice had changed once they had joined the FMU team.

Table 42- Midwives' change of practice since starting to work at the FMU

How has your practice changed since started working at the FMU? • <i>How I talk to women</i> • <i>The information I give</i> • <i>I see them as a whole person</i> • <i>I am able to provide more emotional support for women</i> • <i>I have learnt the 'active birth principles'</i> • <i>I offer women choices</i> • <i>I have discovered 'real midwifery'</i> • <i>I do not intervene unless really needed</i> • <i>How to deal with obstetric emergencies</i> • <i>Work gives me joy</i>

Midwives and MCAs were supported in developing their skills in dealing with obstetric emergencies:

'At the Birth Centre we have a pride of developing people... staff's skills so if you have a mild case of neonatal resuscitation to deal with you would ask the junior midwife to do it and you stand back and you watch her doing it and um... and when, if there is a quiet night, I would go in a room, set up for skills and drills, not tell anybody, ring the bell like it's an emergency and ask them, 'Ok, right we have a shoulder dystocia, what do you do?' and you involve the maternity care assistant' (BC0-MW-F-INT-PART1).

The following table summarises the key practical skills developed by the midwives during their practice at the FMU.

Table 43- Practical skills learned since arrived at the FMU

Practical skills learned:

- Talking to women and facilitating choice
- Assessing without necessarily doing a VE
- Waterbirth
- Supporting women without pharmacological pain relief
- Second stage following women's urge to push
- Birth in different positions
- Physiological third stage
- Facilitating an active birth workshop for women and birth supporters
- Dealing with obstetric emergencies in an autonomous manner

A midwife who originally did not apply to work at the FMU and later joined the team said:

'It was more of a safety thing that's why I didn't apply because it was an opportunity for everybody to apply when it was going to be opened. But I had that feeling that ooh off site. Would it be safe? That's why I didn't apply. But it became to be a different story when I went to do some shifts there and ever since I have been there I have actually seen that midwifery and labour itself is not actually high risk...' (BC3-MW-F-INT).

Despite not applying to become part of the core team at the FMU, because of fear of out of hospital birth, this midwife covered a few shifts as a bank midwife:

'...as a student I was never exposed to normality it was all hospital...' (BC3-MW-F-INT).

Once she was exposed to the FMU practice and environment she felt ready to work there:

'...You see in the labour ward how things can change from normal to abnormal in few seconds and that's actually what put me off. But when I went there, when I was exposed to it... the exposure, the knowledge, the support, and the knowledge of people that have been working there before, they know the philosophy of normality. Actually that helped me to adapt into that kind of setting' (BC3-MW-F-INT).

Reflection was seen as a key tool to improve the FMU and one's practice:

'...Reflecting on things all the time, I think that reflection has been a very important part of my learning' (BC9-MW-F-INT).

'The handover is more well... like telling a story so you say like, 'You remember that woman who, she came three days ago in early labour and this and that,' and I think that's how you learn. You learn by... you know what happened at the beginning and then you see, somebody tells you the bit in the middle and... So you see it makes sense whereas in the hospital you only do the bits and pieces... I remember I used to call the labour ward midnight to see how my woman was getting along and they felt I was feeling guilty, I've done something wrong

because I was phoning because it was not normal to phone to check what happened to your woman and I feel that's really sad' (BC0-MW-F-INT).

During the second wave of data collection, however, many of the band 7 from the first team had left because they did not feel involved enough with the strategic planning of the FMU and involved with decision-making regarding the organisation of the FMU (personal communications). Those who left were substituted partially by band 7 midwives from the community who were not feeling confident with their intrapartum skills:

'From my point of view I think that would have been better for me and I really did feel quite um... not demoralised but... not quite as strong in my intrapartum skills as probably I should have been. But only doing home births and our home birth rate has dropped quite dramatically over the last few years, so probably not quite as skilled from the intrapartum point of view as I needed to be' (BC20-MW-F-INT).

As discussed later in this chapter the FMU went through a transition which caused some instability because the pillars sustaining the philosophy, knowledge and practices within the FMU were missing.

Listening to women and partnership in decision-making

Listening to women and personalised care were described by the following midwife as an essential part of the FMU culture:

'So I guess I possibly listen and think about what is best for that particular woman more than I did at the hospital' (BC1-MW-F-INT).

The approach to partnership in decision-making was described as a partnership in which, having established rapport first, a sense of trust between the woman and the midwife and emotional commitment, the midwife offered information to the woman and discussed options including pros and cons of different possibilities. The autonomy of the woman was respected but the partnership element meant that there was support offered by the midwife to facilitate a personalized plan of care:

'I present the information in the most objective way, that I can in the light of what I know and then I truly have an open conversation not hiding and trying to push the woman's opinion from one side to the other unless it is an emergency situation in which the priorities change; but in normal circumstances I really try to be quite open and honest about the information and what the options are and I try to be clear as possible and then I allow the women to have their time and to think about what they want to do' (BC7-MW-M-INT).

During the fieldwork, I witnessed this process of partnership in decision-making regularly with only few exceptions, which were associated with midwives coming from the community.

Family friendly, the environment and an open door policy

The data suggested an interaction between the physical environment of the FMU and the organisational culture. At the Barkantine birth centre such interaction created positive synergies.

Being a purpose built FMU, there had been particular attention at the planning stage to ensure that the environment was friendly and relaxing:

‘Well they (the steering group) wanted an environment, which was more familiar, so in terms of having the clinical items tucked away, kind of home to home environment. Also they were very clear they wanted the place to have a social model of midwifery care which is also represented by the environment so it was for instance, designed that way so you had the entrance with the sofas and the common area’ (BC0-MW-F-INT-PART1).

The environment was designed on purpose to break the division between staff and service users:

‘Also the idea that you don’t have staff’s places and patient’s places you know, the kitchen is in common, the staff sits and eats in the common area in front of everybody, there isn’t this idea that it’s actually unprofessional to eat in front of the patient, you know, I have a tea, I bring a tea to a woman, we all sit there having a tea, that’s considered normal, which is something that you do at a homebirth but somehow, I don’t know why, in a hospital it is considered unprofessional’ (BC0-MW-F-INT-PART1).

The FMU staff embraced the idea of being family friendly and having an open-door policy:

‘I feel that here we, we welcome everybody, we work with the family and it’s just... it’s much more comfortable for everybody’ (BC20-MW-F-INT).

The implications were a lack of regulation of visiting times and the number of birth supporters that women could have. This is evident by the words of Amina and her husband (British Bangladeshi):

‘Yeah because they, because the room was bigger and they let my family next to me as well, which helped. Usually in hospital they don’t, they just let one person come in...’ (SU32-W-BC-INT-PN).

Amina’s husband said:

‘That was important for me as well. I get more relaxed when I have our own people like, next to me. I don’t need to be scared or anything. But in the hospital, you can’t take more than one people’ (SU31-BS-M-BC-INT-PN).

Women and their family gave feedback about the positive impact the environment had on them as soon as walking through the door of the FMU:

'The reasons why we choose the birth centre is because of the cleanliness and the one to one support that you get from the midwives and the staff here, very homely environment and kind of more peaceful place to be than the buzzing of the hospital. It's just more comfortable and more relaxed' (SU8-W and SU9-BS-M-INT-AN).

Also the staff recognised the paramount role the environment played:

'I think that, first of all it's the environment, it's a calm quiet environment um, the women are made to feel comfortable. The rooms are non-clinical um and the partners are welcomed in to stay. They're allowed to go into the kitchen and just straight away it's just they're able to relax' (BC18-MW-F-INT).

The midwives explained that the design of the rooms helped:

'Because here at the birth centre we don't have labour beds as such... May be if the bed was the sole centre of the room it might be different but here you can't really lie on the bed I means it's just a normal double bed. And women that I have seen that come here they generally want to walk, they want to mobilize, they want to mobilize, they want to do anything that feels natural to them' (BC6-MW-F-INT).

The design of the environment coupled with the openness of the staff and a philosophy which established a power balance on purpose, led to the creation of an 'open door' culture, which was enjoyed both by service users and staff.

Shared leadership

The FMU staff described how the leadership model of the FMU had been through several phases. Particularly the midwives and MCAs who were part of the original team at the FMU, referred to a model of shared leadership among the FMU staff. This was considered possible at the beginning because the FMU was a 'blank canvas' and because of the lack of presence of a manager based at the FMU:

'We didn't have a manager at the beginning well we had the labour ward manager but she wasn't there, but in a way it was good we had the opportunity to manage the place how we actually liked and many of the guideline they were not many but just a few guidelines were changed and we did try to improve at the birth centre and it was like your ideas that they were going to be used' (BC10-MW-F-INT).

Many midwives described how the shared leadership at the FMU shaped the culture within the team and most of the new midwives joining the team in early 2009 described this, particularly as a sense of support by the senior midwives:

'Well within the midwives attitudes for me the most important element is the, the support that you get from your senior midwives' (BC2-MW-F-INT).

A midwife who was originally sceptical about moving to the FMU had eventually totally embraced the concept of shared leadership:

'When I was there [at the OU] it was ok, I was happy but then, when I got to know the Birth Centre and how we work here, um I realise how bad it is at the hospital and here at the Birth Centre one of the things that I really enjoy is that you really get the sense of working within a team. We encourage everyone to you know to have initiatives and make decisions and to have ideas about how we can improve um, the team, so you really get the sense or the feeling of you belong to the team.' (BC16-MW-M-INT).

The vignette below exemplifies one of the shared decision-making regarding how the organisational model of the integrated team was developed. The team tried several ways of managing the integration between community activities and the FMU. The decision to change the shift pattern was not made centrally by senior management but actually arose from the junior midwives from the FMU.

Shift 3- Team meeting May 2011- Lucia Rocca-Ihenacho's observational notes

It is 9 am and the meeting starts in the community midwives room next to the birth centre office. The chairs are organised in a circle and there are 5 midwives. One more midwife arrives half hour later.

The integration of the Barkantine Birth Centre with the Riverside community team has happened and the team is trying out different ways of working and organising the workload.

Until now they have been working 7.5 hours shofts (9 am to 5 pm) in the community and long days at the birth centre (8am to 8 pm).

The midwives working mainly in the community (the more junior ones) are not happy as they feel that there is a lack of skill-mix and the workload is not shared equally. They also feel their work-life balance is not working as they work 5 shifts/week plus two on-calls.

They say that there should be more equal way to distribute the work and for the junior, who also need to get more intrapartum experience, to be more at the birth centre.

It gets agreed that the community shifts will change to long days and there will be clinics running in the evening. The team meeting room will be transformed in an additional consultation room, so there can be 2 clinics running at the same time.

All the midwives participate in the discussion and there is a 'can do' attitude. They are discussing issues in a pragmatic manner, trying to find workable solutions.

Figure 32- vignette with observational data on 'shared leadership'

Many of the midwives who were part of the team in 2008-2009 referred also to the shared leadership in terms of the allocation of leads to several FMU activities such as antenatal education,

continuous professional development, infection control, audit etc... The midwives explained how each midwife volunteered to become the lead for an aspect of the everyday running of the FMU and that plans and actions would be agreed at the monthly FMU team meetings.

The need for a stable core team

The need for a 'critical mass' of midwives and MCAs sharing philosophy, knowledge and skills was mentioned several times during interviews and during the fieldwork in personal communications. The team had struggled to maintain its stability, in terms of retention of midwives, from the very beginning when within three months from the opening of the FMU three midwives resigned in sign of disagreement with the way the FMU was being managed and especially a 'controlling' management style:

'...I think the team felt that quite a lot [under scrutiny by senior midwifery management] in fact after six months, three very experienced midwives, as a sign of protest, they actually quit the job, they went somewhere else. Um, and they wrote this very strong letter to the head of nursing saying that you know, the management was crap and it was felt that they were always under scrutiny, there was no independence for midwifery practice and everything was medically dominated etcetera, etcetera' (BC0-MW-F-PART2).

The issue with staff retentions was therefore directly linked with poor midwifery leadership rather than stress caused by workload or working in a FMU per se.

'... With the lot of coming and going of midwives ah, part of it can be difficult to maintain if you don't have a critical mass of people who all share the same view, if you start having two or three that work in a different way then you start seeing the difference. So I, I've noticed recently few things that make me jump a little bit because it's like... Um, you are sitting having a tea, a woman is coming through the door, it is totally unacceptable for us that you don't look at the woman because you are on your break. So you are officially off and you don't care [laughs] you know, for us that's... you would not see that whereas perhaps some of the new staff arriving...' (BC0-MW-F-PART2).

And another senior midwife from the team:

'They [new team members] need a lot of supervision and um... This is why when the manager comes and says, 'Oh, we are going to get 10 new midwives to take over the Unit,' [laughs] and I'm thinking, 'What?' You really need sort of the... the... the sort of um, balance don't you? You need the senior people who have got good knowledge and skills to support [the junior staff]' (BC9-MW-F-PART1).

The issue was particularly perceived as a lack of retention within the senior midwives' group:

'...and then of course, as there has then been movement we haven't... it's not gone out as like external adverts or like, as set adverts, it's been very much internal, 'Who would like to move?' and some of that is good to help

to assist but yes, if you then have a lot of that movement at your senior level, at your Band Seven level here then there is that dilution when actually they're needing that support and that nurturing so how are you going to then nurture and develop the Band Sixes... (SH6-CM-F-INT).

The retention of staff within the team was such an issue that by the end of my data analysis (2015) there was only one midwife left from the original team in 2008.

Service development, integration (with the community midwives), balanced workload and sustainability

The team tried different models of care in order to find a balance between the amount of workload and avoiding switching towards an industrial model of care. Having a balanced workload was seen as essential. The plans for the FMU were to gradually increase the number of births over the years to a maximum of 500 births. The FMU steering group was clear that the FMU should not fall into the assembly-line mode of care but still be financially viable:

'...you know being able to keep the birth centre not being a baby factory and being really so special by having a fantastic birth experience. So that's a possible concern and I just don't know but what I know about what are ideal models were in terms of numbers of births versus size of the team so that's a possible concern. However, if the numbers have to go up a bit in order to keep it financially viable I think that will still be the best outcome and I think it would be relatively easy to get more people to use it. (SH2-BC-SG-F-INT).

In 2011 with a change in senior leadership roles, the focus changed towards on increasing the number of births. The FMU manager said:

'You know there are plans that really 600 is I think the maximum number of women that we could accommodate there and I don't think there's any plans to try and increase above that but I think it is realistic to have about 600 births and 600 births is about 50 births a month um, and at the moment we've been sort of around 45, 47 something like that so... and that has been um, been achievable' (SH1-BC-F-INT).

With an increased number of births a new integrated organisational model was introduced as the FMU manager explained:

'I think making the changes to becoming an integrated model has, has made it much more sustainable um, it makes it much more... seem much more financially um, viable because of the um, kind of combining of the Birth Centre with part of the community activity' (SH1-CB-F-INT).

With the increase in activity and the move towards an integrated model with the local community midwifery team, however the midwives felt this balance was sometimes lost:

'You constantly rush through. You feel like you are rushing through the women and sometimes you don't want to engage too much in case they need to give you more information that's personal stuff as well as medical stuff. It is horrible but you don't have the time' (BC5-MW-F-INT).

Another midwife pointed out that with the integration with the community midwives, there had been a lack in training and many midwives were not able to offer effective evidence-based information on place of birth:

'I mean, this is just one episode, the other day (woman's name) went out into the community and she came back and said there were so many women, they all knew about the existence of the Birth Centre, but they didn't have any discussions in terms of helping them make a choice' (BC9-MW-F-INT-PART1).

With a sharp increase in activities which now included community midwifery service covering the whole Isle of Dogs peninsula and further afield (covering the old Island midwifery team territory) the midwives could not dedicate any more time to activities such as antenatal workshops or birth centre tours, which were key services for marketing the FMU. Additionally, activities such as team development activities or team building time were discontinued. The unit tour, which was traditionally led by experienced midwives was handed over to junior maternity care assistants without substantial support. This, in the view of several FMU midwives, was partially responsible for the decrease in bookings at the FMU:

'Like for example for a long time now I've been saying, 'Look, we need to become a little bit more involved in the tours.' I mean I had a woman who came to me and said, 'I had this very young girl reading to me off a sheet of paper.' [laughter] 'And that wasn't going to convince me to use the Birth Centre'(BC9-MW-F-INT-PART1).

Some suggested the need for more strategic planning on how to promote the FMU:

'So I think there needs to be a much more um, business plan and promotion of the Birth Centre if we want it to become very strong and um, stable. Because otherwise... and there is this very annoying talking all the time behind scenes a little bit about 'Oh well, at some point the Birth Centre will close' (BC0-MW-F-INT).

Among service users there was surprise about how little the FMU was known among the community, despite having been open for 3 years:

'They didn't tell, even like this time when my little one is born, they didn't tell about it. Suddenly I remember when one of my middle one was born the midwife came and I complained to her that I wasn't happy with the hospital then she said to me, 'Have you ever heard of the Barkantine?' I said 'What is that?' and she say like, 'That's a Birth Centre as well. You should go and see them, you should use this one' (SU31-BS-M-INT-PN).

The team struggled to invest time and energy to develop a strategic plan for increasing the number of births at the FMU. The FMU midwives also felt quite strongly that a FMU should be evaluated in terms of activity not just for the number of births but also for the primary care services provided.

They were instead facing a daily scrutiny by the obstetric unit based on the intrapartum activity only. Midwives were regularly pulled from the FMU to the labour ward, if there were no women in labour.

The vignette below with observational data reports of the tension between the FMU and the labour ward coordinator.

SHIFT 4- June 2011- Saturday 0800-1730- Lucia Rocca-Ihenacho's observational notes

The Coordinator from the labour ward calls asking the name of the birth centre midwife on call.

The BC senior midwife asks the reason for that and the coordinator says that they are busy and need to 'call her in'.

The senior midwife from the FMU replies that the birth centre on call list is for the birth centre or for homebirth, not for the hospital and that they have a midwife off sick. He suggests call the community midwife on call as they don't have any homebirth booked. The labour ward coordinator raises her voice and becomes aggressive. I can hear it from being sitting next to the midwife.

The senior midwife from the FMU replies very calmly but with an assertive voice: 'I am listening and I am telling you that it is not the correct way of escalation, you have to call the community midwife first.... Why don't you send a group pager, asking who is on call in the community? We have two women in early labour and we have to cover for a midwife's clinic as one midwife is off sick'.

After the phone call the senior midwife laughs and says that is always like that, they always try to take midwives from the FMU as if they did not have any intrapartum activity

Figure 33- vignette with observational data on 'balanced workload and sustainability'

The issue of 'being pulled' to the obstetric unit was an ongoing issue and towards the end of this study it was decided to staff the night shift with only one midwife.

The FMU steering group: a missed opportunity for community engagement and sustainability?

The FMU steering group had an influence in setting the vision and the objectives of the FMU, including expectations on strong monitoring of the workload, clinical effectiveness and women's

experiences. The steering group powerfully influenced the selection of midwives and pushed towards a social model of care.

The function of the original steering group, which worked on a voluntary basis, was to lobby for the creation of the FMU and that aspect was a success.

Once the FMU was opened the steering group started worrying about its sustainability:

'I suppose what are the risks to it? So you know, if [the NHS Trust] suddenly you know, runs out of money ...what's to stop the finance director or a bureaucrat saying, 'The figures don't add up, we can't have it.' That is a, you know, a nagging risk. Hopefully they would see that it would be political suicide to close anything like this but you know those are the sorts of questions, if you haven't got a support group protecting it and looking after it you know...' (SH4-BC-SG-M-INT).

For the first year after opening the steering group focused on sustainability and a celebration event was organised, which was very successful. However, not getting any support from the NHS Trust in terms of supporting its existence (actually quite the opposite) the team ran out of steam.

This member of the steering group described however how after the initial push and enthusiasm for the creation of the FMU, there was a missed opportunity as there was a failure to involve the community and increase the number of births:

'... I think that would be really good if you could have you know, an ongoing group of mums who have used the centre or mums and dads who have used the centre, clinicians, midwives, doctors, community workers whatever who are interested in marketing it, continuing to promote it and protect it um...' (SH4-BC-SG-M-INT).

Another member of the steering group commented:

'I think if the people with the passion are side lined which I feel it has been happening over the last couple of years you possibly don't capitalise on that energy because the next step needs to be built at the end with a lot of enthusiasm with the local community and you need people to sell the message who believe passionately and who have time and energy to go out there to Tower Hamlets and tell that this is all about it and keep doing it' (SH2-BC-SG-F-INT).

