

**A Qualitative Study Identifying the Key Components of
Independent Midwifery Practice in Mainland UK**

By

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of Bournemouth University for the degree of Doctor of
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Abstract

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Independent Midwives provide relational continuity of care whilst promoting women's autonomy. They report associated high levels of physiological birth and positive outcomes for women and babies and low levels of interventions (Milan 2004). Since the publication of the Changing Childbirth Report (Department of Health 1993) it has been government policy for these components of care to be incorporated into national maternity services to facilitate higher quality of care, although this policy has as yet to be widely implemented in the United Kingdom (UK). The *Better Births* report (National Maternity Review 2016) has most recently reiterated the need for the inclusion of these components into maternity care in England as a measure to improve care. In Scotland, *The Best Start: five-year plan for maternity and neonatal care* (Scottish Government 2017) sets out their strategy for improving maternity care based on a commitment to provide individualised continuity of care to mothers and babies. The Welsh strategic vision for maternity services (Welsh Government 2011) is less specific, broadly describing respectful care in which the mother and family are the focus. Whilst continuity of care and supporting women's choices are commonly known attributes of independent midwifery care there is little knowledge about the full gamut of this type of practice.

Aims and objectives

The overall aim of this study was to advance knowledge about the practice of Independent Midwives working in Mainland UK.

The objective was to explore Independent Midwives' perceptions and experiences of independent midwifery, through in-depth interviews, and to gain an overarching understanding of what is involved in working independently and providing care for clients. Through this exploration the intention was to identify and understand the essential components of a way of practising midwifery which reportedly work well for both mothers and midwives.

Research design

This study took a qualitative approach, drawing on the principles of constructivist grounded theory methodology and used semi-structured, in-depth interviews to generate the data. With the participants' consent each interview was digitally recorded, transcribed and then analysed using a constant comparative method.

Participants

Eight Independent Midwives were recruited from across Mainland UK using purposive and then theoretical sampling techniques.

Ethical approval was gained from the Bournemouth University Human Ethics Committee.

Findings

Five categories were identified as being key components of the independent midwifery model of care: professional autonomy, time, mother-centred care, knowledge, evidence and practice, and midwifery philosophy.

Conclusions and key recommendations

Professional autonomy is a vital component of independent midwifery practice, enabling Independent Midwives to practise in ways which best serve their clients. They are free to choose how they can best practice in particular circumstances, and importantly, how they apportion their time. Providing continuity of care through caseloading facilitates the establishment of mother-midwife relationships and results in a sustainable work-life balance for the midwives. Time is a critical factor in providing high-quality care. Independent Midwives allot substantial amounts of time to working with their clients and developing their practice, both of which are associated with safer care and better outcomes. The development of mother-midwife relationships results in individualised care and consequently safer care and better outcomes. Independent Midwives' use of a continuum of evidence enables them to incorporate a range of information into the care they provide which caters to the individual needs of the client, resulting in safer care. The midwives' philosophy of normality guides their practice, enabling them to promote health and physiological processes and avoid interventions.

The Independent Midwives' model of care provides mother-centred relational continuity of care in the context of the woman's choices, through a caseloading scheme, as recommended by current government policy for maternity services. This exemplar can be used to assist service providers implement government policy recommendations for maternity care. A

systems-level change is required to enable all midwives to move from providing fragmented care, to providing individualised, relational continuity of care. Midwives need to have greater professional autonomy and more time, in order to effectively provide this type of care. Maternity services need to focus on normality throughout the pregnancy continuum because it promotes health and physiological processes and reduces the use of interventions.

Contents

Chapter 1	Introduction	1
1.1	Definition of a midwife	1
1.2	The development of the midwifery profession in the UK in the 20 th century	1
1.3	The international context	2
1.4	Independent Midwifery in Mainland UK	3
1.5	Continuity of care.....	5
1.5.1	Relational continuity of care	7
1.5.2	Benefits of relational continuity of care	8
1.5.3	Implementing relational continuity of care	10
1.5.4	Challenges to implementing relational continuity of care.....	10
1.5.5	Risk and safety	12
1.5.6	Professional Indemnity Insurance.....	13
1.5.7	Personal factors behind the study: Being an Independent Midwife	15
1.6	Aims and objectives of the study	17
1.7	Introduction summary	17
1.8	Overview of the structure of the thesis	18
Chapter 2	Literature Review	20
2.1	Section introduction	20
2.2	The literature review in grounded theory	20
2.3	Literature Search Protocol	22
2.3.1	Objective	22
2.3.2	Identifying the scope of the review	22
2.3.3	Search methods for identifying studies	22
2.3.4	Database searches	23
2.3.5	Identification of the relevant literature	24
2.3.6	Searching reference lists.....	24
2.3.7	Journal searching	24
2.3.8	Author searching.....	24
2.4	Initial findings.....	25
2.5	Review of the literature relating to the findings	28
2.6	Professional autonomy in midwifery	29
2.6.1	Defining autonomy	30
2.6.2	Tailoring care to meet women’s needs.....	32

2.6.3	Practice development and autonomy.....	33
2.6.4	Advocacy and supporting women’s autonomy	34
2.6.5	Job satisfaction.....	35
2.7	Time and clinical practice.....	36
2.7.1	Time orientations.....	37
2.7.2	Effect of industrialization on time and space	37
2.7.3	Industrialization of childbirth.....	38
2.8	Relationships in midwifery care.....	39
2.8.1	Working in partnership with women	41
2.8.2	Holism	41
2.8.3	Salutogenesis	42
2.9	Evidence and knowledge in healthcare	43
2.9.1	Authoritative knowledge	44
2.10	Philosophy.....	46
2.11	Literature review summary.....	47
Chapter 3	Methodology and research design	48
3.1	Section introduction	48
3.2	Methodology.....	48
3.3	Research design	50
3.3.1	Grounded theory.....	52
3.3.2	Feminist research principles	53
3.3.3	Reflexivity.....	54
3.3.4	Insider researcher	55
3.4	Recruitment	57
3.4.1	Inclusion criteria.....	58
3.4.2	Purposive sampling	58
3.4.3	Theoretical sampling.....	58
3.4.4	Theoretical saturation.....	59
3.4.5	Sample characteristics	60
3.5	Data generation	61
3.5.1	Face-to-face interviewing	62
3.5.2	Intensive interviews	63
3.5.3	Location of interviews.....	65
3.5.4	Pilot interview	66
3.5.5	Main data generation	66
3.5.6	Recording interviews	68

3.5.7	Memo writing.....	69
3.6	Data analysis	70
3.6.1	Transcription and interpretation of the data.....	70
3.6.2	Comparative analysis	72
3.7	Evaluating the quality of the research.....	74
3.8	Research Ethics	76
3.8.1	Gaining ethical approval	76
3.8.2	Ethical Considerations.....	77
3.9	Methodology and research design summary	81
Chapter 4	Research findings	82
4.1	Introduction to the findings	82
4.2	Professional autonomy	84
4.2.1	Quality of care.....	84
4.2.2	Professional freedom	88
4.2.3	Practice development	91
4.2.4	Advocacy	94
4.2.5	Supporting women’s autonomy.....	95
4.2.6	Quality of life.....	98
4.2.7	Peer support.....	101
4.3	Professional autonomy summary	103
4.4	Time	104
4.4.1	Time as an investment in women	104
4.4.2	Time to develop knowledge.....	107
4.4.3	Time summary	108
4.5	Mother-centred care.....	109
4.5.1	Trusting relationships.....	109
4.5.2	Individualized care	113
4.5.3	Holistic care.....	118
4.5.4	Salutogenic approach.....	119
4.5.5	Partnership working.....	120
4.5.6	Communication.....	127
4.6	Mother-centred care summary	131
4.7	Knowledge, evidence and practice	131
4.7.1	Practice development	131
4.7.2	Clinical judgement.....	136
4.7.3	Women’s knowledge	143

4.7.4	Informed decision-making	144
4.7.5	Women’s autonomy.....	146
4.7.6	Knowledge, evidence and practice summary	148
4.8	Midwifery philosophy	148
4.8.1	The normality of the pregnancy continuum	149
4.8.2	Shared philosophy.....	155
4.8.3	Beliefs about women’s autonomy	156
4.8.4	Midwifery philosophy summary	157
4.9	Research findings summary	158
Chapter 5	Discussion.....	159
5.1	Introduction to the discussion	159
5.2	Professional autonomy	159
5.2.1	Providing high-quality care	161
5.2.2	Advocacy and women’s autonomy	162
5.2.3	Quality of life.....	170
5.3	Professional autonomy discussion summary.....	172
5.4	Time	173
5.4.1	Concepts of time	174
5.4.2	Appointment time.....	175
5.4.3	Time and power	180
5.4.4	Caseloading time.....	181
5.4.5	Quality of time	182
5.4.6	Time on-call.....	183
5.4.7	Time and values	184
5.4.8	Time to learn and inform	185
5.5	Time discussion summary	186
5.6	Mother-centred care.....	186
5.6.1	Mother-midwife relationship.....	186
5.6.2	Developing trusting relationships	188
5.6.3	What women want	191
5.6.4	Tailored care	194
5.6.5	Taking a holistic approach.....	196
5.6.6	Incorporating salutogenesis.....	199
5.6.7	Working with women.....	201
5.6.8	Effective communication in midwifery	202
5.6.9	Content of communication	204

5.6.10	Power and communication	205
5.7	Mother-centred care discussion summary	205
5.8	Knowledge, evidence and practice	206
5.8.1	Innovating practice	207
5.8.2	Ways of knowing.....	210
5.8.3	Using clinical judgement	214
5.8.4	Variations in practice	216
5.9	Knowledge, evidence and practice discussion summary.....	217
5.10	Midwifery philosophy	218
5.10.1	Philosophy of the pregnancy continuum as a normal physiological event .	218
5.10.2	Being ‘with woman’	226
5.10.3	Midwifery beliefs and risk perceptions.....	227
5.10.4	Women and midwives shared philosophies	227
5.11	Midwifery philosophy discussion summary.....	229
5.12	Limitations of the study	230
5.13	Discussion summary.....	231
Chapter 6	Model of Midwifery Care	233
6.1	Introduction to the model of midwifery	233
Chapter 7	Conclusion.....	242
7.1	Recommendations for further research	244
Chapter 8	Recommendations	246
References	248
Legislation	296
Appendix 1:	Invitation to Participate in Research.....	297
Appendix 2:	Participant Information Sheet.....	298
Appendix 3:	Participant Consent Form	301
Appendix 4:	Interview guide for semi-structured interviews	303
Appendix 5:	Development of analysis memos.....	305
Appendix 6:	Coding development.....	306
Appendix 7:	Excerpt from interview transcription.....	310
Appendix 8:	Mind Map.....	312
Appendix 9:	Research Ethics Approval.....	313
Appendix 10:	Amendment to ethical approval	317
Appendix 11:	Development of codes	318
Appendix 12:	Memos about NMC action	319

Appendix 13:	Framework for quality maternal and newborn care: maternal and newborn health components of a health system needed by childbearing women and newborn infants	320
Appendix 14:	Article submitted for publication.....	321
	Glossary of midwifery terms.....	341
Figure 1	Model of relational continuity of midwifery care.....	235
Figure 2:	Relationships between the components of relational continuity of care model of midwifery	241
Table 1:	List of databases searched	23
Table 2:	Demographic of participants - 2017.....	61
Table 3	Categories and focused codes.....	82
Table 4:	Comparison of model of relational continuity of midwifery care with QMNC framework and Symon <i>et al.</i> 's identification of components of high-quality care.....	237

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Chapter 1 Introduction

1.1 Definition of a midwife

The Nursing and Midwifery Council (NMC), the professional regulator for midwives, describes midwifery as, 'a distinct profession, with its own standards of proficiency and part of the NMC register' (NMC 2017a, p.3). This is because the care midwives provide childbearing women and their babies requires specific expertise unique to pregnancy, childbirth and the postnatal period. The title 'midwife' is protected in law in the United Kingdom (UK) and only those who have an approved midwifery qualification and are registered with the NMC are legally entitled to practise as a midwife. Only midwives, medical practitioners and students of those professions are legally permitted to attend a woman in childbirth. The exception to this is in the case of an emergency, where anyone can assist a woman. Once registered, midwives must uphold the professional standards as set out in '*The Code*' (NMC 2018) and meet the NMC's revalidation requirements every three years to remain on the register (NMC 2017a).

1.2 The development of the midwifery profession in the UK in the 20th century

The legal regulation of the midwifery profession in England and Wales, in 1902, and in Scotland in 1915, aimed to protect the public by implementing the formal training and registering of midwives (Isherwood 1995). At the time most midwives were self-employed practitioners, receiving payment from clients for providing midwifery services (Towler and Bramall 1986). The 1902 Midwives Act: England & Wales "ensured the survival of the midwife, even if she still had to accept a large amount of medical supervision over her activities" (Carter & Duriez, 1986, p.148). The 1918 Maternal and Child Welfare Act saw the introduction of free state antenatal care at some local authority clinics which whilst improving the provision of care for women in those areas inevitably threatened the livelihoods of midwives who remained self-employed because some women would choose a free option in preference to one which they had to pay for (Isherwood 1995). In 1924 most midwives worked in the community, attending lower social class pregnant women and "receiving fees for their services from those who could pay" (Towler & Bramall 1986, p.210). Creating a national salaried maternity service in England and Wales under the 1936 Midwives' Act made all local supervising authorities responsible for providing such a service (Benoit *et al.* 2005). Whilst self-employed midwives had been able to compete with doctors, by providing less expensive services, they were not able to compete with a state funded

service and consequently by 1942 only a small minority of midwives were practising privately (Dingwall *et al.* 1988). The creation of the NHS in 1948 gave all women free access to obstetric-based hospital services. Cronk (1990) asserts that midwives made a political mistake in 1948 by becoming salaried NHS employees, rather than being contracted practitioners like general practitioners (GPs). Dingwall *et al.* (1988) describe midwives at this time as holding a subordinate position to doctors, which was reinforced in the 1950s when GPs became the first point of contact for pregnant women. As the number of hospital births increased care became fragmented and the relationship between mothers and midwives declined (Isherwood 1995). With the routine medicalisation of birth came a backlash from some women and midwives in the 1970s, challenging the medical authority which now dominated maternity services. During the 1980s NHS midwives tried to improve maternity services by introducing alternative approaches to care with innovations such as the birth centre established by Caroline Flint (Flint 1990). With increasing public interest in unmedicalized birth and discontent with the medical model and being unable to provide continuity of care, some midwives set themselves up in private practice, referring to themselves as Independent Midwives (Hobbs 1998).

1.3 The international context

Internationally there are other examples of midwifery practice existing outside the country's national health service although they differ to the situation in the UK. New Zealand, Canada and the Netherlands have similar economic, sociological and political characteristics to the UK (Gray *et al.* 2016) and so have been selected for comparison. Midwifery was afforded autonomous status in New Zealand in 1990 establishing it as a separate and distinct profession (Walsh 2007). Midwives there may be self-employed, providing continuity of care to a caseload of women as lead maternity carer (LMC) or employed by district health boards as either LMCs or maternity facility staff (Gray *et al.* 2016). The maternity care system is integrated and all LMCs can access additional services, such as obstetric care for an emergency instrumental birth, and continue to provide care for their client. Maternity care is free in New Zealand, with the government paying LMCs for their services, unless a woman chooses to book for care with a private obstetrician, who is then permitted to charge for their services, in addition to the fee they receive from the government (Walsh 2007).

In Canada midwifery regulation and services vary by province and territory, with some yet to recognize midwifery as a profession. The majority of maternity care throughout Canada is provided by obstetricians and family physicians which is confirmed by the Canadian Association of Midwives (CAM) current reports that midwives' provision of birth care across

the provinces and territories ranges from zero to 22.4% of women, with the national average of midwifery involvement in birth being 10% (CAM 2019). Midwives may work in a self-employed capacity or as salaried employees working in community-based group practices. Midwives are often independent contractors, paid by the government for the episodes of care they provide (Gray *et al.* 2016). They are not employed to work in hospitals, however they can access emergency services when necessary although being granted hospital privileges which able them to continue to provide care in the hospital setting is highly variable and proves to be challenging for individual midwives to arrange (CAM 2019).

The situation differs in the Netherlands where midwives can work in independent private practice as primary care providers, in a self-employed capacity, or as hospital-based employees, known as clinical midwives. Approximately 75% of midwives work in primary care and are reimbursed their fees from the national private health care fund (DeVries *et al.* 2013). Primary care midwives are able to transfer women to hospital when required and continue to provide care if appropriate. Two clear differences exist between the practice of Independent Midwives in the UK and those in New Zealand, Canada and the Netherlands. First, UK midwives do not have privileges to practice within the hospital setting without an individually negotiated contract of employment with the specific hospital Trust involved (Royal College of Midwives [RCM] 2017). Secondly, they cannot claim their fees from the government or health insurance organisation for providing their services, meaning that the clients need to pay for their care. This consequently limits the service to those who can afford it rather than it being universally available although, as described in Section 5.6.4, the midwives have creative ways of helping women afford the fees.

1.4 Independent Midwifery in Mainland UK

Independent Midwives in the UK are NMC registrants who choose to work outwith the National Health Service (NHS), in a self-employed capacity, providing maternity services to a caseload of fee-paying clients (Hobbs 1998). They identify with the description 'Independent Midwife' rather than 'self-employed' midwife. A variety of terms; mothers, clients and women, are used interchangeably by Independent Midwives to identify those they provide their services to. However, the British Medical Association (BMA 2017) released guidance to its members recommending that pregnant women not be called 'pregnant women' or 'expectant mothers' as this could be offensive to transgender people and that they should be referred to as pregnant people. Whilst this guidance could be seen as being inclusive there is a danger that the identity of the group of people who call themselves women and who may also choose to view themselves as mothers is obscured and their right to name

themselves is impeded (Saewyc 2017). A counterpoint to the BMA's stance is a campaign by 'ProCreate Project', a UK-based organisation, reflecting the views and beliefs of women who identify with the word 'mother', and supporting and empowering them to reclaim and promote the use of the word 'mother' (ProCreate Project 2018). The term 'mother' is also used by Kirkham (2010) to describe pregnant women and those who have given birth, in her book 'The midwife-mother relationship'. The terms 'mother' and 'mother-centred care' are used within this thesis to reflect the views of the participants and those who identify themselves as mothers.

Independent Midwives are personally responsible for finding their own clients and earning a sufficient income that they can live on, which means that they face financial uncertainty and are subject to fluctuations in the economic climate (Garratt 2014). In general, advertising their services is an ineffective method of acquiring new clients, with women responding better to the more personalized approach of taking recommendations from friends or family. Many who have had personal experience of using the services of an Independent Midwife will choose to rebook for subsequent pregnancies (Hobbs 1998). The midwives have a professional membership organization, Independent Midwives UK (IMUK), with a website which provides information about independent midwifery and helps women locate Independent Midwives local to them. Most of the midwives have their own professional websites detailing the services they can offer, that women can access. Working independently enables the midwives to practise autonomously and determine the type of care they provide (Frohlich 2007). Independent Midwives practise the midwifery role to its fullest extent (Page 2004); meaning that they care for women, with or without complexities, throughout pregnancy, birth and the postnatal period – the pregnancy continuum. They work as the lead health professional, liaising with other health professionals when required, to ensure their clients receive safe, appropriate care (van der Kooy 2010). Their caseloads commonly consist of women with complexities which would be labelled as obstetric risk factors by the NHS. Milan (2004) reports that over 70% of Independent Midwives' clients have at least one of these factors, which may be related to their age, with almost 50% of the women involved being aged 30 or older, or their parity: the number of babies a woman has had previously. Some Independent Midwives have developed skills and expertise in caring for women with twin pregnancies or babies presenting by the breech and are specifically sought out by women wanting to birth such babies physiologically at home, because the NHS can rarely provide this type of care (Francis and van der Kooy 2004; Scott 2013). Independent midwifery represents choice for many women; they do not have to just accept what is

offered by their local NHS Trust, which may be limiting their options (van der Kooy 2007) and leading to infringements of their legal right to determine how, where, and with whom, they choose to birth (Holten and de Miranda 2016).

It is usual practice for Independent Midwives to work in partnership with a colleague (Hobbs 1998; Garratt 2014) which facilitates the provision of an uninterrupted service: enabling the midwives to have back up when they are busy or to take time off. Women exercise choice in determining which midwife will provide their care and will sometimes consult several midwives before choosing the one they feel most comfortable with. Some Independent Midwives describe themselves as guardians of pregnancy and birth (Learner 2004), working closely with their clients to create a respectful personalized plan which incorporates the women's beliefs and choices about the care they wish to receive. Milan (2004) identified that most women who book with Independent Midwives are seeking individualized care, which focuses on addressing and supporting their unique needs. This is sometimes referred to as 'partnership working' (Miles *et al.* 2014; Boyle *et al.* 2016). This terminology can however cause misunderstanding when the midwife is also working in partnership with a colleague. Whilst most women who book for care with an Independent Midwife are seeking support to have a physiological birth, often in their own home, the overarching aim of the midwives is to help women birth safely, on their own terms (Milan 2004). Learner (2004) describes how the midwives work with women helping them to build confidence in their bodies and their ability to birth their babies effectively. She describes the positive approach that is taken in treating the pregnancy continuum as a normal physiological event. Tomkins (2015) highlights that in providing woman-centred support on a one-to-one basis, focusing on tailoring care to the individual needs and wishes of the woman, Independent Midwives meet all the government targets for maternity services. The *Changing Childbirth* report (Department of Health (DH) 1993) recognizes that independent midwifery is at the cutting edge of midwifery. Not constrained by hospital policies or protocols, their practice is considered to be an example of excellence in midwifery care: introducing woman-centred, one-to-one continuity of care and caseloading into midwifery practice when typically, midwifery care is provided in hospitals from an array of unknown healthcare professionals. Hunter (1998) describes Independent Midwives as pioneers of midwifery practice, providing woman-centred care and acting as role models for ideal practice.

1.5 Continuity of care

The type of care ubiquitously provided by Independent Midwives can be described as 'continuity of care' (Garrett 2014). It facilitates the development of trusting relationships

between the mother and midwife, as discussed in Sections 5.6.1; 5.6.2. Definitions of continuity of midwifery care are contested in the literature (Leap 2009) and without clarification it is difficult to know what is meant by the term and what it entails. Numerous and varying descriptions of the model have been offered (Haggerty *et al.* 2003; Saultz 2003; Guthrie *et al.* 2008). Freeman *et al.* (2003) define continuity of care as being a coordinated and smooth progression of care, with patient-centredness as an important element. This definition is open to interpretation and does not make explicit whether there is continuity in the personnel who provide the care or whether continuity refers to the way the service is run. The Royal College of Obstetrics and Gynaecology (RCOG) definition of midwife-led continuity of care is clearer, describing it as care where, 'the midwife is the lead professional in the planning, organization and delivery of care given to a woman from initial booking to the postnatal period' (Thomas and Paranjothy 2001, p.96). They do not however elaborate on whether care is provided by the same midwife, or just any midwife. The RCM's recent position statement (RCM 2016a) makes the distinction that care should be provided by as few midwives, and other maternity staff, as possible and that the aim is for care to be routinely provided by a single midwife who works in partnership with another midwife known to the woman. The statement discusses continuity of care throughout pregnancy and the postnatal period but does not indicate whether it encompasses labour care as well. Sandall *et al.* (2016) provide a fuller explanation, detailing that midwife-led continuity models provide care from the same midwife, or team of midwives, during pregnancy, birth and the postnatal period and this definition aptly describes the practice of Independent Midwives and is discussed further in Section 5.6.1. Working in this way, midwives may provide continuity of care to women in a particular geographical area or to defined groups of women with certain characteristics such as those labelled low-risk, for instance, or identified as being young mothers. Independent Midwives' caseload is usually based on geographical location, although those living in more rural settings may have clients situated across a large area, crossing county and hospital boundaries, and includes women of all risk. In their analysis of the concept of continuity of care, Haggerty *et al.* (2003) identifies three types of continuity: informational, organizational and personal, or relational. Informational continuity refers to the information the care provider has about the client, their medical history and their values and preferences, and links care provided by different health professionals; enabling them to provide an adequate service. Management continuity relates to the consistency and flexibility of care and how it is coordinated when several health professionals are involved. Relational continuity bridges the gap between past, current and

future care episodes through the provision of an ongoing, therapeutic relationship between health professional and client. This definition makes explicit the centrality of the carer in the process and makes redundant the need to clarify whether continuity of care relates to the consistency of the type of care being given or to the continuity of the person providing the care. Continuity of carer in the context of the mother-midwife relationship can be termed 'relational continuity of care' and reflects Independent Midwives' practice. At all levels continuity is designed to provide care which is experienced by the client as connected and consistent with their individual needs, over time (Haggerty *et al.* 2003). Whilst informational and management continuity may provide women with consistency and predictability in the location of care, the understanding of their health status, and the uniformity of their care, they do not provide women with the human connection they seek. Medina-Mirapeix *et al.* (2013) report that management and relational continuity are of most importance to their participants and that disruptions in these areas are a cause for dissatisfaction among clients. Without continuity of carer it is not possible to form meaningful, trusting relationships. However, the provision of continuity of carer does not guarantee the development of such relationships (Aune *et al.* 2011; Kristjansson *et al.* 2013). For this to occur, the creation of intimate, mutual connections with women needs to be an objective of care in itself and not just a happy, but unintentional outcome for some.

1.5.1 Relational continuity of care

As previously noted (Section 1.5), care given to a woman by one or a small number of known midwives is often termed 'continuity of carer', denoting that the continuity refers to the person providing care. When women talk about continuity of care this is usually what they mean. However, when taken at face-value this model can be just that – the provision of care by one midwife or a small group of midwives, the term itself does not imply anything else. But with a belief in the importance of human connectedness, this model of care can be improved by incorporating the development of a trusting relationship as a vital component. The formation of relationships is imperative because, as Sandall *et al.* (2006) report, it is only relational models of midwifery care which positively influence clinical outcomes for women and babies – merely seeing a woman on a regular basis, which counts for continuity of care in some places, will not result in the benefits reported in the research. The term 'relational continuity of care' has thus been adopted by some researchers (Thachuk 2007; Leap *et al.* 2010; Noseworthy *et al.* 2013) to define a specific model of care which is characterized by the underpinning of continuity of care with the existence of a genuine, trusting relationship

between the mother and her midwife. This then naturally leads towards a woman-centred model of midwifery where care is focused on the needs of the individual woman, integrating her beliefs and childbirth choices. For clarity, this term will be used in this thesis when referring to continuity of care provided by one or a small group of midwives in which a trusting relationship is formed between the mother and midwife.

Better Births, the five-year forward view for maternity care in England, provides a vision for improving maternity care in this country (National Maternity Review (NMR) 2016). Based on findings from women and health professionals it highlights women's desire to have continuity in the people who provide their care: reporting their dissatisfaction with hardly ever seeing the same health professional twice. The women describe how they want to develop trusting relationships with those caring for them during such a life-changing experience and to be active participants in their care. *Better Births* proposes major changes to maternity services in England in response to these reports of inadequate care. *The Best Start* report (Scottish Government 2017) responds to a similar picture in Scotland and makes recommendations for the implementation of relational continuity of care which focuses on supporting normal birth processes and avoiding unnecessary interventions. The most recent report into maternity care in Wales (Welsh Government 2011) focuses on the provision of respectful care and places the mother and her family at the centre. It does not specify the implementation of continuity of care in any way, however the *Your Birth We Care* survey (Welsh Government 2017) reported that women want to know their midwives better by having relational continuity of care throughout the pregnancy continuum and to be involved in making decisions in their own care. These findings clearly concur with those of the previous reports from England and Scotland. So, despite policy rhetoric over the last 25 years supporting continuity of care and choice in maternity services by successive governments (DH 1993; DH 2007; DH 2009), and an increasing evidence-base to support its implementation, the reality is that most women still receive fragmented care and have little power in decision-making.

1.5.2 Benefits of relational continuity of care

Relational continuity of care is a means by which safe care is delivered to women, although the exact mechanisms for how benefits are conferred have not yet been identified (Sandall *et al.* 2016). Kirkham (2016a, p.23) emphasizes its importance by commenting that, 'the outcomes of continuity of care are so good that if it was a drug it would be unethical not to give it.' The evidence-base clearly demonstrates the benefits of caring for women in this

way: fewer medical interventions and preterm births, lower risk of babies dying and increased chance of women achieving spontaneous birth (Page 2003; Hodnett *et al.* 2013; Olsen and Claussen 2012; Walsh and Devane 2012; Tracy *et al.* 2013; Sandall *et al.* 2016). It is known that a physiological birth offers the healthiest start for mothers and babies (Page 2013) and therefore relational continuity of care models are being promoted as the optimal way to care for women. In light of the evidence, the World Health Organisation (WHO) recommends the implementation of relational continuity of care as a key strategy for improving maternal and infant health globally (WHO 2016).

Despite the efforts of key figures including Lesley Page, Baroness Cumberledge and Jane Sandall since 1993 to achieve relational continuity of care in midwifery in the UK, wholesale implementation has yet to be achieved. Page (1997) talked of resistance to reforming maternity services and identified a fear of excellence by the NHS as a barrier, when it became clear that *Changing Childbirth* recommendations were not being realized. Many innovative pilot projects were stopped, the reason often cited being that because the service was only offered to certain women, inequity in care was being created. But rather than aiming to improve care for all, the response was to revert the service to the lowest common denominator - fragmented care (Kirkham 2010). To avoid the fundamental changes required in the system and the culture of the maternity service many managers compromised and devised halfway models of continuity, instead of implementing the principles of *Changing Childbirth* (Page 1997). This approach unsurprisingly conferred few of the benefits associated with true relational continuity of care models, where midwives are situated within the community and provide care as the primary midwife to a caseload of women, throughout the pregnancy continuum and with whom they have the time to form meaningful relationships. As if set up to fail, these schemes were soon discredited and then abandoned (Kirkham 2016a). The midwives involved suffered because the compromise way of working was not sustainable: they would frequently be expected to also work within the hospital to cover staff shortages there, even if they had already been working that day, and did not have enough time to provide the level of care required for effective relational continuity of care (Page 1997). Even now, with its indisputable benefits, there continues to be resistance to implementing this model of care (Kirkham 2016a).

The Albany Midwifery Practice was established within King's College Hospital NHS Trust by a group of self-employed midwives in 1997 and was an exemplar of the relational continuity of care model. The Practice, based in Peckham, provided care to an all-risk caseload of disadvantaged women for over twelve years, achieving high rates of spontaneous labour,

spontaneous vaginal birth, initiation and continuation of breastfeeding and low rates of preterm birth and interventions (Edwards 2010; Homer *et al.* 2017). Yet regardless of achieving these excellent outcomes and having popularity amongst those they served, their contract was terminated in 2009, with the Trust citing their poor safety record as the reason. This has tended to be the fate for other similar schemes set up across the country (Kirkham 2016a). Homer *et al.* (2017), in their retrospective analysis of the Albany Practice, reported that their outcomes were better than those of their parent Trust and national figures for NHS maternity services. The study concludes that rather than being an unsafe practice, it was a model of care that provided excellence and is one that should be replicated.

1.5.3 Implementing relational continuity of care

The Department of Health and NHS England have committed to implementing the recommendations of *Better Births* - for maternity care to become safer, kinder and more individualized, through the inclusion of women in the planning of their care, based on a relationship of trust with their midwife - and so maternity services in England face the challenge of putting this into practice. '*Implementing Better Births: Continuity of Carer*' (NHS England 2017) sets out the principles for how this will be achieved, acknowledging that delivering the vision will need to be done at the local level. Implementation will be reliant on locally led innovation, based on the needs of the local population and the financial capabilities of the Local Maternity System; an amalgamation of providers and commissioners of maternity services. For relational continuity of care to be successfully introduced in England, there will need to be a sea change in how most midwives practise (NHS England 2017). Implementing the *Best Start* in Scotland will follow a similar path, with plans to provide relational continuity of care throughout the pregnancy continuum (Grant 2017). The majority of midwives in England and Scotland will need to be willing to adapt to a new way of working: moving away from hospital-based shift work, to practising within the community, in flexible ways which allow them to respond to women's individual needs (RCM 2016a). Maternity services will need to change from being institution-focused (Deery and Kirkham 2007; Dykes 2009; Pilley Edwards 2009) to being woman-focused. Since the recommendations of *Changing Childbirth* to provide continuity of carer were incorporated into national policy, different models of midwifery have been tried across the UK to facilitate this requirement, including: team midwifery, caseloading and variants of them (Sandall *et al.* 2016).

1.5.4 Challenges to implementing relational continuity of care

The success of the plan to roll out relational continuity of care across the country will also be contingent upon the midwives' confidence to do so. Midwifery philosophy is usually described as being based on the premise that the pregnancy continuum is a normal life event (Walsh and Steen 2007; ICM 2014; Sandall *et al.* 2016). There is however contradictory evidence that fear of pregnancy and childbirth is common amongst midwives (Kirkham 2010; Dahlen and Caplice 2014; Plested and Kirkham 2016), which may act as an obstacle to the provision of relational continuity of care. Midwives describe the culture of fear in the workplace: fear of making a mistake, fear of investigation and litigation (Dahlen and Caplice 2014). Fear undermines midwives and women. It causes midwives to become defensive in their practice and to move towards the medical philosophy of care which reinforces birth as an abnormal event (Hood *et al.* 2010). Women lose confidence in themselves to birth safely when they see midwives who are scared, which can lead to increased interventions and their associated negative sequelae (Anderson 2010; Worman-Ross and Mix 2013). A proportion of women will act to avoid these negative situations. Plested and Kirkham (2016, p.29) report that some women experience maternity services as, 'risk obsessed systems driven by fear', which undermine their beliefs about the normality of birth. The participants in Plested and Kirkham's study discuss how the only way for them to protect their birth environment and achieve a normal birth is to do so without a midwife (also known as freebirthing). Notions of iatrogenesis, where complications arise from medical interventions, and the 'risk society' thesis (Beck 1992) fit with these women's beliefs – that technological and medical advances create danger as well as potentially providing benefits. Health professionals commonly focus on the inadequacy of women's bodies to perform appropriately (Scamell and Stewart 2014) but what is less talked about is the risk of proposed interventions (Plested and Kirkham 2016). The assumption made by medicalized health professionals is that the danger lies in the woman's body and, where she refuses to comply, her failure to accept the proposed intervention (Coxon *et al.* 2013). The opposite view is held by proponents of physiological birth - birth is viewed as inherently safe and that risk is introduced through interventions (Holten and de Miranda 2016). Whilst it is not yet fully understood, it is possible that a nocebo effect may occur when risks are presented to women as real possibilities, resulting in an adverse effect on her or her baby's wellbeing (Odent 2013). Symon *et al.* (2015) find increasing evidence for this phenomenon – the suggestion of an adverse outcome contributes to the realization of that outcome. The emphasis on risk in maternity care may be producing the unintended effect of increased morbidity, and potentially mortality, in women and babies. It is easy to see how danger is reinforced in health professionals' minds,

when their fears are realized because what they tell women will happen becomes reality. Dahlen (2010) discusses how we focus on the exception rather than the rule - negative cases are highlighted, whilst positive outcomes receive much less attention. The emphasis on low prevalence risks requires the treatment or management of large numbers of women to avoid a single negative outcome, leading to over-treatment, and the inherent risks therein (Bisits 2016). DeVries (1992) proposes that professional groups emphasize risks to gain control, giving weight to the need for their expertise. Whatever the underlying motivation, Plested and Kirkham (2016) argue that the current maternity system, with its emphasis on pathology, is detrimental to physiological birth, even before interventions occur, and issues of related iatrogenic harm are a consideration. Plested and Kirkham (2016) report that the risk discourse negatively impacts the relationships women have with their midwives. Women experience it as manipulative and coercive, leaving them mistrustful of their care-givers. This has serious implications for the women's safety. If they cannot rely on a midwife to give accurate information they may think the midwife is scaremongering when there is in fact a real danger they need to attend to. Benoit *et al.* (2005) suggest that the emphasis on risk management may be a contributing factor for the failure to implement midwife-led relational continuity of care models across the UK.

1.5.5 Risk and safety

Pregnancy and childbirth discourses are dominated by the medical model which views them as risky events that can only be considered safe in retrospect (Walsh and Newburn 2002; Olafsdottir 2006; Fahy *et al.* 2008; Healy *et al.* 2016; Holten and de Miranda 2016). The medical model is part of a broader discourse in which science is viewed as superior to nature (Fahy 2008). Midwifery practice has largely been subsumed into the medical model of childbirth, based in hospital, with its risk-based practice, reliance on technology and inevitable culture of blame (Benoit *et al.* 2005; Coxon *et al.* 2013). Consequently, midwives increasingly support the view that the pregnancy continuum is a pathological condition, needing medical surveillance and management (Walsh 2007a; Kirkham 2009; Kirkham and Plested 2016). Healy (2016) argues that distorted perceptions about the dangers related to childbirth have resulted in care which only focuses on safe outcomes rather than optimal ones. The current situation in maternity care is paradoxical because childbirth has never been safer and yet pregnancy and childbirth have never been more feared or scrutinized (Coxon *et al.* 2013). Whilst this way of working may be tolerable in the hospital setting where midwives have immediate access to the technology and medical assistance they rely on, it is a starkly different reality in the home-setting. Midwives will be expected to make the leap

from the institution's ideology: that birth is dangerous and therefore should take place in hospital, to an opposing ideology: that birth is normal and needs little technology or assistance. Alternatively, in the bleakest version of this scenario, midwives have to work in an environment they consider to be essentially dangerous. For midwives who have been trained and socialized within the medicalized hospital setting the prospect of moving into a low-tech setting must be a daunting one. Hunter (2004) explores the dilemma created by conflicting ideologies and identifies such conflict as a source of 'emotion work' for midwives, leading to an inferior quality of work-life for them. Barclay *et al.* (2016) report that many healthcare workers perceive birth outside hospital to be risky and associated with poor outcomes, despite a lack of evidence for their fears. Dahlen (2012) highlights that trusting and respecting physiology is essential in order to maximize a woman's chances of achieving normal birth, but also cautions that midwives must never become complacent – birth can be unpredictable. Complications can arise quickly, and midwives need to have the knowledge and skills to address them in the first instance, and for there to be systems in place to make rapid referrals to medical services. As set out in *Better Births and Best Start*, strategies will need to be put in place to support midwives to become confident and competent in their new practice environment, where understanding and supporting women's physiology will be paramount. It is established in the literature that competence and confidence are related (Donovan 2008; Back *et al.* 2017) and whilst confidence does not necessarily lead to competence, a lack of confidence is linked to a reduction in competence. While midwives working for the NHS are facing major organizational and cultural changes in how they work, Independent Midwives are facing their own significant challenge – that of professional indemnity insurance.

1.5.6 Professional Indemnity Insurance

Over the years the provision of indemnity insurance has posed a threat to Independent Midwives' practice. In 2014 the UK Government introduced legislation which requires all health professionals to have appropriate professional indemnity insurance as a condition of their registration. What 'appropriate' cover constitutes has not been made explicit by either the Government or the NMC. Guidance from the NMC (2017b) merely states that it is for the midwife and indemnity provider to determine what is appropriate, according to the scope of their practice. Professional indemnity insurance had been a cause for concern for the Independent Midwives since the RCM withdrew their insurance cover for Independent Midwives in 1994. Initially a number of insurance policies were available but when premiums rose to £15,000 per midwife, per annum it became unaffordable. In 2002 the last insurance

provider withdrew their policy from the market, leaving the midwives in a position where they had to practise without insurance (Independent Midwives UK 2017). In attempting to find a solution to this problem some Independent Midwives formed Neighbourhood Midwives, a private midwifery service, within which the midwives are employed, whilst others chose to remain as members of IMUK, continuing to work in a self-employed capacity. IMUK worked with actuarial and medico-legal teams, using clinical data they had collected over 11 years to understand the risks associated with midwifery care and to create its own indemnity product which reflected those risks (Tomkins 2015; Save Our Midwives 2017).

Following the change in the law in 2014, Independent Midwives practised, using their own indemnity product until concerns about its adequacy were raised by the NMC in 2015. This led IMUK to change its insurance scheme in order to address these concerns. Following another investigation by the NMC, it was ruled in December 2016 that their new insurance arrangement was also inadequate and that those midwives using it were thus not legally able to provide care for women and babies (NMC 2017c), despite the product having been assessed as being adequate by two independent actuaries (Independent Midwives UK 2017). This ruling has had serious implications for women's choice and has posed a threat to public safety because many independent midwifery clients do not wish to receive their care from an alternative provider. Some clients contacted Birthrights, a legal charity protecting human rights in childbirth (Schiller 2017), expressing their intentions to birth without assistance unless their chosen midwife could attend them. The charity has criticized the NMC's ruling as its actions, 'appear designed to cause maximum disruption to Independent Midwives and the women they care for', and, 'that the NMC has shown no concern for the physical and mental wellbeing of pregnant women who have booked with Independent Midwives' (Schiller 2017). It is of note that the NMC has involved itself in a conflict over indemnity insurance, which does nothing to improve the quality of care, and are preventing a group of midwives from practising who provide the gold standard of care, whilst mainstream services, which provide fragmented care and offer little choice to women, factors associated with poorer outcomes, go unquestioned.

Members of IMUK served legal proceedings on the NMC in March 2017, challenging the decision and a judicial review of the case was scheduled for October 2017 (Independent Midwives UK 2017). The court ruled in favour of the NMC in December 2017, finding their decision to be fair and lawful. The midwives now find themselves in a situation where although the guidance tells them that they and their indemnity providers are responsible for ensuring they have appropriate cover for their practice, their governing body is itself

determining what is appropriate, whilst declining to define what 'appropriate' is. It leaves the IMUK in an untenable situation where they are unable to establish what level of indemnity would be acceptable to the NMC. At the time of writing, the Independent Midwives are able to provide antenatal and postnatal care, for which they ironically have appropriate cover via the Royal College of Nursing's (RCN) indemnity scheme, but without additional indemnity arrangements they are unable to provide labour care to women. This is a situation that is unacceptable to many of their clients, who want to be able to choose who provides their maternity care and to have someone they know and trust, accompany and care for them during labour. Some Independent Midwives have sought alternative sources of insurance, from other groups of midwives practising outside the NHS, although this is on an ad-hoc basis and does not involve the IMUK members as a group. Several NHS Trusts in the UK are providing individual Independent Midwives with 'bank contracts' under which the midwives are able to provide intrapartum care. The contracts temporarily employ the midwives and thus entitle them to NHS vicarious liability insurance (personal communication).

The NMC ruling came after data generation in this study had commenced and therefore was not mentioned by the initial participants. The issue came up during one of the later interviews with the participant expressing how much distress it had caused her and her clients, but the remaining participants were reluctant to comment formally. Discussions after the interviews revealed deep anger and feelings of persecution, but the midwives did not want their comments to be directly quoted. Fear for the survival of independent midwifery and women's choice was clearly expressed in these off the record conversations (Appendix 12). At the time of writing, IMUK are seeking a more permanent solution for all their members so that women will continue to have the right to make choices about who provides their maternity care.

1.5.7 Personal factors behind the study: Being an Independent Midwife

My experience of working as an Independent Midwife for many years has given me the drive to undertake this research. A passion for connecting with and supporting women through their pregnancies, births and early parenthood motivated me to explore the unusual approach Independent Midwives take to caring for women. Fifteen years' experience of working independently has raised many questions about identifying the best ways to provide maternity services: ways which fulfil the needs of both women and midwives. It has also led to questions about why this model of care has not been embraced more widely in the UK.

Having regular contact with NHS maternity services has enabled me to compare the different approaches to care and to appreciate how significant some of the differences are: the attitude of midwives to women, the status of women in the care system and the individualization of care. There is a paucity of evidence about the practice of Independent Midwives in the UK (Winter 2002; Fry 2009; Garratt 2014). From the inside it is easy to see how working in this way can bring many benefits to both women and midwives. High rates of normal birth, breastfeeding, and healthy outcomes for mothers and babies (Independent Midwives UK 2014) are the motivation for providing such care. The details of how care is provided and what it comprises are not well known by midwives generally or childbearing women, perhaps because it happens outside the gaze of the NHS. Whilst this is my preferred way of working, the demands of the job can be great: seemingly constant on-call commitments, long working hours, few scheduled days off, modest financial rewards and frequently hostile attitudes from NHS staff when negotiating shared care or when transferring care. These disadvantages are however offset by the satisfaction gained from working so closely alongside women, developing truly meaningful, trusting relationships, helping to build their confidence and supporting them in their choices. To see a woman smoothly and assuredly transition into parenthood is a real privilege. In my practice the women who choose my services are seeking to be active participants in their care: to be autonomous individuals and make informed choices about the care they receive. Many clients are also aiming to have a physiological birth and whilst I cannot guarantee that they will achieve their desired goal, by having continuous one-to-one midwifery support provided by a known and trusted midwife they do increase their chances of having an intervention-free birth (Benjamin *et al.* 2001; Hodnett *et al.* 2013; Dove and Muir-Cochrane 2014; Walsh and Devane 2012).

As an Independent Midwife I contributed to the Independent Midwives' Association (IMA) Database Project which was undertaken between 2002 and 2012, gathering data on more than 5,000 cases. A comprehensive questionnaire was developed to capture a wide range of data about each case, including: the woman's medical and obstetric history, details of the current pregnancy, comprehensive information about the labour and birth, drugs or complementary therapies used, maternal positions, foetal positions and any interventions required. Postnatally details were recorded of: the assessment of maternal blood loss, maternal and neonatal wellbeing, condition of the woman's perineum, any illness of mother or baby in the six weeks following birth, mode of infant feeding and any related difficulties experienced. Data on the first 750 cases was published by Milan (2004) which provided

evidence for the positive clinical outcomes associated with independent midwifery care, the remaining data has however never been made public. As part of this study I made repeated requests to gain access to the database but was not granted approval. Although this data is not essential to my research it would have added more context to the study and potentially strengthened the rationale for wanting to understand Independent Midwives' practice.

1.6 Aims and objectives of the study

The overall aim of this study is to advance knowledge about the practice of Independent Midwives working in Mainland UK.

The objective is to explore Independent Midwives' perceptions and experiences of independent midwifery, through in-depth interviews, and to gain an overarching understanding of what is involved in working independently and providing care for clients. Through this exploration the intention is to identify and understand the essential components of a model of midwifery which reportedly work well for both mothers and midwives.

With little existing research about Independent Midwives it is important to gain a comprehensive picture of what independent midwifery entails rather than arbitrarily selecting a single aspect of their practice to study. Hearing from the midwives themselves about what they consider to be the key components of their model of midwifery will add to the body of midwifery knowledge.

The aims and objectives led to two questions:

- 1) What constitutes independent midwifery from the perspective of Independent Midwives?
- 2) How do Independent Midwives experience practising as Independent Midwives?

1.7 Introduction summary

In this chapter I have provided a definition of the midwife and set out how the Independent Midwife fits into the legal framework for midwifery. The chapter discusses the scope of the Independent Midwife and how they organize the relational continuity of care they provide through a one-to-one caseloading approach. The considerable benefits of providing this type of care are explored alongside the recommendations of *Better Births, Best Start* and governmental policy support for this model of working, which enhances the quality of care and improves safety for mothers and babies. The challenges to midwives of providing

continuity of care are examined and the barriers identified. My personal experience of being an Independent Midwife is made explicit in this chapter, as are the reasons for undertaking this study.

1.8 Overview of the structure of the thesis

This thesis is divided into eight chapters.

Chapter Two: Provides a two-stage approach to reviewing the literature. An initial literature review, relating to independent midwifery in the UK, was undertaken to locate this study within the existing body of knowledge and ensure that duplication was avoided. The approach taken examined the evidence specifically about Independent Midwives and avoided reviewing the surrounding midwifery literature that would presuppose the participants' responses about their perceptions and experiences of independent midwifery. The main literature review took place after data generation and analysis and relates to the findings of the study.

Chapter Three: Offers a description of the research design and methodology for the study, demonstrating how the research was approached using the principles of Charmaz's constructivist grounded theory. The process followed in this research is presented, documenting the journey from the selection of constructivist grounded theory as an appropriate method for this type of study, to gaining ethical approval, to the recruitment strategy and data generation methods employed. The process of data analysis, in accordance with the chosen method, is detailed outlining how data were transformed through coding and the development of categories.

Chapter Four: Introduces the research findings from the interviews with the participants in this study. Five categories have been developed from the findings: professional autonomy, time, mother-centred care, knowledge, evidence and practice and finally, midwifery philosophy.

Chapter Five: Provides a critical discussion and analysis of the five key categories developed in this study in relation to the literature. Each category is addressed separately in subsections and how they relate is explored further in chapter six.

Chapter Six: Introduces a relational continuity of care model of midwifery that was developed from the analysis of data generated from this study. It provides an explanation of the interconnectedness and interdependence of the five categories identified as the key

components of independent midwifery and demonstrates how they all contribute to the provision of safer care and improved outcomes.

Chapter Seven: Presents the overall conclusions of the work presented in this thesis, as well as identifying areas for further research.

Chapter Eight: Offers recommendations for policy, practice, Independent Midwives and education.

Finally, the Appendices provide additional material which support this thesis.

Chapter 2 Literature Review

2.1 Section introduction

This chapter outlines the rationale for undertaking a literature review in research generally and the counter view of grounded theorists for not doing so in the initial stages of a study. The search protocol for the review is set out and the means by which relevant papers were identified. Eight papers were retrieved in the initial search and then reviewed. A review of the literature after data generation and analysis were commenced, relating to the findings is then presented.

2.2 The literature review in grounded theory

The initial review was carried out at the beginning of the PhD process in 2016. The undertaking of an initial literature review prior to embarking on data generation is however not generally recommended by grounded theorists (Glaser & Strauss 1967; Glaser 1998; Charmaz 2014; Holton and Walsh 2017). The reasoning behind this recommendation is to help the researcher avoid the risk of preconceiving their findings and to enable them to remain open to what emerges from the data (Holton and Walsh 2017). Glaser (1998) states that researchers should come to the research with as few preconceived ideas about the phenomena as possible. Many authors (Strauss and Corbin 1998; Walls *et al.* 2010; Thornberg 2012) reject this view however, arguing that it is unlikely that researchers will be unfamiliar with their subject area. This is especially true within the healthcare setting, where many professionals choose to research their own area of practice (Rees 2003), as is the case with this study.

Within grounded theory the literature review is usually undertaken once data generation and analysis have started and is used as a source of data within the study (Charmaz 2014). It is argued that to undertake an initial literature review presupposes the findings of the study and assumes a focus which may turn out to be irrelevant. This activity may thus waste the time and efforts of the researcher (Holton and Walsh 2017) and is therefore not recommended in the texts. However, not undertaking an initial literature review contrasts with most other approaches to qualitative research where it is considered a key starting point, locating your research within the existing body of evidence and ensuring that the research you are proposing has not already been carried out (Rees 2003; Green and Thorogood 2005; Berg 2009; Holloway and Wheeler 2010; Webster *et al.* 2014). Despite the recommendations to review the literature later in the research process I chose to do so in the early stages in order to locate my research within the wider body of knowledge and to

avoid duplication. The initial review entailed the appraisal of the existing research specifically about Independent Midwives in the UK. A total of eight papers were found, six of which I was already familiar with (Isherwood 1989; Milan 2004; Milan 2005; Fry 2009; Symon *et al.* 2009; Symon *et al.* 2010), and two which are unpublished theses (Winter 2002; Garratt 2014). On reflection and with further reading about grounded theory I realize I could have addressed the procedural requirement of doing a literature review by offering a contextual overview of the topic rather than attempting to locate all the extant research and identifying the gap in the evidence. I purposely did not look at evidence that presupposed the findings of my study, such as the effectiveness of certain common elements of midwifery care.

Keeping up-to-date with relevant literature is key to working as an Independent Midwife, which was the reason I was already conversant with most of the research. Had I not undertaken an initial literature review I would still have had knowledge of the extant evidence and inevitably have brought that to this study along with preconceived ideas about the subject. Therefore, a strategy was required to ensure the quality of my study; I needed to make sure that I remained open to the data I generated and avoided trying to fit them into existing ideas, as Glaser (1998) advises. I have closely examined my influence on the study, achieving this through the practice of reflexivity which will be explored further in Section 3.3.3.

Glaser (1998) states that researchers must come to research without preconceptions: to have an open mind. But perhaps that is not a realistic proposition. Thornberg (2012) suggests that everyone comes with some existing knowledge that can influence how they conduct their research and how they interpret the data. What is more important, it is argued, is to be open about the effect researchers have on their research and to be more analytical about these influences. It may be that the foundations of grounded theory are more deeply embedded in the positivist traditions, than is obvious from initial reading of the texts, which espouse the importance of objectivity in research and drive the need to justify or avoid subjectivity (Charmaz 2014). By embracing the inevitable existence of subjectivity, we can strive to understand more about its effects, and acknowledge that it exists to some extent in all research. Holloway and Wheeler (2010) assert that it is impossible for a researcher to have a neutral and unbiased stance and suggest instead that researchers need to be clear about their perspective and be reflexive and transparent about their approach.

2.3 Literature Search Protocol

2.3.1 Objective

The objective of this literature review is to explore existing research evidence about the practice of Independent Midwives in the UK and to ensure that this proposed study will make a unique contribution to knowledge and not repeat previous research. An additional review of the literature took place during and after the data generation, as part of a constant comparative method, where new data are compared to extant evidence.

2.3.2 Identifying the scope of the review

2.3.2.1 The research questions:

1) What constitutes independent midwifery from the perspectives of Independent Midwives?

2) How do Independent Midwives experience practising as Independent Midwives?

The aim of the questions is to establish the details of how Independent Midwives practise, identifying the broad approaches as well as the nuances of what they do. The research question did not fit well with the Population, Intervention, Comparison, Outcome (PICO) search planning method and it was therefore not utilized. The lack of fit for many studies has been identified by Huang *et al.* (2006) as a weakness of the PICO model. As this topic has not been well researched the decision was made to undertake a broad search (scoping exercise) of literature relating to Independent Midwives in the UK, to assess the number of articles found and ascertain whether the volume of papers retrieved would be feasible to screen and then evaluate.

2.3.3 Search methods for identifying studies

2.3.3.1 Key term

To keep the search broad, the key term used was 'Independent Midwife'. The truncation 'midwi*' was used to cover the closely connected key word variants of midwife, midwifery, midwives, and to optimize the efficiency of the searches. I have searched using alternative terms such as 'private midwife' but this is not how this group of midwives are usually identified and the searches did not generate any applicable results. I have attempted to search the key term using inverted commas, to search for that phrase, however with some databases this has resulted in no papers being found, therefore I have opted to search large numbers of papers with the aim of identifying all possible studies.

2.3.4 Database searches

Table 1 details the online databases that were searched and demonstrates the number of papers identified in each one.

Table 1: List of databases searched

Key concept: Independent Midwi*	Limiters: peer-reviewed	Papers removed
Database	Number of papers	Duplicates
mySearch:		258
CINAHL	267	
Social Sciences Citation Index	45	
Science Citation Index	43	
Scopus	44	
Medline Complete	12	
PsychINFO	11	
SocINDEX	5	
Environment Complete	5	
Business Source Complete	3	
British Library EThOS	3	
JSTOR Journals	3	
Arts & Humanities Citation Index	2	
Education Source	2	
SPORTDiscuss	1	
Communication Abstracts	1	
Academic Search Complete	112	Unknown
BNI	312	Unknown
Cochrane Library	0	0
Global Health	16	0
Journals OVID	39	0
Medline Complete	149	2
Intermid	2725	989
Internurse	45	0
PubMed	32	0
ScienceDirect	956	Unknown
Scopus	116	Unknown
Web of Science	375	Unknown
WHO	0	0
Open Grey	2	0
Total no. of papers	5629	1249

2.3.5 Identification of the relevant literature

A total of 5629 citations were found. Duplicates from the combined database searches were removed using Endnote software and also a manual approach, resulting in a collection of 1084 papers which were screened by title and abstract for relevance. From that, 32 papers relating to independent midwifery were assessed for eligibility. 24 papers were excluded because they were opinion pieces, leaving eight research papers for inclusion. Five papers were qualitative studies and three were quantitative. Two of the quantitative papers related to the same study, so in total there were seven pieces of research directly related to Independent Midwives practising in the UK to review. Whilst there were a large number of papers which would have informed this study and provided context, to have selected them at this stage would have been to presuppose the findings of the research. Alerts were set up on the databases to identify any relevant newly published articles.

After searching the databases further explorations were undertaken to find more papers. Papaioannou *et al.* (2009) and Aveyard (2010) state that there are four main methods for searching the literature. In addition to searching electronic databases the researcher can search reference lists, hand search relevant journals and search identified authors for further pieces of research.

2.3.6 Searching reference lists

In this method each relevant article was reviewed for the citation of further articles pertinent to the study. This produced a snowballing effect where one article led on to the identification of another.

2.3.7 Journal searching

Where possible paper journals were hand searched for further papers by checking contents pages. Electronic journals were also searched for related articles to those identified as relevant to the study.

2.3.8 Author searching

Once an author is identified as a useful source a further search is carried out of their name to see if this leads to additional papers not so far identified. I have made attempts to contact relevant authors and experts on the subject. I spoke to one researcher who at the time of this review was studying how Independent Midwives use intuition in their practice for her PhD studies. The findings were incorporated into the study during the writing of the

discussion chapter, after the thesis had been completed. I have also contacted several Independent Midwives across the UK to ascertain whether they have been involved in any research that I have not retrieved in my searches. So far none of the midwives have reported that they have been involved in projects other than those identified in this review.

None of these additional methods of literature searching revealed any further papers relevant to this study.

2.4 Initial findings

Eight papers reporting on seven studies are reviewed here.

Isherwood (1989) undertook a qualitative study which aimed to examine what it is like to be an Independent Midwife. Using semi-structured interviews and field observations, data were collected from 23 midwives and eight of their clients. This descriptive study identified how the midwives arranged their work, which was usually home-based, how their fees were negotiated and how tests and clinical referrals were arranged. It was observed that the midwives spent much time with their clients, forming close relationships which were often maintained beyond the episode of care. The midwives provided one-to-one care to their clients, in partnership with a colleague. The women explained their reasons for choosing to have care from an Independent Midwife, which was often to facilitate a homebirth, that had not been possible with the NHS. Women's choices were acknowledged and clearly formed the basis for care. The midwives described how working outside the NHS freed them from the constraints of hospital policies and enabled them to fulfil the role of the midwife and as a result to become more self-confident in their practice. Financial insecurity and problematic encounters with NHS staff were common features of this way of working. Whilst providing little analysis, this study illustrated the broad working patterns of Independent Midwives and the challenges they faced.

Winter (2002) conducted a qualitative grounded theory study exploring how Independent Midwives assess progress in labour. This unpublished master's thesis found that in the absence of prescribed protocols midwives develop a rich store of skills and knowledge which assist them in assessing progress in labour. The importance of the relationship between mother and midwife was highlighted in this study. The role of trust and communication between mother and midwife was key to the midwives being able to care effectively for the women. Winter emphasized the importance of the midwives' confidence in labour as being a physiologically effective process, unique to each woman, that progresses at its own rate. The concept of time with respect to caring for women in labour was a particular focus. The

nature of the process of labour rather than its duration was explored with the participants and contrasted with the care routinely given in hospitals where the emphasis is on clock time. Winter introduced the idea of the use of different forms of knowledge and the role of intuition and instinct in midwifery, as innate sources of evidence that some people possess.

In the first of two papers, Milan (2004) published the initial findings from the IMA Database Project, in which prospectively collected quantitative data, gathered between 2002 and 2003, about the practice of Independent Midwives in the UK and outcomes for mothers and babies were presented. Independent midwifery practice was described as low intervention midwifery, based in the home setting. The initial data concerned 750 client care episodes and suggested that the rates of normal birth, home birth, healthy maternal and neonatal outcomes and breastfeeding were higher amongst women receiving independent midwifery care compared with NHS statistics for the same period, whilst rates of pharmacological induction and caesarean section were lower. These results were surprising given that 70% of the clients were considered to have at least one obstetric risk, by NHS definitions.

In the second paper, Milan (2005) compared the initial data from the IMA Database Project with other published studies of caseload midwifery practice, within the context of risk, as risk had been identified as a common characteristic of independent midwifery clients. These studies were; the One-to-One Midwifery Evaluation (McCourt and Page 1996), the North Staffordshire Comparative Study (North Staffordshire Changing Childbirth Research Team 2000), the Birth Under Midwifery Practice Scheme (BUMPS) (Benjamin *et al.* 2001) and the Albany Midwifery Practice (Sandall *et al.* 2001). A limitation of the study was that it was not always possible to define the numbers involved or the terminology used in the published studies to enable matched comparisons. This second paper gave details of more specific outcomes for women such as; labour induction rates, the use of epidural anaesthesia in labour, perineal trauma, blood loss, health at discharge and continuity of care in labour, demonstrating equal or improved outcomes in these areas compared with the other caseloading studies. The study was not able to give comparative outcomes for women with several known risk factors as these figures were not available from the other studies, although the author did compare the IMA data with national maternity statistics for the same period, finding that rates of complications were lower in the group cared for by Independent Midwives. The conclusion of the paper is that outcomes for women receiving independent midwifery care are as good as, and in some areas better than, the outcomes of published caseloading studies in the UK. It is suggested that the size of the caseload is significant to the safety of care and the sustainability of work. None of the Independent Midwives chose

to have an annual caseload of more than 30 women. Some of the other caseloading studies reported numbers in excess of 40 per annum and an associated high midwife turnover rate. Whilst being able to demonstrate the clinical outcomes of independent midwifery care the study was unable to provide an explanation for how they were achieved. Milan speculated that the explanation may lie in the relationship developed between mother and midwife and recommended this as a topic for further exploration.

Fry's phenomenological study (2009) explored Independent Midwives' experiences of supporting women to birth their placentas, finding that the midwives work in partnership with women, using their knowledge and experience, and acting as guardians to support the physiological process in an optimal environment. Fry described the importance of information exchange about the physiology of the birth of the placenta, between midwife and women, which enabled the women to give informed consent. Supporting the physiological birth of the placenta was usual practice among Independent Midwives, differing from the practice of most NHS midwives which involves routine medical and pharmacological interventions.

A study using the data from the IMA Database Project, conducted by Symon *et al.* (2009), added support to some of the positive findings reported by Milan (2004). They found that clinical outcomes across a range of variables were much better for independent midwifery clients but, more importantly, they reported that perinatal mortality rates were significantly higher for women receiving care from Independent Midwives compared with NHS care. They raised concerns that the Independent Midwives' care might be a contributing factor to these deaths. This matched comparison study was criticized by Shorten and Shorten (2009) for flaws in its methodological approach, in trying to compare disparate datasets and for its inappropriate defamatory reporting. They concluded that the study had largely failed to achieve matching between the two groups and that generalisability of the results was not appropriate due to the small numbers of births conducted by Independent Midwives compared with the NHS. After data from 'high risk' mothers in both groups was adjusted for, no statistical difference was found.

An urgent follow up study by Symon *et al.* (2010), involved a review of the cases by a senior academic to ascertain factors that might have contributed to the deaths. It set out to establish whether the 15 perinatal deaths described in their previous study (Symon *et al.* 2009) were attributable to care provided by the Independent Midwives. This study reviewed the case notes and interviewed the midwives involved. All but one of the pregnancies was

classified as high-risk. For seven of the deaths all the professionals involved in the review of the cases agreed that the deaths would have occurred regardless of the way in which the labour was managed. In the remaining eight cases, it was felt that caesarean section may have changed the outcome, however in all cases the pregnant women had declined this option. Care management by the Independent Midwives was judged to be clinically acceptable within the context of the mother's choices. This study concluded that if women have the right in law to be autonomous then their decision-making, even in high-risk situations where the safety of the baby may be compromised, must be accepted.

Garratt (2014) explored the relationship between Independent Midwives and their clients in her unpublished PhD thesis, as recommended by Milan (2005). She interviewed 20 Independent Midwives using a two-part interview technique in which the participants were initially invited to tell the story of their lives as midwives as an uninterrupted dialogue, and then in the second part were asked more direct questions about the relationships they developed with their clients. The findings of her phenomenological study build on the earlier observations made by Winter (2002) and Fry (2009) about the fundamental role of the relationship in providing effective midwifery care and are supported by the review of midwife-led continuity models of care (Sandall *et al.* 2015), which concluded that women who receive this type of care are less likely to experience interventions and more likely to be satisfied with their care, with no adverse outcomes compared with other models of care. The study confirms the lack of evidence about this group of midwives and the potential for further research that would illuminate the profession generally about the type of midwifery they practise.

As the literature reviewed here concerned differing aspects of independent midwifery practice it is not possible to draw an overall conclusion. The studies by Isherwood, Winter, Milan, Fry and Garratt did however all identify that the relationship between the mother and midwife, and the adoption of a woman-centred approach to care were key features of independent midwifery. Papers by Milan (2004; 2005) and Symon *et al.* (2010) both demonstrate that independent midwifery offers a safe option of care for women, whilst Symon *et al.* (2009) erroneously reported increased infant mortality rates for women receiving care from Independent Midwives.

2.5 Review of the literature relating to the findings

As recommended in grounded theory texts (Charmaz 2014), the main literature review in this study was undertaken following the commencement of data generation and analysis.

So, whilst the structure of this thesis may appear to suggest that the literature review preceded the data generation and analysis it was in fact undertaken in response to the emerging findings. During and following the development of codes and categories the literature was extensively searched for evidence that linked to each of the five findings. That evidence was incorporated into the discussion and analysis of the findings (Chapter 5). The same search strategies were employed as for the initial review, including searches of electronic databases, papers journals, reference lists and subject specific authors.

This section reviews the literature relating to the five categories developed from the data; professional autonomy, time, mother-centred care, knowledge, evidence and practice and midwifery philosophy. The search for literature relating to the use of time in midwifery practice required an adapted approach because the search strategy was initially unsuccessful, failing to yield any useful papers. Considerable efforts were made to locate literature about the allocation and use of time in midwifery care and the rationale for the duration of appointments within differing models of care. However, consultation with the lead librarian confirmed that there is a paucity of research on this subject. A variety of search terms were used to identify papers relating to this topic; midwi*, midwifery care, models of midwifery care, antenatal care, AND time, appointment time and consultation time, and whilst these terms generated more than 2250 results, they yielded only 36 papers warranting review. Of these papers, 11 were relevant to the topic but only referred to time in midwifery in abstract or non-specific ways, highlighting a lack of time or recommending more time in practice, without providing any evidence or quantification of the optimal time required for effective practice. As normal database search methods did not identify a useful list of relevant papers a strategy was devised whereby papers citing seminal works in other disciplines were located and their reference lists searched for further sources of information, as recommended by Horsley *et al.* (2011). A separate search of e-books also revealed some further information. Much of the research concerning the duration of healthcare appointments focuses on medical general practice and thus that evidence has been extrapolated and applied to this study.

2.6 Professional autonomy in midwifery

In this section literature relating to professional autonomy in midwifery is reviewed. The definitions of professional autonomy are examined and the extent to which midwives in the UK have professional autonomy is explored. The impact of professional autonomy on clinical practice in terms of how care is provided, what care is provided and how women

are supported is reviewed and analysed here and related issues are discussed further in Section 5.2.

2.6.1 Defining autonomy

The word autonomy is derived from the Greek words 'autos' (self) and 'nomos' (law) (Oxford University Press 2018a). Hashimoto (2006) discusses the term 'Professional Autonomy', its origins and the related concept of professionalism. The World Medical Assembly (WMA) adopted the term in 1987 and it is now commonly used across different disciplines to mean the free positive activities implemented by health professionals (Hashimoto 2006). Definitions of professional autonomy vary widely, Marshall and Kirkwood (2000) define it in terms of decision-making, power and authority and Lewis and Batley (1982), as the freedom to make discretionary decisions within a scope of practice. Draper (2004, p.6) explains that professional autonomy should not be confused with autonomy per se, stating that 'professional autonomy refers to the freedom to exercise judgement related to one's profession within the bounds of one's professional expertise.' Marshall and Kirkwood (2000) highlight that discretionary decisions cannot be the application of standardized protocols or rigid routine decisions. They assert that decision-making is a fluid process dependent on the individual needs of the client.

The issue of whether midwives are autonomous practitioners is one that is frequently overlooked in the literature, with an unquestioning assertion that midwives are autonomous (DH 1993; Bluff and Holloway 2008; NMC 2009a; Page *et al.* 2008). More critical analyses of what autonomy means have however reached contradictory conclusions, casting doubt on whether midwives in the UK can claim professional autonomy at all. Symon (1996) asserts that any realistic notion of an autonomous profession would exclude their control by another profession. Tew (1998) and Pollard (2003) remind us that midwifery in this country is controlled by the nursing and medical professions and therefore cannot make the claim to be autonomous. Pollard (2003) adds to this argument by contending that midwifery in the UK is not an autonomous profession because, to have that status, as set out by the International Confederation of Midwives (ICM 2011), the profession must be self-governing and self-regulating. Ledward (2004) supports this position arguing that midwifery practice is clearly influenced by medical and managerial directives and thus it cannot claim to be free from external control. Clarke (2004) goes further by stating that autonomy in midwifery is a myth and maintaining that midwives cannot demonstrate autonomy when their practice is controlled by policies, protocols and contractual obligations. Because of the lack of

consensus and because autonomy has a personal meaning to most midwives, this study uses the participants' descriptions and understanding of autonomy to clarify the concept under discussion. Their interpretation of being autonomous practitioners is in the practical sense that in their day-to-day practice they determine when and where they work, and which practices they employ. This understanding is in keeping with NMC guidance (2009a). Independent Midwives may not have influence over how they are regulated or governed, but on a practical and personal level they shape their own practice (Sections 4.2.1; 4.2.2; 4.2.3) and this is explored further in Section 5.2.

It can be argued that midwives working within hospitals have little professional autonomy because national and local guidelines, policies and protocols shape practice, which the midwives are expected to conform to (Davies and Iredale 2006; Dixon *et al.* 2017). They are generally also unable to determine the conditions or working arrangements in which they practise, being affected by the pressures of understaffing and the consequences of fragmented care, over which they have no control (Crowther *et al.* 2016). Dixon *et al.* (2017) report that self-employed midwives have high levels of autonomy and, at the same time, low levels of work-related stress and mental or physical illness, more commonly referred to as 'burnout'. Hofmeyr *et al.* (2014) and Sandall *et al.* (2015) add that professional autonomy for midwives results in excellent outcomes for women and babies. This evidence supports the experience of the participants in this study and is discussed in Section 5.2.

Despite the common conception that midwives are autonomous practitioners, there are sanctions for those midwives who do not comply with managerial and medical control of maternity care (Section 4.2.2) and who support women that resist conventional medical advice (Edwards *et al.* 2011). These midwives find themselves being investigated and disciplined in spite of government policy promises about women's choice and autonomy (DH 1993; 2007; 2009), and NMC (2018) edicts that state that the midwife must prioritize people and respect their right to accept or decline treatment. Such conflicts place great pressure on midwives (Curtis *et al.* 2006a; Walsh and Steen 2007). Whilst the discussions about the tensions between a midwife's contractual obligations to her employer and the legal requirements of her governing body are not new (Clarke 2004; Whittle 2004; Walsh and Steen 2007), it seems that there is no longer a simple choice to be made. Debates about who the midwife should choose to comply with made it appear that this was a binary decision; either her employer, or her statutory regulator, because it was not possible to comply with both at the same time. Reported cases (Kirkham 2011b) show that the situation is however not as straightforward as this, and despite choosing to support women's rights to

decision-making, and upholding the standards of the Code, midwives who respect their client's right to decline recommended medical treatment have found that the NMC are not supportive of their conduct, despite the Code stating that this is exactly what they must do. Midwives have been criticized by the NMC for listening to women too much (Kirkham 2011b) and one midwife was forced to undergo assertiveness training in order to be able to persuade women to accept treatments they had decided to decline (Edwards *et al.* 2011). This misuse of the regulation places the midwife in an untenable position and creates very clear obstacles to the provision of woman-centred care. Kirkham (2011b) also reports that Independent Midwives are much more likely to be investigated than their NHS colleagues which was a real fear expressed by one of the participants (Section 4.2.6) and is discussed further in Section 5.8.4.

2.6.2 Tailoring care to meet women's needs

As previously outlined (Section 1.3.1), *Better Births* and *Best Start* report that women want to choose the type of care that fulfils their needs. They talk about the importance of developing relationships with their midwives and having relational continuity of care throughout pregnancy, birth and the postnatal period, which is woman-focused and reflects their choices. The incorporation of these elements of care into independent midwifery practice is examined in Section 5.2.2. Despite initial concerns that this model of care may be detrimental to midwives (DeVries *et al.* 2001), there is an increasingly irrefutable body of evidence which demonstrates that working in a relational continuity of care model is in fact beneficial to them and is associated with a decreased likelihood of burnout (Mollart *et al.* 2013; Yoshida and Sandall 2013; Dixon *et al.* 2017). It is postulated that the high levels of autonomy associated with this model of working contribute to the reported beneficial effects on midwives (Jepsen *et al.* 2017). Marmot (2004) adds to the evidence by stating that professional autonomy is central to any employee's job satisfaction. The importance of job satisfaction to the participants is discussed in Section 5.2.4. Evidence from the World Health Organisation (WHO) (Stavroula *et al.* 2003) links levels of autonomy to health status, reporting that globally, work-related stress and illness are associated with low levels of occupational autonomy, providing compelling humanitarian and economic reasons for increasing individual's autonomy at work.

Postnatal care was identified in *Better Births* and *Best Start* as being an area of maternity services needing significant improvement, with women describing the provision as inadequate and not supportive of breastfeeding or maternal mental health. In contrast to

what is provided by the NHS, postnatal care constitutes a significant part of the comprehensive service Independent Midwives provide to all their clients (Section 5.2.2). The evidence about the value of postnatal care was however found to be inconsistent by Yonemoto *et al.* (2017), in their Cochrane review of postnatal care. The varying models of care included in the review may account for these inconsistencies, as in some of the studies care was delivered by unknown health professionals, without any continuity. The authors tentatively conclude that more individualized care may improve outcomes for women. Barimani and Vikstrom (2015) propose that continuity of care postnatally is required in order to provide good quality care, whilst Sandall *et al.* (2015) comment that there is little information about continuity of care and postnatal wellbeing of mother and baby beyond the immediate postnatal period, suggesting that more research is needed in this area. It may be that as has been found with continuity of care during pregnancy and labour, the beneficial effects of having care from a known and trusted midwife are also conferred during the postnatal period. It would be surprising if this was not the case.

2.6.3 Practice development and autonomy

Having the autonomy to determine and change practice was an important finding in this study and was viewed as a benefit of working in independent practice. Practice development is also closely linked to Independent Midwives' use of a wide range of sources of knowledge and evidence in their work and is considered in Section 5.8.1. Innovating practice is challenging and it is not surprising that midwives working for the NHS find it difficult to affect change in their practice areas. Many practices within the NHS become habituated, making innovation and practice development difficult and slow to achieve (Sheridan 2010; Freemantle 2013). Richens (2002) reports that a lack of autonomy was a significant barrier and Hundley (2000) identifies staff shortages, lack of time and poor morale as further challenges to research utilization. These findings are supported by Colvin *et al.* (2013) in their systematic review of barriers to change in midwifery practice. Powell Kennedy *et al.* (2012) tell us that midwives face challenges in implementing practice-based evidence and report that authority plays a significant role in forming practice. Practice may be based more on custom, or long-standing policies, than on evidence and midwives commonly do not hold the authority to introduce innovations. This can lead to midwives concealing unauthorized practices which they consider to be beneficial to women, and whilst this may help the individual woman, it does nothing to further midwifery knowledge or practice. Covert practices cannot be researched or audited to ascertain their efficacy or add to the body of knowledge.

2.6.4 Advocacy and supporting women's autonomy

Advocacy and support for women's autonomy are closely linked to midwives' professional autonomy. Kirkham (2011a) and Smith (2014) both note the interconnectedness of midwives' and women's autonomy. When midwives have high levels of professional autonomy they are able to support and facilitate women's autonomy and ideas relating to this are explored in Section 5.2.3. Definitions of advocacy range from guarding clients' rights to autonomy to seeing one's role as serving the clients' best interests (Finlay and Sandall 2009). Prochaska (2015) asserts that advocacy is an important part of upholding women's autonomy and enabling them to make the choices they wish to make. Advocacy is assumed to be an essential part of midwifery (Riddick-Thomas 2009; NMC 2018), however the dilemma NHS midwives face between supporting women and complying with Trust requirements often means that they are expected to disregard women's rights by persuading them to submit to medical recommendations (Edwards *et al.* 2011). Beauchamp and Childress (2013, p.101) define autonomy, at its most basic, as being a person's ability to make decisions, 'free from both controlling interference from others and limitations that prevent meaningful choice'.

Human rights are not new to maternity care but there is an increasing focus on how the law can be used to improve care for women (British Institute of Human Rights 2017). The Human Rights Act (1998) is a framework that midwives can employ to help guide practice and protect women's rights and is a useful tool when advocating for women. This is now being recognized in the NHS as illustrated by the appointment of Professional Midwifery Advocates, following the disappearance of midwifery supervision (NHS England 2017).

The law in the UK is very clear about the rights of mentally competent women to decline medical interventions (British Institute of Human Rights 2017) but many healthcare practitioners feel conflicted when it could result in the death of the mother or baby and will pressure women to comply with their recommendations (Hindley and Thomson 2005). There is often misunderstanding amongst obstetricians and midwives about the extent of a woman's autonomy, and whilst they believe that women should make the final decisions about their care they paradoxically also believe that the woman's rights to do so can be overridden if there is danger to life (Kruske *et al.* 2013). Discord over decision-making frequently leads to serious pressure on women's autonomy, with women reporting some degree of intrusion where clinicians apply increasingly intense pressure including: manipulation, punishment and judgment, badgering and the final escalation - assault

(Jenkinson *et al.* 2017). In this final scenario women are threatened with or receive actual treatment without their consent. Kruske *et al.* (2013) demonstrate the inconsistencies that exist in healthcare professionals' support of women's autonomy, although perhaps there is uniformity in that they are happy to support women's autonomy up until the point where they perceive real danger and thereafter, they no longer support it. Such practice is a far cry from the woman-centred care health professionals purport to provide, where care is based on the woman's physical, psychological, and social needs (Leap 2009).

Failure to support women's autonomy is associated with women's withdrawal from antenatal care and rising rates of freebirth, where women plan to birth without an attending midwife or doctor (Dahlen *et al.* 2011; Plested and Kirkham 2016). These decisions increase risk and thus it can be said that failure to support women's autonomy results in increased risk to women and babies.

A survey of dignity in childbirth (Birthrights 2013) found that women's experience of birth affects how they feel about themselves and the relationships they have with their partners and babies. A positive influence was associated with physiological birth, whereby women felt respected and able to assert their choices, whilst a negative influence was strongly associated with instrumental birth wherein women experienced disrespect and lack of consent. Negative experiences, worryingly, were shown to have an adverse impact on the woman's relationship with her baby. It is interesting to note that the midwives surveyed in the Birthrights study initially misunderstood the concept of dignity. They took dignity to mean a woman's physical privacy whereas in law the term encompasses the associated notions of respect and autonomy, and human rights law.

2.6.5 Job satisfaction

Job satisfaction is a key factor in sustainable practice in midwifery and within Independent Midwifery it is linked to autonomy, the relationships formed as a result of caseloading and the quality of care (Section 5.2.4). The research about models of care which involve midwives getting to know women demonstrates that the ability to form trusting relationships results in job satisfaction and acts as a motivator (Newton *et al.* 2014; Sandall *et al.* 2016). The converse is also true - that midwives experience dissatisfaction when they are unable to build relationships. In their germinal study of why midwives leave the profession, Ball *et al.* (2002), found that lack of autonomy, dissatisfaction with care and inability to form relationships with clients were key reasons. This report was revisited in 2016 (RCM 2016c) and the findings show that the five main reasons now for leaving, or

wanting to leave, are: inadequate staffing levels, unhappiness about working conditions, dissatisfaction about the quality of care they are able to give women, unhappiness with the model of care they work in and dissatisfaction with the workload. These issues all relate to having little professional autonomy and being unable to make the improvements needed to make working as a midwife a sustainable option. In their recent survey of midwives, Hunter *et al.* (2018) describe the unacceptably high levels of work-related stress, anxiety and depression reported by their respondents. Two thirds of those surveyed were considering leaving the profession, which would compound the shortage of midwives and have implications for the quality and safety of maternity care.

2.7 Time and clinical practice

Literature relating to the concept of time in clinical practice is reviewed in this section and analysed in light of the importance the participants place in their use and perceptions of time as discussed in Section 5.4.

Time is commonly considered to be a universal concept (Stevens 2009). Our experience in the Western world is that life is controlled by the clock, measured in hours, minutes and seconds. One might think it has always been this way and is viewed similarly by all people and yet clock time is a relatively recent construct and not representative of all cultures in the world (Hall 1990). Greenwich Mean Time (GMT) was originally set up in the fifteenth century to aid naval navigation, however international agreement on global time measurement was not reached until 1884, when GMT was established as the international standard. It is still used as the main standard time against which all time zones are referenced globally (Greenwich2000 2017). It was not until 1880, when the Statutes (Definition of Time) Act received Royal Assent, that unified time was legally established across the UK.

The need for unification of time came initially with the development of the railways. For trains to run safely and efficiently, synchronization was a necessary development and thus 'Railway Time' was introduced (Harrington 2003). Prior to that, time was calculated locally by cities and towns, according to their longitude, using local mean time (Harrington 2003). The time of sunrise differs by approximately half an hour in Britain, from East to West (Howse 1997). Up until the 1800s most people had no requirement for accurate clock time in their everyday lives, life was based on the natural rhythms of days and seasons. Time was local, considered at the communal level, with each town having a public clock for people to refer to (Thompson 1967). Midwives practising in this era would have worked in response to women's biological rhythms, attending births when they spontaneously occurred and

remaining with the woman until the baby was born; clock time was not then a factor in childbirth (McCourt and Dykes 2009). The railways brought uniform time to Britain, transforming ideas about time and space (Henning 2017), thus enforcing a new adherence to punctuality - hence the clock came to rule people's lives in Western cultures (Thompson 1967).

2.7.1 Time orientations

Time, despite our perceptions in the Western world, is not a universal concept, and beliefs about time remain profoundly different from culture to culture (Levine 2005). Hall founded the field of intercultural communication in 1959. Hall (1990) discusses how cultures are either monochronic or polychronic in their time orientation, which has implications for how they organize their time and space. Monochronic orientation is associated with individualistic, low-context cultures, typical of industrialized countries, where time is linear and dictates virtually every aspect of the day and is viewed as a valuable commodity, one which can be invested, spent or wasted (Neuliep 2009). In contrast, polychronic orientation is associated with collectivistic, high-context cultures, where less emphasis is placed on clock time. These different orientations make interactions between the two cultures problematic, if not impossible (Hall 1990). In polychronic orientated cultures time is conceived as being cyclical, following the rhythms of natural cycles and timescales – day moving to night and season transforming to season. Within this way of life time may be measured by how long it takes to complete tasks as opposed to the situation in linear temporality where time dictates the duration of the activity (Levine 2012). People in polychronic cultures will often describe the passage of time in terms of an activity such as milking a cow or baking bread (Thompson 1967). Life operates at a slower, less regulated pace. Time orientations in the context of independent midwifery are discussed in Section 5.4.4.

2.7.2 Effect of industrialization on time and space

The Industrial Revolution and the emergence of factories brought large numbers of people to a single place for work where tasks were meted out for completion over specific timeframes. This required the application of organization and structure to people's lives (Thompson 1967). Industrialization and clock time were inextricably linked, with an increasing focus on the amount of work which could be achieved in a given period of time. The clock was required for the coordination and control of people and machines - time-management had been invented (Choucri 2012). People 'clocked' in and out from work at predetermined times, and time set the parameters for their activities. This system can be

seen today in the shift work of midwives on hospital wards. People are allocated areas of work in order to facilitate optimal outputs of productivity each day (Walsh 2007b). The concept of linear time is the dominant view in Western cultures, in which time is constructed as an unfolding unidirectional straight line, moving from the past to the future without repeating itself (Walsh 2007b). Clock time is external to the person, with no connection to the natural rhythms of the body or seasons and, as Choucri (2012) explains, creates a conflict in midwifery practice between a woman's physiological processes during the pregnancy continuum and the health institutions which are governed by clock time.

2.7.3 Industrialization of childbirth

Bringing maternity care into the hospital setting has real parallels with industrialization and factory working. Doing so fundamentally changed midwifery practice and the care women receive (Hunt and Symonds 1995). Historically, midwives had been based in the community, providing care for families they knew at home (Heagerty 1997). Their continued employment depended on building a good reputation – evidenced by women's satisfaction with their practice. Women would give references to family, friends and acquaintances for those midwives they valued (Towler and Bramall 1986) - very similar to the system currently used by Independent Midwives (Section 4.2.2). McNiven *et al.* (1992) describe how midwives took a holistic view of women and care was individualized, empathic and connected. This may however be a rosy picture of the state of midwifery care at that time. It is important to consider that not all midwives would have been exemplary in their practice, because without an approved education programme, great variations existed in how they were trained and how they then cared for women. Midwifery care was also not universally available, with some women unable to afford the services of a midwife.

The adoption of the 'industrial' or 'commercial' model by the NHS has resulted in a focus on the efficiency of the organization rather than whether the needs of clients and patients are being met (Perkins 1997) and is considered in Section 5.4. Perkins (1997, p.173) goes on to say that the adoption of business principles by the NHS, that aim to increase economic efficiencies and the productivity of its workforce - professionals who have a caring ethos and who expect to control their own work processes – is, 'so inappropriate as to be bizarre'. And yet this is what has happened over the last 30 years. Midwives have lost control over how they work, and temporal pressures and high workloads serve to restrict and compromise their practice (Choucri 2012; RCM 2016c). The NHS has been described by many as providing a production line model of maternity care (Walsh 2007b; Dykes 2009; Kirkham 2010).

Women have voiced their dissatisfaction with what they term 'conveyor belt care' most recently in *Better Births* (NMR 2016). Kirkham (2017) has concluded that there is a clash of values between the commercial model the NHS is now run on and those of midwifery practice which are based on personal connections with women. Kirkham goes on to recommend the adoption of a different approach that facilitates autonomous midwifery practice which, evidence demonstrates, results in excellent outcomes for women and babies and which is cost-effective (Ryan *et al.* 2013; Hofmeyr *et al.* 2014; Sandall *et al.* 2015). But despite the evidence that supports midwives having more autonomy, those working in mainstream maternity services continue to feel powerless and unable to affect their own working conditions (RCM 2016c).

Time and space are linked in a literal way in the workplace in Western culture (Thompson 1967). The space a person works in reflects the rank they hold, and the status they have. The lower down the hierarchy the more visible they become and the closer their time is measured (Giddens 1987). As Giddens explains, front line workers - junior midwives - in the case of midwifery, operate within large open spaces - wards - where their productivity can be supervised, by matrons or managers. They have timetables - off-duty rosters - that are dictated to them by those in more elevated positions. In contrast, higher grade workers - managers, often have their own space - an office - where they are subjected to little scrutiny and can determine their own timings. Having high levels of professional autonomy and no hierarchical structure to their practices means that Independent Midwives do not experience midwifery in this way (Section 4.4.1).

2.8 Relationships in midwifery care

The concept of the mother-midwife relationship is key to this thesis. The literature relating to continuity of carer and the relationship between mothers and midwives is reviewed here and discussed in Section 5.6. The many benefits for women, babies and midwives associated with it (Kirkham 2010; RCM 2016a; Sandall *et al.* 2015) were discussed previously (Section 1.5.2). This relationship, because of its individualized and holistic nature, incorporates people who are important to the woman – her baby, partner, children, parents or friends, and although not explicit in its wording, the mother-midwife relationship is not exclusionary. The concept seeks to understand the woman in her social context, to enhance the support she has and consequently to strengthen her emotionally and psychologically (Leap 2009).

Pilley Edwards (2005) discusses how the importance of the relationship has largely been discounted by maternity services, resulting in continuity of care which does not include the

level of engagement that women view as vital to their care. The White Ribbon Alliance for Safe Motherhood (2011, p.1) states that the relationship is, 'vitaly important... women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma.' The quality of the relationship is fundamental to the quality of care (Hunter *et al.* 2008) and whilst this may seem to be stating the obvious it is notable that many women do not have the experience of developing a trusting relationship with a midwife (NMR 2016).

Whilst relational continuity of care is generally assumed to be desirable, McCourt *et al.* (2006) highlight a potential problem with care being provided exclusively by one midwife – that being if the midwife is practising sub-optimally the safety of the women in her care could be compromised. Poor practice however is always a threat to women's wellbeing and should not be emphasized only as a problem of the continuity of carer model. The issue does however accentuate the importance for honesty and responsibility amongst midwives and the need for reflexive practice and ongoing evaluation of midwifery competency.

Tracy *et al.* (2013) describe relational continuity of care as a complex intervention, comprising multifaceted components which work within an intricate network of connections. Braithwaite *et al.* (2009) explain that complex systems frequently have similar natural properties, as identified in the field of mathematics. The people working within systems are considered to be one such property. They form networks within it and their collective behaviours and attitudes impact the systems in which they work. Health services constantly face the question of how to improve care and often focus on hierarchical strategies for imposing reforms, which frequently only result in limited improvements. Braithwaite *et al.* (2009) assert that clinicians are key to these efforts, working most effectively when they can determine their own practice and work within networks which reflect their attitudes. The interactions between clinicians and the individuals they care for, which lie at the heart of healthcare, are often overlooked in the delivery of models of care and strategies employed to increase the quality of care. Improving communication and relationships between clinicians and patients, or clients, and enhancing service-users' decision-making and autonomy are vital elements of any initiative to improve care. Taking a bottom-up approach to effecting change thus seems to be a tactic that could facilitate the successful implementation of new models of care.

2.8.1 Working in partnership with women

Guilliland (2014) defines midwifery as a professional partnership with women, which enables a deeper understanding of women's needs and wishes and results in them being able to make informed decisions which optimize their wellbeing. This working arrangement is reflected in Independent Midwives' practice (Section 5.6.7). The concept underpinning partnership working relies on the formation of meaningful relationships with women that result in women being able to exercise choice and make informed decisions (Pairman 2010). Equitable negotiation between the partners is how trust is built and shared understanding achieved (Guilliland 2014). According to MacGregor and Smythe (2014) mutual respect and trust are vital for effective partnership working and without them partnerships are likely to break down. The rationale for working in partnership is that it is associated with good clinical outcomes and high levels of maternal satisfaction (Dahlberg and Aune 2013). Tracey *et al.* (2013) propose that caseload midwifery results in better outcomes than standard maternity care because of the partnership relationship between mother and midwife that is inherent within it. This supports the evidence from Sandall (2016) that it is only models of midwifery with a relational element that confer health benefits to women and babies. Women are more likely to labour effectively and require fewer obstetric interventions where effective partnerships exist. Partnership working has also been found to sustain midwives in their practice (McAra-Couper *et al.* 2014) which ultimately improves care for women.

2.8.2 Holism

Holism is an important element of Independent Midwifery practice highlighted within the findings (Section 4.5.3) and considered in Section 5.6.5. Here the concept, its definitions and relevance to midwifery care are reviewed. Holism derives from the Greek word 'holos' meaning whole, whilst health and healing stem from the Greek word 'hale', which also means whole (Merriam-Webster 2018a). McEvoy and Duffy (2008) contend that holism and health are thus inter-related concepts involving the individual person as a whole, where the connections between mind, body, spirit and the social context of life are appreciated. Understanding how the harmonious interplay of these elements positively influences wellbeing is central to effectively caring for people. Women receiving fragmented care describe their antenatal appointments as being utilitarian, focusing only on completing physical checks, which they find inadequate in meeting their needs. Women ask for a more holistic approach in which they do not feel objectified: merely the subjects of medical surveillance (Pillely Edwards 2005). Holism requires a midwife to appreciate the full context

of the woman's life and to incorporate it into her care (Walsh and Steen 2007). Pope *et al.* (2001) propose that holism is achieved by providing care throughout the pregnancy continuum, a key feature of independent midwifery (Section 5.6).

2.8.3 Salutogenesis

This concept emerged as underpinning independent midwifery practice (Section 4.5.4). Whilst exploring how some people who experienced extreme adversity were able to remain resilient and positive about life, Antonovsky (1987) questioned how health is created and from that developed a new theory for health known as 'salutogenesis'. The word 'salutogenesis' is derived from the Latin 'salus' meaning health and the Greek 'genesis' meaning origin – literally meaning the origin of health (Antonovsky 1987). He defines health as a movement along a continuum between poor health and good health, dispelling the notion of health as being either good or poor (Smith *et al.* 2013). Antonovsky (1987) describes 'generalized resistance resources' that can sustain health even during adversity, these include internal resources (knowledge and attitude) and external resources (social support and access to services). The ability to use these resources to maintain or improve health is termed 'sense of coherence' and is central to successfully coping with challenge. It results in a mindset that perceives the world is comprehensible, manageable and meaningful to the individual (Antonovsky 1987). The concept of sense of coherence proposes that individuals who are orientated towards seeing the challenges in life as orderly, predictable and happening in a way they can understand (comprehensible), who have skills, ability or can find and use resources to meet the demands of the challenges (manageable) and view the challenges as interesting and satisfying and having purpose which deserves their investment (meaningful), are more likely to view the world as coherent (Smith *et al.* 2013). Strong sense of coherence has been proven to be generally predictive of good health (Lindstrom and Eriksson 2010), women with a strong sense of coherence are more likely to have uncomplicated births (Oz *et al.* 2009). Ferguson *et al.* (2016) report that these women are half as likely to have a caesarean section compared with women who have low sense of coherence. Antonovsky (1990) discusses how an individual faced with a stressor enters a state of tension. When efficiently resolved it is not pathogenic, however when tension remains it is transformed into stress, which leads to disease. Antonovsky (1990) maintains that it is not the stressor per se that is pathogenic but the inability to resolve tension and prevent its transformation into stress. The concept of salutogenesis and its application to midwifery are explored in Section 5.6.6.

2.9 Evidence and knowledge in healthcare

Independent Midwives' use of diverse forms of knowledge became apparent in the findings (Section 4.7). Since the concept of evidence-based practice was introduced in the 1990s (Sackett *et al.* 1996) it has become the mantra for healthcare providers. Practice must be based on evidence, an argument contested by the participants (Section 5.8.2), but what constitutes evidence is often ill-defined (Fairbrother *et al.* 2016). The original model was narrow in its definition of what represents credible evidence and reflected the positivist approach taken by medicine, by focusing on interpreting and applying only rational scientific research to practice. The dominance of the medical paradigm with its preference for quantitative research is clear in shaping practice (Stewart 2001) and there historically has been little tolerance for other forms of knowledge within evidence-based practice (Fahy 1998). Kitzinger (2005) tells us that midwives must be able to understand and critique all forms of evidence in order to challenge doctrine and rigid practises.

Over the centuries midwifery practice and knowledge have been undermined and dominated by patriarchal establishments, most recently the medical profession (Donnison 1988). In the middle ages midwives were attacked for their empirical approach to healing in which they used experimental methods to develop and guide practice. They were considered a threat to the Church for using their senses rather than faith or doctrine, in contrast to the doctors of the time, who were validated by the Church, and based their practice on untested rituals, superstition and religious dogma (Ehrenreich and English 1973). During this time two developments resulted in the curtailment of women practising as healers and midwives: firstly, the establishment of medical schools within universities, which systematically excluded women from studying. Complete male control of the practice of medicine was achieved with the introduction of licensing laws prohibiting anyone other than university trained doctors from practising, and secondly, the campaign promoted by the Church, endorsed by civil authorities and supported by the medical profession, to brand women healers as witches (Ehrenreich and English 1973). Healers and midwives were widely discredited, and their brutal persecution effectively suppressed their activities and blocked the passage of knowledge to other women (Willis 1995).

A paradigm shift in the era known as The Enlightenment brought advances in the natural sciences and people moved from beliefs in religious doctrines to the assertions of the men of science that they could solve humankind's problems (Smart 1993). Claims were made that diseases could be eradicated, and improvements made to the safety of childbirth, and thus during the 1800s childbirth care changed dramatically (Fahy 1998). Medicine gained

credibility through its scientific claims and midwifery was dismissed as unscientific and thus inferior (Donnison 1988). Having so successfully discredited midwives, male practitioners and barber-surgeons were able to make inroads into maternity care and so began the move to medicalized care. Midwives' clinical experience and expertise were no longer seen as credible forms of knowledge.

Fast forward to the twentieth century, when, in the UK, the medical establishment, with its power and authority over maternity care, undertook a persuasive campaign recommending the wholesale move of childbirth to hospital on the basis of 'safety' and finally gained complete dominance over childbirth (Clews 2013). This widened their client base from the monied classes to all childbearing women (Donnison 1988) and resulted in the fragmentation of maternity services and further devaluing of midwifery care. Birth was safest in hospital, according to the evidence presented in The Peel report (DH 1970) and the aim was for 100% of births to occur in hospital. This report was bolstered in 1984 by an unsubstantiated statement from the Government Maternity Services Advisory Committee asserting that moving birth to hospital had contributed to a dramatic reduction in stillbirths and neonatal deaths, and the avoidance of many birth injuries (Osbourne 2004). The drive towards total medicalization of birth disregarded evidence demonstrating the benefits of non-medicalized care. A study by Allison (1996) comparing community midwifery care with medical hospital care between 1948 and 1972 found that outcomes for women receiving community midwifery care were as good as, and often better than, for those receiving hospital care. This midwifery evidence was not incorporated into maternal health policy and the dominant medical paradigm took precedence. Tew (1998) demonstrated that the conclusions reached by government about the increased safety of hospital birth were not borne out of evidence. Her analysis of maternal and infant mortality statistics showed that improvements in maternal and infant morbidity and mortality were primarily due to advances in public health, sanitation and nutrition, resulting in a healthier population, rather than obstetric care. Despite her unbiased and clear presentation of the evidence, medical journals refused to publish her paper (Young 1999). For decades evidence which does not support medicalization has failed to influence policy or practice whilst medical opinion has dominated practice and overlooked the benefits of less medicalized approaches.

2.9.1 Authoritative knowledge

Jordan (2014, p.95) tells us that in any scenario a number of different ways of knowing will exist and that 'some will carry more weight than others.' Certain types of knowledge become

respected and socially endorsed - authoritative - and consequently others become devalued and suppressed, an observation made by the participants (Section 4.7.1). Whether a particular form of knowledge is accepted and valued is determined in part by the status of the person, or group, who hold it, and so knowledge is linked to power. Jordan (2014) reminds us that the label 'authoritative knowledge' is not indicative of the accuracy of the knowledge but rather the trust people have in it and the group who hold it. She also observes that those who champion alternative knowledges are dismissed as ill-informed, foolish or even troublemakers.

In some arenas, including childbirth, knowledge has become exclusive and limited to authorized personnel in a hierarchical manner. Jordan (2014, p.116) describes how medical knowledge 'is not only privileged, but also supersedes and delegitimizes other potentially relevant information sources such as the woman's experience or intuitive knowledge'. It is held that some people, pregnant women for example, are not entitled to contribute to the knowledge because they do not hold a position of authority (Davis-Floyd and Sargent 1997). Authoritative knowledge forms the basis on which decisions and actions are made (Jordan 1993) and in this way women are generally excluded from the process. Since midwifery was subsumed into medicine, the dominant profession in childbirth, the authoritative knowledge of childbirth has been the scientific and rational and midwives are expected to respect and conform to it, whilst their own professional knowledge is devalued or dismissed (Parratt and Fahy 2008). Notions of authoritative knowledge and the effect it has on practice are discussed in Section 5.8.

Midwifery was not the only form of healthcare subjected to delegitimization by the medical profession. Starr (1982) recounts how until the mid-20th century medical care in the United States was provided by a range of male and female practitioners including: homeopaths, naturopaths, folk healers, barber surgeons and midwives. This situation changed in response to the Carnegie-funded Flexner Report, which revealed a wide array of unregulated and competing schools of medicine. The report led to higher standards of medical education and the endorsement of allopathic medicine, with considerable funding being provided to conventional medical schools and doctors, placing them in a position of cultural authority, whereby what they espouse is perceived culturally as the truth. It also led to the forced closure of non-conventional medical schools and the invalidation of alternative forms of healthcare. Ehrenreich and English (1973) note that allopathic medicine at that time was the domain of the white, upper/middle-class male, as was the case in Western Europe, whilst

the alternative models of healthcare had been inclusive of women and black people, of all social classes.

2.10 Philosophy

Philosophy was identified by the participants as a key determinant of their midwifery practice, influencing how they work (Section 5.10). Here philosophy and the concept as it relates to midwifery is explored. Differing explanations exist about philosophy. The following definitions are congruent with the meaning ascribed by the participants. Philosophy is: 'a theory or attitude that acts as a guiding principle for behaviour' (Oxford University Press 2018b), 'a particular system of beliefs, values and principles' (Cambridge University Press 2018) or 'a theory underlying or regarding a sphere of activity or thought' (Merriam-Webster 2018b).

Many assertions are made about midwives' philosophy in the literature, with sweeping statements claiming that midwives perceive the pregnancy continuum as a normal physiological event, and even suggesting that all midwives hold the same viewpoint (Thachuk 2007). The ICM (2014) defines midwifery philosophy as founded on the belief that pregnancy and childbearing are normal physiological processes for most women, where midwifery care is holistic and continuous and takes place in a partnership with women which recognizes their rights to self-determination. Whilst this is a laudable aspiration for the profession, it is idealistic and not representative of mainstream midwifery practice. Evidence demonstrates that this is not the common experience of women or midwives (RCM 2016a; NMR 2016). The omission of these basic elements of the midwifery philosophy in NHS maternity services is evidenced by *Better Births* recommendations that relational continuity of care and informed choice be implemented in England and by *Best Start* in Scotland. The need for these recommendations is dispiriting because it has been government policy to provide these elements of care since the publication of the Changing Childbirth report (DH 1993). The Independent Midwives have demonstrated throughout the findings that it is feasible to consistently work in a way that incorporates relational continuity and women's autonomy (4.2.5; 4.5.1).

Despite the contention by the midwifery profession that birth is a normal, physiological event, 93% of births in the UK occur within obstetric units (Miah and Adamson 2015), with women having little continuity of care (NMR 2016) and where women's rights to self-determination are rarely translated into practice (Hindley and Thomas 2005; NMR 2016). The idea that midwifery practice is embedded within beliefs of normality is also directly

contradicted by the evidence regarding fear of childbirth within the profession (Reiger and Dempsey 2006; Fenech 2016). Soltani *et al.* (2015) show that some midwives will give inaccurate information to women about the safety of homebirth in order to deter women from choosing it. The acceptance of midwives to practise within settings that promote the notion of the pregnancy continuum as a dangerous event, which requires testing, surveillance and interventions, potentially demonstrates the lack of conviction they have about the normality of childbirth (Hindley and Thomas 2005). Hospitalization is a marker of the medical focus now on the pregnancy continuum, rather than the midwifery focus claimed by the midwifery profession (Walsh and Newburn 2002). Defensive or fearful midwifery is perceived as a risk to the environment needed for normal birth (Plested and Kirkham 2016). Such an approach can create a self-fulfilling prophecy where midwives' fear of birth disrupts the woman's psychophysiology and increases the incidence of complications, which further reinforces the midwives' beliefs in the dangerous nature of pregnancy and childbirth and the need for medicalized care.

Houghton *et al.* (2008) find that, because of their lack of faith in physiological birth and beliefs about the safety of hospitals, some midwives give biased information in favour of hospital birth. The perceived need to use interventions only bolsters the view that hospitals are the safest place to birth, as that is where the equipment and medical staff are. Midwives' beliefs in these circumstances clearly affect their practice and potentially limit women's choices. Not all midwives are able to practise in accord with their philosophies however, and those who believe in the normality of the pregnancy continuum may be curtailed in their practice when they are compelled to follow medicalized guidelines. This results in them having to manage their conflicted feelings whilst work - what Hunter (2004) describes as 'emotion work'. The dissonance these midwives experience causes them to feel stressed and suffer poor psychosocial health which is a significant factor in midwifery attrition.

2.11 Literature review summary

This chapter has clearly set out the rationale and objective for the literature review and detailed the methods used to search and retrieve relevant papers for review. It has shown the process of selection and provided a review of each of the papers retrieved. The initial review was undertaken at the beginning of the study, to confirm that this research was novel and to situate it within the extant literature. The main review came after data generation and analysis had commenced and relates to the key findings of the study.

Chapter 3 Methodology and research design

3.1 Section introduction

This chapter details the methodology and research design employed in exploring the practice of Independent Midwives working in mainland UK. It illustrates why the research approach utilized was selected and how it addresses the aims and objectives of the study. The research design is made explicit, setting out the research techniques, or methods, for gathering and analysing the data. The process of identifying the relevant ethical considerations of the study and seeking ethical approval from the university are outlined and reflected upon.

3.2 Methodology

The term methodology refers to the philosophical framework underpinning the research approach used (Creswell 2013). It provides the justification for using a particular approach and has implications for the research methods adopted (Saunders *et al.* 2012). Research philosophy refers to the researchers' beliefs and assumptions about the nature of reality (ontological assumptions) and the development of knowledge (epistemological assumptions) and guides the way in which data should be gathered, analysed and used (Liamputtong 2014). As research is essentially about producing knowledge, epistemology constitutes a key research concept (Ormston *et al.* 2014). A researcher's own values (axiological assumptions) will influence what they research, the methods selected and how they interpret and present their findings. The process of understanding their own research philosophy requires the researcher to develop reflexivity, the ability to scrutinize their beliefs, thinking and actions and to become aware of the relationship between their philosophical stance and how they carry out the research (Saunders *et al.* 2012).

Ontology refers to assumptions about reality, the nature of being or existence and affects how the researcher views and studies their research subject, whilst epistemology relates to assumptions about knowledge, what represents acceptable, valid and legitimate knowledge and how this can be shared with others (McLaughlin 2009). Types of legitimate knowledge range from numerical to textual data and from facts to interpretation, and consequently this variety gives the researcher scope in how they conduct their research (Saunders *et al.* 2012). Crotty (1998) discusses the close relationship between ontology and epistemology, claiming that they are interdependent and difficult to differentiate conceptually. He maintains that an ontological stance implies a particular epistemological stance and vice versa.

Whilst the literature often depicts research philosophies as opposite, or even conflicting (Denzin and Lincoln 2011; Flick *et al.* 2004), Creswell (2014) proposes that the types of

assumptions that research philosophies make can be mapped onto a continuum between the two opposing extremes of positivism and interpretivism (also known as constructivism) which underpin the different research paradigms. Positivism is based on the assumption that there is an objective, real world that lies outside the experience of the individual and can be subjected to study and quantification. The researcher is considered to be detached and independent of what is researched. In contrast, interpretivism is based on the assumption that humans interpret their experiences and create their own reality and where the researcher is part of what is researched and their interpretations are key contributions to the research (Creswell 2014). Constructivist researchers believe that there are multiple truths which are individually constructed (Lincoln *et al.* 2011). Charmaz (2014) expands on this, asserting that people's experiences, opinions, beliefs and the context of their lives are fundamental to how they construct their own realities. These research philosophies and theoretical perspectives lead the researcher to making choices about methodologies and methods which align with the aims of the study and how they can best be addressed. The main methodological choices are qualitative, quantitative or mixed approaches to research (Creswell 2014).

My philosophical stance is founded on the interpretivist/constructivist philosophy which embraces a complex view of reality and acknowledges my influence on, and contribution to, the research. Typically, an interpretivist philosophy is associated with the qualitative research paradigm whilst a positivist philosophy aligns with the quantitative research paradigm (Saunders *et al.* 2012). Qualitative research is concerned with 'the qualities of entities, and processes and meanings that are not experimentally examined or measured in terms of quantity, amount or intensity or frequency' (Denzin and Lincoln 2011, p.8). Holloway and Wheeler (2010, p.3) describe qualitative research as 'a form of social enquiry that focuses on the way people make sense of their experience and the world in which they live.' It is characterized by its focus on the emic perspective – the views of the participants, their perceptions and interpretations (Rees 2003). This approach enables the researcher to gain a deeper and more detailed understanding of participants' perceptions (Silverman 2010). Husserl (1931) maintained that due to the nature of humans and their capacity for consciousness the study of human subjects should employ research methods that differ from the positivist approach. Qualitative methodologies offer a way of exploring and understanding the meaning individuals or groups give to problems or issues and involves the analysis of language and words (Hickson 2008). The focus of qualitative research is commonly on the generation of theories, rather than the testing of hypotheses (Rees 2003;

Bell 2010; Creswell 2014). Quantitative methodologies have a different philosophical underpinning, positivism, based on the assumption that reality exists outside the experience of the individual, is measurable and can be subjected to investigation and quantification. Typically, quantitative data are numerical and presented in graphical forms. This methodology aims to establish causal explanations and test hypotheses, although this is not absolute (Holloway and Galvin 2017).

For this study a methodology is required which will enable me, as the researcher, to explore and understand how Independent Midwives work, identifying the components of practice they consider elemental to sustainable, safe and effective midwifery care. The qualitative research methodology is usually employed to understand meaning and human experience and as I am aiming to increase knowledge and understanding of independent midwifery practice by generating data, which represent the complex nature of Independent Midwives' perceptions and experience of practice, this methodology will fit the study aims. It will enable me to explore their knowledge, thoughts and ideas in depth. One of the key strengths of the qualitative research approach is the potential to generate rich, full data, which provides the researcher with robust material for building a substantial analysis (Charmaz 2014) and as such adds to my rationale for using this research approach.

3.3 Research design

The research design is the overall strategy for how the researcher will conduct the research. It comprises a set of methods and procedures for fulfilling the study aims and concerns identifying the sources from which the researcher will generate data, how this will be done and how they will be analysed. It considers ethical issues, the influence of the researcher and potential limitations which could impact the study, such as time, money and recruitment of participants (Saunders *et al.* 2012).

Having identified that using a qualitative approach was appropriate for this PhD investigation it was necessary to explore which of the various qualitative research methods would be suitable. Ethnography was initially considered because it is a means of 'obtaining a holistic view of people in their physical and socio-cultural environment and making sense of their behaviour and interaction within that setting' (Donovan 2000, p.132). However, as an Independent Midwife and not having a clinical caseload at that time, I did not have professional indemnity insurance for the intrapartum period, and consequently I anticipated that there could be legal issues with being present at births as a registered midwife, even in the role as a researcher and observer. This approach was therefore discounted.

Other options which could have been selected were: discourse analysis which is a general term covering a variety of approaches to the analysis of language and how it constructs meaning (Saunders *et al.* 2012), or phenomenology which focuses on participants' interpretations and recollections of lived experiences, and generating meaning and gaining insights into those phenomena (Saunders *et al.* 2012). Gaining an understanding of grounded theory however made it clear that as an under-researched group Independent Midwives would be suitable subjects to be studied using this Grounded Theory approach. Decisions regarding the chosen research paradigm and methodology were based on how the aims of the study could be best addressed. To meet these aims a qualitative approach has been adopted, drawing on the principles of constructivist grounded theory; a contemporary version of grounded theory (Charmaz 2014), and incorporating notions of feminist research principles. A qualitative approach presents the best way to explore the thoughts and experiences of participants and, as previously stated, the aim of the study was to gain in-depth insights into the practice of Independent Midwives in Mainland UK, by capturing their ideas, perceptions and views about the way they practise and their rationale for doing so. Qualitative research is characterized by its focus on the emic perspective – the views of the participants, their perceptions and interpretations (Rees 2003), which makes it a good fit for this piece of research. It is concerned with 'the qualities of entities, and processes and meanings that are not experimentally examined or measured in terms of quantity, amount or intensity or frequency' (Denzin and Lincoln 2011, p.8). Holloway and Wheeler (2010, p.3) describe qualitative research as 'a form of social enquiry that focuses on the way people make sense of their experience and the world in which they live.' The qualitative approach enables the researcher to gain a deeper and more detailed understanding of participants' perceptions (Silverman 2010). Qualitative research offers a way of exploring and understanding the meaning individuals or groups give to problems or issues and involves the analysis of language and words (Hickson 2008). The focus of qualitative research is on the generation of theories, rather than the testing of hypotheses (Rees 2003; Bell 2010; Creswell 2014).

Philosophical assumptions will underpin every researcher's research strategy and methodology (Liamputtong 2014). Whilst the literature often depicts quantitative and qualitative research approaches as opposite and even conflicting theories (Denzin and Lincoln 2011; Flick *et al.* 2004), Creswell (2014) proposes that a continuum of philosophical research paradigms exists, underpinning the different research methodologies, where at one end lies positivism, based on assumptions that there is an objective, real world that lies

outside the experience of the individual and can be subjected to study and quantification, and at the other lies interpretivism (also known as constructivism), based on the assumption that humans interpret their experiences and create their own reality. Constructivist researchers believe that there are multiple truths which are individually constructed (Lincoln *et al.* 2011). Charmaz (2014) asserts that people's experiences, opinions, beliefs and the context of their lives are fundamental to how they construct their own realities.

3.3.1 Grounded theory

Grounded theory is a general research method which can be qualitative or quantitative in nature, although it is commonly perceived to be a qualitative method (Holton and Walsh 2017). The original version of this method was introduced by two American sociologists, Barney Glaser and Anselm Strauss, in 1967. The purpose of a grounded theory is to develop theory from the data, through a process of induction, that will explain patterns of behaviour, in the area of interest (Rees 2003; Breckenridge and Jones 2009). Patterns of behaviour are explained through a proposition. These propositions are said to form a theory that is grounded in the data (Rees 2003). The use of grounded theory is appropriate where little or no research exists (Strauss and Corbin 1998) and as has been demonstrated in the literature review (Section 2.4), there is a paucity of evidence concerning independent midwifery practice.

Grounded theory consists of 'systematic, yet flexible guidelines for collecting and analysing data to construct theories from the data themselves' (Charmaz 2014, p.1). It involves the simultaneous generation and analysis of data, utilizes comparative methods and provides strategies for constructing theories (Charmaz 2014). The contemporary version Charmaz has developed shares much with the original grounded theory documented by Glaser and Strauss (1967), in that it includes the inductive, comparative, emergent and open-ended approach described therein. It also incorporates strategies such as coding, memo-writing and theoretical sampling which are in line with the original statement. Charmaz (2014) argues that her variation addresses criticisms about the original version of grounded theory; that it was based on outdated epistemology, relied on the authoritative voice of the researcher and considered there to be an objective external reality, whilst simultaneously maintaining the neutrality of the researcher as merely an observer. The constructivist grounded theory version was selected to underpin this study because its interpretive nature (Birks and Mills 2015) aligns well with a study exploring the perceptions of a group of health professionals providing care which is not mainstream and where the interaction between researcher and

participants is considered to result in the co-construction of the research (Holton and Walsh 2017). By starting with the assumption that social reality is multiple and constructed, Charmaz (2014) takes the researcher's position, perspective and interactions with the research into account, rejecting the notion of the expert researcher and neutral observer who merely witnesses phenomena and objectively reports on what they have seen. Researchers must examine and make clear how their preconceptions shape the research rather than attempting to eliminate or refute their influences. The researcher will influence the study in many ways, and as such will need to take a critical approach to the role they take in shaping the outcomes of the research – a process known as reflexivity (King and Horrocks 2010), see Section 3.3.3.

3.3.2 Feminist research principles

Midwifery is a female dominated profession, providing care to women and as such it seemed appropriate to develop a methodology which was influenced by feminist research principles. The ideals of feminism in part relate to the valuing of women's experiences and opinions, and the desire to improve the position of women in society (Rees 2003). I have not aimed to conduct a piece of feminist research, it is feminist in that it explores Independent Midwives who are an under-researched group and seeks to illuminate their experiences of providing midwifery services. This study has sought to give Independent Midwives the opportunity to have their voices heard and to enhance understanding of their care amongst the midwifery profession generally.

Practically, feminist principles have been used to guide how the research was conducted. According to Silverman (2014) the subjective nature of qualitative methods makes them the most appropriate for understanding women's experiences. Feminist principles place the participants at the heart of the research, contributing directly to the generation of knowledge (Barnes 1999). To align with these principles, research methods should be respectful and non-exploitative of its participants (Silverman 2014). Walsh (2004) asserts that the primacy of women's experience must be a key value in feminist research and that this is achieved through listening to and valuing their contributions.

Feminist sociologists Stanley and Wise (1990) write about the personal involvement of both the researcher and participant, highlighting the power relationships between them. To address the issue of power imbalances, I initially consulted several Independent Midwives to ascertain their views on which research topics would be valuable to them. During the discussions, many ideas were put forward, such as how supporting physiology impacts on

outcomes and how midwives' belief systems affect their practice. My appraisal was that all the proposed areas of practice would be interesting and important research topics but that what was needed first was the development of the big picture of independent midwifery practice, from which subjects could be selected for further investigation. It was agreed by the group of Independent Midwives that this would be a good starting point and could form the basis of a body of evidence concerning independent midwifery. I also involved several participants in the development of interview questions and in determining how the interviews should be run. My aim was to reduce power imbalances in this study by having participants take an active role in its development. Brinkmann and Kvale (2015) however contend that there is inevitably power asymmetry in research, even if it is not the intention of the researcher to exert it.

3.3.3 Reflexivity

Having a reflexive stance is an essential strategy when undertaking qualitative research (Charmaz 2014). This is a process described by Creswell (2014, p.247) as how, 'the researchers reflect about how their biases, values and personal background, such as gender, history, culture and socioeconomic status shape their interpretations formed during the study.' Charmaz (2014) reminds us that as researchers we influence our research at all stages. This starts at the beginning of the study when we determine what will be examined, the design of the research and what that enables us to see. It continues during the data generation process, analysis and the development of the grounded theory. Our life experiences, pre-knowledge and values affect how we interpret and perceive the world. We are not passive or objective recipients of information. We make assumptions about what is real and what has value, and these govern our responses. Throughout the research process I have closely examined my influence on the study through the practice of reflexivity, learning to become self-critical and to examine how my world view - my perspectives and biases generally - may have affected the research as well as how my perspectives, biases and existing knowledge specific to independent midwifery shape the way the research is conducted; how I generate and interpret the data, and subsequently develop the theory. These are key areas where bias may be introduced and where reflexivity is crucial (Fox *et al.* 2007). My aim has been to be open about the biases I bring and to acknowledge them, rather than attempting to block them, and to remedy instances where I have allowed them to influence the study. Creswell (2014) recommends keeping a written record of reflexive practice as a way of developing self-awareness and demonstrating transparency.

It can be difficult not to start a research project from one's own perception of what a particular experience means or entails. My intention, by engaging with Independent Midwives before undertaking the study, and involving them in certain aspects of the research design, was to overcome potential bias on my part about what the important questions to ask were and what the starting point should be. Each step taken in the research process, from recruitment, to data generation, analysis and development of the theory has been clearly reflected on and documented in memos which will be discussed further in Section 3.5.7. The interview process is a key point at which bias can be introduced into a study, by leading the participants and forcing their responses (Holton and Walsh 2017). This could result in data which only reflect the views of the researcher and what they assume to be of importance. Reflection after each interview and transcription was helpful to me in identifying whether I was inadvertently directing the participants. Charmaz (2014) urges the researcher to become aware of taken-for-granted assumptions they have and to remain open to what their participants are telling them.

Holton and Walsh (2017) suggest that staying immersed in the data during analysis reduces the chances of introducing personal bias and that documenting thought processes about the development of codes helps the researcher ensure that codes are directly linked to the data. Charmaz (2014) tells us that data analysis is a process vulnerable to the researcher's bias and advises researchers to ensure that they do not impose their preconceptions onto the codes and categories they develop during data analysis. A strategy I adopted to minimize my influence at this stage was to have my supervisors check the process of data analysis, looking at how codes and categories were identified and developed, ensuring that they fitted with the data and not my preconceived ideas. I wrote reflective notes during the research process to check and remediate my influence and to increase the transparency of my study. An example of this is evidenced in the following excerpt:

'I can see that the process of developing and understanding codes and where they fit has continued throughout the writing process. In trying to find the relevant quotes for a code sometimes I find that they don't exist and that I have projected my own perceptions onto the coding process... my ideas might be related but not exactly reflected by the midwives. This has been a really good check – if it's not in the transcriptions it can't go in the findings...'

3.3.4 Insider researcher

Insider research is defined as 'the study of one's own social group or society' (Naples 2003, p.46). Ryan (2015) challenges the idea of a fixed insider or outsider status, asserting that

they are not unitary identities. I have reflected on my experience of conducting interviews and understand how I may have been viewed as an insider, as a fellow Independent Midwife, whilst simultaneously being viewed as an outsider, in my role of researcher. Pelias (2011) stresses that being an insider can have its advantages as well as its disadvantages. Known hazards of working in your own backyard include that of coercion or undue influence to participate over people known to the researcher (Unluer 2012). Some people may also feel duty-bound to get involved and others may worry that it may disadvantage them if they do not participate (Nowicka and Cieslik 2014). Having considered the situation beforehand I felt confident that due to the nature of working independently the midwives in this case would not feel pressured into taking part as there were unlikely to be any consequences to their involvement, or lack thereof. As highlighted by McDermott (2013) the situation could have been different if I was in a position of influence over them and their careers, by being their manager or supervisor of midwives.

My closeness to the research topic and my prior knowledge and insights into being an Independent Midwife will have influenced this research at all stages (Burns *et al.* 2012). My idea for doing the research came from working within the field and knowing that there was little evidence about independent practice. The development of the interview guide was informed by my working knowledge of how Independent Midwives practice and the recruitment of participants was partly influenced by the professional relationships I have built with some Independent Midwives. There were certain benefits to me as insider researcher: I belonged to this group (Simmons 2007), although not currently carrying a clinical caseload, and was able to gain the trust of the participants as one of them, I knew which questions to ask to encourage them to respond fully during interviews, I shared some common experiences with the participants and understood the language and terminology they use. Independent Midwives are not a homogenous group however, and it was therefore not assumed that I would know how they all individually approach their role as a midwife and was open to learning about different, and equally valid styles of midwifery.

Knowing the group also meant that I knew who some of the key figures in independent midwifery were and could gain access to them. The potential disadvantages included: that the participants may have felt judged by me, if they perceived that I practised in ways differing to theirs, or if they assumed that my knowledge inferred deficiencies in their own. Theoretically these factors may have inhibited them from being open about their practice (Pelias 2011). My experience however was of being welcomed into the midwives' lives and

that they spoke freely and honestly about their practice and their rationale for doing what they do.

As a practising Independent Midwife, my knowledge and experience of the research topic makes me both part of the field of research and the research process. I have practised independently for more than fifteen years and therefore have insights into this way of working. Some of my working practices are commonplace amongst Independent Midwives, such as the physiological support of the birth of the placenta whilst others - supporting twin and breech birth - are not. I fully expected to hear more examples of practice variants as I interviewed midwives from different areas. Undertaking this research has given me the opportunity to consider independent midwifery from an academic perspective, rather than a practice one and has enabled me to examine the underpinning evidence and rationales for this model of midwifery and how they relate to each other, which I had not consciously thought about before.

3.4 Recruitment

As an Independent Midwife with many years' experience I knew a lot of practitioners I could invite to take part in the study. However, I felt that it was also desirable to have the views of people I did not already know and so I contacted independent practices and individuals via public information available on the IMUK website. I attended the IMUK inaugural national conference in 2016, to exhibit my poster about the study, and talk to Independent Midwives. I received a mixed reception from the delegates, a few were suspicious that participating in the study might result in disciplinary action if anything they said was deemed to be in conflict with professional standards, by the NMC. The majority were however more positive and many expressed an interest in finding out more about the purpose of the study and what would be involved if they chose to participate. 15 midwives from the conference said they would like to participate and a further five midwives contacted me in response to email invitations (Appendix 1). They were given participant information sheets (Appendix 2) and asked to contact me via email if they wanted to be included. During the recruitment process I outlined the nature of the research methodology and explained that it was unlikely that I would need to include all 20 of the volunteers. In the early stages of grounded theory research, it is not possible to accurately predict the number of participants that will be required. Once theoretical saturation was reached I would not need to interview any further participants and that stage of the data generation process would cease. It was agreed that I would contact the midwives again if I wanted to interview them. Four potential participants withdrew from the study before completing the recruitment process.

3.4.1 Inclusion criteria

The most important inclusion criterion is that the participants have personal knowledge and experience of the subject under examination (Merriam and Tisdell 2016). For this doctoral study it was imperative that the participants had experience of working as Independent Midwives in this country. Whilst independent midwifery exists in other countries it does so in different forms and under different regulations which may therefore not be applicable to experience in the UK. A requirement to be English speaking was applied because of time constraints and the financial implications involved in providing translation services. It is however unlikely that there are any Independent Midwives in this country who do not speak English fluently.

3.4.2 Purposive sampling

The initial method of sampling used in this study was purposive. Creswell (2014) defines this as the selection of individuals who will best help the researcher to understand the research problem. To gain as wide a range of responses as possible I aimed to include participants with a variety of clinical experience and differences in age. Five midwives were initially selected from those who had volunteered to take part as they could provide a wide range of insights, based on the spectrum of experience and knowledge they possessed. Haber (2014) asserts that a disadvantage of this method of sampling is that it makes generalizations about the results problematic, but as qualitative research does not aim to make generalizations this drawback is not germane. In keeping with constructivist grounded theory methodology each interview recording was transcribed and coded before the next interview took place; in doing so it was possible to make constant comparisons between the emerging codes. This enabled decisions to be made about what data to collect next and where to find them. Charmaz (2014) advises that once potential categories have been identified a theoretical sampling approach can be adopted.

3.4.3 Theoretical sampling

Holton and Walsh (2017) describe theoretical sampling as an iterative process – a cyclical activity where constant comparative analysis of data leads the researcher to seek participants who can further illuminate and develop categories identified in the data. Theoretical sampling is one of the foundational pillars of grounded theory (Breckenridge and Jones 2009); sampling is directed towards the generation and development of conceptual theory as opposed to creating a descriptive account. It is an evolving process guided by the

emerging theory. Theoretical sampling enables leads to be followed up as they arise in the data and allows the data generation to become more focused, integrating the theory (Glaser and Strauss 1967). After completion of the coding for the sixth interview it was considered that theoretical saturation may have been reached. This is defined as the point when fresh data yield no new properties which develop the emergent categories (Holloway and Galvin 2017). Prior to undertaking the data generation, between ten and fifteen interviews were planned based on broad recommendations from Charmaz (2014) and my supervisors. It is difficult to accurately predict how many participants will be required because the process of grounded theory relies on the data revealed by individuals and the in-depth interpretation of it. Glaser (1998) asserts that there are no numbers in grounded theory, only a process of sampling until data saturation is reached and completeness achieved. Charmaz (2014) reasons that the number of interviews required is based on achieving saturation, depending on what the researcher seeks to know and the analysis. Conducting two further interviews helped explore the codes and categories which had already been developed and to confirm that no new properties or insights relating to those categories were arising from the data. This was the point when data generation ended.

3.4.4 Theoretical saturation

The notion of theoretical saturation is contested (Guest *et al.* 2006; Mason 2010; Fusch and Ness 2015; Galvin 2015), although surprisingly this is rarely reflected in textbooks (Rees 2003; Denzin and Lincoln 2011; Saldana 2011; Creswell 2014). The concept was introduced by Glaser and Strauss (1967) in relation to grounded theory and is taken now as a generic marker of quality for different types of qualitative research (O'Reilly and Parker 2012). O'Reilly and Parker (2012) argue that its meaning needs to be clarified in relation to other qualitative methods and should not be transferred unquestioningly. The meaning of theoretical saturation is made clear within grounded theory methodology – it is the point where the data generation process reveals no new information or insights relating to the study's aims (Charmaz 2014, Holton and Walsh 2017), and as such has been used in this study to justify sample size, and when and why data generation ceased. It may be that a caveat to the term should be applied here – that within the financial and time constraints of a doctoral study, and the skills of this novice researcher, the categories were developed as far as was possible.

3.4.5 Sample characteristics

The study was undertaken with participants from across Mainland UK. No midwives from Northern Ireland chose to participate in the study. In total, eight participants were interviewed during this study. With 63 midwives currently registered as Independent Midwives with IMUK (IMUK 2017), this sample represents 12% of the group. Seven of the participants practised in both urban and rural settings, with the remaining one working in rural locations only. Working across large geographical areas which incorporate both urban and rural settings is common within independent midwifery practice. The participants were all English speaking, aged 31 - 70, with experience of independent midwifery practice varying from 4 - 27 years. All have children of their own, having experienced childbirth personally at least once (see demographic details Table 2). Care has been taken within this table not to collate so much information that it makes identification of the participants possible. The number of women in the participants' caseloads varied widely, ranging from those working full-time and choosing to have maximum numbers (usually no more than four women expected to birth in any one month) with at least one month a year clear for holidays, to those working on a part-time basis or in areas where there were fewer women choosing to engage independent midwifery services. The caseloads vary from five to ten clients a year to over 40 in some cases. The number of clients a midwife can take will depend on the support she has from her colleagues to provide clinical backup, which reflects the guidance given by Hobbs (1998) in *'The Independent Midwife'*. Because the midwives have to find their own clients, their workload and thus income can vary greatly from year to year.

Table 2: Demographic of participants - 2017

Pseudonym	Age*	No. of children	Years qualified	Years worked as an Independent Midwife	Geographic location	Location of Interview
Claire	41-50	2	4	4	Urban and rural	Colleague's home
Steph	61-70	3	17	11	Urban and rural	Home
Rebecca	31-40	2	8	3	Rural	University
Alison	51-60	2	21	17	Urban and rural	Home
Lisa	41-50	2	20	18	Urban and rural	Home
Jane	61-70	4	40	26	Urban and rural	Home
Chris	61-70	1	35	27	Urban and rural	Home
Deb	31-40	1	18	13	Urban and rural	Interviewer's home

*Age is given as a range to avoid potential identification of participants

3.5 Data generation

Debate surrounds the use of the terms to describe how information is produced for analysis in grounded theory research. Birks and Mills (2015) contend that data generation refers to the researcher's direct involvement with the source of data, i.e. the interviewee, to produce information, whereas during data collection the researcher has little influence over the data source. Holton and Walsh (2017) do not distinguish between the two, simply using 'data collection'. Charmaz (2014) however, uses the term 'data gathering', almost implying that the process is objective, which does not reflect her general views that the researcher has a major impact on how and what data are produced. 'Data generation' is used in this study as it reflects the notion of constructivism and acknowledges the researcher's active role in creating the research material. Creswell (2014) supports the argument that the selection of the data generation method and what is observed are influenced by the researcher – their values, assumptions and preconceived ideas. Creswell contends that being reflexive is key to this process.

Undertaking interviews seemed to be a pragmatic way to generate the data required for this inquiry. The value of interviewing in grounded theory research is evidenced by the number of studies that depend on it as their main strategy for generating data (Birks and Mills 2015).

King and Horrocks (2010) explain that one-to-one interviews offer a robust strategy for data generation because they enable the researcher to explore, in depth, the experiences of the people who have substantial first-hand knowledge of the research area. It was this explanation that drove my choice to employ this strategy. The objective was to gain detailed responses to the interview questions, which would result in the generation of rich data as Denzin and Lincoln (2011) describe. Rich data provide the researcher with detailed, focused information for developing a substantial analysis (Charmaz 2014). Such data provide thick descriptions of the participants' feelings, opinions and actions whilst giving the context of their lives, enabling the researcher to understand what is happening from the participant's perspective – giving them the insider's view (Rees 2003). Whilst interviewing is an oft-used method of generating data by grounded theorists (Charmaz 2014), it is not the only one available. Grounded theory uses all strategies for data generation, including: observations, visual and auditory media, and surveys (Holton and Walsh 2017). Bell (2010) asserts that the method of data generation influences what material is produced and should be determined by the research question.