After the initial opening phase of the FMU the steering group had envisaged to introduce a community coordinator role, in order to lead the involvement of local mums and dads:

'One of the things that we did in the steering group in the past year or two was sort of design a possible paid role for somebody to sort of work on the community relations and publicity and public awareness because may be one of the struggles that we had is just keeping it going the and the initial job was actually to keep it going' (SH2-BC-SG-F-INT).

Unfortunately, the steering group was dismantled in 2011 and the idea of having this paid role never developed.

Interpretation

In the model below I illustrate the key landmarks of the FMU within the organisational dimension.

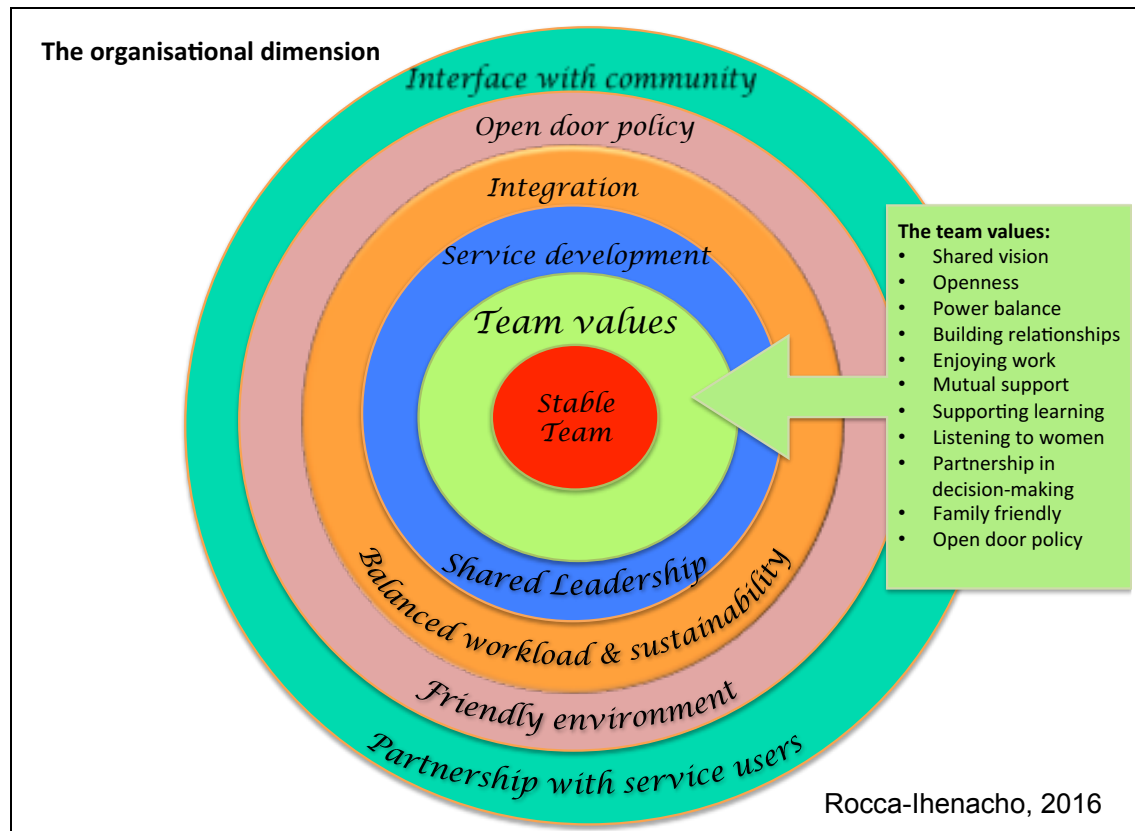


Figure 34- The organisational dimension of a FMU

The analysis of the data revealed 11 core values which guided the practices of the FMU staff. These team values were shared and passed over to the new staff joining the team via a process of socialisation to the FMU 'way of working'. The team however needed a 'critical mass' of midwives and maternity care assistants who shared philosophy, knowledge and skills in order to maintain the shared culture within the FMU.

Power balance was articulated both among staff by rejecting hierarchical division of work and by openness as well as with the women and their birth supporters via partnership in decision-making.

An enjoyable working climate was maintained by building relationships among colleagues and service users as well as by a culture of sharing and mutual support among FMU staff.

A focus on continuous development of the service was fostered with an everybody's business approach, particularly in the first wave of data collection, even if at times it was difficult to maintain due to what the midwives described as interference arising from a hierarchical NHS management approach that many midwives experienced as very controlling, in contrast with the philosophy of supporting more shared decision making with women and more shared leadership within the professional team.

Towards the end of my data collection a sharp decline of the FMU was noticeable. The integration of the community midwives without effective investment in training and development had caused a 'crisis' within the FMU team. Many midwives eventually left and the number of births declined rather than increased. The opening of the new Royal London Hospital site in April 2012 caused an increased decline in the number of births. During my data analysis in 2013-2014 several of the Barkantine midwives reported fear of closure of the FMU due to the continuous decline of the number of births (personal communications).

Conclusions

In this Chapter I have reported and interpreted the data on the organisational dimension of the Barkantine birth centre and examined the key elements of a well-functioning FMU from an organisational perspective. The importance of those key elements was not only highlighted by their presence in the first wave of the data collection, but also by their absence or decline during the second wave of data collection, which was associated with a decline of the performance of the FMU. In the next chapter I discuss the women's perspectives and experiences.

Chapter 10- The woman's dimension

Introduction

In this Chapter I discuss the service users' views and experiences. The group of service users represented the wide ethnic and socio-cultural diversity of the borough in which the FMU is located. Many of the women recruited and their husbands were British-Bangladeshi. Karen, a British woman who both agreed to be interviewed and her birth observed, was from a vulnerable background with a history of domestic violence from her current partner (Jim) who had mental health and anger management issues. This case represented well how FMU with a de-regulated system in terms of birth supporters can have a positive effect. In fact both mothers of the couple attended the birth and Jim's mother helped in keeping him calm and relaxed. The birth centre did not resolve the underlying issues, but certainly did not exacerbate them either. In a hospital setting things could have turned heated quite easily by a lack of personalised care and a tendency to a more institutionalised approach. Most of the British-Bangladeshi women strongly appreciated the de-regulated visiting times, which allowed the family to visit and bring food.

In this chapter I will examine in detail the key aspects of care which women and their families particularly appreciated, together with some dissonant data.

Establishing rapport and trust

The service users described how the midwives and other staff at the FMU were skilled in establishing a rapport, which made them feel welcome and at ease even if they hadn't met the midwife before.

Sima, an Indian woman who had her second baby at the FMU commented on the rapport that the midwife established quickly with her by listening, 'tuning in' and having a physical contact even if she had not met the midwife antenatally:

'...Because she knew you see like, as soon as she, she held my hand and I was pressing it and there was some kind of contact and she knew what I was feeling and she could see um, and that's when she knew that was a good time to go in the pool and I listened to her and then it happened really quickly after that so... um' (SU21-W-INT-PN).

Shazna, a British Bengali woman, who had her first baby at the FMU, commented about trusting her midwife:

'Yeah so, I felt because she was there with me during the labour I felt like I could ask her for help, um, if it was any other midwife I probably wouldn't have asked to be honest. I probably would have just struggled along sort of thing because he wasn't feeding, he hadn't fed for quite a while, I don't know why. So I asked (woman's name) and she you know, she helped me, she stayed with me for a little bit and she, she you know, told me what to do and you know, that felt really reassuring. Yeah' (SU10-W-INT-PN).

Need for continuity of carer

On the other hand Enrique and Maria a Portuguese couple expecting their first child, despite being really pleased with the care received at the FMU, acknowledged that having more continuity of carer would have made the antenatal care experience even more meaningful:

SU2-F: 'I would feel more comfortable [with the same midwife] but I don't have any bad experience until now even though I changed midwives. They are all friendly and I have never had any complaint about any of them. They all deliver good services but I would say yes if I could have the standards of having one midwife from the beginning till the end I would have preferred that because she would follow ...like you have a psychologist you would want to have that psychologist till the end. If something happens you feel a little bit more'

SU3-M: 'Vulnerable'

SU2-F: 'Vulnerable. So I think pregnancy is something very special and personal to a mother especially nowadays. You want someone who knows all the steps and you don't have to repeat the story again and again' (SU2-W-and SU3-BS-M-INT-AN).

All the women, whom I have recruited and who have experienced continuity of carer at the Barkantine, really appreciated it. In some more complex cases having some degree of continuity of carer made the difference in both outcomes and experiences.

Feeling safe: balance between control and support

Many service users referred to a feeling of safety when cared for at the FMU, mostly linked to the sense of support received and perceived. Amina, a British Bengali multiparous woman, who had her second and third baby at the FMU said:

'The one to one care and just knowing that... look you know what, we are here and if anything happens don't worry you know, you're in safe hands... I think the other things like the pool and you know, pain relief and things like that, I think they come second to feeling safe 'cause just having a midwife there with me made me feel...

Even though the midwives ... You know they're not physically doing anything for you, it's just the fact that they're there reassuring you. Just made me feel a lot safer then, then you know... Like the pool and other things, they just...' (SU8-W-INT-PN).

Shamina, a British Bengali multiparous woman said postnatally:

'I really liked it, the midwives were really friendly, when you see a friendly face you know you are going to be in safe hands, 'cos' I had a few bad experiences in hospital... (SU4-W-INT-PN).

'She was she was an angel, she let me do my own thing, when I wanted to push she said 'just let your body talk,' 'when you want to push your body is ready to push so you just push', when she went out of the room I got kind of scared, she only went out for a few seconds just to get something, but when she is in the room kind of feel safe, but when she is popping out I was like 'oh god, come back soon, come back soon, you know' even my sister was there, but you know it feel safe to have somebody there with you'(SU4-W-INT-PN).

Amina, also added:

'The most important thing I would say is just the support from the staff, the way they talk to you, the way they make you feel you know, [man in background stops speaking] you feel comfortable um, especially I say the first time because obviously I had never been through pregnancy or birth before so I think I was really scared' (SU8-W-INT-PN).

Amina experienced marked differences in the sense of support between the hospital and the FMU:

'I think just the reassurance because um, obviously it's like you're kind of... You're in pain anyway um, and you know [child scream] just the fact that you've got a midwife there with you like all the time getting that care one on one um, I think that, that is just really reassuring .. the midwife was telling me look, 'this is happening, that is happening' (SU8-W-INT-PN).

Similarly, during the antenatal interview Enrique, Maria's husband said:

'It's really a good choice and I think I love the place, it's so quiet and every time I go there I feel peace of mind I can say; Yes we do have a peace of mind is always very good. And the services are really good and the make you feel comfortable as well so I think that is really important. Aah what else?' (SU3-BS-M-INT-AN).

Shazna's husband Ali (second baby, British originally South Asian), described the considerable difference in the level of support offered at the FMU and at the obstetric unit:

'That was good care as well because the midwife, she helped her a lot. How she helped her getting clean, put in the bath like... She does almost everything and the hospital when the baby was born, they just say to you, 'Oh there is a bathroom there, you go in there yourself,' they didn't even try to help her... [at the FMU] it's like everything is next to you. It's like your own house. It's so comfortable, that's so nice... Even though if you ask for the midwife to come and help, they will come and help with their smiling face...' (SU31-BS-M-BC-INT-PN).

Many service users referred to the fact that the FMU staff would always offer support in an unobtrusive manner, they knew that if they needed support they could call for help but often similarly they would appreciate the privacy.

Feeling in control – the need for support – the Taijitu

The findings from service user's accounts suggest a dynamic relationship between the need of control, a sense of feeling in control and the level of support needed. Women always expressed the need of control over the environment, privacy and over their care. Different women presented at the FMU with different needs. Some women from very early labour needed substantial support because they were not feeling in control, or had less support from their birth partners. Other women maintained high levels of control throughout labour requiring the midwife to only have a marginal role. When labour became very intense many women, who previously enjoyed their autonomy, experiencing the intensity of labour, lost the sense of control, which meant requiring an additional level of support by the midwife. This dynamic behavior in terms of the women's needs during labour is represented visually in the model by the shape of the Taijitu which is the symbol for Yin Yang.

Most people just call it the yin yang symbol. The summation of Yin and Yang forms a whole. One effect of this is: as one aspect increases the other decreases to maintain the overall balance of the whole.

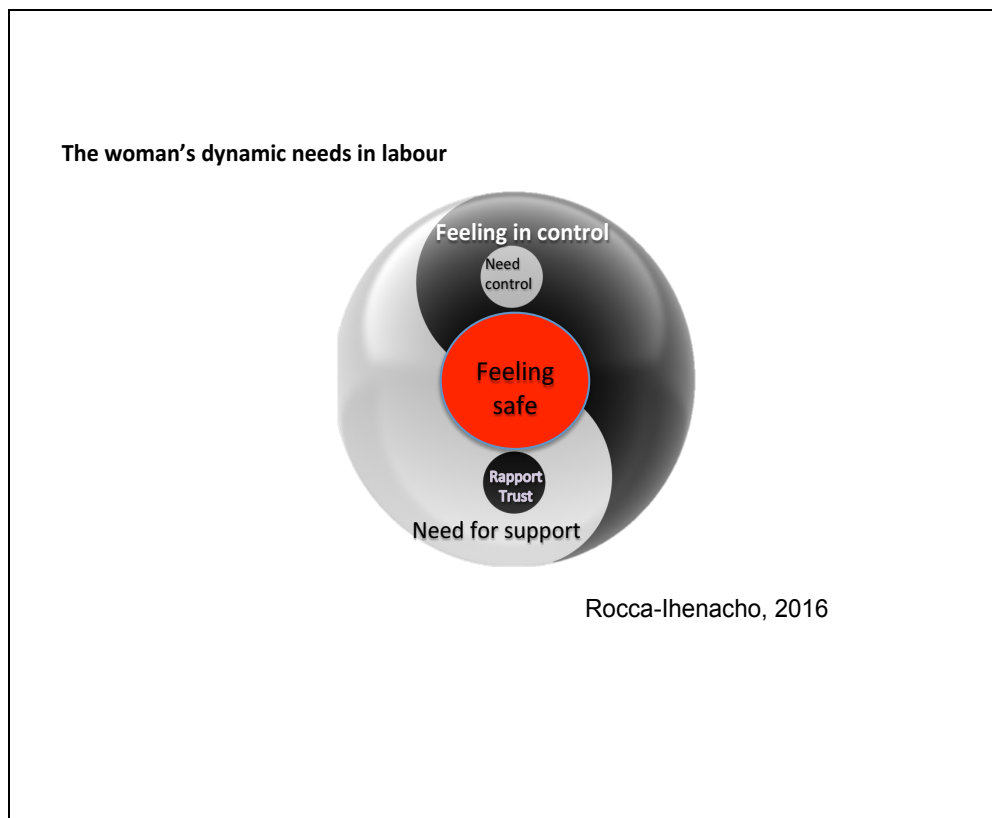


Figure 35- The woman's dynamic needs in labour

This visual representation can be useful not only to understand women's needs but also to explain how midwives might have to behave very differently with different women and at different times of labour with the same woman.

Some couples were very autonomous and privileged a care from the midwife, which was respectful of their autonomy and privacy. Often in initial phases of labour, these couples preferred for the midwife to leave them in the room, knowing she would be available when called.

'It wasn't too bad... I was quite settled in the room and yeah, it was ok um, I was walking around, my contractions were slowly, slowly starting to get stronger um, I think in between... I think um, the midwife that saw me first... Yeah I think in between she popped in as well didn't she? She just came and she just checked on me...' (SU8-W-INT-PN).

And referring to the second stage of labour Amina said:

'I felt relaxed I felt like I could you know... Even though I was in pain I was still very much in control whereas in the [hospital] I just felt like I wasn't in control of anything...' (SU8-W-INT-PN).

Fatima, a British Bengali multiparous woman said:

'(Laughing) ...The fact that in the hospital they stick you on the bed and they tell you almost what to do and here you have control over what you want to do that would help you. So I was just more comfortable to lean

on the pillow and the fact that I had the choice to do that really helped me. So although the pain is equally the same and is hard work but the fact that I had to make the choice helped' (SU6-W-INT-PN).

A midwife described how the midwives at the FMU would respect women's privacy:

'Women are given more privacy here and you know it's more her space the midwife will come in and do the checkings and then she will go out and leave the couple two of them there it's very important really and you see the change of the people's behaviour and they will have a different position when you come in. So it's so much trust put in the couple together not like this is a hospital space and we can tell you what to do' (BC25-MW-F-INT).

'Is the room itself I think it is more personal in terms of the parent themselves as a couple' (SU2-W-INT-PN).

In the postnatal period as well many couples were quite keen to have their privacy:

'I chose to go [B] again because ...because you get your own privacy you know, even after the birth you know' (SU8-W-INT-PN).

This control and privacy provided the women with a feel of safety, which allowed them to relax and 'let it go', to paradoxically allow women to release control over their bodily functions, to lower defense mechanisms and allow the body to labour physiologically.

When labour became very intense sometimes women developed a sense of 'losing control' as their body took over and the sensations became very intense. At this point woman, having established a trusting relationship with her midwife, needed an increased level of support in order to feel safe again.

Yoko, a Japanese woman having her second baby expressed the need for increased support when the labour became very intense and the need for the midwife to lead her more in this phase of labour:

'Like I only remember that the contraction was very painful (laughing) and it's just that I want my midwife to lead me a little bit and also to get my opinion as well that's all I want (SU1-W-INT-PN).

Fatima said about the time when she started to feel the urge to push:

'One of the big thing I noticed here when I was screaming and shouting the midwife said: "well done, well done you are doing very well" (Laughing) while at the hospital I felt like you could scream the way you wanted and the midwife never did anything. The pain was the same but it was just different because here the midwife was saying that's good you are doing very well while at the royal London they just sit and never said anything' (SU6-W-INT-PN).

Participants unanimously expressed great appreciation for the level of support and encouragement that they received from the FMU staff.

Having time and information

Women and their birth supporters referred to the concept of having time in several ways: having time to discuss things with the midwife during appointments, not feeling rushed because of the midwife workload during labour or postnatally and having time to let their body to labour physiologically.

Salma had the first and her second baby at the FMU and she said about the lack of pressure felt at the FMU:

'Um, being looked after um, the space in the room, um, advice given, um we were made to feel relaxed, there was no type of pressure or tension like I would have felt in Hospital, ah, we were really at ease here and um... that's like, these are the main reasons ...' (SU20-W-INT-PN).

Maria, a Portuguese woman expecting her first child commented:

'...And they always care about you. They don't rush you like I said in the Hospital. They really take care about you and they try to make a bond with you the first moment you go there (SU2-W-INT-PN).

Having enough balanced information to support their decision was mentioned by most women and their birth supporters as a fundamental need, which sometimes in previous pregnancies was not met. Most of the service users cared for by FMU midwives described the wealth of information received by the FMU staff. Some women also mentioned their GP as a source of information as well as friends, relatives and social media.

Yoko explained how the information provided by the FMU midwives helped planning for a waterbirth for her second child:

'Yes because the first one I delivered in Japan and it was a completely different thing so I didn't know what a water birth is, I didn't know what active birth is. So it was nice to get to know what the active birth is (SU1-W-INT-PN).

Another woman said that she did not know about the FMU until her GP provided her with information about the different places of birth and helped her making a decision:

'I went to my GP and she told me that I have choices where I would want to have my baby whether at Hospital or at the Barkantine birth centre and another one (midwifery unit) was in central London' (SU2-W-INT-PN).

The data suggested that the local GPs were supportive of the FMU with many women learning about the existence of the Barkantine from their GP.

Having options and support

Both women and their birth supporters expressed the need of having options in order to make plans for labour and birth. These options were particularly useful if expressed as part of an open discussion in which the midwife or GP listened to the woman's preferences. This need of having options was therefore mediated through establishing rapport and possibly building a relationship over a period of time, which resulted in a partnership in decision-making.

Maria, found the GP particularly useful in helping her making a decision about place of birth:

'And then she told me (my GP) that because I wanted something more of a personal experience and I dint not want to use any analgesics like epidural and I wanted the water birth. She told me that there is Barkantine and there are new facilities' (SU2-W-INT-PN).

Fatima expressed satisfaction with the way the FMU helped her deciding her plans for labour and birth:

'The midwife gave me a lot of information about the different types of births that I could have so definitely I choose the water birth. I didn't considered it before but when I was there I liked it and the midwife gave me a list of the things which I need to bring with me because I didn't realize that I needed a mirror if I am having a water birth' (SU6-W-INT-PN).