3.5.1 Face-to-face interviewing

Interviewing the participants face-to-face was the preferred method because as Patton (2002) asserts, it allows for the establishment of a trusting rapport with the participants, in order to obtain honest, in-depth responses. It allows for the observation of non-verbal as well as verbal data present in personal interactions (Hiller and DiLuzio 2004) which can be valuable forms of communication, adding to the meaning of the responses, which may be lost in interviews conducted via telephone or video calls (Berg 2009). It was interesting to observe how the mannerisms, gestures and facial expressions of the participants gave additional information and context to the words spoken by the participants, especially when being ironic or humorous. As a novice researcher, I was interested to note how much of this type of communication makes up a conversation and how the words spoken constitute only a small part of what is conveyed. Mehrabian (1972) established that human communication is made up of three elements: words, body language and tone of voice, and that the words spoken form only a small part of that communication. The nature of human communication did pose a challenge when trying to convey the meaning of the message being delivered by the participants purely through its translation to the written word (Section 3.6.1). I did consider video recording the interviews as a way of capturing these aspects of communication and spoke to several of the potential participants about it. Their views

however were that they felt quite uncomfortable with the idea and thought it could be inhibiting.

How the interviewer is perceived by the interviewee can shape the interaction and thus the data generated (Rees 2003). I was aware that my appearance could potentially affect the dynamics of the interview and was therefore mindful not to act or dress in a way which appeared too formal or out of keeping with the participants. I did not want to appear as if I felt superior in anyway. I was conscious of my language and paid attention to not using technical or jargonistic terms that they may be unfamiliar with. Mostly, in my experience, Independent Midwives behave and dress in a professional but relaxed and informal manner, which is what I aimed to mirror.

3.5.2 Intensive interviews

Charmaz (2014, p.56) has coined the term 'intensive interviews', describing them as 'gently-guided, one-sided conversations where the respondents can talk freely, exploring their perspectives of their personal experience of the research topic, with few time constraints.' Wengraf (2001, p.3) defines research interviews as 'a special type of conversational interaction', and Berg (2009, p.105) adds to the definition by stating that they are 'a conversation with the purpose of gathering information.' Gubrium *et al.* (2012, p.3) describe them as 'an active process between interviewer and interviewee', explaining that both parties are necessarily and unavoidably involved in creating meaning from the interviewee's responses. They argue that meaning is not simply elicited by appropriate questioning, it is actively co-constructed during the interview, which fits notions of constructivism. In contrast however, Holton and Walsh (2017) imply that interviewers take a passive role in the process, suggesting that initial interviews are characterized by the researcher sitting and listening, after they have asked the opening questions, contributing few comments. It is only in later interviews, that are directed by the developing data, that see the researcher asking direct questions relating to the codes created in the analysis and taking a more discursive approach. I adopted a range of these approaches, initially due to inexperience and later as a deliberate strategy for developing theory.

Maynard and Purvis (1994) highlight the development of rapport with participants as being imperative to the interview process. Rapport is essentially about the development of trust and enabling interviewees to feel confident to disclose information. According to King and Horrocks (2010) building rapport is a key component of effective interviewing. I set aside time before each interview to chatting and establishing rapport, and ensuring the participant

fully understood the purpose of the study and what would happen during the interview. My experience of developing relationships with midwifery clients supported this process. Building rapport is in keeping with the feminist notions, which underpin this study, promoting equality between interviewer and interviewee (Maynard and Purvis 1994). Bell (2010) highlights the need for the researcher to be skilled in asking questions and probing responses appropriately. If the participant moves freely between topics the conversation can flow without interruption, if not, the researcher will need to be more participatory and make judgements about how to effectively guide the process. Charmaz (2014) discusses the importance of language in interviewing and creating a balance between asking significant questions and gaining forced responses from participants. Researchers need to be aware of how they shape the data, especially during the interview process.

Bell (2010) asserts that preparation is required for conducting effective interviews and one of the approaches used in this study was the development of an interview guide (Appendix 4), which was used as a flexible framework for the interview. The purpose of the guide is to help elicit views and opinions about the research topic (Creswell 2014). This was helpful in the early interviews when I wanted to maintain a broad approach to generating data by asking the same questions. The transcription of the interview and initial analysis before the subsequent interview facilitated constant comparison of the data. As the data generation process progressed the questions were developed, in response to the analysis of the early data, and became more focused on the evolving codes, which is in keeping with recommendations from Charmaz (2014). Prior to undertaking the interviews, I practised my skills with my supervisory team as well as with two academic colleagues. These were useful exercises as they drew attention to areas of my technique which could be improved upon. I was able to reflect on my approach and responses to the interviewees and make adaptations to them.

As discussed by Rees (2003), the advantages of interviews are that they are less likely to lead to misinterpretations of the questions and provide richer data than questionnaires, because the opportunity to answer is less restricted and the participant can ask for clarification. The presence of the interviewer can encourage participants to answer questions fully, exploring a greater depth of meaning than with other methods. The main disadvantages concern the high level of skill required of the interviewer, the danger that interviewees feel the need to provide socially acceptable answers or worry that they will be judged if they answer too honestly, along with the time and monetary implications involved in conducting face-to-face interviews. In this study I considered that the benefits afforded by conducting face-to-face

interviews outweighed the drawbacks. Being able to meet and connect with the participants resulted in all but one interview being relaxed and conducive to open and honest responses.

3.5.3 Location of interviews

Herzog (2012) focuses on interview location, stating that within methodological guidelines little consideration is paid to where they take place and who decides. She asserts that location plays an important role in constructing reality and thus constitutes a vital part of the interview. For this reason, location should not be viewed merely as a technical matter. Often the interviewer determines where it will take place (Gubrium *et al.* 2012). From feminist research principles (Barnes 1999), actions which seek to address inequalities should be integrated into the research design and as such, interviewees were encouraged to choose the location and time of interviews. Democratization is achieved through the parties becoming partners in organising the event. Berg (2009) and Brinkmann and Kvale (2015) comment on the importance of having a comfortable private environment which is sensitive to the participant's needs. Brinkmann and Kvale (2015) also elaborate on the specifics of the location and interviewee choice. They highlight the potential disadvantage of home interviewing when the presence of family and friends could disrupt the process. This was not however an issue as most of the midwives' families were used to them conducting meetings in their homes and sometimes having consultations with clients and were thus conscious not to interrupt.

The interviews in this study all took place at a time and location of the participants' choosing, although the unpredictable nature of their work meant several interviews needed to be rescheduled because the midwives were unexpectedly unavailable; attending women in labour. The majority were conducted in the participants' own homes. As they are self-employed professionals, I was respectful that the participants were taking time when they could have been working, to help me conduct this inquiry, and that I needed to be flexible in where and when we met. As the study was conducted across Mainland UK this involved travelling considerable distances to undertake the interviews. Having a choice about location was important to the participants. Those choosing their own homes, where they felt safe and in control, were able to relax and talk freely, as described by King and Horrocks (2010). I was a guest in their domain and this helped to create a power balance between us, much as I had experienced when providing home-based care to midwifery clients. One participant chose to meet at the university, on a day when she had a pre-arranged meeting there and was happy to be interviewed in a seminar room. This interview was far less relaxed than

those conducted at home, as was discussed in Section 3.5.5. Another participant chose to come to my house for her interview as she lived over three hundred miles away and was conveniently visiting my area during the interview period. As a colleague, I knew her well and felt that my home was familiar enough for her to feel comfortable and at ease. The participants were very willing to accommodate my needs; one chose to have her interview at a colleague's house where we were both attending an independent midwifery meeting, whilst another provided me with a room to stay in overnight when I travelled a considerable distance to interview her.

3.5.4 Pilot interview

As part of the preparation, a pilot interview was conducted (Charmaz 2014) which enabled me to test the interview questions on someone who had knowledge of the subject area, and to give me experience in interviewing actual participants. It was agreed with the supervisory team, prior to the interview, that the data collected would be included within the study. The interview took just over an hour to complete and yielded over 7,000 words. It generated surprisingly rich, interesting data and introduced topics which were further explored in the subsequent interviews. I was able to reflect on the experience and think about some of the practical issues that had arisen. Because I was not an experienced research interviewer, I had not considered how I would deal with noises and interruptions that happened around us and so was unsure of how to respond. At one point the interviewee's dog awoke, and yawned loudly, neither of us said anything but it caused us to giggle, which we struggled to stifle. I did not know at that stage whether it was acceptable to have dialogue on the recording that was not relevant to the interview. Dogs featured in most of the interviews and subsequently I became confident enough to respond to the situation, where for example, the dog barked to be let out, or whined to be stroked and would just say that that event would not be transcribed, and then return to the interview.

3.5.5 Main data generation

The remaining seven interviews took place over the next six months. They lasted between one and two hours and generated some 8,000 – 15,000 words each. Using reflection, I critiqued my performance at each interview and sought ways to improve my skills. I quickly became aware of how different these types of interviews were from those in clinical practice and that my skills were quite basic. This was not a problem during the first two interviews; I was mindful to have minimal input into the interviews, asking questions and then listening to the responses, whilst offering non-verbal encouragement, until the participants concluded

their answer. I felt that the participants were quite formal in their responses and not as relaxed as they had been prior to the interview, which may have curbed their responses. I was however keen not to introduce too much of my own influence into the data and to follow the advice provided by the literature (Hopf 2004; Brinkmann and Kvale 2015). The third interview however, was significantly different because the participant was nervous and seemed to be very self-conscious about her answers. She answered very succinctly and frequently looked at me, giving non-verbal gestures, demonstrating that she was not sure how she should be answering the questions. I made a decision to make the interview more conversational to put her more at ease and to show her that it was safe for her to say anything she wanted and that her responses were valid, as illustrated in the following excerpt from the memo made at the time:

'The participant was quite nervous and answered questions in a very succinct way which didn't allow for full exploration of the question. I felt I needed to take a more interactive role in the interview to encourage her to talk more freely and expansively. I felt that although I was making suggestions she was assertive enough to say if she felt the suggestion was inaccurate or one she didn't agree with.'

In our conversation following the interview, the participant said she had felt very exposed during the interview and concerned that her words made her vulnerable to professional criticism and perhaps even investigation of her practice. This happened within weeks of the NMC decision to stop Independent Midwives providing labour care because they considered their professional indemnity insurance to be inadequate. She wanted to express her anger and sorrow at the perceived injustice of the action and the detrimental effect it was having on both Independent Midwives and their clients. I reiterated my commitment to protecting her identity and maintaining anonymity throughout the research process and offered her the opportunity to read the transcript of the interview. We spoke a few days later and she said she did not now feel the need to read the transcript and that she trusted me to fairly represent the information she had given and to provide context to her answers. The atmosphere of the interview is discussed by Hermanns (2004) who stresses that it is the role of the interviewer to create an environment which is so relaxed and open that the participants can express their opinions without fear. This interview was undertaken in a seminar room at the university. There had been no opportunity, as I had planned, for us to meet first to develop rapport, because the participant's previous appointment had overrun, and she had only an hour left for the interview. On reflection, it may have been better to have rescheduled the interview for a time when it was possible to spend some time together

to establish a connection. This may have allayed her feelings of vulnerability, but at the time of the interview we had already rearranged the meeting twice and it seemed pragmatic to continue and not miss the opportunity.

In order to utilize the constant comparative approach each interview was transcribed, and potential codes identified, before the next was conducted, see previous discussion (Section 3.5.2). A feature of grounded theory is that data generation and analysis are concurrent processes (Birks and Mills 2015). After analysis of the third interview many codes had been constructed and it was appropriate to start selecting participants who could provide data to further illuminate these, i.e. theoretical sampling (Section 3.4.3). As previously described (Section 3.5.2) basic analysis of the data enabled the interview questions to be adapted and developed for use in subsequent interviews, to further explore the emerging codes which were important to the participants. New data were still being generated at this time, with participants introducing novel ideas and experiences and so previous data could be discussed whilst fresh thoughts were incorporated into the data and explored in successive interviews. This approach facilitates theoretical saturation and is usual in the process of generating data in grounded theory (Charmaz 2014). At this stage tentative categories were being developed from the initial codes (Section 3.4.3). The final two interviews became more discursive as I believed that theoretical saturation had most likely been reached and wanted to explore my development of the initial codes and potential categories. I needed to be aware of how much I was leading the interviewees during these interactions, as we discussed my early analysis, and how this might impact the findings. Charmaz (2014) cautions the researcher to be aware of this situation and to be mindful of the influence they may have on forcing the data and also to remain open to new information being presented to them. The participants were both confident, forthright people who did not hesitate to say if they disagreed with me about the proposed codes and categories. Whilst this is not the role of the interviewee, it was helpful to me to see clearly how potentially I could steer the participants' answers. The exercise enabled me to avoid pursuing preconceived ideas I had about independent midwifery and to ensure that the data was all coming from the participants themselves.

3.5.6 Recording interviews

The interviews were digitally recorded with the participants' permission, which is the most common recording method (Brinkmann and Kvale 2015). This facilitated verbatim transcription and supported the coding process (King and Horrocks 2010). As Patton (2002) advises, I kept note taking to a minimum during interviewing as it is often a distraction to the

participants. Holloway and Galvin (2017) assert that recording and transcribing interviews is the method which produces the best database for analysis. I wrote memos soon after each interview (Section 3.5.7). The recordings are securely stored in accordance with the Data Protection Act 1998 and Bournemouth University (BU) guidelines (Research and Knowledge Exchange Office (RKEO) 2014).

3.5.7 Memo writing

'Memos in grounded theory are records of thoughts and ideas in relation to the research project' (Birks and Mills 2015, p.39) and are vital to developing a grounded theory. Charmaz (2014) describes memos as informal notes, using unofficial language because they are for personal use. This description allowed me to write in a spontaneous way, just jotting down thoughts or ideas as they occurred, which encouraged me to do so frequently without thought for the structure or grammatical correctness of the note. My memos, following interviews, documented issues which remained most impressed upon me and/or which seemed of most importance to the participant. This helped give context when I was transcribing the interviews later and acted as an aide memoire. Sometimes conversations happened outside of the interview which were pertinent to the research and these were also noted down. Memos also provide the evidence for how you conducted the research, mapping activities, events and decisions made during the process, and as such my memos include plans for how to recruit participants and which midwives would have the most valuable contributions for the later stages of data generation. These were those midwives with extensive experience of independent midwifery, and also those who have shown evidence of analytical thinking about the subject. Several participants have published articles or books relating to professional practice and demonstrated higher thinking about the implications of midwifery care. I also recorded challenges experienced in the research process and the steps undertaken to overcome them, such as losing participants before having the opportunity to interview them and having to identify and recruit new participants with equally valuable knowledge and experience.

According to Holton and Walsh (2017) analytic memos help raise the data to a conceptual level. They assist the researcher in keeping track of her thoughts and the rationale for the development of codes and categories. Referred to as 'memoing', in this context it is a continual process which records the connections between data, codes and categories. Memos are designed to be working documents which are revisited and developed. The ongoing constant comparative reasoning involved in memoing helps to eliminate the

possibility of preconceiving the findings by keeping the researcher closely involved in the data and their analysis. It promotes creative thinking and captures it in a space that is tangible and can be accessed when needed. Some ideas for codes emerged as early as the transcription stage of the first interview and were recorded in memos as they occurred to me (Appendix 5). I wrote memos about coding decisions as I went through the analysis, as recommended by Charmaz (2014), which aided my decision-making as well as being a reminder later about my justification for coding developments. I found diagrammatic representations of the codes and the decisions made about their development into categories enabled me to make sense of the patterns in the data and how codes were related. These representations were developed numerous times as my thinking about the data became clearer. They helped me to see where codes were repeated and how they could be incorporated into different categories with subtle differences in meaning or use. An example of this can be seen in Appendix 6, where the focused code 'practice development' has been incorporated into the categories 'autonomous practice' and 'knowledge, evidence and practice'. Charmaz (2014, p.162) describes memo-writing as 'a pivotal step between data collection and writing draft papers,' explaining that it helps the researcher to closely engage with the data and identify the links between data and codes. To avoid duplication of writing, memos can also be used to incorporate reflexive thinking. I found this strategy to be beneficial as I could incorporate my thinking about the development of codes, for example, whilst considering my influence on that process.

3.6 Data analysis

3.6.1 Transcription and interpretation of the data

The initial analysis involved writing post-interview memos and listening to, and transcribing the interview recordings verbatim, as soon afterwards as was practicable - usually the next day. This approach enabled me to remember details of the event which were not captured on the recordings, such as the atmosphere of the interactions and the non-verbal cues which coloured the information participants gave, such as eye contact and posture. The first two transcriptions were as literal as I was able to achieve, including all the hesitations and repetitions uttered by the participant which, according to Holloway and Galvin (2017), results in the fullest and richest data. My reading of them afterwards made me see how disruptive their inclusion was, and how they made the participants appear ponderous and uncertain, which had not been the case. In speech, an 'er' can go almost unnoticed but when transposed into the written form it takes as much importance as the meaningful words

uttered, which can result in the wrong emphasis (Collins *et al.* 2016). I made the decision to remove all such, but those which did demonstrate a moment when the participant was considering their response or clarifying something they had said. The amended transcript better represented the way in which the participants had responded and captured the meaning of their words more accurately. Having more experience and skill in transcription would have helped in making decisions about how to best capture meaning and how to do it efficiently. The time limitations of undertaking this study were a factor in how well I was able to develop my skills. The process of transcription was long, taking approximately six hours to word-process an interview lasting an hour, although this reportedly is typical for an inexperienced transcriber (Flick 2004). I chose to undertake the transcribing myself as I would have more understanding of the context of the recording than someone who had not been present at the interview. It was invaluable to me, knowing the context of the participant's responses, and being able to fully understand the meaning they were wanting to convey. Bell (2010) asserts that there is no value in the researcher transcribing all the interviews once they have gained experience of processing one or two, arguing that their time is best placed elsewhere. I however found it to be very helpful in becoming immersed in the data.

After transcribing the first interview and encountering many time consuming and frustrating problems whilst trying to listen, manually stop the recording, type what I had heard and remembered and then rewind to confirm my transcription, I invested in transcription software and a foot pedal to help me. This was enormously helpful, and I was able to easily move back and forth between the recordings and the transcripts to ensure I had captured the nuances and unspoken meanings behind the words, suggested perhaps by a sigh, or laughter. Having been the interviewer and made memos I was able to remember the context of comments which was not necessarily audible, such as a shake of the head or the shrugging of shoulders to indicate disbelief. I found that sarcasm and irony could be difficult to portray as the verbatim transcription often gives no hint that the opposite meaning of what was said was in fact intended, this situation is verified by King and Horrocks (2010). Where necessary a note was added to the transcript to explain this use of language and to give context to the words. As Gibbs (2007) comments, memos and reflective notes written during transcription are also part of the analytical process and can be useful later in developing coding ideas.

The transcription itself is a constructive process where transcribers interpret what they hear and ascribe meaning in the text they create (Kowel and O'Connell 2004) and so are subjective representations of the interview. Charmaz (2014) acknowledges that the researcher can

influence the research even during this stage and emphasizes the perpetual need for reflexivity throughout the research process. It is noted by Kowal and O'Connell (2004) that transcriptions characteristically result in a reduction of the primary and secondary data and as such it must be recognized that they cannot be perfect depictions of interviews.

3.6.2 Comparative analysis

The research findings were generated from the data through the development of initial codes, focused codes and then categories. Theoretical coding is an advanced method which can be used thereafter to help the researcher to suggest possible relationships between the categories developed from focused coding (Charmaz 2014). Saldana (2016) describes codes as short labels, most often generated by the researcher, which encapsulate what is happening in a segment of the data. Analysis in constructivist grounded theory (Charmaz 2014), although similar to, departs from the analytical processes of classic grounded theory, which proposes the development of open and selective coding, followed by theoretical coding (Birks and Mills 2015).

3.6.2.1 Initial coding

In total, eight Independent Midwives were interviewed before theoretical saturation was reached. Once the first transcript was completed, line by line reading was undertaken. Each line was then assessed for what was happening in the data and potential units of meaning were identified, resulting in the deconstruction of the data. Charmaz (2014) describes this as a heuristic device which encourages the researcher to think analytically about the data. As a novice, this appeared to be a good starting point; there are however advantages and disadvantages to all approaches. Charmaz (2014) argues that it encourages the researcher to actively engage with the data and promotes a more trustworthy analysis. Holton and Walsh (2017) assert that the requirement for line by line coding of transcripts comes from a misunderstanding of Glaser's writings and that this approach may lead to an analysis which does not go beyond description, because of the volume of data it produces. Further reading of the methodology literature caused me to change my strategy. Allen (2003) cautions against this microscopic examination, arguing that coding of individual lines can result in a loss of meaning when data are separated from their context. Whilst continuing to read line by line I started coding larger segments which contained the whole meaning the participant was conveying.

The transcriptions were set out in a table format, comprising two columns to help with the analysis. Segments of meaningful data were identified and highlighted within the interview

transcript in the first column and then recorded in the adjoining coding column as tentative codes (Appendix 7). This enabled potential codes to be easily identifiable and traceable back to the data. It also helped to optimize the efficiency of the process of comparison. I noted down the emergent ideas in a mind map (Appendix 8). After the second interview was transcribed and the data deconstructed, the tentative codes were compared with those from the first, looking for similarities, differences and connections in the data, as described by Holloway and Galvin (2017). This process was followed for all the subsequent transcripts, comparing each new one with the previous ones until all the data segments had been identified and developed into initial codes. This approach ensures that the developing theory is grounded in the data (Walker and Myrick 2006). Any additional codes identified were added to the mind map which helped to identify patterns. If there were different codes for the same topic, I generated a code which incorporated them all. The map helped me to see where connections might exist and how to start developing more abstract terms. When I allocated a code to a unit of data I attempted to use a word or term which explained what I thought was going on. 'In vivo' coding was employed when the participant's own words encapsulated a broader concept in the data, or reflected the language used in their culture. Saldana (2016) suggests this form of coding is particularly appropriate for novice researchers who are learning how to code data.

The iterative process of constant comparison continued throughout the preliminary stages of analysis, rechecking codes with data segments and comparing initial codes with each other. According to Gibbs (2007), this process enhances the rigour of the analytical process. Glaser (1978) describes this phase of analysis as being particularly susceptible to the researcher's pre-knowledge and that to avoid subconsciously applying preconceived codes they must be reflexive and constantly critique their analytical decisions. Researchers construct codes based on their experience, knowledge and views (Horton and Walsh 2017). The experience I have of independent midwifery enabled me to understand the participants' perspectives, and to construct codes which reflected these. Knowing the field could have resulted in me preconceiving the data because independent midwifery had been my lived experience, and because I have beliefs and biases about it. However, I found I was listening to ideas and opinions that were dissimilar to mine, or unexpected, and was surprised how the midwives talked about issues which I had not previously considered and therefore could not have pre-empted.

3.6.2.2 Focused coding

Corbin and Strauss (2008) recommend asking questions of the data, such as 'who, what, when, where and how', and 'what is going on here?', to start conceptualising the data. This process generated more than 70 initial codes. Once all data had been coded, the next level of analysis, developing focused codes, was undertaken. This method of analysis is in keeping with constructivist grounded theory (Charmaz 2014). Comparison of initial codes leads to the identification of codes with similar characteristics. Focused coding advances the theory of the study. Similar initial codes are grouped together and subsumed into more abstract concepts known as focused codes (Charmaz 2014). This is not a linear process; the comparison of initial and focused codes is iterative and continues until the researcher achieves completeness in categorizing the data (Charmaz 2014). This stage sharpens and condenses what has already been done in the analysis. Continuing the comparative method of analysis, the related focused codes were shaped into five categories, which reflect the participants' perceptions of independent midwifery practice: autonomous practice; time; the mother-centred care; knowledge, evidence and practice; and philosophy.

I attended NVivo software training at BU in preparation for the data analysis. However, with further reading, I realized that using a manual method would better suit my approach and for the size of this study it was appropriate because computer aided software is most helpful for large or complex studies (Holloway and Galvin 2017). I found that the process of transcription ran smoothly into the identification of initial codes and development of focused codes. Word software on the computer helped me edit, organize and store transcripts and memos and avoid the unnecessary use of paper, and the 'find' function helped me locate topics by searching for specific key words in each transcript, and later when retrieving quotes, which made the process much easier and quicker than having to read through entire transcripts each time. Familiarity with the transcripts also helped in this process - I was able to picture which participant had talked about specific topics. An observation by Holloway and Galvin (2017) is that researchers who do not use computer software in their analysis have a better knowledge of the data. Horton and Walsh (2017) caution against using analytic software in grounded theory because this methodology requires the conceptualization of data through constant comparison from codes to categories, which necessitates lateral and creative thinking and which the program is unable to achieve.

3.7 Evaluating the quality of the research

Qualitative research plays an important role in informing the field of healthcare with the aim of increasing the quality of practice and as such ensuring the quality of this research is vital.

Bryman *et al.* (2008) tell us that because of the rise of qualitative research in recent times there is a growing interest in assessing the rigour of this approach and an increasing need to establish agreed quality criteria. Rees (2003) provides a guide for assessing the quality of qualitative research. He explains that trustworthiness, authenticity, dependability and confirmability are criteria used to establish that findings are a true representation of the data. Trustworthiness can be compared to the concepts of reliability and validity in quantitative research. Authenticity is demonstrated through the thick descriptions provided by the researcher about the way the research was conducted, whilst dependability, which can also be called reliability, is confirmed through strategies such as prolonged and in-depth data generation. Finally, Rees asserts that confirmability is achieved through the auditability of the study and how well the findings are supported by the data, and the fittingness of the research - the degree to which the findings can be transferred to other contexts. Forrest Keenan and van Teijlingen (2004) explore the issue of quality in qualitative research, looking at the relevance of the terms validity and reliability commonly used in quantitative research. Validity refers to truthfulness of the findings; the degree to which they represent the social phenomena under examination which, they assert, qualitative research is able to do because of the descriptive accounts given of the research process and the rich data generated. Reliability can be understood in relation to the consistency with which the findings can be replicated. As qualitative methods are criticized for not being consistent or reproducible, in addition to the inability to generalize their findings, it seems that these quantitative ideas of quality are not appropriate for qualitative research (Forrest Keenan and van Teijlingen 2004). Bryman *et al.* (2008) report that most researchers in their study regarded validity as relevant to qualitative research and there was some support for credibility and confirmability as criteria whilst transferability and dependability were less likely to be endorsed. Bryman (2015) tells us that the debate concerning the evaluation of qualitative research and appropriate criteria to use is ongoing, with little consensus amongst researchers. Cohen and Crabtree (2008) and Sandelowski (2015) argue that the nature of qualitative research and the diversity of approaches make it difficult to establish common quality criteria. Kapoulas and Mitic (2012) claim that qualitative research, because of its view of the social world as subjective, contextual and complex, must seek to establish reliability at the design level by employing transparent methods and techniques, and keeping detailed records of the processes undertaken during the research.

The quality in this study has been evidenced in thick, transparent descriptions of how the research was undertaken. The research methodology, the development of the interview

questions with the supervisory team, the details of where interviews were conducted and over what period of time, how the interviews were developed over time in response to data collection and the rationale for stopping data generation are all explained. During the latter interviews emergent codes and categories were discussed with the participants and their views gained on the appropriateness of codes in representing the data which had already been collected. The offer of 'member checking' was made to the participants - a method for increasing the credibility of a study by getting the participants to check their data for accuracy - none of them however took up the offer. The inclusion of disconfirming cases is reported to improve the trustworthiness of qualitative studies (Silverman 2010). Although there were few of these instances, the findings chapter (Section 4.7.2) documents Claire discussing her belief that midwives should not incorporate their personal knowledge into practice and should rather use only research-based evidence. In contrast to this there was consensus amongst the remaining participants that clinical experience was a valuable form of knowledge which should be used to inform the care they provide.

The robustness of the study was also demonstrated by the inclusion of verbatim quotes from the data in the findings chapter to support the generation of codes. Analytic and reflective memos and diagrams demonstrate the method of data analysis in the development of codes and categories and the iterative process that was involved, supporting the rigour of the research. This process was checked by the supervisory team who looked at the transcripts and records detailing how codes had been identified and the resultant categories developed, ensuring that they fitted with the data. Additionally, I invited one of the participants and an academic familiar with independent midwifery practice to review the development of the codes and categories. The findings were further validated by the integration of extant research evidence in the discussion chapter (Section 5). Whilst the interpretation of the data and the development of the findings of this qualitative study are inevitably subjective, measures have been put in place which clearly demonstrate the steps undertaken during the research and enable others to assess the quality of the findings.

3.8 Research Ethics

3.8.1 Gaining ethical approval

Undertaking any research with human subjects needs to uphold participants' human rights (Ramcharan 2014). Research ethics is a code of research practices and principles considered to be the correct way to protect the rights of people who are involved in research Rees (2003). Webster *et al.* (2014) highlight ethics as being the essence of how we treat

participants well. Ethical approval was sought and gained from BU's Research Governance Committee (Appendix 9). The university's research ethics code of practice (Research and Knowledge Exchange Office 2014) and The Code (NMC 2018) were used to guide the design and conduct of the study. Preparation for the submission to the Committee included the development of participant invitations, information sheets and consent forms (Appendices 1-3) and the risk assessment. An amendment to the approval was awarded in January 2017 (Appendix 10), to conduct telephone or online interviews for participants living in very remote parts of the UK. In the event, this method of interviewing was not undertaken as the relevant participants withdrew for personal reasons. Because Independent Midwives are self-employed and provide care for women in a private arrangement it was not necessary to seek ethical approval from the National Health Service (National Research Ethics Service 2009; Department of Health 2010).

3.8.2 Ethical Considerations

The four founding principles of respect for individual autonomy, beneficence, non-maleficence, and justice have been considered and respected throughout the execution of this study.

3.8.2.1 Respect for individual autonomy

This principle is achieved through informed consent. In this study, all potential participants were provided with a letter of invitation (Appendix 1) and those who expressed an interest were then provided with an information sheet (Appendix 2), which detailed the purpose of the study and what their involvement would entail, and a consent form (Appendix 3). It was explained that participation was entirely voluntary and that non-participation would not result in any disadvantage to them personally. It was also made clear that participants were free to withdraw at any point up until their data had been anonymized and incorporated into the study. Permission was also specifically sought from the participants to record their interviews using a digital audio recorder. The participants' were asked again, prior to the interview taking place, whether they were still happy to be interviewed. Consent forms were signed prior to the generation of any data and then securely stored in accordance with the Data Protection Act 1998.

3.8.2.2 Beneficence

Beneficence refers to actions intended to benefit other people. In the context of research this largely means the benefit for society at large, and perhaps less for those directly involved in the research. In this study, the participants can benefit from the opportunity to have their

voices and opinions heard and to bring greater understanding to the midwifery profession and the public of independent midwifery practice.

3.8.2.3 Non-maleficence

This principle stands for doing no harm and in this study relates to the protection of the participants' identities, by using pseudonyms and their comfort and safety during the interview process. Confidentiality and anonymity are frequently used interchangeably but have distinctly different meanings. In the context of data generation, King and Horrocks (2010) argue that researchers should not aim to maintain someone's confidentiality as this suggests that anything said during an interview, for example, would remain private and not be divulged. It would render the interview a pointless activity if the information could not be repeated. They go on to suggest that researchers should seek to offer participants anonymity, by concealing their identities, so that the information given cannot be connected to the participants. The use of pseudonyms is a common method for hiding a person's identity.

There were particular sensitivities around upholding the anonymity of this group that had to be considered in this study and any papers resulting from it. The small number of UK Independent Midwives and the high profile some of them have within the larger profession due to the publication of papers and books and presenting at conferences and workshops have made them a 'visible' group. The unusual cases some Independent Midwives are involved in may also have resulted in contributions within this research that could be identifiable by some readers.

Some participants in this study did however express the view that they did not need anonymising and would be happy for their data to be attributable to them personally. Whilst I respected their views I was aware of the need to protect their clients' confidentiality. I proposed that the use of pseudonyms would help to conceal their clients' identities and on this basis the participants were happy to be anonymized. As there are only a small number of Independent Midwives in the UK, identification of their clients can be made relatively easily, particularly if other details such as geographical location are revealed. Pseudonyms were used in preference to other methods of anonymization, such as the allocation of numbers, as I considered referring to people as numbers to be dehumanising and I was keen that the voices of real women should be heard through the research. Each participant was invited to select a pseudonym of their choosing, which was then used to safeguard their identity.

Confidentiality must be considered in relation to what will be done with the data collected - the consent forms, digital recordings of the interviews and transcripts (Brinkmann and Kvale 2015). Following completion, the consent forms were safely stored in a locked drawer, in a locked office and were only accessible by myself. Recordings of the interviews were securely stored on a password locked computer after being deleted from the digital recording device. Transcripts of the interviews were only accessible to the supervisory team, and only after anonymization of all the data had been undertaken. Not only were the participants anonymized but also those named by the participants. People within the public domain who were named by the participants were not anonymized. Any locations which could identify the participants or those they have cared for were obscured, if mention was made of a particular part in the country, it was renamed as part of a much larger area, i.e. Northumberland would become the north. Identifying factors such as details about pregnancies or births were made vague, in order to prevent identification of participants or their clients. The participants were asked not to disclose too much detail of specific incidents that could identify them or their clients but there were occasions when, because of unusual characteristics of a case, it could have been possible to recognize the individuals concerned. During transcription it also became evident that at times too much information had been revealed and details needed to be removed or obscured. The following description of a twin birth was a prime example of the measures taken to avoid identification:

'...this is a woman with twins, birthing at home. She has had x babies and she always had x or x hours knowing it's coming... active labour, so she literally had from her first twinge, she had the first one in x hours x minutes... and then I arrived and that did something and then there was a x hour gap until the second one was born...' (XXX)

A story about a family who lived in an unusual location was so rare that the inclusion of any details about them would have been likely to lead to their identification and were therefore not included in this thesis. Likewise, the details of the care and support given to a woman who had had multiple caesarean sections also threatened to reveal her identity, or that of the participant, and thus were not included.

The use of multiple quotes from individual participants did increase the chance of identification and consequently careful attention was paid to ensuring that readers would not be able to build up a picture of them or their clients from, for example, a collection of notable cases. The participants were invited to read the transcripts of their interviews, however none of them chose to do so. I did not explore their reasons for not choosing to do

so but felt that the participants trusted me and were confident that I would not misrepresent them or reveal their or their clients' identities. The data have been stored and will then be destroyed in accordance with the Data Protection Act 1998.

Consideration for how to protect participants and prevent harm during the data-generation process was another important ethical issue that need to be addressed. All participants were asked to choose the time and place of the interview which would be most convenient, comfortable and acceptable to them, with the majority electing to be interviewed in their homes. During each interview every effort was made to treat the participants sensitively and respectfully. Although it was not considered likely, I was also mindful of the possibility that distress could be caused by talking about their midwifery practice and whilst this eventuality did not arise, my contingency plan was to stop the interview if the participant became distressed and to continue only once they gave their consent to do so. In my contingency I also considered the support the participants could seek from their Supervisor of Midwives regarding their experience of being interviewed and the issues it raised. I intended to suggest this to the participant if it became necessary. The participant information sheet (Appendix 2) also gave details of the university should there be any complaints about the study.

Prior to the commencement of the study some Independent Midwives voiced concerns about the potential for being identified during the research process and then investigated by the NMC for their opinions or reported midwifery practices (Section 3.4). Unsurprisingly most of these midwives chose not to be involved in the research. Two participants however chose to be interviewed despite these concerns and spoke about how vulnerable they felt. They described the intolerance they had experienced by NHS staff for practices which were not conventional and how this restricted their practice. Another declined to talk in depth, 'on the record', about the specifics of certain aspects of practice because they feared that despite them being supported by evidence, they would not be acceptable to those in positions of authority, and for whom such practices are not mainstream. Those who spoke about their beliefs in intuition or spiritual guidance did so with trepidation (Section 4.7.2), worrying that this could result in negative judgements and potential investigation and disciplinary action. They also expressed their sadness at not feeling able to freely talk about such issues and the lost opportunities for the profession to enhance knowledge and practice. In the planning of this study I had considered the possibility that examples of unsafe practice could be disclosed during the interviews. After discussion with my PhD supervisors it was

agreed that in this situation, I would advise the participant to discuss the issue with her Supervisor of Midwives. The situation did not arise however during any of the interviews.

3.8.2.4 Justice

Justice relates to the fair treatment of the participants in a study and the equal distribution of the resultant social benefits. To facilitate fairness, the recruitment process should be inclusive of the whole range of potential contributors, not just those who are vulnerable to coercion (Rees 2003). Whilst the Independent Midwives form a small group of people, with many similarities, time was taken to ensure that a range of participants was selected which represents differing experiences and backgrounds. The honouring of agreements between researcher and participant is also an important element of justice which must be upheld (Beauchamp 2003). On completion of this study the intention is to disseminate the evidence to a wide audience of health professionals, policy-makers and service users so that they may benefit from the findings.

3.9 Methodology and research design summary

This chapter outlines and justifies all aspects of the methodology and research design for the study and the measures taken to ensure the quality of the research. The ethical considerations are also detailed, and the steps taken to address them.

Chapter 4 Research findings

4.1 Introduction to the findings

This chapter contains the findings from the eight interviews in which experiences and perceptions of Independent Midwives were explored. The analysis, as outlined in Chapter 3, generated five, separate but somewhat overlapping categories which reflect the participants' perceptions of independent midwifery practice: (1) professional autonomy ; (2) time; (3) mother-centred care; (4) knowledge, evidence and practice; and (5) midwifery philosophy. These categories and the focused codes they comprise of are set out in the table below.

Table 3 Categories and focused codes

Category	Focused codes
Professional autonomy	Quality of care Professional freedom Practice development Advocacy Supporting women's autonomy Quality of life Peer support
Time	Time as an investment in women Time to develop knowledge
Mother-centred care	Trusting relationships Individualised care Holistic care Salutogenic approach Partnership working Communication
Knowledge, evidence and practice	Practice development Clinical judgement Women's knowledge Informed decision-making Women's autonomy
Midwifery philosophy	Normality of the pregnancy continuum as a physiological event Shared beliefs Women's autonomy

The first category, professional autonomy, incorporates the perceptions the participants have about the impact not working for an organization has on their practice. It illustrates how the midwives shape their day-to-day work and highlights choices they make about the manner in which care is provided. Not being constrained in their practice by policies, protocols or guidelines was an important aspect of working independently. Within this category the participants reflect on a sustainable work-life balance and the benefits of being supported by colleagues.

The second category, time, refers to how Independent Midwives' choice to allocate time was perceived by them as being a crucial component of their practice and relates to the amount of time they assign to appointments with their clients, and the way they choose to use time in their professional lives to develop their clinical knowledge and practice. Time is seen as an investment, in their clients as well as in the development of their own clinical knowledge and practice. Without adequate time, the midwives felt that they would be unable to achieve many of the aims of their care, specifically the development of trusting relationships with their clients, a concept they valued highly.

The category mother-centred care comprises the many constituent parts which make up this model of care, and shows the inter-relatedness of those constituents. The importance of providing care where the woman is the focus is highlighted by all the participants.

The category knowledge, evidence and practice represents Independent Midwives' use of varying forms of evidence and experience to support practice and help women to make informed decisions which they consider a key element of independent practice. The category links directly to providing individualized care by involving the active participation of women in shaping their own care.

The final category, midwifery philosophy, reflects participants' beliefs about the nature of pregnancy and childbirth and women's involvement therein. The data shows the participants' ways of providing care are grounded in the belief that the pregnancy continuum is a normal physiological event for the majority of women, but that physiology can be disrupted by physical and psychological factors, affecting the body's ability to function effectively. Beliefs about the autonomy of women are discussed and women's centrality to care. The remainder of the chapter addresses these five categories in detail.

4.2 Professional autonomy

This category consists of the focused codes which relate to the midwives' perceptions about how working independently of an organization affects the way in which they practise, and the care they provide. Seven focused codes have been integrated to form this category:

- Quality of care
- Professional freedom
- Practice development
- Advocacy
- Supporting women's autonomy
- Quality of life
- Peer support

The following seven sections outline and explain these codes in more detail.

4.2.1 Quality of care

This code was common throughout the data. All participants appreciated the care they provide and often compared it to their experiences of providing care within the NHS. All had undergone their midwifery education in the UK and so had experienced midwifery practice within the NHS, even if they themselves had not practised there as a qualified midwife. Providing care that is perceived to be excellent is a top priority for the Independent Midwives. Provision of high-quality midwifery care is the foundation of their practice with the individual needs of the woman being at the heart of the care they provide, whilst the business and financial aspects of their practice appear to take less precedence. Independent midwives often earn less than their NHS colleagues but reported finding other, non-financial, compensations in their way of working which offset this, as discussed later within this chapter (Section 4.2.6).

Many talked about how they value their care by comparing it with their experiences of providing NHS midwifery. They talked about the constraints of working within the NHS and how this affected quality of care. Being able to provide care which caters to the specific needs and desires of the woman was seen as essential to practice.

Claire had attempted to work both as an NHS and an Independent Midwife but found that being able to give individualized, respectful care to independent clients highlighted the inadequacies of NHS care.

'...we negotiated it down [the contract hours] so I could do both. I could work for the NHS part-time and I could be an Independent Midwife part-time, and that doesn't work, that doesn't work because I was going from a situation where I was on a ward in a very busy unit with a lot of women who weren't getting the kind of care I felt that they deserved, to a situation where I was working in a way that was great... I found that too much... I could not go from the one type of midwifery which felt very 'with woman' and very supportive of women's choices... to a situation where I felt like a 'glorified drug pusher'... wheeling a trolley around and saying to people, 'Do you know what this is for? Do you know why you are taking this?' No! And then I would be criticized for taking too long.' (Claire)

Alison was not alone when she talked about the personal job satisfaction she gained from working independently and how in her opinion it is the correct way to provide midwifery care.

'It feels brilliant, it feels... like the, sort of the 'right way' to do midwifery.' (Alison)

Several of the participants described experiencing a reduction in the individualized care they were able to give within the NHS and how moving into independent practice has allowed them to practise as they feel they need to, to meet the needs of the women.

'I moved... and was working in the community and I found I was very dissatisfied with the care I was able to give because of the time pressures and the sheer numbers of women and having to rush through the day and not being able to care, give the care, I wanted to give... the continuity of care with women and to support them no matter what, so, be there for them... it's about really supporting that woman... the opportunity arose to do some back up for the independent team, in the area and I just thought 'Ah this is a different way of working, I could do this! Why not, why not just do this?' [laughs] so I did.' (Rebecca)

In Jane's view, Independent Midwives provide the highest level of continuity of care, which enables them to positively affect their clients. Her experience is that providing such care brings her real job satisfaction.

'...it's 'A' star continuity of care, isn't it?' Being an Independent Midwife... it's hard work but it's the best work in the world, isn't it? Because it's just... it's so amazing, you can really make a difference... one person at a time.' (Jane)

These data demonstrate the midwives' focus on the quality of care they provide, and how they choose to provide care in a way that they see as fulfilling the needs of the women. Working autonomously means they have the choice to work in whatever way they see best serves their clients.

An important advantage of being autonomous practitioners is that the midwives can determine the size of their caseload, enabling them to ensure they have the time and capacity to provide high-quality care.

'...certainly looking after the number of women you have is a key point, four or five women due in any one month... that obviously you are not overstretched in the time you have available... it may also be dependent on whether you want to work full time or part-time - how many women you care for - but that's... it doesn't compromise the time you have for women, I think that's a real key thing... (Deb)

Valuing the amount of care women have before, during and after birth was again highlighted as part of the concept 'Time' (Section 4.4.1). The midwives placed significant importance on being able to deliver care which provides women with frequent appointments throughout the pregnancy continuum. All describe providing high levels of clinical, social and emotional support postnatally, with women having appointments of at least an hour, initially on a daily basis, during the first week, gradually decreasing over the following weeks, based on the women's needs and wishes. The provision of high levels of postnatal care within independent midwifery was highlighted by many and contrasted with how the NHS currently provides care. Breastfeeding support is a major constituent of postnatal care because high proportions of their clients choose to breastfeed.

The high level of postnatal support is seen by the participants as a vital constituent of their care. Postnatal care was described as a valuable intervention in preventing problems or detecting them early, enabling the midwives to avert serious complications.

'I would typically do ten, eleven, twelve postnatal visits over a period of four weeks... Providing that care allows me to head off lots and lots and lots of problems that would have developed if I saw her the day after the birth, day five and day ten... because in that time all sorts of things can go really, really badly wrong... it's a very powerful piece of midwifery providing intense postnatal care.' (Steph)

Providing long-term postnatal care for women experiencing complications, or for whom more psychological support was required, was described by several interviewees and illustrates the flexibility in their approach. Continuity of care is seen as vitally important and hence in most cases, care is not concluded until complications are resolved, or on-going treatment and support have been arranged.

'I've got a lady now that... she'll be eight weeks?... Postnatal?... But she had a lot going on and a wound infection... so she needed more support... it really is individualized...' (Rebecca)

The approach taken by the midwives enables them to provide care tailored to the needs of the individual woman.

'...afterwards [after the birth] it's daily [postnatal care] for a week or so then I drop alternate days the next week and then it's once or twice a week until the care ends. It's all flexible... it's about what the woman needs, some have less, some have more... if there are any problems I will end up seeing her for weeks until the issue is resolved... women need real support postnatally... it's huge... all the changes they are faced with.' (Lisa)

Comprehensive postnatal care is considered to support mothers to make a successful transition into effective parenthood, where they are able to care for, and nurture, their babies optimally. This is described by two of the participants as the ultimate overall aim of the midwifery care Independent Midwives provide. For many participants, the relationship with their clients can last for many months following the end of care. In this period, they may act informally to provide ongoing support, as known and trusted people.

'...one of the advantages of the way we work is obviously with extended postnatal visiting, and so many of our clients feeling they can ring us when the baby is six months old [laughing] for a quick chat... but yeah, I think the, the potential influence over their confidence in parenting and therefore their ability to parent is probably what our care lays the foundation for.' (Chris)

In summary, Independent Midwives choose to work in ways that they value and that they view as being in the best interests of their clients. The mothers are the focus of the care and the midwives appreciate the autonomy they have to practise as they and their clients choose. The provision of full postnatal care is a key component of their practice and is considered vital in the mother's transition to effective parenthood.

4.2.2 Professional freedom

The second code 'professional freedom' relates to how the midwives' practice is framed only by the standards set out by the NMC and the agreements they form with their clients. The Independent Midwives' practice is neither constrained by institutional policies or protocols, nor the needs of a system. Working independently means the midwives are able to practise to the full extent of the midwifery role, providing care throughout the pregnancy continuum. Independent midwives frequently refer to the women they care for as clients.

'We take our lead from our clients, for sure... it's about... well it's not about ticking boxes, it is not about delivering care that has to be delivered, it's about working with the women really, and being guided by what is right for her... Being led by her rather than an organization, not constrained by an organization...' (Alison)

Having fewer practice restrictions enables the midwives to incorporate ways of working which support women's physiology and is underpinned by the belief that for most women the pregnancy continuum is a safe, normal event.

'Thinking about what other people have to conform to, it's actually quite liberating not being constrained by employer's policies and guidelines, isn't it? Independent Midwives have this belief in normality because there is evidence for it, so it could be their experiential evidence or there's all the evidence from biologists and anthropologists and geneticists... there is, if you want to look up how the hormonal pathway works, it's not just that some Independent Midwives made it up one day, this has come from laboratory-based biologists... so it's pretty irrefutable...' (Chris)

Practising in this way can however cause problems when they are scrutinized by NHS staff who view divergence from their own practice as a form of deviance and implement investigations into the midwife's practice.

'If we transfer in, or there's some reason a supervisor gets involved, they can't accept that what we've been doing isn't wrong... we haven't abided by the timescales they use, but there's no evidence to support them... expectations of labour progress, you know 1.5 cm per hour! [laughs], women labour at their own rate, they're not all the same, it's stupid to imagine they would be, we get criticized for it... the woman and baby are fine but that's not good enough... we didn't stick to the myth about time that they do...' (Claire)

The participants talked about how practising independently of organizations removes the tension they had experienced as employed midwives caught between the requirements of the organization, their responsibilities to comply with NMC standards and their clients' wishes.

'... if you're an employed midwife... you've got another layer of management that you've got to comply with and I think personally that that's immoral, I don't see how you can put the woman at the centre of care and your, your professional responsibilities at the centre of care AND pay, and pay due respect to an employment contract, I can't see how that is... I've never been able to see how those three things are sustainable... If I'm an NHS midwife and I go to Mary and she's in labour and my employer says you've got to come away, she's not in strong enough labour, but my midwifery instinct says the minute she's on her own she's going to crack on, I've got... If I choose not to do what my employer tells me to do I'm at risk of losing my job, but will be complying with my moral obligation to my client and my professional regulation, equally if I do what my employer says I won't be sacked but I could lose my PIN, because I put the woman in danger... and then lose my job...' (Steph)

The colloquial 'PIN' in the quote above refers to midwives' official registration with the NMC. The data demonstrate that leaving the system enabled the midwives to work freely within their professional regulations and to wholly support their clients. Experiencing conflict with NHS management, for supporting women's decisions and not following Trust guidelines, was a reason for one of the participants to choose to work independently.

'People say, 'Why did you leave the NHS?' and I very much was in that... you know... felt that so strongly, I was either with the system or with the woman and... well I knew where I stood and it got me into trouble in the NHS and so I had to come out of the NHS and... yeah, you know, standing with one or the other, it was like your midwives' rules or the hospital rules...' (Deb)

In order to provide relational continuity of care, which the participants believe to be a beneficial model of midwifery to mothers and babies, the Independent Midwives universally adopt a caseloading approach, where women are able to choose their midwife or midwives. The midwife is then responsible for providing and negotiating, where necessary, all the care the woman needs during the pregnancy continuum.

'... women choose their midwife as well, so rather than being allocated with a midwife the woman is making a choice, so she is choosing a midwife she feels comfortable with... They call us, from the website, or maybe a friend has been one of our clients...' (Alison)

The participants aim to provide high levels of continuity, because having a trusting relationship with their care provider is important to their clients and is a conscious choice they have made.

I try and provide as high a level of continuity of me as possible because if a woman's chosen to book you... and she may have met other Independent Midwives... so has sort of made a conscious decision to choose you, from others, so they are wanting you in that sense and what you offer...' (Deb)

Where additional considerations arise, the midwives appropriately refer women to other health care professionals for specialist opinion or treatment.

'...She then had a labour that was stop, start, stop, start over three days, baby was fine, she was fine, but in the end, she got to fully and nothing happened, labour stopped and so we said, you know, when I made an internal, sounds as if I do them all the time, but just on these occasions... I could feel a little pair of crossed feet... So, I said, 'We're not going to get anywhere, we really do need...' it was the mother that said to me, 'I'm going to have to go in and have a section, aren't I?' So, I said, 'Yeah I think so.' So, we went in and... they did a beautiful section...' (Jane)

Without institutional constraints, the midwives are able to determine the way they work with individual women and can therefore offer flexibility in the provision of care, according to mutually agreed arrangements with their clients. The scheduling and duration of appointments are made based primarily on the needs and wishes of women but also the midwife's working commitments and preferences. As discussed in Section 4.5.2., under 'Individualized care', scheduled care is usually provided in women's homes, during normal working hours, although most of the midwives will facilitate some appointments for evenings and weekends so that husbands, partners and other significant people can be involved. This flexibility enables the individual needs of women and their families to be catered for.

'I think independent midwifery benefits women because we're not so constrained by policies and protocols... I think Independent Midwives are probably freer to support women wholeheartedly... it's easier to do when you know the woman...' (Chris)

In summary, the professional freedom Independent Midwives experience enables them to determine how they practise, within the values and standards set out by the NMC. It enables them to provide individualized care in a way they and their clients choose and to not be constrained by the policies, protocols and working practices of an employing organization.

4.2.3 Practice development

Changing and advancing practice make up the third code 'practice development' which referred to the benefits of working in an environment free from institutional constraints. The application of evidence from different scientific disciplines to midwifery practice contributes to new understanding about psychological and physiological processes relating to pregnancy and childbirth. Evidence from animal husbandry, nutrition and human physiologists has provided knowledge about mammalian birth, and the dangers of disrupting uncomplicated cases. Independent Midwives seek out such information in order to inform and advance their practice.

The evidence from immunologists on the pathway for stress and infection and prem birth is fascinating. What if the stress the system causes pregnant women also causes them to succumb to infection? Stress immunocompromises them! Limiting their choices, not listening, telling them what to do... Does that explain our low rates of prem birth? Our clients aren't stressed out... they often say that... 'All the stress is gone now'... when they book with us... when you know that, the problems you can cause, you change what you do, you're more mindful of what you say, how you say it.' (Lisa)

Jane's interest in nutrition and pregnancy outcomes has led her to seek out information that helps her support women who are pregnant with twins. She is also critical of NHS advice on nutrition and the evidence used by the National Institute for Clinical Health Excellence (NICE).

'Independent Midwives have good outcomes with multiple pregnancies, with twins in particular... because we are talking about diet, we're talking about eating more protein... we're talking about eating complex carbohydrates, vitamin B, vitamin C, plenty of water and salt to taste because when you are carrying twins you have an almost double haemodilution by the end of your pregnancy... you have to put in what your body needs otherwise it's going to say, 'Ay these babies are safer outside' and then you've got prematurity... The NHS is bloody thick about diet... NICE guidelines... not enough evidence... let me on that board and I'll pull all the pieces [of evidence] together...' (Jane)

Deb talked about using knowledge of how physiology works to help create a birth environment which facilitates a woman's requirements to labour effectively. The environment is considered to be a very important factor for enabling women to birth safely and physiologically.

'When you optimize the environment, in whatever way a woman needs... our beliefs are completely underpinned by evidence, hard... written evidence as well as what we see every day in our practice... women can labour, they are relaxed and confident. A quiet dark room... no disturbance, they're safe and secure... their hormones flow - oxytocin, endorphins - you can see progress, labour getting bigger, more intense, enveloping her... We all get it [oxytocin], it's contagious.' (Deb)

The autonomous nature of independent midwifery enables the participants to determine which practices they use, based on research evidence, their professional experience and the choices of their clients. Independent Midwives have been at the forefront of developing practice and challenging mainstream methods in areas including providing relational continuity of care, home birth, supporting physiological birth, birth of the placenta, breech and twin births.

'...we have been known for pushing the boundaries of practice, VBAC [vaginal birth after caesarean section], cord clamping, breech and twins of course...' (Deb)

The concept of undisturbed birth and how to practise in such a way that does not disrupt a woman's physiology is a significant factor in how the Independent Midwives provide care in labour. Utilising evidence from physiologists and researchers the midwives have developed their birthing practices; they understand how the woman's brain and the body interact during labour and they incorporate into their practice ways of working which do not disturb birth. The midwives are very aware of the impact their behaviour can have on changing or supporting a woman's birthing physiology and highlight the importance that already knowing the woman has on this.

'...I think it is so empowering for them to be in their own environment, it's theirs ... there isn't that fear there, isn't that, is someone going to knock on the door and ask if anyone wants a cup of tea? Or 'Is there a monitor in here I can borrow?' That kind of thing just doesn't happen at home... so it sets up the birth to be as undisturbed as it possibly can.' (Alison)

The following quote demonstrates specifically, the midwife's cognisant thought processes about ways in which they can act, that support the woman's release of oxytocin in labour, and protect her from factors which may cause her to release stress hormones. These practices are the normative way Independent Midwives care for women during childbirth and yet they are still to be incorporated into mainstream midwifery.

'I guess we are probably more focused on supporting the development of oxytocin and the natural physiology of labour and less obsessed than our NHS colleagues with ticking boxes of risk assessment, which seems to drive their care currently.' (Steph)

Lisa commented on how knowledge about parturition in other mammals is not applied to human birth in mainstream midwifery and that disregarding the effects of external factors can disrupt birth.

'...we are mammals... we need to remember that... to take lessons from what they do, mostly they just get on with it... we have all seen animals being born and we are so respectful of their labour, we're told not to disturb the cat, 'She's in the airing cupboard, but it's dangerous if you go take a look'. Why is the mainstream not linking that to human birth? They continue to put women in unfamiliar, bright, noisy environments with strangers who come in and out at will and disturb her, it's no wonder women struggle to birth in hospital, the conditions couldn't be more... uncondusive to labour...' (Lisa)

Some low-level interventions, such as talking to women or instructing them in what to do, are viewed as significant factors which can interfere with labour. Deb spoke about observing NHS midwives working, who are not aware of the harm caused by these interventions.

'I haven't seen that [acknowledgement that low-level interventions cause disruption] being incorporated into hospital care, even NHS homebirth midwives are still interventionist, even if it's from instructing women to do things... which is possibly one of the more depressing areas where midwives who potentially are working much more with physiological birth and the believed understanding of how the hormonal interplay works... they are still doing stuff... talking... whispering, which really alarms women... telling them to push...you know?' (Deb)

In summary, the participants believe that working autonomously of an organization gives them the freedom to innovate and develop their midwifery practice, based on emerging research-evidence, the wishes of the mother and their advancing knowledge and experience. Having the control to implement novel ways of working enables the midwives to enhance

the safety of care for women. Practice development is also considered later in this chapter, within the category 'Knowledge evidence and practice' (Section 4.7.1).

4.2.4 Advocacy

This code was developed from the participants' descriptions of how respecting and supporting the mother's legal right to make informed decisions is a crucial element of Independent Midwives' practice. In the following quote Chris discusses the emergence of human rights law in childbirth and how this helps midwives to provide the care the mother chooses, by advocating for her. She describes how human rights laws enable all midwives to support women's informed decisions where they differ from what is advised in clinical pathways and guidelines, but that this can be problematic for midwives employed by organizations.

'...yes and up to the Midwives' Rules disappearing that was legally enshrined in our law, our regulation told us we must support the woman regardless of the policies... but I think also with the human rights stuff that's coming out now... that's going to be a really powerful political tool for midwives to be able to support and enable women to birth their way even when the hospital says other... and I think if you are seeing the woman as an entity with rights... that you violate at your peril... that just strengthens the midwife-woman relationship, when the midwife is supporting the woman... we need to think about who we serve – woman or hospital... you have to be brave... stand up to the hospital... 'this is what the woman wants'...' (Chris)

The care Independent Midwives provide is based on the woman's individual needs and wishes, and respect for their informed decisions. The need for advocacy becomes more apparent when the mother has interactions with other health professionals, who are less respectful of the legal concept of mothers' autonomy, or where examples of poor advice or practice are evident. It was reported that sometimes it seems that the hospital health professionals are not used to women questioning the treatment that is being recommended, which raises concerns about how informed consent is gained from women.

'I had one consultant turn to another consultant, when I'd asked in four different ways... the client was turning down the plan that they were proposing or recommending, in fact, strongly recommending, and I said, 'Well, my client has already said she's not willing to accept induction of labour at 36 weeks so would you, is there another... what's the plan b?' Didn't get that! 'What would be an alternative?' Ask the same question a different way, no! 'Ok,

so she's not going to do that, she's just said she's not going to do that, so what would you suggest instead?' Didn't understand that, and on the fourth time of asking she actually turned to her colleague, who was another consultant, in a different area, and said, 'I don't think SHE understands!' [C laughs] pointing to me! I was like, 'Ohhh stunning!' [laughing].
(Claire)

The participants talked about having to advocate for clients when they were being questioned by NHS staff and how they needed to reiterate the rights of the woman to decide which interventions or treatments she receives.

'You know, I have been questioned when women have made decisions that are very unusual... you know, 'Do you think she is of sound mind?' Just because she is making a decision you can't get your head around... you can't accuse her of being mentally unstable... but that does happen...' (Deb)

The coercion of pregnant women was raised by several participants, Lisa felt that she needed to accompany her clients when they were seeking medical opinion or deciding which interventions to accept.

'...sometimes I feel like a bodyguard... protecting her from negative forces that seek to gain her compliance, women don't need to comply... they need to do what's right for them...'
(Lisa)

In summary, the mother's choices for her midwifery care are unwaveringly respected and supported by the Independent Midwives. There is no conflict in where their loyalties or responsibilities lie, because they are autonomous practitioners. Where other healthcare professionals are involved, the midwives may need to act as advocates in helping women negotiate the care they are going to receive, because the women's human rights to make their own decisions may not be well respected.

4.2.5 Supporting women's autonomy

This code was developed because women's autonomy is a central component of the care provided by Independent Midwives. It will be explored further within the categories 'Knowledge, evidence and practice' and 'Midwifery Philosophy' (Sections 4.7.5 and 4.8.3). It is relevant within the category of 'Professional autonomy' because it is the choice of the Independent Midwives to fully respect and support women as individuals, who have the right

to make decisions about their lives. As autonomous practitioners they are in a position to fully support women in their choices and decisions, not being compromised by the needs of an organization which requires women to conform. In fact,

'...her autonomy is absolutely paramount.' (Claire)

Clients are expected to be fully engaged in making informed decisions about the care they receive; to enact their autonomy. The midwives help women achieve this by sharing information with them and sign-posting resources where women can find their own material which enables them to make their decisions. A lot of time is devoted to this activity during antenatal and postnatal appointments and this will be addressed separately under the category of 'Time' (Section 4.4.1).

'Most appointments will involve some discussion about an issue the woman needs to make a decision on, or wants to find out more about... it might be feeding or parenting and I will flag up resources... books, websites, other mothers... you know? She needs information so she can make choices... the right choices which feel comfortable... or she may have decided to breastfeed but needs information about how to do it... positioning and attachment... yeah?' (Lisa)

Supporting women's autonomy is considered to be easier as an Independent Midwife because they work in a culture where women's decision-making is accepted as being absolute. Knowing their clients and understanding their beliefs and opinions aids the midwives in comprehending the decisions the women are making and supporting them effectively. Having wide experience of the range of normality also helps the midwives to see that what a woman is choosing is not necessarily dangerous, an example of which could be a woman declining an induction of labour for post-maturity when she and her baby are well and supporting the woman in her decision to wait for the natural onset of labour.

'I think in the NHS you might pay lip service to supporting the woman, so you've still had to... you've written in the notes 'refused' something or other, rather than what we would write in the reports, 'Supported so and so's views to...' so it takes away the woman hasn't actually refused, she has made a decision to do something different and I think it is easier to do that as an Independent Midwife, it is easier to do when you know the woman, it's easier to do when you have had the experience of a lot of normality...' (Chris)

A developing understanding of autonomy enables the midwives to see that all choices, whether they fit with the midwife's beliefs or not, must be respected.

'I think when I started as an Independent Midwife I also thought that women would choose normal birth, and actually they do... but some women might choose 'that' and you think, 'OK, that's different', but if that's what that woman wants then that's... my role is to support her and not to persuade her otherwise.' (Alison)

A calm and constructive approach is taken in difficult situations where women are considering options which have potentially negative consequences. Her decisions are carefully explored and the midwife ascertains the woman's appreciation of the situation, but this is done in a sensitive and supportive manner.

'...but at the same time being very cognisant of the possibility that she could be making decisions that could put her or her baby at risk and being... calmly helping her be very clear about what those risks might be and whether she understands those risks and whether she is prepared to accept the consequences of making that decision. Doing it in a way that is balanced... not scaring her, exploring with her...' (Steph)

Women's autonomy is assisted by the midwives' approach to information sharing and their encouragement of the women in discovering their own information about relevant issues.

'We have much more time to look at research evidence, about whatever it is... whatever the woman's care throws up... so whatever it is there is much more time to really look at the evidence, discuss any concerns they have, look at alternative literature... I would tell them what local guidelines are... give them access to the NICE guidelines and encourage them to read this and find their own information... and then let them make their decision, that's the... I kind of point them in the direction of where to find information and then it's up to them.' (Rebecca)

In summary, the participants hold women's autonomy as sacrosanct; a right which must never be violated. Their support of mentally competent women's decisions does not falter, even when those choices are very unusual and not in line with medical advice. The midwives place great significance on the process of information sharing and strive to ensure that their clients are making fully informed decisions about the care they receive and thus acting autonomously.

4.2.6 Quality of life

This code was described in terms of being able to achieve a positive work-life balance, experiencing significant job satisfaction, and feeling low levels of stress, as a result of being professionally autonomous, compared with alternative ways of working. Being self-determining in when they work as well as in the manner in which they work was perceived as beneficial, as it enables the midwives to have flexibility in their professional and private lives.

Chris described how she became an Independent Midwife in order to be able to provide good parenting to her own child. She was able to combine work and home life by taking her daughter with her to antenatal and postnatal appointments or by organising her work to fit with alternative child care.

'I went into independent midwifery in order to provide good mothering alongside good midwifery... I had come from being a community midwife where I could provide reasonably good midwifery but at the expense of working long hours...I would take Kate with me... she would be asleep next to me, or feeding... or playing on her mat [laughing] or I would go do my visits when Pete got home.' (Chris)

Claire found the contrast between working independently and for the NHS to be particularly striking. The reward of working independently outweighed the financial implications of being self-employed and was part of a common mindset amongst the participants.

'...to completely work as an Independent Midwife is privileged, I know it is privileged, I don't earn as much... but actually, my work life balance is way better, I'm less stressed... it's a hugely rewarding way to work, I can't describe how rewarding this is, I get a huge sense of job satisfaction, so yeah, I earn less money but I'm not swapping it.' (Claire)

The style of practice, with the woman at the centre of care, brought significant job satisfaction and is captured in the following quote.

'I love the relationships we have, the people you meet, the experiences you have, seeing different walks of life, the diversity of women... their lifestyles... their take on life... I have learned so much from them... It is incredibly rewarding, it is a rich way to work, fragmented care feels so impoverished... I remember it vaguely [laughing]... every midwife, obstetrician should experience this... it would be illuminating I'm sure.' (Lisa)

The midwives were keen not to portray their practice in idealistic terms and did talk about some of the stresses they experience, including, financial concerns, tiredness, and the emotional pain they feel when caring for women they have close relationships with, who have difficult or traumatising childbirth experiences.

'...I'm not going to have a guaranteed income... Independent Midwives getting burnt out... because we obviously do as well, because there are different stresses... when a birth becomes difficult and traumatic, for whatever reason... a bad outcome... you feel it more, it, it, you take it very personally, it can be really quite painful. I would think that NHS midwives most probably don't feel that way, I'm making a big judgement here but because you haven't got the close connection, why would you? You would feel obviously upset and traumatized professionally, but perhaps if you don't have that closeness you don't get that pain so much? Sometimes it's exhausting wanting, wanting the absolute best for women, it does drain you emotionally sometimes, very much...' (Alison)

The responsibility for attending births and providing continuity of care throughout the labour, no matter how long it is, can lead to extreme fatigue, but because the midwives decide when and how they work, they are able to recover from such tiring experiences and reschedule their work accordingly.