And she also commented on the support and the options offered by the midwife at the time of birthing:

'The midwife was really nice and she stayed with me the whole time. When my labour pain was really intense and I think it was time for the baby to come out I was very comfortable leaning over a pillow and I had to turn round but the midwife told me that I don't need to do that you can just stay in that position if you are comfortable and I can deliver the baby. So I stayed in that position where I was leaning over the pillow' (SU6-W-INT-PN).

Amina mentioned about the moment of the birth of her second baby:

'...at the fourth contraction that I kind of pushed, she got a mirror and she said 'oh I can see the head coming out, and right at the end when the baby was coming out she said to me 'you can either catch the baby or I can do it' my sister said 'I don't think she can do it, so you get the baby' and as soon as the baby came she passed the baby to me and I looked at the baby and that was amazing, even though I had other three babies that moment it so special'(SU8-W-INT-PN).

Amina commented on the effect of the pool in labour and the fact that for her first baby in hospital she did not have that option:

'Um, but um, yeah, the very fact that I... I didn't have a, a um you know, a pool birth you know, at first (baby) and then second time round I had it... I had noticed a very, very big difference. In the pool you're a lot more relaxed you know, it's like it helps with the pain um, just the, just the fact of the water I think is, is so relaxing and it made my whole experience, the whole birth a lot better. Whereas in [RL] I was... What they, what they did to me was they just told me to lie down' (SU8-W-INT-PN).

Yoko recalled not having any option when she gave birth in Japan to her first baby:

'I didn't have any choice in Japan; I just needed to stay on my back in bed but here they have so many positions' (SU1-W-INT-PN).

The level of options offered by the FMU staff was highlighted by all participants whom I interviewed and/or observed during my fieldwork.

Partnership in decision-making

Sima, while having her second baby experienced some complications and an ambulance was called. She eventually still gave birth at the FMU. Despite the slightly complicated situation, the midwife still offered her options for the birth:

'.. so the ambulance was on, on hold downstairs and they took me out of the pool because I was bleeding and they said I wouldn't be allowed to.... I mean it wasn't medically right for me to go back into the pool so... they said any position you are comfortable... just get into any position that you want and that was something that I hadn't anticipated. I thought it would be like the first time and ... so I had no idea about positions or anything so I said um... I just went ah, on the beanbag with my back out um...' (SU21-W-INT-PN).

Yoko commented about how she planned the birth with the FMU midwife:

'Aah I just went to the room and get talking with the midwife and we planned how it was going to be' (SU7-W-INT-PN).

Participants appreciated the way staff were discussing options and offered choice coupled with support. This approach of partnership in decision-making was shared by most staff during the first wave of data collection but I noticed inconsistencies in the second wave of data collection, after the integration of the community midwives.

Preparing for birth

All the women who were interested in giving birth would attend a FMU tour at 20 gestational weeks. The tour included a visit of the unit as well as a discussion about the philosophy of care, the use of non-pharmacological pain relief and a description of the care they would receive.

'Yes it was good that we had a tour of the birth centre before I gave birth and I visited maybe twice before the second one was born so that I can get familiar with the clinic and familiar with the people and that really helps' (SU1-W-INT-PN).

Women were encouraged to attend antenatal education and some of the participants interviewed attended yoga classes or hypno-birthing courses.

A considerable number of women planning to give birth at the FMU attended the 2-hour workshop run by the FMU, which was a very practical session on which things to do in labour to make things easier. Yoko attended the workshop:

'So during the workshop I went into the birthing pool and just tried how it was going to work and my husband positioned behind me and how he was going to help to cut the cord or something like that, because in Japan it's always from the Doctor or midwife who provide the information to us but I think at the Barkantine its us who say what we want to and I think it's wonderful' (SU1-W-INT-AN).

Yoko went on to have a waterbirth and she felt delighted with her experience.

Most of the FMU midwives reported the active birth workshops as being key in helping women and their birth supporters preparing for birth. Midwives stressed out how women who had previously had a baby at the hospital benefitted from the workshops as they had to be reoriented towards a more active approach to labour and birth.

Nesting environment near home

The importance and impact the environment has on both service users, families and staff as well as the concept of nesting and midwifery units has already been discussed at length by Walsh (2005) and Newburn (2009). This study confirms the importance of the environment on making women feel relaxed and labour physiologically.

The vicinity to their homes made many to opt for the FMU as they particularly valued being in their own community where also relatives could come and visit at any time.

Maria commented about the first time she visited the FMU:

' Yes it feels different (from the hospital) and the first time we went there we were not expecting such a good place how it is built and the finishing with such a friendly environment because when we first went there it was really friendly the environment. Like what he said we went there and we had a peace of mind and we went inside and you don't feel like you are in a maternity' (SU2-W-INT-PN).

Many women took the decision of giving birth at the FMU after attending the tour:

'Yah 50% I made up my mind and when I saw up stairs and did a tour I was then 100% sure that I want to deliver at the Barkantine' (SU1-W-INT-PN).

'With the tour I think what was good for me was it was very wholly and I liked the fact that it looked homely and also just because of the environment I felt that there wouldn't be a lot of rushing around. I also felt that the fact that they explained what would happen if there was a problem' (SU6-W-INT-PN).

Shazna particularly appreciated the lack of 'assembly-line' mode at the FMU and being able to stay in the same room throughout labour, birth and the postnatal stay:

'Um, yeah um. The labour felt a lot more personal I felt like I was in my own space I didn't feel like I was invading anybody else's space [baby laughs]. Because with the hospital you're in labour in one room then you move to another ward aren't you? Um, so that... it felt like, I'm not here all the time and you just... felt like it wasn't mine. Whereas that room, I gave birth in that room and I stayed in that room um, for another day or so, so it felt mine and I felt safe in that environment that...it just felt a really comfortable environment' (SU10-W-INT-PN).

Closeness to home was mentioned several times:

'I just wanted to be close to home um, and just wanted a nice environment where I would feel natural um and like I was at home which was exactly what happened' (SU21-W-INT-PN).

'The Docklands midwives gave me the option to have the baby either at the hospital or at the Barkantine, and me and my husband decided for the Barkantine. It is closer to our home and friends and family can quickly come instead of going all the way to the Royal London' (SU4-W-INT-PN).

Several women and birth supporters explained how having the FMU nearby made a huge difference to them as they could pop in to ask questions if anxious about something or ask a relative to bring food in while in labour.

Focused on transition to parenthood and wellbeing

Many women and their birth supporters commented about the positive effect of the FMU on them and the transition to parenthood. Those who had previous children commented on the differences between the FMU and the hospital.

Fatima particularly noticed a difference in the way she felt postnatally:

'I am feeling different because last time I was quite emotional with the experience with my first child even if it was seven years ago I still remember that birth because it was so bad and it was so painful and horrible...But now I feel that my confidence is a little bit better even though I still can't speak very much English things

happened a lot quicker this time around. The fact that I was in one room, the fact that everybody could come in and there was no time table even at night somebody was with me and we could stay that made a big difference for me' (SU6-W-INT-PN).

She particularly appreciated the access to her family in the postnatal period:

'I really liked the fact that I did not need to wait for visiting hours before the family come and visit me. I really appreciated that my family came in together, they walk in together it wasn't like one or two at a time and they were really helping me, they were talking to me, they were talking about the baby so I found that to be a big difference' (SU6-W-INT-PN).

Shazna had access to continuous breastfeeding support postnatally as she was experiencing difficulty in feeding her baby:

'Yeah. Ah, but it... Another thing with the midwife was that she... when I had problems with, with breastfeeding and you know, she was there to show me whereas in [RL] it was kind of like, not really spoken about, to be honest. It was kind of like' (SU10-W-INT-PN).

Many of the midwives referred to the golden time of when they could provide baby massage groups and postnatal support for the women in group settings through the baby café group. These activities were discontinued in 2009 when the focus moved on increasing the number of births.

Some midwives also commented during the fieldwork as a personal communication that since the integration with the community midwives and the increase in targeted births they were finding it more difficult to dedicate enough time to women postnatally and sometimes they would spend several hours before being able to see a postnatal woman who was at the FMU as busy with labouring women or attending clinics.

Dissonant data: midwives losing mindfulness?

Interestingly Amina, who had her second child at the FMU and was very pleased about the care she received in labour, had a different experience of the FMU when she went to give birth to her third baby, as it was extremely busy and short of staff. In fact once I arrived at the FMU I had to eventually drop my role of an observer and had to assist two births, including Amina's. I have reflected about this episode in my reflexive diary and an account is reported in the reflexive account at the end of this chapter. I also discussed it further postnatally with Amina and her husband:

'The third time around I felt a lot more anxious than the second time around um, mainly because the, the birth centre was quite busy um... So I did feel quite anxious then... I noticed the difference that... the second time

round, 'cause it wasn't that busy the midwives were a lot more friendlier. Um, when I went in they were talking to me and you know but, but the third time round when I went in I... I did feel um, the difference because they were rushed and the... I think she was the Senior Midwife that came um, briefly talked to me about the fact that it was quite busy and um you know... She wasn't, she wasn't not friendly but at the same time she wasn't... very friendly because I think she just felt like you know, she felt under pressure because of the number of people that were there um' (SU8-W-INT-PN).

Amina's husband Ali commented following the experience at the FMU for the birth of their third baby:

'Midwives I think generally um, the only difference I would say is... That I've seen is, when midwives are not stressed um, out basically they are a lot more friendlier and they, they I think they just feel a lot more relaxed themselves. Rather than... and when someone does come in like for an appointment or anything or for a tour you know, then, then you know, parents will choose the birth centre because they'd, they'd feel like you know, the staff there are really friendly and they communicate well...' (SU9-BS-M-INT-PN).

Brown and Ryan (2003) assert that mindfulness can be compromised by dividing attention with multiple tasks, being worried, distracted or by refusing to acknowledge a thought, emotion or motivation. The two previous quotes of service users' experiences are very interesting because they demonstrated how, when the workload exceeds the midwives' capacity to cope, automatically the ability to focus and to communicate' effectively are lost and the midwife is dragged into 'mindlessness'.

Interpretation

In the following figure the key aspects of women's needs are visually summarised to offer a map of the woman's dimension.

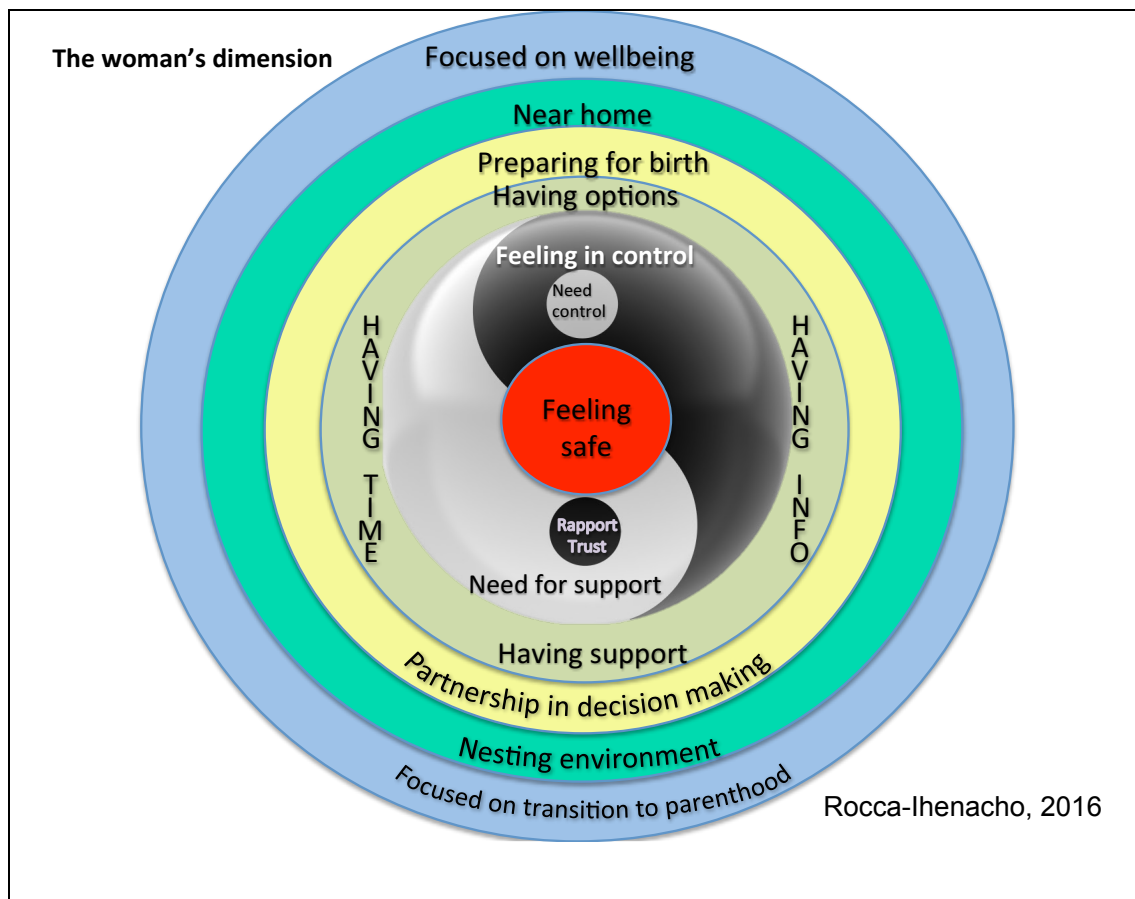


Figure 36- The dimension of women's needs in labour

Women described the most important aspect of care was to feel safe. This was a mix of physical and emotional safety, which was the result of a trusting relationship with the midwife as well as a dynamic connection between the need of control and the need of support. The service users described how the midwives and other staff at the FMU were skilled in establishing a rapport, which made them feel welcome and at ease even if they hadn't met the midwife before. In some cases the women had continuity of carer and this had a positive impact on the women.

By being fully present and exercising mindfulness, midwives were able to read the nuances of the emotional changes and needs of the women and were able to adjust the care offered. The midwives were able to offer more privacy or full physical and emotional presence depending on the needs of the women. When the activity at the FMU became excessive midwives lost their mindfulness. Women and their birth supporters perceived it as a loss of the usual friendliness on part of the midwives.

For women having control, having time with the midwife, having information and options offered to them was perceived as very important. A focus on the transition to parenthood and birth preparation as part of the care offered by the FMU midwives was seen as a bonus.

A friendly environment which welcomed women, their partners and their families was seen as very desirable.

I argue that the FMU was able to moderate some of the social disadvantages of which some of the women were victim and offered the possibility of the creation of health (salutogenesis).

The creation of social capital was a missed opportunity as there were signs of possibility of creation of community networks of mutual support and growth but those were not utilised at the time of this study.

Conclusions

In this Chapter I have explored service users' views and experiences and proposed a model which summarises the key aspects and needs expressed by women and their birth supporters while women giving birth at the FMU.

SECTION FIVE

Introduction to the Section

In this section I discuss the findings of my ethnographic study in light of the wider literature. I integrate the knowledge that arose from the systematic review and the meta-synthesis with the findings of my ethnography as well as indicate possible ideas for further research on FMUs. In the conclusions, I summarise the key findings of my PhD and I discuss how the thesis contributes to the larger body of knowledge on the topic. At the end of the Conclusions, recommendations and implications for research, education and practice are also discussed.

Chapter 11- Discussion

My thesis has specifically addressed the question of what are the key landmarks which describe a well-functioning FMU. The aim of both my ethnographic study and the meta-synthesis on qualitative studies on FMUs was to start developing a comprehensive understanding of the key characteristics of FMUs in terms of philosophy, organisational culture and practice.

I have presented the data from the perspectives of the individual midwife working at the FMU, from the organisational level and from women's perspectives and proposed visual 'maps' of the key landmarks of FMUs which attempt to capture the essence of FMUs.

When focusing on the individual dimension of the midwives and interpreting the data, I found useful using the SDT by Deci and Ryan (2007) as it particularly offered help in interpreting the relationships between some of the key categories which emerged through the interpretation of the data. Therefore, despite not using the SDT prospectively for the analysis of the data, I found it useful when making sense of the findings.

I also propose in this discussion chapter an integrated model (figure 37) which aims at capturing the essence of the three models previously developed (figures 28, 34, 36).

An open question remains whether the characteristics of FMUs should be the same as for the AMUs. Further research will be needed in order to answer this question.

The status quo

The alienation caused by industrialised maternity care settings has created a dissonance between the internal need for relatedness and autonomy as the midwife is forced to focus on tasks rather than relationships (Kirkham, 1999; 2010; Kirkham and Stapleton, 2000). A professional disempowered discourse of having 'no choice' has led some midwives to complying with the industrial system, which has been strongly allied with the medical model of birth (see Chapter 2). In the industrial maternity services midwives, can become alienated and women can feel betrayed by midwives who function 'with institution' rather than 'with woman' (Kirkham, 2010).

Disempowered midwives may display 'bad faith' when rather than taking responsibility for their own feelings and actions, they pass over responsibility to 'powerful others' (O'Connell and Downe, 2009:605) declining personal agency.

The lack of coherence between the midwifery discourse of being with-woman and the pressure of an industrialised maternity care system coupled with a professional attitude of denial of the personal emotional needs has led midwives into an unsustainable situation of stress and burnout (Sandall, 1997, 1998; Ball et al., 2002; RCM 2009).

Reports into systemic failure of NHS Trusts such as the Francis (2013) and Kirkup (2015) reports highlighted how organisational culture and poor inter-professional relationships were root causes of poor clinical outcomes. The reports emphasise how organisations in which behaviours were extrinsically motivated by having to comply to regulations and inspections led to unsafe practices (Francis, 2013; Kirkup, 2015).

The findings from a follow up study (McCourt et al., 2014) to the Birthplace in England study (Brocklehurst et al., 2011) explored further organisational and cultural aspects of midwifery unit care in several case studies of AMUs. The authors concluded that cultural and organisational characteristics had a profound influence in the way the AMU performed.

Deci and Ryan (2007) argued that interpersonal contexts that facilitate satisfaction of the basic psychological needs for competence, autonomy, and relatedness enhance autonomous motivation. Additional studies have also found that organisational cultures that feel pressuring and controlling the individual undermine intrinsic motivation, whereas those that feel supportive and informational enhance intrinsic motivation (Deci, Connell, and Ryan, 1989; Deci, Schwartz, Sheinman, and Ryan, 1981; Vansteenkiste, Simons, Lens, Sheldon, and Deci, 2004).

We could argue that staff wellbeing and the creation of social capital ignite a virtuous cycle of self-maintenance and self-regulation without the need of control (McKinlay and Starkey, 1998). Deci and Ryan also argued that autonomous motivation predicts persistence and adherence and is advantageous for effective performance, especially on complex or heuristic tasks that involve deep information processing or creativity (Deci and Ryan, 2007)

My argument

I argue that the lack of oppression, the support of personal development and the creation of connections which created an enjoyable climate at the FMU, was linked with the creation of health (salutogenesis) and social capital for both service users and providers.

I propose that well-functioning FMUs can be the hub for the creation of virtuous cycles of salutogenesis and social capital, which can self-maintain as long as the antecedents of autonomy, competence and relatedness are maintained.

In Figure 37, I summarise in an integrated model, the key landmarks for well-functioning midwifery unit.

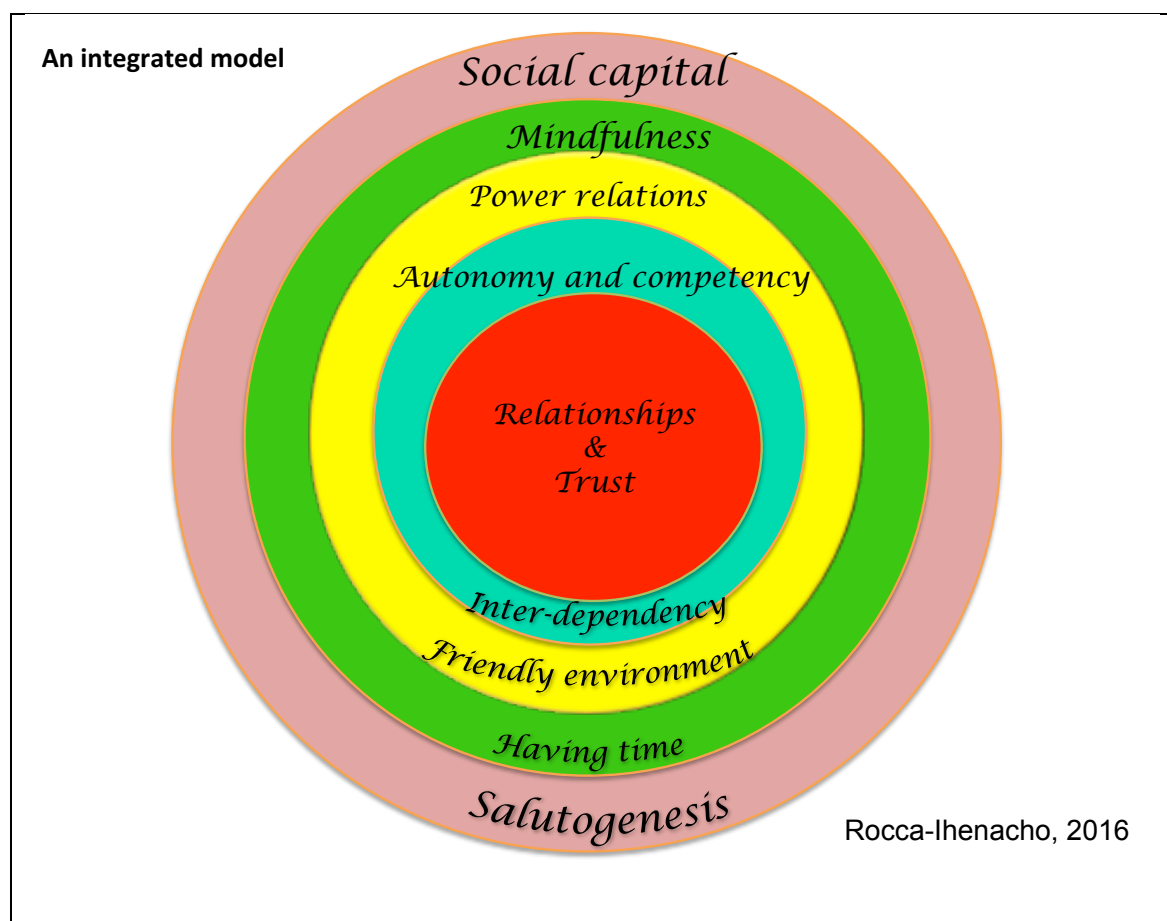


Figure 37- The integrated model

Building relationships, trust and reciprocity

Building relationships creates trust, meaning, a sense of safety and motivation for both the woman and the midwife (McCourt and Stevens, 2009). Being 'with-woman', however, cannot be a prescription and obtains meaning only when naturally arising from a reciprocal meaningful relationship (Deery and Hunter in Kirkham, 2010).

Anderson (2006) in her conference presentation 'Midwifery as alchemy: is trust the key?' highlighted the central importance that a reciprocal relationship based on trust played in the woman-midwife relationship. Building relationships, encompassed by reciprocity, was a key finding not only in my ethnographic study and meta-synthesis, but has also emerged from research on continuity midwifery models (McCourt and Page, 1998; Walsh, 1999; Page, 2003; Fleming and Downe, 2007; McCourt et al., 2006; McCourt and Stevens, 2009).

The model of care offered by the FMU that was the focus of this study wasn't based on caseloading; many midwives, however, had some degree of continuity and the aspect of 'knowing the woman and being known' (McCourt & Stevens, 2009) emerged consistently during interviews and participant observation.

If we reflect on what well-functioning FMUs and case-loading teams have in common we could argue that some of the key elements are conditions that enable: building relationships, competency, autonomy and interdependency (relying on mutual support) (McCourt et al, 2014).

The interesting fact is that the creation of health mediated via relationship building seems to apply to both the women and the midwives. This could be due to a reduction of anxiety and stress caused by the trusting relationships between the women and the midwives and among the midwives themselves.

Autonomous midwives who enjoy their work

In this study midwives referred to the conflict they faced when they had previously worked in the obstetric unit as dominated by process-mentality and becoming 'doing-midwives'. On the other hand, participants felt emotionally rewarded by working in an environment such as the FMU in which there was coherence between their identity and philosophy as well as being able to build relationships with the women and among themselves.

The importance of having a sense of ownership and control over work patterns was evident in this study and consistent with other research on FMUs (Walsh, 2006, 2006a, 2007, Deery, 2007). Similar findings also emerged from studies on models of care, which are not based on an industrial model such as caseload midwifery (Stevens and McCourt, 2002b; 2009).

Autonomous women: whose body, whose decision?

One of the values shared among FMU midwives in this ethnographic study was 'partnership in decision-making' (see chapters 8 and 9) which informed their power relation with the woman and how decisions were made. The approach to decision-making described by the FMU staff during the interviews and observed during participant observation was extremely different from that described in Annandale's study (1987) which portrayed midwives struggling to strike a balance between their clients' needs and the impositions of protocols from the hospital 'if you are two weeks off we risk you out' (Annandale, 1987, p.242). In this ethnographic study the concept of partnership highlighted the fact that decision-making was mediated via a relationship between the woman and the midwife, which entails a sense of reciprocal trust.

This reciprocal trust meant that the midwife trusted the woman in developing her own agency and autonomy and was consistent with the findings of a previous study on the same FMU (Macfarlane et al., 2014b).

There were some exceptions to the practice of partnership in decision-making, particularly noticed in the second wave of data collection, when the integration of the community midwives created some instability within the team. This also highlights the importance of having a critical mass of midwives who had experience of FMU working and enacted the shared culture.

If the stability and skill-level of the team is not safeguarded the unit can slip towards either an increase in transfers because of the lack of practice confidence or the opposite, which is a philosophy of natural birth without the substance of consistent and safe clinical practice (Kirkup, 2015).

The culture of the FMU was maintained by a core team of midwives who had a clear shared vision and had identified the aim of the FMU as to provide safe and personalised care which supported physiology and women's choices.

Annandale (1987, 1988) describes how the FMU midwives, struggling to find a balance between women's wishes and the constriction of hospital governance, often tried to impose choices on their clients.

Prochaska (2015) stresses that in the UK however clinicians' practice is regulated by abiding to the principles of women's autonomy and it seems important that midwives and other maternity services professionals develop a clear idea of the legal issues around woman's decision-making processes.

Another aspect of woman's autonomy was the decision of birthplace. This study did not specifically focus on the aspect of choice of place of birth. Coxon et al. (2014) argue that women are pressurised by societal perception of birth as risky to conform to the norm (birthing in the obstetric unit). It is also suggested that women who gave birth in OU are most likely to opt again for OU for a following pregnancy, even when eligible for midwifery-led settings (Coxon et al., 2015).

Pitchforth et al. (2009) exploring women's choices around place of birth concluded that 'women engaged differently in the choice process, ranging from "acceptors" to "active choosers."' (Pitchforth et al., 2009, p.42).

Not only factors such as the way professionals presented choice, distance, clinical factors had an importance on decision-making, but the perception of what was the norm and social networks also had an influence on choice regarding place of birth. The meta-synthesis also highlighted how societal views on birth and risk had strong influence on decision-making particularly when birth centres were considered 'against the norm' and risky (Annandale, 1987, 1988; Walker, 1995; 2000; Esposito, 1999; Hunter, 2003; Shuster, 2006; Deery, 2007; 2010; Stone, 2012).

Inter-dependency: free standing not standing alone

McCourt et al. (2011) stressed the importance of integrated services which foster positive inter-professional relationships as key features for service quality and safety. The importance of integration of services is highlighted by Mannion et al. (2005), McCarthy et al. (2009), the King's Fund (2009) and the Maternity Review: Better Births (2016).

The 2015 Maternity Review, which has led to the publication of Better Births (2016), has indicated pathways for the transformation of industrial and impersonal maternity services into personalised ones based on continuity of carer models. Better Births (2016) also introduces the concept of

community hubs, based for example in children's centres or midwifery units and highlighted the importance for the community hubs to be fully integrated with the acute services. The FMU, focus of this study, could be conceived as a community hub in which different services dedicated to maternal and child health could be integrated within the same 'hub'. This would encourage working across professional boundaries.

Robust evidence on midwifery units, including my meta-synthesis of qualitative research on FMU included in this thesis, as well as my ethnography, other case studies of MUs (McCourt, 2011; McCourt et al., 2014) and a meta-synthesis by Walsh and Devane (2012) have, however, highlighted the risk of tense relationships between MUs and OUs.

Research focusing on FMUs as part of National Health Services demonstrated conflicting relationships perceived by the FMU staff as not only in case of transfers, but also a sense of oppression caused by senior management felt by FMU staff (Deery, 2007; Deery et al., 2010; Stone, 2012). The relations between FMU and hospitals in studies from the US highlighted different dynamics. Being FMUs privately owned by independent midwives, there was a lack of internal tension with management, because the leadership was internal and congruent with the other midwives' philosophy. However, tensions manifested when women needed to transfer to hospital units. The tensions in Annandale (1987, 1988) were related to the imposition of hospital guidelines and in case of transfers to the OU. In other studies the attention was focused on the experiences of women who birthed at the FMU and did not include midwives' views (Esposito, 1999; Shuster, 2006).

McCourt et al. (2014) highlight the presence of a 'Them and us culture' in their study of AMUs in England, if in some instances the development of a culture of 'us' versus 'them' could have strengthened the sense of unity among FMU midwives (Deery et al., 2010; Stone, 2012). Rayment (2011) on the other hand argues that some of the emotional benefits of being in a MU could potentially be moderated by negative relationships with the OU, which can be a cause of stress.

The risks are:

- The coexistence of different identities and philosophies among the midwives (being-doing) which highlight where loyalties lie (with woman or with institution).
- The clash of two paradigms: the Medical Model and the Social model (Bradshaw, 1994).
- Lack of opportunities for knowing each other and establishing positive relationships.

The findings from the Birthplace organisational case studies (McCourt et al., 2012) suggested that a negative relationship is always a risk, but not inevitable if the service has good leadership.

When developing new midwifery units it would seem therefore logical to include a proactive element of developing positive relationships through socialisation, which uses the knowledge around organisational culture and building social relations ad hoc to improve interdisciplinary work and working across geographical boundaries (Khalili et al., 2013) This should not be left to chance, but proactively integrated in the organisational development of OU and MUs and included in both undergraduate and in-service training (Khalili et al., 2013).

Better Births (2016) highlights the importance of working in an interdisciplinary manner and across boundaries. The integration of the FMU with other services such as community midwifery, obstetrics and health visiting seems to be key. It would be interesting to explore new ways of working across boundaries, in which a positive relationship is fostered among different services coupled with the maintenance of autonomy. In this study an attempt was made by the FMU manager, by liaising constantly with the OU. It was partially successful, but further research is needed.

It would seem important to develop a common vision, which highlights the importance and contribution of all parties to the common mission of enhancing maternal and child health, increase the opportunities for staff across working environments to getting to know each other as well as increasing the interdisciplinary opportunities for training.

Competency

The midwives in this study described the opportunities for continuous development and learning from each other, which the FMU provided. Particularly in the first wave of data collection the midwives enjoyed attending the 'Keeping Birth Normal Workshop' offered to all midwives when starting at the FMU as an in-service full day workshop. They also learnt by assisting birth with colleagues and receiving support and mentorship. The midwives who had just joined the FMU team found the possibility of having two midwives for the birth as a luxury, which led to shared practices (by listening and observing each-other), mutual respect (by observing other midwives' skills) and support (having another supportive midwife present).

Midwives found the support particularly useful when they had just joined the team, as they would be 'socialised' into the FMU philosophy and practice. This 'buddying' system has already been described by Rayment et al. (2015).

McCourt et al. (2011; 2012; 2014) and Rayment et al. (2015) emphasise the need to develop and maintain midwives' skills as there is the assumption that midwives are skilled in assisting physiological birth, but this assumption was not supported by the fact that most midwives trained in hospital settings. Another important aspect was the need for further training for midwives in supporting partnership in decision-making including communication, listening and counselling skills (Rance et al., 2013; McCourt et al., 2014; Rayment et al., 2015).

In my study midwives expressed positive experiences in the FMU related to the possibility of following up the outcomes of the care provided, being able to provide continuity of care to women. This 'deconstruction of the assembly-line' as described by Walsh (2006) led to the positive consequence of generating new ways of developing by learning from the observation of undisturbed physiology, by observing other midwives, by asking for second opinions to colleagues and by receiving feedback from peers as well as from the women and their birth supporters.

Power relations: From compliance to engagement

The FMU in my study and those included in the meta-synthesis fostered an attitude towards relationships based on a sense of devolved decision-making rather than authority and hierarchy (Walsh, 2006; Deery, 2007; Stone, 2012). This was the case in this ethnographic study, which indicated the two concepts of shared leadership among staff and shared decision-making with service users.

Data from this study as well as findings from Kirkham (2010) and Deery et al. (2007) suggest that often there is a tension between the need of autonomy and ownership within FMUs and the wider organisational culture within the NHS Trust, which often fosters more oppressive management styles.

Engaged staff perform better and share a pride of continuously improving self and the service provided (Salanova et al., 2005). Not only does the evidence support a link between organisational climate and employee loyalty but also having an indirect effect on service users/customer's loyalty mediated via the quality of employee/customer interaction (Salanova et al., 2005).

A key limitation was that this engaged approach was not fully consistent as it was not found in the wider NHS Trust, which had a more hierarchical style of decision-making and management.

Friendly environment

The concept of 'friendly environment' includes not only the physical space but also the implication of how the environment is used as well as hinting to the emotional environment and the sense of support (Walsh and Downe, 2010).

The environment for FMUs staff was an expression of their values and philosophy. Midwives and MCAs in the FMU studied would take pride from looking after the environment with a real sense of ownership. This finding was present not only in my data but also in all the studies included in my meta-synthesis (Annandale, 1987, 1988; Walker, 1995; Esposito, 1999; Walsh, 2005; Schuster, 2006; Deery, 2006; Deery et al., 2010; Stone, 2012).

The findings of my ethnographic study highlight also how the environment had a strong impact on the sense of well-being among staff.

The characteristics of the environment seem to have such a strong impact on the women's capacity to labour (Buckley, 2003; Walsh, 2010; Leap and Hunter, 2016) as well as on staff that it seems unethical not to ensure a suitable birth environment to all women and a healthy environment for staff. The principle of friendly environment and nesting (Walsh, 2005) can be applied to all settings and not only to FMUs and AMUs (Leap and Hunter, 2016).

Having time and Mindfulness

Mindfulness is an attribute of consciousness and it is believed to promote well-being (Brown and Ryan, 2003). The origin of the concept of mindfulness has its roots in Buddhist and other contemplative traditions (Brown and Ryan, 2003). The stress-reductive effect of mindfulness practice is well-established (Garland et al., 2011) and mindfulness meditation-based interventions have been introduced with positive impact for their therapeutic efficacy in reducing distress (Greeson 2008).

In the field of childbirth preparation mindfulness has been introduced as a technique for preparing positively for birth. (Duncan and Bardacke, 2010; Fisher et al., 2012; Dunn et al., 2012). The term mindfulness has not however been mobilized yet into the midwifery professional context or discourse.

A very similar concept has been described by some midwifery scholars: Kennedy (2000) described 'the art of doing nothing well' as the midwifery art of unobtrusive presence. A participant in Kennedy's study described this as 'the mastery of doing nothing' (Kennedy, 2000, p.12). Leap (2000) also speaks about the idea that 'the less we do the more we give' highlighting the importance of a quiet presence, which allows the midwife to connect with her 'conscious and sub-conscious knowing' (Leap, 2000:6). Berg (2005) highlights how the presence and availability of the midwife had an important impact on the women's perception of care. The term used in this context is 'enduring presence' (Berg, 2005). Olafsdottir (2009) describes the act of 'being with' or 'sitting over' (from Icelandic) the woman during birth as key for learning and developing midwifery skills. Olafsdottir (2009) argues that 'being with' the woman, the continuous presence, facilitates a deep connection with the birthing process and the woman, which allows midwives to learn to listen to their inner voices. The knowledge developed is called 'inner knowledge'. Olafsdottir (2009) reports that midwives described this knowledge as being a combination of skills, knowledge and deep perceptions captured by the unconscious mind. I would argue that mindfulness functions as an essential precursor for the creation of inner knowledge.

Despite several terms that have been used to describe the same concept (Kennedy, 2000; Leap, 2000; Berg, 2005 and Olafsdottir, 2009), the term mindfulness, however seems to capture all the different dynamics and aspects in one phenomenon:

- Practical: guiding midwives in how to be 'with women'.
- Organisational: suggesting a FMU needs to 'make time' for the woman and the midwives and provide an environment that avoids continual distraction.
- Salutogenesis for the woman because of the stress-reductive effect of mindfulness (Garland et al, 2011).

Olafsdottir (2009) pointed out that that the Icelandic midwives interviewed in her study connected 'being with' (mindfulness) with safety. In my findings as well, many midwives described how the initial fear of being out of hospital was completely overturned by a sense of safety by being able to exercise mindfulness in their care. They described how they felt safe at the FMU and unsafe at the OU because of the mindlessness they were forced to accept. Covington (2005) linked the presence of the nurse

with a perception of 'safe space' from patients' perspective. The interesting new dimension is however the perception of safety from the midwives' perspective linked to the mindful presence.

Social capital

Walsh (2010) argued that a strong sense of ownership, deregulated work patterns and a blurred line between personal and working spheres contributed to the happiness of the FMU midwives. In his study he described how staff would go above and beyond what would be required from them as employees (Walsh, 2010). Once work is enjoyable and colleagues are seen as friends, automatically one ceases to perceive work as a duty and it turns into 'your favorite chocolate bar' (Walsh, 2010).

My study points in the same direction. Interestingly my fieldwork captured a transitional period between a more unregulated phase of the FMU (first wave of data collection), in which autonomy and ownership were strong and a second more regulated phase (second wave of data collection) when the FMU integrated with the community team and a FMU manager was appointed. In the second wave of data collection the experiences seemed to tilt towards more negativity, but it could have been a transitional phase due to the integration period, which led to instability of the team. Certainly the wider literature points to the need of developing services which foster social capital and instigate positive dynamics within the teams as well as service users (McCourt et al, 2011; 2014).

At the time of this study the FMU had only made limited progress in developing social capital in the sense of really being part of the local community and community mobilisation .

A salutogenic maternity unit?

A working environment and organisational culture which is based on building relationships, a sense of autonomy and fosters the natural need for competence leads not only to what are traditionally considered safe clinical outcomes (Deci and Ryan, 2007), but also to salutogenesis (creation of health) (Downe, 2010) for both service users and providers.

We are hopefully moving towards a new era in which the salutogenetic (or iatrogenic) impact of maternity services is acknowledged and measured in terms of cost-effectiveness, which considers the wider public health effects of maternity care (Downe, 2010).

Many of the salutogenetic features of FMU and caseloading are still being discovered and studied but seem to be related to the impact in reducing stress and anxiety in pregnant women (and midwives) (Sandall et al, 2015; McCourt et al, 2017).

A quick grasp can be obtained by reflecting on the health, emotional and financial impact of reducing premature birth by 24%, which was one of the findings of a Cochrane Systematic Review (Sandall et al., 2016). If continuity of care was a 'magic pill' it would be unethical not to offer it to women. However because it involves 'human intensive' work the implementation of this 'intervention' has been unethically delayed.

Downe (2008) has proposed a shift from a maternity service culture based on risk to one based on salutogenic factors (factors which create health). I argue that FMUs and caseloading models of care could become integrated models of care, which share the same philosophy, culture and practices. Following the recommendations of The Maternity Review: Better Births (2016) FMUs could become community hubs which can provide primary care services with a focus on a social model of maternity care.