'...there are stressors and tiredness can be an issue... but usually only in the short-term... you might be up all night at a birth and then need to go see someone with a problem, so you're tired that day but you sleep and then it's back to normal again...' (Lisa)

Professional interactions with NHS staff can be another source of stress for Independent Midwives when referring or transferring clients to hospital care. The midwives talked about occasions when they encountered hostile attitudes or felt bullied by NHS staff. Conflict may arise from the Independent Midwives advocating for their clients and supporting their choices, when they do not match usual hospital practice. Such incidences have resulted in Independent Midwives being reported to Supervisors of Midwives and as such represent a considerable source of stress.

'... I can't let encounters with the NHS that have been negative, and they're not all negative, we have some really positive encounters with the NHS... but when you have a bad one, it's personally bad, it's personally damaging... I had a situation where I had two... paediatricians, putting a heck of a lot of pressure on me, personally, to put pressure on my client, personally, and I refused to do that... I had a huge amount of pressure and background threats, you know,

the threat of social services, the threat of me being reported to my supervisor and the NMC... that's almost enough to make you change your practice, to conform... as an outsider having to sometimes engage with that system, that can be really fraught, really, really difficult... midwives working outside the NHS are more likely to be referred, I know that, and it's a little sword of Damocles hanging over me the whole time.' (Claire)

'...being criticized and investigated just because you do things differently can be... challenging! [laughs]. Not doing as they do and being hauled over the coals for it can be hard, especially when what they do is not evidence-based and we're supposed to do it just because they do – it's custom and practice – not evidence-based.' (Deb)

Many described independent midwifery as a way of life; a life-style choice. The commitment to providing relational continuity of care and therefore working unpredictable hours means that work impinges on home life from time to time.

'...to be a true midwife I think it has to be a way of life and you have to weigh that up, you know? I actually said to the children, 'Do I stay as an Independent Midwife or should I go back to the NHS?' and all four of them, there's a twelve year gap between the eldest and the youngest, they all said, 'Oh God no, you've got to stay as an Independent Midwife'... and it was my family's decision and my husband had to learn to cook and my children had to learn to cook...' (Jane)

Whilst providing high levels of relational continuity of care Deb was careful to point out that midwives working in this way need to be realistic about what they can offer and achieve, in part to avoid disappointing their clients, if they are unavailable to provide care at any point, and to avoid over-working themselves.

'Some Independent Midwives try and look after all their clients by themselves... I don't think that, certainly for me, it's not totally feasible that, and I think you have to be realistic as well that you may be with somebody else for a birth, when someone else labours, you may be ill, if you've got children they may need you, so caseload for me certainly is about potentially having support from your midwifery colleagues... setting expectations is really important because that links into the relationship you have with a woman and about trust and honesty, that, you know, you have to set out what you offer honestly at the beginning so that a woman can quite clearly make a clear choice that that's the right type of care for her... because as much as independent care is all consuming, an all passionate vocation, and I think a lot of

Independent Midwives live and breathe midwifery, you, you do... even if you're single and you don't have any children, you still have a life.' (Deb)

The extent of the disruption to home-life is somewhat determined by the size of the midwife's caseload and the working arrangements she has with colleagues and this will be explored further in the next code.

In summary, the participants reported experiencing a positive work-life balance because they are able to determine how they work and when they work. It is accepted that births and unplanned visits can happen at any time and as such this way of working is described as a life-style choice. Practising independently brings significant job satisfaction to the midwives. Independent midwifery is not however portrayed idealistically, and stressors such as tiredness, financial insecurity and interactions with other health professionals all represent potentially negative pressures for the midwives.

4.2.7 Peer support

The nature of the support given to each other by Independent Midwives was an important facilitating feature of the midwives' practice and resulted in the development of this code. The support takes two different forms; that of clinical backup and advice, and psychological support. For several participants, it was a factor without which they may have found practising independently an impossibility. Having colleagues, locally and across the country, they could turn to for advice or support was a vital part of working independently. The potential to become isolated as a lone worker is high and the midwives strive to create networks that minimize that difficulty.

'...talking with colleagues, Independent Midwives... fantastic source of support... (Alison)

Working as close-knit teams, where colleagues can easily talk to each other about clinical issues or concerns, and exchange information or opinions helps the midwives to be confident that they are giving appropriate, safe care.

'...I also really value my colleagues... we are constantly bandying about messages and communicating together... so we have a forum of Independent Midwives, so I'm not working alone, I'm working... with people with years and years of experience... on... different things... it is invaluable, invaluable, I couldn't work like this if I didn't have that network of other people's experience...' (Rebecca)

Claire's report of her contrasting experiences of peer support demonstrates how little help was available to her as a newly qualified midwife working in the NHS and how this could have compromised the safety of those she was caring for. The support she receives from her independent colleagues is an essential factor in her provision of safe, appropriate care.

'I feel way better supported... as a newly qualified [midwife] I got precious little support, in fact, very little, in the NHS, and I got tons within independent practice. I feel that if I walk into a situation now, and I'm two years on, and I'm out of my depth or there's something that I'm not quite sure about, I can pick up the phone and I've got about eight people that I could phone for really good information... I never felt that, I felt like if I walked out of a room and asked somebody for help I wouldn't necessarily get it and I was surrounded by more experienced staff, but they were stressed and busy and having to cope with their own overburdened workload and they just didn't have time to support us new starters.' (Claire)

As discussed in the previous section, working entirely alone as an Independent Midwife can present challenges of being unable to provide care whilst busy or ill and for this reason most Independent Midwives work with at least one other midwife who provides a proportion of the scheduled clinical care and is available for unscheduled work such as labour care.

'We tend to work either as lone practitioners with back up from another local IM... or in partnership with an IM colleague.' (Lisa)

Developing an effective working relationship with local colleagues is vital if the midwives are to provide shared care which meets the needs of their clients. It is important that the midwife considers what impact her colleague may have on the client and her care and so the careful selection of a suitable colleague is necessary. Deb explains how the selection of midwives who provide clinical back-up for her is important in the care she provides. She is careful to select midwives she thinks will be an appropriate match for her individual clients.

'I talk to women... at an initial consultation... that I aim to provide about eighty per cent of your care and all women will have a second, back-up midwife, because I may be unavailable and I speak to the women about how many visits they think they may need or want to feel comfortable with another midwife... some women don't want any visits, and they are just happy knowing that they feel the colleague I have chosen will be appropriate... and trust your judgement... I talk about the different colleagues I work with, how we all do have pretty similar sorts of beliefs about midwifery, about care, about... informed decision-making, that

kind of thing but that we are all individuals and we have all got different personalities so, some of us you may get on with, some you may not.' (Deb)

Knowing your colleague when attending a birth was seen as a benefit to being able to provide safe and effective care for women.

'My colleague and I, we usually, we're always aware that each other is at a birth, we know where each other's clients are... we kind of... we almost just know! It sounds a bit weird, but we kind of know how things are going to be... it just flows... it's so easy... I am going to know who my buddy will be, whereas perhaps an NHS midwife wouldn't necessarily know who her buddy is going to be... so that might change the dynamics of a birth space, hugely... My buddy and I know each other, how we think, what we feel, what we do... It's easy... no need to say anything.' (Alison)

Building relationships with colleagues and choosing those who work in like-minded ways results in consistency of care, which is to the benefit of women, who suffer when the advice or approach of professionals is in conflict. Some participants talked about unspoken communication between themselves and their colleagues and having a shared understanding of what was happening, without needing to verbalize it.

'I was sitting there thinking, 'I wonder if Anne would mind if I asked if I could make an internal examination' and then Anne said to me, 'Jane would you mind doing an internal?'... and at some point, I was thinking we need to call an ambulance, and then Anne said, 'I'm just going to call an ambulance' and yet neither of us had said anything.' (Jane)

In summary, the participants felt that the close professional relationships developed with their colleagues enables them to work effectively in the clinical setting, providing care which meets the needs of all their clients. They provide emotional and psychological support to each, which may be crucial during challenging times.

4.3 Professional autonomy summary

The participants talked about how practising autonomously enables Independent Midwives to work in ways which they see as being right for them and their clients and facilitates the provision of individualized care. Providing high-quality care is a key consideration for the midwives. Independence from institutional policies, guidelines and constraints on practice means that the midwives have freedom to support and implement the decisions women

make about the care they wish to receive. The participants were clear about where their responsibilities lie; they are with the client and the professional standards set out in the Code. Having the freedom to develop practice based on emerging evidence is perceived as a benefit of working independently. Supporting women's rights to autonomy is a basic tenet of independent practice and the midwives strive to ensure that their clients are actively involved in making informed choices about the care they receive. Independent midwifery is viewed very positively by the participants because they are self-determining; they work on their terms, in a way of their choosing, which brings significant job satisfaction. Whilst the midwives reported stressors such as tiredness and financial insecurity, their overall perception is that their way of working is very beneficial to them. Peer support plays an important role in facilitating this way of practising, through the provision of clinical backing and partnership working, and emotional and psychological support.

4.4 Time

This subject was assigned a separate category because it was felt to be absolutely pivotal to how Independent Midwives provide care. The category is made up of two codes:

- Time as an investment in women
- Time to develop knowledge

The following two sections outline and explain these codes in more detail.

4.4.1 Time as an investment in women

This code resulted from the participants' unanimous views that being able to allocate appropriate amounts of time enables them to practise mother-centred midwifery. The decision to invest an hour or two of their time to scheduled visits, antenatally and postnatally, demonstrates the value they place on having personal contact with women and their families and getting to know them. The development of a genuine, trusting relationship with a woman is seen as a key constituent to independent midwifery care and will be explored in detail in the category 'mother-centred care' (Section 4.5). Being able to develop such a relationship is however contingent upon having the time to connect with the woman and to get to know her and her family.

'...we have more time... we allocate a minimum of an hour for an appointment instead of fifteen or twenty minutes, if you're lucky... We can give more time and that probably leads or contributes to a different ethos. The luxury of time is one I wouldn't swap for anything... everything comes back to time and being able to spend time. I think because we've got that

time we can have a more holistic approach... We're coming back too, there's always time to pick up a conversation... it's not tick box... we don't have to complete a task that day... it rolls on...' (Claire)

The investment of time facilitates the process of mother and midwife learning to trust and understand one another; it is a respectful, reciprocal relationship which develops.

'The hours you put into getting to know the woman and opening up for her to know you... Sometimes she needs to talk and talk, to get clear... you can't really put a time on that... sometimes we've had several cuppas before we're done [laughs]...' (Chris)

Rebecca commented that having time was a significant differentiating factor between practising as a midwife independently and for the NHS.

'I think... the number one thing that is different for me is time and this is something that I... it's inconceivable working NHS wise, where you'd get 15 minutes maybe, that you could take two hours, or maybe three doing a booking... an antenatal appointment, I would book out two hours... it's really getting to know the family, getting to, you know, understand them.' (Rebecca)

In addition to devoting one or two hours per appointment, the participants report also seeing their clients often during the antenatal period and then frequently for at least a month after the birth. Over the course of the pregnancy, depending on when the woman chose to book for care, the mother and midwife could feasibly have spent more than 15 hours together.

'...in general, after booking I see them once a month and then from 32 weeks fortnightly and then from 37 weeks weekly up until the birth...' (Rebecca)

The time is not only used to get to know one another, but also to explore the woman's birth and parenting choices and to enable her to become informed about whichever subjects she feels are relevant and important. The allocation of time, hand-in-hand with the midwives' belief in women's right to autonomy, facilitates the process of truly informed consent, and as such is viewed as a valuable investment.

'We talk at such length during the pregnancy... the women really work out what is important to them, what is going to help them... I spend a lot of time shredding the evidence with the woman, so she knows the limitations of what is cited... often studies were not methodologically sound, often guidelines are not clear about how they were reached...' (Lisa)

Appointment length is flexible and tailored to suit the needs of the woman.

'...the women say how they want the appointments to run... sometimes they don't have much time... or feel happy that everything is ok and so that appointment might only be half an hour... other times they might ask if they can make you lunch... and then you know they want to talk at length about something.' (Steph)

The majority of the time spent during appointments is in dialogue with women rather than undertaking clinical observations. As will be explored further in the category 'Knowledge, evidence and practice' (Section 4.7.3), it is through discussion with the woman, and recognition of her knowledge, that many complications are identified; women having the opportunity to verbalize their concerns or feelings during appointments is vital in helping midwives provide safe appropriate care.

'So, the time we invest in talking, because over an hour or an hour and a half's appointment, you might be doing only ten minutes clinical care, so the rest of it is talking... we refer women to information... we will pull in as much information as we can, we also go back to original research and try to explain that to people because sometimes original research isn't exactly represented the way you'd expect...' (Claire)

Time spent with women in labour was significantly different compared to NHS practice. The midwives attend their clients from when they request support and adherence to routine timeframes for labour is not followed.

'When you're birthing you call us when you want us and we stay for as long as you want us, and if that means that I go to someone's house and things aren't really happening yet, then I can go to bed in their house and that's fine...' (Claire)

...'midwives can look horrified that you've been there for three days and either think she wasn't in labour or that it was unsafe for her to go so long before transfer...' (Rebecca)

The benefits of providing continuity of care and developing relationships was seen as particularly important when arriving at a birth. Already having knowledge of the woman, her pregnancy and medical history means that time is saved by not having to read the notes. It also means that the woman is not disturbed by asking her questions and trying to ascertain her birth choices.

'When you arrive you already know her and her history... what she has planned, it saves time at that point, no asking questions and disturbing her... you already have the picture... It's interesting because our women only ring us when they need us, I think they are so confident

and believing in themselves that they don't call for every little thing they're unsure of...'
(Chris)

Knowing women over a period of time helps the participants to see the consequences of certain aspects of care. It can lead to the creation of new knowledge about the advantages and disadvantages of particular practices.

'When you see a woman in pain... eight - ten weeks after she's had an episiotomy... when she says she can't imagine ever having sex again... that makes you think... think about what gains were made when she was cut... do they outweigh what she's still going through? Was it so critical to get the baby out at that moment? Would a few more minutes have really made a difference? Stop forcing her to push! That would help! I haven't done one [episiotomy] since going independent and that's many years now... decades even [laughing]... tears don't seem to have the same ongoing pain... it's interesting really...' (Chris)

In summary, the midwives view the investment of time as pivotal to the provision of their care. Frequent hourly appointments during pregnancy facilitate the development of the mother-midwife relationship, and women's informed decision-making processes. Care during labour is continuous and time limits are not routinely applied to the length of labour. Postnatally, the hour-long appointments aid the transition of the woman to motherhood, support her and her family to care for their newborn baby, and enable effective breastfeeding support.

4.4.2 Time to develop knowledge

The second code relates to how time forms an essential element in the participants' acquisition of new knowledge and skills. The participants were conscious of spending considerable amounts of time searching for new information and critiquing evidence and guidelines. Because care is individualized and not based on clinical pathways, the information shared with women needs to address their personal needs, thus a broad knowledge and understanding of all the relevant evidence is required by the midwife.

'I'm not there to tell them what to do, I am there to support their wishes and respect their wishes but also to support them in information finding... if things come up that I'm not sure of, or is new to me then we go out there and we research it, I encourage them to do that and we come back together and discuss it... it doesn't stop me going off and having another look

and researching or speaking to colleagues or getting other professionals' opinions and bringing that information back to the table...' (Deb)

It was felt by some participants that Independent Midwives spend more time than those working for the NHS in developing knowledge about issues relating to practice.

'I probably spend more time keeping in touch with research and going to study days and making sure stuff's not passing us by, than I would do if I was just working for a Trust.'
(Claire)

Jane believes an honesty exists between her and her clients where if she does not know about a certain subject she can go and spend time informing herself.

'And you can be honest, completely honest and say, 'Well I don't know anything about that, I'll go and look it up' or, 'Let's go and see what we can find out about that situation'...' (Jane)

Several participants talked about the forum the Independent Midwives have established which is a highly valued resource used frequently by the participants to enhance knowledge and disseminate information.

'The forum, that can be a great place to chuck in a thought or a query and you'll get some great responses... links to evidence...' (Lisa)

In summary, the midwives describe how they allocate time to developing their knowledge in areas relating specifically to individual clients. They are keen to ensure they are up-to-date with current evidence, so they can be confident that they are sharing with women the best information available.

4.4.3 Time summary

The participants consider the allocation of generous amounts of time to client appointments to be a vital factor in the provision of a model of midwifery centred on forming trusting relationships. Having time to also continue their learning and develop new skills was felt to be an important feature of working independently and improving care.

4.5 Mother-centred care

This category demonstrates the complexity of care required in order to provide respectful, individualized care which is focused on the mother and the decisions she makes about the care she chooses to receive.

Six codes have been incorporated to form this category:

- Trusting relationships
- Individualized care
- Holistic care
- Salutogenic approach
- Partnership working
- Communication

The following six sections outline and explain these codes in more detail.

4.5.1 Trusting relationships

Developing a mutually trusting relationship between mother and midwife was described as being key to independent midwifery practice and as such forms this first code. The relationship facilitates mutual understanding and respect, it enables women to gain confidence in themselves and the care they have chosen and it invites intimacy and disclosure of deeply personal information which enables the midwives to provide appropriate and sensitive care. A deep connection is formed between the mother and the midwife which it is felt facilitates care that best caters to the woman's needs.

Consensus amongst the participants is that their clients are seeking relational continuity of care when they book with Independent Midwives.

'I would say... I'm going to pluck a number out of the air... about fifty per cent now come to me saying I can't bear it, I see a different midwife every time I go to my antenatal appointments, I want to see the same midwife. I want to know who's going to be at my birth...' (Steph)

Knowing a woman, and the context of her life leads to an enhanced understanding of the woman's needs. Being able to provide the best possible care is at the heart of the midwives' practice.

'...the whole thing is... actually making our lives easier, as midwives, because we really get to... the whole purpose is to really get to know those women and you can trust them, and

those women really get to know you... so that those families really get to know you and you've got trust.... I think the antenatal period is absolutely vital, we can do so much, not just about health, it's about building trust, about building confidence... so I think that's... it's... it's based on building that trust and then that leads onto... just so much better care, we're not supposed to say, 'it's better' but it jolly well is.' (Jane)

Lisa commented on how trust needs to be reciprocated for her to provide the best care.

'We talk about the trusting relationship and I think it is often not clear that this is mutual trust, not just the woman trusting me. I need to trust her... that she is being honest with me, that if there are any difficulties in her life... or worries, she confides in me. I need to know that her plans are really what she wants... she's not saying she wants a homebirth to please someone else, or a hospital birth for that matter. Her deep beliefs will affect her in labour...'
(Lisa)

What constitutes a relationship and how this differs from rapport was highlighted in the following quote and will be explored further in the discussion chapter (Section 5.6.2). It is asserted that the formation of relationships is claimed by some midwives when in fact it is only rapport which has been established.

'Well, yeah I think students who may get to see women a couple of times in a pregnancy because of... they've got a three or four month community placement, which is great, and maybe realize they are seeing the women more often than they will do when they are qualified, they're thinking, 'Wow yeah, this is relationship building', rather than rapport building but that's the... they're not seeing the full spectrum of relationship building because obviously we know it goes way above and beyond that, and certainly independent care is an example of the further end of the spectrum, again, and in terms of what that can be but if you've never seen that, and you see a woman two, three times during her pregnancy you're probably going to think, 'Yeah I've got a really good relationship with the women I care for because all the other midwives I talk to just see women once', which yes, it is better, but it is nowhere near what it can be, could be, should be [laughs]... I work in partnership with 'Sarah' I usually have 30... 35 clients a year, we work closely, seeing each other's clients and providing back-up... (Deb)

The midwives talked about how having a trusting relationship with a woman makes it easier to care for her and how it can encourage women to make disclosures of intimate issues which may impact her during the pregnancy continuum.

'I think when you get to know the women it's easier to judge when they are feeling out of sorts, whether that's antenatally, intrapartum or postnatally... We see them... I think our average is 14 times in pregnancy... we get to know them, there's consistency in our approach, it's me and one other...' (Chris)

It is felt that the quality of the relationship formed between the midwives and the women facilitates the disclosure of sensitive information which may not be divulged to other people who were less well-known or trusted.

'...sometimes because of the nature of the intimacy of our relationship things are revealed that are desperately personal, and only for that woman and it helps us to know those desperately personal intimate things so that we can provide better care...' (Steph)

The midwives felt they were in a position of privilege, where women trusted them enough to share the private details of their lives.

'...people tell you stuff as an Independent Midwife that they almost certainly wouldn't tell you in any other circumstances, so it's not just about their clinical welfare, it's about their psychosocial welfare, what's going on in their family, how their relationships are panning out. All of this information, that's quite a privilege to know your clients' lives that intimately... is quite a privileged position, there's a lot of trust... if someone's relationship is in tatters during the pregnancy that has an impact and not knowing that would possibly mean that you weren't providing the level of care that you needed to...' (Claire)

It was reported that within an established relationship, women feel they can trust the information or advice given by the midwife and that it is proportionate and individualized to their case.

'...they are probably happy with you picking up a problem because they know you are not going to over-react and you are going to talk it through and at the end of the day it's going to be their decision what you do with that...' (Chris)

The women also learn to trust that the midwives are not going to start undermining their autonomy if complications arise; their decision-making and autonomy is real and is respected, even if they are making unusual decisions which could have negative consequences or which the midwife would not choose themselves.

'...I think that [the relationship] does build trust... I'm... not being prescriptive and saying, 'Oh this is what the policy is, this is what you have to do... they... they end up... tend to like, own

that really for themselves if they've... I think that is empowering, it has... it does build that relationship trust because they know I'm not going to tell them what to do... it's... it's... a respect, it's a relationship with respect...' (Rebecca)

One participant talked specifically about Independent Midwives having a high proportion of clients who have experienced sexual abuse and how developing a trusting relationship particularly benefits them.

'We did talk about probably 40% of the women that we work with as Independent Midwives as being abused, sexually abused, so yes there's that... because at least when they are working with you as an individual... again it comes down to trust... they will trust you and therefore they will be able to birth.' (Jane)

Linking to midwives' philosophy, the participants found that their belief in the normality of the birthing process affected women's perceptions of it. Because the women trust their midwives it enabled them to develop a real confidence in their ability and to birth safely and effectively.

'My belief in birth, my experience of it over many years now makes me very confident that it works... it really does... but only in the right environment... and we talk about that... having the right information, the right space... people, you know? And the women become confident when they understand the physiology... the psychology... the emotion... they can see how it can work, they can see why we are so confident, and it helps them... they birth really well, they're confident, not fearful or mistrusting.' (Deb)

Because the midwives place great importance on the formation of a trusting relationship many will not offer a reduced service, such as birth-only care. The rationale is that the relationship facilitates safer childbirth, and that not knowing a woman when caring for her in labour poses a risk to safety, they are thus not prepared to compromise women or themselves by caring for those they do not know.

'I would never, ever reduce my care, I wouldn't do what I am often asked to do, I will say, 'No thank you'. I will not do one or two visits antenatally and then the labour and one or two visits postnatally, that is abusing what I believe to be good midwifery care, so I won't do it... and so... I won't, well the whole point of working with a couple is that you get to know them and they get to know you... you will often find that if you try and do it too quickly you will miss something vital...' (Jane)

In summary, the midwives described the development of trusting relationships with women as being key to the care they provide. They explained how, by developing a trusting relationship with a woman, they are able to provide better, safer, more appropriate and sensitive care which addresses the woman's needs. The midwives perceive that women feel more confident in the information and guidance they are being given, when they know and trust their midwife; they do not fear that the midwives are following clinical guidelines instead of providing the care the women have chosen. Having knowledge and understanding of the women enables the midwives to support them more safely and effectively and this was given as a reason for not wanting to offer birth only care, where there is little opportunity to develop a trusting relationship.

4.5.2 Individualized care

This code relates to how the participants provide care which addresses the needs of their clients. As a group, Independent Midwives use a caseloading approach to care. Caseloading is the conduit for providing mother-centred and relational continuity of care. The terms caseloading and continuity of care are frequently used interchangeably to mean care provided primarily by one midwife for the entirety of the maternity care episode. Providing individualized care is a conscious choice the midwives make in how they care for women - they could create generic clinical pathways and guidelines as seen in NHS care, but choose not to do so. As previously outlined (Section 4.4.1), the time allocated to frequency and duration of appointments is based flexibly on the individual requirements of the woman so, even at this basic level, care is individualized. Providing individualized care respects the rights of the mother to choose the care she receives and tailors care to her personal needs.

'... the number one priority for them [Independent Midwives] is that they want to be... have that continuity with women and they want to support them no matter what, so be there for them.' (Rebecca)

Being able to provide individualized care is dependent on the development of a trusting relationship, which is contingent on the provision of continuity of care.

'Yeah, so I think with continuity of care the aim is to build up that trusting relationship between both of you, so that women can be more open to potentially discussing concerns they may have that they might not mention to a stranger, that could really impact on their care or their birth experience... it includes a lot more because with the same person, and a good amount of time, you develop that relationship which then brings other aspects with it

that enhance the care even further... calm, we want women to be calm, relaxed, so often they come and they are so stressed... so... there's quite a few bits that actually develop from a true continuity of care...' (Deb)

Providing individualized care, which respects personal autonomy, places the woman at the centre of care and necessarily involves her in making decisions about the care that she wants to receive. This links closely with the code 'women's autonomy' and will be explored further in this chapter (Sections 4.7.5 and 4.8.3).

'...for me the important thing is that the woman and the baby are at the centre of care, at the centre of planning and are active participants in care decisions and, and following through of care plans so that the best possible outcomes are achieved for both within the frame that the circumstances permit...' (Steph)

Some women seek independent midwifery services when they have been unable to negotiate the care they need from the NHS.

'There are some common threads, I definitely think... and mostly they would be women who just feel that they are not getting a service that sits comfortably with them... They're not, they're feeling that their choices perhaps aren't being respected, they're feeling that they are not being listened to... they want to... feel as confident as they can be that they will have the birth of their choice, that their choices will be respected.' (Alison)

Others seek out independent midwifery care because they feel that the care they received from the NHS previously was abusive.

A lot of my clients have had negative previous experiences of the NHS and don't want to repeat it... will spend good money to avoid it... (Jane)

The following quote demonstrates that some independent midwifery clients have experienced previous birth experiences as abusive and want to avoid it by not engaging with the NHS.

'We still get a lot of women coming to us who feel traumatized by their experience with the NHS and want to try something different, something on their terms... where they're listened to and where what they think... or want matters. Some talk about birth rape and that's really terrible... you know, the midwife constantly putting her fingers in and telling her to push... it's really upsetting to hear that this crap is still going on...' (Lisa)

Some visits with clients may turn out to be purely social interactions where no clinical care is given, because the woman does not want any interventions and has no concerns. The opportunity to talk serves to strengthen the relationship and deepen mutual understanding.

'... I go into a woman's home, we're talking about things... we've been chatting for... what... however length of time and I haven't done anything... I will just make a note that we had a conversation, we discussed... everything was normal, no concerns about anything in particular, she didn't want anything doing...' (Alison)

The diversity of clients was a point of interest for the participants. Some are wealthy, however many clients have very low incomes despite having to pay for their care.

'I probably had assumed, haha, in my ignorance that an independent client would have one common denominator which would be disposable income. No! We might be in a very fortunate position as, as a collective of four, that we can take on clients who haven't got the ability to pay upfront, or pay straight away, but they are... we get the... huge houses, well-heeled, professional couples, we do get them, with the big cars and all the rest of it, and all the trimmings, and we also get the opposite, polar end, socioeconomically.' (Claire)

The midwives talked about how the care they provide is woman, or client-led, starting from the point where the woman sought out the services of the midwife.

'From the outset we base care on the woman's needs, we make appointments based on her needs...how often, when, how long. Some women only need a fairly routine schedule of visits, you know, monthly then fortnightly and then weekly running up to the birth. But others... they may need more frequent visits, or something might happen, we had one case where her marriage was suddenly on the rocks... she didn't know what to do, so we went more often, and we just supported her emotionally... helped them get counselling... it really is individualized... it has to be.' (Lisa)

The woman-led approach runs through the appointments, with women determining what they need and want to discuss, and which elements of clinical care they choose to have.

'...I can ask very open-ended questions and then talk about what comes from those, so rather than the closed ended questions that demand a yes or no answer, from the... from the woman, I can say, 'How are you?' and whatever's important to her at that time, will be what she tells me about, and then the appointment becomes very client-led.' (Claire)

An example of providing individualized care by Rebecca highlighted a client who had needed postnatal care for eight weeks after complications had arisen.

'...she's needed more support, so... yeah that's... so that's discharging two months after the birth, it really is individualized, yeah.' (Rebecca)

Care is tailored to the woman's wishes - sometimes this may take the form of 'routine care' where the woman requests it, but more commonly women will choose to only have selected elements of the care that would be provided routinely in hospitals.

'...it's not that we don't provide routine observations in labour, we can and we do, where the client agrees that that's acceptable to her but we do have some clients who prefer, for example, minimize, or not give consent to vaginal examinations in labour. So, we... obviously we will have talked to that client in the antenatal period about what the benefits of doing them are and the difficulties that sometimes come up with doing them, what are the limitations of the information that you get but also other ways in which we might estimate her progress through labour... and support her in her choice.' (Steph)

Care is delivered in a place of the woman's choosing, which is usually her own home. This setting has an influence on the interaction between mother and midwife. Women usually feel more in control and relaxed when they are in their own environment. Meeting in the woman's home helps to create equality between mother and midwife.

'...The other difference I really think is seeing them in their own home. So, not only the time but it is also that they're comfortable, relaxed, in their home and I'm in their space, a guest in their space... their lives, for that time, not them coming to me in a clinic... that has a big impact on the relationship and... what is shared at those times and how comfortable they feel and I think that... women will... are then given that opportunity to share whatever they need to because they feel comfortable to, in that space.' (Rebecca)

Home-based care was also considered in terms of positively balancing issues of power and control between mother and midwife, which in turn affects the provision of individualized care.

'It's in the home, which I think makes a lot of difference to power relationships, so rather than someone having to come into my clinic which is my domain, I go into their home which is their domain, I'm a guest, I think that that's a big difference... we talk... and I listen... what does she want... need?' (Claire)

Steph felt that the home-based appointments made discussions collaborative and thus contributed to the further development of the relationship.

'...we would provide antenatal care in their own homes at a time that suits us both, most of our appointments are much longer than an antenatal appointment in the NHS, they are very relaxed and have a different 'quality' about them, they are interactive discussions, women are learning about how their bodies work, how labour works... they are the building up of these important relationships...' (Steph)

Women are helped to prepare for birth and parenthood, learning about their bodies, what happens physiologically during the pregnancy continuum, and how to support their physiology.

Women need to have a strategy for birth, they need to understand what is happening and why... we talk about the physiology of birth, what needs to happen, what the contractions are doing, what the baby is doing... if they can see the positive in experiencing birth then they will be able to roll with the labour, it's taking them to what they want... to having a baby in their arms... The women who can see the point in contractions... it works really well for them... they don't tense up against their labour, they don't resent it, they feel powerful that they're producing these... these waves of power... that will enable their baby to be born. They are not victim to labour, they are the creators of labour and they find ways to deal with the intensity of it... (Lisa)

The midwives described how they felt that the quality of their care was endorsed when women booked with them for subsequent pregnancies. This was also considered beneficial because the existing relationship made it easier to care for the women second time around.

'I have several clients who have come back four times for care... that's an endorsement isn't it? Most come back at least one more time... Each time gets easier because the relationship just cements... is so solid... you know what each other is thinking by then, I know what she wants... she knows what I will say... it's great and you become friends for life...' (Lisa)

In summary, the choice to provide individualized care is associated with promoting women's autonomy. Women are positioned at the centre of care which is tailored to meet each woman's personal needs and requirements. The woman is able to choose her midwife and the basis on which she receives midwifery care. The frequency, timing and duration of appointments are decided by the woman, in agreement with her midwife. Home-based care facilitates the equitable position a woman has during the appointments and contributes to a

relaxed environment where the woman can feel comfortable to discuss any issues which are important to her, in an unhurried atmosphere. Many women show their appreciation of the service they received by booking for care with their next pregnancy.

4.5.3 Holistic care

Discussions as to how independent midwifery care encompasses the woman's physical, psychological and social wellbeing resulted in this code. The provision of time and continuity of care enables them to explore all these issues with their clients. There is an understanding and acknowledgement of how the mind and the body interact.

'I think that because we've got the time we can have a more holistic approach... so it's not just about their clinical welfare, it's about their psychosocial welfare, what's going on in their family, how their relationships are panning out...' (Claire)

Providing such a holistic approach to care is viewed as a strategy for maintaining normal physiology and psychology throughout the pregnancy continuum.

'...and it's not just on the physical basis of pregnancy... we're talking about emotional, we're talking about mental care, we're talking about... just about everything about her... we're about keeping things normal and that has to be the emotional and mental side of things that has to be interlinked, it's not just the physical things.' (Jane)

Deb details the different ways in which she provides holistic care. She pays particular attention to language and the effect that can have on psychology and thus physiology.

'You need to change the language here. We looked at the environment in terms of kind of how that was, I wanted to look at her psychology, was there something in the psychology that maybe had not been addressed, was there something from her history that was affecting her at a certain point in her labour and she shut down? I wanted to look at her body structure, so we talked about chiropractic or osteopathic work, pelvic alignment, that kind of thing... I use homeopathy, reflexology, aromatherapy... done courses... you know... the change of language though... seemed to come quite quickly when she realized... what she... she hadn't realized what she was saying about herself... 'I am a failure, I can't do this', and she was, 'God!' she, she got onboard with that one big style and really kind of... changed her language and, you know, I didn't have to sort of... sort of suggest other things, she kind of... I noticed she really took that on herself and ran with that herself which I thought was great, because that... that's so going to change her, you know, her mental state which is going to affect her physical state... so... and yeah... and she laboured... and she birthed half an hour later.' (Deb)

In summary, the midwives take a view that the working of the mind and body influence each other and thus need equal consideration when caring for women. Social wellbeing also impacts a woman's physical and psychological health and therefore knowing the context of the woman's life is important in being able to effectively support her. Incorporating non-conventional medical approaches such as reflexology and osteopathy is a frequent feature of this holistic style of midwifery.

4.5.4 Salutogenic approach

Although the midwives did not use the term 'salutogenesis', this code was distilled from the way they describe their approach to midwifery care which fits with this concept of health. With pregnancy, childbirth and breastfeeding being considered normal physiological events the support and promotion of health becomes an important constituent of their care. The focus is on normality, not pathology and risk, and links in with the holistic approach to care that they use.

'... certainly, my approach is one of calm and everything is normal until proved otherwise... we all need to be calm and relaxed, then it works. Her body works as it should, and we can think clearly...' (Chris)

Mainstream maternity care is currently focused on risk and causes women to be stressed about what can go wrong. This fear-based approach is seen as having a negative effect on women's experience and potentially on their outcomes.

'I feel that there is so much fear put into women's ability to be pregnant even... and to enjoy it and... be confident in the health of their baby and the wellbeing of their baby... that kind of anxiety that it induces often... yes, it's not helpful [laughs]....' (Alison)

Jane's health promoting approach to care includes examining a woman's diet and discussing what the woman can do to promote a healthy pregnancy.

'I always get them, always, to write me a diet diary over five days... I say put everything down... chocolate bars, everything... and we can go through and tweak, because you can't do a big diet change when you're pregnant it's beyond belief, but use that time, when you know that you are wanting to put good stuff in because you want to grow the baby well, understand that your tastes change... use that time just to tweak and so I sit down with them and go

through it all...they need all the vitamins, protein... as I've said... and no pressure, don't stress them over it.' (Jane)

In summary, the pregnancy continuum is considered to be a physiological event in a woman's life and as such, care is designed to focus on the normality of those events and to promote ways of achieving and maintaining women's physical and psychological health.

4.5.5 Partnership working

The notion of working alongside women led to the formation of this code. Interviewees described the approach they have to working with their clients as one which is egalitarian. Whilst having knowledge about pregnancy and childbirth, the midwife does not assume an authoritative position over the woman. Women bring their own knowledge and experience which contribute to the way care is arranged and provided. Women's opinions and wishes are valued in this way of working and are essential in a situation where women are required to take responsibility for their decisions. The midwives are clear that they are choosing to work in a way that facilitates women's empowerment and self-determination and does not impose limitations on those rights.

'So, it's very much about working err... it's an old, ach, over-used term... 'in partnership with women', one of the things that's absolutely central to independent practice, and I think what is... should be central to all midwifery practice, but doesn't seem to be, is a sense of mutuality.' (Steph)

Partnership working links closely with women's autonomy. The midwife works together with the woman to help her identify her own needs and then the woman is supported in making decisions about her care.

'I'm there to support her wishes... and respect them... ultimately it's that woman's choice, she chooses what path to take and that will almost, we create our own plan together for that individual situation, for that individual woman but it's her responsibility to make a choice that she feels comfortable with... not my responsibility to choose that for her... bar immediate emergency situations where obviously your clinical experience needs to kick in... we have to tell them what the NHS would say... I mean offer [laughs]... part of informed choice is letting women know what the NHS do...' (Deb)

The approach of the midwives is not hierarchical, they consider women to be their equals as previously discussed (Section 4.4.2).

'Working alongside them rather than a top down approach...' (Rebecca)

Lisa talked about responsibility in midwifery care and how women need to be helped to make the right decisions for themselves and which they are prepared to be accountable for.

'I want to take responsibility for what I do... not hide behind some poor doctor, or the system. I want women to take responsibility for what they do... their choices... it doesn't work if they don't, I can't be held responsible for what they do... or don't do...' (Lisa)

The flexibility with which care is provided has been discussed previously (Section 4.5.2), and this also links to the notion of partnership working. A negotiation of how, when and where care is delivered takes place between mother and midwife.

'Practically it's easy because for most of us, most of our clients, we would provide antenatal care in their own homes at a time that suits us both...' (Steph)

Having respect for women helps shape the organization of care. When midwives recognize and respect the woman's self-knowledge and her own insights into her needs, care can be provided accordingly.

'Women are sensible, they know what they need... You need to listen to what they're saying. If something stresses them out that can't be good. They know what's best for them and their babies. If they ever say they think something is wrong I listen and I act, they may be very unspecific but they are getting a general feeling of unease and that's coming from somewhere.' (Lisa)

Flexibility around care in labour was considered a very important aspect of care, with midwives attending when the women feel they need support. Women do not need to have been diagnosed as being in established labour for the midwives to be there. This type of support helps women who are experiencing long and difficult early labour and enables them to maintain normality.

'...I will go to see the woman whenever she needs me, if that's in very early labour... and she just wants somebody else there... the partner is anxious so, or she's anxious, so she wants someone else there... yeah and so it does happen that I'm there for three days and... and so

that's why we always have a back-up midwife to come and take over because it can take that long... swap over so that one of us can go to sleep, you know... and be there for that entire labour, which in the NHS... I've never done before... that was a lot to learn, it was a lot to... kind of realize... oh yes, this is normal ... this is what women go through, all that time when we are sending them home [laughs] but actually this is what they're going through that entire time, and that was quite a shift for me, in understanding and, you know... Seeing that whole process of labour...' (Rebecca)

Being able to provide care when women feel they need it is another example of how working in partnership can benefit women. They are not told when they need care and when they can access it, if a woman needs her midwife there for psychological support then that is considered to be as worthy as if it was for physical reasons.

'We stay with them in labour, for the duration, and it's us... it's usually one of us, for the whole thing, there may be two of us for the end of it, but, it's... we stay... so there's a completely different approach to providing care because it's not... we don't have to barrier it, so there's no gate keeping on, for example when to call us in... When you're birthing you call us when you want us and we stay for as long as you want us, and if that means that I go to someone's house and things aren't really happening yet, then I can go to bed in their house and that's fine... there's no gate keeping, the women decide when they need us and that might be for some psychological support, to calm them, or it might be that there's something clinically that they need, or it might be that they need, that's just when they need a midwife to be with them and I think that that's really important...' (Claire)

Providing birth support from the same, known midwife brings benefits as the context and progress of the labour are clear; the midwife can see the whole picture and can more easily get a sense of whether the labour is advancing normally.

'Yes, looking for the bigger meaning, in isolation... in fragments, it doesn't mean much... that's why continuity of carer is so important, you see the story unfolding before you, in its context...' (Lisa)

The idea of having a professional friendship with their clients was raised by several participants and serves to describe the strength and mutuality of the relationship that develops between the mother and midwife. The nature of the bond that forms between them brings benefits to both.

'To have almost a professional friendship, it's not a friendship, because that wouldn't be appropriate, but it has the quality of a friendship in that it's, it works both ways. I provide information, support, options to women... the women because they know... that I am seeking to provide them with the best care that they can get within the framework that I work in and therefore they feel able to trust what I say...' (Steph)

The effect of developing close relationships with clients added to the pleasure of working independently.

'...it's what gives it... being independent, what gives it the glow is the... the loving a woman and, and really feeling part of her family and her life and becoming almost a professional friend...' (Alison)

Rebecca found that the relationships she develops are beneficial to her, as well as the woman, and the experience is so positive that working with her clients does not feel like a job which has to be done but more like an enjoyable activity you choose to do.

'I can build those relationships with women ... that are really nourishing, for me as well as for them, it's a mutual... mutually enjoyable friendship, a relationship... and... it doesn't, it doesn't feel like work to me...' (Rebecca)

Several talked about having ongoing friendships with women who had previously been clients.

'I've got lots of lovely friends now... from being a midwife. I have in fact just had a phone call from one of my... an ex-client who is now a friend, you know? And her daughter is now thirteen years old and I have another client who's a friend, who's coming round later... so some of them are genuinely... become friends... but all of the women I have worked with I would consider a kind of a friend...' (Alison)

Jane talked about the need for Independent Midwives to have self-awareness about why they work as they do and to understand why feeling needed might be important to them. Knowing themselves and their motivations are considered important elements in being able to provide effective care.

'I think that's the other thing that as Independent Midwives we will look at why we are in the caring profession, to know what's in us that needs to be needed... and that's interesting, you have to know yourself to be able to then support people without judgement...' (Jane)

The mutual nature of the partnership was described as benefiting the midwives because they learn from their clients and their shared experiences. Respect for the woman means that the midwives are receptive to being taught new information by them, whether it is about specific medical conditions the women have or simply from being open to other people's experiences, perspectives, knowledge or approaches to life.

'...and the amazing women you meet on the journey and for them I am eternally grateful 'cos they're the ones that have given me the experiences I've had, the knowledge I have... they've given me the opportunity, opened the door for me to go down that journey, go down that path, do that... I would never have read that piece of research because if hadn't have met you, I wouldn't have come across that particular, your particular history and it's amazing... wow!... Met amazing women... taught me some amazing things... to trust, to believe...new ways of thinking, living.' (Deb)

Working in partnership with women and developing genuine, respectful relationships brings many opportunities for the midwives to grow and learn throughout their careers. It leads to enhanced understanding of themselves and other people and informs the care they provide women.

'I believe we have a role as partners to women who are pregnant, we travel with them, we are both changed by the experience, by knowing one another... I have been so changed by the many experiences I have had... the different ways of being... different approaches to life... you become less and less judgemental when you see such differences and how they can all work. I've learned so much from the women I have worked with... I had to unlearn so much of what I learned within the NHS...' (Lisa)

The equitable nature of partnership working means that the midwives do not present themselves as the experts in relationship. They come with extensive knowledge but acknowledge that there are inevitably going to be subjects in which they have little experience, which is particularly true of medical conditions and how they personally affect the individual woman.

'Learning... from the woman really, I mean she is often... she had a bigger source of knowledge... if she's had an unusual condition, women are hugely knowledgeable about their conditions... So, it's like, 'Oh I've never come across that before, tell me a bit about that,' they would definitely know how... how they manage their condition... I looked after a woman a couple of years ago who had... she had type 1 diabetes and... she chose a homebirth and

obviously knowledgeable about her diabetes... more than I was... so I had to, try to get myself up to speed, type of... the way she took her insulin, so she was very knowledgeable about herself how it affected her... and particularly how it impacted on her, things like managing hypos, the best way that she managed her hypos was fruit juices, they would instantly make her pick up, and she knew how she felt when she was... when her blood sugars were getting very low... all that kind of stuff. So, she would... was an amazing source of information about the diabetes... how it impacted on her... so yeah it... and that's great, you know? To trust and believe her expertise... her knowledge and experience.' (Alison)

The idea of women's empowerment and autonomy being essential constituents in the provision of respectful, mother-centred care is one that is endorsed by the Independent Midwives and links closely to informed decision-making.

'...that's one of the things I think about, our way of providing midwifery care, supporting women in their choices, families in their choices, lays down the foundation for their parenting 'journey', I don't like that actually, it's too jargonistic... but it lays down their confidence in their ability to parent... so I think in some ways we are changing the world... because we are enabling this group of people to know they can do it, they can make decisions for themselves, they can make decisions that are right for their baby... and that's really helpful when they are assailed by all the doubt and all the other health care professionals telling them what they should do...' (Chris)

Genuine partnership working only exists if women have the opportunity to think about what they want and make decisions accordingly. Having established that the woman has all the information she needs the participants respect and uphold those decisions.

'The focus is really on providing women with support for their choices...providing them with peace of mind that they have a midwife who will support them throughout and not waver if things get serious... won't turn around and then start telling them what they've to do. I have had women say, 'I'm so pleased we found you because now I can relax into this and stop fighting for what I want.'...' (Lisa)

The midwives spoke about the confidence they place in women's decision-making and felt that with proper support, women make choices that are appropriate for them and their babies and that midwives should not be fearful of supporting women in their right to act autonomously.

'I have complete, absolute belief that women always make the right choice... at the time they make the right choice... I so firmly believe that... they make the right choice, what's right for them and right for their babies and despite what obstetricians or other midwives might tell them they genuinely... all their actions are guided by what they believe is right for them... and if they're supported absolutely in that then the choice will always be the right one for them and a good outcome is... probably almost always guaranteed...' (Alison)

Partnership working and knowing the woman enables the participants to assess the process the woman has gone through and to understand how she has reached her decisions, which enables the midwives to respect and support the woman and the choices she has made.

'Yes respecting how women come to a decision, some will research it to the nth degree... look at PhD studies, you know, look at RCTs [randomized controlled trials], you know do... really go into it and make a decision, some will base it on a gut instinct and who are we to say which is more valid... you know? If you, I think it's done easily once you... when you have high continuity, individualized care, time with women, you can quite easily assure yourself that whatever, however... what the basis of the decision was made it is actually a true and valid one... that you can obviously have quite clear evidence that the woman is capable of... mentally... capable of making that decision.' (Deb)

It was described how, rarely, some women will make decisions which may result in the death of their baby.

'...the element of the mind... like when women are choosing to do a certain thing over the norm... 'Well my mental risk is greater if I do that, so I will actually take a greater physical risk...' (Deb)

Women's autonomy enables them to make decisions that may not be acceptable to others but the participants are very clear that this is her legal right and that she must be supported in her decisions.

'...Most women will do everything they can to prevent harm to their babies... but very rarely there will be a woman who chooses not to undergo surgery... that, that as a choice is not acceptable to them and that is their right... and I hope that never changes in law... it is so important that they have control over their bodies.' (Lisa)

In summary, the midwives report how partnership working facilitates mother-centred care by enabling women to participate equally in the planning and provision of their care. A flexible approach is taken in how, when and where care is delivered, which suits both the

mother and the midwife. The development of strong, intimate bonds between mother and midwife is described as being like a friendship and the importance of mutuality in these relationships is highlighted by the participants. The respectful nature of the relationship facilitates an ethos of reciprocal learning and further demonstrates the equality of the partnership. Supporting women's empowerment and rights to autonomy are key to working in partnership.

4.5.6 Communication

The final code reflects the significance participants placed on their interactions with clients. They talked at length about the importance of communication; having the time to communicate effectively as well as the manner in which they do so. The midwives allocate considerable amounts of time to interacting with their clients which, in part, facilitates communication (Section 4.4.1); their attitude about women's autonomy and the input women should have in their care also influences how they connect and how women's voices are heard.

'I think that because we've got the time... I can have open-ended questions, which means that when somebody says to me... when I go into a situation, an antenatal appointment, postnatal, whatever, rather than having to run through quickly, a schedule of tasks I can go in and I can ask very open-ended questions and then talk about what comes from those answers...' (Claire)

The participants are careful, when sharing information and supporting women in their decision-making, not to be prescriptive or tell women what they should do. The language they use is deliberately shaped to encourage women to explore their options and make decisions that feel right to them, without pressure from the midwives.

'I think it [communication] differs enormously because I think all Independent Midwives are aware of the woman's right to self-determination and because that underpins everything you do, that's why you don't offer advice, so you might say, 'This is a really good book, I will leave it for you', that might be as strong as your advice comes, or you'd say, 'If you're thinking of this or this, 'so and so' is a good source, you can have a look at it'... but you wouldn't say to somebody, 'I think you should do this because it's policy and likely to be in your best interest', because you'd expect the woman to know what is in her own best interest...' (Chris)

Having an awareness of the power of communication was discussed by most interviewees. A midwife's beliefs will be apparent in her communication with the woman.

'How a midwife thinks will impact on how she behaves, specifically how she communicates, whether that's communicating verbally, with body language, with written data, with her interactions both with the woman and possibly other members of the multidisciplinary team, so all those communication aspects will have an impact on the sort of care she might recommend or how she might provide information... how she responds to what the woman says or wants.' (Steph)

The use of fear-based language was considered to be harmful to women and as such its use is avoided by the participants. When a woman's rights and autonomy are acknowledged and respected the need to coerce her into making certain decisions does not exist, she is free to make her decisions, whatever they are.

'Yes, and we try and say it in a very non-scary way... because their choice has validity to them, we just... check in with them... explore their reasoning... to be honest they don't have to have a logical reason... it might be a feeling they have... it might be based on what's happened before. It could be gut feeling... intuition whatever you want to call it. Some of course do look at the research evidence but it's not so helpful in making individual decisions, is it?... it can be background information.' (Chris)

The use of coercive or intimidating language by health professionals is seen by interviewees as a violation of the woman's rights. Informed consent was considered as not valid where a person has not made a free choice and, as such, is an infringement of a woman's right to autonomy.

'...all too often women are coerced... bullied... frightened... into making decisions that the NHS stipulate... my duty of care is to the woman and to respecting her and her human rights to be autonomous... to make her own decisions... which I then uphold... how's a woman's physiology been changed when you've scared her? How have you made things more dangerous by putting the fear of God into her?' (Lisa)

Rebecca highlighted how language can be used to over or under emphasize risks and that without knowing the woman, and her beliefs and perceptions of risk, the information will not be personally relevant to her.

'Their own individual circumstances... what does a percentage mean to them? And how much is a 1% chance increase of a stillbirth, how does that sit with them... their feeling about it?... so, there's a 99% chance that everything goes well. Rather than... using... fearful... language, or language that can induce fear... just look at it very objectively and... there's a small

increased chance of 'x' and there is a small increased chance of 'y' with the intervention. We must talk about the risk of the intervention not just of the threat the woman's body presents... that's what I would aim to do anyway. (Rebecca)

Jane recounted a story about a GP who had scared a woman so much that she was considering a termination, by saying that her baby would be too big to be born normally because of the disparity in size between her and her husband.

'When you've got a great big tall dad and a little mum... so I can't say to her definitely don't worry about it, but let's look at the facts properly, don't go frightening her... telling her she won't get the baby out normally... was that based on hard evidence? No, of course it wasn't, but now you have fear... and can women birth well when they are fearful? No!' (Jane)

The power of language to change physiology was a subject frequently discussed in the interviews and how scaring, or stressing women can change how their bodies function.

'I remember talking to somebody about care plans and saying that's why often women with long care plans go in and end up with the worst outcome, it's not because they've got a care plan it's because of the staff attitude, language, body language, verbal language, everything there... and it affects the woman, yeah, psychologically, which affects her physically which then obviously affects the outcome.' (Deb)

Lisa identified that causing pregnant women to experience negative stress can have a detrimental effect on her and her baby and questioned why health professionals are not more aware of the consequences of their actions or words.

'Stress is such a bad thing for pregnant women... and their babies... why doesn't the 'system' understand that? Stressing women out leads to... poorer outcomes... stress hormones have a bad effect on mothers and babies...' (Lisa)

Communication in labour was highlighted as especially important in supporting physiology. The participants were cognisant of how talking can alter neocortical functioning and have negative consequences for how effectively a woman labours. Even if the language used is positive, it still causes disruption to the woman as she engages her logical brain in order to respond.

'...if you talk you force the woman to engage her neocortex, that inhibits her limbic system... you've now changed that woman's physiology... you've changed the course of her labour merely by saying something... how powerful are WE? We must never forget that... we can be

a force for good or a force for bad... I have had many women who despite knowing them very well weren't able to labour with me in the room... so I would be in the kitchen... occupied... but listening... or camped on the stairs... quietly, just listening... you pick up so much from just listening to women... you don't even need to see them... you can tell what's going on from her noises... what she is or isn't saying... but she will tell us if we listen... if we're receptive... her noises are key bits of information.' (Lisa)

The midwives adopt strategies which support women to labour physiologically because they understand how the mind and body work together and appreciate how they can inadvertently interfere with that process, even if it is just by speaking to her.

'...when I go into their home to start with I just generally sit there and observe for 10, 15 or 20 minutes?... Just to get a kind of a feel about what's happening... but I also think that's important for... from a midwifery point of view of making an assessment about how powerful a woman's contractions might be, how she is coping, just the dynamics of the labour. So, I... I would say I am a very... quite a quiet midwife, I tend... I don't disturb her, she's in the flow, I mean... I am jabbering away now but I... I tend to sit quietly, sit on the floor and just observe... not disturbing her...' (Alison)

The use of negative language was considered to cause the woman to enter a fearful state where she was unable to labour effectively because the balance between stress hormones and oxytocin had been disrupted.

'...You get to be right if you tell a woman, 'You're not progressing' so then her adrenaline levels are going to go up as she worries about what's going to happen and why her body's not working... then her oxytocin levels are going to go down, she is going to progress even less well, so, you're right, she isn't progressing and then she thinks, 'Oh my God I am a failure' and... 'You don't work well enough'... ooph! Yeah it just tumbles out of control, really quickly and literally, it's just a few choice words... you could seriously crash a whole birth experience...' (Deb)

In summary, effective communication between mother and midwife was reported as an essential constituent of providing mother-centred care, enabling women's opinions and desires to be heard, and for their autonomy to be respected. Language is considered to be a powerful tool which can be used positively or negatively. Using language which scares or stresses women is believed to be detrimental to women and their babies, by adversely changing a woman's psychophysiology.

4.6 Mother-centred care summary

The participants discussed many factors involved in providing mother-centred care, recognising links between them. They assert that the creation of trusting relationships is linked to the provision of safe and individualized care. Working in partnership supports women's autonomy and decision-making and also facilitates the individualization of care. A holistic approach caters to women's physical and psychosocial needs and links to beliefs about the normality of pregnancy and ways in which to promote health. Effective communication is seen as key to building relationships and working constructively with women.

4.7 Knowledge, evidence and practice

The use of evidence, rather than institutionally developed protocols, policies and guidelines, is a core element of Independent Midwives' practice. Although there is overlap with several of these codes in previous findings, it was useful to consider the participants use of non-conventional forms of knowledge and evidence as a separate category because it is significant in their practice. This category is formed by five codes:

- Practice development
- Clinical judgement
- Women's knowledge
- Informed decision-making
- Women's autonomy

The following five sections outline and explain these codes in more detail.

4.7.1 Practice development

This code in part overlaps with the findings about professional autonomy and freedom to update and innovate practice in light of new evidence (Section 4.2.3). These findings introduce the participants' willingness to accept and incorporate diverse forms of evidence, not just those resulting from formal research studies. The code was formed from comments about how working autonomously as an Independent Midwife means that there is freedom, within NMC requirements and client preferences, to develop and enhance practice in response to a variety of forms of knowledge. Using a range of knowledge and evidence to support practice was viewed as being valuable by many of the participants, who felt that only using the accepted research findings and existing clinical guidance could limit advances in care. Their belief in the normality of the pregnancy continuum has led the midwives to

enhance their knowledge of physiology, particularly relating to childbirth, which they use to help inform clients when making decisions and crucially, during the labour itself to support women.

'Waterbirth! There is good evidence from physiologists about how it is safe, healthy babies can't drown, women don't get water embolisms... these are the mainstay of my practice, I've attended conferences and read the decent research... You know from the Netherlands and Waterbirth International and yet I still hear NHS midwives saying what the temperature 'should be'... women know and it should be left up to them... or that women have to get out for the placenta and how the woman can't have one today because there's nobody on who's qualified to do it, there is no qualification! Just knowledge and common sense... and... and how long did it take for not clamping the cord to be accepted? It's still barely done in many places, even now, a nod... a few seconds... The Supervisors don't listen to us about this information, they have their policies despite them being old and not based on evidence ' (Lisa)

Frustration is conveyed here about the slowness of the maternity care professions to incorporate new information from different disciplines and to change practice.

'...Well they had a fantastic physiologist from Edinburgh... so, he's not talking about women he's talking about animals, so my question to him was, 'Why on earth are you not teaching obstetricians?' Why is that not in general knowledge, within our system? He said, 'Well I've tried and I don't know what else to do.' We've got all of this knowledge about... epigenetics... coming through, but is that being linked into our practice? No, it's not!' (Jane)

The participants talk about how they apply research from different disciplines to inform and advance their practice. This can be done with relative ease because of their autonomy.

'Scientific research seems to faze them [midwifery supervisors], we search and find scientific papers, maybe biology or immunology or genetics... veterinarian science... and apply them... we can learn a lot from the vets, they get it... We've had several clients who were vets and their insights are amazing...' (Lisa)

Being able to analyse and critique evidence and recommendations is an important part of independent practice; this is done to help women understand the evidence as well as to increase their own knowledge and determine which evidence is trustworthy and can thus be incorporated into practice.

'We can access the publications much easier now and yet, for what? It's not applied! You've got all of this stuff, and we need to be critical about it... and I think Independent Midwives... we are good at critical thinking, we have to be, we have to be that bit more interested in the job we are doing because it's our way of life and we are passionate...' (Jane)

The commitment by the participant in the following quote to being conversant with the information her clients have access to, and to having a critical eye when reading different resources is apparent. Her frustration and anger at the quality of information that is sometimes given to women is clear. Women use information to help them make good decisions and poor or inaccurate information sabotages their efforts to do so.

'...he said [obstetrician friend], 'I give them this study, which you sent me' - which was basically saying that certainly after 34 weeks there's no evidence to support that... that caesarean section improves the outcome at all... - and then he said, 'I give them the RCOG leaflet as well,' because they support vaginal twins apparently, and I read it and I was like, 'For fuck's sake have you actually read the leaflet?' Because it says... obviously... it acknowledges that different twins have different risks patterns, completely, and then it said about the placentas... 'Your placentas are more likely to fail', just a sweeping statement... so I said to him, 'So, tell me how two placentas growing separately are more likely to fail than one?' and he went, 'Oh, I don't know' and I said, 'That's what it says in the RCOG leaflet' and he went, 'Well I haven't actually read it,' and I went, 'You're giving it out and you've not fucking read it? Come on!' and he went, 'OK'. (Deb)

Independent Midwives often support women in situations that may not be accepted within mainstream maternity care. Many have knowledge, skills and experience in supporting twin and breech births that are now rare within the profession generally. In situations where there is little good-quality evidence, they apply other forms of evidence, such as the principles of anatomy and physiology, clinical expertise, women's knowledge and evidence from countries where the practices are more common.

'Well I think we have to do that [use formal evidence], otherwise you're not going to be taken seriously... but we use a lot of what would be dismissed as anecdotal evidence... single cases... now my argument is that until people start talking about what they've noticed you're not going to know what you want to know, or what you don't know... The breech stuff, for goodness sake, the Hannah Trial really did for that, but look at anatomy, we have now two or three studies that have said that the outcomes are better when the women are on all fours or upright... we knew that already! Been doing it... Andrew [Andrew Bisits is an Australian

obstetrician] sits them on a special birthing chair, but I said, 'What position do the women get into when they are birthing the baby?' and he said, 'Oh they are usually, they drop off it and go onto all fours...' they are moving their pelvis around the baby's head - it's anatomically correct, when you know how the baby has to be born... but we receive such little support with looking after these women, pressured to just go to hospital... sections... you know? But our knowledge of anatomy and physiology... and how to support it is correct...' (Jane)

After a home birth of twins, where several hours passed between the two births, Deb reflected on the experience and how little is known about the normal physiology of twin births. She considered how, whilst interventionist protocols are adhered to by health care professionals, which restrict the normal birthing process, advances in knowledge about the physiology of twin births cannot be made. The participants are keen to search for evidence which has perhaps been overlooked and to contribute to knowledge by undertaking their own research.

'I actually spent the rest of the day liaising with the consultant midwife... she was just delighted afterwards, she said, 'I'm so proud of you all for just sticking with it and going with what that woman wanted'... she was...genuinely really was pleased and was like, 'Look this just proves we don't have a clue about physiological twins and how long that gap should be' and she acknowledges that actually we [mainstream maternity services] do mess a lot up. I spoke to obstetric colleagues and a few of them have said... particularly one, who trained and worked in 'xxx' [overseas country], he said, 'Oh 24, 48 hours, you know, we used to see that all the time,' because they didn't augment women, in 'xxx', they did just wait and he said, 'You know they weren't all dying left, right and centre', these were women who were coming in and were receiving health care, but he was saying, 'Yeah it happened all the time' and the second babies didn't all just die, of course... So yes, I think it would be good to spend some time really having a good look at the stuff about the gap between twins... review our cases.' (Deb)

Not following usual or standard care can bring real pressure to bear on the participants and their clients from NHS staff.

'She didn't want a section but had been pressured into agreeing to one by the hospital. She knew she could birth safely but they said the baby could die or she could bleed heavily. Which was true, but it's put in such a way that made it seem likely... inevitable... in the end she went into labour before the section date and she wanted to continue with her plan. We informed the hospital and they went mad, 'the baby will die at home, don't you realize that?' Her

knowledge said differently though, she'd laboured well before, birthed... and she knew she could do it. All was well and she quickly went on to have a lovely birth in the end but we had to turn the phone off because they [hospital staff] kept ringing, evermore frantic and hysterical. They sent an ambulance and we had to tell them to wait outside and not stress her out...' (Lisa)

Spending time reflecting on practice is viewed as an important learning exercise and a way of improving and developing practice.

'It's always useful reflecting on different births... or incidents... and sharing with other people so that everybody can learn from your experience... sometimes they are positive and sometimes negative... we don't just look at the negative... what helped a positive outcome? That can help change what we do...' (Chris)

As a group, Independent Midwives have created a forum on which they post new information, share knowledge and have discussions about clinical issues.

'...and then people will jump into that thread on the forum and discuss it and say, 'Have you thought of this? Have you considered that? Here's the link to another piece of research' so it's almost like we have a hive mind of knowledge, information and perception, reflection that we can tap into, which is incredibly valuable, I can't tell you how amazing that is...' (Steph)

Challenging poor practice, when they encounter it, is an additional way Independent Midwives seek to improve care not only for the individual women they are working with but potentially for all women who access the maternity services.

'I remember one woman who'd decided to transfer in and still wanted a physiological third stage... the midwife just went ahead and clamped the cord... wouldn't listen... and then when we asked if she could unclamp the maternal end she said no, that the woman would bleed if she did that... I had to take her aside, and quietly explain the A and P [anatomy and physiology]... [laughing]' (Lisa)

Often a problem is compounded by the use of inappropriate or coercive language by other health care professionals, which compromises informed consent and women's autonomy, and thus their safety.

'...the woman had decided she wanted to go in eventually... and you know what appeared to be a lovely midwife, her language was absolutely terrible and I... in the end I had to say something to her and I said it in the nicest possible way and I kind of ribbed her about it

because I kind of know her a bit from being in and out of that hospital and... she was like, 'Oh, gosh I didn't realize I had said that, 'Oh yes that does sound bad doesn't it?' I can't remember exactly what it was but... something like, 'Oh we'll have to start the drip in two hours' for example, there were a few, several things she said which were like that... 'Will we? Really?' (Deb)

The following quote depicts an example of how a woman's autonomy can be ignored by health professionals in a situation where the midwives most likely thought they were doing what was best for the baby but without regard for the woman's right to make her own decisions.

'...I was doing a bank shift and was given a woman who had a preterm baby on the neonatal unit and I was told that she hadn't expressed any milk and I said, 'Ok'... and I went and said, 'Hiya I'm 'Claire', how you doing?and she went, 'I don't care what you say, I'm not doing it!...'You're that Independent Midwife, aren't you? She'd been threatened that the Independent Midwife, who was coming on shift, would make her express milk, and I said, 'Right, ok', first thing is I don't make anybody do anything', I explained that I would support her to express if that's what she wanted to do but if she'd had all the information she needed and she didn't want to do it, I would respect that, and she went, 'That's what I want' and I said, 'Right! Ok, fine... Later she called me and said, 'How do I do this? I'll give it a go! I tried explaining to the midwives about their poor approach... that fell on deaf ears!' (Claire)

In summary, practice development is considered a valuable part of independent practice, with the midwives seeking ways to improve care for women and babies. The underpinning belief that the pregnancy continuum is a normal physiological event motivates the midwives to increase their knowledge of physiology and the ways in which they can support or enhance it. Multi-disciplinary evidence is used to inform and advance practice. The midwives devote time to reading new literature and take an analytical approach to appraising the evidence. Reflection is a key process in evaluating their own performance and improving practice. Challenging poor practices they witness is another way the midwives strive to make improvements for all women who use maternity services.

4.7.2 Clinical judgement

The second code resulted from remarks about being able to use clinical judgement. As previously noted (Section 4.2.2), their practice is not determined by an organization or written guidelines and protocols. They do use NICE and local NHS Trust guidelines, as

resources to inform themselves and their clients in the decision-making process, but these are not regarded as rules to which they must conform.