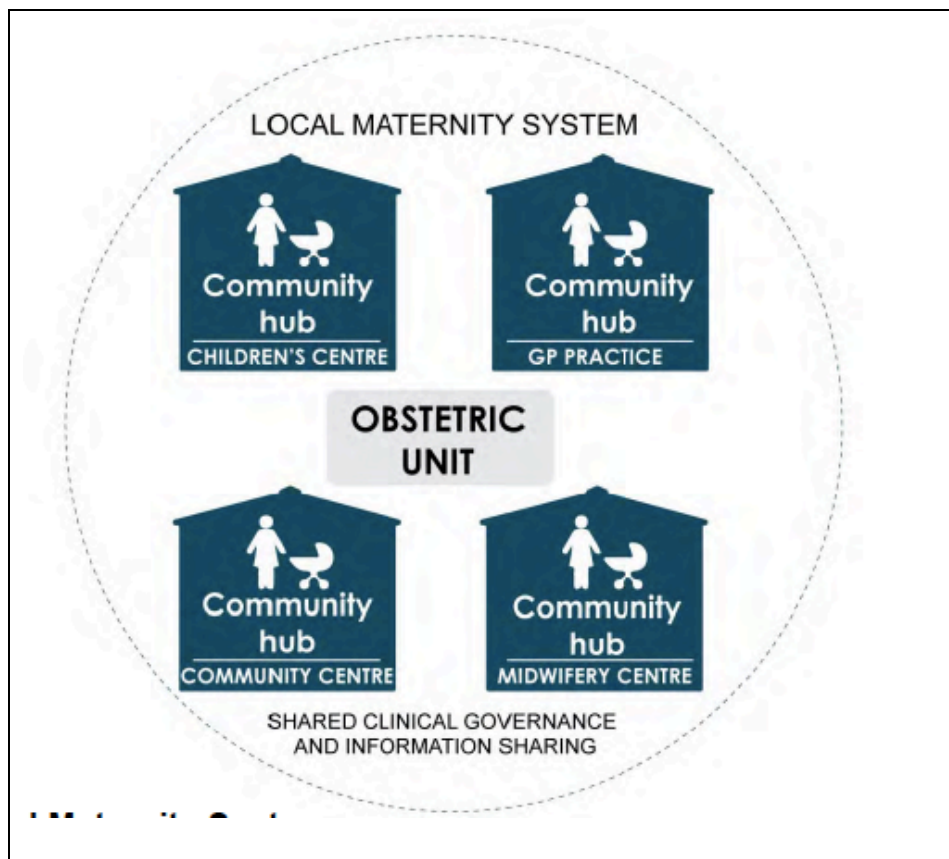


Figure 38- Local Maternity Systems as recommended by The Maternity Review: Better Births (2016)

Scaling up midwifery units

Since the publication of NICE (2014) we are faced with the task of implementing best evidence on place of birth and NICE recommendations. In doing so, not only we are confronted with challenging the societal view of what is perceived as the norm for birthplace, and working with professionals to ensure the options are presented in the most balanced manner, but we are also facing an additional challenge. The evidence suggests that midwifery units are the safest and most cost-effective option for well women with uncomplicated pregnancies but there are still several unanswered questions regarding how to implement evidence into practice.

Hollowell et al. (2015) highlighted that since 2010, when the Birthplace data was collected, the number of midwifery units (particularly AMUs) has increased. The characteristics of these units in terms of size, staffing, and admission criteria, may well have changed. Concerns have therefore arisen regarding the generalisability of the Birthplace findings to current models of service provision and clinical practice. This calls for an urgent need for monitoring and evaluation of current services (Hollowell et al. 2011).

If we consider place of birth as a complex intervention, we need to define and describe the intervention in detail (MRC, 2008). Midwifery units are not a uniform intervention and this matters because safety and effectiveness depends on implementing new midwifery units which are consistent with the characteristics of those evaluated in the Birth place study.

Rayment et al. (2015) suggest the hypothesis that differences in midwives' skills, confidence and competence in normal birth might be partially responsible for the different outcomes between AMUs and FMUs.

Reflections on the research process

I have already partially discussed my experience of the fieldwork in the Methods Chapter.

I have also discussed the two episodes in which I decided to drop my researcher role to become actively involved as a midwife in chapter 4.

I could work clinically because I was employed by the NHS Trust in which I conducted my study. In the case of the birth, which I attended because there wasn't any other midwife available, I feel that as a midwife my duty of care came before my role as a researcher. In the second case when I stepped in to facilitate an antenatal workshop, I felt compelled to help the midwife who was struggling and also because the situation was becoming uncomfortable for the service users as well. I therefore decided to intervene. I feel that this can be seen as the far end of the 'participant observer' spectrum and completely embrace my decision.

In research terms this has added layers of reflection for my understanding of positionality.

Reflections on the fieldwork, representation and writing this thesis

The main difficulty I encountered while starting the fieldwork was changing role from clinician to researcher. There was an initial sense of awkwardness and vulnerability, which improved with time. Finally, I enjoyed the privilege of observing care without clinical involvement. There was the need to explain my new role to my colleagues, but once they saw me in my new role as a researcher it became easier.

There has been an occasional conflict between being observer and my moral and professional obligations. Even if the agreement was that my role would not include clinical duties, on two occasions I felt I had to intervene to fulfil my Duty of Care under the NMC code. In the first case I was observing an antenatal group and the midwife had to leave to attend an emergency. The group was left alone for more than 30 minutes and was getting impatient. I had the dilemma between observing their growing impatience or to take over and finish the session. I chose the second option.

On the second occasion, I was observing a birth and the midwife was overwhelmed by five women in second stage, giving birth at the same time. I did not have any other alternative than supporting her and getting involved clinically. In retrospect, I have to say that those episodes did not constitute an issue of regret. It was quite clear to me that intervening to help my colleagues was the only viable option in view of the circumstances.

During the fieldwork, I have often reflected on how my personal experiences might have influenced my approach to data collection (what I saw as important to record/ask) and interpretation.

If from one hand I have attempted to remain close to the data by using many direct quotations, on the other hand my views as a mother, a researcher and a midwife who experiences tension in relationships with senior management within the Trust, have certainly influenced my interpretation of the data.

During the fieldwork, I have often witnessed fantastic care and very committed staff but also that the overall culture of the midwifery senior management team was hierarchical and the leadership lacking. As a strong believer in multi-disciplinary collaboration and partnership in decision-making with staff and service users, I felt frustrated by the centralisation of decisions and disempowerment of stakeholders. I felt that the birth centre had great potential but it was being failed by the senior leadership as the leadership style was making staff feel unvalued.

During my fieldwork, I could clearly perceive how the birth centre was drifting into neglect. It was very painful to watch and the only power I had was that of representing the 'golden age' of the birth centre and stressing how the positive culture of a birth centre does not happen by accident but by hard work and collaboration.

Strengths and limitations of the study

During the planning phase of my ethnographic study, the conduction of data collection and analysis I have always referred to the quality criteria described by Walsh and Downe (2005) as a framework for guiding my study and ensuring good quality.

To my knowledge, this is the first ethnographic study conducted in an urban purpose-built FMU, which also reported the views and experiences of service users from a very diverse background. As the aim was contributing to the theory generation on the field of FMUs, ethnography as the chosen methodology was a strength.

The ethnographic study was contextualised within the historical and policy background and also with two robust systematic literature reviews of clinical outcomes and qualitative studies focused on FMUs. In the Introduction (chapter 1) I have addressed the aim, objectives as well as the research question for this study. In chapters 3 and 4 I have fully justified the theoretical background of the study, I have discussed the rationale for using ethnography and described the methodology as well as the methods of data collection and the 'audit trail' to the analysis.

In chapter 4 I have also described the rationale for the sampling strategy and described the recruitment procedures. I have also justified the large number of participants due to the request from the Ethics Committee to gain formal written consent for all service users involved, including antenatal workshops.

The data analysis was grounded in the data and I have included also deviant data, which helped further understanding the power dynamics within the field.

The ethnography was conducted in an ethical manner, attempting to be as aware as possible of the power dynamics in the field. Being familiar with all the staff at the FMU, I have invested particular attention at ensuring that none of the participants felt compelled to take part. I have been also very unobtrusive with my participant observation in order to avoid interfering excessively with the care provided but decided to be more involved if necessary for the safety of the woman.

Limitations of the study

Being an insider researcher and having knowledge of the field and staff prior the conducting of the ethnographic study, I did not have the advantage of a 'fresh eye' approach to the field, which has been

described as advantageous when conducting ethnography (O'Reilly, 2009). In order to compensate for this limitation, during the fieldwork I have engaged in conversations and formally interviewed service users and students who were having their first experience of the FMU. Their fresh experience of the FMU was very important for my data collection. On the other hand, I had the advantage of the 'verstehen' and I was able to access the 'backstage' dynamics (O'Reilly, 2009).

Another limitation had been being pregnant with hyperemesis while conducting part of the data collection. If this has not impacted in a thorough schedule of interviews and participant observation it has limited my ability for example to explore further the use of photography as part of the data collection as well as the use of comments on social media about the FMU. If on one hand I don't think this has compromised the robustness of my ethnographic study, on the other hand it was for me a missed opportunity.

Chapter 12- Conclusions

In this Chapter I summarise the key findings of my PhD research and discuss how the thesis contributes to the larger body of knowledge on the topic. Recommendations and implications for research, education and practice are also discussed.

Key findings

Midwives' identity, autonomy and ownership emerged as important themes in this study. A professional identity dichotomised between 'being' and 'doing' midwives was consistent with previous research (Kirkham, 1996, 1999, 2010; Hunter, 2004; Hunter and Deery, 2009; Rayment, 2011; Cooper, 2011). My data, however, suggested that the midwives' identities were not fixed and that a supportive environment could facilitate an identity shift from 'doing' to 'being'.

The philosophy embraced by the FMU staff was grounded on a physiological and social model of birth in which interventions had to be justified and the midwife was seen as an expert facilitator. There was also a clear understanding and recognition of the woman's autonomy and a principle of partnership in decision-making were practised.

Skills in supporting physiological birth, sound communication and information-providing skills as well as being able to offer personalised care were cited by both midwives and MCAs as core skills for staff working in a FMU environment.

'Having time, making time and giving time' (as discussed in chapter 8) to women and one to one care was a precedent to the creation of mindfulness in the midwives which previous research has linked to psychological wellbeing (Brown and Ryan, 2003). Service users perceived the mindful care provided by the FMU midwives as friendly, personalised and supportive but when the workload became excessive the service users could perceive the stress midwives were under.

The analysis of the data revealed 11 core values (shared vision, openness, power balance, mutual support, supporting learning, building relationships and creating an enjoyable workplace, listening to women, partnership in decision-making, family friendly and open door policy) which guided the practices of the FMU staff. Power balance was articulated both among staff by rejecting hierarchical

division of work and openness as well as with the women and their birth supporters via partnership in decision-making.

These team values were shared and passed over to the new staff joining the team via a process of socialisation to the FMU 'way of working'. The team however needed a 'critical mass' of midwives and MCAs sharing philosophy, knowledge and skills was in order to maintain the shared culture within the FMU. The stresses of the interface with the wider institution and the still rather marginal position of the FMU within it had a significant impact on staff retention and this had the potential to damage the effectiveness of the FMU.

The service users described how the midwives and other staff at the FMU were skilled in establishing a rapport, which made them feel welcome and at ease even if they hadn't met the midwife before. In some cases the women had continuity of carer and this had a particularly positive impact on their experience.

Women said the most important aspect of care was to feel safe. This was a mix of physical and emotional safety, which was the result of a trusting relationship with the midwife as well as a dynamic connection between the need of control and the need of support. Physical safety included an environment which was relaxed, welcoming and deregulated.

By being fully present and exercising mindfulness, midwives were able to read the nuances of the emotional changes and needs of the women and were able to adjust the care offered. When the activity at the FMU became excessive midwives lost their mindfulness and women as well as their birth supporters perceived it as a loss of the usual friendliness.

For women having control, having time with the midwife, having information and options offered to them was perceived as very important. A focus on the transition to parenthood and birth preparation as part of the care offered by the FMU midwives was seen as a bonus. Service users experienced the FMU as a friendly and welcoming environment, which offered a family focused birth experience.

The FMU not only offered a birthing place which had a positive impact on service users, but the data suggests that the FMU had also a positive impact on the staff at a personal psychological level. The concept of creation of health (salutogenesis) therefore applied to both staff and service users (McCourt et al., 2016). The literature suggests that FMUs are associated with positive outcomes for women from

disadvantaged social backgrounds or vulnerable therefore mitigating for the negative health outcomes usually linked to social deprivation (Esposito, 1999; Overgaard et al., 2012).

The creation of social capital was a missed opportunity in the FMU focus of my ethnography as there were signs of the possible creation of community networks of mutual support and growth but those were not utilised at the time of this study. The wider literature on the subject however suggests that the creation of social capital could be a desirable side-effect of FMU care.

Contribution to knowledge

This post-critical ethnography builds on previous research on FMUs and contributes to the theory generation within the field. The study aimed at answering the following research questions:

- How do service users, midwives and other staff experience maternity care within a FMU?
- How are midwifery philosophy, culture and practice enacted within a FMU?

This study is the first ethnography of a purpose built FMU in an inner-city area. It therefore sheds light on key organisational aspects of how an FMU can function in city areas where maternity services are under constant pressure.

It expands the understanding of the key characteristics of FMUs and relationship between the professional dimension of the midwives working within the FMU, the organisational dimension of the FMU and womens' experiences and needs.

On the basis of both my ethnographic study and the findings of the meta-synthesis I argue that well functioning FMUs offer effective care focused on the needs of the woman and her family and facilitate the transition to parenthood by tailoring care around individual needs and wishes rather than being focused on an 'industrial', highly regulated model of care. The environment and organisation of work in the FMU not only generated health (salutogenesis) in the women but also created a positive climate among staff, who felt that their basic needs of autonomy, competence and relatedness were met. The positive climate at work and the establishment of relationships at work led to the creation of a sort of

social capital, which created a positive feedback loop of self-maintenance of the philosophy, culture, knowledge and skills at the FMU.

Key contribution to the debate about FMUs:

- My study suggests that midwives' professional identities are not fixed and they can be supported in the transition to a woman-centred and relational type of care by socialising and practising in a conducive environment.
- Within FMUs midwives' skills and knowledge of physiological birth can develop when midwives work within a culture which embraces values such as mutual support and supporting learning.
- The FMU in my study was the 'midwives' territory' where vicarious nesting took place for the benefit of the woman. Women's ownership of the FMU was originally aimed for by the FMU steering group but not achieved at the time of this study.
- Mindfulness arose as a key feature of FMU practice. When the workload balance was lost, midwives became mindless and this had implications on services' users experiences.
- The meta-synthesis as well as my ethnography suggests that midwives' ownership and autonomy should be encouraged. At the same time fostering a wider organisational culture which values midwives' work and contribution to the service coupled with positive intra and inter-professional relations are key. This was not achieved in the FMU focus of this study but the data and wider literature suggests that an interplay between what defined in Chapter 9 as 'autonomy and dependency' could be beneficial (McCourt et al, 2016; Douglas's, 1992; 1996).
- The concept of FMUs as a salutogenetic birth place is reinforced and further expanded by this study, which suggests that the creation of health is not only related to the women but also the staff working at the FMU as well (MaCourt et al., 2016). This finding is key as it may offer some viable solution to the issue of midwives' burnout.
- Lastly this study suggests that there is potential for the creation of social capital within FMUs and beyond in to the local community. This could offer benefits particularly to women from disadvantaged backgrounds or vulnerable, which could be a key public health feature of FMUs. There is also the potential to take 'social capital' back into the wider maternity service.

This study also contributes further to the understanding of the insider-researcher role and being 'mojado' ethnographers within the field of women's health and undervalued professions. This study has led me to move towards Participatory Action Research, which moves even further in terms of 'researching with' rather than 'researching on'.

Implications for research

Research to further investigate the relationship between organisational culture, staff engagement and wellbeing within MUs would be important considering the high level of burnout within midwifery (Sandall, 1997, 1998; Ball et al., 2002; RCM 2009). My ethnographic study focused on a FMU and further research would be needed to specifically identify the distinctive characteristics of FMUs and AMUs. These two models of care are often referred to as if they were one model of care with the same characteristics but the evidence suggests that they are quite different (Nice Quality Standards, 2015). Further research on differences and similarities would be important and what these are related to. This might also help further unpick what makes FMUs work even more effectively than AMUs.

It would also be interesting to test whether the models proposed in chapter 8-9 and 10 in this thesis could be used for the improvement of MUs or to guide the development of new ones. I will discuss this further in the Implications for Practice section of this chapter.

Substantial work is needed in the following areas:

1. The systematic review on FMUs clinical outcomes highlighted heterogeneity of outcome measure and study design, which made meta-synthesis impossible. More work is needed on harmonising outcome measures for the clinical outcomes on FMU and there is potential for better harmonization of study design.
2. The systematic review also demonstrated the limitation of the clinical outcomes collected at present, which are based on a medical paradigm of childbirth and do not acknowledge the potential for health improvement associated with FMUs. Identifying salutogenetic outcome measures for midwifery units would therefore a useful focus for future research.
3. Evaluating the long term effect of FMU care with a cost-effectiveness approach.

4. Developing and testing educational interventions to enhance midwives' readiness to work in midwifery-led settings.
5. Explore if the concept of mindfulness could be linked to safe practice within FMUs and elsewhere.

Recommendations and implications for education

In the Recommendations for research section above I have suggested that further research is needed on strategies for enhancing midwives' readiness to work in midwifery-led settings. This is an educational priority in view of the NICE Intrapartum Guidelines recommendations for scaling up midwifery-led birth settings and previous research suggesting that midwives often do not feel ready to work in midwifery-led settings (McCourt et al., 2011; 2012; 2014).

Educational projects on ways of improving interdisciplinary collaboration within maternity care teams would also be crucial to ensure safe and effective care.

Implications for practice and policy and regulation

Ensuring consistency of practices and service delivery for FMUs is essential. McCourt et al. (2011; 2014) suggest that there is wide variation of culture and practices within different MUs.

One of my future aims is to develop FMU and AMUs standards. There is potential to also develop assessment /self-assessment tools and recommendations to guide those in charge of opening new midwifery units in order to focus on the creation of well-functioning and sustainable MUs.

The evidence suggests that FMUs based in the community with a strong autonomy and local leadership as well as positive integration to the OU and wider health and social care services could have a significant positive impact on the health of the women and their families. The findings from my study, the meta-synthesis conducted and the wider literature suggest that FMUs could perhaps be better suited to be sitting strategically more within community services than acute services in order to reach the full potential of their public health benefits.

Further research by the candidate

In view of the findings of this study I have made plans for further research with the aim of implementing the findings of this ethnography and the wider knowledge on FMUs in Participatory Action Research case study. In early 2016 I was successful in securing a National Institute for health Research Knowledge Mobilisation Fellowship for a multi-site case study on the implementation of NICE recommendations for place of birth for healthy women with uncomplicated pregnancies. This Fellowship is a partnership between the Models of Care group within City University London Maternal and Child Health Research Centre, led by Professor McCourt and the Capacity building theme, led by Professor Sandall at the Centre of Implementation Science within King's. The aim is to identify successful Implementation Science strategies to scale up the use of midwifery-led birth settings.

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APPENDIXES

Appendix 1: Amendment 1 approval



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Tel: 020 3311 7254

14 May 2012

Mrs Lucia Rocca-Ihenacho
Senior Midwife/Researcher
Barts and The London NHS Trust
121 Westferry Rd
E14 8JH

Dear Mrs Rocca-Ihenacho

Study title: The Barkantine Birth Centre (BaBC): an ethnographic study of the philosophy, culture and practice in a freestanding urban midwife-led unit.
REC reference: 10/H1102/65
Amendment number: 2
Amendment date: 16 April 2012

The above amendment was reviewed at the meeting of the Sub-Committee held on 16 May 2012 by the Sub-Committee in correspondence.

Ethical opinion

The Committee found no ethical issues.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	4.2	20 March 2012
Notice of Substantial Amendment (non-CTIMPs)	2	16 April 2012

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

RandD approval

All investigators and research collaborators in the NHS should notify the RandD office for the relevant NHS care organisation of this amendment and check whether it affects RandD approval of the research.

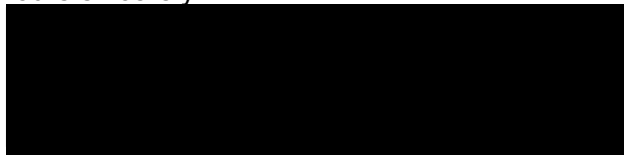
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1102/65:
correspondence

Please quote this number on all

Yours sincerely



Professor David Caplin
Chair

E-mail: 

Enclosures: List of names and professions of members who took part in the review

Copy to: Dr Gerry Leonard, The JRO

NRES Committee London - South East

Attendance at Sub-Committee of the REC meeting on 16 May 2012

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>
Professor David Caplin	Physicist	Lay
Mr Roy Sinclair	Pharmacist	Expert

Appendix 2 : R& D Approval



FINAL R&D APPROVAL

Miss Lucia Rocca
The Barkantine Birth Centre
121 Westferry Road
London
United Kingdom E14 9RC

Joint Research and Development Office
Queen Mary Innovation Centre
5 Walden Street
Whitechapel
London
E1 2EF

Dear Miss Rocca

Tel: 0207 882 7250
Fax: 0207 882 7276

21st February 2011

Protocol: The Barkantine Birth Centre (BaBC): an ethnographics study of the philosophy, culture and practice in a freestanding urban midwife-led unit
ReDA Ref: 007352
CSP: 52691
REC Ref: 10/H1102/65

I am pleased to inform you that the Joint R&D Office for Barts and The London NHS Trust and Queen Mary, University of London, has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project. Approved study documents are as follows:

Type	Version	Date
REC Approval		06.12.10
Protocol	v.4.1	06.08.10
Associated Staff Consent Form	v.5	October 2010
Staff Consent Form	v.5	October 2010
Service Users Information Sheet	v.5	October 2010
Birth Centre Staff Information Sheet	v.5	October 2010
Participant Consent Form	v.5	October 2010
Hospital Staff Information Sheet	v.5	October 2010
Maternity Unit Associated Staff Information Sheet	v.5	October 2010

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BLT and QMUL policies that reinforce them, you can obtain details from the Joint R&D Office or go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint R&D Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 0207 480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely



Gerry Leonard, Head of Research Resources



The Royal Hospital of St. Bartholomew. The Royal London Hospital.
The London Chest Hospital. The Queen Elizabeth Children's Service.

Head of Research Resources: Gerry Leonard

Information leaflet for birth centre staff

I would like to invite you to take part in a research study, which is being carried out as part of my research for a PhD. Before you decide, you need to understand why the research is being done and what it would involve for you. As principal investigator, I will go through the information sheet with you and answer any questions you have. This should take about 10 minutes. Please take time to read the following information carefully. You may wish to talk to others about the study.

PART 1

The Barkantine Birth Centre: a study of the philosophy, culture and practice in a freestanding urban midwife-led unit.

What is the purpose of the study?

Freestanding midwife-led birth centres such as the Barkantine, have not been studied in depth. We would like to understand more about the points of view and experiences of staff and of local women who might choose to use the centre, along with their relatives. We are also interested in the views of the staff working at the hospital consultant-led unit, to which women might transfer if required.

This project aims:

- 1. To study the care provided in a freestanding birth centre focusing on the experiences of service users and providers.
- 2. To shed light on and help to explain how midwifery skills are used and care is provided in a freestanding birth centre.
- 3. To investigate the perception of risk and choices among service users, birth centre staff and consultant-led unit staff.
- 4. To investigate the relationship between the birth centre and the hospital consultant-led unit.

Why have I been invited?

I am inviting all the staff from the Barkantine Birth Centre to participate in this research study.

Do I have to take part?

It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you to keep. If you agree, I will then ask you to sign a consent form to show you agree to take part. You are free to withdraw at any time, without giving a reason. If you

withdraw from the study, I will destroy all your identifiable information, but will need to use the data collected up to the point of your withdrawal.

It is important that you do not feel under pressure to consent just because the researcher is a colleague. Declining to take part will not have an adverse impact on your position at work. If you decide to take part it is important that you are as frank as possible in your replies during the interview. You can rest assured that all the data will be anonymised so your comments will not be identifiable'.

What will the study process involve if I take part?

All the birth centre staff have been invited to participate in this study. If you agree to participate you can help in four different ways. You may want to consent just to one or two of the proposed activities or all of them:

- 1) You could agree to be interviewed by me. The interview will last about an hour.
- 2) You could agree to take part with other staff in focus groups.
- 3) You could agree to let me observe the care provided during antenatal clinics, in labour or while you are facilitating antenatal classes.
- 4) You could agree to have pictures taken while you are working.

The fieldwork at the birth centre will last a maximum of six months. Your participation in the study will last about 3-4 months, but it is unlikely to exceed one interview, one focus group and the observation of three shifts. I might ask a few participants to do a follow up interview once I have started analysing the data.

What will I have to do?

If you agree to participate in the study we will set a mutually convenient time for the interview. You can choose to have the interview at the birth centre, in which case your travel expenses will be paid, or at your home. If you agree to participate in the focus groups, participants will set a time convenient to all. Any observation of practice will be previously agreed with you. I will observe a maximum of three shifts while you are on duty. If you consent for pictures to be taken, you will review all the photographs I take and select those which I can use and keep for the project.

What are the possible disadvantages and risks of taking part?

When conducting interviews there is always the risk of uncovering topics, which may be sensitive for the people being interviewed. If, at any point in time I realise a participant is becoming distressed, I will suggest discontinuing the interview. If it seems appropriate, I may offer a participant the opportunity to speak to a supervisor of midwives, as well as discontinuing the research activity. Counseling is also available to staff via 'Confidential Care' services.

The observation of the birth centre activities will be unobtrusive. It is possible that the observation process may make some participants feel sensitive or uncomfortable, however. In that case, you could ask me to leave without needing to give me explanations. I hope however that with my role being that of a 'participant observer', the risk of feelings of intrusion will be minimal. I will support the case midwife by offering help with minor practical jobs, such as making coffee or fetching things in order to 'fit' into the scene without disturbance.

What are the possible benefits of taking part?

Experience in previous research projects has shown that many midwives have enjoyed interviews and focus groups and found them interesting and stimulating. I also hope that the results of the research will be useful to you as a member of staff in informing practice at the birth centre.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

I cannot promise the study will help you individually but the information I get from this study will help the Trust to improve midwifery practice and the care for pregnant women generally.

Should you complain about the way you have been dealt with during the study or any possible harm you might suffer, this will be addressed. The detailed information on this is given in Part 2.

Expenses

As you will be interviewed in your time off at the birth centre, your travel expenses will be paid. Alternatively I could come to your home for the interview.

If you have found the information in Part 1 interesting and you are considering taking part, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I decide to participate?

If you agree to be **interviewed** we will set a mutually convenient time when you are off work. The interview can take place at the birth centre, at the hospital, at your home or at another convenient place. The interview will be based on themes such as: your professional background, how you see midwifery practice, your experience of working at the birth centre etc...

If you agree to take part in **focus groups**, these will take place at the birth centre. Topics for the focus groups will be specific issues in midwifery practice, which are raised by the group or have arisen during the interviews.

The **participant observation** will focus on the care provided during the antenatal clinic, in labour or when facilitating antenatal classes. After observing a shift, I will write field notes, which I will then analyse, using a method called modified Grounded Theory. At the beginning of my fieldwork I will observe all aspects of midwifery practice but as the fieldwork develops I might restrict my observations to specific aspects of the practice. I am not focusing on individual midwives but on practices, which are shared by the group. This will help me in understanding and exploring the specific culture shared by a group.

Taking **pictures** of the activities and people involved is part of the tradition of the research method I am using. After the people involved have agreed for them to be used, the pictures will be analysed in a similar way as text. I will look for recurrent themes and compare them with the themes emerging in the written text.

What will happen to the information I provide?

I will follow ethical and legal practice and all the information about you will be handled in confidence. Your name will only appear on the consent form, which will be kept secured in a locked cabinet in the Midwifery Department of City University London. Only my supervisors or the translators if needed and I, will have access to this data. Interviews and field notes will be entered onto a computer for analysis using a pseudonym. Your name will be kept safe and not appear at any time in the research data or in the report. Data will be stored securely at City University London for the duration of the study and in the Barts and the London Trust Archives after the study is finished.

Confidentiality, consent, substandard practice and the safeguarding of children.

The only personal information, which I shall collect about you during the course of the research is the information on the consent form. The consent form will be kept strictly confidential, and only anonymised information will leave the Trust premises. You can rest assured that I will never interfere in the care you provide to the woman/couple. The only cases in which I will have the duty to breach confidentiality will be if I have concerns about the safety of a woman or her child. In the unlikely case that I observed practice which did not conform with the NMC code of practice, I would be required to follow the Trust escalation procedure, which includes involving the shift co-ordinator or line manager after discussing this with you in private in the first instance. In the case of any concerns about child protection it will be my duty to follow the usual Trust escalation procedures.

What will happen to the results of the research study?

The results of the study will be submitted as a PhD Dissertation as well as being made available more generally to people concerned with midwifery care locally and more widely. Presentations

will be organised to disseminate locally within the NHS Trust, commissioners, the Primary Care Trust and service users in Tower Hamlets. Relevant findings will also be disseminated via journals, conferences at national and international level. If you are interested in the research findings I will be very pleased to invite you to a presentation held in the Trust and forward you a summary of the research findings.

What happens if I don't want to carry on with the study?

You are free to withdraw at any time, without giving a reason. If you withdraw from the study, I will destroy all your identifiable information, but I will need to use the data collected up to your withdrawal.

What if there is a problem?

I believe that this study is safe and do not expect you to suffer any harm because of your participation in it. If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (My mobile number is 07989 230313) you remain unhappy and wish to complain formally, you can do this via the consultant midwife Alison Herron [REDACTED] or via email [REDACTED] or Michelle Keeler, the birth centre manager [REDACTED] or via email [REDACTED]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Barts and the London NHS Trust but you may have to pay your legal costs.

Who is organising the study?

I am a senior midwife from the Barts and the London NHS Trust and I am undertaking a PhD at City University London funded by the National Institute of Health Research.

Who has reviewed the proposal for this study?

This study has been funded by the National Institute for Health Research. In addition all research in the NHS is looked at by independent group, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favorable opinion by the South East Research Ethics Committee.

Who can I contact if I have any question or concern?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (My mobile number is [REDACTED]) you remain unhappy and wish to complain formally, you can do this via Alison Herron or Michelle Keeler.

Information leaflet for service users

I would like to invite you to take part in a research study, which is being carried out as part of my research for a PhD. Before you decide, you need to understand why the research is being done and what it would involve for you. As principal investigator, I will go through the information sheet with you and answer any questions you have. This should take about 10 minutes. Please take time to read the following information carefully. You may wish to talk to others about the study.

PART 1

The Barkantine Birth Centre: a study of the philosophy, culture and practice in a freestanding urban midwife-led unit.

What is the purpose of the study?

Freestanding midwife-led birth centres such as the Barkantine, have not been studied in depth. We would like to understand more about the points of view and experiences of staff, local women who might choose to use the centre, along with their relatives. We are also interested in the views of the staff working at the hospital consultant-led unit, to which women might transfer if required.

This project aims:

- 1. To study the care provided in a freestanding birth centre, focusing on the experiences of service users and providers.
- 2. To shed light on and help to explain how midwifery skills are used and care is provided in a freestanding birth centre.
- 3. To investigate the perception of risk and choices among service users, birth centre staff and consultant-led unit staff.
- 4. To investigate the relationship between the birth centre and the hospital consultant-led unit.

Why have I been invited?

I am inviting maternity service users and their relatives to participate in this research study. This includes pregnant women with uncomplicated pregnancies, their birth supporters, husbands or partners. I would also like to involve a few grandparents.

Do I have to take part?

It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you to keep. If you agree, I will then ask you to sign a consent form, to show

you have agreed to take part. You are free to withdraw at any time, without giving a reason. If you withdraw from the study, I will destroy all your identifiable information, but will need to use the data collected up to the time when you withdraw.

It is important that you do not feel under pressure to consent. You can rest assured that declining to take part in the research will not affect the quality of the care you will receive. If you decide to take part it is important that you are as frank as possible in your replies during the interview. All personal data will be removed so your comments will not be identifiable.

What will the study process involve if I take part?

If you agree to take part you can help in different ways. You may want to consent just to one or two of the proposed activities or to all of them:

- 5) You could agree to be interviewed by me. The interview will last approximately one hour.
- 6) You could agree to take part with other women in focus groups.
- 7) You could let me observe the care you receive while attending an antenatal clinic appointment or let me sit in with your antenatal classes.
- 8) You could agree to let me be present during your labour/birth.
- 9) You could agree to have pictures taken while attending the birth centre tour, the active birth workshop, an antenatal appointment or while you are in labour or giving birth.

The fieldwork will last a maximum of six months. Your participation in the study will last about 3-4 months, but it is unlikely to exceed one interview, one focus group and the observation of your labour/birth. I might ask a few participants to do a follow up interview once I have started analysing the data.

What will I have to do?

If you participate in the study we will agree with you a mutually convenient time for the interview. You can choose to have the interview at the birth centre or at the hospital, in which case your travel expenses will be paid, or at your home. Any observation of your care will be previously agreed with you. If you agree for me to be present during your labour you will let me know when the labour has started and I will meet you at the birth centre or at the hospital. If you consent for pictures to be taken, you will review all the photographs I take and select those which I can use and keep for the project.

What are the possible disadvantages and risks of taking part?

When conducting interviews there is always the risk of uncovering topics, which may be sensitive for the people being interviewed. If, at any point in time I realise a participant is becoming distressed, I will suggest discontinuing the interview. If it seems appropriate, I may offer a participant the opportunity to speak to a supervisor of midwives, as well as discontinuing the research activity. Counseling is also available via your GP.

My observation of your antenatal or labour/birth care will be unintrusive. It is possible that the observation process may make some participants feel sensitive or uncomfortable, however. In that case, you could ask me to leave without needing to give me explanations. I hope, however, that with my role being that of a 'participant observer' the risk of feelings of intrusion will be minimal. I will support the case midwife by offering help with minor practical jobs, such as making coffee or fetching things in order to 'fit' into the scene without disturbance.

What are the possible benefits of taking part?

Experience in previous research projects has shown that many research participants have enjoyed the interviews and focus groups and found them interesting and stimulating.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

I cannot promise the study will help you individually but the information I get from this study will help the Trust to improve midwifery practice and the care for pregnant women generally.

Should you complain about the way you have been dealt with during the study or any possible harm you might suffer, this will be addressed. The detailed information on this is given in Part 2.

Expenses and payments

If you agree to be interviewed at the birth centre or at the hospital, your travel expenses will be paid. Alternatively I could come to your home for the interview.

If you have found the information in Part 1 interesting and you are considering taking part, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I decide to participate?

If you agree to be **interviewed**, we will set a mutually convenient time. The interview can take place at the birth centre, at the hospital or at another convenient place including your home. The interview will be based on themes such as: your experience of maternity care, the choices you are making for the birth, your perception of the midwives and reasons for choosing your planned place of birth.

If you agree to participate in **focus groups**, these will take place at the birth centre or at the hospital. Topics for the focus groups will be specific issues to do with the Maternity Services such as how decisions are made about your maternity care, your experience of care, or any other issues, which are raised by the group or have arisen during the interviews.

The **participant observation** will focus on the care you receive during antenatal clinics, in labour or during the antenatal classes. After each day of observation I will write field notes, which I will then analyse using a method called modified Grounded Theory. At the beginning of my fieldwork I will observe all aspects of midwifery practice but as the fieldwork develops I might restrict my observations to only specific aspects. I am not focusing on individual midwives but on practices, which are shared by the group. This will help me in understanding and exploring the specific culture shared by a group.

If you agree for me to be present during your labour and the birth of your baby, I will be 'on call for you' and will do my best to be there. In some cases, for instance if I am working clinically in the hospital, I might not be able to guarantee my presence for the whole labour.

Taking **pictures** of the activities and people involved is part of the tradition of the research method I am using. After the people involved have agreed for them to be used, the pictures will be analysed in a similar way as text. I will look for recurrent themes and compare them with the themes emerging in the written text.

What will happen to the information I provide?

I will follow ethical and legal practice and all the information about you will be handled in confidence. Your name will only appear on the consent form, which will be kept secured in a locked cabinet in the Midwifery Department of City University London. Only my supervisors or the translators if needed and I, will have access to this data. Interviews and field notes will be entered onto a computer for analysis using a pseudonym. Your name will be kept safe and not appear at any time in the research data or in the report. Data will be stored securely at City University London for the duration of the study and in the Barts and the London Trust Archives after the study is finished.

Confidentiality, consent, substandard practice and the safeguarding of children.

The only personal information, which I shall collect about you during the course of the research is the information on the consent form. The consent form will be kept strictly confidential, and only anonymised information will leave the Trust premises. You can rest assured that I will never interfere in the care provided by your midwife. The only cases in which I will have the duty to breach confidentiality will be if I have concerns about the safety of a woman or her child. In the unlikely case that I observed practice which did not conform with the NMC code of practice, I would be required to follow the Trust escalation procedure, which includes involving the shift co-ordinator or line manager after discussing this with your midwife in private in the first instance. In the case of any concerns about child protection it will be my duty to follow the usual Trust escalation procedures.

What will happen to the results of the research study?

The results of the study will be submitted as a PhD Dissertation as well as be made available more widely to people concerned with midwifery care locally and more widely. Presentations will be organised to disseminate locally within the NHS Trust, commissioners, the Primary Care Trust and service users in Tower Hamlets. Relevant findings will also be disseminated via journals, conferences at national and international level. If you are interested in the research findings I will be very pleased to invite you to a presentation held in the Trust and forward you a summary of the research findings.

What happens if I don't want to carry on with the study?

You are free to withdraw at any time, without giving a reason. If you withdraw from the study, we will destroy all your identifiable information, but I will need to use the data collected up to your withdrawal.

What if there is a problem?

I believe that this study is safe and do not expect you to suffer any harm because of your participation in it. If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (My mobile number is [REDACTED]). If you remain unhappy and wish to complain formally, you can do this via the PALS service (Telephone 020 7943 1335, Minicom 020 7943 1350, E-mail PALS@bartsandthelondon.nhs.uk), the consultant midwife Alison Herron [REDACTED] or via email [REDACTED] or Michelle Keeler, the birth centre manager [REDACTED] or via email [REDACTED]).

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Barts and the London NHS Trust but you may have to pay your legal costs.

Who is organising the study?

I am a senior midwife from the Barts and the London NHS Trust and I am undertaking a PhD at City University London funded by the National Institute of Health Research.

Who has reviewed the proposal for this study?

This study has been funded by the National Institute for Health Research. In addition all research in the NHS is looked at by independent group, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favorable opinion by the South East Research Ethics Committee.

Who can I contact if I have any question or concern?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions ([REDACTED]).

Appendix 5: Staff Consent Form

STAFF CONSENT FORM (Version 5, Dated October 2010)

Title of project:

The Barkantine Birth Centre: a study of the philosophy, culture and practice in a freestanding urban midwife-led unit.

Principal Investigator: Lucia Rocca-Ihenacho

Study Number:

Participant Identification Number for this study:

Please initial box to indicate agreement

1.	I confirm that I have read and understood the information sheet dated October 2010 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and that this will not have an adverse impact on my position at work.	
3.	I understand that relevant sections of any of the anonymised data collected during the study may be looked at by responsible individuals from regulatory authorities or from the Barts and the London Trust or City University London, where the data are relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
4.	I agree to take part in the above study and to let the researcher observe the care I provide at the birth centre/hospital (excluding intrapartum care).	
5.	I agree to take part in the above study and to be interviewed as well as to let the researcher observe the care I provide at the birth centre/hospital (including intrapartum care)	
6.	I agree to let the researcher take pictures while I am caring for labouring/ birthing women. I will review the pictures and select those, which I will agree can be used for the research. The rest of the pictures will be destroyed.	
7.	I agree to be interviewed as part of the above study.	

Telephone number.....E-mail.....

Preferred time to phone you.....

Please specify which language.....

Name of Participant

Date

Signature

Investigator

Date

Signature

1 copy for Participant, 1 for Investigator and original to be kept in medical notes

Appendix 6: Service Users Consent Form

SERVICE USERS CONSENT FORM (Version 5, Dated October 2010)

Title of project:

The Barkantine Birth Centre: a study of the philosophy, culture and practice in a freestanding urban midwife-led unit.

Principal Investigator: Lucia Rocca-Ibenacho

Study Number:

Participant Identification Number for this study:

Please initial box to indicate agreement

1.	I confirm that I have read and understood the information sheet dated October 2010 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my maternity care or legal rights being affected.	
3.	I understand that relevant sections of any of the anonymised data collected during the study may be looked at by responsible individuals from regulatory authorities or from the Barts and the London Trust or City University London, where the data are relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
4.	I agree to take part in the above study letting the researcher observe my antenatal appointment with the midwife.	
5.	I agree to take part in the above study and let the researcher observe my antenatal class.	
6.	I agree to take part in the above study and let the researcher observe my tour of the birth centre.	
	I agree to take part in the above study and let the researcher be present at my labour/birth.	
7.	I agree to let the researcher take pictures of my antenatal appointment. I will review the pictures and select those, which I agree can be used for the research. The rest of the pictures will be destroyed.	
8.	I agree to let the researcher take pictures of my antenatal classes/tour. I will review the pictures and consent for which picture can be used for the research. The rest of the pictures will be destroyed.	
9.	I agree to let the researcher take pictures of all my care, including labour and birth. I will review the pictures and select those, which can be used for the research. The rest of the pictures will be destroyed.	
10.	I agree to be interviewed as part of the above study	

DUE DATE.....Telephone number.....E-mail.....