'...as a self-employed midwife, I haven't got a manager telling me what I may or mayn't do... I haven't got a set of guidelines, I mean I do... I do pay attention to and take respect for... for example NICE guidelines, where they are evidence-based and some are and some aren't, Royal College of Obstetricians and Gynaecologists... very useful information out there... I pay a lot of attention to it, I don't regard it as a tram line that I have to stay on, I regard it as a useful information source...' (Steph)

After attending a clinical emergency skills training day Jane was faced with the same scenario in her clinical practice. During the training, she had been instructed to transfer immediately to hospital in the event of a foetal bradycardia but felt that that course of action would not be the most appropriate in her current situation.

'...the next birth I was at I got exactly that scenario, I was completely freaked out and so I thought what do I do? What do I do? Do I do what they said, transfer her into hospital, I think, 'Oh for goodness sake no', turned her over, FH [foetal heart rate] came up, she was ok so she rested there for a while and she went upstairs had a wee then she came down got on with pushing the baby out, everything was perfectly alright. Now was there cord entrapment? I don't know, but that's midwifery skills...' (Jane)

Having only one labouring woman to attend to at a time was considered to be a strength of independent midwifery as the midwife can focus her attention on what is happening and use her clinical judgement, knowing the full context of the labour.

'Well the way I see it is that if I'm there and I'm paying attention to every little thing, of what's going on, the movements and the contractions... you can... pick all of those things up... you've been there the whole time and... that's using clinical judgement and assessment rather than filling in a graph.' (Rebecca)

Without written policies and protocols to determine how clinical cases are to be handled the midwives base their practice on a combination of research-based evidence, women's choice and clinical experience; the triad of true evidence-based practice. Claire, a midwife who has been qualified for two years, however expressed her reservations about using her own experience as a source of knowledge, although she did consider women's knowledge to be valid.

'...I'm always a little bit wary of my personal experience or other people's experience, what's really important is that woman's personal experience, her family's personal experience... so yes, I think personal experience is important if it's the woman's personal experience, I think that mine has a place but it's not, it shouldn't ever lead, and I think other clinicians' experience has a place but it shouldn't ever lead... we have to be research-based' (Claire)

As previously noted in Section 4.2.6, Claire expressed a fear of being investigated or referred to the NMC and it may be that not incorporating her own experiences into her practice is a strategy for avoiding such actions.

Alison explains how she felt about supporting women in the past to have homebirths when the research evidence reported it as unsafe.

'Supporting women at home is so normal, it's where it always happened... throughout history, midwives and women together... but I kind of felt on the back foot when the evidence the doctors were coming out with was all about the dangers of homebirth... everyone should be in hospital to be safe. People thought we were a bit mad to do homebirths or said we were 'brave' to do it. I just felt that they were not doing the right research and that if they did they'd find it was a safe option... it felt safe... the mums and babies were well and happy... my experience didn't match the research, but it was still real... the women were birthing safely... and now we have that, that bit of paper, and we can feel justified, what we do IS evidence-based [laughs]...' (Alison)

Knowing the woman, through the development of a trusting relationship, helps the midwives in using their clinical judgement. Having an understanding of the woman, her normal behaviour and how she usually responds, enables the midwives to detect changes from the norm and can alert them to developing problems.

'...so, I wasn't aware until probably a couple of years in, of the benefit to me of knowing the women so well, because I did know my... community clients fairly well... but I think it's only after being on-call only for your women or the women you know and you know where they live and you know what they want... that you can appreciate the benefits and how much easier it is to look after them... I think when you get to know the women it's easier to judge when they are feeling out of sorts, whether that's antenatally, intrapartum or postnatally, in fact I think it's probably much easier to pick up the signs of a woman having a problem postnatally if you've got to know her antenatally, and you've been there for the birth and

women can't dissemble as much if they know you well and they probably don't want to... it's just so much easier when you know them...' (Chris)

For the midwives, knowing the context of the woman in labour is considered a factor which facilitates the provision of safe care. A simplistic example of this is: if a midwife knows that the woman is usually a calm and rational person, not prone to panic, seeing her in an agitated state can alert the midwife to the development of complications which the woman is only sensing on an intuitive level.

'...you know the woman, you see her labour behaviour in context with the rest of her life... you can see normality or you can see abnormality, it's open to your senses, you see, hear, feel what is happening...' (Lisa)

Knowing a woman's beliefs and preferences also guides the midwives in how they provide care. Having had the opportunity during pregnancy to comprehensively discuss what care a woman wants during labour can help minimize disruption during that time. Knowing a woman's beliefs about her own body and her ability to birth enables the midwife to provide individualized care that is respectful and supportive of her and her birth.

'...by being able to get to know women, with continuity and individualized care, you can get to understand where you will fit in... with that woman. Someone may want physical touch... massage... some would freak out if you did that, so for me trying to find that level is really important to try and achieve... if you look after somebody... that you don't have that time to build that relationship with, that's quite hard because you are having to ask questions or making decisions, at a time when you would normally not choose to, so if you look after someone you've literally met once, and then they're in labour... it's a challenge. Labour ward midwives who meet a woman for the first time in labour, God! It feels almost overwhelming to me now, it feels really wrong... But on the level of knowing how to care for a woman, in the end you have to work with your knowledge of her and what innately feels right, you know?...' (Deb)

Having good knowledge of the evidence that underpins certain practices can provide the midwives with evidence to support not providing 'routine care'. Being able to explain how guidelines were formulated can help women understand the quality of the evidence they contain and that some are only based on a consensus of opinion, rather than research findings. For some women, this makes it easier to make different choices which they feel are more appropriate for their individual case.

'Often guidelines are not clear about how they were reached... foetal monitoring for instance... it's little known that it was a panel of obstetricians and midwives who negotiated, for hours... until they came up with the arbitrary timings of every 15 minutes in labour and then after each contraction during pushing... what wasn't considered was how disruptive this can be for women... constantly being disturbed, constantly focusing on what could go wrong... how can labour progress normally then? Hormonal physiology is not considered and it is key... we must learn and accept the consequences of our interventions... the unintended consequences.' (Lisa)

Helping women to understand the level of evidence included in guidelines enables them to make truly informed decisions, which is critical when women are wanting to take responsibility for their actions. RCOG Green Top Guidelines provide practice recommendations about specific conditions which are aimed to help clinicians and women in their decision-making.

'I use a lot of their [RCOG] stuff actually, particularly the Green Top Guidelines, where they grade the evidence, if it's like, grade three or four, you can use that to your advantage, completely... 'We do it because we think it's a good idea' [laughing] 'Ok, great, but that means that there is no strong evidence-based research on it, so actually if a woman wants to choose to do something different really that's not a problem then, is it?' (Deb)

What constitutes valid evidence was often questioned by the participants. Some rely on their senses or the feelings that they have about a particular situation to guide their practice. During labour the use of the senses may be employed in preference to invasive procedures, such as vaginal examinations, to assess a woman's progress.

'...if you are observing you are walking with them, you should do it in a way that you are there observing supportively, because that's what we're doing, and again that goes back to using our senses, all of our senses, apart from taste, hopefully [laughs], urm that, that's where you are gathering all of your information about how this birth is going. Xxx [fellow Independent Midwife] had made an internal examination, which again we don't do very much because we're gathering in our information in different ways, but there is not a lot written about it, that's accepted knowledge... And it should be, because it's basic midwifery. You know, even in Japan they had a little poster way back in 1999 on how to recognize the dilatation without making an internal... because that's... to make an internal is not trusting the woman...it's disrespectful...' (Jane)

Several of the midwives talked about using unwritten, embodied knowledge to guide practice - theirs as well as that of their clients. The knowledge may be experienced as just a feeling, or it could come as a direct instruction. The explanations for this knowledge vary from having a gut feeling about a situation, to a synthesis of previous experiences which guides the midwife's actions, to a sense of being instructed in what to do.

'...it was very interesting about how as a midwife one synthesizes the... the experiences of providing lots of midwifery care and it feels like instinct but it's probably a synthesis of previous experiences, I don't know whether it is instinct or synthesis, and I don't really care, but there is a voice in my head that says, 'I know this looks dodgy but it's going to be fine' and there's a voice in my head that also says 'There's nothing fundamentally wrong but my belly hurts, we need to go to hospital.' And I don't... I can't articulate it better than that, I don't think it is instinct, actually I think it's a combined synthesis of previous experiences and sometimes I don't understand why it is, until after the event, I think... hmmm... I am going to say something a bit crazy now, alright? Crazy stuff! [sighs] I have a spiritual belief that there are birth angels that come to births and I think that sometimes they tap on my shoulder and say, 'Steph, notice that, notice that, that's not right, do something.' (Steph)

One of my memos (Appendix 11) records my deliberations over what to do with information such as this which could be negatively judged by readers and potentially even lead to investigation of Independent Midwives' practice.

Jane described experiencing embodied sensations when she attends women in labour. Like the baby, she is able to feel the dilatation of the cervix on her head. This helps her understand how the labour is advancing and whether there are complications such as the baby having a persistent asynclitic presentation – a situation where the baby's head is tilted towards one of the shoulders which can cause difficulties as the baby is not in line with the birth canal.

'You know if I told you when I am at a birth and I can't feel the cervical dilatation on my head... I'm linking with baby, I always ask for permission to do so with the mother, some will say, 'No thank you', but we are both working to birth this baby... if I can't connect to him here [on the woman's abdomen] I will hunt here [different place on the abdomen] and people who have worked with me have sat and watched me and if baby is coming down like that [head tilted] I will often be... [Interviewer: You are showing the position of the baby's head using your head?]'... Yes, well where does that come from? That's a bit spooky...' (Jane)

Lisa has explored the concept of intuition in order to understand what is happening when she experiences unexplained feelings or thoughts.

'Sometimes you do get a feeling about something... Malcolm Gladwell talks about it in 'Blink' – what was thought to be intuition is perhaps a bringing together of knowledge and experience... that you hadn't consciously connected before... and it seems familiar... you know it... women have it too, they get a feeling... a gut feeling... that something is wrong... or is right... despite appearances... The gut feeling can be quite strange... when you can't explain why you feel a certain way... but listening to it is so important... sometimes it makes you look at something in more detail, makes you question your thinking... your assumptions... it can be one bit of information that adds to the puzzle picture you're building about the woman, about the labour, say...' (Lisa)

Jane explained her belief that there is an external source of knowledge that informs her at times of need and guides her practice.

'...she'd got him anterior but he couldn't be born that way so he had to rotate posterior and... we were now getting decels [deceleration in the foetal heart rate] and I just thought what have I got to do? And this is... you know we're working with powers that are age old... age old and that's what you should be doing... when you are in that situation your hands are being guided by somebody else and so I pushed this baby back gently, you know this is an old midwifery skill which nobody ever talks about, disimpacting the head... the RCOG has it, but obstetricians don't know about it... you disimpact, so I pushed him back a little bit, between contractions, flexed the head - because of all the yoga... she'd masses of room round the back, the sacrum was, you know, wide - so I pushed him like that [gestures] and then he... as a contraction came he came direct OP [occipitoposterior] and... I said, 'Push' and I flexed his head as she pushed and we got the baby out...' (Jane)

In summary, the participants describe how they are able to use clinical judgement because they are not constrained by organizational or medical protocols. Clinical judgement is one element of the triad of evidence-based practice that they utilize when planning and providing care. They use different sources of evidence to support their practice and by spending time with women they gain valuable knowledge which enables them to provide safe care. The midwives take a critical approach to interpreting research findings and assessing how guidelines are developed. They talked about the validity of different sources of evidence and how clinical judgement may be influenced by forms of knowledge which can be described as

embodied, including intuition. The concept of spiritual help in the form of angels or a guiding force was also discussed by some participants.

4.7.3 Women's knowledge

This code was developed because the participants believe that women have valuable and pertinent knowledge about themselves and their circumstances which can be incorporated into care, to the benefit of the woman and her baby.

'...one of the other things you get with respectful care is a... an acknowledgement that you the health care professional don't have all the answers and the woman has knowledge of herself, that she may not recognize... but that is equally important in, in reaching what are often joint decisions...' (Chris)

Women can be the first source of information for a midwife that all is not well and that complications are beginning to develop. Listening to women and trusting and respecting what they say can help keep women and their babies safe.

'...women know, if you don't listen to women you're an idiot, that's my big one, I think. I can't think of a time when I found clinically something that was a big surprise because the woman... she already knew... she'd already told me... So, it tends to be that clinical findings just back up what the woman already knew and told you, and if you listen, and if you've got the time to listen and... you don't ask closed ended questions, you leave it open, she tells you, she already knows.' (Claire)

Observing how different their practice is now, as Independent Midwives, leads inevitably to comparisons with their experiences of working for the NHS.

'I don't know, perhaps within the NHS... sounds like I am knocking the NHS and I'm not... but perhaps that gets drummed out of them a bit... that they become a bit suspicious of women, women's knowledge, innate knowledge about... if they have a medical condition or a... a more complicated pregnancy... that it's... a perhaps a little bit disregarded? Possibly? I know that now, I rely heavily on what women tell me... how they can inform me... it's an important element.' (Alison)

In summary, the participants believe that women's knowledge and experience are valuable sources of information which can be used to enhance and individualize the care they provide.

The women will often be able to alert the midwives to complications and concerns, which helps guide care.

4.7.4 Informed decision-making

The principle of informed decision-making is closely linked to women's human right to take personal responsibility for how they conduct their lives and forms the third code. Informed decision-making is based on women using a range of evidence to support them in deciding on the care that will best suit their needs. Evidence is not limited to research findings; women may also choose to use experiential evidence or embodied knowledge, or a combination of them. This enables women to choose care based on evidence they consider valid, and which is congruent with their own beliefs and knowledge. Respect for women's decision-making leads to the provision of individualized care.

'When you're accepting their decision or their reasoning... or their way of reaching a decision, you think, 'Yeah that makes sense, I can understand that' and you might not agree with it, you don't have to agree with it, but you can understand how, why they have reached their decisions and that they are valid decisions for them but if you think they're about to jump off a cliff like a lemming you tell them... have a conversation about it...' (Chris)

It is vital to ensure that women understand the potential consequences of their decision-making. A delicate balance is required so as not to alarm a woman whilst still being honest and ensuring she is fully informed.

'... your responsibilities as a registrant to support women's decisions to decline certain aspects of care, I mean, it's not simply, 'Yes of course you have the right to decline everything', you must still at the same time ensure that that mother and that baby are kept as safe as possible, so you talk through the decision, does she understand its implications?... But you do it calmly... sensitively... it's not my place to tell a woman what she may or may not do with her body...' (Steph)

Women are not obliged to base their decision-making on research evidence and will frequently rely on a sense they get, based on self-knowledge.

'I do see you have to be really careful that it's not all about the research evidence... women can see that it's not about them and will make their own choices... this feels like the right thing for me, this is what I know instinctively... so it could be way more valid, the fact that

maybe she's in tune with her body, in tune with her mind, using her own knowledge rather than basing a choice on a load of paperwork... because the statistics may not be relevant, they're not about her, they're an average... but she is expected to base her decision on them, so actually yes, the other decision-making way of using innate knowledge, or a feeling... intuition... actually may be way safer...' (Deb)

Women are encouraged to explore resources which help inform them about subjects personally relevant. The midwives do not tell the women what they should do, they help their clients to find information and explore their ideas and feelings, which enables them to make their own decisions. As reported in Section 4.4.1, the participants invest a lot of time in discussing evidence and options with clients and supporting them to make decisions which suit their individual needs.

'We try very hard not to steer clients' decision-making, and sometimes that will bring us into conflict with other providers, we will give them as many... a menu of options, for any given situation, explain as far as we can, the pros and cons of each of their options, and then say, 'Go!' It's not our decision-making, it's... it's theirs and sometimes they make decisions that I wouldn't have made and that's fine, that's good...' (Claire)

The midwives have a responsibility to not steer their clients in their decision-making and strive hard to achieve this. In part, this is achieved by addressing as many issues as can be anticipated in the antenatal period so that women are prepared and informed and able to make decisions in acute situations.

'Yeah, I'm very aware of that, that... if I'm their primary care giver for the pregnancy that I have a... a huge responsibility... not to influence their... or to try not to influence their decisions... even if they look to me in a moment and say, 'What would you do?' you know? I really find that, that's... that's it's not for me to say... I'd rather have given them all the information in advance... so that they can... really own that decision for themselves, but I'm aware that they're looking to me at certain points... I've a real responsibility to give them ALL the information not just what I would want them to do...' (Rebecca)

Supporting women and helping them become confident are considered to be factors which enable women to make appropriate decisions.

'...if they feel empowered and they are supported they make the right choices about what is right for themselves and their babies...' (Alison)

In summary, informed decision-making necessitates the active participation of women in their own care and enables that care to be respectful and individualized. Women are guided to sources of information and encouraged to also make their own searches. Research findings are not the only source of evidence used in the process and women may choose to make decisions based on their own experiences, self-knowledge or instinctual feelings for what is right for them. Women make their own decisions about the care they choose to accept and are fully supported by the participants, even if they are making unusual choices.

4.7.5 Women's autonomy

The final code reflects women's human right to take personal responsibility and to make decisions about how they conduct their lives. This is a fundamental tenet of independent practice. Having autonomy enables women to choose the care they believe will best serve their needs and which is consistent with their beliefs and values. Respect for women's autonomy facilitates individualized care.

'...we uphold their right to be autonomous, to make individual decisions and choices... we respect their choices... they may not be my choices but that's not important and we do not quail if things get difficult... so often NHS midwives are happy to support until the event actually occurs and then they start telling the woman what to do and not respecting her choices anymore...we do not abandon our position of support...' (Lisa)

The establishment of a trusting relationship links strongly to women's autonomy because respect for women is embedded within it. Women are confident that their autonomy will be upheld and their decisions will be respected.

'...they really want to know who their midwife is going to be and they want to build up a relationship, because that feels right... they want to... feel as confident as they can be that they will have the birth of their choice, that their choices will be respected...' (Alison)

How women make decisions is based on their concept of risk and this will be individual, based on previous experiences and their outlook on life. It is considered by the participants to be important to establish a woman's way of thinking about risk in order to understand her decision-making.

'...yeah, I like to discuss the concept of risk with clients as well and... because I say to them you know, 'Your risk taking will be different from mine, some people choose to cross the road at a pedestrian crossing, every time they cross the road and they will press the button and

they'll wait... that's your choice as an individual, as a human, as an adult, there are clear human rights to make those decisions, you're mentally capable... others, they weave through the traffic... they can't be waiting around every time they need to cross... that's their choice... some women ride their horse' (Deb)

The participants talked about the threats they see, to women's human right to be autonomous. Hospital staff are using social services to pressure women into complying with their preferred options for care by asserting that women are placing their babies at risk.

'There's somebody else wanting to have twins at home, she's got everything set up, researched it all. Knows what will work for her and now social services have been involved... putting her babies at risk, that's what they're accusing her of... threatening to take them off her at birth if she goes ahead...' (Jane)

Deb describes how hospital protocols are used which place the needs of the unborn baby above those of the woman and how this is at odds with the legal status of the foetus in the UK currently.

'It is to the detriment of women, I think we should say that, and I will say it because, look at caesarean section for breech, you know, women are having caesarean sections which you know quite clearly are physically not good for them and much more likely to lead to complications, on the basis that it's better for the baby and the baby card is always played... like induction at seven days over or ten days over, the baby card... the dead baby card is always played... always and if you say in law actually... the unborn baby doesn't have a right, I'm not saying you just disregard it and don't even talk about the potential... potential increased issues for the baby, but it's been completely skewed and it's used as a control method... how can that be informed consent or informed choice, you know? The woman's... her responsibilities are taken away from her... completely.' (Deb)

The breach of those women's rights who seek an alternative to the mainstream is considered to be a form of state control.

'And it isn't really until we get involved with somebody who has social services involved that we realize how insidious and destructive that is... we've had a couple recently and you think, 'That's so awful', because somebody is making different decisions and not conforming... they're considered to be poor parents because they don't tick the boxes for the right people!

Maybe they're a bit stroppy, or maybe they just don't like authority... but the threats are really serious...' (Chris)

In summary, women's autonomy is reported to be central to the provision of independent midwifery care. Upholding a woman's right to autonomy enables her to make whichever decisions she considers to be right for her. Within independent midwifery care a woman's decisions about the care she chooses to receive are final. Women's decision-making being overridden is seen by the midwives as a breach of human rights law. Women's autonomy links to knowledge and practice because they are involved in deciding which types of evidence they value and which they choose to include in their decision-making process.

4.7.6 Knowledge, evidence and practice summary

The participants relate using varied sources of evidence to support, change and develop practice, making improvements for the women and babies in their care. Their practice is not constrained by institutional or medical protocols and they are free, within NMC regulation and the agreements they make with their clients, to practise as they see best serves mothers and babies, using underpinning research findings, and experiential and embodied knowledge. Without being bound to policies, protocols or guidelines the midwives are able to use clinical judgment, as one element of the evidence-based practice triad, when providing care. The two other elements: research evidence and the woman's choice, are interwoven into the decision-making process. Some women may choose to balance all three elements when making their decisions, and some may base their decisions only on how they feel. This raises the question of what constitutes valid evidence and will be further explored in the discussion chapter (Section 5.8).

4.8 Midwifery philosophy

This category was developed because the participants asserted that what midwives believe directly affects the way in which they provide care to their clients, which impacts the outcome for the mother and baby. The category is made up of three codes:

- The normality of the pregnancy continuum
- Shared beliefs
- Women's autonomy

The following three sections outline and explain these codes in more detail.

4.8.1 The normality of the pregnancy continuum

When asking about their philosophies, some participants preferred to use the word 'belief' instead of philosophy.

'My philosophy? Erm... I think I could talk more about my beliefs... I'm not sure about theories of philosophy... my beliefs are that women are really, really good at having babies... that women are always... always make good, informed choices, if they are supported and respected...' (Alison)

The first code results from the most commonly discussed belief, which was that the pregnancy continuum is a normal, healthy and physiological life event, for the vast majority of women. The stance in normality shapes the approach the midwives take when providing care. The pregnancy continuum is not seen as inherently risky, or safe only in retrospect. Deb discusses the contribution Michel Odent, an obstetrician and researcher in the field of physiological birth, has made in the following quote.

'I think again it's having that belief... I've always been interested to know stuff and learn more about birth physiology and read about it... I've attended so many workshops and conferences... Michel Odent's work is very interesting... on the basis of him being a physiologist as well as an obstetrician and... all the information about the hormonal cascade, the neocortex, that really changed my understanding and my practice... you know and just that belief again, it's an innate belief about women's power and ability to give birth... with that belief we support, we give space, we respect, we enable... and then the women can get on and do what they need to do.' (Deb)

Their belief in physiology means that the participants are less likely to intervene. They believe that there are potentially harmful consequences to routine interventions, which are often overlooked in mainstream care.

'...physiology should be given the best chance because mostly it gets it right, that less is often more, that the less you do the more advantage you'll get...' (Claire)

Induction of labour for prolonged pregnancy is an example of a routine intervention which the participants feel is inappropriate and places women at risk; they argue that the medical approach does not trust in the woman's ability to safely birth her baby.

'...women are put under such great pressure to have an induction because they have gone past their due date... due date! ... When was that ever accurate? We worry too much about time. I generally talk about the period of time in which we can expect the baby to arrive... a specific date is rarely helpful... how many women birth on that date spontaneously? Very few... it's madness to think all women will have the same length gestation, we all develop and grow differently... humans are not homogenous and we create problems when we try to force them to be... how many women have been induced when they were not ready? We have to trust in the process and doctors have lost that. We have really low rates of induction for this and the outcomes are healthy mothers and babies who birthed at the right time for them... they know how to do this, know when the time is right and all these interventions are not helping.' (Lisa)

Trust in birth physiology is demonstrated by the high proportion of births the midwives attend in the home - homebirth is the mainstay of their practice.

'Mostly we have women who are wanting to have a homebirth... that's the most common thing probably with Independent Midwives... that most of our clients choose homebirth.' (Alison)

Being confident about birth is seen as being beneficial to women, enabling them to trust in the process because they can see that the midwife they have come to know and respect also trusts in it.

'...certainly, my approach is... everything is normal until proved otherwise and because the women have got to know that approach and that's what we believe, the woman comes to believe in her own abilities to do it, because... because you believe in her she believes in herself... And I think that, that's possibly the key to why it works so well most of the time? But I think all those little bits, that you have done, the time getting to know, the sharing the stuff about your life with her, she gets to know you, your beliefs, and her beliefs become stronger...' (Chris)

Whilst birth is considered physiological by the participants it is often not immediately apparent to women how they will work through it and it is at this time that the midwives can help the women to see that they are capable of birthing well.

'...I think I have a deep belief that women can do it and have extreme reserves of power and strength that they don't always know is there, or... so, encouraging them to believe that,

really, and having that belief that they can do it I think has a knock-on effect, or kind of resonates, or influences everyone around...' (Rebecca)

Alison's unshakable confidence in women's ability to birth is seen here and that confidence is reassuring to women in itself.

'...I think we're very confident in our own practice, in our, in our belief about birth...I think my beliefs are that women are really, really good at having babies and they can see that, and I think that helps them, boosts them...' (Alison)

Although the following quote has been used previously in the context of communication, the participant clearly explains the importance of midwives' beliefs and how they impact midwifery practice.

'...How a midwife thinks will impact on how she behaves, specifically how she communicates, whether that's communicating verbally, with body language, with written data, with her interactions both with the woman and possibly other members of the multidisciplinary team, so all those communication aspects will have an impact on the sort of care she might recommend or how she might provide information...' (Steph)

Whilst the midwives believe that birth is a natural process that works successfully most of the time, they talked about how it is possible to disrupt the woman's physiology and contribute to adverse outcomes. Deb describes how a midwife's beliefs and attitude can affect the care she provides to a woman and how that can negatively influence the birth outcome.

'The language you use, totally and completely affects women, their heads their bodies... It's all interconnected, it's like women who... the whole sorry affair of women with care plans, that they end up with everything they don't want... having seen so many labour ward midwives scoffing at birth plans and then leaving the woman completely by herself, giving no continuity, no time, no relationship build up, no trust build up, not caring and potentially that has a real impact on psychophysiology... and then their use of language and their tutting at the birth plan and, 'Ooph, wow, we don't really do that here' and... the midwives come back into the staff room and say, 'Oh my God have you seen room four's birth plan? It's like three pages long, oh she's going to end up in theatre, isn't she?' and then she does end up in theatre and it's like, 'You made that happen, you have hugely influenced that outcome' and I totally believe that...' (Deb)

Chris highlights that some midwives think they are supporting physiology whilst the placenta is being born by not administering syntocinon, however they are unaware that they are disrupting the process and potentially creating problems.

'...we still get student midwives coming out with us who haven't seen what I consider a normal physiological birth... you know, they maybe think they've seen one, or they've seen one naturalized... physiological third stage... but the woman was on her back and told to push the placenta out but they didn't use drugs, so it was considered as normal... physiological, it was in part physiological but it was still an interfered with birth... with the potential for complications... the talking, the disruption, speeding things up by getting her to push. These things change physiology and can cause bleeding, there's a real lack of understanding.'
(Chris)

Interventions which are commonplace in the NHS, such as amniotomy, are used infrequently by the participants because they base their practice on the evidence that demonstrates the negative consequences they can have.

'Rupturing the membranes... it's custom and practice in the hospitals but I don't do it, it's dangerous and can really change the course of the birth for little benefit. They [membranes] are there for a reason, lots of reasons... when we mess with nature there are unintended consequences – foetal distress, increased pain for mum... and baby... more difficult births... can the baby move as well once there is no liquor? What about the precautionary principle? We must know that what we do doesn't cause harm... the burden of proof is on the safety of the intervention, not on us justifying not doing it... like not clamping the cord until it has stopped pulsing...' (Chris)

Although some women will experience complications the participants considered it to be important that this is kept in perspective because if all women are pathologized then an iatrogenic effect will be seen in some.

'...having an essential belief in women's ability to grow and birth their babies safely... but not blindly... the vast majority of women can do it, if supported... but still there will be a few women that aren't able on the day... for whatever reason... to birth spontaneously... but you need to keep that in context and not treat all women like it is not going to work... 'cos you get to be right that way... start intervening with all women and soon all women are having some kind of complication and now pregnancy and birth look dangerous... precarious... and you stop trusting and you start monitoring and restricting all women and lo and behold!

Pregnancy is now a dangerous condition... you can see how it happened in the hospital system... mess with women, don't support them, knock their confidence and now childbirth doesn't work properly... put them in a clinical room and you can almost guarantee that it doesn't work properly...' (Lisa)

The participants are cognisant that physical interventions can adversely affect women, contributing to poorer outcomes. These interventions are frequently overlooked as causes of disruption because they appear to be insignificant, such as merely being present in the room with a labouring woman. The fear many health professionals have of pregnancy and birth is seen as another factor which can have detrimental effects on women.

'I trust... that for most women it will be normal... evidence shows that pregnancy and birth are... physiological events, not pathological... for most, the majority of women... and whilst we support, don't disrupt, undermine or talk... make unhelpful suggestions and don't meddle... don't do an 'ARM' [artificial rupture of membranes] or whatever, it stays that way. Supportive care is key, doing what women want, need... fewer sections... interventions... we know that now, we see it, we have the evidence but I think fear of pregnancy, birth... and breastfeeding... mistrust in the process now dominates pretty much all the health care professionals involved and it just makes things worse...' (Chris)

After attending homebirths as an Independent Midwife, Lisa concluded that she had no prior experience of birth which was physiological in its entirety. It led her to a greater understanding of the impact of seemingly trivial interventions and how these could be leading to dangerous complications for many women.

'I realized I'd never seen a truly physiological birth in my training, or working in the NHS... because even if the woman came in and just birthed there would be interference afterwards... the mad panic to get the syntocinon into her... for the placenta... the rush to cover the baby... get a hat on it... the flurry... totally disrupting that part of labour... swamping her with so much information and stimuli, no wonder so many women bleed after the baby is born... it can be so chaotic... either excitement and relief because it went well or stress because it nearly didn't go well... midwives generally don't think about undisturbed birth at this time... even if they did during the rest of the labour... We are way too interventionist at that time. When we're at the home though, the environment remains quiet, generally I encourage the mum to scoop up her baby, to look at the baby... the oxytocin is flooding her system... at this

point it is so important that you as the midwife take a step back... let nature take its course.'
(Lisa)

Acknowledging the unintended consequences of being present at a birth is an issue that was brought up numerous times.

'...we need to acknowledge how much we affect women in labour... how we can knock her off course... you go into the room and her contractions stop... or dwindle... or you say something and make her focus on you instead of being submerged in the moment.' (Lisa)

The idea of midwives being an unevaluated intervention in labour has been spoken about within the independent midwifery community. How midwives affect a woman is yet to be formally established.

'What is the midwife? That watchful eye, security, the trusted person, in the background, or is she the presence waiting for the inevitable problems to arise, giving the message to the woman that this can't be relied on? Because I'm... what I've become more and more aware of is my own intervention, is the midwife an intervention? We've talked about language, body language... obviously they are affecting women, so yes, I could be, you know, myself, could steer the course of a labour... My negativity or positivity affect the women.' (Deb)

Not only do the midwives believe women can grow their babies and birth them safely they also believe that the experience the woman has is crucial. Regardless of how the baby is finally born, it needs to be an acceptable experience to the woman and one that is not damaging to her physically or psychologically.

'It's the birth the woman makes choices about, so perhaps she wanted a homebirth... but on the day it doesn't pan out... she then makes the decision to transfer to hospital... she knows she has tried everything at home... it hasn't worked... now she will see what the hospital can do to help... she already knows what the options are and she is fully aware of the downsides of augmentation... rupturing the membranes, putting the drip up... monitoring the baby but she makes the choice herself and... in the round this is all there is left... but her eyes are open to the imperfect options... but the perfect ones didn't work... if she ends up with a section it will have been her choice, not pushed upon her... They may be disappointed if they don't get their homebirth but they were part of the decision-making and that makes a huge difference to how they feel later...' (Lisa)

A cause for concern is the focus of maternity services on mortality, whilst it seems that little attention is paid to morbidity – the physical and mental aftermath experienced by some women.

'...what frustrates me greatly is well, one, their obsession with just mortality because they... I just wonder whether some doctors actually give any credence to morbidity and the things that women can be left with, and the baby, things they can be left with for the rest of their lives, you know? It's not enough to just be alive at the end of it, they need to be healthy, intact, able to live well... it's about quality... quality of life... physical and mental.' (Deb)

In summary, interviewees firmly believed in the normality of the pregnancy continuum for most women. They explained, however, that physiology and thus outcomes, can be significantly disrupted by interventions and the negative attitudes or beliefs of health workers. The philosophy, or beliefs, a health care professional has about the nature of pregnancy and childbirth play an important role in how they provide care for women, how they present information, offer interventions and support physiology.

4.8.2 Shared philosophy

The participants' observations about how they often share the same beliefs about midwifery care and childbirth with their clients results in this code. Shared beliefs may be one of the reasons the woman elects to engage an Independent Midwife. There is often concurrence with the decisions made by women although, as previously discussed, this is not a requisite of care and women will be supported no matter what choices they make.

'I think... they're frequently shared decisions but that may be because the majority of the clients do share our philosophy of birth which is why they have sought us out...' (Chris)

Many women actively seek out midwives who are like-minded and who will be comfortable supporting her choices. Independent Midwives will often be contacted by women who have pregnancies with additional considerations, such as those expecting twins.

'...so, she is choosing a midwife... that she feels comfortable with, that she has probably interviewed, that they have a lot of... that their sort of philosophy of birth and what the woman is looking for are similar. She may be having twins and believe this to be just an unusual pregnancy rather than necessarily a dangerous one... she may believe that fewer interventions will be safer, to let nature work...' (Alison)

In situations where the mother and midwife do not hold the same beliefs about childbirth, e.g. the woman is choosing to have a planned caesarean section, for non-medical reasons, they will have shared beliefs about the woman's right to decide and to be effectively supported in the decision.

'...women come to us for all kinds of reasons and it's not only women that really want to have everything... natural, and don't want any intervention whatsoever... I mean, I have had women book with us who want elective caesareans so... they wanted that support throughout that process... to know they had all the information, would get the support, be respected in their choices, not judged.' (Rebecca)

In summary, the participants discussed how they have beliefs in common with their clients. These may be about the nature of childbirth and physiology, and the best environment in which to support them. Where women choose medicalized births however, which the midwives may not consider to be in the best interests of women and babies, the belief that women have the right to choose their care is what enables them to work effectively together. Women's choice is respected and they are fully supported in their informed decision-making.

4.8.3 Beliefs about women's autonomy

The final code relates to an important constituent of independent midwifery care. Aspects relating to women's autonomy have been previously reported in this chapter (Sections 4.2.5 and 4.7.5). It has been developed as a code within this category because it is the Independent Midwives' fundamental beliefs about women's autonomy that results in its incorporation into their practice. The participants discussed at length how they encourage and support their clients to take a proactive role in how care is planned and delivered. They believe that women should be the protagonists in their maternity care, where they determine who will provide their care and how this shall be done. The women are the focus of the care and in control of what happens to them. Women's autonomy was described as elemental to independent midwifery care. The women have the opportunity to engage in information sharing, throughout the pregnancy continuum with their midwife, but ultimately, they are responsible for making choices and reaching their own decisions. Regardless of whether the midwife agrees with those decisions, they are unwaveringly supported. As autonomous individuals, women are considered to have the right to make whichever decisions they like.

'...women will often make decisions that we... we may not think are great, so I am just thinking women who have the elective sections for absolutely no medical reason, but we don't spend time trying to persuade them not to do that, we just make sure that they understand that there's an increased risk, well certainly of morbidity to both her and the baby... it's validating their choices that I think is probably the most important thing because it, it's an outward show of respect for them and their decisions, isn't it?' (Chris)

The concept of autonomy and the respect for women's decisions is predicated on women having the time to explore and discuss their ideas, preferences and concerns with their midwives and being able to make the decisions which best suit their individual needs and circumstances.

'...I think definitely being in control of the decisions they've made and really owning those decisions is key but also having the time to discuss every little thing is how they become clear about their choices...' (Rebecca)

In summary, the midwives have a steadfast belief that their clients should be centre stage of their midwifery care and that they should be in control of that care, which interventions they receive and where that happens. This belief underpins all the care the midwives provide. Women are encouraged and supported to make informed decisions about their care, based on evidence that is valid to them, and to take responsibility for those decisions. Whether the midwives agree with the woman's decisions or not, providing that she is mentally competent, they support her unreservedly.

4.8.4 Midwifery philosophy summary

The participants discussed how their beliefs about the pregnancy continuum affect the way they provide care. They have a belief that pregnancy and birth are physiological events for the majority of women, and that if they are supported appropriately, women will be able to birth their babies safely and care effectively for them afterwards. Women's knowledge and experience are considered to be valuable resources which are used to facilitate the individualization of care. The women are encouraged to include their own knowledge when making decisions about the care they choose to receive. Shared beliefs between the woman and the midwife are usual within independent midwifery. Many women actively seek midwives to provide their care who have a belief in the normality of pregnancy and birth and who are not fearful of the processes. Those women who choose to have a medicalized birth

will share a common belief in the rights of women to make such decisions and to be supported appropriately. The belief in women's right to autonomy is an underpinning tenet of independent midwifery and enables women to be in control of their care, making decisions about who provides their care, where it is provided and what it comprises.

4.9 Research findings summary

This chapter has presented the results of the data analysis. Five categories have been developed from related focused codes. The five categories represent the most important components of independent midwifery practice as identified by the participants in this study.

Chapter 5 Discussion

5.1 Introduction to the discussion

In this chapter I critically analyse and discuss the findings of the study as presented in the previous chapter and link them to the literature reviewed in chapter 2. This thesis has generated rich data about independent midwifery practice and provided clarity about the participants reasons for working independently and providing care in the manner in which they do.

5.2 Professional autonomy

The notion of being 'truly' autonomous practitioners was one which emerged strongly from the data. The participants contrasted working for the NHS with practising independently, commenting on how not working for an employing organization positively impacts the way they work; how it enables them to determine their approach to practice, take control of their workload and to be supportive of their clients and colleagues (Sections 4.2.1 - 4.2.3). It allows them to practise in ways which reflect their professional philosophies and values and beneficially impacts on their quality of life. Independent Midwives make a choice to be autonomous - wanting to be responsible for their practice when they could perhaps have an 'easier' job in the NHS, largely following guidelines and protocols. Professional autonomy is seen as an enabling factor to the implementation of what the interviewees consider best practice (Section 4.2.2).

What is meant when we talk about autonomy? Jordan and colleagues (2013), for example, describe midwives as having autonomy when they merely have control of the scheduling of their day-to-day workload, but this represents only the most basic interpretation of autonomy. In the analysis of this PhD study, autonomy appears to start with the midwives electing to work independently of an organization and choosing to take full responsibility for their practice. The concept of autonomy then extends to being able to determine the model of care they adopt, the philosophical basis to their practice, the specific practices they utilize, and the manner in which they support women. In this way they are able to weave their values, philosophies and beliefs into the care they provide, achieving parity between their beliefs about the pregnancy continuum and their midwifery practice. Pollard (2003) finds in contrast to this aspiration that not all midwives want to be autonomous, some are content to view autonomy as choosing to support their employer and following NHS guidelines.

Although no professional can claim to be without any kind of constraint Independent Midwives are seen to demonstrate higher levels of autonomy compared to their NHS colleagues (Pollard 2003; RCM 2005; Page *et al.* 2008). Independent Midwives' practice has the same statutory regulation as employed midwives and as such they are bound by the standards set out in the Code (NMC 2018), thus they are not free to practise in any way they choose, but within what is defined to be the sphere of midwifery practice. They can also only undertake practices which are within the limits of their professional competence (Ledward 2004). The participants' practice is significantly influenced by the requirements of their clients, who may have specific wishes or needs for their care, such as having a low interventionist approach, where what conventionally might be seen as routine procedures are not incorporated into care. Independent Midwives are some of the few midwives in the UK enacting the full role of the midwife (Isherwood 1989; Garratt 2014) and cited this as one reason for deciding to work independently. Being able to provide antenatal, labour and postnatal care to the same woman was highlighted as an important aspect of working independently. The midwives in this study compared their current experience of autonomy with that of when previously working for the NHS, describing how they felt they had had little or no professional autonomy as employees; no control over the model of care they worked within, little control over working patterns and little or no control over their workload or the time they had to care for women and babies (Sections 4.2.1 and 4.2.2).

Whilst considering professional autonomy, as reviewed in Section 2.6.1, some participants recounted examples of when Supervisors or NHS midwives had tried to limit their practice and the experiences they had had of being questioned, and even formally investigated, for not practising in accordance with local NHS guidelines (Section 4.2.6). These guidelines may not even have been evidence-based, one example was the requirement within the NHS for recording water temperatures when women are using a pool in labour and prescribing the range of temperatures considered appropriate for labouring women. This has become custom and practice although there is no evidence to support its use (Harper 2014). One participant described how she uses evidence from the Netherlands and Waterbirth International to support her practice in relation to waterbirth and but that this is rarely accepted when she is questioned about this aspect of her midwifery care (Section 4.7.1). Knowing the women and having time during pregnancy to discuss, in depth, issues relating to waterbirth enable the participant to provide individualised and not protocol-based care. It was noted by the participant that women, unsurprisingly, have different needs when using water in labour. For some women the water must be warmer than temperatures prescribed

by NHS guidelines to feel the benefits and for others the temperature considered to be correct in the guidelines is too hot. The participant described how the condition of the mother and baby were considered on an individual basis, concluding that women know which temperature is best for them and that applying limits, which are not even evidence-based, is not helpful. Other examples of attempts to curtail their practise by NHS staff or midwifery supervisors who view differences in the care they provide as wrong, is discussed further in Section 5.8.4.

The participants in this PhD research described their experience of professional independence as bringing professional freedom, being neither restricted by authoritative texts nor the organizational requirements of an employer (Section 4.2.2). They work in a non-hierarchical structure, as equals amongst colleagues. This is a key factor in maintaining professional autonomy (Pollard 2003). The care they provide wraps around the woman and her family, being individualized to their specific needs and desires, and enabling her to feel relaxed and confident about the care she is receiving (Milan 2005; Garratt 2014). Independent Midwives are free to determine which forms of care to adopt, or adapt, as new evidence emerges or in response to the needs of their clients. The provision of postnatal care was an example of being able to deliver a service which is supported by evidence (MacArthur *et al.* 2002; Barimani and Vikstrom 2015; NICE 2015) but which currently is not a real priority for NHS maternity services (NMR 2016). The Independent Midwives report that they provide high levels of care postnatally, seeing women intensively during the weeks following birth (Section 4.2.1). This is a choice they make because they and their clients consider it to be a very important strategy in supporting women, both physically and emotionally, in their transition to parenthood (Milan 2005). Their experience is that it supports breastfeeding and enables early identification of emerging complications in the health of the mother and baby generally (Section 4.2.1). The IMUK website (Independent Midwives UK 2014) reports breastfeeding rates of 79.4% after four weeks amongst their clients, compared with average national rates of 24% at six weeks. With the short and long-term benefits of breastfeeding to mother and baby now well established (Ip *et al.* 2007; Sankar *et al.* 2015), postnatal care can be considered as a powerful public health measure, which falls easily within the sphere of midwifery practice.

5.2.1 Providing high-quality care

The high quality of the care Independent Midwives provide is pivotal to their practice and being unable to give such care within the NHS was a reason some gave for choosing to move

into independent midwifery (Section 4.2.1). The desire to give high-quality care is not exclusive to Independent Midwives of course, and surveys have found that the inability to provide such care is one of the main reasons midwives give for leaving the profession (Ball *et al.* 2002; RCM 2016c). It is noteworthy that some midwives seek a solution to this problem by becoming independent practitioners, whilst the majority appear unable to see any alternative but to leave the midwifery profession completely. Midwifery-led, relational continuity of care, is seen by the Independent Midwives as the best way to provide women with the care they want and need (Section 4.2.1). Women are the focus and are actively involved in determining what care they need and how it is delivered. As discussed previously (Section 1.5.2) the relational continuity model of midwifery care is now well established as being beneficial to women and babies, resulting in fewer interventions and better clinical outcomes (Hodnett *et al.* 2013; Allen *et al.* 2015; Sandall *et al.* 2015). The care provided by Independent Midwives fulfils the needs of their clients (Isherwood 1989; Waters and Steele 1992; Milan 2005; Garratt 2014) and reflects the wishes of the women documented in *Better Births and Best Start*.

5.2.2 Advocacy and women's autonomy

The concepts of advocacy and women's autonomy are closely linked and were important findings within several different components of independent midwifery practice. Professional autonomy, notions of authoritative knowledge and philosophy all encompassed considerations of women's rights to make decisions about their care and how midwives can support them.

Advocacy, as described in Section 2.6.4, and how it is facilitated by professional autonomy, was discussed at length by the participants (Section 4.2). Here, the meaning of advocacy, which reflects the participants' interpretations, refers to respecting women's right to autonomy and acting to ensure those rights are not overridden. The participants found that they could fully advocate for their clients when interacting with other health professionals and not feel conflicted about it (Section 4.2.4). Women's autonomy was viewed as sacrosanct by the participants as they described the support they provide to women in making decisions about their care and how they, as midwives, do not allow their own views to influence women's choices (Section 4.2.4). As highlighted in Section 4.2.4, Independent Midwives' clients frequently make unconventional choices about their care and this can be a source of tension between them and hospital personnel and is a situation where women need to be fully supported in their decision-making. The participants described how they

would need to accompany clients to hospital appointments, as the women felt they would be bullied into changing their decisions (Section 4.2.4). Finlay and Sandall (2009) discuss how advocating for clients can place midwives in conflict with their colleagues, as evidenced in the findings of this study (Section 4.2.4). Participants reported experiencing intense pressure to coerce their clients in these situations or being subjected to bullying and intimidation themselves.

Supporting women's autonomy is central to independent midwifery practice and was discussed at length by the participants in different contexts (Sections 4.2.5; 4.7.5; 4.8.3). It underpins the care provided because in this partnership the women have control and responsibility for deciding how they want their care to be shaped and which interventions, if any, they choose to receive. Supporting autonomy is linked to midwives' philosophy and the value they place on women's rights to make decisions about the care they choose to receive. One of the reasons cited by women for choosing independent midwifery care is that they want to be autonomous and exercise control over their maternity care, and to have midwives who understand and respect this position (Anderson 2002; Walcott 2003; Milan 2005). When women engage the services of Independent Midwives there is a meeting of minds about the rights of the woman to make choices about her life and her family (Section 5.10.4). In the context of a trusting relationship, which is facilitated by continuity of care, and time to explore and discuss evidence and options, the women are fully supported in the decisions they make (Section 4.2.5). This long-standing approach is congruent with the ruling of the Supreme Court in the case of *Montgomery versus Lanarkshire Health Board* (*Montgomery v Lanarkshire* 2015) in which the woman's legal right to make autonomous decisions was reiterated and supported (Farrell and Brazier 2015). This ruling has updated English and Scottish law on informed consent, resulting in a paradigm-shift away from a paternalistic model to one where patients are the holders of rights and can take responsibility for their treatment decisions. Although, as *Better Births* and *Best Start* reveal, women are still reporting a lack of autonomy in maternity care and receiving treatment with giving informed consent.

The literature regarding decision-making has been critical about 'informed decision-making', suggesting that it is an isolating experience where women are just provided with information and left to make choices and to live with the consequences, with little further input from their health professionals (Spoel 2004; Cooke 2005). This is not the situation that was described by the participants (Section 4.2.5) and does not reflect the context of relationship-based care. The midwives made it clear that they are not trying to absolve themselves of

responsibility in this process, but that they do not believe that the decisions are theirs to make. Findings by Noseworthy *et al.* (2013) are consistent with the Independent Midwives' practice and acknowledge the complex nature of decision-making and propose that a relational model of decision-making, which takes into account the social context of individual women's lives, facilitates this process.

Connections are made between midwives' and women's autonomy in Section 2.6.4, and it makes sense that if midwives are constrained in their practice they will feel unable to support women in choices which fall outside these constraints. It may also be that the midwives' mindset in these circumstances is such that they believe that the preferred choices, identified in policies and guidelines, are the safest and most appropriate and should therefore be conformed to by women – a paternalistic approach common to the medical model of care (Walsh and Newburn 2002). With its positive association with women's ability to make informed decisions, there is a cogent argument for re-establishing midwives' professional autonomy.

The participants have a strong belief in the value of women's rights to make decisions about the care they receive (Section 4.8.3). Their clients are encouraged to take responsibility for which interventions they have antenatally, for the place and type of birth they plan and for how they will care for their baby: the method of feeding they choose and the style of parenting they adopt. The midwives understand the importance a trusting relationship and effective communication play in this process (Thachuk 2007) and as such, building trusting relationships is a key priority (Section 4.5.1). The concepts of truly informed choice and women's autonomy underpin their care.

Women's knowledge and experience are rarely considered authoritative in orthodox maternity care systems, as explored in Section 2.8.5. The participants however, were unanimous in explaining that they regard women's knowledge as a valuable resource which contributes significantly to the individualization of care they provide (Section 4.7.3). This discussion considers the worth of women's knowledge and how that informs and supports their decision-making. Independent Midwives work in a non-hierarchical way with their clients, with equal value afforded to their respective knowledge and beliefs, using lateral knowledge as opposed to the hierarchical arrangement of knowledge associated with the concept of authoritative knowledge (Jordan 2014). The participants challenge the notion that there is one superior form of knowledge that should shape practice, and which is based on research findings. They resist pressures from other health professionals and those in

positions of power to limit the sources they use as evidence (Section 4.7.1). They consider women's experience, innate knowledge, intuition and feelings to be authoritative and thus appropriate to inform the individualized plan of care. Thachuk (2007) describes how honouring the knowledge women bring to the relationship is reflective of an equitable partnership, whilst Kemp and Sandall (2010) remind us that women and midwives' appreciation of each other's knowledge is part of the connectedness that comes from forming relationships and promotes trust between them. As discussed in Section 5.6.4, individualized care is associated with higher quality care and better outcomes (Carolan and Hodnett 2007; Aune *et al.* 2011; Tracy *et al.* 2013) and it can therefore be argued that valuing women's knowledge is associated with better outcomes. These findings demonstrate the important interdependence of relationships, trust, respect, knowledge, individualized care and safety.

Evidence for the efficacy of women's knowledge in childbirth comes from the field of anthropology. Trevathan's work (1997) proposed that until five million years ago, before birth was social, the individual birthing woman held power over her birth. She would decide where to birth, which position to adopt and perhaps when the birth occurred; timing it with when she felt comfortable and safe. Trevathan (1997) suggests that changes in human development, with the natural selection for bipedalism around this time and later, encephalization (the evolutionary increase in the size and complexity of the brain, in particular the development of the cortex), meant that it became evolutionarily advantageous for females to seek support and assistance. They were most likely to have sought this help from those similar to themselves - nearby females who had personal knowledge or experience of birth. Communication in these ancestral people was not language-based and so it is conjectured that both the labouring female and her companion would have contributed equally in this interaction, probably learning from each other. Trevathan surmises that female knowledge and support started around five million years ago and contributed to higher survival rates of mothers and babies. The transfer of this valuable knowledge, and the support women provided to each other - what we might well call continuity of care in labour - continued from then until recent times, when medicine became the authoritative paradigm, and women's knowledge was devalued as irrelevant or worthless. Walsh and Steen (2007) concur that the marginalization of women's knowledge is a recent phenomenon and results from the hierarchy of knowledge that has developed in our society which values technical and scientific knowledge over lay knowledge.

The ancient knowledge and support of our foremothers was evidenced by Klaus *et al.* (1986), in a study of a population which employed traditional birthing practices, as not only resulting in more positive feelings about birth but vitally, improving biomedical outcomes. This was later replicated in the United States by Kennell *et al.* (1991). As outlined in Section 1.5.2 and commented on in Section 4.8.1, women who receive continuous support in labour are less likely to need caesarean sections or instrumental births and have shorter labours, whilst postnatally they have increased breastfeeding rates and lower incidences of anxiety and depression. This essential element of care was lost from practice as more medicalized and technological approaches to childbirth took precedence and has had to be reintroduced to maternity care. Yet 27 years on from Kennell *et al.*'s ground-breaking research it is still not mainstream practice in the UK for women to be accompanied in labour by a known and trusted midwife (NMR 2016).

Women's autonomy is bound by the forms of knowledge they can use to inform their decision-making. Often within mainstream maternity services the concept of choice and autonomy is limited by the small number of options they offer to women which are deemed acceptable. Women are strongly encouraged to comply with the authoritative knowledge of the medical profession and to disregard their own embodied and experiential knowledge (Denbow 2015). Jordan (2014) however has observed that women have an inner knowing about their bodies which is very reliable. Her studies have shown that women know when they are pregnant, without the need for a pregnancy test and in cases of state-ordered caesarean section, women who insisted that this was not a necessary procedure were proven to be right in retrospect. The participants talked about honouring their clients' decision-making and respecting the evidence they used to inform those decisions. Some of their clients spoke about listening and responding to what 'felt right' for them, using instinctive or intuitive knowledge (Section 4.7.4), rather than selecting from a number of research findings or guidelines the one that was most acceptable. Clients are viewed respectfully by the participants as individuals who competently live their lives in a way that suits their needs, freely making decisions everyday about issues that impact on them. The midwives believe that their clients should continue to make important decisions that affect their lives and be responsible for decisions made about their care. When women can incorporate their own knowledge into their decision-making the real benefits of individualized care can be reaped (Tracy *et al.* 2013). Women should not have to justify the validity of the evidence they choose to use, because they are legally entitled to be autonomous, however women do need to understand that in exercising their autonomy they also need to take responsibility for the

decisions they make. This is a challenge within a blame-based culture where somebody must be at fault when adverse situations arise and women understandably do not want to be blamed if things do not go as planned.

Milan (2005) reports that many women who book with Independent Midwives are seeking control over their care. The midwives take the principle that women's rights to make decisions are absolute (Sections 4.2.5; 4.7.5 and 4.8.3), even if on rare occasions those decisions endanger the women or their babies (Symon *et al.* 2010). Holten and de Miranda (2016) find that women with existing complications, who choose to go outside the 'system', to freebirth or to have homebirths, desire high levels of autonomy and take full responsibility for the outcomes of their decisions, good or bad. Brione (2015) maintains that the right to proper autonomous decision-making for competent adults must be protected, even if it results in the death of some babies. During acute events where the woman chooses not to accept recommendations or interventions the midwives maintain their support and ensure the woman has ongoing information as her situation changes (Section 4.2.5). They do not abandon the woman, in contrast to the findings by Jenkinson *et al.* (2017) which gives accounts of both doctors and midwives withdrawing care from women who had declined treatment.

The importance of incorporating women's risk tolerance into care planning was highlighted by the participants who discussed the different perceptions women have of what they consider to be risks (Section 4.7.5). This approach is supported by Brione (2015) who finds that women's autonomy must be respected through the incorporation of their life values and attitudes to risk into discussions about their options and decisions. It is crucial that women understand that life cannot be risk-free and that they manage risk every day: when choosing what they eat, which forms of transport they use or how they exercise (Lothian 2012) – the examples are endless. For some women hospitals are perceived to pose a threat to their safety and for others, hospitals are the haven they are seeking to ensure healthy outcomes. Place of birth does not guarantee the outcome desired by a woman but being in a place where she feels safe and calm is more likely to result in a safe and positive birth experience (Huber and Sandall 2007), wherever that is, reinforcing the need for women's autonomy to be respected.

For many women the integrity of their physical and mental health is of paramount importance, and they will make decisions to safeguard themselves (Section 4.5.5). Hill (2017) supports these findings, stating that simply being alive after the birth is not enough, women

need to feel physically and psychologically healthy. For maternity services the focus is on the most basic of outcomes - the avoidance of mortality - whilst morbidity, especially relating to women, is a seemingly accepted consequence of the interventions intended to avoid mortality (Lothian 2012). Women commonly endure surgical interventions such as episiotomy and caesarean section, with the associated risks of haemorrhage and infection, for foetal benefit (Jenkinson *et al.* 2017) and for them birth can be a traumatising event, physically and psychologically. Being mentally healthy is key to being effective parents (Lovejoy *et al.* 2000; Kavanaugh *et al.* 2006) and is a clear aim of the Independent Midwives (Section 4.5.3), who focus on ensuring that the pregnancy and birth are experienced as positive life events which enable the mother to care for and nurture her baby successfully. Maternity services are accused of trivialising women's experiences of childbirth and focusing on short-term outcomes, and not acknowledging long-term harm that can result from care (Wendland 2007). Women have been criticized for wanting a positive birth experience and denounced as selfish (Kitzinger 2006), but this only shows a lack of understanding about how poor experiences affect women's ability to be effective parents. Negative birth experiences and psychological trauma are reported to be linked with postnatal mental health problems (Ayers 2017), which are in turn linked to long-term negative effects on infant health and development (Hay *et al.* 2001; Field 2011). Women's experiences must thus be prioritized in order to promote maternal and infant wellbeing.

Midwives working in the NHS usually have competing interests they have to fulfil when gaining informed consent from women, such as compliance with medical protocols and the ethos of the unit in which they work. Hindley and Thomson (2005) comment that consequently the concept of informed consent becomes a catchphrase and is rarely translated into practice. The participants discuss in detail how they are unwavering in their beliefs about women's ultimate right to decision-making and how professional freedom as independent practitioners enables them to support women's autonomy (Section 4.2.2 and 4.2.5). Boyle *et al.* (2016) describe how women want to have personalized care but despite the political support for relational, woman-centred care, women do not experience a relationship with their midwife which then facilitates individualized care through informed decision-making. Powell Kennedy *et al.* (2010) however report that in an attempt to normalize birth, the women in their study had the final choice about their birth care, which was respected by staff, although they gave no examples of choices which may have jeopardized the health of the mother or baby and how well those decisions were upheld. As independent practitioners the participants have no such dilemmas: their professional

responsibility is to ensure women have the information they want and need to make decisions. They spend time in discussion with women, ensuring they understand the issue at hand and the related information, thus facilitating choice and informed consent.

Notions of shared decision-making are common in the midwifery literature (Davies *et al.* 2009; Freeman *et al.* 2004; Murray *et al.* 2006), however they were strongly refuted by the participants who maintain that women cannot exercise their autonomy if they have to make shared decisions, which inevitably are compromises and the result of negotiation between the two parties. It may well be the case that the midwife agrees with the woman's choices, but this is not a necessary component of the decision-making process. The midwives are not giving permission or sanctioning decisions – the women are free to make whichever decisions they choose, providing they are competent adults. Daemers *et al.* (2017) report that there is variation in the extent to which midwives involve women in the decision-making process, with some offering women real choice and others using clinical guidelines to direct women's decisions. Women's choices are supported whilst they fall within the guidelines, but midwives are less willing to facilitate them if they fall outside the guidelines. Midwives working across NHS Trusts can be conflicted because of variations in local policies and guidelines, which does raise questions about the quality of evidence that such documents are based on. Some midwives describe how they incorporate their knowledge of the woman into ways to support her decision-making and this may explain the variations seen in practice, with some midwives providing continuity of care and being able to develop relationships whilst others provide fragmented care and do not have the opportunity to form relationships with women which negatively influences how they facilitate decision-making. Noseworthy *et al.* (2013) propose a model of decision-making which fits within the context of the mother-midwife relationship, emphasising the personal, interpersonal, social and political factors which influence the process. This model more closely reflects how Independent Midwives help their clients to inform themselves and plan care which fulfils their individual needs.

OBoyle (2013) discusses how the statutory requirement for midwives to have indemnification compromises women's autonomy. This is most clearly seen in practice outside national health services where insurance providers place restrictions on midwives working independently, by applying exclusions for cases such as a breech or vaginal birth at home after caesarean section. Being unable to have care from their chosen midwife results in some women having only one choice left and that is to birth alone. The midwives then face a real dilemma, do they break the law and provide care, do they abide by the law and

leave a woman without the care she wants and needs, or do they stop supporting women's autonomy and force them to make choices dictated by indemnification requirements?

5.2.3 Quality of life

Professional autonomy has a positive effect on quality of life, according to the participants, a finding which concurs with the evidence presented in Section 2.6.5, with many of them commenting on how job satisfaction and work-life balance was improved once they practised independently (Section 4.2.6). Since there are no fixed work patterns the midwives are able to be flexible in when they plan routine appointments with women, fitting in with their personal commitments such as childcare. Whilst the unscheduled work of attending women in labour is largely unpredictable, the midwives talked about the joy they experience when setting off, even in the middle of the night, to support a woman with whom they have developed a close relationship. Gilkison *et al.* (2015) found that this passion for midwifery is in part what sustains midwives. A recent blog by Jacqui Tomkins, Independent Midwife and Chair of IMUK (Birthrights 2017) illustrates this attitude perfectly.

"I became an independent midwife almost 20 years ago. It has been an overwhelming joy to be able to determine my own volume of work and to work with women and families that I can take the time to listen to and get to know very well. This has also been hugely beneficial for my family who know that I will be at most of the big family events we want to share but if I do have to miss the occasional celebration they are to be found helping me pack the car in an excited state as I get ready to help another family welcome in their newest family member".

Satisfaction with working in the way they choose was seen as a very positive benefit of practising independently and was a motivator for its continuance. Developing close, trusting relationships with their clients was described as a particular source of pleasure and job satisfaction (Section 4.2.6). which was cited in this PhD study by the participants as another reason for leaving their NHS jobs. They discussed how they made the conscious decision to address concerns they had about practice and took more control of their professional lives by working independently (Section 4.2.1). They talked about seeing the disappearance of continuity of care within the NHS, having less time to care for women and realizing that they could only work in the way they felt best served women if they became self-employed.

Whilst working independently brings the benefit of many professional freedoms it also presents challenges to the midwives; both occupational and personal (Section 4.2.6). The

unpredictable nature of their working hours and the sometimes long working patterns are potential causes of burnout in health professionals (Dykes 2009; Yoshida and Sandall 2013) but these are not viewed by the participants as barriers to working independently. It seems that when an individual makes a decision to work in this way these factors do not become negative stressors, and that they are able to cope with the challenges. However, if such conditions are imposed on them it is likely that they do become sources of tension or anxiety (Mollart *et al.* 2013). This way of viewing work links with a salutogenic approach to life. Salutogenesis is a theory of health promotion, put forward by Antonovsky in 1979, in which people can manage their lives positively and remain healthy when they are able to understand their circumstances as being consistent and predictable, when they feel they can cope with those circumstances, when life makes sense and when the challenges they face are worthy of commitment (Eriksson and Lindstrom 2006). The concept is explored further in Section 5.6.6. The participants talked about their commitment to their clients, wanting to make a positive difference to them, and how this is a real motivator for working independently (Section 4.2.1). These findings are supported by Learner (2004) and Francis and van der Kooy (2005) who have written about their experiences of working as Independent Midwives. The relationship built between the women and midwives adds to this sense of commitment - wanting to be there for someone they know and care about. The evidence about burnout in midwifery has highlighted how having relationships with their clients has positive effects on midwives' health, protecting them from feelings of stress and being overwhelmed (Yoshida and Sandall 2013; Newton 2014; Henriksen and Lukasse 2016). A good quality of life, in part, makes independent practice a viable option. Donald *et al.* (2014) report that the midwives in their study needed to make conscious efforts to ensure that they were able to maintain a good work-life balance when caseloading, by individually creating innovative ways of practising which facilitated sustainability. Their strategies included creating trusting and supportive collegial relationships and having a shared philosophy with their peers.

Having good collegial support was emphasized as a vital element in being able to work independently and without it the participants doubted whether they could continue to practise (Section 4.2.7). It has been identified in the research relating to bullying within midwifery, as a factor which sustains midwives in practice (Curtis *et al.* 2006a; Kirkham 2007). Conversely, a lack of support from colleagues leads to stress and a consequential decrease in the quality of care provided, which compromises the safety of women and babies (Yoshida and Sandall 2013). So, building positively supportive, collegial relationships enables

midwives to practise effectively, safely and sustainably, to the benefit of women and their babies. These professional relationships are also key to providing high-quality clinical support. The participants talked about working with colleagues they know and trust, and with whom there was philosophical alignment. They believe that these relationships are beneficial and enhance the care they provide (Section 4.2.7). These findings correspond with those of Moore (2009) and Gilkison *et al.* (2015) who both identify peer support as a key component of successful midwifery practice. In addition to providing clinical support to each other the participants reflected on the value they place in their colleagues as sources of knowledge and skills. They will seek advice or guidance from colleagues when they encounter unusual clinical situations (Section 4.2.7) an observation also made by Kacary (2005) and Garratt (2014).

5.3 Professional autonomy discussion summary

Choosing to work in a self-employed capacity enables Independent Midwives to have high levels of professional autonomy which enables them to practise in ways which are beneficial to both the women they serve and themselves. They are able to determine the model of midwifery they use and how they work on a day-to-day basis. Continuity of care is the preferred model of care because, in the context of a trusting relationship, it confers benefits on both mother and midwife. Women experience fewer medical interventions and have more positive outcomes compared with those receiving fragmented care, and for midwives, having professional autonomy is associated with sustainable practice and lower levels of work-related stress and mental or physical illness. Their professional autonomy is used to support the development of their practice. New evidence can quickly be incorporated into practice, enhancing the service they provide. Well-evidenced practices such as the comprehensive provision of postnatal care, which has been devalued and reduced to a minimal service by mainstream maternity care providers, are delivered with the conviction that the intervention is indeed beneficial to women and babies. Working independently of an employing organization allows Independent Midwives to fully support their clients' autonomy and not be conflicted by NHS Trust guidelines and policies, or employment obligations. They are able to incorporate women's choices into care, facilitating a truly individualized approach. Peer support plays a crucial role in facilitating this way of practising, through the provision of clinical backing and partnership working, and emotional and psychological support. The midwives are free to arrange this support as they see fit.

5.4 Time

Time was underlined in the findings chapter as a vital issue in providing independent midwifery care and relates to the time allocated by the midwives to personal contact with their clients, and the time the midwives spend developing their skills and knowledge (Sections 4.4.1 and 4.4.2). Time is seen by the participants as a key enabler for being able to provide responsive, high-quality care, for creating mutually trusting relationships and facilitating individualized care through discussion and support of women's autonomy.

The use of the word 'commercial' describes the current values of the NHS, which now focuses on cost, efficiencies and productivity, as discussed in Section 2.7.3. Whilst this may be fitting in the production of inanimate objects it fails to provide an appropriate service for human beings, at a time which is pivotal in their lives (Pilley Edwards 2005). Running small businesses and providing a fee-paying service could see independent midwifery labelled as a commercial model of midwifery, they however eschew this concept. It is the values of these midwives which differentiates their care from that of the NHS and other health providers. Their practice is not based on time or economic efficiencies associated with the commercial model, but focuses rather on helping women achieve positive outcomes (Milan 2005; Garratt 2014). Their practice is rooted in the relationships they form with women and the principle of placing women at the centre of care. They almost entirely work in women's homes, at a time of mutual convenience taking as much time as is needed to fulfil the woman's needs. Because their time is not limited by shift patterns they are free to work as long as they need. Providing relational continuity of care means that they can address issues over a number of appointments and the need to complete tasks on a given day is not such a concern.

In what might seem to be the antithesis to a successful business strategy, the midwives will curb their income, by limiting the size of their caseload, to ensure they have the time and capacity to provide the highest levels of care (Section 4.2.1). This approach is supported by Garratt's (2014) study of Independent Midwives. Having too many clients compromises the time that can be spent with each woman and consequently affects the quality of care being provided and makes the work unsustainable for midwives (Sandall 1997). A large caseload potentially reduces the continuity of care some clients receive because the midwife may be busy with one woman when another requires her attendance. My personal experience of working in this way is that with a caseload of three to four women due in any one month, and working in partnership with another midwife, the women's continuity of care is not compromised. The participants aspire to providing very high levels of continuity (Section

4.2.2), and usually work in partnerships so that their clients are rarely attended by an unknown midwife. The generous allocation of time is a pre-requisite to being able to provide this type of care.

5.4.1 Concepts of time

The participants did not talk specifically about concepts of time, however the data generated from their interviews revealed a use of time that is largely unconstrained by clock time (Section 4.4.1) and thus differs from mainstream midwifery. As discussed in Section 2.7.1, cultures can be described as being either monochronic or polychronic in nature. These two orientations are evident within the context of contemporary maternity services with hospital-based midwifery having a more monochronic time culture and independent midwifery a more polychronic culture (Section 4.4.1). This dichotomous classification is of course over simplistic and individual variations will exist. It is likely that communication between people who know each other well - friends and family - will be high-context in both cultures, with common experiences resulting in an unspoken understanding.

The Independent Midwives' concept of time, in keeping with polychronic orientation, follows biological patterns of time, and affects the way they perceive the pregnancy continuum (Section 2.7.1), this finding is in concurrence with Winter (2002). Pregnancy is not rushed, and in the absence of pathology, natural variations in the length of pregnancy are recognized. Women are not pressured to consent to induction of labour just because they are nearing or have reached a particular date. The unique biological cycles and processes of individual women are accepted and respected and the passage of time itself is not seen as a risk (Section 4.8.1). This links to the concept of 'slow midwifery' in which an adherence to clock time is viewed as disruptive to mother-midwife relationships, and perhaps more significantly, to the mother's physiology. In suggesting the adoption of slow midwifery, Brown and Chandra (2008) promote the development of deeper connections with women and a greater confidence in women's physiology. The pregnancy continuum within Western culture is set against a ticking clock, with faster being deemed better than slower, and with induction for prolonged pregnancy and augmentation of slow labour being commonplace. Millard (1990) contends that the clock has become a symbol of science and discipline, and thus it can be argued by extension that, to not be bound by time is to be unscientific and undisciplined. One participant described how when transferring a labouring woman into hospital, the staff there were unable to understand why routine timeframes were not adhered to, by the midwife or her client (Section 4.4.1). When transferring care, the participant had reported

that their client had been in labour for two days and now wanted medical intervention. This long period of time spent in labour was not acceptable to the NHS staff who follow time-based guidelines for caring for women in labour, even though both mother and baby were well. It is of note that according to Miller *et al.* (2015), women who are able to ‘take their time’ in labour have significantly higher odds of having a vaginal birth.

The use of routine interventions disregards the ebb and flow of the individual woman’s physiology. Whilst in the case of induction of labour for prolonged pregnancy there is evidence to show that there is a small increased risk of foetal death after 42 weeks gestation (Weiss *et al.* 2014), it has been observed that many inductions of labour are taking place before that time, at 40 and 41 weeks (Dekker 2016), when perhaps it is assumed that less time being pregnant is advantageous and that there are no detrimental effects to intervening. The slow movement centres on quality, not quantity. It does not advocate that we do everything slowly, for there are times when swift action is appropriate, but that the speed of work is balanced to meet people’s needs. Along with a slower pace of midwifery the Independent Midwives tend to have a ‘low-tech’ approach, which reflects their beliefs in the normality of the pregnancy continuum, focusing on health, not pathology. Putting their beliefs about pregnancy aside, it would be impractical and financially prohibitive to have hi-tech equipment such as that used within hospitals. They do however enable women to have access to medical services, as required, for example for ultrasound scanning or assessment of maternal or foetal wellbeing. The picture being drawn of Independent Midwives is perhaps of a traditional and even old-fashioned group, making them appear stuck in the past and resistant to change or advances in healthcare. However, since the UK government (Maternity Safety Programme Team 2016) clearly promotes individualized, woman-centred, continuity of care, in the context of a trusting relationship, and is encouraging the promotion of alternatives to hospital births as a way of achieving safer birth, it is possible to see that independent midwifery practice is situated both in the past and the future of midwifery. Government policy may even be seen as a vindication of their long-established practice.

5.4.2 Appointment time

The findings from this study, which demonstrate how the participants use their time (Sections 4.4.1 and 4.4.2), echo bygone eras of midwifery, where the focus was on fulfilling the needs of the women. The participants described how appointments usually last longer than an hour, the rationale for which is not based on evidence but on what feels right. Appointment length is not rigid, the midwives are responsive to the women’s needs, and will

take more time when required and occasionally less when women are confident and comfortable with the care they are receiving and ask for shorter appointments (Section 4.4.1). These findings support those of Winter (2002) and Garratt (2014) who have both researched aspects of independent midwifery practice. The participants contrasted this situation with working in the NHS and how it had not been possible to spend much time with each woman, usually no more than 15 minutes, describing how a tick-box approach was often necessary to keep to the schedule (Section 4.4.1). They reported that the demands of NHS timeframes dominated and subverted the requirements of the women, preventing them from giving good-quality care or developing trusting relationships with women. Deery (2008) in her action research study found that when time is limited, non-clinical aspects of work take priority over care given to women and babies, resulting in lower quality care. Wieggers (2007) and Warmelink *et al.* (2015) also identified lack of time as being a factor associated with reduced quality of care. When there is insufficient time to care important physical and psychological issues can be missed, opportunities to promote health are lost and women are discouraged from raising concerns or being active participants in their care. Symons *et al.* (2019) have also identified lack of time as a major issue in clinical practice, reporting that it impacts on achieving individualized care and the provision of public health measures, such as breastfeeding information, which have implications for women and babies health.

Searching for information about the use of time in midwifery, or the length of appointments, revealed very little specific evidence about how or why appointments are currently scheduled. As a midwife who has experience of midwifery within the NHS I know that appointments are routinely scheduled to be 15 minutes long and yet this is not evident within the literature. Whilst references to time are not uncommon within midwifery literature they generally discuss the lack of time experienced by women and midwives in abstract terms. Women report that they would like more time with their midwives (NMR 2016c) and yet no specific details are given about how much time they do have and how much more they would like. Midwives describe not having enough time to provide good care to women and babies (RCM 2016c) and yet there is no quantification of what that time is. Exploration of the NHS website reveals detailed information about the schedule of care during pregnancy: which weeks appointments are held, and which tests or procedures will be offered, but provides no guidance on how long these appointments can be expected to last. In consultation with women, *Better Births* recommends the implementation of a relational continuity of care model of midwifery throughout England and the provision of an extra ten minutes for

antenatal and postnatal appointments. Whilst this will potentially be a positive step, it is surprising that this proposed increase is not put into context with the current situation. How much more time does ten minutes, in percentage terms, represent, how was this figure reached and what is the purpose of this extra time? Johnsen (2015) recognizes the importance of time in midwifery practice and highlights that recent reforms of maternity services across Europe, with increased standardization of care and links to institutional efficiency, has resulted in practice that is more likely to meet the needs of the institution than those of the women. More of the midwives' time is spent on completing tasks and administrative duties than caring for women and babies. Whilst their participants described not having enough time to provide adequate care for women this again was not quantified. From Johnsen's study it appears that the demands of the institution take precedence over the needs of the women, and with increasing amounts of non-clinical work for midwives, having more time per se may not benefit women. Ring-fencing midwives' clinical time or employing administrative staff to undertake non-clinical tasks may be the only way to ensure women receive the care they need and want. The Francis Report (2013) highlighted the devastating effects of failing to put patients first, strongly criticizing the Mid Staffordshire NHS Foundation for placing the needs of the institution ahead of those of their patients. A major recommendation of the Francis Report was to make patients the first priority in all that the NHS, and other health care organizations, do.

Wiegers' ongoing research into the workload of Dutch primary care midwives (Wiegers 2007; Wiegers *et al.* 2014) is the only midwifery evidence found that specified the amount of time spent with women during appointments. Wiegers *et al.* (2014) have found that since 2001 midwives are working longer hours with more time spent on non-client related activities. This finding supports the conclusions of Johnsen (2015) that midwives are increasingly spending time involved in non-clinical work. The study by Wiegers *et al.* (2014) reveals that on average the midwives spend 19 minutes per antenatal appointment. In real terms the amount of time they spend with women has increased but, as a proportion of their workload, time with women has decreased. It is not clear whether patient needs drive this allocation of time or whether workload is the primary determinant.

Stapleton *et al.* (2002) report that, because of their time-pressured agenda, NHS midwives adopt a strategy of manipulating communication during appointments, which discourages women from asking questions. In doing so women are denied the opportunity to discuss issues of importance, which is likely to impact informed decision-making, and consequently disempower the women, and result in care which is less safe and leads to poorer outcomes

for women and babies. This contrasts starkly with the Independent Midwives' practice which is embedded in effective communication (Section 4.4.1) and where women are actively encouraged to participate in discussions and contribute knowledge they have about relevant issues. An observation made originally by Hart (1971) is that educated and affluent women get more time during clinical consultations, than those who are less advantaged. Less advantaged women are already more likely to experience poor health and pregnancy outcomes and this further widens those inequalities. This observation has also been discussed by Kirkham *et al.* (2002b) who describe how midwives stereotype women. Materially deprived women are assumed to have lower literacy levels and desire for information and thus are given fewer explanations and time for discussion than articulate, middle class women, which has a direct and negative impact on their care. These findings are however refuted by Deveugele *et al.* (2002) in their cross-sectional study of general practice, in six European countries. Their study of over 3500 cases found that neither patients' educational nor social status affect appointment duration. The video-taping of consultations may however have altered how the doctors interacted with their patients, potentially making them more attentive than when not being recorded.

Although there is limited data to determine the optimal duration for clinical appointments (Wagenaar *et al.* 2016; Ahmad *et al.* 2017), general practice research demonstrates that longer consultations are associated with better patient outcomes, greater attention to psychosocial issues, fewer prescriptions, greater patient compliance and increased patient satisfaction (Freeman *et al.* 2002; Wilson and Childs 2002). These studies show that general practitioners have also experienced a diminution in consultation times, and as a consequence have focused on how to improve the content quality of the consultation, by undertaking training in effective communication skills (Dugdale 1999; Ogden *et al.* 2004). This is an approach which could be adopted by the midwifery profession, considering that midwives' response to a lack of time is to restrict communication. Wagenaar *et al.* (2016) found that shorter appointments are associated with less history taking and public health discussions, and Hopkins' (1973) germinal work on GPs and consultation times found that short appointments enabled the practitioner to identify only very obvious health problems whilst more subtle conditions could be left undetected and undiagnosed.

Birthrate (Ball 1992) is a well-validated tool for helping maternity services establish safe midwifery staffing levels (Walsh 2007a). The authors of Birthrate Plus (Ball and Washbrook 1996) assessed that midwives working in a caseload model need 38 hours per case for women with uncomplicated pregnancies and 43 hours for those with complications.

However, these recommendations have not been adopted across the NHS. Few midwives work in caseloading models (NMR 2016; Sandall *et al.* 2015) and those providing antenatal and postnatal care commonly work on the basis of 15 minutes per appointment, as described by the participants (Section 4.4.1). How can trusting relationships be built and maintained in such a short time, particularly when it will be a rarity that the same midwife provides all the woman's appointments? The reduction in antenatal and postnatal appointments over the past two decades has resulted in many women having little time with their midwives, and on fewer occasions. Women report that they feel NHS postnatal care is inadequate and poorly resourced, with women on average having 3.1 appointments with a midwife (NMR 2016).

The British Medical Association (BMA) recently published *Safe working in general practice* (BMA 2016), a report calling for an increase in GP appointment time from 10 to 15 minutes per patient. Whilst their rationale is that the increase will enable doctors to ensure the provision of safe, high-quality care, the proposed 50 per cent increase is not supported by any evidence. As Wagenaar *et al.* (2016) state, there is no evidence about what the optimal amount of time required for consultations is. Appointment length appears to be based solely on the simple mathematical calculation of how many hours a general practitioner is paid for, divided by the number of patients they are required to see, with no consideration of the individual needs of patients and this situation is clearly reflected within mainstream midwifery practice.

Vedam *et al.* (2017) have shown the importance time plays in women's autonomy: their sense of agency and their ability to make informed decisions. In their study a tool was developed and validated by women using the maternity service, which assessed their experience of decision-making in maternity care. Longer appointments were associated with increased levels of autonomy and involvement in making decisions. The study highlighted that women need time to consider information about their care and to discuss their options before weighing up the best choice for them. This research, frustratingly, did not accurately quantify the amounts of time they were referring to. Short appointments were defined as less than 15 minutes in duration whilst longer appointments could be anywhere between 15-65 minutes. Time however is not the only factor involved here, healthcare professionals need to have the willingness to engage in discussions with women, rather than being prescriptive, and to respect women's right to make decisions, as well as upholding the decisions women finally make. Women's decision-making will be explored further in Section 5.8.5. Hernan (1993) found that it is not time per se which is important in consultations but

the quality of that time. Hernan showed that women attending antenatal clinic wanted to be treated like human beings, not objects which need processing, and wanted time to discuss concerns or other issues of relevance. It seems that little has changed over the last three decades, as these findings are supported by more contemporary studies in which women talk about their dissatisfaction with production line maternity care (Hunt and Symonds 1995; Walsh 2007b; Dykes 2009; NMR 2016).

5.4.3 Time and power

Lack of time and the resulting dissatisfaction with the quality of care provided are two crucial factors cited by midwives for choosing to leave the profession. All the participants spoke about the importance of being able to determine the amount of time they spend with their clients (Sections 4.2.1; 4.2.2 and 4.4.1). Having time to provide effective care is vital to midwifery practice (Ball *et al.* 2002; NMR 2016). Both these studies have explored the issue of time with midwives in depth and despite a 14-year gap between the research, little has changed. It is interesting that this situation does not go unnoticed by women, who often sympathize with their midwives because of the temporal pressures they experience but see them as an oppressed group within maternity services (Kirkham and Stapleton 2001; Stapleton *et al.* 2002; Dykes 2009). There is an irony that *The Code* (NMC 2018) emphasizes the crucial role of midwives in empowering women, and midwifery literature (Fahy 2002; Lukasse and Pajalic 2015) frequently discusses the idea of midwives empowering women, without any in-depth analysis of how this works. How is one oppressed group realistically able to empower another? Kirkham (1999) has long since highlighted the necessity for midwives' empowerment if they are to be able to help women achieve enfranchisement. Dahlberg and Aune (2013) explain that relational continuity of care gives midwives the opportunity to provide care in a holistic manner, resulting in personal growth for the woman in relation to pregnancy and birth, which in turn promotes her empowerment. Whether it is even possible for one person to empower another is a discussion beyond the scope of this thesis.

Time and how midwives use it is closely linked with professional autonomy (Jepsen *et al.* 2016). Hunter *et al.* (2015) conducted a small qualitative study which evaluated midwifery practice on a single postnatal ward, finding that midwives have little control over the time and space in which they practise, negatively impinging on their ability to effectively support breastfeeding. This paper clearly demonstrates a link between working conditions, specifically how midwives use their time, and their professional autonomy. The Independent

Midwives' choice to have long appointment times reflects their high degree of professional autonomy (Sections 4.2.1 and 4.4.1). They have identified time as being crucial to providing effective care and have thus incorporated it into their practice; there are no organizational controls or demands on their time.

5.4.4 Caseloading time

In their practice Independent Midwives adopt aspects of a polychronic orientation to time, with appointments occurring when needed and taking as long as necessary (Section 4.4.1). Although some appointments are scheduled, their duration is adaptable; other visits will be in response to issues arising on the day and may therefore occur outside of what is conventionally considered to be normal working hours, i.e. the 9-to-5 work pattern. Time is used flexibly to meet the needs of both the women and the midwives. This adaptation to an alternative concept of time has also been observed in employed midwives using a caseloading model of midwifery (Sidebotham *et al.* 2015; Newton *et al.* 2016), where it became clear that a different way of working to hospital-based midwifery was required, because the model is orientated to women's needs and responding to those needs as and when they occur. Walsh (2007b) has concluded that shift work is not appropriate for midwives working in a caseloading model.

Being the primary midwife for a woman and not working shift patterns means that caseloading midwives have no fixed end point to their work and no-one they need to hand care over to and as such, tasks or discussions can be rolled over to another day: time is more fluid. As described by Choucri (2012), time in continuity of care is cyclical. Midwives working in a caseloading model visit the same woman again and again, providing care which has a less restrictive feel to it. Since the model is based on the relationships built between mothers and midwives it needs to be acknowledged that time is also required to establish and maintain that connection (Baas *et al.* 2015; Sidebotham *et al.* 2015). This is an area Choucri (2012) highlights as being affected by time poverty, to the detriment of women and midwives, and reflects the low priority afforded to mother-midwife relationships in mainstream maternity care. Longer consultation times within independent midwifery practice are used for the psychosocial aspects of care: developing trusting relationships, getting to know the context of the woman's life and discussing issues of importance, this is discussed further in Section 5.6.4. Milan (2005) surprisingly talked about the 'luxury of time' in her research of independent midwifery practice and yet time is anything but a luxury: it is a necessity. As a practising Independent Midwife, she would have been all too aware of the

essential need to have enough time to form trusting relationships and provide effective care to women and their families. Language is all important when trying to convey meaning and using the term 'luxury of time' could be misinterpreted by some as being non-essential and thus dispensable.

As found in Section 4.4.1 the development of a trusting relationship is time dependent. The participants allocate considerable amounts of time to getting to know their clients and developing trusting relationships. People who have little time cannot relate well with others (Kirkham 2010). Van der Kooy (2009, p.524) states that time in midwifery care is, 'key and there can be no shortcuts without compromising quality of care.' The allocation of time for this purpose demonstrates respect for the woman and tells her that she is worth investing time in and getting to know, which can greatly increase her confidence (Carolan and Hodnett 2007; Newton *et al.* 2016). A lack of time leads to superficial interactions which impacts on information exchange, informed choice and ultimately safety (Pillely Edwards 2005). Newton *et al.* (2016) report that time spent getting to know women reaps many rewards, by enabling them to jointly develop care plans and prepare for birth and parenthood. Newton *et al.* (2016) also demonstrate that midwives are able to identify complications earlier when they have formed trusting relationships and thus reduce the need for medical interventions. This was discussed in Sections 4.5.1 and 4.7.3. Time invested in the relationship benefits both mother and midwife as care can be individualized and over the course of the pregnancy continuum the midwives are able to see the effects of that care, which enables them to improve their practice and to gain in confidence (Stevens 2011). Boyle *et al.* (2016) assert that time is a significant factor in forming relationships and being able to establish an emotional bond. Carolan and Hodnett (2007) argue that finding out who a woman really is and what she wants from her care is time consuming and that sharing information which builds trust is also time consuming, and so provision needs to be made for this within relational continuity of care models. Finlay and Sandall (2009) describe how midwives adopt a detached attitude to work and focus on completing tasks and meeting the needs of the institution when time constraints exist. In these circumstances women are not given the opportunity to form relationships. Low staffing levels are also a barrier to building relationships as this creates time constraints (Carolan and Hodnett 2007).

5.4.5 Quality of time

The participants described their appointments as having a different quality about them, time in which to fully discuss issues of importance, time to focus and be present with the woman,

time to relax, time for the woman to feel able to talk and be listened to (Section 4.4.1), which are not dissimilar to the conditions required for successful interviewing (Section 3.5.2). It is interesting to note that researchers are fully cognisant of the effects that the environment and the atmosphere have on participants and strive to achieve favourable conditions for interviews (King and Horrocks 2010; Herzog 2012) and yet this is not a consideration for consultations in mainstream midwifery. Waiting times, in clinics and hospitals, are also a significant barrier to the effective delivery of antenatal care, with an inverse relationship being described between waiting times and women's satisfaction (Wagenaar *et al.* 2016; Ahmad *et al.* 2017). However, this is rarely an issue in independent midwifery practice, with visits being conducted in women's homes and the midwives having enough time to schedule appointments realistically (Section 4.4.1).

A number of the participants talked about how for some appointments there may be no measurable outputs, they may not have undertaken any clinical observations or measurements (Section 4.4.1), but in spending time with the woman, talking, they have moved closer to establishing a trusting relationship, which in itself confers benefits to the woman and her baby (Sandall *et al.* 2015; Homer *et al.* 2017). This approach however, does not sit comfortably with the current NHS model of maternity care and its commercial basis. As previously discussed (Section 5.4.1), with commercialization comes measurement of productivity; people are expected to account for their time and demonstrate their productivity. Divergence from this task and time orientated approach can cause dissonance and conflict, especially when differing models interact (Walsh and Devane 2012). Such clashes are not restricted to just Independent Midwives; NHS community midwives and those midwives working in ways other than the mainstream, also experience judgement and misunderstanding of their practice and what they are aiming to achieve (Jepsen *et al.* 2016). Use of time relates to the culture you operate within, therefore there is not just a difference in how time is used, with it comes a difference in culture, which can result in misunderstanding and an incompatibility of approaches.

5.4.6 Time on-call

The amount of time the participants spend on-call was not viewed as problematic in this study. Interviewees felt that working independently in a caseloading model resulted in a better work-life balance compared to working for the NHS (Section 4.2.6). This contradicts the evidence from Collins *et al.* (2010) who report that caseloading midwives find the on-call commitment to be an onerous element of their working lives, negatively impacting their

private lives, and creating a barrier to the sustainable provision of relational continuity of care. The weight of the evidence demonstrates that caseloading is in fact a beneficial model of working for midwives (Newton *et al.* 2011; Jordan *et al.* 2013; Mollart *et al.* 2013; Yoshida and Sandall 2013; Crowther *et al.* 2016). Newton *et al.* (2016) found that over time, caseloading midwives were able to balance the advantages and disadvantages of that work model, helping them to rationalize the time they are committed to working. The support of the employer is however fundamental in caseloading and many schemes have failed because the midwives were required to cover staff shortages in the hospital as well as managing their caseload (Sandall 1997; Newton *et al.* 2016), which calls into question the value maternity services place on caseloading when hospital staffing issues take priority. Having the professional autonomy to choose to work in this way may help to explain the differences in the acceptability of caseloading to midwives (Jepsen *et al.* 2017). Independent Midwives have not been subjected to working in the caseloading model by a manager, they perceive the benefits of the model and make a free choice to practise in that way (Section 4.2.2).

The importance of knowing their clients was discussed by the participants in relation to time. The midwives described how establishing a relationship with their clients saved them time later because they knew the woman and her history, where she was and what her plans were for birth and parenting (Section 4.4.1). During unscheduled visits, such as labour or appointments for urgent issues, the participants valued having pre-existing knowledge of the woman and not having to repeat discussions the woman had already had. Knowing a client's plans and preferences for her birth meant not having to disturb her with questions during labour which saved time but more importantly enabled the midwives to support the woman's psychophysiology more effectively. Odent (2002) and Buckley (2009) have reported on the psychological and physiological processes of birth and how these can be disrupted by seemingly benign interventions such as talking. The participants also explained how they were infrequently called by women they knew, and if they were called it would be to attend labour or an acute situation which needed an immediate response (Section 4.4.1). Newton *et al.* (2016) also found that caseloading midwives are called, or are required to attend their clients less, compared with midwives providing on-call services for women they do not know.

5.4.7 Time and values

As a commodity, time, and its allocation are value-laden, reflecting the worth placed on an activity; with low-value activities having little time spent on them. In modern NHS maternity

care much time is allocated to technological interventions, which are highly valued by the medical model, and society in general, such as ultrasound scanning, whilst time spent in consultation with women, listening to them and engaging in conversations which build relationships, is minimized (Walsh 2007b). A dichotomy exists within NHS midwifery services: on the one hand, midwifery is said to be fundamentally based on relationships with women (Hunter *et al.* 2006; Kirkham 2010) and, on the other, midwives are denied the time to actually develop those relationships (Ball *et al.* 2002; Warmelink *et al.* 2015; RCM 2016c). Somewhere between the rhetoric and the service provision there has been a reprioritization of values, with tasks, time and money taking precedence over the creation and nurturing of human relationships, which has also been impacted by the systematic fragmentation of midwifery care (Dykes 2009). As a risk-averse institution, it is interesting that the NHS has not identified lack of time as a modifiable risk factor to women and babies and made efforts to minimize the effects of this threat.

5.4.8 Time to learn and inform

All the participants spoke about the considerable amounts of time they spend exploring the literature, updating themselves on professional issues and helping women to make sense of the evidence pertaining to their particular circumstances (Section 4.4.2). Without institutional policies and protocols to follow, it is important that Independent Midwives remain up-to-date in their knowledge of current evidence and as such they devote substantial time to exploring emerging research and studying relevant topics they may be unfamiliar with, such as rare medical conditions relating to their clients. Their close working relationships with independent colleagues facilitates the sharing of new knowledge and skills through informal discussions, their online forum and educational workshops, helping to ensure that they provide appropriate, high-quality contemporary care. This observation is supported by Kirkham (2016b) who tells us that close, supportive working relationships foster learning. Action research by Deery (2008) in one NHS Trust found that community midwives did not find time to invest in themselves as professionals through supervision meetings and clinical updating and that the Trust, despite having a policy requiring all staff to update their skills, did not provide the time for them to do so, thus placing women and babies' safety at risk. By taking a proactive stance to developing new knowledge Independent Midwives enhance the safety and individualization of care they provide. This they undertake voluntarily and at their own expense. The information they share with or signpost women to is similarly personalized, helping women to understand their own situations and to make decisions which feel appropriate to them. A recommendation from

both *Better Births and Best Start* for improving the quality of NHS maternity care, is for health professionals to be given sufficient time to participate in ongoing professional development.

5.5 Time discussion summary

Time is a key factor in providing safe and sustainable maternity care. Having sufficient time enables midwives to provide continuity of care and develop mutually trusting relationships with women, which result in improved physical and psychological outcomes for women and midwives. Adequate time facilitates women's participation in the planning and delivery of care which meets their individual needs and is also associated with improved outcomes. Having time to connect with women and provide high quality care are factors which improve staff retention and thus improve safety. Conversely, a lack of time is related to poorer quality of care and results in negative outcomes for women and babies. Midwives who leave the NHS cite a lack of time to provide high quality care and form relationships with the women they care for as a key factor in their decision. Independent Midwives allot substantial amounts of time to their professional development, a measure recommended for all maternity healthcare professionals by *Better Births*, which leads to improved care for women. Inadequate time is identified here as a significant, yet modifiable risk to women and babies.

5.6 Mother-centred care

This section discusses the elements of care involved in accommodating the individual needs of the mother and promoting and supporting health. The development of the category is designed to indicate the focus of the service on the mother rather than on those of the midwife, or a health organization.

5.6.1 Mother-midwife relationship

The formation of the mother-midwife relationship is identified by the participants as perhaps the essence of independent midwifery practice (Section 4.5.1). The definition of relational continuity (Section 1.5) aptly reflects the model used by the participants (Section 4.5.1). Relational continuity of care is characteristic of independent midwifery and the participants clearly described their experience of it (Sections 4.5.1); some work as the primary midwife for a caseload of clients, commonly working with another midwife to provide back up for each other and ensure that clients will be cared for by a midwife they have a relationship with, even if their primary midwife is unavailable. Others work in partnership with a colleague, sharing the caseload and providing equal amounts of care to their clients.

Working in these ways facilitates the development of meaningful, trusting relationships between them and their clients; a finding supported by Newton *et al.* (2016). Working in larger teams dilutes this effect (Todd 1998; Farquhar 2000) and, as women have reported, it is the quality of the relationship they value. Merely achieving familiarity with a midwife is seen as superficial and inadequate (Aune *et al.* 2011; Pilley Edwards 2005). Relational continuity of care is provided to women throughout the pregnancy continuum and is achieved through having an appropriately sized caseload which enables quality care to be delivered to all clients. This approach guarantees consistency of care, avoids the giving of conflicting information and enables a mutual understanding to develop between the midwife and the woman, as highlighted in several interviews (Section 4.5.1).

The notion of the relational continuity of care model presenting a risk to mothers (Section 2.8) was discussed by the participants. It was felt that as Independent Midwives are selected by their clients (Section 4.2.2), rather than being allocated, as is usual in NHS services, it is less likely that the midwives would be able to practise in a suboptimal manner because potential clients rely on the reputation of the midwife and the recommendations of other women when choosing who will provide their care. Independent midwifery clients are potentially more able to terminate their contracts with their midwives if they are dissatisfied with their care (Cronk 2010) and thus poor practice is likely to become visible. Working closely with colleagues provides opportunities for Independent Midwives to assess and compare their own practice and to identify areas needing development, helping to ensure high quality of care (Section 4.7.1).

Offering relational continuity of care means that the midwives must commit to being available to their clients by being on-call and by scheduling time off only when their clients are not due to birth (Hobbs 1998). This requires a structured approach to planning which periods of time the midwives will be available to work and deciding when new clients can be booked, in order to avoid bottle necks in care and the possibility of the midwife being away when a client births. Some Independent Midwives will take a month or more off at a time to balance the demands of their role (Hobbs 1998; Garratt 2014). Whilst there is structure in the large picture of how they work, their day-to-day work is flexible and subject to change, depending on the needs of their clients.

The plethora of evidence about relational continuity of midwifery care (Section 1.5) clearly demonstrates the many benefits it affords to women, babies and midwives (Waldenstrom and Turnbull 1998; Hodnett *et al.* 2013; Tracy *et al.* 2013; Sandall *et al.* 2015) and as such is

now considered best practice (Sandall *et al.* 2015). There however continues to be resistance to developing midwifery practice in the mainstream so that women receive continuity of care (Dove and Muir-Cochrane 2014). This resistance comes from those midwives who see it as a burdensome work form (Sidebotham *et al.* 2015) and managers who are faced with restructuring services to accommodate it (Catling and Homer 2016; Kirkham 2016a). NHS midwives report that the current way they work is stressful, unrewarding and unsustainable (RCM 2016c) and yet it appears that few are prepared to change to a system which, although it would involve embracing a new concept of working, would bring them professional autonomy and the control over their working lives that they are seeking. It would also bring real job satisfaction and improve the care they provide women, resulting in better outcomes for women and babies (Tracy *et al.* 2013; Sandall *et al.* 2015).

Some midwives question whether women really do want continuity of care, although this seems to reflect their own reticence about this way of working, given the large body of evidence to the contrary about women's experiences and opinions of maternity care, which supports their desire for relational continuity of care, in addition to the documented benefits conferred on women when they do receive such care (Sidebotham *et al.* 2015). Many independent midwifery clients book again with subsequent pregnancies because they are so satisfied with the care they received (Hobbs 1998). Foureur *et al.* (2009) have however observed that some midwives working in this model have begun to place limits on when and who they will provide care to, thus compromising the benefits of the model. It is clear that half-hearted delivery of the model will not result in all the benefits women and babies need. Those midwives who have experienced providing true relational continuity of care, like their independent colleagues, are better able to achieve a work life balance (Section 4.2.6), describing how their working day is more flexible, enabling them to still make their own families a priority whilst acknowledging that sometimes the needs of their clients means that they work late into the evening or during the night (Jepsen *et al.* 2016; Newton *et al.* 2016). Because they are autonomous practitioners, caseloading midwives are free to reschedule their work the following day, perhaps asking their colleague to undertake a routine appointment for them, to avoid becoming excessively tired (Newton *et al.* 2016).

5.6.2 Developing trusting relationships

The mother-midwife relationship is referred to in many papers, often without elucidating what is meant by it. Section 4.5.1 suggests that when the Independent Midwives refer to the relationship they are signifying one based on the development of mutual trust and

respect, in the context of mother-centred continuity of care. Within the current system of fragmented care, health service midwives will often talk about forming relationships with women, and being able to do this quickly, particularly in labour (Aune *et al.* 2014), but what they are really describing is establishing rapport. Relationships differ from rapport in their depth and substance, and whilst rapport is a positive element of interactions between women and midwives, it is superficial and does not result in the development of trust or create mutual knowing and understanding (Pillley Edwards 2005).

From the very beginning of their contact both the Independent Midwife and the woman assess each other to determine whether they feel they can work effectively together (Section 4.5.2). The consultation appointment is very important for getting a sense of the potential to form a reciprocally trusting relationship, because without it many of the benefits of having an Independent Midwife will be lost. A woman will often 'shop around' to find the midwife she feels will best meet her needs. The decision to work together is however a mutual one, coming after the shared exploration of ideas, values and beliefs. From this foundation the trusting relationship can evolve, however creating trust is a process and does not occur spontaneously (Lewis 2015). Getting to know each other and developing a mutual understanding is identified as important for trust to grow (Section 4.5.5). A positive first meeting is important for initial trust to be created and subsequent interactions give women the opportunity for that trust to be tested and developed, where appropriate (Lewis 2015). Pairman (1998) suggests that certain beliefs or philosophies need to be held by the midwife for a relationship to be formed and that the provision of continuity of care, where adequate time and a focus on the woman exist, is one of them.

Perhaps the reluctance to make the development of relationships a priority in mainstream midwifery care comes from a misunderstanding of their purpose. Perhaps the comfort and enjoyment of a relationship is all that is seen by onlookers and that this is judged to be a luxury with no significant benefits; one which can therefore be dispensed with. However, the purpose of developing trust is to assist women in achieving their goal of safe birth, in whatever way is appropriate (Lewis 2015). The participants emphasize the vital importance of developing trust with their clients (Section 4.5.1). Pillley Edwards (2005, p.186) argues that the connection between trust and safety is, 'profoundly and irrefutably tenacious.' Kirkham (2010) and Howarth *et al.* (2012) assert that the quality of the relationship is linked to quality of care. Safety is improved through the development of trust - a characteristic of high-quality relationships (Williams *et al.* 2010; Davison *et al.* 2015). The achievement of trust is likely to increase safety because women will work with their midwives towards safe

decisions and will feel confident to believe in and act on concerns raised by midwives (Pilley Edwards 2005; Leap 2010; Sandall *et al.* 2016). When trust exists, women are more likely to discuss sensitive issues, leading to safer care (Thorstensen 2000). This experience was highlighted by several participants who were cognisant of women's need to feel safe and able to trust their midwife before being able to confide intimate information (Section 4.5.1). According to Lundgren (2004) and Davies and Iredale (2006) mutual trust can enhance a woman's confidence and positively influence her capacity to birth spontaneously. Parratt and Fahy (2004) argue that trust enables women to have faith in the birth process and to let it take its course naturally, an observation reported by the participants (Section 4.5.1). A trusting relationship equips the midwife with in-depth knowledge and understanding of the woman's physical, psychological and social wellbeing which enables her to provide safer care (Section 4.5.1), an issue often not understood by midwives not working in continuity of care models (Sidebotham *et al.* 2015). Stevens (2011) observes that caseloading midwives are considered to have higher levels of competence because of the intimate knowledge they have of each woman in their care. Newton *et al.* (2016) comment that relationships contribute to positive outcomes through the provision of individualized care, being able to engage with women throughout the whole episode of care and enabling them to be active participants in planning care. Fragmented care prevents women from making meaningful relationships (Kirkham 2010) and is associated with safety concerns and poor-quality care according to the stillbirth and neonatal death charity, SANDS (2015).

To be able to develop trust a woman needs evidence for the trustworthiness of her midwife – how much does the midwife's practice reflect her stated beliefs? How well does the midwife support the woman's autonomy when there is dissonance between her choices and hospital protocols? Do their interactions constitute safe environments for the woman to disclose deeply personal information? The answers to such questions will enable a woman to determine whether trust can be placed in the midwife. A midwife has similar needs, she will want to feel that she knows the woman and can trust her – that what the woman is telling her is honest and accurate and reflects her beliefs and intentions (Section 4.5.1). It is important for midwives to be able to trust that their clients know what they want, what they need, and that they are able to remain as autonomous individuals (Thorstensen 2000), thus avoiding the midwife from slipping into an authoritarian role when there is divergence from the normal. Aune *et al.* (2014) and Dahlberg and Aune (2013) describe how being mentally present and displaying interest and involvement in a woman's life can enhance trust, however this trust needs to be maintained and nurtured throughout the episode of care

(Lewis 2015). Sensitively listening to women and observing their responses to interactions contributes to the knowledge a midwife has about her client; who she is and what she needs, again enhancing the sense of trust between them (Sections 4.5.6; 4.7.3). The vital role of listening, in building knowledge and trust, is supported by Killingley (2016). According to Aune *et al.* (2014) sharing information creates certainty and assurance, and thus contributes to developing trust, that both mother and midwife can depend upon, at a time of unpredictability. Section 4.5.2 suggests that open honest dialogue is key in building meaningful relationships. Women do not want didactic information-giving, they want to engage in substantial discussions where differences of opinions can be broached (Pillely Edwards 2005). Whilst trust must rest on common values, this does not mean that women and midwives must have a common viewpoint (Kirkham 2010). Where respect and honesty exist, midwives can support women's values and their rights to be autonomous even if there is dissonance with their own values (Section 4.8.2). Midwives are not responsible for the choices women make, but they are responsible for ensuring women have all the information they need and that it is provided in a balanced way (Pillely Edwards 2005).

5.6.3 What women want

The findings show that many women who employ Independent Midwives do so in order to have relational continuity of care (Section 4.5.2) and this is also evidenced by Milan (2004) and Garratt (2014). However, studies examining women's preferences for maternity care from across the world demonstrate that within the birthing population many differing views exist, making the planning of maternity systems challenging (DeVries *et al.* 2001). Whilst there is a desire amongst some women for homebirth, or environments which are homely, such as birth centres, there are also those who want to birth in hospital settings where they feel safe because of their proximity to medical staff and technologies. With the increasing evidence for the risks posed by medicalized hospital care, with its increased rates of intervention and associated morbidity (Thiessen *et al.* 2016; Carlson *et al.* 2018) and the benefits of low intervention maternity care (de Jonge *et al.* 2013; Dixon *et al.* 2014; Halfdansson *et al.* 2015; Li *et al.* 2015), it is possible that women may begin to change their views about where is safest for them to birth.

The evidence about women's desire for relational continuity confirms that it is an important element of care to women, and pivotal to their experience (Kirkham 2010; Beake *et al.* 2013; Sandall *et al.* 2016; Davison *et al.* 2015; Fawsitt *et al.* 2017). McCourt and Stevens (2009) highlight that knowing a midwife is more than having just met her a couple of times and for

women it is the true nature of a relationship that matters. Women report feelings of vulnerability during childbirth (Simkin 2002) and express the need to have a kind, caring and connected person with them during this time (Howarth *et al.* 2012). Empathy is intrinsic to effective midwifery care, enabling midwives to emotionally connect with their clients; to value, accept and understand their experience (Moloney and Gair 2015). However, research evidence suggests that close mother-midwife relationships might result in emotional trauma for midwives (Leinweber and Rowe 2010) and that having to use empathy 'too much' is associated with compassion fatigue and burnout (Figley 2002), leading to concerns about the wellbeing of midwives and their retention. This issue was discussed by the participants (Section 4.2.6), one of whom felt that acute situations could be painful and upsetting for the midwife because of the closeness to their client, but she explained that this was normal and an expected part of having meaningful relationships with people. Other participants described going through difficult experiences with their clients and being able to support each other during the process. Hunter (2006) reports midwives feeling unprepared, unsupported and overwhelmed by their strong emotional involvement in practice, which may reflect the culture of the work setting and lack of support from their colleagues and managers. In contrast, the Independent Midwives describe the supportive culture they work within and how this helps to sustain them in practice (Section 4.2.7).

If midwives withdraw from developing relationships with their clients the quality of care will be compromised (Leinweber and Rowe 2010), thus in the interest of safety, models of care which support the formation of relationships need to be implemented. A growing body of evidence about continuity of care demonstrates the positive effects good relationships can have on midwives. Section 4.5.5 illustrates the beneficial effects of relational continuity as perceived by Independent Midwives. They describe the joy of working with women in this way and sharing their transformative experiences. Their job satisfaction outweighs the challenges of working independently and helps to sustain them. Jepsen *et al.* (2016) contend that the relationship provides a supportive context in which mother and midwife are able to cope with trauma together and Dixon *et al.* (2017) and Mollart *et al.* (2013) conclude that midwives who provide continuity of care through caseloading and build meaningful relationships have better emotional health and less burnout compared with colleagues working within the hospital system, where care is fragmented.

Satisfaction with their care is the most important qualitative outcome for women experiencing childbirth because it is an important indicator of the quality of care (Harvey *et al.* 2014). Whilst there are few details from the Independent Midwifery Association

Database Project, Milan (2005) reports that maternal satisfaction levels amongst Independent Midwives' clients compare well with those of published caseload studies. Hobbs (1998) infers high levels of satisfaction amongst those women who repeatedly book for care with Independent Midwives. Section 4.5.2 details how the midwives see repeat bookings as an endorsement of their good practice and the women's satisfaction with it. Satisfaction is highly linked to the relationship women have with their caregivers (Kirkham 2010, Sandall *et al.* 2015), and is associated with postnatal wellbeing, confidence, the mother-infant bond, the mother's ability to effectively care for her infant and the wellbeing of the family (Cornally *et al.* 2014). These outcomes demonstrate that the effects of a relationship have far-reaching consequences. Definitions of satisfaction, what it comprises and how to measure it accurately are however contested (van Teijlingen *et al.* 2003). Some studies show that women report high levels of satisfaction with their care (Jacoby and Cartwright 1990; Johnson *et al.* 2002), although an inherent problem with measuring this outcome is that women may be reluctant to be critical about their care, resulting in an overestimation of their experience. In more recent studies (Williams *et al.* 2010; McKinnon *et al.* 2014; NMR 2016) women have been more forthright in their views and spoken about their dissatisfaction with aspects of their care, including the lack of relational continuity.

Aune *et al.* (2011) report that greater satisfaction is associated with feelings of calm and enhanced mother-infant relationships, providing a possible explanation for the improved outcomes reported by Cornally *et al.* (2014). Sections 4.5.2, 4.5.4 and 4.5.5 suggest that the creation of calm is an intentional goal for Independent Midwives. Several examples are given about the risks of introducing stress and the dangerous, disruptive effect it can have on normal physiology. They appreciate that calm does not just place women in a positive psychological state, it also affects their physiology and consequently their clinical outcomes. Huber and Sandall (2007) discuss the positive outcomes associated with calm on the pregnancy continuum and how it is created within trusting relationships. They propose that optimal oxytocin levels are responsible for the positive outcomes associated with relational continuity of care, via the oxytocin calm and connection system (Uvnas Moberg 2011). In trying to explain the mechanism by which relational continuity of care benefits women Kirkham and Jowitt (2012) have examined the role beta endorphin plays in human physiology. Only relatively recently discovered (Snyder 1974), beta endorphin is a natural opioid substance, which Kirkham and Jowitt (2012) describe as a hormone of relationships and bonding; being released during social and physical interactions and creating feelings of wellbeing and calm and having beneficial effects on physiology. Kirkham and Jowitt (2012)

consider it likely that the positive outcomes associated with relational continuity of care are achieved by optimizing beta endorphin levels. Pert (1997) theorizes that the nervous, endocrine and immune systems interconnect throughout the body, working interdependently. This theory supports findings by Wadhwa *et al.* (2011), that high levels of stress in pregnancy are associated with immuno-compromise and pre-term birth, and Sandall *et al.* (2016), that relational continuity of care is associated with feelings of calm and significantly lower rates of preterm birth. Zanardo *et al.* (2001) report that high levels of beta endorphin at birth facilitate bonding between mother and baby and enhance the initiation of breastfeeding by activating the release of prolactin. Like oxytocin, beta endorphin affects those caring for women and has a role in creating calm within them and enabling them to give the best care possible (Kirkham and Jowitt 2012).

5.6.4 Tailored care

Providing individualized care is a fundamental component of independent midwifery as highlighted in the interviews and is facilitated by the trusting relationship (Section 4.5.2). Routine and standardized care are replaced by that which is specifically tailored to the needs and desires of their clients. Women make decisions about where and when care takes place as well as what the content of that care will be. Some choose to avoid screening tests during pregnancy and others may wish for no routine interventions during birth, such as taking blood pressure measurements or monitoring the foetal heart rate. Being able to support and accommodate clients' individualized requirements is identified as a typical part of providing true woman-centred care (Leap 2009). The personalization of care is dependent on women taking responsibility for their decisions (Morgan 2015) and, whilst some women may not welcome this, it is a common characteristic of Independent Midwives' clients who are seeking empowerment and the opportunity to have control over their experience (Section 4.5.5). This finding is supported by Milan (2005), in her analysis of Independent Midwives' practice and their client-base and Barbieri (2103) who wrote about her experience of having independent midwifery care. Individualising care has been a key recommendation of government policy since the publication of *Changing Childbirth* (DH 1993). Pope *et al.* (2001) describe how providing a high-quality service is dependent on understanding that care must fulfil the needs of the individual and that to deliver effective care routine approaches are not appropriate. To achieve this goal, it is necessary for health professionals to work in partnership with clients. Pope *et al.* (2001) propose that within maternity services adopting woman-centred care is the most fitting method, but it does require that health professionals be suitably knowledgeable and skilled to provide such a flexible service.

Individualized care is the outcome of enabling women to make informed choices about their care, respecting those choices and then providing care which incorporates them. Individualized care is not just about helping women achieve a normal birth, although for the majority this is likely to be the case, it is about supporting all women to birth in whichever way they feel is most appropriate (Section 4.5.2). Care based on the individual woman is associated with good outcomes and maternal satisfaction (Carolan and Hodnett 2007; Aune *et al.* 2011). Forming relationships with clients is key to enabling midwives to view them as individuals and to providing individualized care (Dahlberg and Aune 2013). Newton *et al.* (2016) assert that relationships contribute to positive outcomes through midwives working with women, supporting them to be active participants and developing individualized plans of care. Downe *et al.* (2006) discuss the importance of understanding each woman's birth as unique and using reflexive, skilled practice to provide responsive individualized care instead of protocols and standardized pathways. Despite the evidence supporting individualized care, lack of time remains a constant and frustrating barrier to its implementation. Lohmann *et al.* (2018) report that midwives understand the importance of giving individualized care and aspire to providing it but are prevented from doing so due to staff shortages and lack of time. This experience is repeatedly reported in the literature (Ball *et al.* 2002; Hunter *et al.* 2015; RCM 2016c).

Independent Midwives' clients are a diverse group, with socioeconomic status being a clear area of difference. In Section 4.5.2 the participants describe the women booking for care as ranging from those working in higher professional positions to those who have never been employed. They explain that a significant proportion of their clients could be classified as socially disadvantaged, because they have low incomes and may live in poor housing conditions. This in itself is not seen as problematic and as with their other clients, the midwives support and enable them to make informed choices and to have individualized care. Time is spent with the women getting to know and understand their specific needs, values and beliefs. Together they share information, explore ideas and ensure that the women are fully informed and understand their options. Many of these clients will pay their fees over several years and for some, the midwives will even waive the fees.

This situation contrasts with mainstream services where it is recognized that the ability to obtain individualized care varies amongst women, with socially disadvantaged women in particular being detrimentally affected. Such women are identified as having less choice concerning their care options (Carolan and Hodnett 2007) and are more likely to be labelled as 'high risk', resulting in them following a medicalized pathway of care and thus not

receiving midwifery continuity of care (Ebert *et al.* 2014). Social disadvantage is associated with poorer birth outcomes and a higher incidence of maternal and infant mortality compared with the general population of childbearing women (Sandall *et al.* 2016). So, those at greatest risk, and thus who would most benefit from individualized care are often those who do not receive it, further increasing inequalities in health (Kirkham *et al.* 2002b). Ebert *et al.* (2014) report that the disadvantaged women in their study did not feel safe to participate in decision-making because: they felt compelled to conform to recommendations made by midwives, relying on the midwife 'knowing best', the women understood that the midwives were unlikely to provide them with information that could educate them and enable them to make informed decisions, and finally that attempts to make decisions for themselves were not supported by the midwives.

Whilst unusual in independent practice (Milan 2004), preterm birth is one of the top ten causes of death globally, with socioeconomic risk factors being the main cause. Wisanskoonwong *et al.* (2011) report that although medical interventions are ineffective in preventing preterm birth amongst women who are socio-economically disadvantaged, there is evidence that providing holistic, woman-centred care however, is associated with fewer preterm births and thus has the potential to reduce inequalities in health. Sandall *et al.* (2016) emphasize how good-quality care, based on women's individual needs, in the context of relational continuity of care, can reduce the impact of these inequalities. They also report that this type of care results in a reduced incidence of preterm birth. These findings support the experience of Independent Midwives. Milan (2004) relates how independent midwifery is associated with high levels of relational continuity of care and lower rates of preterm birth compared with the national average. The participants affirmed that it is not unusual for their clients to experience socioeconomic disadvantage (Section 4.5.2), which may be surprising to some, thus identifying them as women at increased risk of preterm birth.

5.6.5 Taking a holistic approach

The findings (Section 4.5.3) report that independent midwifery care incorporates women's physical, psychological and social wellbeing, acknowledging that they impact on each other. This was described as being holistic. Individualized care and holism are identified as closely linked concepts (Pope *et al.* 2001). For care to be holistic it needs to be based on the needs of the individual (McEvoy and Duffy 2008). The inclusion of the concept of holistic care elevates the continuity of care model, because it necessarily involves the development of a meaningful relationship, which facilitates and enhances the quality and thus safety of

midwifery care. The positive association between continuity of care and quality of care only exists, as previously discussed (Section 1.5), within the context of a meaningful relationship (Sandall *et al.* 2016). Thus, the quality of the mother-midwife relationship must be the focus of midwifery care because without it the myriad potential benefits cannot be realized. As has been highlighted in Section 4.5.1, the relationship is most beneficial when the mother and midwife can get to know and understand each other, over a period of time during which trust and confidence are built, which is an observation substantiated by Kirkham (2010). McCourt *et al.* (2006) contrast the type of care Independent Midwives offer - being a constant source of support for women throughout pregnancy and accompanying them on their journey to parenthood - with the more commonplace experience of providing fragmented, disconnected care to unknown women, where there is no opportunity to develop relationships or provide continuity.

Adopting a holistic approach entails knowing a woman sufficiently well that care can be provided in a sensitive and knowledgeable way, which responds to all the woman's needs, be they physical, psychological or social (Mccourt *et al.* 2006). Newton *et al.* (2016) report that midwives feel better equipped to provide individualized care to women when they have intimate knowledge of them and their personal circumstances and this perspective is clearly expressed by the participants (Section 4.5.2). People are constructed by their personal history, experiences, culture, values and beliefs - these factors need to be considered in order to be able to understand and view someone as an individual (Crowther and Hall 2015). Having the whole picture of a woman's life enables midwives to understand her emotional and psychological wellbeing - not just the physical - and to help the woman feel safe, to take up her power and to grow in confidence (Kirkham 2010).

Crowther and Hall (2015) argue that midwives need to recognize the spiritual nature of the birth experience in order to meet the holistic needs of women. Birth is a social, economic, emotional and spiritual event marking a significant transition in a woman's life (Mccourt *et al.* 2006). Spirituality is described as the human need to find meaning and purpose in life, with or without religious beliefs, and it is recognized that childbirth is intensely meaningful for women (Walsh 2002; Crowther and Hall 2015). To provide spiritual care it is necessary for the practitioner to have self-awareness and an understanding of their own spirituality. Beck (1990) suggests that spiritually aware people share characteristics of being: loving, gentle, generous, hopeful, connected, and accepting. Clarke (2013) contends that person-centred care is spiritual care and cautions against efforts to define spiritual care or mandate it into care processes as this may result in a tick box exercise where reductionism rather than

holism is achieved, rendering spiritual care meaningless. Crowther and Hall (2015) explain that where midwifery care is woman-centred, spiritual care is an inherent element therein. Whilst not explicitly discussed by the participants it is possible to infer from the data (Section 4.5.3) that the care they provide is likely to attend to their clients' spiritual needs. Conversely, according to Crowther and Hall (2015) spiritual care is likely to be missing in services where fragmented care is the norm.

Davis-Floyd (2001) describes a holistic model of healthcare, which encompasses a range of healing modalities ranging from nutrition to traditional healing techniques such as Chinese medicine. In this sense it can be seen as substantially different from the holistic 'approach' incorporated into midwifery care which really only extends as far as considering the woman as an individual, respecting her values and beliefs and understanding the emotional and psychological aspects of pregnancy and birth. Few midwives include alternative forms of healing, into their practice, such as complementary or nutritional therapies (Hall *et al.* 2013). Whilst some of the participants have additional qualifications enabling them to provide certain therapies, including aromatherapy, homeopathy and reflexology (Section 4.5.3), those without will instead work closely with complementary therapists to support women who choose to receive such care. The holistic model of healthcare outlined by Davis-Floyd (2001) differs from the technocratic, or medical, model, which emphasizes mind-body separation and views the body as a machine, by claiming oneness of mind, body, spirit and environment and defining the body as an energy field in constant interaction with other energy fields. The discovery that the brain is not only located in the head but extends throughout the central nervous system (Pert 1997) supports the claim of oneness or 'holism'. Addressing the emotional and psychological states of women will affect their physical condition and as Davis-Floyd (2001) asserts, doing so is not just helpful, it is an essential aspect of maternity care; being able to truly connect with women enables them to function optimally (Section 4.5.1). The holistic model emphasizes the existence of the body as an organism and unsurprisingly, like most other mammals, humans have a basic need for emotional interactions with others and respond positively to loving touch, kindness and respect (Uvnas Moberg 2011). Given that most people are aware of the importance of psychological and emotional connections in their private lives it seems strange that there may be little recognition of this in their professional dealings with women. There is a drive within maternity care currently to teach practitioners how to give humanized care, in an attempt to rectify the situation where women report their treatment by health care

professionals as being unkind, uncompassionate or distant (NMR 2016). The need for this seems anomalous with the purpose and philosophies of the maternity professions.

5.6.6 Incorporating salutogenesis

In addition to providing individualized, woman-centred, holistic care to their clients, Independent Midwives describe what is a salutogenic approach to maternity care, although they do not themselves use the term (Section 4.5.4). Independent Midwives work in a health-promoting paradigm, which is contradictory to that of risk avoidance taken by health services. They explain (Section 4.5.4) that they consider the pregnancy continuum to be a healthy, normal state of being, which should remain undisturbed by unnecessary medical interventions or worrying words, as these increase the incidence of complications and potentially create ill health (Jordan and Murphy 2009; Olsen and Claussen 2012). The focus of care is not on a constant search for pathology, or risk thereof, but is instead situated in the context of health, moving towards it, or maintaining it. A recent meta-synthesis on the psychological impact of physiological birth (Olza *et al.* 2018, p1) reports that women experience such births as ‘an intense and transformative psychological experience that generates a sense of empowerment.’ This experience positively affects women’s confidence, their transition to parenthood, and their relationship with their babies. Thus, giving birth physiologically not only benefits women physically it also positively impacts their emotional and psychological health. Although this is a small study it provides evidence for the holistic benefits birthing physiologically brings to mothers and babies.

Throughout the findings chapter, evidence from the participants has clarified the measures they employ which support their clients, with the objective of achieving optimal physical and psychological outcomes for women. Perez-Botell *et al.* (2015) report that little research has looked at salutogenic framing within maternity care. The research by Meier Magistretti *et al.* (2016) has helped locate the Independent Midwives’ practice within Antonovsky’s theory of salutogenesis and demonstrate how it corresponds with the concept of sense of coherence in promoting wellbeing for women. Independent Midwives are setting the stage for long term health by practising as they do. Dahlberg *et al.* (2016) assert that midwives who focus on promoting normal birth and positive experiences also promote good health. In relating the Independent Midwives’ activities to sense of coherence it is possible to demonstrate how they promote wellbeing. Independent Midwives’ practice is in accordance with the findings of Meier Magistretti *et al.* (2016), as outlined here. Sense of comprehensibility is achieved by investing in getting to know and understand a woman and

developing a reciprocal, trusting relationship in which the woman feels safe and able to cope with her situation (Section 4.5.1). Through conversations and interactions, the woman understands the way in which the midwife practises, and how and when care will be provided. Time is available to discuss and exchange information about pregnancy, birth and parenting and prepare her for the forthcoming events (Section 4.4.1). She is encouraged to discover information for herself, to find her own solutions and then to make decisions about her care options. Ongoing conversations and interactions clarify the woman's objectives during her journey towards parenthood and build her confidence in herself, her ability to grow and birth her baby, and the midwifery care she receives (Section 4.2.5). The woman can feel secure within the relationship and has certainty about what will happen; the midwife will be a constant presence throughout her care and she will be supported in her decisions. Sense of meaningfulness is achieved by helping the woman to have the motivation to meet the challenges of pregnancy, birth and parenthood and encouraging them to commit to their aims (Section 4.5.2). Understanding the benefits of physiological birth to mother and baby can be a strong motivating factor for many women and elicit the required strength and determination to achieve this outcome. Women are encouraged to understand the process of pregnancy and birth and to see how it affects their body, the sensations they experience and their emotions (Section 4.5.2). Being able to appreciate, for example, that pregnancy has not failed or become pathological just because the due date has passed can enable a woman to make an informed choice not to have an induction of labour and to allow her physiology to continue working in its unique way. Likewise, understanding why the uterus contracts in labour, what the process of birth is and how fear and tension can make it more painful can help women work with their bodies and enter a state of confidence and relaxation which optimizes physiology (Section 4.5.2). Sense of manageability comes from having the resources needed to make things manageable. Within the Independent Midwives' practice this is achieved mainly during the antenatal period when women develop skills, confidence and the knowledge they need to deal with the challenges of pregnancy and birth. The trusting relationship women develop with their midwives provides the unwavering support they need and ready access to information and other resources. The support gives women inner strength and enhances their ability to birth physiologically (Dahlberg *et al.* 2016).

Salutogenesis applies equally to midwives and having a strong sense of coherence enables them to function effectively in their professional capacity, as well as maintaining their own health (Meiers Magistretti *et al.* 2016). The participants did not talk about having a conscious

strategy for promoting their own health, but it is clear that the way they practise is sustainable and enables them to work long-term in this model of midwifery. Being able to understand the needs of the women they care for through ongoing communication, optimizing the skills and knowledge they use to provide care and having a work environment that supports the relational continuity of care approach to midwifery results in care that is beneficial to both mother and midwife and is consistent with evidence from Meiers Magistretti *et al.* (2016).

5.6.7 Working with women

Working with women is an important feature of independent midwifery (Section 4.5.5). The participants describe how, whilst having knowledge about pregnancy and childbirth, the midwife acts as a 'professional friend', rather than the traditional authoritative expert with power and control. Some participants define this practice as 'partnership working' whilst others refer to it as 'working alongside women'. The New Zealand model of midwifery is based on partnership working and mirrors this inclusive approach. Like independent midwifery in the UK, partnership working focuses on providing, woman-centred care, in the context of relational continuity, where women have the right to make informed decisions about care, which meets their individual needs (Pairman 2010). Boyle *et al.* (2016) argue that there needs to be more evidence about this way of working and clearer definitions of what is meant by partnership working. They emphasize that the formation of partnerships is reliant on midwives having adequate time to provide continuity of care which facilitates the creation of trusting relationship. Their data suggest that without relational continuity of care, midwives exert coercive power in their dealings with women and that most of those women do not feel that they are offered choices about their care, whereas women who can form relationships feel empowered and able to exercise choice. Freeman *et al.* (2004) argue however that power is inevitably unequal in midwifery partnerships but state that it does not necessarily affect the success of the collaboration. The participants unanimously stressed the equality of their partnerships and the absolute autonomy their clients have (Section 4.5.5) however, according to Garratt (2014) Independent Midwives may not recognize the power they exercise when informing and supporting women to make choices. Section 4.5.2 suggests that the participants are aware of the potential for a power imbalance but endeavour to ensure it is not realized.

Partnership working, as outlined by the Independent Midwives, links closely to the principle of women's autonomy (Section 4.8.3). In her non-authoritarian role, the midwife supports

the woman, guiding her to sources of knowledge where necessary and enabling her to make decisions. The woman's own knowledge also contributes to designing safe care (Section 4.7.3). Through their relationship women and midwives can constructively share a range of information that enables the women to decide upon the most appropriate course of action that meets their specific requirements. As previously discussed (Section 4.5.2), working collaboratively supports flexibility in when, where and how care is provided, resulting in individualized care.

5.6.8 Effective communication in midwifery

One of the central attributes of a 'good midwife' is effective communication (Nicholls *et al.* 2011). The importance of having effective communication with their clients was frequently spoken about by the participants, with many references to the amount of time and effort spent getting to know each other, developing a mutually trusting relationship and reaching an understanding about the woman's needs (Section 4.5.6). The NMC (2018) states that to practise effectively, a midwife must be able to communicate clearly, this includes: using terminology that people will understand, addressing people's communication needs, using a variety of verbal and non-verbal methods, being culturally aware and checking for understanding. Communication is embedded within pre-registration education for midwives in the UK, with the demonstration of competency in this area being a pre-requisite of registration (NMC 2009b). National and international guidance on improving maternity care (WHO 2016; NICE 2017) also emphasizes the importance of effective communication in providing high-quality care. However, despite the significance attributed to the role of communication in maternity care, there is no consensus definition of 'effective communication' (Chang *et al.* 2018). It might be assumed, that as a requirement of registration, midwives are skilled communicators, however, women continue to report that they want better communication from their carers (Alderdice *et al.* 2016; NMR 2016).

Hunter *et al.* (2008) provide evidence suggesting that many health care professionals' communication skills require support and enhancement, although they question how this can be done, stating that there is little evidence about the development of communication skills within maternity care. They comment on the lack of research as being surprising given the well-documented link between ineffective communication and poor clinical outcomes. Ten years on, Chang *et al.* (2018) identify a lack of evidence about the impact of interventions to support effective communication between maternity care staff and women in labour, concluding that there is a need for robust research to identify the characteristics of effective

communication training. Whilst not addressing the lack of definition, or the ways to improve communication skills, Aune *et al.* (2014) and Hunter *et al.* (2008) assert that the quality of the relationship is inevitably linked to communication and that effective communication is essential for safe practice. Tinkler and Quinney (1998) indicate that it is good relationships which lead to better communication and Bowers *et al.* (2015) add to this by reporting that continuity of care facilitates improved communication, helping to establish trust and a willingness to confide in the midwife. With a focus on building effective relationships, facilitated by providing time for open discussions, it can be inferred that Independent Midwives are skilled communicators. They rarely have restrictions on the time they have for appointments and are not constrained by a tick box approach to care (Section 4.5.6). Appointments are client-led and designed to fulfil the woman's needs, whether they are physical, psychological or emotional.

One of the most essential elements to women, in their interactions with midwives, is being listened to, a skill not specifically outlined by the NMC. Section 4.7.3 provides accounts of the importance of listening to women and how it enables safer care to be provided. Dahlberg and Aune (2013) report that not being listened to is one of the main factors causing negative experiences for women and Kirkham (2010, p.255) asserts that being listened to is fundamental to any relationship, stating that, 'it validates and affirms us' and is what women want from their midwives. Garratt (2014) identifies listening as a key communication skill amongst Independent Midwives, leading to the development of meaningful relationships. Learner (2004) describes how listening to women during antenatal appointments helps to identify and understand their needs, provide individualized care and prepare them for birth and parenthood. She adds that listening during childbirth enables the midwife to detect the audible, non-verbal, clues women give and assess the condition of the mother in a non-interventionist manner. Sandall *et al.* (2016) emphasize the significant role listening to women plays in contributing to the benefits of relational continuity of care; when given the opportunity women will discuss concerns and disclose potentially harmful behaviours, enabling the midwife to tailor care and improve safety. Kirkham *et al.* (2002a) report that midwives working in fragmented systems see little point in really listening to women they are unlikely to meet again and focus instead on the completion of tasks, which has clear implications for women's safety.

Whilst the Independent Midwives incorporate time for chatting and having discussions into their appointments (Section 4.5.6) many NHS midwives are unable to do so and thus develop strategies to be able to keep within the limited time they have, which can be detrimental to

communication. Some adopt a business-like approach, speaking very quickly, which enables them to deliver a lot of information in a brief period but also deters women from speaking and interrupting them (Pilley Edwards 2005), whilst others used closed questions or body postures to discourage women from talking (Stapleton *et al.* 2002). Pilley Edwards (2005) contends that midwives who do not encourage chat learn little about women's pregnancies or their concerns, which inevitably and detrimentally affects the quality of care.