Preferred time to phone you.....

Language in which you wish to communicate with the researcher:

English ☐ Sylheti ☐ Bengali ☐ Other ☐

Please specify which language.....

_____ Name of Participant	_____ Date	_____ Signature
_____ Investigator	_____ Date	_____ Signature

1 copy for Participant, 1 for Investigator and original to be kept in medical notes

Appendix 7: Birth Centre outcomes

Since the opening of the Barkantine Birth Centre a detailed audit has been maintained. Findings have been presented yearly at the Barts and the London NHS Trust, now Barts Health Maternity Services Audit Meeting. A dedicated audit was needed as the NHS Trust maternity system was not equipped either to identify site of activity or record data relevant to birth centre care.

Presenting accurate data with positive clinical outcomes has played an important role in strengthening the image of the FMU within the NHS Trust (personal communication by a service manager). Several midwives from the Barkantine had allocated time dedicated to the audit activity. In this section, I report on some key findings for the three years (2008 to 2010) leading up to the period of data collection in order to provide a picture about clinical outcomes of the FMU in the years prior to commencing the fieldwork.

Midwives Miriam Martin, Michelle Keeler, Kirstie Savege, Kerry Mahoney and Jenny Haddon collected and analysed the data presented here. Professor Macfarlane, from City University London also provided some initial assistance for the data collection tool development and the analysis of the data. The audit of the Barkantine was also presented at the Sixth Normal Labour and Birth Research Conference in Grange over Sands (2010) in a plenary session by Midwives Michelle Keeler and Miriam Martin.

Workload and transfer rates

The FMU gradually increased its activity over the years. In the first year 622 women booked for care at the FMU. This included women at all gestations including booking at 10 gestational weeks. In 2010 the number increased to 948 women being booked. The number of births increased from 304 in 2008 to 438 in 2010.

Table 44 - The Barkantine Birth Centre workload 2008-2010 (Barkantine Audit 2008-2010)

	2008	2009	2010	Total
Women booked at Birth Centre	622	848	948	2418
Antenatal change of plan	204 (33%)	329 (39%)	399 (42%)	932 (39%)
Started labour at Birth Centre	418	519	549	1486
Intrapartum transfers	114 (27%)	98 (19%)	111 (20%)	323 (22%)
Birthed at Birth Centre	304	421	438	1163
PN transfers (% of BC Births)	31 (7%)	37 (9%)	34 (8%)	102 (9%)

It is difficult to interpret the antenatal transfer rates because of the changes in the model of care. The antenatal transfer rates refer to the transfers before the onset of labour but the gestational week in which the audit was commenced varied from booking (before 12 weeks) in 2008 to 36 weeks in 2009. Also the integration of the community midwives from the local team created a period of reassessment within the team in which there was variability of practices regarding recommendation for transfer (personal communication, Barkantine Midwife).

As with the Birthplace in England Study (2011) there was a significant difference between the intrapartum rate of transfer for nulliparous and multiparous women. The main reasons for intrapartum transfers were meconium-stained liquor and delayed 1st and 2nd stages. Only 2% of women who started labour at the FMU, transferred for an epidural.

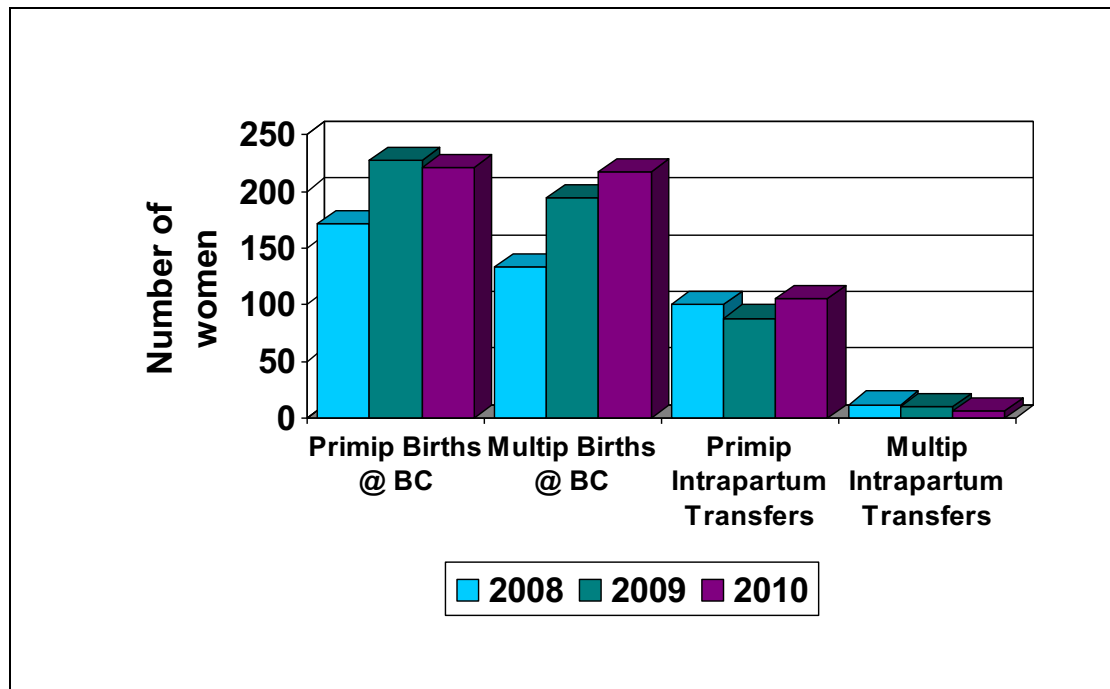


Figure 39 -Births and intrapartum transfers by parity 2008-2010 (Barkantine Audit 2008-2010)

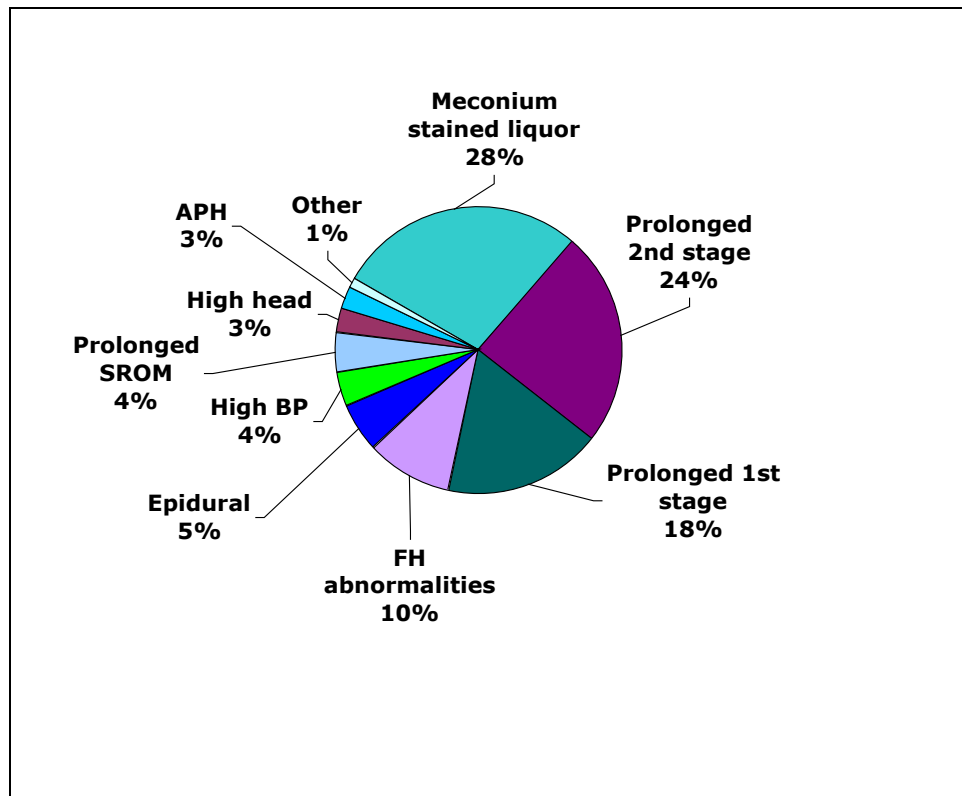


Figure 40- Reasons for intrapartum transfer (Barkantine Audit 2008-2010)

Birth

The majority of women, who birthed at the FMU, birthed either in the pool or on a mat on the floor. The most likely position for birth was all fours and only 10% of women gave birth in semi-recumbent position. Many women opted for non-pharmacological pain relief and 39% of women giving birth at the FMU did not use any pharmacological pain relief. Most women used the birthing pool (89%) and 48% of women had a water birth.

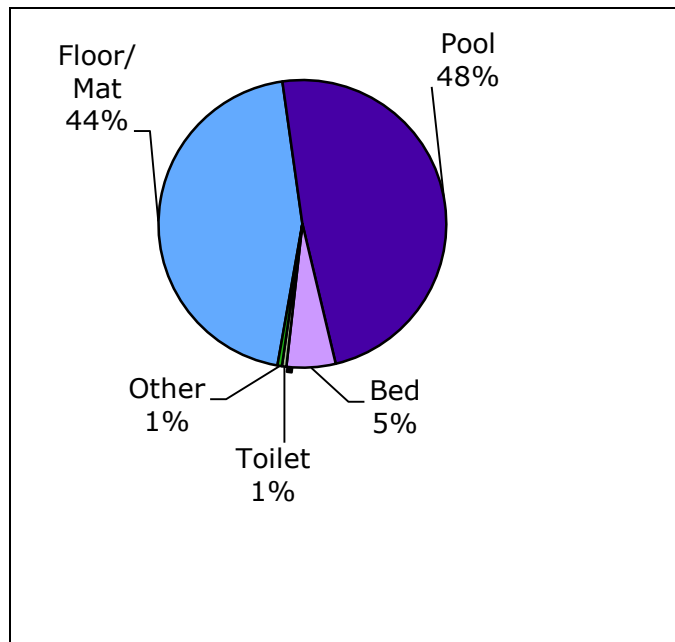


Figure 41- Where the women gave birth (Barkantine Audit 2008-2010)

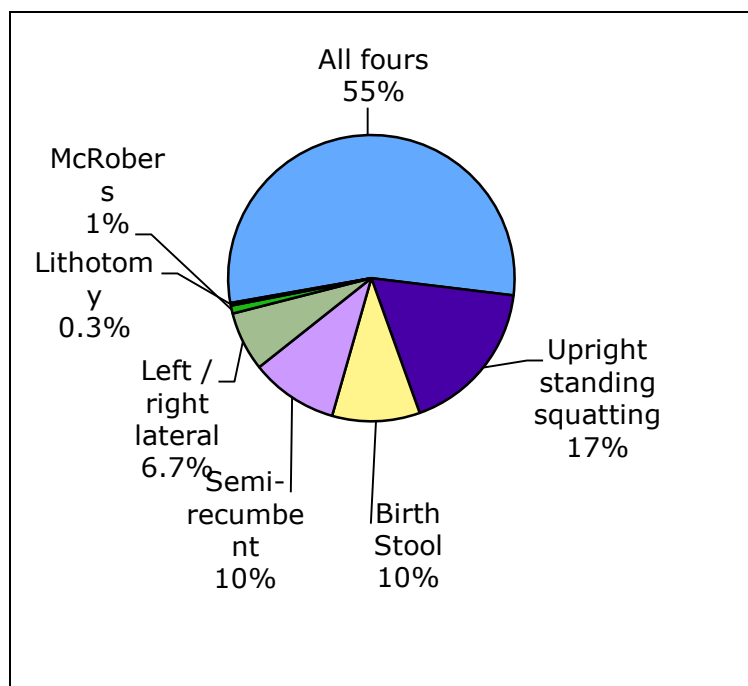


Figure 42- Maternal position for birth (Barkantine Audit 2008-2010)

Among the 1486 women, who started labour at the Barkantine, 85% had a spontaneous vaginal birth, 8% a Cesarean section and 7% an instrumental birth. Of women who transferred in labour 31% had a spontaneous vaginal birth, 31% an instrumental birth and 38% CS.

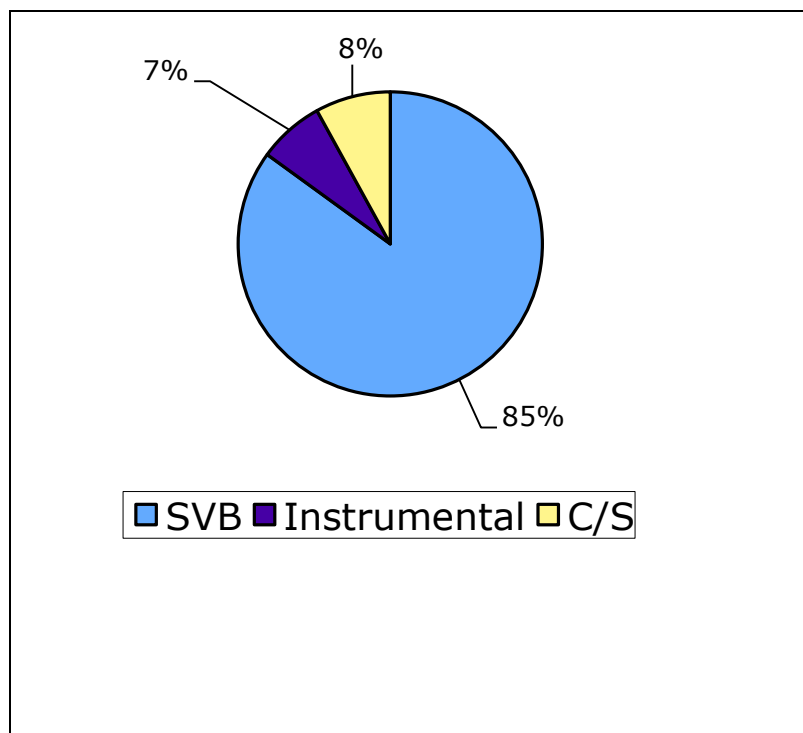


Figure 43- Mode of birth for all women who started labour at the FMU for the three years period 2008-2010 (Barkantine Audit 2008-2010)

Perineal outcomes

The audit from 2008 and 2009 shows more intact perineums, fewer 1st degree tears and equivalent 2nd degree tears for women who gave birth in the pool. Only women who were having a completely straightforward labour would be recommended to stay in the birthing pool. If the second stage was longer or any complication had arisen, the

woman would be recommended to leave the pool. The rate of episiotomy for the years 2008 and 2009 was 3% and the rate of 3rd degree tears was 1.5% (11 occurrences). Of these 8 were on land and three in the pool.

The perineal outcomes showed a low rate of episiotomy (3%) and a low incidence of third degree tears (1.5%).

The audit from 2008-2009 suggested that 6 out of 11 third degree tears occurred while the woman birthed sitting on the birthing stool. The midwives reported that the practice was reviewed accordingly (they stopped using the stool for birthing) and the following year the incidence of third degree tears was even lower.

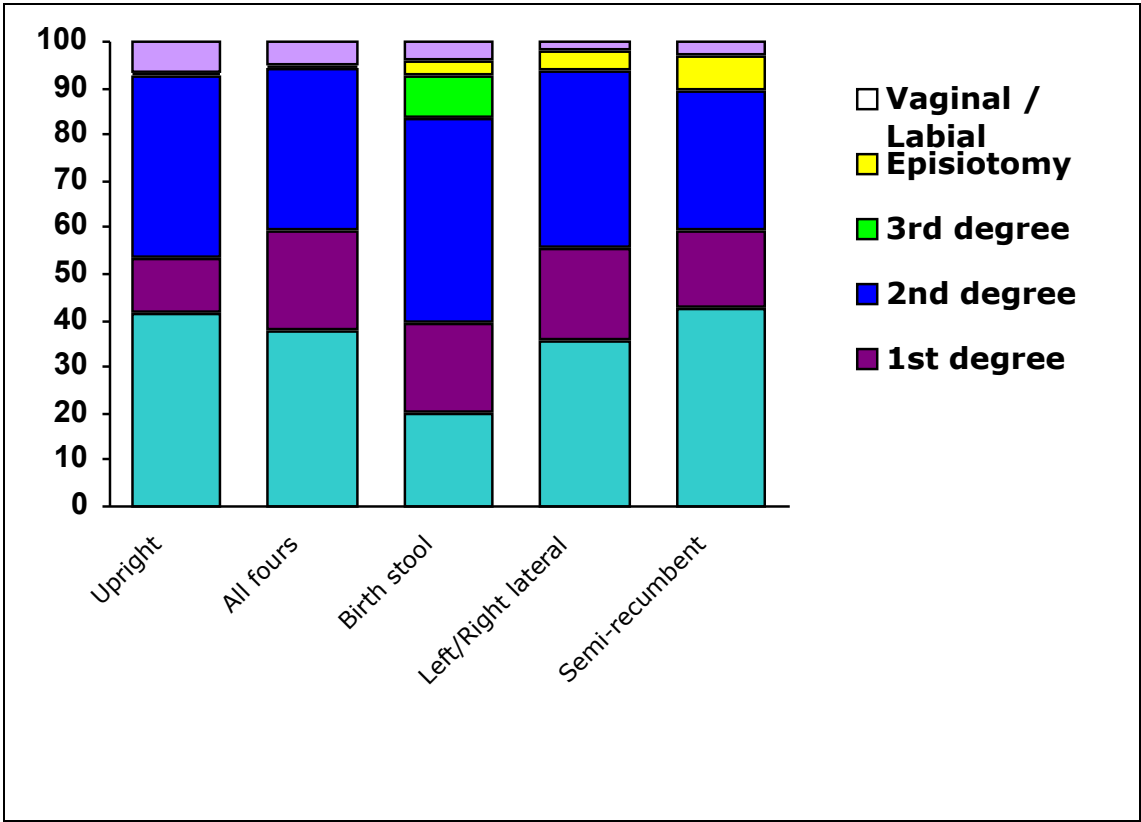


Figure 44- Perineal outcomes for 719 women depending on the birthing position for years 2008-2009 (Barkantine Audit 2008-2010)

Management of third stage

Physiological third stage was supported and encouraged within the FMU and 38 % of women giving birth at the Birth Centre had a physiological 3rd stage, while 52% had active management. This was not associated with a delay in the third stage; in fact 80% of placentas were delivered physiologically within 30' from birth. In 10% of cases the physiological management was followed by active management either for excessive bleeding or a delay in the delivery of the placenta.

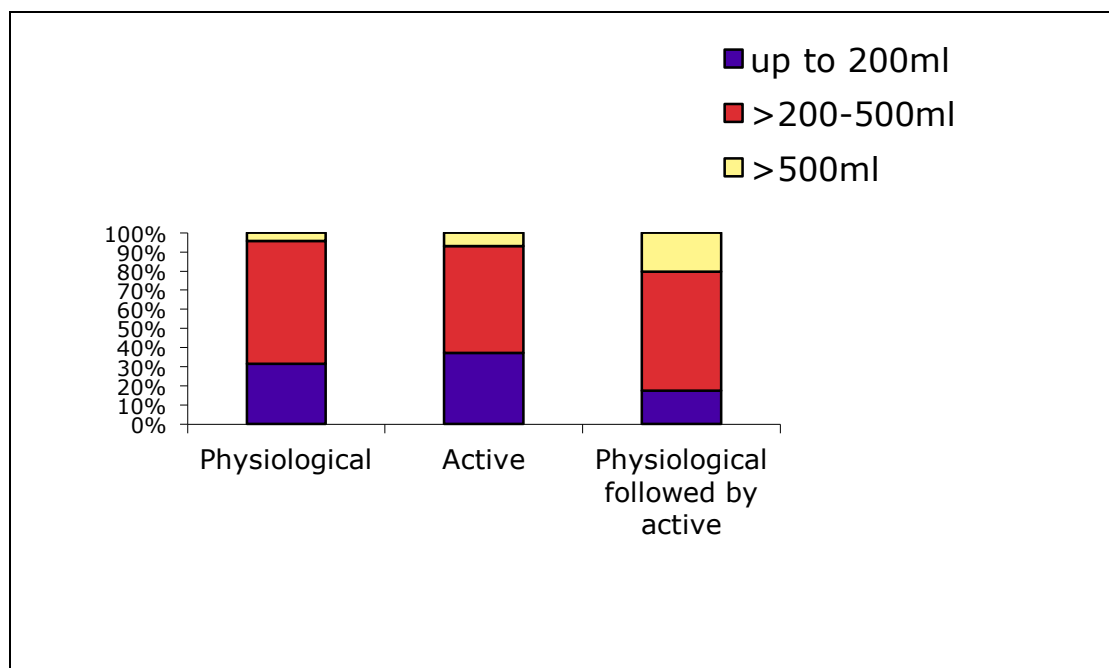


Figure 45- Management of third stage (Barkantine Audit 2008-2010)

Of the 1163 women who gave birth between 2008 and 2010 at the FMU 20 were transferred postnatally for PPH.