5.6.9 Content of communication

The participants discuss the efforts they make in not only providing women with accurate information but also encouraging them to find their own sources. Lengthy discussions are held between them and their clients to share, assess and verify information. Conversations are revisited throughout the episode of care and new information is found when situations, or evidence change. This process is considered vital as great emphasis is placed on their clients' autonomy and responsibility to make informed choices (Section 4.5.2). Pilley Edwards (2005, p.174) argues that the structure of maternity services can reduce the meaning of communication to that of conveying limited information in a way that ensures conformity. She describes the difficulty women experience in getting information when they have no relationship with their midwife and how what information is given is often, 'formulaic and didactic', based on assumptions about what they need to know. This does not lead to the kinds of exchanging of information that women seek, in order to be able to make informed decisions. Pilley Edwards (2005) further explains that women want to move beyond routine, superficial talk to having meaningful, personal discussions. Relational care is reported to increase the satisfaction women have with the information they receive (Borelli 2014; Brock *et al.* 2014; Sandall *et al.* 2015; Williams *et al.* 2010). Dahlen *et al.* (2010) suggest that the clear communication of information by midwives is essential in enabling women to exercise informed choice and that balanced information reduces women's fears and increases confidence. Aune *et al.* (2014) explain that sharing appropriate information creates predictability and confidence resulting in the development of trust and ultimately leading to the benefits of creating calm, outlined by Huber and Sandall (2007). McKinnon *et al.* (2014) identify that unmet informational needs are linked to negative experiences because informed choice is dependent on the provision of information. Soltani *et al.* (2015) report that midwives are the main source of information for women and as such need to ensure that they are using appropriate resources to inform women. They recount how some women in their study decided against homebirth based on inaccurate or insufficient information given by their midwives.

5.6.10 Power and communication

The word 'allow' and its use in restricting women's choices came up in passing in several interviews but was not discussed in detail as it was viewed as not applicable to themselves, but rather an issue relevant only to midwives who do not respect women's autonomy. The participants' previously stated position on women's right to autonomy makes it clear that they have equitable relationships with their clients (Section 4.2.5). According to Pope *et al.* (2001) the role power plays in communication is highlighted by the decision of some midwives to 'allow' women only certain choices. Using the word 'allow' indicates the existence of a power relationship in which the midwife ultimately has control over what the mother can do. By limiting the availability of choices, the midwife limits the opportunities for individualized care, thereby reducing the safety of care, and restricts the woman's human rights to be autonomous. Cronk, an Independent Midwife (2010, p.61), discusses the challenges faced by Independent Midwives, of keeping options open to women in the face of pressure from other health professionals to close or control them. She explains how she crafts her words to hold conversations with her clients as equals, not as an overpowering expert. She describes the relationship Independent Midwives have with their clients as having a 'different flavour' to that between an NHS midwife and her clients. The nature of the relationship in independent midwifery starts on a different footing, with the two meeting and assessing each other's suitability, each then deciding whether the situation is acceptable to them. A business arrangement then follows, where the midwife agrees to provide certain elements of care and the woman agrees to pay her. The relationship starts off as an equitable partnership. Garratt (2014) explains how the relationship in independent midwifery focuses on supporting and enabling women to make autonomous decisions and reflects the centrality of the concept of being 'with woman'. The balance of power indicates the values and beliefs the midwives hold about women's rights to make choices and have control over their care. It has been government policy since *Changing Childbirth* (DH 1993) for women to have choice and control over their care and yet reviews of the maternity services reveal women's ongoing dissatisfaction with the lack of choice and control they experience (DH 2007; NMR 2016).

5.7 Mother-centred care discussion summary

Considered the essence of independent midwifery practice, mother-centred care, embedded within the mother-midwife relationship, brings many benefits to women and babies. This approach seeks to understand the woman in her social context and to strengthen her

emotionally and psychologically. The relationship is developed through the continuity of carer model which can then be described as relational continuity of care. The formation of trusting relationships is imperative because it is only relational models of midwifery that positively affect clinical outcomes. The quality of the relationship is key to the quality of care. Relational continuity results in fewer babies born preterm, higher rates of physiological birth, satisfaction with the experience and breastfeeding, as well as improved mother-infant bonding and maternal mental health and helps to reduce social inequalities in health. Trusting relationships invoke feelings of calm in women, enabling their physiology to work optimally. This may in part explain the observed benefits of relational continuity. Independent Midwives' experience of relational continuity of care involves providing care throughout the pregnancy continuum.

The connection between trust and safety is inextricable. Trust can enhance a woman's confidence and positively influence her capacity to birth physiologically. The success of relationships is dependent on there being adequate time for the mother and midwife to connect and develop a deep knowledge and understanding of each other. This process enables the midwife to provide safer care - those midwives working in relational continuity models are considered to have higher levels of competence because of the intimate knowledge they have of their clients. Relationships contribute to positive physical and psychological outcomes in part because they involve providing individualized care. A lack of time is a constant barrier to providing individualized care.

Women commonly employ Independent Midwives because they want relational continuity. They often feel vulnerable during childbirth and need a kind, connected person to support them. The relationship is not only beneficial to mothers. Midwives who can develop trusting relationships find joy in working with women and have high levels of job satisfaction. They also experience better health and less burnout. The creation of calm also affects midwives and enables them to give optimal care.

5.8 Knowledge, evidence and practice

It became evident from discussions with the participants that they take a broad approach when considering what constitutes valuable knowledge and evidence for practice (Section 4.7). Without pressure from an employer to conform to protocols and policies, they draw on a wide range of resources to inform their practice, which includes research evidence, personal, embodied and experiential knowledge, as well as their clients' knowledge and experience. They have a good understanding of research and how to critically appraise

papers and guidelines, which they often do with their clients to enable them to appreciate the quality of evidence. They are keen to also incorporate information from a multidisciplinary evidence base, one such example being microbiological and immunological research findings which demonstrate the significance of the microbiome in human health, as a means of appreciating the bigger picture in which midwifery care exists and how midwives' actions can have far reaching ramifications long after their involvement has ceased, for good or bad. The relational continuity of care they provide, and the length of time they are involved with clients following birth, enables them to observe the long-term consequences of care, be they physical or psychological (Section 4.4.1). This knowledge helps inform and develop their practice. Seeing, for example, the long-term effects of an episiotomy can give perspective on the advantages and disadvantages of such an invasive surgical intervention, which may remain hidden from midwives who can only provide fragmented care and only see an immediate benefit in expediting birth or avoiding a spontaneous tear.

Relating to concepts of knowledge and authority (Section 2.8.5) the safety of homebirth is a typical example of the influence medical evidence and opinion has over evidence from midwifery and the social sciences. The authority and power of the medical profession overrides evidence demonstrating the advantages of low intervention homebirths which can benefit not only those with uncomplicated pregnancies, but also a range of women who have some additional considerations not impacted by their place of birth, yet who conventionally are strongly advised against having a homebirth (Li *et al.* 2015). Some of the participants spoke about the conflict they had experienced in the past when their intuitive feelings, supported by clinical experience, was that homebirth was a safe option for most women, and helped them to avoid interventions which could introduce harms, whilst the only available published evidence asserted that it was not a safe choice (Section 4.7.2). They talked about feeling vindicated when research evidence started to show that it is a safe option (de Jonge *et al.* 2013; Dixon *et al.* 2014; Halfdansdottir *et al.* 2015; Li *et al.* 2015) and which is now reflected in national guidance (NICE 2017).

5.8.1 Innovating practice

Being able to innovate care was identified in the context of professional autonomy and in the Independent Midwives' use of diverse sources of knowledge. This finding is supported by the evidence presented in Section 2.6.3. It was viewed as a crucial element of practice by the participants who spoke about having the opportunity and authority to incorporate new knowledge from various sources into practice to advance and improve care (Section 4.7.1).

The ability to responsively change practice, in light of new evidence, was highlighted as a feature of independent practice that is dependent upon their professional autonomy and is one seen as being highly beneficial to women (Section 4.2.3). A prime example of their practice development is leaving the baby's umbilical cord unclamped at birth, to facilitate physiological birth of the placenta and optimal transfusion of blood from the placenta to the baby (Section 4.2.3). It has long been known that routine clamping of the cord is detrimental to the baby and that the effects of the medically managed third stage of labour had not been evaluated in terms of the impact on babies (Downey and Bewley 2012). It is more than 20 years since this became a topic of conversation amongst the Independent Midwives and their supervisors (personal communication), and research evidence began to emerge about the benefits to babies (Kinmond *et al.* 1993; Narenda *et al.* 1998; Rabe *et al.* 1998) and yet it is only now really becoming integrated into practice within the NHS.

The participants continually question and reflect on what they do and why they do it; is it what they were taught? Is there an expectation from someone in authority to practise in a certain way? Is it based on personal experience, or is it shaped by clinical evidence? This raised the issue, during interview, of what constitutes credible knowledge and led to discussions about the value placed on different sources of knowledge in the era of evidence-based practice, where a hierarchy exists which places research-based evidence above all other forms of knowledge (Holmes *et al.* 2006).

The merits of evidence-based practice versus the use of unrestricted sources of knowledge in healthcare is hotly disputed in the literature (Porter and O'Halloran 2008). Whilst significant advances in healthcare have resulted from the implementation of evidence-based practice it is argued that it is not sufficient to address the complexity of care (Porter and O'Halloran 2008). Pilley Edwards (2005) describes the formulaic approach to care, based on policies and protocols, as 'midwifery by numbers' and argues that midwives are more than transmitters of evidence-based information; that midwifery is more than scientific evidence. Aikins Murphy (2011, p.323) concurs, telling us that without incorporating women's views into care 'we risk not being caregivers but merely evidence providers.' Women recognize and value midwives as a source of evidence-based and experiential knowledge (Pilley Edwards 2005).

Evidence-based practice in its current form, where there is an over-reliance on research evidence and an exclusion of clinical knowledge and client preferences, is too simplistic and damages health care by failing to meet the needs of the individual (Holmes *et al.* 2006). This

view correlates strongly with those of the participants who argue that whilst it can be useful, research evidence in isolation does not present adequate information to provide care that meets the individual needs of clients (Section 4.7.4). They contend that years of clinical experience offers valuable knowledge and information which can be drawn upon and appraised alongside research evidence and the personal knowledge of the woman. This is particularly relevant for home-based midwifery which has been under-researched and where therefore there is a reliance on experiential knowledge. The home environment can significantly influence a woman's physiology in ways not seen in the hospital setting (Fahy 2008) and thus attempting to apply practices which have been developed and tested within hospitals may not be appropriate, or safe. Any suggestion that a practice is effective, whether that stems from experience or research, should be considered as evidence (Pearson *et al.* 2007) and whilst evidence from research is still believed to be more reliable than anecdotes or opinion these should be viewed as best evidence where no research results exist. It may be that working independently exposes the participants to more areas of practice which have little or no evidence base, because they are non-medicalized, and as such they have little option but to use alternative sources of evidence.

As reported in Section 4.8.1, the participants' beliefs about pregnancy and childbirth are closely linked to practice. Hunter (2013) observes that evidence is likely to be incorporated into practice when it corresponds with midwives' beliefs and thus it may not always be related to the highest quality of evidence. The participants describe how they explore and assess evidence which resonates with their world view and experience, often discovering new information not reflected in mainstream practice (Section 4.7.1). One example was waterbirth and the incorporation of evidence from physiologists about the mechanisms which protect babies from drowning during waterbirth, and mothers from suffering water embolism (a theoretical condition where water from the birth pool enters the mother's circulation during the separation of the placenta from the uterus), alongside the experiential evidence from colleagues and clients. Independent Midwives have become very knowledgeable about this form of birth despite the relative lack of applied research evidence (Section 4.7.1). They use personal and collective experiential midwifery knowledge to support women to safely use water during childbirth, alongside women's knowledge and reliable research findings where they exist. The participants are keen to share their experience and knowledge of practices not common in mainstream midwifery such as twin and breech birth (Section 4.7.1), in order to advance midwifery knowledge generally and thus to improve care for all women experiencing these conditions.

5.8.2 Ways of knowing

Being able to accept women's knowing as a credible source of information requires the midwives to understand ideas about authoritative knowledge (Section 2.8.2) and how certain forms of knowing come to be considered legitimate whilst others do not. The development of the philosophy of positivism by Comte in the 1800s placed science at the top of the hierarchy of knowledge (Boucouvalas 1997), whilst theological knowledge, intuition and instinct were relegated to the bottom. Instinct is described as our innate tendency towards a particular behaviour, in contrast to a learned response, whilst intuition is a process that enables humans to know something without reasoned thought, bridging the gap between conscious and subconscious thoughts (Cholle 2012). Gladwell (2007) presents evidence of mental processes which work rapidly and automatically in acute situations when urgent responses are required, integrating small pieces of information, we have gathered over time but not previously consciously connected, into new knowledge. In such circumstances we subconsciously recognize patterns, make links and draw these pieces of information together, resulting in a form of knowing that until now has been called 'intuition'. He argues that far from being mystical, it is the synthesis of accumulated knowledge based on years of experience and practice and is no less valuable than consciously acquired knowledge. Intuition is described by Laughlin (1997) as one of two modes of consciousness that humans possess, the other being reasoning. The use of intuition in childbirth has been discussed for many years, with Davis-Floyd and Davis (1996) claiming that it is a valid form of knowledge, although not one currently respected by contemporary culture. With childbirth being so embedded in the technocratic model of birth, women and midwives are under considerable pressure to conform to it and the knowledge it values.

Despite it being commonplace in independent midwifery practice (Section 4.5.3) many midwives are reluctant to embrace a holistic approach which values connection and trust between mother and midwife and which does not rely on guidelines and protocols, for fear of condemnation and sanctions from their profession (Davis-Floyd and Davis 1997; Byrom and Downe 2015; Healy *et al.* 2016). Rational thinking holds that the medical or technocratic approach to childbirth can control labour and reduce uncertainty about safety (Parratt and Fahy 2008). However, it has already been shown that such an approach increases risk and harm to women and babies, through physical and psychological interventions (Section 5.6.3). Women are unique, each birth is unique and trying to fit birth into the narrow parameters of medical protocols will reconstruct many labours as abnormal (Davis-Floyd and Davis 1996). The pregnancy continuum does not follow a rigid pattern and each woman will react

differently on physical and psychological levels in response to her changing circumstances, meaning that care pathways and prescribed ways of working cannot provide the individualized care women ask for (Helberget *et al.* 2016). Adherence to rules and prescribed ways of working stops midwives from thinking about individual situations, which is dangerous (Kirkham 2011b), and care becomes standardized and not centred on women's individual needs, which is associated with poorer outcomes (Tracy *et al.* 2013).

Hall *et al.* (2012) conclude that having a reliance on authoritative knowledge can enhance health care professionals' integrity, but at the expense of women's integrity, leaving them feeling doubtful about themselves and their ability to birth, rather than empowered and confident, which midwifery care is supposed to promote (Helberget *et al.* 2016). Fry (2007) contends that whilst ideas of inner knowing - non-rational, non-logical and intuitive thinking - are dismissed and devalued by scientists and the medical profession, it is time for such ways of knowing to be integrated into maternity care. Her study of Independent Midwives' practice revealed that they incorporate inner knowing into their model of care. Cholle (2012) suggests that we need to use both instinctual knowledge and reasoned thinking to make the best decisions. Fry (2007) proposes that a continuum of childbirth knowledge can be created with the observed, objective, externalized and measured at one end, through to the unobserved, subjective and internal at the other, leading to the valuing of forms of knowledge other than the technical or scientific and resulting in enhanced understanding of the pregnancy continuum. Fry's most recent research (2017) explores concepts of inner knowing with Independent Midwives working in the UK, developing previous ideas about intuition and a continuum of childbirth knowledge and describing a 'holistic knowing' in which different forms of knowledge are valued, and that enhances the safety of maternity care.

Some participants described a type of knowing which manifests itself in forms they perceived as the channelling of ancient wisdom into their bodies, the presence of birth angels or embodied sensations (Section 4.7.2). They described how in certain situations they would hear an internal voice or see a vision guiding them to be vigilant of something or directing them to take action. There is little evidence about this phenomenon and Fry (2017) speculates that the use of this type of knowledge may be new, perhaps a part of 'new age' thinking. It could however be that most midwives are reluctant to discuss such beliefs for fear of condemnation and judgement and an ensuing investigation of their practice by those in positions of authority. Davis-Floyd and Davis (1997) wrote about midwives' embodied knowledge, bringing to light accounts of midwives experiencing feelings, images or auditory

messages guiding them. Olafsdottir (2006) described this phenomenon as an aspect of midwives' inner knowing. Terming it as spiritual, or even transcendent. The midwives in her study did not believe they were psychic but were instead receptive to higher powers such as God and perhaps more sensitive to situations and signals from people. Having a connection with the woman seemed to enhance their receptivity. Davis-Floyd and Davis (1997) found that midwives consider the connection they have with themselves and the woman facilitates the flow of inner knowledge. In certain situations, the midwives in their study reported having a warning sense of a situation needing attention. The midwives attributed a high degree of accuracy to their intuitive feelings. Fry (2017) also reports on this type of knowing, referring to it as a form of 'noticing' and giving several instances when midwives described sensations or emotions that seemed to provide them with knowledge or information. Fry (2017) too noted that an intimate connection to the woman was key to the midwives having such experiences. It is possible that Independent Midwives are reporting this phenomenon because of the close relationships they are able to make with their clients and that midwives providing fragmented care have fewer opportunities for this to occur.

Parratt and Fahy (2008) refer to concepts of inner knowing in terms of '*nonrational*' knowing and suggest that the use of purely scientific rationality limits thinking and understanding because it excludes experiential and embodied knowledge. They assert that scientific knowledge alone is not sufficient when caring for pregnant women. The *nonrational* is described as being based in personal, subjective and emotional thinking rather than in reason and logic. It comes into view often in acute situations where people respond automatically - when there is no time for reasoned thought - using their instincts and intuition. Parratt and Fahy (2008) propose that women and midwives incorporate *nonrational* knowledge into planning care and responding to the changeable circumstances of the pregnancy continuum.

Holten and de Miranda (2016) report that resistance to the medical model is common amongst women who seek to birth outside the system and that many of those women rely on intuition as a source of authoritative knowledge. This observation was confirmed by the participants in Section 4.7.3. Jackson *et al.* (2012) report that some women who have previous negative experiences of medicalized care, which they perceive placed them at unnecessary risk or caused actual harm, reject mainstream maternity care in subsequent pregnancies - their experiential knowledge tells them that this form of care is unsafe for them. Other women distrust midwives, because they are perceived to support a medicalized approach to care, and prefer to follow their own instincts instead (Holten and de Miranda 2016). Women such as these will often seek care from Independent Midwives, as was

described by the participants (Section 4.5.2). Able and Browner (1998) introduced the idea of 'pragmatic women' arguing that for some, the decision to reject medicalized care is a personal, pragmatic choice made in a particular situation, rather than just being a reaction to the prescriptive nature of such care.

Plested and Kirkham (2016) explain how some women listen to their innate senses and knowledge about their bodies to guide them, which is supported in the findings of this study (Sections 4.7.3 and 4.7.4). Women will often describe having a gut feeling about the right course of action for them, knowing instinctively what they need (Levy 2005). A woman's use of instinctual knowledge will become evident during birth if she is free to behave as she wishes. Women will act in ways which optimize their physiology (Odent 1994): moving, eating, sleeping or even dancing, according to what feels right. Modern maternity care is designed to make women feel that they have no knowledge about the pregnancy continuum, with pregnancy being confirmed by experts, early scans confirming the ongoing viability of the pregnancy, and testing and surveillance confirming the appropriate development of the baby. These interventions override a woman's knowledge of what is happening within her body and raise doubts that her body can safely grow and birth a baby (Katz Rothman 2001). This situates childbirth within the realms of pathology and distances it from the normality which the midwifery profession purports to believe in. Jordan and Aikins Murphy (2009) explore how risk assessment and the use of technologies destroys the trust and confidence women have in their knowledge of pregnancy and birth. This may lead to anxiety and fear and the adverse effects stress hormones can have on women and their babies, as previously discussed (Section 5.6.3). Conversely, acknowledging a woman's knowledge is fundamental to enhancing her confidence and helping her to cope effectively during the pregnancy continuum (Helberget *et al.* 2016). As noted by Thachuk (2007), belief in the legitimacy of a woman's knowledge is indicative of an equitable relationship, which in itself is beneficial to women.

As has been discussed previously (Section 5.2.3), the autonomy Independent Midwives have enables them to determine their own practice; to avoid commonly used, outdated methods which are associated with harms to both mother and baby. Routine practices such as directed pushing for women in labour (Calderyo-Barcia 1979; Prins *et al.* 2011), or amniotomy (Smyth *et al.* 2013), are rejected in favour of more physiologically based approaches which do not introduce potential dangers to women or babies and which are congruent with their beliefs about the nature of the pregnancy continuum. The holistic use of knowledge enables them to work with women who have complex pregnancies and whose

choices the NHS is unable or unwilling to support (Section 4.7.1). They utilize knowledge and skills generally lost from mainstream practice, such as how to safely support the physiological birth of twins and babies in breech positions. This results in improved care for women choosing this option and avoids the now routine use of caesarean section for such cases, with its increased risks of morbidity and mortality.

One participant acknowledged that sometimes they are working in uncharted waters with unusual circumstances, because the evidence does not include data on unmedicalized cases (Section 4.7.1). Her example related to twin births where physiology is supported, and nature allowed to take its course, in contrast to the interventions which are commonplace in mainstream care in such cases to expedite the births. They must in these instances rely on their experiential knowledge, senses, observations, instincts and intuition, alongside those of the mother, to assess the situation and guide them in their actions. This can lead to the generation of new knowledge and prompt research which explores the phenomenon and ultimately improves care for women.

5.8.3 Using clinical judgement

The participants used the term 'clinical judgement' to describe the proficiency, perceptiveness and knowledge they have acquired through clinical experience. They identify their use of clinical judgement to inform care as a freedom of working independently, as autonomous practitioners, and seeing the value of knowledge and evidence in their widest sense (Section 4.7.2). It was felt that this was significant in enabling them to give the individualized care women seek. Clinical judgement is based on in-depth knowledge of the woman and her circumstances, theoretical knowledge, clinical experience and intuition. This diverse array of knowledge enables the midwives to respond to situations individually (Section 4.7.2). Clinical guidelines and training are also borne in mind when assessing clinical situations, being considered sources of potentially useful information, but are not used as prescribed methods for practice. Davis-Floyd and Davis (1996) believe that effectual clinical judgement is facilitated by mother-midwife relationships, where connection, understanding, trust and empathy enable the appropriate individualization of care.

The introduction of evidence-based practice (Section 2.9) and the increasing use of clinical guidelines have generated much debate about the restrictions they place on the use of clinical judgement (Spence 2014; Fava 2017). Whilst the founders of evidence-based medicine maintain that the strategy incorporates research evidence, clinical expertise and patient choice (Sackett *et al.* 1996; Feinstein and Horowitz 1997) there is now an over-

reliance on the research evidence element. Page *et al.* (2008, p.250) recount how the evidence-based practice paradigm is often accused of creating a 'cook book mentality with a recipe approach rather than an exercise in clinical judgement.' The inability to use clinical judgement in mainstream practice is an observation made many times over the decades within the midwifery literature (Robinson *et al.* 1983; Clarke 2004; Lewis 2010). Spence (2014) argues that evidence-based practice is flawed and fuels overdiagnosis and overtreatment and leaves no room for clinicians' discretion or judgement, because they are compelled to practise in accordance with 'the evidence'. He raises concerns about the use of research findings from authors with conflicts of interest, maintaining that this is rife amongst funded studies, and criticising the Cochrane Collaboration and the National Institute for Health and Care Excellence for not excluding them because of this.

Fava (2017) claims that evidence-based medicine is bound to fail, in part due to its reliance on randomized controlled trials (RCT) that were not designed to provide answers for the treatment of individual patients. These studies provide information based on averages and do not account for individual risks and reactions, so cannot be applied directly to individual people. He also raises concerns about the manipulation of research and practice by commercial organizations. Accad and Francis (2018) also argue that evidence-based practice is flawed and leads to standardization of care. They assert that practitioners who deviate from the evidence, choosing to use their clinical judgement instead, are not following evidence-based practice, although the proponents of evidence-based practice would say that they are. Accad and Francis (2018) contend that this approach is undermined if practitioners can pick and choose when they apply the evidence. A circular argument ensues where it is claimed that evidence-based practice protects against clinicians' error of judgements, whilst their judgement is necessary to evaluate the quality and relevance of the evidence and when to apply it. It is concluded that the value evidence-based practice purports to place on clinical judgement is either idealistic or insincere.

Clinical judgement is a vitally important element of care, it is personal and aims to determine what is best for a particular client at a particular time, whilst standardized care can only identify what is best for the average person in average circumstances (Accad and Francis 2018). Richardson (2017) reflects on his experience of being taught by the founders of evidence-based practice, Drs Sackett and Engel, explaining how they were able to interweave clinical judgement and relevant research evidence into person-centred care. Perhaps their vision and intention to provide the best care for individuals has been adulterated by the desire to standardize practice in the belief that it is beneficial or that the subtlety and skill of

their approach has not been adequately appreciated or understood. Dahlen (2010) writes about the hazards of allowing clinical practice to be ruled by research evidence and placing too much emphasis on the findings of studies. She argues that there is a 'deluded' trust in scientific evidence. Her example is that of The Term Breech Trial (Hannah *et al.* 2000), a multi-centre randomized controlled trial, which has changed practice globally so that most women carrying babies presenting by the breech now undergo caesarean section. The trial has been widely and robustly criticized for its methodology and claims of generalisability because of the differences between the groups of women included in the trial and the variations in the expertise of the healthcare professionals in supporting vaginal breech birth (Waites 2003).

5.8.4 Variations in practice

The participants were very aware that their practice is compared to that of the NHS and that they are often criticized when there is a divergence (Section 4.2.2). Their analysis of a guideline, for example, may be that the recommendations are not supported by strong evidence and consequently they will choose to incorporate other forms of knowledge and perhaps come to different conclusions about the best way to provide safe care. They feel bound to explain to their clients what the NHS would offer in any particular circumstance, which requires knowledge of many different hospital trusts' policies, because they have clients living across a wide geographical area and there is commonly variation between hospitals' guidelines (Section 4.5.5). Such inconsistencies raise doubts about whether hospitals are in fact basing practice on current evidence. This information is of course not reciprocated, women are not presented with the care options offered by Independent Midwives when receiving hospital care.

Midwives have been investigated for practising in ways that differ from the NHS and some disciplined for it. Wagner (1995) and Kirkham (2011b) tell us that independent practitioners are disproportionately more likely to be investigated than those working for health services. Such midwives are disciplined for practices which are not considered by the mainstream to be evidence-based and yet that same mainstream body of midwifery persists in upholding unproven practices such as fragmented care and resisting implementing continuity of care models of midwifery for which there is ample evidence of significantly beneficial effects. Practitioners working outside the mainstream have been heavily scrutinized by hospital staff, with their notes being checked, looking for evidence of mistakes, omissions or of divergent practice (Wagner 1995), in an attempt to control or restrict their practice. Those midwives

who listen to women and respect their choices are particularly vulnerable to disciplinary action (Kirkham 2011b) and yet they are practising in accordance with NMC guidance. This threat is a strong deterrent to midwives entering or remaining in independent practice (Wagner 1995) and is a source of stress previously discussed (Section 4.2.6). Whilst the desire to control midwives continues, it has serious implications for women's freedom to choose the care they want to receive, a concept supported by Department of Health policy (Maternity Safety Programme Team 2016) but one stymied in practice (NMR 2016).

Foucault (1980) wrote about the inseparable link between power and knowledge. He understood how some groups exercised more power than others and argued that groups have knowledge that is expressed in discourses and that those discourses are the basis of power. It is society, and not the group, that decides which discourses become authoritative and thus 'truth' is socially constructed. Those groups seeking to exercise more power will always contest competing discourses. Foucault theorized that power and knowledge are synergistic - a group which has its knowledge accepted as true will become powerful. With power comes discipline and control through a system of punishment and reward. He called this 'disciplinary' power. This is a subtle form of control which requires the co-operation of the subject and only becomes apparent when it is resisted. As observed by the participants (Section 4.2.6) this can be realized when not conforming to normative hospital practices and may lead to sanctions for both the midwife and the mother.

5.9 Knowledge, evidence and practice discussion summary

Sources of knowledge are many and varied although only some will be held as credible, or authoritative. Independent Midwives choose to find their information from a wide range of sources, which the autonomy of independent practice allows. The diverse knowledge is used to innovate practice and to inform and improve care for women. Pressure comes to bear on them from orthodox midwifery and medicine to conform to the norm and sanctions can be imposed when they do not do so. In practice generally, some midwives resort to concealing unauthorized practices which although they may prove beneficial to individual women do not enable evaluation or dissemination of the knowledge where benefits are demonstrated.

It is argued that the complexity of maternity care requires a more sophisticated approach than just the application of research findings or guidelines. To provide the enhanced safety of individualized care, a model of care which is inclusive of a range of knowledge is required. Clinical judgement, based on knowledge of the woman and her needs, and the midwife's clinical experience and skill is a valued element of care. A holistic approach to forms of

knowledge facilitates the provision of care which meets women's individual requirements and incorporates their knowledge, values and beliefs. Women have valuable knowledge about their bodies and what they need to effectively grow and birth their babies which Independent Midwives integrate into care. This approach results in better outcomes than for those who receive standard care.

5.10 Midwifery philosophy

In this study, philosophy as explained by the participants, refers to the way they view the women they care for, the nature of the pregnancy continuum, and their role as midwives (Section 4.8). Their philosophies form the basis for the model of midwifery they offer, where the pregnancy continuum is considered to be a normal physiological event and in which women are competent active participants, deserving of respectful care that focuses on them and which promotes their wellbeing. Hunter (2004) explains that midwives' philosophy is influential in shaping their practice and the type of care they offer. She goes on to state that conflicting ideologies in midwifery practice negatively impact midwives' working lives and consequently the quality of care they give.

When asked about their philosophy of midwifery several participants preferred to use the word 'belief' rather than philosophy, explaining that they had deeply held personal ideas and feelings about the normality of the pregnancy continuum, and how women should be cared for, but that these were not based on any knowledge of formal philosophical theories (Section 4.8.1). The other participants used the terms 'philosophy' and 'belief' interchangeably and were comfortable in doing that. The midwives discussed how the philosophy of being 'with woman' is at the heart of their practice, but also developed this, explaining how their philosophy extends beyond this and beyond beliefs about the normality of childbirth, to incorporate beliefs about women's rights to be self-determining individuals and the valuable knowledge women can contribute to their own midwifery care. The midwives' philosophy is enacted by developing trusting relationships with their clients, placing the women and their families at the centre of care, acknowledging and respecting women's knowledge, supporting their decision-making, and having shared goals.

5.10.1 Philosophy of the pregnancy continuum as a normal physiological event

Supporting women to have homebirths is an indicator of the beliefs Independent Midwives have about the normality of childbirth (Section 4.8.1). Their approach is low-tech and low-interventionist and aligned with the findings from two ground-breaking studies by Sosa *et al.*

(1980) and Klaus *et al.* (1986) that demonstrate that it is largely the social support offered to women in labour which is beneficial and enables them to achieve safe spontaneous birth. Social support is described as having numerous attributes including: being a good listener, physical touch, comfort, encouragement, emotional support, calmness, information giving, helpfulness, affirmation, empathy and kindness (Hunter 2002). Sosa *et al.* (1980) and Klaus *et al.* (1986) established that the continuous presence of a female companion (a doula) during childbirth could shorten labour and decrease the caesarean section rate. The studies have been replicated by Kennell *et al.* (1991), whose findings endorse those of the two earlier studies, showing significant reductions in caesarean section rates and the incidence of operative births. They also demonstrate that support is associated with a reduction in the use of exogenous oxytocin (a synthetic drug used to induce uterine contractions) and shorter labours. Milan (2004) explains that low rates of intervention and operative births are associated with the supportive care provided by Independent Midwives. Section 4.8.3 documents the respectful attitude the participants have towards their clients and corroborates the claims made by Milan (2005) about the nature of independent midwifery care. Hodnett *et al.* (2003; 2013) also conclude that social support in labour confers benefits to women and babies. Why these findings were not adopted and incorporated into midwifery care, as a means of improving outcomes, is difficult to understand. It is striking that it was the 'active management of labour' protocol, developed by O'Driscoll and Meagher (1980), that was instead adopted by service providers globally and which persists in medicalized care which is standard in mainstream maternity services.

This change in childbirth care illustrates the power and authority of Obstetrics whereby they were able to implement a highly medicalized, interventionist approach with little evidence to support it. The protocol involves a medicalized approach comprising the invasive artificial rupturing of membranes (amniotomy), early in labour and aggressive use of exogenous oxytocin, continuous foetal heart monitoring, along with the continuous presence of a midwife (Impey and Boylan 1999). The two technological elements of the protocol have been widely adopted across the world, whilst the element of continuous midwifery support has largely been omitted. Paradoxically this was the one element of the protocol for which there was evidence supporting its use in labour. Claims that active management of labour reduces caesarean section rates are inaccurate; Thornton (1996) reports that there is no evidence that routine amniotomy and use of oxytocin reduce caesarean section rates. Clinical trials of some of the components of active management in the late 1980s and early 1990s (Thornton and Lilford 1994) conclude that it is the psychological support component

of the protocol and not the obstetric interventions which account for quicker labours and fewer operative births. Their recommendations are that women should be provided with continuous midwifery support in labour but not the other components of active management. Goer (1993) observes how the protocol has resulted in: the diminution of individualized care and women's autonomy, increased medical interventions and costs to health services, and the introduction of physiological and psychological hazards to women.

Active management of labour has situated mainstream childbirth care in a high-tech environment. Advances in medical technology have resulted in childbirth care which is dominated by routine use of interventions (Romano and Lothian 2008). Whilst the active management of labour protocol is no longer formally used in the UK, its medical components have become integral to birth care (Downe and Dykes 2009; Begley 2014). Protocol-based care now dominates hospital practice, with frequent use of vaginal examinations and adherence to partogram protocols for tracking labour progress. The use of amniotomy and exogenous oxytocin are commonplace and consequently there is a reliance on equipment which is necessary to detect complications arising from these interventions (Tracy *et al.* 2007). There has been a lack of consideration for the potential harms caused by interfering with nature; Keirse and Chalmers (1989) caution that interventions should be clinically proven to lead to better outcomes than letting nature take its course, before being utilized. The participants showed acute awareness of the potential for causing harm by intervening without good reason, talking about how they avoid applying time limits to women's physiology and act in ways which support and optimize natural childbirth processes (Sections 4.4.1 and 4.8.1). Their approach is supported by Renfrew *et al.* (2014) in their identification of characteristics of care associated with high-quality maternity care. They highlight the need for optimizing physiological processes throughout the pregnancy continuum, sanctioning expectant management and advocating the judicious use of interventions.

Begley (2014) argues that without sound evidence demonstrating that interventions result in more good than harm, they are merely interferences. An example given by the participants was the common use of amniotomy in the NHS and its rarity in independent midwifery due to the known harms it can cause (Section 4.8.1). Rupturing the membranes around the baby is associated with statistically significant increases in abnormal foetal heart rates and foetal distress (Goffinet *et al.* 1997), possibly due to compression of the placenta, umbilical cord or baby, because rupturing the membranes removes the protective buffer they provide from the uterine contractions, by distributing the increased pressure throughout the amniotic fluid. The use of oxytocin frequently follows amniotomy, in the

cascade of interventions. Oxytocin increases the risk of hyperstimulation of the uterus. This causes restriction of the blood flow to the uterus thus increasing rates of foetal oxygen deprivation, distress and cerebral palsy (Elkamil *et al.* 2010), and following the birth causes postpartum haemorrhage for the mother (Simpson and James 2008). Hyperstimulation of the uterus also increases the risk of uterine rupture which is associated with high rates of morbidity for both mother and baby (Al-Zirqi *et al.* 2017). A significant consequence, and perhaps ulterior motivation, of shortening childbirth through induction and augmentation of labour is that hospitals have been able to minimize women's occupancy on the labour ward and to accurately plan staffing levels (Thornton 1996). This highlights the focus of maternity services on the organizational needs of the health institution rather than the women they are serving and contrasts sharply with the participants' accounts of the centrality of their clients to the service they provide (Sections 4.5.2).

The three elements of the biomedical model: pathology, body as machine, and technology (Davis-Floyd 2001; 2003; Ratcliffe 2002; Simonds *et al.* 2007) can be clearly seen at work in contemporary birth care, with the view of pregnant bodies as defective mechanisms and unrealistic expectations of how quickly women's cervixes naturally dilate, leading to unnecessary technological interventions (Davis-Floyd 2002). This stance is clearly at odds with the participants' perspectives which regard women's bodies as well-designed and capable of achieving natural birth (Section 4.8.1) and fits with the social model of midwifery, which will be explored later in this discussion. The RCM (2016b) report high levels of interventions during childbirth, with only 22% of women who experienced spontaneous onset of labour having an intervention-free birth. It is notable that data were not collected about interventions during the birth of the placenta, a key stage of labour, making it likely that very low numbers of women experience a completely physiological birth. Goer (1993) describes how with only a focus on the separate parts of a woman's body, the role of obstetricians and their assistant midwives, is to attempt to fix the faulty element – usually the uterus - using the technology of artificial hormones, infusion pumps and monitoring devices. No consideration is given to the whole woman or how her emotional and psychological states may be affecting her physiology when the biomedical approach is used in childbirth, because separation of the mind and body is a key value of medicine and regarding the constituent parts of the body in isolation is believed to enhance understanding (Davis-Floyd 2001). Consequently, women's fears and anxieties are not addressed and needed improvements to the birth environment are not attended to. A key element of

independent midwifery practice is to provide holistic care which addresses the woman's physical, psychological and emotional needs and has been addressed in Section 5.6.5.

Midwives who have only known this biomedical approach will struggle to see the normality of childbirth. Reliance on foetal electronic monitoring for example, is still a mainstay of intrapartum care (Nelson *et al.* 2016), despite the evidence demonstrating that it does not reduce the incidence of brain injury (Graham *et al.* 2006). Monitoring is linked to increased instrumental births and their associated harms to mothers and babies (Nelson *et al.* 2016). Amniotomy remains commonplace despite the guidance to support its withdrawal as a routine practice (NICE 2017), because it is now habituated into intrapartum care (Smyth *et al.* 2013). The cascade of obstetric interventions with its acknowledged potential for causing harm is well-documented but remains a feature of everyday midwifery practice (Jansen *et al.* 2013; Buckley 2015). Without critical thinking it is possible to see childbirth as a faulty process which needs surveillance and intervention to maximize healthy outcomes, whilst the possibility that surveillance and interventions are themselves causing complications and harm is ignored.

Active management of the third stage of labour has become so embedded in birth care that few midwives question its use or even view it as an intervention (Begley 2014), despite the fact that the ICM (2008) states that expectant care of women birthing their placentas is a core midwifery skill. The acceptance of this intervention by midwives reveals the fear that even if women have birthed their babies spontaneously their bodies cannot be trusted to safely finish the process - doubt clearly remains over how safe physiological birth really is (Thomas 2009). Houghton *et al.* (2008) report how midwives perceive medical interventions to be a part of normal birth and without it spontaneous birth is unlikely to happen. Fahy *et al.* (2010) however, demonstrate that when skilled midwives use holistic psychophysiological care to support women in birthing their placenta, women have significantly lower rates of postpartum haemorrhage compared to those who have had active management of the third stage of labour. They highlight that this practice requires midwives to understand the effect a woman's environment, physiology and psychology can all have on her body's ability to function optimally, as discussed by the participants (Sections 4.8.1).

In light of mounting evidence, several authors (Foureur 2008; Uvnas Moberg 2011; Odent 2015; Olah and Steer 2015) are cautioning against the use of exogenous oxytocin, which is now used ubiquitously in hospitals globally, to induce or augment labours perceived to be taking too long, because of the emergence of long-term sequelae from the disruption of the

endogenous oxytocin system. Identified sequelae include autism and obesity, in addition to the well-documented short-term effects already discussed (Section 5.10.1). Downe (2014) comments that there is a growing evidence-base that associates intrapartum interventions with increased risks of long-term autoimmune disorders, diabetes and even certain cancers. Whilst the observations of Goer (1993) are now historical, little has changed on labour wards and women are still subjected to high levels of routine interventions (Odent 2015). Davis-Floyd *et al.* (2009) claim that over-medicalized care is counter-productive because unnecessary interventions are associated with increased morbidity. Findings from Dahlen *et al.* (2013) support these claims, concluding that the continual rise in medical interventions for low-risk women may be contributing to increased rates of morbidity for mother and babies, with no reduction in mortality.

Independent Midwives describe low levels of intervention and high levels of physiological birth in their practice (Milan 2004; IMUK 2014). In contrast, Redshaw and Henderson (2015) report on a survey conducted by the National Perinatal Epidemiology Unit (NPEU) in which the findings demonstrate contrasting high rates of interventions within NHS maternity services; 40% induction of labour, 46% continuous foetal monitoring in labour, 41% operative or assisted birth, 26% episiotomy and 54% use of pharmacological analgesia. Only 16% of women report having one midwife attend them during labour and over 26% had four or more midwives involved in their birth care. Reports from 42% of women that their baby had been 'delivered' by a doctor were noted by Redshaw and Henderson (2015): commenting that there seem to be fewer births being conducted by midwives than in the past. Foureur (2008, p.76) declares that, 'we need to promote and protect normal birth simply because the future of humanity depends on it.' With rising rates of caesarean sections Odent (2015) questions whether we will even need midwives in the future, as caesarean birth becomes the norm for humans. This will of course not be without detrimental consequences. Although the safety of caesareans has improved impressively since the 1990s (Liu *et al.* 2007), there are more subtle, long-term sequelae, which are becoming evident, such as the disruption of oxytocin secretion and its effect on brain function, social behaviour and breastfeeding (Hultman *et al.* 2002, Glasson *et al.* 2004; Uvnas Moberg 2011). These reasons alone warrant further exploration of ways in which women can be better supported to birth physiologically and avoid complications for themselves and their babies, some of which may not become apparent for many years.

A belief in the normality of childbirth and the need to provide social support is not sufficient to promote and protect normal birth, midwives also need to be aware of the impact the birth

environment has on women - the physical space occupied by a woman and those people who accompany her (Sections 4.2.3; 4.5.6 and 4.8.1). Fahy *et al.* (2008) assert that because the medical model adopts a reductionist approach to women, where the uterus is considered to function in isolation from the woman's mind, it cannot consider the effect of the environment on labour, which simultaneously operates holistically and on multiple levels. The Independent Midwives demonstrate the need for a deep understanding of women's psychophysiology in facilitating positive outcomes (Sections 4.5.6 and 4.8.1). The evidence shows that midwives' behaviour is also regulated by their hormones – the presence of high levels of oxytocin is associated with empathic, competent care (Byrom and Downe 2010; Uvnas Moberg 2015). These participants recognize the connection between mind and body: the interplay between neurology, psychology and physiology, as demonstrated by Pert (1997). For each birth the midwives give consideration to which factors enable the woman to feel safe and secure and to relax into childbirth, and which make her fearful (Section 4.2.3). What women need to labour effectively has been discussed in the literature (Anderson 2002; Huber and Sandall 2007; Fahy *et al.* 2008; Odent 2013; Buckley 2015; Sakala *et al.* 2016) and principally comprises: privacy, safety, security, the presence of known and trusted people, darkness, quiet, calm, warmth and food. The findings show that Independent Midwives are cognisant of these requirements and incorporate them into practice (Section 4.2.3). Integrating these elements into the birth environment enables the limbic system - the amygdala, hippocampus and hypothalamus, to function optimally and regulate endocrine activity (Swenson 2006). In childbirth the limbic system is concerned with the release of the hormonal cocktail which drives and moderates labour (Odent 2015). It is now accepted that there is a delicate balance between the levels of oxytocin, beta endorphins, prolactin, melatonin, and catecholamines, amongst many other substances, which maintain labour but also make it sustainable and tolerable for mother and baby, although this process is not yet fully understood (Dixon *et al.* 2013). Endogenous oxytocin is described by Uvnas Moberg (2011) as an evolutionarily ancient hormone. It is a substance comprising nine amino acids which is present in all mammals. Its existence over millions of years is indicative of its essential function for mammals.

When in an optimal state for labour, women describe feeling removed from their physical reality, being 'in the zone' and having altered perceptions of time (Odent 2013; Buckley 2015; Dixon *et al.* 2013). The neocortex - the part of the brain concerned with higher logical reasoning and self-awareness (Swenson 2006) - takes a secondary role, becoming more quiescent, allowing the limbic system to dominate so the body can proceed to birth, and

unless the woman is disturbed and made to address issues mentally, such as answering questions, it stays that way (Foureur 2008). Section 4.2.3 reveals the importance, to Independent Midwives, of not disturbing a woman in labour in achieving physiological birth. They demonstrate knowledge about the effects of being obtrusive to women which is supported by Foureur (2008) and Dixon *et al.* (2013); re-engagement of the neocortex can cause the limbic system to lose dominance and for labour to slow. In undisturbed birth adrenaline and nor-adrenaline, stress hormones, which are antagonistic to oxytocin, remain low, until the latter stages of childbirth, and oxytocin and beta endorphin flow optimally, maintaining the rhythm of uterine activity and providing the woman with natural analgesia, helping her remain relaxed and allowing her body to open and release the baby.

Disruptions to a labouring woman, such as a lack of privacy or safety, as can happen when being looked after by an unknown midwife, in a room where anyone can enter, can cause the woman's brain to release adrenaline and nor-adrenaline. These hormones prevent the release of oxytocin, the key hormone required for labour, resulting in complications such as longer labours, with increased interventions that attempt to rectify the situation, and subsequent disruptions to breastfeeding and maternal-infant attachment (Buckley 2015). An unfriendly midwife can cause anxiety and stress in a woman and detrimentally affect her physiology whilst a friendly midwife can calm a woman and enhance her physiology (Uvnas Moberg 2011), thus a midwife's attitude and how she interacts with a woman are not just a matter of niceties, they are important external factors which influence how a woman's body functions.

Buckley (2009) advocates for more research to ascertain the full effects of disruption on physiology in childbirth and the postnatal period. In their research into physiological care of women during the birth of the placenta Fahy *et al.* (2010) demonstrate the importance of midwives' knowledge and understanding of normal physiology at that time. The midwives in their study focus on the birth environment and not disturbing the woman after the baby is born; instead remaining in the background and enabling the woman to focus on her baby. Skin-to-skin contact with the baby, breastfeeding, keeping mother and baby warm and having a midwife who sensitively supports the woman are key elements for promoting optimal physiology. These activities cause women to release more oxytocin and less adrenaline following the birth, reducing the risk of postpartum haemorrhage. Foureur (2008) asserts that midwives who understand the importance of undisturbed birth and work to promote it are the true guardians of birth.

In the home setting the participants discuss how they are able to help the woman create an environment and atmosphere which is conducive to physiological labour (Section 4.2.3). The preparation for this starts during pregnancy, with the development of a trusting relationship in which the woman feels secure and confident to explore her birth options and to learn about how her body works and which factors are likely to be helpful to her in labour and which might hinder (Section 4.5.2). Fear is a significant inhibitory factor to labour (Uvnas Moberg 2011) and so the mother and midwife will candidly explore issues of concern or anxiety for the woman over the course of the pregnancy. The midwives are also mindful of how birth and the environment affect them, as this will also influence the woman. The work setting has an impact on how midwives practise, Hammond *et al.* (2014) report that the physical environment and the culture of the work place may influence midwives' behaviour and activities. Rooms set up with clinical equipment suggest danger and create tension in those working within them, whilst homely settings suggest normality and engender feelings of confidence, calm and safety. Brief and Weiss (2002) describe how people's emotions and feelings at work influence performance, including judgement, risk-taking and helping behaviour. There is a clear implication that stressful work environments which induce tension and anxiety have negative effects on a person's ability to work competently (Byrom and Downe 2010). Situations in which midwives feel calm and confident lead them to release oxytocin, which is crucial in providing appropriate, compassionate and sensitive care (Donaldson and Young 2008). Creating a sense of calm is one of the midwives' aims when providing birth care (Section 4.5.4). Oxytocin release is associated with trust behaviours, empathy and helping behaviours and is described as the calm and connection system by Uvnas Moberg (2011). Midwives who are stressed and releasing catecholamines cannot release oxytocin to the same extent and are less likely to be able to provide the type of empathic care which nurtures and supports women effectively (Uvnas Moberg 2015).

5.10.2 Being 'with woman'

The 'with woman' philosophy of care underpins Independent Midwives' practice (Section 4.2.1). As an age-old hallmark of midwifery, it is much vaunted by the profession and could be assumed to be a ubiquitous facet of midwifery care and yet the inability to enact that philosophy is cited by midwives as pivotal in their decision to leave the profession (Hunter 2005; Curtis *et al.* 2006b). Contemporary NHS maternity services with their fragmented and institution-centric models of care do not facilitate the practical enactment of the 'with woman' philosophy (Hunter 2004). This philosophy derives from the word 'midwife' itself, which literally means 'with woman' (Hunter 2009). The concept defined by Hunter (2009) is

the provision of emotional, physical, spiritual and psychological support by the midwife in the context of the woman's wishes. The philosophy emphasizes the engagement of midwives on an emotional and psychological level with women and not just the undertaking of physical tasks or mere physical presence (OBoyle 2014). In contemporary maternity services being 'with woman' seems to be an idealistic aspiration rather than a reality of day-to-day midwifery care. Several authors (Hunter 2004; Skogheim and Hanssen 2015; Plested and Kirkham 2016), have described midwives as being 'with institution' rather than 'with woman' because their practice is dominated by meeting the demands of their employer rather than the needs of the women they care for. By choosing to be self-employed, Independent Midwives ensure that they are 'with woman': their clients are the focus of care and their individual needs and choices are the basis of that care (Section 4.2.2).

5.10.3 Midwifery beliefs and risk perceptions

Beliefs about childbirth, and hence the care women should receive, are intertwined with notions of risk. Clear distinctions can be seen between birthing philosophies when examining the models of care used during the pregnancy continuum. The medical and social models of childbirth, as developed by Wagner (1994), are often misinterpreted as conflicting and profession specific, with doctors all subscribing to the medical model and midwives to the social model (Walsh and Newburn 2002). The medical model is typified by its focus on pathology and use of technology to reduce morbidity and mortality. Risk is identified through the application of statistics rather than on the basis of individual factors. In contrast the social model, seen as the midwifery model, is characterized by its focus on health and normality, and taking a low-tech, non-interventionist and holistic approach, which incorporates the needs of the individual woman (Walsh 2007a). These simple descriptions represent extreme versions of the differing ideologies and it is likely that most practitioners hold more moderate, flexible views of childbirth and how to provide the best care for women. Analysis by MacKenzie-Bryers and van Teijlingen (2010) proposes that these models are fluid, existing on a continuum along which medical and midwifery professionals may occupy any position. Where midwives place themselves on this continuum will depend on their education, experience and the culture of their workplace (Hammond *et al.* 2013).

5.10.4 Women and midwives shared philosophies

Having a shared philosophy with their clients was viewed by the participants as a common experience and an important aspect of providing individualized care and enabling the development of a trusting relationship (Section 4.8.2). Many women will hire an

Independent Midwife because they share a philosophy about the normality of the pregnancy continuum (Milan 2005). In this situation women are able to relax, knowing that there is no conflict about their beliefs and that they will be supported in them. Relationships have been found to be most successful when women and midwives share the same philosophy (Sharpe 2004). Hunter *et al.* (2008) assert that a midwife's philosophy, alongside her professional autonomy and working conditions, determine the quality of the relationships she forms. Fleming (1998) reports that beliefs which underpin some midwives' practice, such as, 'birth is safest in hospital', are not necessarily shared by their clients and that this can cause tensions in the relationship. Section 4.8.2 shows that when women have a medicalized philosophy of birth, and perhaps plan to have a caesarean birth, the participants are able to support them by respecting their choices.

Some women elect to have care from an Independent Midwife because of the relational continuity and individualized care they offer, and not because they are wanting an unmedicalized experience. They choose to birth in hospital where they feel their safety and experience can be enhanced using medical technologies (Section 4.8.2). For these women, sharing a belief about their right to make informed choices which will be respected, is what bonds them with their midwife. Trusting that their midwife will support them helps women to relax and avoid the effects of stress on the pregnancy and birth (Huber and Sandall 2007). Women who choose independent midwifery care are usually wanting to be in control of their experience, commonly with the aim of achieving a physiological birth, but not necessarily so, but nonetheless need a likeminded midwife to work with (Davison *et al.* 2015). They do not want to be in conflict with their midwife; they want to be supported and respected and to have positive experiences.

A midwife's overarching belief in women's right to be autonomous can supercede conflicts regarding the nature of pregnancy and childbirth and is likely to increase safety by increasing the trust the woman has in the midwife. The more trusting the relationship is, the more likely the woman and the midwife are to be able to work together to achieve a desirable outcome (Pilley Edwards 2005). Sandall *et al.* (2016) highlight that community-based continuity of care models have a philosophy orientated towards the woman's needs rather than those of the institution. This approach along with the greater professional autonomy associated with community working, aids the development of meaningful, trusting relationships.

Helberget *et al.* (2016) comment that women in their study value having a shared philosophy with their midwives and that this is more important to them than having continuity of carer. They identified that the relational context is important to women but that relationships are formed based on common ideas and beliefs about care and respect for women and therefore as long as this element is present in all their midwives, women are happy to have the involvement of numerous midwives. Davison *et al.* (2015) confirm that having a shared philosophy is a fundamental requirement for some women but in their study the women also wanted to develop a trusting relationship with that midwife. For these women the goal was to achieve an intervention-free birth and had found the mainstream system to be restrictive and focused on risk rather than the needs of the individual. Consequently, they went about identifying a midwife who understood their beliefs and could help them achieve their goals. Edwards (2010) describes how women feel vulnerable and uncertain when there is no shared ideology about birth and birth care. Childbirth is more than just a biological process; Kitzinger (2011) emphasizes that it is a powerful, life-changing experience, impacting on women's sense of self, their mental health and ability to care for their family. The quality of the woman's experience is a top priority for Independent Midwives, positive experiences are likely to increase women's confidence and self-esteem (Hildingsson *et al.* 2013) whilst negative ones can detrimentally affect their mental, physical and social wellbeing (Williams *et al.* 2010). Conflict between women and their caregivers about beliefs and choices leads to a loss of trust, compromise in the quality of care and potentially a rejection of care by the woman (Thorstensen 2000; Plested and Kirkham 2016). Trust is fundamental to effective midwifery and 'entails a firm belief or confidence in the honesty, integrity, reliability and justice of another person' (Thorstensen 2000, p.406). Birth is described as a time of vulnerability for women (Edwards 2010), during which they need trusted people who will support their beliefs and values, in order to feel safe enough to let go and allow labour to take its course (Anderson 2010). Trust can be used to overcome differences in beliefs between women and midwives so that where a shared philosophy does not exist there is trust that each will act with integrity. Midwives need to trust in the women they care for to know and do what is best for them, whilst women need to trust that midwives will respect them and their choices and provide reliable and effective care based on their needs (Thorstensen 2000).

5.11 Midwifery philosophy discussion summary

Philosophies form the basis for the model of care Independent Midwives provide. The pregnancy continuum is considered to be a normal physiological event and women

competent participants in the planning of care. Respectful woman-focused care promotes women's wellbeing. The 'being with woman' philosophy is at the heart of Independent Midwives' practice and results in women receiving individualized care that centres on them. This type of care results in the creation of calm and optimizes physiology and improves outcomes. Supporting women supports physiology which results in normality being maintained.

A midwife's philosophy shapes her practice and the care she offers. The participants' beliefs in the normality of the pregnancy continuum are reflected in their low-tech approach and support of homebirths. Whilst some may consider this approach to be regressive it is associated with high levels of physiological birth and reduced levels of morbidity. Defensive or fearful midwifery is perceived as a risk to the environment needed for normal birth, so that women are unable to labour effectively. Fear about the safety of childbirth also leads to over-medicalization which is counter-productive and results in increased morbidity for women and babies. Having a shared philosophy is a fundamental requirement for some women, especially those aiming for an intervention-free birth. Women value having a shared philosophy and feel vulnerable and uncertain when it is absent. Conflict about beliefs can lead to a loss of trust and consequently compromise the quality of care.

5.12 Limitations of the study

The strengths of this research were previously discussed in Section 3.7. and measures taken to ensure the quality of the study were detailed therein. The criteria of trustworthiness, authenticity, dependability and confirmability were used to establish that the findings are a true representation of the data and to demonstrate how the study was conducted.

The small size of this study, as in many qualitative studies, could be seen as a limitation. However, the sample size in grounded theory studies is determined by theoretical saturation (Section 3.4.3); the point at which no new properties relating to the research aims are yielded from the data and data generation stops (Charmaz 2014). This point was reached after eight interviews, nullifying the need for further interviews. The findings from this study do resonate with the extant evidence, which suggests credibility and the potential to provide insights into other situations.

The NMC's action, which resulted in Independent Midwives being unable to provide intrapartum care, based on the premise that their professional indemnity insurance was inadequate (Section 1.5.6), came in the middle of the data generation process. This may have impacted the study by inhibiting the participants' responses to the situation (Section

3.8.2.3), although the politics surrounding Independent Midwifery was not the focus of this study and I chose to concentrate on exploring their practice and identifying its constituent parts. Most participants did not talk about it specifically however, Appendix 12 provides examples of data from three participants who whilst wanting to talk about the decision were unwilling to have their comments personally attributed. They were concerned that speaking frankly about what they perceived to be an injustice may bring further sanctions from the NMC. Whilst this action had an immediate and significant effect on their practice the participants did not see it as a permanent situation. At the time, they were focused on seeking a judicial review of the decision and having it overturned, so that they could practice freely again. This legal challenge was unsuccessful (Section 1.5.6) and it might be that if the participants were interviewed now that they would respond differently.

Their unwillingness to speak about the NMC's action does raise the possibility that there could have been other subjects that they chose not to speak about, again possibly for fear of repercussions from supervisors or their governing body. Whilst this study did not aim to explore specific clinical practices, such as how the midwives provide care during the birth of the placenta, it is recognized within midwifery research that some participants may withhold details of their practice fearing that differences (seen as deviation) from usual practice may result in them being reported by the researcher, in accordance with NMC standards (Rees 2003). My dual role of researcher and Independent Midwife may therefore also have impacted the responses given by the participants (Section 3.3.4). It is possible that the participants made assumptions about my understanding or knowledge of independent midwifery and issues surrounding it and which may have led to some subjects not being discussed.

As a doctoral study there was only one researcher performing the data generation and analysis. A second researcher could have provided more opportunities for discussion and development of the codes and categories. The analysis was however discussed with the supervisory team throughout the process as one strategy for ensuring the quality of the study (Section 3.7). A further consideration was that as a researcher and Independent Midwife I may have limited or encouraged participants' responses. I was however struck by their honesty and willingness to talk openly during the interview process about their practice.

5.13 Discussion summary

This chapter has critically analysed the five categories identified in the findings as the key components of independent midwifery, alongside the extant literature. Links have been

demonstrated between the categories and the evidence and in doing so the interconnected and interdependent links between the categories have been established. The limitations of the study have also been identified here.

Chapter 6 Model of Midwifery Care

6.1 Introduction to the model of midwifery

From the analysis of the research conducted for this thesis a model of relational continuity of midwifery care has been developed which is introduced and outlined in this chapter. The connections between the components became clear in the previous chapter and will be developed further here, where the evidence is drawn together to form a relational continuity model of care (Figure 1). The model will be evaluated using Renfrew *et al.*'s (2014) high-quality maternal and newborn care (QMNC) framework (Appendix 13) and Symon *et al.*'s (2016) identification of key components and characteristics of quality care. McCourt *et al.* (2006) emphasize the importance of clarifying concepts to ensure they are clearly defined so that elements of care can be evaluated like with like, helping identify those which are effective.

Here, the connections between all five key components of independent midwifery care are summarized and the extent of links between them made evident. Professional autonomy emerged in the discussion chapter as a vital component of midwifery. Hofmeyr *et al.* (2014) and Sandall *et al.* (2015) demonstrate excellent outcomes when midwives have autonomy over their practice. As highlighted in Section 5.2, it enables midwives to determine their own practice and to shape their working lives in ways which focus on the women. Autonomy facilitates the provision of midwifery that is responsive to women's individual needs and to providing relational continuity of care which is now considered best practice (Jepsen *et al.* 2017). By having control over when and how they work, midwives can allocate the time needed to connect with women and develop trusting relationships, whilst achieving an acceptable work-life balance for themselves (Newton *et al.* 2014; Sandall *et al.* 2016). This situation can be beneficial to both mothers and midwives. Women experience fewer interventions and higher rates of physiological birth and satisfaction (Hodnett *et al.* 2013; Tracy *et al.* 2013; Sandall *et al.* 2015) and midwives have lower levels of work-related stress when they have professional autonomy, making their practice more sustainable (Dixon *et al.* 2017). Autonomy is key to innovating practice and implementing methods of work which enhance the quality of care for women and thus improves outcomes (Richens 2002; Colvin *et al.* 2013).

The provision of adequate time has been demonstrated to be a critical factor in providing safe care and is linked closely to professional autonomy (Section 5.4). It helps facilitate the development of the mother-midwife relationship (Carolan and Hodnett 2007; Boyle *et al.*

2016) and thus the individualization of care through women's participation in its planning (Sidebotham *et al.* 2014; Baas *et al.* 2015; Newton *et al.* 2016). Individualization of care is associated with better outcomes for women (Carolan and Hodnett 2007; Aune *et al.* 2011). Having adequate time enables midwives to provide safe care, through relational continuity of care, and to identify emerging complications, be they physical, psychological or social (Wiegers 2007; Warmelink *et al.* 2015; Newton *et al.* 2016). Having time allows midwives to develop their practice and ensure that the care they offer is safe and promotes women's health (NMR 2016). Midwives who lack time cite it as a significant cause of stress and a reason for leaving the profession, both of which result in poorer care and increased risk to women (Ball *et al.* 2002; RCM 2016). Time from the woman's perspective allows expression of concerns and the space to confide personal issues which may have a significant impact on her or the care she requires (Vedam *et al.* 2017).

Mother-centred care is achieved through the development of the trusting relationship which is contingent on midwives having autonomy and time, and working in the relational continuity of care model (Section 5.6). Relational care is associated with better outcomes for women, both physical and psychological (Kirkham 2010; Sandall *et al.* 2015). Trusting relationships invoke feelings of calm in women which in part accounts for their better outcomes (Huber and Sandall 2009; Kirkham and Jowitt 2012). This situation can be contrasted with the undesirable, but common state where women experience high levels of stress during pregnancy (Section 5.6.3). This is associated with preterm birth, infections and other sub-optimal physiological responses, due to high levels of stress hormones (Wadhwa *et al.* 2011). Relational continuity of care has been shown to reduce the effects of social inequalities in health, by reducing the rates of preterm birth in women living in poverty - a group who experience high rates of preterm birth (Sandall *et al.* 2016). Midwives providing relational continuity of care derive real job satisfaction and are less likely to suffer work-related stress (Jordan *et al.* 2013; Mollart *et al.* 2013 Yoshida and Sandall 2013; Crowther *et al.* 2016). They are consequently more likely to find their work sustainable which impacts positively on the midwifery workforce, which impacts positively on women's safety and outcomes.

When a midwife knows a woman, because she has a trusting relationship with her, she is more likely to view the woman with respect and acknowledge her opinions, beliefs and right to make decisions about care (Dahlberg and Aune 2013). Midwives who provide relational continuity of care are considered to be more competent because of the knowledge they have of their clients and the trust that runs between them (Stevens 2011). Incorporating women's

knowledge enables care to be individualized, resulting in safer care and better outcomes (Tracy *et al.* 2013; Jordan 2014). The application of midwives' knowledge and experience contributes to safer care as again it enables care to address the needs of the individual woman (Davis-Floyd and Davis 1996; Newton et a. 2016).

Midwifery philosophy is a key determinant in how midwives practise (Houghton *et al.* 2008), although those working within health services may experience dissonance between their beliefs, in normality for example, and the medicalized culture of the institution which requires them to practise accordingly (Hunter 2004). Those who believe that the pregnancy continuum is a physiological event are more likely to practise in ways which promote and support physiological birth, which in itself promotes health (Walsh 2007a; Carlson and Lowe 2014). Women and midwives who share philosophies are more successful at developing trusting relationships (Davison *et al.* 2015; Helberget *et al.* 2016) and trust and safety are inextricably linked (Pilley Edwards 2005). Those who believe in the efficacy of the mother-midwife relationship are more likely to provide relational continuity of care and reap the benefits of individualized care for the women and themselves (Olafsdottir 2006). Women who trust in themselves have an increased capacity to birth physiologically, thus increasing safety and improved outcomes (Lundgren 2004; Davies and Iredale 2006).