Neonatal outcomes

The majority of newborns were in good condition at birth. Most babies who needed resuscitation responded well to inflation breaths. Only 10 neonates out of 719 babies

needed to be supported with ventilation of which three included chest compression. Only two babies had an Apgar score of less than 7 at five minutes. At 5 minutes 723 babies had an Apgar score more than 7.

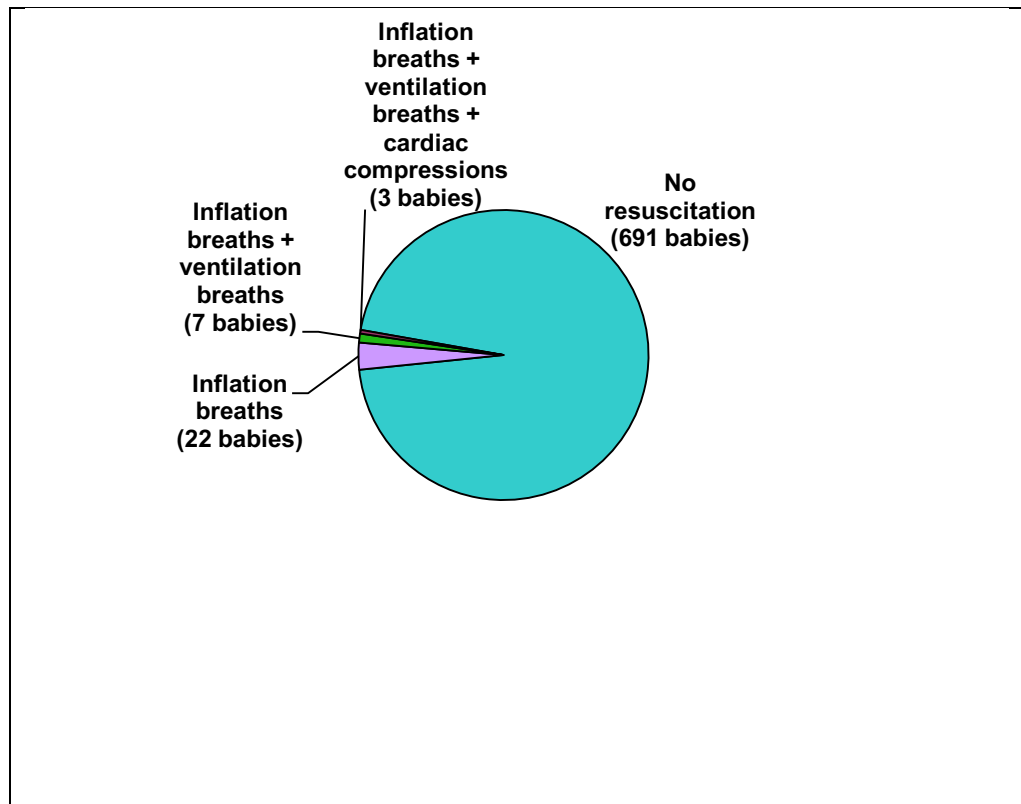


Figure 46- Neonatal resuscitation (Barkantine Audit 2008-2010)

Interval between admission and birth

It is interesting to note that 42% of multiparous women gave birth within two hours of arrival and that 50% of all births occurred within four hours of arrival. The FMU explained this as a consequence of the advice and work done in the active birth workshop offered as an integral part of the FMU care as well as the advice and support provided on the phone when women were in latent phase of labour.

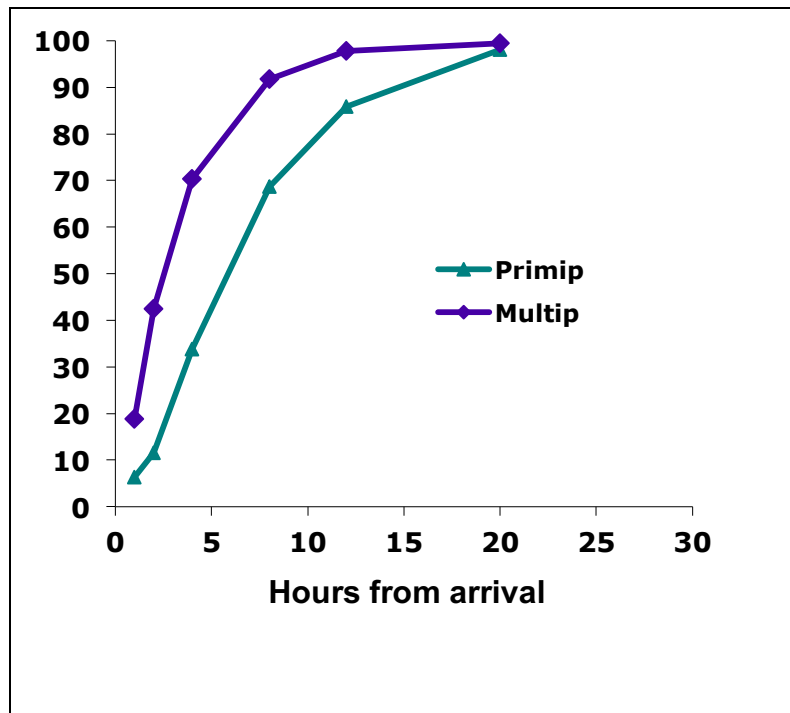


Figure 47- Interval between admission and birth (Barkantine Audit 2008-2010)

Reasons for postnatal transfer

A total of 102 women were transferred postnatally to the OU. This equals to 9% of all births.

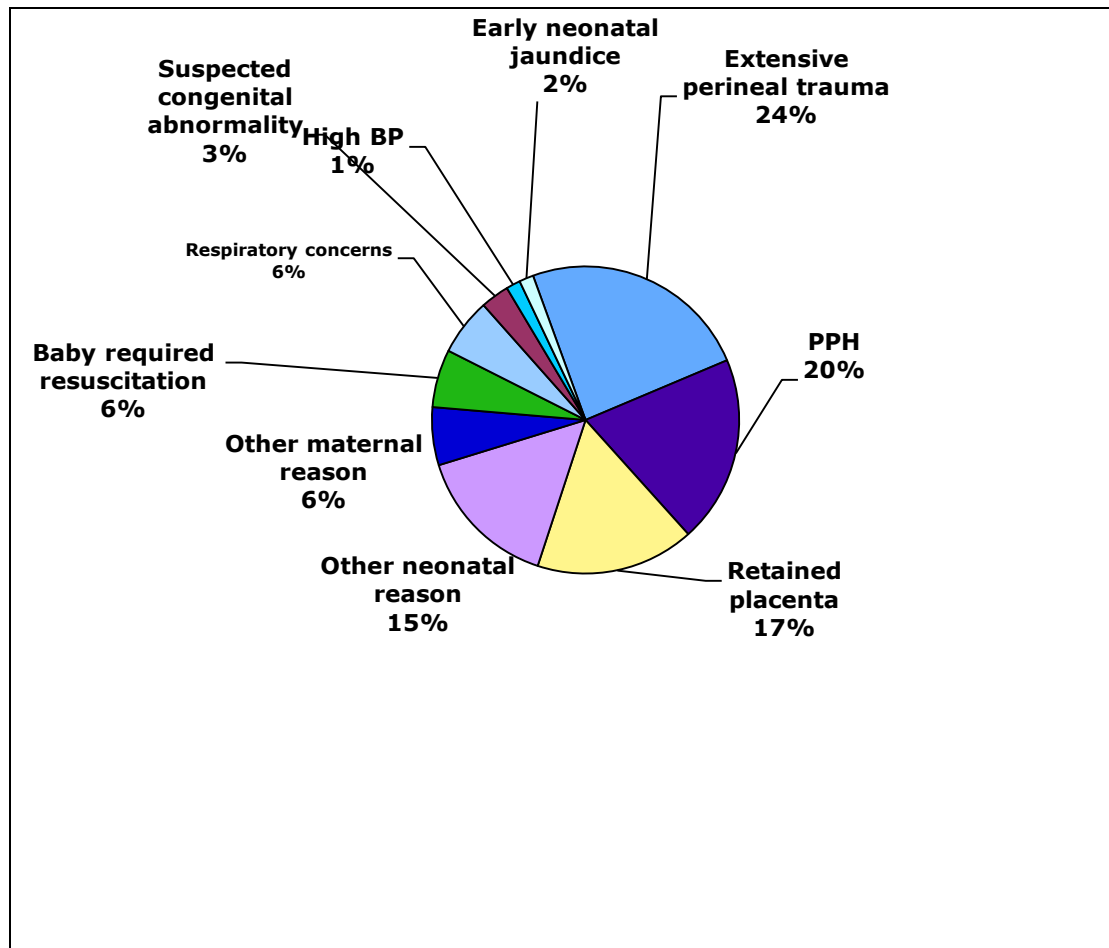


Figure 48- Reasons for postnatal transfers (Barkantine Audit 2008-2010)

The main reasons for postnatal maternal transfer were extensive perineal trauma, post partum haemorrhage and retained placenta. The most common neonatal cause for transfer was respiratory concerns. Neonatal transfer would happen always in case of a neonatal resuscitation which required chest compression or which required ventilation for more than five minutes.

Conclusion

This Chapter provided an overview of the context of the Barkantine Birth Centre.

I described the wider context of the maternity services, the model of care offered by the FMU as well as a brief description of the operational procedures.

I also offered an overview of the activities, transfer rates and clinical outcomes.

The work on the audit was conducted by Barkantine Birth Centre midwives and was not part of my data collection. It was provided for use in this study together with other operational procedures and clinical guidelines as part of key documents for the FMU.

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XSL Stylesheet: **HU Tag Cloud with Code Colors** - A simple tag cloud viewer browser for HU entities

Description: A tag cloud is a visual depiction of content tags used in your HU. More frequently used tags are depicted in a larger font; display order is alphabetical. This lets you find a tag both by alphabet and by frequency. Codes can also show their assigned colors (both in the code selection and the result box).

HU: **Ethnography-2010** by **Lucia Rocca-Ihenacho**

[BS-good experience] [BS-support and caring] [FMU as offering choice] [FMU-AMU] [FMU-NOT having time] [FMU-against hierarchies] [FMU-as maximising opportunities for normal birth] [FMU-as opportunity for learning normal birth] [FMU-as salutogenesis] [FMU-balanced workload] [FMU-being away from OU] [FMU-environment supports normal birth] [FMU-family friendly] [FMU-friendly environment] [FMU-full presence/Mindfulness?] [FMU-having time] [FMU-integrating comm mws] [FMU-issues with tours of unit] [FMU-issues with transfer] [FMU-lack of positive leadership] [FMU-more continuity of care needed] [FMU-mother's territory?] [FMU-need for critical mass] [FMU-negative cases] [FMU-ownership] [FMU-partnership with the woman] [FMU-positive activities] [FMU-positive leadership] [FMU-power balance] [FMU-recommended by friends] [FMU-relationship with OU] [FMU-role of MCA] [FMU-selecting low risk women] [FMU-skill-mix] [FMU-social capital] [FMU-some skills inconsistency] [FMU-spiritual/midwifery] [FMU-sustainabiity] [FMU-teamspirit] [FMU-the beginning] [FMU-threat of closure] [FMU-transfer as trauma] [Fear among staff] [H- as assembly-line] [H- as doctor in charge] [H- as interventionist] [H- birtha snormal in retrospect] [H- lack of ownership] [H- negative environment] [H- not appreciated] [H- power imbalance] [H- socialising into hospital practice] [H- unable to build rapport] [H-as lack of choice for women] [H-as lack of mindfulness] [H-hierarchical culture] [H-lack of active birth skills & knowledge] [H-lack of motivation to learn] [H-lack of positive leadership] [H-lack of respect] [H-lack of respect for privacy] [H-lack of support] [H-lack of time] [H-resistance to change] [MCA-mastery and purpose] [MCA- support] [MCA-need for support integrating] [MCA-ownership] [MCA-respect] [MW- do not enjoy work] [MW- fear of out of hospital] [MW- keeping skills] [MW- shared vision] [MW-Continuous development] [MW-active birth skills] [MW-as just doing the job] [MW-autonomy] [MW-avoiding side effects of interventions] [MW-being compassionate] [MW-being mw- doing] [MW-birth as physilological] [MW-boundaries of normality] [MW-building a relationship/continuity] [MW-carrying the can] [MW-empowered] [MW-empowering women] [MW-enjoying work] [MW-establishing rapport] [MW-feeling appreciated] [MW-giving time] [MW-having time] [MW-having to justify satisfaction/ownership] [MW-making time] [MW-mastery] [MW-mutual support] [MW-need exposure to normal birth] [MW-need for support integrating] [MW-not developing] [MW-offering choice] [MW-openness] [MW-personalised care] [MW-providing information] [MW-purpose] [MW-real midwifery] [MW-reflection as learning tool] [MW-respecting privacy] [MW-responding to woman's needs] [MW-shared philosophy] [MW-skills & Knowledge] [MW-supporting physiology] [MW-supporting women] [MW-teamspirit] [MW-trusting women's body] [ORG-them and us culture] [Obs-being, doing mws] [Reflexivity note] [W- salutogenesis] [W-accpeting idea of transfer] [W-birth supported involved] [W-embracing physiological birth] [W-feeling in control] [W-feeling safe] [W-having information] [W-having options] [W-having support] [W-having time] [W-limitations of FMU] [W-near home] [W-need control] [W-need for support] [W-nesting environment] [W-partnership in decision-making] [W-preparing for birth] [W-previous negative experience in H] [W-rapport and trust] [W-uncertainty of transfer] [W-want privacy] [W-would like more continuity] [W-lack of personalised care] [mw-normality at all costs]

Appendix 9: List of codes and associated groups



Codes: List of Codes and Associated Groups

Codes	Code Groups
BS-good experience	W- feeling safe
BS-support and caring	- Interface with service users - W- feeling safe
FMU as offering choice	Interface with service users
FMU-AMU	
FMU-NOT having time	- Balanced workload and integration with the community mws - Having, making and giving time and Mindfulness
FMU-against hierarchies	- Friendly environment, open door policy, Vicarious nesting - Team spirit culture and ownership
FMU-as maximising opportunities for normal birth	
FMU-as opportunity for learning normal birth	
FMU-as salutogenesis	- Friendly environment, open door policy, Vicarious nesting - Interface with service users - Salutogenesis and social capital
FMU-balanced workload	- Balanced workload and integration with the community mws - Integration with wider services - Salutogenesis and social capital
FMU-being away from OU	
FMU-environment supports normal birth	- Friendly environment, open door policy, Vicarious nesting - W- Focused on wellbeing and transition to parenthood - W- Nesting environment
FMU-family friendly	- Interface with service users - W- Focused on wellbeing and transition to parenthood - W- Nesting environment
FMU-friendly environment	- Friendly environment, open door policy, Vicarious nesting - Interface with service users - Salutogenesis and social capital - W- Focused on wellbeing and transition to parenthood - W- Nesting environment
FMU-full presence/Mindfulness?	

	✦ Balanced workload and integration with the community mws ✦ Salutogenesis and social capital
FMU-having time	✦ Balanced workload and integration with the community mws ✦ Having, making and giving time and Mindfulness ✦ Integration with wider services ✦ Interface with service users ✦ Salutogenesis and social capital
FMU-integrating comm mws	✦ Balanced workload and integration with the community mws ✦ Integration with wider services
FMU-issues with tours of unit	
FMU-issues with transfer	
FMU-lack of positive leadership	✦ Shared leadership
FMU-more continuity of care needed	
FMU-mother's territory?	✦ Friendly environment, open door policy, Vicarious nesting ✦ Interface with service users
FMU-need for critical mass	
FMU-negative cases	✦ Shared leadership
FMU-ownership	✦ Team spirit culture and ownership
FMU-partnership with the woman	✦ Team spirit culture and ownership
FMU-positive activities	✦ Salutogenesis and social capital
FMU-positive leadership	✦ Shared leadership
FMU-power balance	✦ Friendly environment, open door policy, Vicarious nesting ✦ Salutogenesis and social capital ✦ Team spirit culture and ownership ✦ W- Partnership in decision-making
FMU-recommended by friends	
FMU-relationship with OU	✦ Integration with wider services
FMU-role of MCA	
FMU-selecting low risk women	
FMU-skill-mix	
FMU-social capital	✦ Salutogenesis and social capital
FMU-some skills inconsistency	
FMU-spiritual midwifery	✦ Team spirit culture and ownership

	• Mws identity and the right team • Philosophy, knowledge and skills • W- Rapport and trust
MW-identity	• Mws identity and the right team
MW-involving the birth supporter	• Philosophy, knowledge and skills • W- Partnership in decision-making
MW-job satisfaction/ownership	• Shared leadership • Team spirit culture and ownership
MW-making time	• Having, making and giving time and Mindfulness • Interface with service users • Philosophy, knowledge and skills • W- Partnership in decision-making
MW-mastery	• Mws identity and the right team • Team spirit culture and ownership
MW-mutual support	• Philosophy, knowledge and skills • Team spirit culture and ownership
MW-need exposure to normal birth	
MW-need for support integrating	
MW-not developing	
MW-offering choice	• Philosophy, knowledge and skills
MW-openness	• Interface with service users • Philosophy, knowledge and skills • Team spirit culture and ownership
MW-personalised care	• Interface with service users • Philosophy, knowledge and skills • Team spirit culture and ownership • W- Rapport and trust
MW-providing information	• Friendly environment, open door policy, Vicarious nesting • Interface with service users • Philosophy, knowledge and skills
MW-purpose	• Mws identity and the right team
MW-real midwifery	• Interface with service users • Mws identity and the right team • Philosophy, knowledge and skills

MW-avoiding side effects or interventions	
MW-being compassionate	• Mws identity and the right team • Philosophy, knowledge and skills
MW-being mw-doing	• Having, making and giving time and Mindfulness • Mws identity and the right team • Team spirit culture and ownership
MW-birth as physiological	• Philosophy, knowledge and skills
MW-boundaries of normality	• Philosophy, knowledge and skills
MW-building a relationship/continuity	• Friendly environment, open door policy, Vicarious nesting • Team spirit culture and ownership
MW-carrying the can	• Philosophy, knowledge and skills
MW-empowered	• Mws identity and the right team
MW-empowering women	• Interface with service users • Philosophy, knowledge and skills • W- Partnership in decision-making
MW-enjoying work	• Mws identity and the right team • Philosophy, knowledge and skills • Team spirit culture and ownership
MW-establishing rapport	• Friendly environment, open door policy, Vicarious nesting • Philosophy, knowledge and skills • W- Partnership in decision-making
MW-feeling appreciated	
MW-giving time	• Friendly environment, open door policy, Vicarious nesting • Having, making and giving time and Mindfulness • Interface with service users • Philosophy, knowledge and skills • W- Partnership in decision-making
MW-having time	• Friendly environment, open door policy, Vicarious nesting • Having, making and giving time and Mindfulness • Interface with service users • W- Partnership in decision-making
MW-having to justify interventions	• Philosophy, knowledge and skills
MW-holistic care	• Interface with service users

W-having options	✦ W- Having info, options, time and support ✦ W- Partnership in decision-making ✦ W-Need for control and Feeling in control
W-having support	✦ W- Having info, options, time and support ✦ W- Need for support ✦ W- feeling safe ✦ W-Need for control and Feeling in control
W-having time	✦ W- Having info, options, time and support ✦ W-Need for control and Feeling in control
W-limitations of FMU	
W-near home	✦ W- Near home
W-need control	✦ W-Need for control and Feeling in control
W-need for support	✦ W- Need for support
W-nesting environment	✦ W- Nesting environment ✦ W- feeling safe
W-partnership in decision-making	✦ W- Partnership in decision-making ✦ W-Need for control and Feeling in control ✦ W-feeling safe
W-preparing for birth	✦ W- Preparing for birth
W-previous negative experience in H	✦ W-feeling safe
W-rapport and trust	✦ W- Rapport and trust ✦ W- feeling safe ✦ W-feeling safe
W-uncertainty of transfer	
W-want privacy	✦ W- feeling safe ✦ W-Need for control and Feeling in control
W-would like more continuity	
h-lack of personalised care	
mw-normality at all costs	