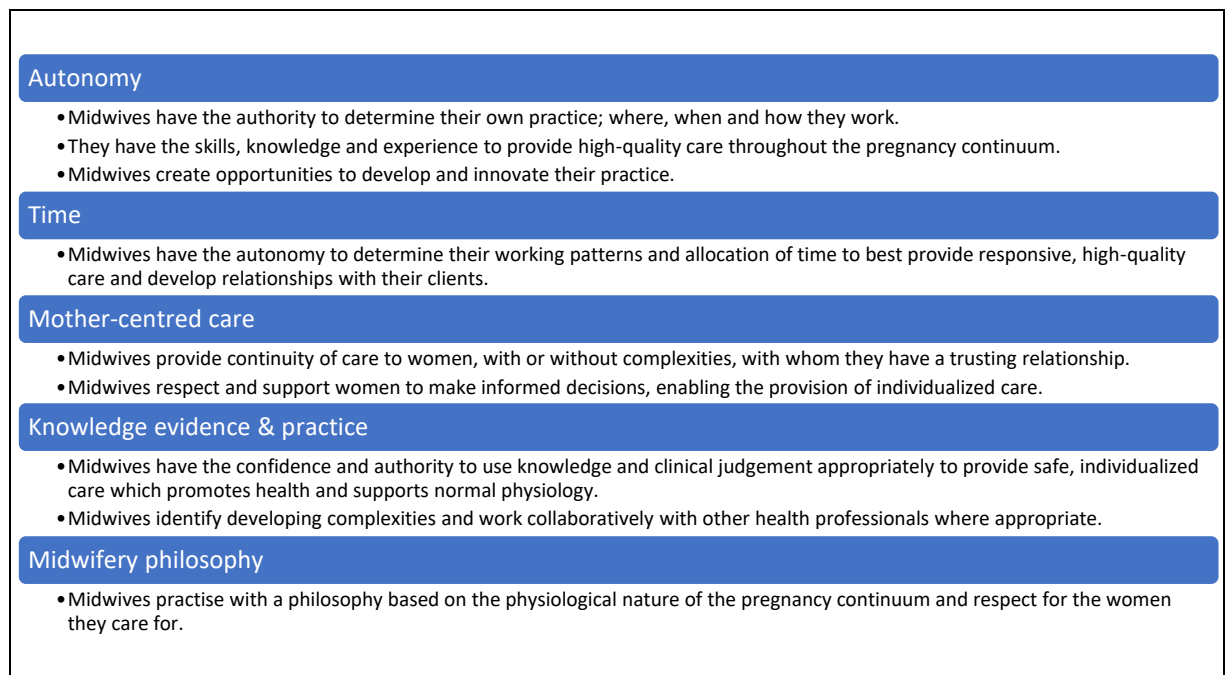


Figure 1 Model of relational continuity of midwifery care

This model has the characteristics Fahy (2012) claims meet the benchmark for being considered a midwifery model of care and is in accordance with the evidence supporting effective midwifery practices. Fahy (2012) describes a model of midwifery as one in which midwives practise in line with professional definitions of midwifery philosophy and where they have the skills and knowledge to provide continuity of care to women, with whom they have a relationship, throughout the pregnancy continuum. Within a midwifery model of care midwives understand, promote and support undisturbed birth and have the knowledge and clinical reasoning necessary to engage in decision-making processes. Finally, midwives are adept at using their clinical judgement in normal and abnormal situations and accept responsibility for their decision-making.

This model is examined and evaluated here (Table 3) alongside the QMNC framework developed by Renfrew *et al.* (2014), and Symon *et al.* (2016) who identify the characteristics and components of high-quality care.

Table 4: Comparison of model of relational continuity of midwifery care with QMNC framework and Symon *et al.*'s identification of components of high-quality care

Model of relational continuity of midwifery care	Renfrew <i>et al.</i> (2014) QMNC criteria	Symon <i>et al.</i> (2016) components of quality care
<p>Autonomy</p> <ul style="list-style-type: none"> Midwives have the authority to determine their own practice; where, when and how. Caseloading is the method of working They have the skills, knowledge and experience to provide high-quality care throughout the pregnancy continuum Midwives create opportunities to develop and innovate their practice 	<p>Not identified within the criteria</p> <p>Organisation of care Care providers</p> <p>Organisation of care</p>	<p>Autonomy not specified as a component</p> <p>Caseloading is supported for its positive effects on birth outcomes and women's preference for it</p> <p>Small caseloads associated with higher levels of continuity and quality of care</p> <p>Midwifery knowledge and skills have a significant impact on safety of care</p>
<p>Time</p> <ul style="list-style-type: none"> Midwives have the autonomy to determine their working patterns and allocation of time to best provide responsive, high-quality care and develop relationships with their clients 	<p>Not specifically identified within criteria</p>	<p>Not specifically identified as a component of high-quality care</p>
<p>Mothered-centred care</p> <ul style="list-style-type: none"> Midwives provide health promoting, individualized continuity of care to women, with or without complexities, within a trusting relationship Midwives respect and support women to make informed decisions, enabling the provision of individualized care 	<p>Organisation of care</p> <p>Practice category – education, information, health promotion</p> <p>Values</p> <p>Philosophy</p> <p>Practice category – assessment, screening and care planning</p>	<p>Individualized care is associated with improved outcomes</p> <p>Respectful care is associated with improved outcomes</p>
<p>Knowledge, evidence & practice</p> <ul style="list-style-type: none"> Midwives have the confidence and authority to use knowledge and clinical judgement appropriately to provide safe, individualized care which promotes health and supports normal physiology Midwives identify developing complexities and work collaboratively with other health professionals where appropriate 	<p>Organisation of care</p> <p>Care providers</p> <p>Philosophy</p> <p>Practice category – promotion of normal processes</p> <p>Practice category – first-line management of complications</p>	<p>Midwifery knowledge and skills have a significant impact on the safety of care</p> <p>Timely identification and management of complex cases reduce morbidity and mortality rates</p>
<p>Midwifery philosophy</p> <ul style="list-style-type: none"> Midwives practice with a philosophy based on the physiology nature of the pregnancy continuum and respect for the women they care for 	<p>Philosophy</p> <p>Values</p>	<p>Underpinning philosophy is a factor in the efficacy of midwifery practice, linking to promotion of normality and health</p>

Renfrew *et al.* (2014) confirm the essential contribution midwifery makes to improvements in the quality of maternity services and the reduction of maternal and newborn mortality. Their analysis of what constitutes high-quality care is helpful in verifying that the components of practice required to provide high-quality care and likely to result in positive outcomes are present in Independent Midwives' practice. They endorse a more physiological approach to care by highlighting how the overuse of interventions designed to manage complications is causing significant iatrogenic harm to women and identify the vital need for maternity services to focus on the normal physiological processes of the pregnancy continuum and to promote practices which support it. This stance is one clearly demonstrated as underpinning Independent Midwives' practice. To achieve this in maternity care generally Renfrew *et al.* (2014) suggest that this requires a shift from the current situation where care is centred on the identification and treatment of pathology. A move from fragmented care is proposed, to a system which provides supportive continuity of care, is tailored to the individual needs of the woman and promotes health. Again, these have clearly been demonstrated to be fundamental elements of independent midwifery care.

Within the QMNC framework the philosophy and values of midwives is seen as a crucial component in effective care, whereby those who believe in the normality of the pregnancy continuum have an approach which is supportive of physiology. Independent Midwives' belief in the physiology of the pregnancy continuum guides them in the care they provide, the way they communicate with their clients, and the methods they adopt to help maintain or optimize normality. Respectful care in the context of trusting relationships is highlighted by Renfrew *et al.* (2014) as an essential aspect of maternity care for women, which supports individualized care and encourages them to engage with maternity services. The participants expounded the crucial nature of respect and the development of trusting relationships in providing effective, safe care to their clients. It was however surprising that professional autonomy and time – two components of independent midwifery identified by the participants as vital in being able to provide high-quality care – were not included in the QMNC framework. It is possible that these components are assumed to be ubiquitous in midwifery practice and therefore not specified, yet the literature provides clear evidence that they are not (Stapleton *et al.* 2002; Pilley Edwards 2005; Deery 2008; Hunter *et al.* 2015; Jepsen *et al.* 2016).

Using the QMNC framework Symon *et al.* (2016) have developed a strategy for identifying and assessing the features of care models which are likely to be resulting in improved outcomes for mothers and babies. They comment that there is often a lack of reporting in studies about midwifery models regarding the content of care, the values or philosophy underpinning the model, the promotion of normality, women's decision-making or the competency of the workforce, which creates difficulties in determining which models are likely to be effective. This thesis has provided a clear and detailed account of independent midwifery. The practice categories in the framework set out the characteristics of care required by all women and the specialist care required by women and babies presenting with complications - all women require: education, information and health promotion; assessment, screening and care planning and promotion of normal processes and prevention of complications. Women with complications require timely identification and referral to appropriate services. These characteristics have been identified within independent midwifery practice.

Symon *et al.* (2016) identify caseloading midwifery as a model which should be supported for its positive effects on birth outcomes and women's preference for it, over more traditional shared care models. The size of the caseload is fundamental to the quality of care, with smaller numbers associated with higher levels of continuity and quality of care, and these findings are corroborated by the participants. The values and philosophy underpinning care which respect and support women's autonomy and result in individualized care are recognized as being factors in the efficacy of midwifery practice and link to the promotion of normality and health and have been explicitly described by the midwives in this study. Midwifery knowledge and skills have a significant impact on the safety of care and emphasis is placed on the timely identification and management of complex cases and emergencies and the inclusion of multi-disciplinary team working to reduce mortality and morbidity rates. How independent midwives develop their knowledge and skills and use them to provide high-quality care has been explored extensively in this study. The provision of postnatal care from a known midwife who has knowledge of the pregnancy and birth is tentatively suggested by Symon *et al.* (2016) to confer benefits on women including: feeling psychologically supported, improving breastfeeding rates and preventing postnatal depression. It is indicated that continuity of care postnatally may also improve longer term outcomes. The participants are more assertive in their claims about the benefits of postnatal care. They have always provided relational continuity of care postnatally and been able to observe its effects, whilst the health service has reduced its provision to a minimum. The

lack of evidence about the benefits of this care may just be a reflection that this care is not in evidence within mainstream services and therefore unable to be researched.

The model for midwifery developed in this thesis has been demonstrated to align closely with the QMNC framework. It identifies the presence of the components and characteristics of high-quality care described by Symon *et al.* (2016). The efficacy of this model of care is determined by the provision of the entire package of care - all the interlinking and interdependent components must be present in order to achieve optimal outcomes, for women and midwives. Individually it has been proven that each component is beneficial, but does an accumulating effect occur when all the components are present and used in conjunction? Is the whole greater than the sum of its parts? This possibility is suggested by McCourt *et al.* (2006) who argue that models of care such as this are complex and that merely distinguishing their constituents does not necessarily provide information about the overall benefits they confer.

To illustrate the complex nature of this model, and the connections between and interdependencies of the components, which necessitates the inclusion of them all within the model for it to be wholly effective, graph theory has been utilized (Figure 2).

A graph (G) is a data structure that is defined by two sets of components: dots, called vertices (V), or nodes, and lines connecting two vertices known as edges (E). A graph can be used to simplify complex relationships and provide a visual representation of interconnected objects and demonstrate how they are related. $G = (V,E)$ is the formal mathematical notation for defining graphs (Chartrand and Zhang 2012).

The graph is used to provide a visual representation of the components of Independent Midwifery and demonstrates their connections. Each component is represented by a vertex and the connections, which in this case represent dependencies, between vertices are shown using lines known as edges. The arrows show the direction of dependency between two vertices.

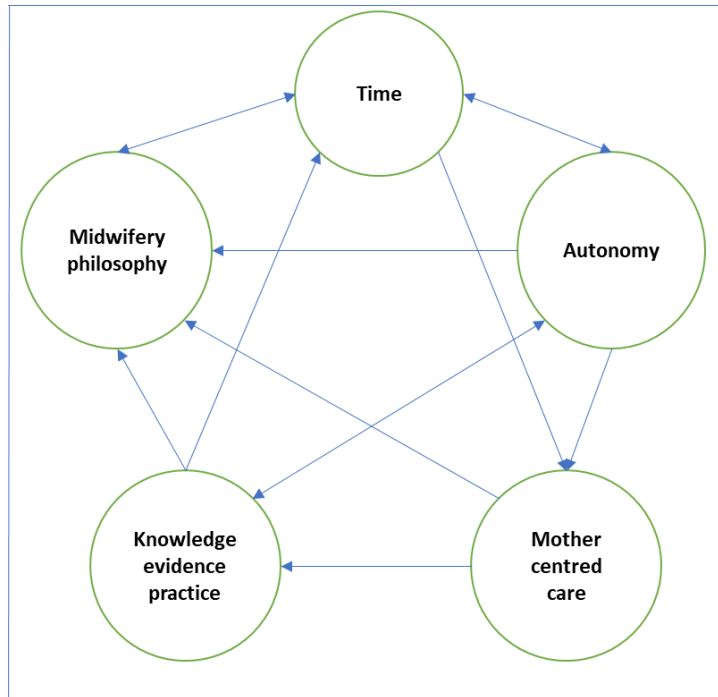


Figure 2: Relationships between the components of relational continuity of care model of midwifery

This study has identified the key components of midwifery care provided by Independent Midwives and demonstrated that their implementation into practice is supported by extant evidence. For example, there is an association between relational continuity of care, individualized care and the allocation of adequate time and positive health gains. It is therefore suggested that by incorporating elements of care into practice such as these, which are established in the literature as resulting in physical and psychological benefits, care can be enhanced and improvements made to outcomes for mothers and babies.

Chapter 7 Conclusion

This thesis is a unique exploration of the perceptions and experiences of Independent Midwives working in Mainland UK, offering fresh insights into their practice and contributing original evidence to the body of knowledge about them and their model of midwifery. A gap was identified in the literature regarding independent midwifery with previous studies having only examined specific elements of Independent Midwives' practice such as their approach to supporting the birth of the placenta or the ways in which they assess progress in labour. Whilst generating valuable knowledge these studies did not provide the full context of independent midwifery practice.

The current study identified five, interrelated, key component parts of independent midwifery practice. First, it can be concluded that professional autonomy is a vital factor in enabling Independent Midwives to practise in ways they consider best serve their clients. Without the constraints of an employing organisation they have the professional freedom to choose which model of care they utilise and how they apportion their time. This facilitates the establishment of mother-midwife relationships and an acceptable and sustainable work-life balance. They are able to implement practice innovations easily and quickly and make improvements to the care they provide. Section 5.2.2 provides corroborating evidence of the importance of professional autonomy in providing high-quality, sustainable midwifery care. Section 2.6.4 substantiates the link between midwives' and women's autonomy and how this enables women to make informed choices.

Secondly, time was found to be of great significance in being able to practice safely and effectively. Whilst there is not a large body of evidence about time in the midwifery literature, it is a subject the participants talked about in detail. In studies regarding midwifery retention, midwives cite lack of time as a factor which prevents them from giving high-quality care and as a leading reason for them leaving the profession (Sections 2.6.5 and 5.4.3). A lack of time is also identified as a significant factor in low-quality care and poor outcomes (Section 5.6.4). Independent Midwives choose to allocate significant amounts of time to getting to know their clients and developing trusting relationships with them and their families, which confers benefits to women and their babies as discussed in Section 5.4.1. Without the constraints of shift working they are free to determine when they work. They have flexibility in rearranging appointments when they have unexpected commitments and are able to balance work and rest with relative ease which supports the sustainability of their practice. Section 5.4.7 incorporates evidence which shows that midwives' inflexibility

in when they work has been a contributing factor to the failure of some continuity of care schemes. Independent Midwives' model of care is orientated to their clients' needs and so they work when they are needed and take time off when they are not. It can be concluded that their approach to use of time is more fluid than that of hospital services, which are generally embedded in clock time, and also centres on the needs of the women.

Thirdly, mother-centred care is the resultant outcome when Independent Midwives provide respectful continuity of care that attends to the woman's personal and changing requirements. Continuity of care enables the establishment of a trusting relationship between the mother and midwife. This facilitates the individualization of care and results in safer care and better outcomes for women (Sections 5.6.1 and 5.6.4). Whilst there is a lack of clarity in the literature about what constitutes continuity of care (Section 1.5), the participants in this study have clearly elucidated what they mean by continuity of care - it is the provision of respectful, individualised care throughout the pregnancy continuum, by a known midwife, with whom the woman has established a trusting relationship and is more accurately termed relational continuity of care.

Fourthly, the knowledge and evidence Independent Midwives use impacts how they practise and the quality of care they provide. Their autonomy enables them to determine which types of evidence can be used to guide them and notions of there being a single form of authoritative knowledge are rejected by them (Section 5.8.2). They appreciate the value and validity of experiential and inner knowing and do not see it as inferior or less authoritative than evidence gained from research studies. Because of the complexity of maternity care Independent Midwives believe that the inclusion of evidence from their own experience and that of their clients is required in order to provide the safest, most individualised care. In the findings (Section 4.7.2) they argue that the application of research findings or guidelines alone is insufficient. This belief is substantiated in Section 5.8.5, where the evidence demonstrates that in order to provide individualised care and gain its associated improved outcomes, women's knowledge and values must be integrated into the plan of care. Section 5.8.1 provides support for the inadequacy of research-based evidence in addressing the multifaceted nature of maternity care. Independent Midwives' use of a wide variety of sources of knowledge is in keeping with recommendations for the adoption of a continuum of childbirth knowledge, described as 'holistic knowing', for enhancing the safety of care (Section 5.8.2).

Finally, philosophy underpins and guides Independent Midwives' practice. They consider the pregnancy continuum to be a normal physiological event. Consequently, the care they provide is designed to promote or enhance physiology, and thus promotes women and babies' health (Section 5.10.1). Their belief in normality guides them to avoid routine interventions which may introduce iatrogenic harms, and to tailor care to the specific needs of the woman. The participants report a high degree of congruence in their philosophical beliefs with their clients which is demonstrated in Section 5.10.4 to result in the successful development of trusting relationships, which in turn is associated with more individualization of care and improved safety and subsequently better outcomes. The participants' beliefs in women's right to autonomy and respect for their decision-making also contributes to better outcomes because it facilitates provision of care which is individualised to their particular needs (Section 5.2.2).

The original contribution from this study is the identification of the key components of independent midwifery, and exploration of their connections and dependencies, and the development of a model of relational continuity of midwifery care reflecting those findings.

The findings are also important because they add to the literature around relational continuity of care, supporting women's autonomy during the pregnancy continuum and sustainability in midwifery. These findings can be applied in relation to theoretical, policy and practice recommendations.

My aim is to inform others of the findings of this study, which I hope will result in improvements to women and midwives' experiences of maternity care. I will disseminate the findings and knowledge gained from this study through presentation at conferences and the publication of articles. I have submitted an article for publication already, relating to the issue of time in midwifery (Appendix 14).

7.1 Recommendations for further research

This study has shed new light on the practice of Independent Midwives in Mainland UK, bringing clarity about what they believe to be the key components of their model of midwifery. The Independent Midwives have spoken about the benefits their care brings to women (Section 5.6.1), and as such a further area which would be interesting to research is the women who choose to engage the services of Independent Midwives. Further research is needed to explore their reasons for electing to receive this model of care and to seek their experiences and perceptions of it. This would enhance our knowledge about the importance of relational continuity of care and choice in maternity care, from women's perspectives.

In light of the actions of the NMC during the course of this research it is important to conduct research with Independent Midwives to gain greater understanding of their decision-making process around determining the inadequacy of the professional indemnity insurance product Independent Midwives had arranged with their insurer (Section 1.5.6). It seems for Independent Midwives to be able to arrange adequate insurance they need to understand what the basis was for determining their previous cover as being inadequate.

Finally, further research is needed in the way some Independent Midwives are apparently dependent on NHS bank contracts to practice (Section 1.5.6). We need research into how this professional contract can affect their ways of working.

Chapter 8 Recommendations

This study should be of interest to policy makers and commissioners who are currently planning and commissioning maternity services, in-line with government maternity policy, to include relational continuity of care, women's choice and postnatal care. Awareness of the findings of this study would support the introduction of these new ways of working in the NHS and help avoid the pitfalls experienced previously when attempts have been made to introduce relational continuity of care.

Since this study suggests that the relational continuity model of care can be a sustainable and satisfying way of working for midwives (Sections 5.2.3; 5.6) policy-makers and commissioners should consider that providing this model of care, throughout the pregnancy continuum, not only benefits women but also midwives as it is a rewarding model of care for them which could improve retention of midwives in the NHS. As shown in this study (Sections 5.2; 5.4) the provision of relational continuity of care is contingent on the presence of professional autonomy and time and as such measures need to be taken that afford midwives greater autonomy and time in which to provide this model of care effectively.

This study will also be informative to universities who are educating the midwives of the future. Universities should incorporate more relational continuity of care approaches into midwifery education so that students develop an understanding of the crucial role individualised, relational continuity of care plays in providing the safest care to women (Section 5.6.1) and the concomitant benefits it confers to midwives (Section 5.2.3).

As discussed in Section 5.2.3 Independent Midwives provide valuable support for their colleagues which makes their practice sustainable. Independent Midwives must ensure that they continue to provide each other with the positive emotional and psychological support alongside the exchange of ideas, knowledge and skills which promotes high-quality care. Independent Midwives' re-engagement with the government to find a suitable solution to the professional indemnity insurance issue is encouraged here as this could enhance public safety and choice (Section 5.2.2).

In order to make relational continuity of care a viable option for mainstream NHS maternity services a systems-level change is required within the organisation which enables midwives to move from a fragmented system to one in which individualized, mother-centred maternity care is available to all and in which midwives are professionally autonomous. The findings

from this study demonstrate the crucial role professional autonomy has in the provision of relational continuity of care and support this recommendation (Section 5.2).

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Legislation

Data Protection Act 1998

Human Rights Act 1998

Montgomery v Lanarkshire Health Board [2015] UKSC 11

Statute (Definition of Time) Act 1880

Appendix 1: Invitation to Participate in Research



Version 2.0

June 2016

Invitation to Participate in Research

Study: How do Independent Midwives view Independent Midwifery?

I am conducting research exploring the practice of Independent Midwives, as part of my PhD at Bournemouth University. The reason for this study is that despite evidence demonstrating that Independent Midwives provide care that results in higher rates of spontaneous birth, healthy mothers and babies, and breastfeeding compared with NHS care, there is little research looking at what they do and how they achieve these outcomes. Therefore this study aims to interview Independent Midwives and explore the care they provide to women throughout pregnancy, labour and the postnatal period.

Participation in the study is entirely voluntary and will involve being interviewed about your midwifery practice. I anticipate that the interview will take 60-90 minutes and will be arranged at a time and place to suit you.

The findings from this study will contribute to the body of evidence about Independent Midwifery practice and help health professionals and women using maternity services to understand how Independent Midwives' care results in safe outcomes for mothers and babies.

To be eligible to participate you would:

- Be a Nursing and Midwifery Council registered midwife
- Have experience of providing care as an Independent Midwife in the UK
- Be English speaking

I am very keen to include you in this research. If you are interested and would like further information please contact me:

Michelle Irving – Post Graduate Research Student

Email: mirving@bournemouth.ac.uk

Phone: 01202 625677

Mobile: 07799038376

Appendix 2: Participant Information Sheet



Participant Information Sheet

June 2016 (Version 2.0)

You are being invited to participate in a research study. Before you decide whether you wish to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish, before making your decision. You can contact me if there is anything that is not clear or if you would like more information.

Study Title

'Independent Midwifery in the United Kingdom as Perceived by Independent Midwives'

What is the purpose of the study?

I am undertaking this research as part of a PhD at Bournemouth University. The aim of the study is to explore the care provided by Independent Midwives. There is very little research looking at what Independent Midwives do and their reasons behind particular practices. The Independent Midwives Association database project (Milan 2004) demonstrated that care provided by Independent Midwives results in higher rates of spontaneous birth, healthy mothers and babies, and breastfeeding compared with care provided by the NHS. The database project was unable to provide an explanation for how Independent Midwives achieve these outcomes and so this research aims to extend the findings of the project by explaining how Independent Midwives care for mothers and babies.

Why have you been chosen?

As an Independent Midwife it is anticipated that you have relevant knowledge and experience of providing Independent Midwifery care to women that will inform this study.

Do you have to participate?

Your participation is entirely voluntary. If you choose not to take part you will not experience any penalties. You are able to withdraw from the study, without prejudice, and without explanation up until your data has been analysed. Until this point any data you

have given will not be used in this research. If you do choose to participate you will be asked to sign a consent form, although you will still be free to withdraw after that time.

What will taking part involve?

You will be invited to participate in an individual, semi-structured interview about your midwifery practice. The interview will be arranged at a time of your convenience and it is estimated that the interview will last 60 to 90 minutes. The interview can be conducted face-to-face, in a private place of your choice, such as your home, or by Skype if you prefer, and will be digitally recorded to enable transcription and analysis of the data.

Possible disadvantages

It is not anticipated that participating in this study will result in any harm to you. However, it is possible that in retelling past experiences you may feel uncomfortable or become emotionally distressed. If this happens the interviewer will help you to seek extra support if necessary, this could include your Supervisor of Midwives or your General Practitioner.

Possible advantages

Participating in this study will give you the opportunity to share your knowledge and experiences in supporting women throughout their midwifery care. This study will enable the midwifery profession to understand the care given by Independent Midwives and the ways in which practice can be developed, with the potential for improving the experience of women and babies.

Will my participation be kept confidential?

Your identity, any identifying factors and information from your interview will be kept confidential. Your information will not be shared with anyone other than the researcher. The researcher's supervisors will have access to your data after anonymisation, thereby protecting your confidentiality. Excerpts from your interview, that are included in the final paper, will be anonymised and you will not be identified. A pseudonym of your choosing will be used to maintain your confidentiality. Recorded interviews and transcripts will be securely stored and destroyed after completion of the study, in accordance with the Data Protection Act 1998. Bournemouth University's Research Ethics Code of Practice (2014) requires that data is retained for five years after the award of the degree. After this time the data will be securely destroyed.

What will happen to the findings of the research study?

The findings of this study will be disseminated via a PhD thesis, conference papers and journal articles. The findings will be made available to all research participants. A copy of the thesis will be held at Bournemouth University library.

Who is funding this study?

This study is funded solely by the researcher

Who has reviewed this study?

Bournemouth University Research Ethics Committee – approval granted 24/6/2016

Organisation: Bournemouth University

Researcher: Michelle Irving (Registered Midwife and PhD student)

Email: mirving@bournemouth.ac.uk

Bournemouth University

Faculty of Health and Social Science

R605 Royal London House

Christchurch Road

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BH1 3LT

Tel: 07799038376

Supervisory team:

Professor Edwin van Teijlingen

Email: evteijlingen@bournemouth.ac.uk

Tel: 01202 961564

Dr Catherine Angell

Email: cangell@bournemouth.ac.uk

Tel: 01202 961543

If you have any questions or require further information about this study please contact me, Michelle Irving

If you have any complaints about this study please contact:

Deputy Dean for Research and Professional Practice

Bournemouth University

Faculty of Health and Social Science

Royal London House

Christchurch Road

Bournemouth

BH1 3LT

Appendix 3: Participant Consent Form

Participant Consent Form (Version 2.0)

June 2016

Title of study: "Independent Midwifery in the United Kingdom as Perceived by Independent Midwives"

Name of researcher:

Michelle Irving

Contact details:

Bournemouth University
Faculty of Health and Social Science
R605 Royal London House
Christchurch Road
Bournemouth
Dorset
BH1 3LT
Email: mirving@bournemouth.ac.uk
Tel: 07799038376

Organisation: Bournemouth University

Supervisory team:

Professor Edwin van Teijlingen

Email: evteijlingen@bournemouth.ac.uk
Tel: 01202 961564

Dr Catherine Angell

Email: cangell@bournemouth.ac.uk
Tel: 01202 961543

Please
initial box

I confirm I have read and understood the participant information sheet dated June 2016 version 2.0 for the above study.	
I confirm I have had the opportunity to ask questions.	
I understand my participation is voluntary and I am free to withdraw, without explanation, anytime until my data has been analysed.	
I understand my involvement will be to participate in a semi-structured interview, in a private setting of my choice, lasting approximately 60 to 90 minutes.	

I give permission for the interview to be digitally recorded by the researcher for later analysis and understand that my confidentiality will be protected by changing my name and removing any identifying factors in the documentation.	
I understand that I will be able to choose a pseudonym for the purpose of protecting my confidentiality.	
I give permission for the supervisory team to have access to my data after anonymization.	
I understand that material relating to the study e.g. interview recordings, transcripts, coding process and consent forms will be securely retained for a minimum period of 5 years in accordance with the University Code of Practice (2014) after which it will be securely destroyed.	
I agree to take part in the above research project.	

Printed name of participant Date Signature

Printed name of researcher Date Signature

When completed 1 copy to be given to the participant and 1 copy to be securely stored by the researcher.

Appendix 4: Interview guide for semi-structured interviews

Interview guide for semi-structured interviews (version 3)

Interview questions

1. Age – a. (21- 30) b. (31-40) c. (41-50) d. (51-60) e. (61-70+)
2. Can you tell me if you have personal experience of birth?
3. How long have you practised as a midwife?
4. How long have you worked independently?
5. Is there is a typical way Independent Midwives provide care?
Prompts
 - Continuity of care
 - Mother-midwife relationships
 - Centrality of care to woman and her family
 - Decision-making
 - Information exchange
 - Schedule of care
6. Can you tell me how Independent Midwives work differently from midwives working for the NHS?
Prompts
 - Routines of care
 - Time
 - Effect of employer/employee arrangement
7. Are there any differences in how you provide care antenatally, during labour and throughout the postnatal period?
8. Are you aware of the stats for your practice?
What do you think of them?
How do you maintain your outcomes over time?
9. Can you tell me about the knowledge, evidence, guidelines or policies on which you base your practice?
Prompts
 - Personal experience
 - Women's preferences for care
10. What is your philosophy as an Independent Midwife?
Prompts
 - If you and your colleagues have a discussion about this what would it be about?
 - Feminist view point – valuing women's voices, opinions and choices
 - Equality in relationships

Ideology
Model of midwifery care
Physiology vs hazardous event

11. How does it feel to be an Independent Midwife?

12. How would you describe your typical client?

Prompts

Age

Education

Social grade of chief household income earner

Parity

Previous birth history

Self-selection criteria

Do you have a selection criteria for the women you care for?

13. Is there anything else you expected me to ask you?

14. Is there anything you would like to add?

Appendix 5: Development of analysis memos

Memo 1

Basic analysis of the first interview, listening to the digital recordings of the interview as soon as possible after the interview took place. Listening and transcription was initiated the next day following the data collection. Many expected issues were discussed, would be surprising if having worked as an IM for nearly 20 years that many would be unexpected. 'Claire' talked about the support she receives from colleagues and how this enables her to practise this way – for some reason I had overlooked this, even though I have also found it invaluable over the years. It is good to be surprised. I can't claim to have always been analytical about what I do professionally, I support women because they respond well to it and because it feels right, I haven't researched formally what all the benefits are. Already leaping out at me as a disconfirming case is Claire's belief that women never make decisions that may place their babies at risk, it will be interesting to see if anyone else has those thoughts.

Memo 2

After the second interview was transcribed and initial coding undertaken I compared the codes with those from the first interview, I was able to see similarities with 'Claire's' interview as well as some new ideas from 'Steph'. The midwives talk in terms of known, established aspects and models of care such as continuity of care and I am struggling to see how I can elevate that to a concept, as it already is one. Their in-vivo codes are the end point of the analysis. They also talk about the 'relationship' – another well-established midwifery concept. What I am going to do is to ask them about what that means to them, to find out for example what continuity of care looks like to them individually, almost going backwards in the process, so does it include continuity of carer throughout pregnancy, labour and the postnatal period? Continuity of care in the NHS frequently only means during the antenatal period, and rarely during labour, so I need to make this distinction clear.

Appendix 6: Coding development

Initial codes	Focused codes	Categories
Getting to know the woman Emotional bond Intimacy	Trusting relationship Trusting relationship Trusting relationship	Relational mother-centred care
Caseloading Continuity of care and carer Client-led care Home-based care Individualised care (it's seamless, it's easy, it flows Alison p4) Care based on women's needs and wishes	Individualised care Individualised care Individualised care Individualised care Individualised care Individualised care	
Psychological and physical care of family Pregnancy and childbirth treated as normal events	Holistic care Salutogenic approach	
Flexibility of care Professional friendship Mutuality and reciprocity Learning from women	Partnership working Partnership working Partnership working Partnership working	
Supporting empowerment of women Use of evidence in decision-making	Women's empowerment Women's empowerment	
Woman has power Women making informed decisions Women encouraged to explore sources of knowledge	Women's autonomy Women's autonomy Women's autonomy	

<p>Respecting what women say Women having opportunity to discuss thoughts and feelings Communicating as equals Trusting women's ability to birth (distrust disempowers)</p> <p>Conscious use of open questions – facilitating discussion Awareness of non-verbal communication Use of unemotive, non-medicalised language Listening to women</p>	<p>Women's autonomy Women's autonomy Women's autonomy Women's autonomy</p> <p>Communication Communication Woman-centred communication Respectful communication</p>	
<p>Freedom and choice to allocate time in practice Time to develop mother-midwife relationship Time to research sources of knowledge</p>	<p>Time as an investment Time as an investment Time to develop knowledge</p>	<p>Time as a valued resource</p>
<p>Valuing providing high-quality care</p> <p>Practising to full extent of the midwifery role Not constrained by institutional or medical protocols Practice not compromised by the needs of a system Compliance with NMC Code Caseloading Flexibility of care Wanting to be responsible for own practice Using your senses</p> <p>Advancing practice through challenging mainstream practice</p> <p>Challenging poor practice, poor advice Supporting women's human rights</p>	<p>Quality of care</p> <p>Professional freedom Professional freedom Professional freedom Professional freedom Professional freedom Professional freedom Professional freedom Professional freedom</p> <p>Practice development</p> <p>Advocacy Advocacy Advocacy</p>	<p>Autonomous practice</p>

Protecting women from institutional pressure/coercion to conform Information sharing Supporting informed decision-making Better work life balance Job satisfaction Less stress Psychological and clinical support from independent colleagues	Supporting women's autonomy Supporting women's autonomy Quality of life Quality of life Quality of life Peer support	
Developing knowledge of physiology Applying knowledge of physiology to practice Application of multi-disciplinary evidence Analytical thinking Reflective practice Challenging poor practice, poor advice Not constrained by institutional or medical protocols Working as they see right Wanting to be responsible for own practice Use of evidence in decision-making Women encouraged to explore sources of knowledge Information sharing Women making informed decisions	Practice development Practice development Practice development Practice development Practice development Practice development Clinical reasoning Clinical reasoning Clinical reasoning Informed decision making Informed decision making Women's autonomy Women's autonomy	Evidence-based practice
Belief and trust in physiology of pregnancy and childbirth Women know what's right for them Shared beliefs	Birth as physiology Women's knowledge Shared philosophy	Philosophy

Women in control of care Women at centre of care Protecting women's human rights/dignity Respecting women's knowledge Information sharing	Women as protagonists Women's autonomy Women's autonomy Women's autonomy Informed decision-making	
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Barriers to be woven through the findings

Fear of investigation and discipline

Fear/need to conform to conventional practices

Work life balance

Appendix 7: Excerpt from interview transcription

<p>women's choices. I think when I started as an Independent Midwife I also thought that women would choose normal birth and actually they do... but some women might choose 'that' and you think, 'OK that's different,' but if that's what that woman wants then that's... my role is to support her and not to persuade her otherwise. I suppose a better example probably would be homebirth, that's the most common thing probably with Independent Midwives is that most of our clients choose homebirth... but not all women start off on their path with homebirth.</p> <p>I: Yeah, yeah</p> <p>A: So, it really comes down to supporting what women want...what else? Yeah relationships, time, normality... certainly I think Independents are very... autonomous creatures... very... we're quite 'gobby'... yeah, I think we are... we're quite confident... I think we're very confident in our own practice, in our, in our belief about birth... that, I mean, I have thought about, you know, I've been an Independent for a long time, thought about, all about, what I believe in... and I think that what I believe in now is probably slightly different from when I first started as an Independent... or what my focus was, it's now... I have complete, absolute belief that women always make the right choice, at the time they make the right choice... I so firmly believe that... they make the right choice, what's right for them and right for their babies and despite what obstetricians or other midwives might tell them they genuinely, all their actions are guided by what they believe is right for them... and if they're supported absolutely in that then the choice will always be the right one for them and a good outcome is... probably almost always guaranteed</p> <p>I: Yes</p> <p>A: I have probably wandered off a little bit [laughing]</p> <p>I: No, no, that's all really good stuff</p> <p>A: Gone off the subject... about what the common beliefs are of Independents</p> <p>I: Yes. So how might, it might seem like a similar question, how do you think they work differently from midwives who work in the NHS?</p>	<p>IMs completely supportive of women's choices</p> <p>Most women choose to have a normal birth but not all</p> <p>Role is to support choice not to persuade woman otherwise</p> <p>Most clients choose homebirth</p> <p>Not all women start off wanting a homebirth</p> <p>Supporting what women want</p> <p>Relationships, Time, Normality, Autonomy</p> <p>'Gobby'</p> <p>Confident in practice and belief about birth</p> <p>Absolute belief that women make the right choices for themselves at the time</p> <p>Women's actions are guided by what they believe is right</p> <p>If supported in their choices then good outcomes are almost always guaranteed</p>
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A: I think **we take our lead from our clients**, for sure... it's about... well it's **not about ticking boxes**, it is **not about delivering care that has to be delivered**, it's about **working with the woman really and being guided by what is right for her**

I: Yeah

A: Being led by her, rather than by an organisation, **not constrained by an organisation...** so yeah that's the biggest difference.

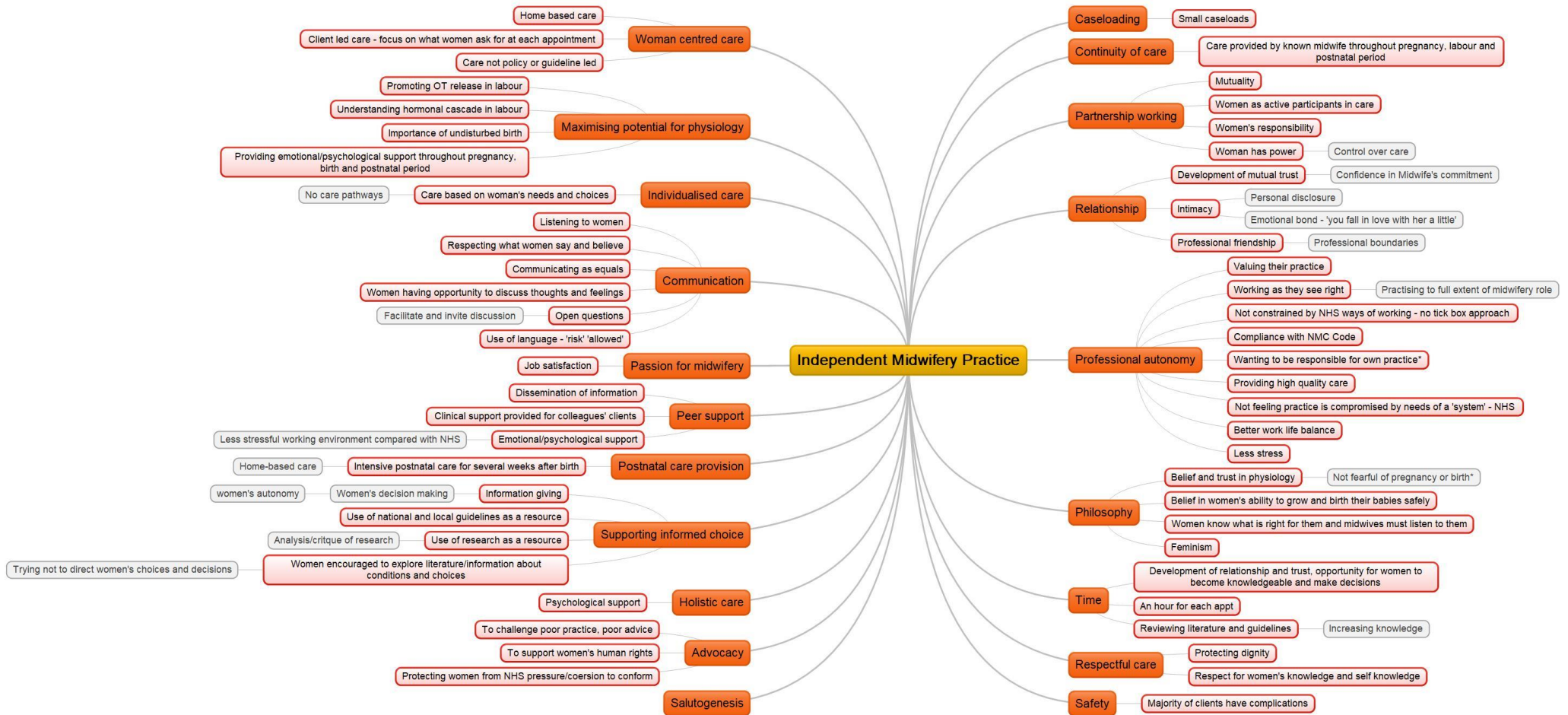
IMs take their lead from the woman

Not a tick box exercise

Not about providing routine care

Partnership working, being guided by what she needs Practice not constrained by an organisation

Appendix 8: Mind Map



Appendix 9: Research Ethics Approval



Research Ethics Checklist

Reference Id	11510
Status	Approved
Date Approved	24/08/2016

Researcher Details

Name	Michelle Irving
School	Health and Social Care
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, DEng)
Course	Postgraduate Research
Have you received external funding to support this research project?	No

Project Details

Title	How do Independent Midwives view Independent Midwifery?
Proposed Start Date of Data Collection	01/08/2016
Proposed End Date of Project	19/09/2020
Supervisor	Edwin van Teijlingen

Summary - no more than 500 words (including detail on background methodology, sample, outcomes, etc.)

This research project aims to develop an understanding of how Independent Midwives work and how they achieve the positive outcomes for mothers and babies that have previously been identified in the literature (Milan 2004, 2005). Milan (2004, 2005) demonstrated that the care provided by Independent Midwives resulted in better outcomes for women and babies, in terms of normal birth rates, healthy mothers and babies, and breastfeeding rates, compared with care given by the NHS in the same period. What is not known is how the midwives try to achieve these results. Very little research has been undertaken into the practice of Independent Midwives in the UK, and of the six studies that have been conducted (Winter, 2002; Milan 2004, 2005; Symon et al 2009; Symon et al 2010 and Garratt 2014), none have provided an overall picture of what they do, how they do it, or why. Milan (2005) is explicit in stating that more research is needed to identify the components of care which help to promote the good outcomes associated with Independent Midwifery care. In order to inform the midwifery profession, providers of maternity services and people who access maternity services I aim to develop theory about Independent Midwifery practice and how it relates to clinical outcomes, by taking a qualitative approach and using Grounded Theory. Grounded Theory is considered to be an appropriate method for research where little evidence about a phenomena exists (Holloway and Wheeler 2010). Using one-to-one, semi-structured interviews will give the midwives the opportunity to explore and voice their opinions, feelings and experiences of being Independent Midwives and providing care for their clients. Initially, purposive sampling will be used to select participants. Independent Midwives across the UK, with extensive experience and knowledge of practising independently will be invited to participate. As the data is analysed themes will emerge which will then inform me about the direction of data collection I need to take. Thereafter theoretical sampling will be undertaken, selecting participants who can inform the study further, helping to develop the emerging theory (Huberman and Miles 2002). Creswell (2013) suggests that this process may involve 20-60 interviews, although I am anticipating the figure being to closer to 10-15, based on recommendations from Charmaz (2014) and my supervisory team.

External Ethics Review

Does your research require external review through the NHS National Research Ethics Service (NRES) or through another external Ethics Committee?	No
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Research Literature

Is your research solely literature based?	No
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Human Participants

Will your research project involve interaction with human participants as primary sources of data (e.g. interview, observation, original survey)?	Yes
Does your research specifically involve participants who are considered vulnerable (i.e. children, those with cognitive impairment, those in unequal relationships—such as your own students, prison inmates, etc.)?	No
Does the study involve participants age 16 or over who are unable to give informed consent (i.e. people with learning disabilities)? NOTE: All research that falls under the auspices of the Mental Capacity Act 2005 must be reviewed by NHS NRES.	No

Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (i.e. students at school, members of self-help group, residents of Nursing home?)	No
Will it be necessary for participants to take part in your study without their knowledge and consent at the time (i.e. covert observation of people in non-public places)?	No
Will the study involve discussion of sensitive topics (i.e. sexual activity, drug use, criminal activity)?	No

Are drugs, placebos or other substances (i.e. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	No
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Will tissue samples (including blood) be obtained from participants? Note: If the answer to this question is 'yes' you will need to be aware of obligations under the Human Tissue Act 2004.	No
--	----

Could your research induce psychological stress or anxiety, cause harm or have negative consequences for the participant or researcher (beyond the risks encountered in normal life)?	No
Will your research involve prolonged or repetitive testing?	No
Will the research involve the collection of audio materials?	Yes
Is this audio collection solely for the purposes of transcribing/summarising and will not be used in any outputs (publication, dissemination, etc.) and will not be made publicly available?	Yes
Will your research involve the collection of photographic or video materials?	No
Will financial or other inducements (other than reasonable expenses and compensation for time) be offered to participants?	No

Please explain below why your research project involves the above mentioned criteria (be sure to explain why the sensitive criterion is essential to your project's success). Give a summary of the ethical issues and any action that will be taken to address these. Explain how you will obtain informed consent (and from whom) and how you will inform the participant(s) about the research project (i.e. participant information sheet). A sample consent form and participant information sheet can be found on the Research Ethics website.

Gaining information directly from Independent Midwives about their experiences and opinions is key to this qualitative research. Participants will only be included in the study once they have voluntarily given informed consent. Potential participants will be contacted through the Independent Midwives' Association and via their professional websites. I will provide them with a participant information sheet about the research and the opportunity to discuss the research further, and a consent form for them to sign should they choose to be involved. Participants can withdraw from the study anytime until the start of the data analysis. Participants' identities will be anonymised and they will be able to choose their own pseudonym to ensure confidentiality. Any other identifying data, such as age and geographical setting will be removed or rendered too vague for them to be identified, such as giving an age range or a regional location. Participants will be asked to give informed consent for their interviews to be audio recorded prior to being interviewed. Audio recording will be employed for two reasons; so that the interviewer is not absorbed in writing notes and is thus able to fully engage with the participant, and to enable the interviewer to capture almost all the comments made by the participant, which will enable accurate transcription of the data. In accordance with the Data Protection Act (1998) and Bournemouth University Research Ethics Code of Practice (2014), the project documentation - the recordings and transcriptions - will be anonymised, securely stored electronically and retained for five years after the award of the degree. The interviews will be conducted in a place of the participants' choosing, most likely their own homes. This raises some issues of safety for the interviewer. I have considered the issues concerning lone working and have consulted the National Health Service (NHS) guidance 'Not Alone: A guide for the better protection of lone workers in the NHS' (NHS 2009) and the Health and Safety Executive (HSE) guidance 'Working alone: Health and safety guidance on the risks of working alone' (HSE 2013). These provide strategies for safe, lone working such as having an agreed plan to inform the supervisory team of the time and place of interviews, and names of interviewees. The guidance has raised my awareness of the importance of planning for safe travel, ensuring the roadworthiness of the vehicle, and scheduling realistic time frames for travel. I will also make certain that I have a charged mobile phone so that designated people can be contacted regarding my whereabouts. Although the risk is low there is potential for participants to become emotionally distressed during the interview. As the interviewer I would sensitively support the participant at the time, interrupting the interview if appropriate, and assist the participant in obtaining additional support if necessary, from sources such as their General Practitioner or Midwifery Supervisor.

Final Review

Will you have access to personal data that allows you to identify individuals OR access to confidential corporate or company data (that is not covered by confidentiality terms within an agreement or by a separate confidentiality agreement)?	No
Will your research involve experimentation on any of the following: animals, animal tissue, genetically modified organisms?	No
Will your research take place outside the UK (including any and all stages of research: collection, storage, analysis, etc.)?	No

Please use the below text box to highlight any other ethical concerns or risks that may arise during your research that have not been covered in this form.

--

Appendix 10: Amendment to ethical approval

From: Research Ethics
Sent: 17 January 2017 10:39
To: Michelle Irving
Subject: RE: Minor amendment to ethical approval

Hi Michelle

Your amendment has been approved via Chair's Action.

Please keep this email on file as formal notification.

If you have any further questions, please contact me.

Kind regards

Sarah

Sarah Bell

Research Governance Adviser

Research, Knowledge Exchange Office

From: Michelle Irving
Sent: 06 January 2017 09:56
To: Research Ethics
Subject: Minor amendment to ethical approval

Dear Sarah,

Thank you for your email. Since I gained ethical approval for my study (Ethics ID 11510) I have been asked by several potential participants whether they could be interviewed via Skype rather than in person. I have altered the participant information sheet accordingly and attached it to this email. The participant consent form does not need altering as I did not specify that the semi-structured interviews would be done face-to-face.

Many thanks for your help.

Kind regards
Michelle Irving
Midwifery Lecturer/Practitioner
PhD student
Faculty of Health and Social Science (HSS)
Ext: 61542
Room R609
Royal London House

Appendix 11: Development of codes

Memo: Interview 3

This interview has brought up many of the same topics as the first and also introduced some unanticipated aspects of IM care. This participant has raised an interesting issue about her belief in birth angels and how they may guide practice. I am not sure how to tackle that as I can see it will be scoffed at by mainstream midwives and potentially the NMC who might take issue with it.

I am not sure how I will integrate that into the findings as it is a controversial issue and not one accepted by mainstream midwifery/medicine. Will discuss with supervisory team on how to handle it and any other controversial issues that may arise in later interviews.

Appendix 12: Memos about NMC action

1. The participant talked about the NMC's failure to protect women's safety by declaring the IMUK indemnity product to be inadequate. She clearly expressed her anger that despite the product being ok'd by two independent actuaries as being adequate the NMC had taken it upon themselves to decide that it wasn't – with the result that IMs are now unable to provide intrapartum care. Some of their clients have said that they will freebirth rather than have care from an NHS midwife they do not know or trust.
2. The participant was furious whilst explaining the results of the NMC's actions which prevent IMs from giving intrapartum care. She talked about her disbelief that although continuity of care is evidenced as resulting in safer outcomes the NMC are preventing IMs from providing this to clients having been informed that these women will, as a result choose to have no care instead, which is associated with increased risk. She spoke about the IMUK plan to seek judicial review of the decision and having the decision overturned. The potential to create a new indemnity product exists but without knowing what the NMC deems to be acceptable this is very difficult to do.
3. The midwife spoke about the ongoing determination the NMC had to destroy their practice. She felt that the NMC had little understanding of IMs and the service they provide. She also believed that they failed to understand the issue of women's choice and the importance of having an alternative to the NHS which for some women is an unacceptable choice. It was felt that the NMC was putting women at risk rather than protecting them from risk, as is their remit. She went on to talk about how the NMC support substandard midwifery care by the NHS everyday, because they do not provide continuity of care or provide enough time for midwives to give high quality care.

Appendix 13: Framework for quality maternal and newborn care: maternal and newborn health components of a health system needed by childbearing women and newborn infants

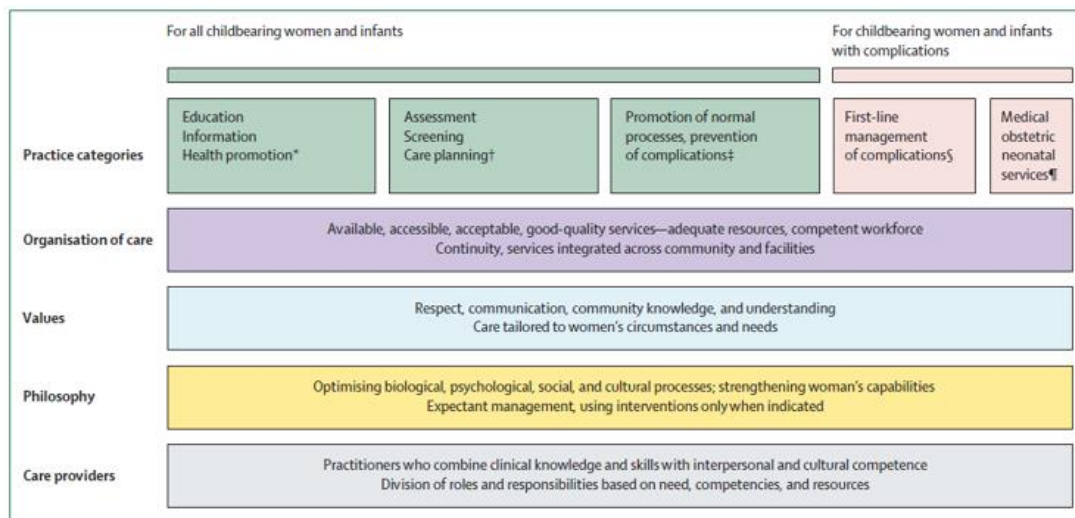


Figure 2: The framework for quality maternal and newborn care: maternal and newborn health components of a health system needed by childbearing women and newborn infants Renfrew et al. (2014)¶

Appendix 14: Article submitted for publication

Manuscript title: Independent Midwifery Practice: A Matter of Time

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Abstract

Background: Independent Midwives in the UK are self-employed practitioners who provide relational continuity of care to fee-paying clients. One of the selling points of independent midwifery is that women receive personalised care, within the context of the trusting relationship they have built with their midwife, which is largely seen in the amount of time and attention the women get from their midwives.

Methods: The main objective of this paper is to examine the role time plays in independent midwifery practice. A qualitative approach was used in this study based on a grounded theory methodology. Data were generated from in-depth, one-to-one interviews of eight Independent Midwives, which took place between 2016 and 2017. Participants were recruited from across the UK, initially using purposive sampling and latterly theoretical sampling. Each interview was digitally recorded, transcribed and then analysed using a constant comparative method.

Ethical approval was granted by Bournemouth University Research Governance Committee.

Results: The participants identified that having generous amounts of time was an essential component of independent midwifery practice. They considered time in terms of that spent with clients, developing trusting relationships and providing individualised woman-centred care, and that time used in developing their knowledge and practice to enhance the care they provide.

Conclusion: Having adequate time is critical to the safe and sustainable delivery of midwifery care. Independent Midwives apportion generous amounts of time to caring for their clients. This facilitates the provision of continuity of care and the development of trusting relationships, resulting in safer outcomes for mothers and babies. Having adequate time supports women's active participation in their care and decision-making processes, leading to positive childbirth experiences. The participants also allocate considerable amounts of time to developing midwifery skills and knowledge which further facilitates the provision of safe care.

Keywords: Independent Midwives, Midwife-mother relationship, Woman-centred, Informed decision-making, Continuity of care, Professional development

Background

This paper looks at the role time plays in independent midwifery practice from the perspective of those midwives: exploring how time affects the experience of providing care for women and their families. In the UK Independent Midwives are registered midwives who choose to work in a self-employed capacity, offering midwifery services to fee-paying clients [1]. Whilst being regarded by some as providing the 'gold standard' of midwifery [2], because they provide the care set out in government policy, there is a lack of formal data on the practice of this group of midwives. Although there is a general awareness of independent midwifery practice in the UK by other midwives, there is often misunderstanding about how Independent Midwives practise. Providing personalised care is one of the main selling points of independent midwifery in the UK and this is seen in the amount of time and attention women get from their midwives. Being self-employed practitioners, Independent Midwives have high levels of professional autonomy, which enables them to determine the model of care they employ. As a group, they are characterised by the relational continuity of care they offer women, through a case-loading model of midwifery. Continuity of care is provided to women throughout pregnancy, labour and the postnatal period, within the context of a trusting relationship, usually by one midwife, working in partnership with one or two colleagues who provide professional back up when the primary midwife is busy or taking time off [3,4]. In this way women are always cared for by a known midwife. This study looks at independent midwifery practice from the perspective of those midwives, examining the issue of time and how it impacts the care they provide.

The issue of time was identified by all the participants as a significant component of their practice. The concept of time as we have come to know it is relatively new [5]. Greenwich Mean Time (GMT) was originally set up in the UK in the fifteenth century to aid naval navigation, however international agreement on global time measurement was not reached until 1884, when GMT became the international standard. Unified time across the UK was not legally established until 1880, when the Statutes (Definition of Time) Act received Royal Assent [6]. Knowing exactly what the time was in hours, minutes and seconds only became a necessity with industrialisation and the development of the railways (6). Prior to this people measured the passage of time in terms of day and night and the changing seasons: biological or cyclical time [7]. Women's biological rhythms: their menstrual cycles and pregnancies would have been recognised as happening in biological time, with natural variations between and within individuals being a feature of normal physiology [8].

There are cultural differences in how time is perceived [5]. Cultures are described as either monochronic or polychronic in their time orientation, which has implications for how they organise their time and space. Monochronic orientation is associated with individualistic, low-context cultures, typical of industrialised countries, where time is linear and dictates virtually every aspect of the day. Time is viewed as a valuable commodity – one that can be invested, spent or wasted [9]. In contrast, polychronic orientation is associated with collectivistic, high-context cultures. Less emphasis is placed on clock time, time is conceived as being cyclical, following the rhythms of natural cycles and timescales. Within this way of life, time may be measured by how long it takes to complete a task as opposed to the situation in linear temporality where clock time dictates the duration of the activity [10]. It is suggested that these different orientations make interactions between the two cultures problematic, if not impossible [5]. It can be argued that these two orientations are evident within the context of contemporary maternity services, with hospital-based midwifery having a more monochronic time culture and case-loading midwifery a more polychronic culture.

Moving maternity care to hospitals, combined with shift working, has resulted in a lack of continuity of care for women [11]. A midwife will leave work at the end of her shift and not necessarily when the needs of the woman have been met, handing over care to a colleague. She may not be scheduled to work again until after the woman has left the hospital, resulting in fragmentation of care. In this model, midwives' workload is determined by institutional timeframes and not by the woman's time. Hunter *et al.* [12] demonstrate that hospital-based midwives have little control over when, or where, they work. Within such a monochronic orientation the duration of tasks is set by the time available, whereas in polychronic cultures, time is linked to more natural rhythms and tasks take as long as they take and are undertaken as and when they are required, for example, in the absence of complications, women are supported to go into labour and birth their babies in their own time, without pressure or restrictions. Clock time is external to the physiological rhythms of the body [13] and adherence to it can disrupt physiology and increase the risk of complications to mother and baby [14]. Midwives, not only independent ones, working in continuity of care case-loading models have found that the way they need to use time is different to that used within the hospital system, because they are providing individualised woman-centred care [15-17]. To provide this care, a midwife, where she determines her own work pattern, will attend clients when needed, such as for labour, however when the women in her caseload have no requirement for her attendance, the midwife does not work.

Although she may be available to work, by being on-call, this approach avoids midwives being on shift when there is no work to be done and facilitates responsive care when women need it. The midwives can take advantage of quiet times, resting and recuperating, before the work starts again [15]. Synchronizing with the ebb and flow of the workload makes this work-form sustainable.

Methods

The main objective of this paper is to advance knowledge of independent midwifery in the UK by examining the role time plays in Independent Midwives' practice.

A qualitative approach, based on Charmaz's contemporary variant of grounded theory, was used to explore and explain Independent Midwives' perceptions and experiences of providing midwifery services to their clients. Grounded theory consists of systematic, yet flexible guidelines for generating and analysing data to construct theories from the data [18]. Patterns of behaviour are explained through a proposition. These propositions are said to form a theory that is grounded in the data [19]. The use of grounded theory is appropriate where little or no research exists [20], and there is a paucity of evidence concerning independent midwifery practice. Charmaz's version is based on the assumption that social reality is multiple and constructed and takes the researcher's positions, perspectives and interactions with the research into account [18], rejecting Glaser and Strauss' notion of the expert researcher and neutral observer [21]. Charmaz [18] maintains that the researcher must examine and make clear how their preconceptions shape the research, rather than attempting to eliminate or refute their influences. The process of 'reflexivity' was used in this study to critically appraise the effect of the researcher on the research.

Data generation and analysis

Data were generated from in-depth, one-to-one interviews with midwives practising independently in the UK. Eight midwives from across the country were interviewed between 2016 and 2017. All were women who spoke English as their first language, aged 31-69, and with experience of independent midwifery varying from 4-27 years. Initial sampling was purposive: the researcher approached midwives they knew could provide a wide-range of insights. Theoretical sampling was used once initial themes were identified: participants who could explore the themes and further develop the theory were selected for interview. Using semi-structured interviews, the interviewer had a framework of questions which were used to guide the direction of the conversation and to elicit further information where necessary.

With permission from the participants, the interviews were digitally recorded and transcribed.

A characteristic of grounded theory is the practice of concurrent data generation and analysis [18]. In this way, analysis identified which data needed to be explored and developed, thus building the grounded theory. Data were coded manually using line by line analysis and then conceptualised into themes which explained groups of related codes. Data sets underwent a process of constant comparison: identifying similarities and differences, until no new insights or themes were forthcoming, reaching so-called theoretical saturation [22].

Results

The category 'Time' emerged from the data as being key to independent midwifery practice. The participants reported that time was pivotal to how they provide care and as such the subject was explored in detail. The way they perceived their professional time was in terms of: 1) time spent with clients and, 2) time used in developing their skills and knowledge. The code 'time as an investment in women' was developed because the participants unanimously believed that allocating generous amounts of time to working with their clients enabled them to practise truly relational mother-centred midwifery.

'...we have more time. We can give more time and that probably leads, or contributes, to a different ethos. The luxury of time is one I wouldn't swap for anything... everything comes back to time and being able to spend time. I think because we've got that time we can have a more holistic approach...' (Claire)

The investment of time facilitates the process of mother and midwife learning to trust and understand one another; it is a respectful, reciprocal relationship which develops.

'The hours you put into getting to know the woman and opening up for her to know you...' (Chris)

Rebecca commented that having time was a significant differentiating factor between practising as a midwife independently and for the NHS.

'the number one thing that is different for me is time and this is something that I... it is inconceivable working NHS-wise that you could take two hours or maybe three doing a booking... an antenatal appointment, I would book out two hours... it's really getting to know the family, getting to, you know, understand them.' (Rebecca)

In addition to devoting one or two hours per appointment, the Independent Midwives report also seeing their clients often during the antenatal period, and frequently, for at least a month after the birth. Over the course of the pregnancy, depending on when the woman books for care, the mother and midwife could feasibly have spent more than 15 hours together.

'...in general, after booking I see them once a month and then from 32 weeks fortnightly and then from 37 weeks weekly up until the birth...' (Rebecca)

The time is not only used to get to know one another it is also used to explore the woman's birth and parenting choices and to inform her about whichever subjects she feels are relevant and important. The allocation of time, hand-in-hand with the midwives' beliefs in women's right to autonomy, facilitates the process of truly informed consent, and as such is viewed as a valuable investment.

'We talk at such length during the pregnancy... the women really work out what is important to them, what is going to help them... I spend a lot of time shredding the evidence with the woman, so she knows the limitations of what is cited... often studies were not methodologically sound, often guidelines are not clear about how they were reached...' (Lisa)

The majority of the time spent during appointments is in dialogue with women rather than in providing clinical care. It is through discussion with the woman, and recognition of her knowledge, that many complications are identified; women having the opportunity to verbalise their concerns or feelings during appointments is vital in helping midwives provide safe care.

'So, the time we invest in talking, because over an hour or an hour and a half's appointment, you might be doing only ten minutes clinical care, so the rest of it is talking... we refer women to information... we will pull in as much information as we can, we also go back to original research and try to explain that to people because sometimes original research isn't exactly represented the way you'd expect...' (Claire)

In summary, the midwives view the investment of time as pivotal to the provision of their care. Frequent, hour-long appointments during pregnancy facilitate the development of the mother-midwife relationship, and support women's informed decision-making processes. Postnatally, hour-long appointments aid the woman's transition to motherhood, support her and her family to care for their newborn baby, and enable effective breastfeeding support.

The second code relates to how time forms an essential element in the participants' acquisition of new knowledge and skills. The participants were conscious of spending considerable amounts of time searching for new information and critiquing evidence and guidelines. Since care is individualised and not based on clinical pathways, the information shared with women needs to address their personal needs, thus a broad knowledge and understanding of evidence is required by the midwives.

'I'm not there to tell them what to do, I am there to support their wishes, and respect their wishes but also to support them in information finding... if things come up that I'm certainly not sure of, or is new to me then we go out there and we research it, I encourage them to do that and we come back together and discuss it... it doesn't stop me going off and having another look and researching, or speaking to colleagues, or getting other professionals' opinions and bringing that information back to the table...' (Deb)

It was felt by some participants that Independent Midwives spend more time than their NHS colleagues in developing knowledge relating to practice.

'I probably spend more time keeping in touch with research and going to study days and making sure stuff's not passing us by, than I would do if I was just working for a Trust.' (Claire)

Jane believes an honesty exists between her and her clients where if she does not know about a certain subject she can go and spend time informing herself.

'And you can be honest, completely honest and say, 'Well I don't know anything about that, I'll go and look it up' or, 'Let's go and see what we can find out about that situation'...' (Jane)

Several participants talked about the forum the Independent Midwives have established which is a highly valued resource used frequently by the participants to enhance knowledge and disseminate information.

'The forum, that can be a great place to chuck in a thought or a query and you'll get some great responses... links to evidence...' (Lisa)

Thus, the midwives describe how they allocate time to developing their knowledge in areas relating specifically to individual clients. They are keen to ensure they are conversant with current evidence, so they can be confident that they are providing up-to-date care and sharing with women the best information available.

Discussion

The participants have identified the benefits of allocating generous amounts of time to their clinical practice and have thus incorporated it into their practice. For them the allocation of time facilitates the development of genuine, trusting relationships with women and the provision of woman-centred continuity of care [16,23], which are essential components of independent midwifery care. The presence of these components also has ramifications for women's autonomy and their ability to make appropriate decisions about the care they receive [24]. The midwives' decision to invest an hour or two of their time to scheduled visits, antenatally and postnatally, demonstrates the value they place on having personal contact with women and their families. The duration of appointments is flexible, so the midwives can be responsive to the women's needs: the appointment finishes when the woman's needs have been met. They contrasted this way of working with their experience of working for the NHS, where appointment times were routinely limited, which is supported by Garrett [25], and which they considered restricted discussions about available choices and the development of relationships.

Better Births [26] reported that women feel they do not have enough time with their midwives and would like to have more time. Women have consistently spoken about experiencing maternity services as a production line and the dehumanising effect this has on care [11,26-28]. A recommendation of *Better Births* is for an increase of ten minutes for antenatal and postnatal appointments, to support the implementation of continuity of care models of midwifery, but the report does not state what the provision is currently, although anecdotal evidence says it is approximately 15 minutes. Little evidence exists in the literature about what is the optimal duration for appointments [29,30], with what does exist coming from general medical practice research. Whilst the midwifery literature [31-33] commonly refers to time, it is in non-specific terms, such as 'not having enough time', or 'wanting more time'.

Policy directives over the last 25 years have recognised the detrimental effects of fragmented care by consistently recommending the implementation of woman-centred, relational continuity of care [26,34,35], although they have not yet been widely adopted. To provide such care, midwives need enough time to establish trusting relationships with their clients. This means having time during appointments to get to know the woman and identify her individual needs, it also entails having time to see the same woman throughout her

maternity care [16,23]. A lack of continuity prevents the establishment of a relationship and results in fragmented care for the woman, with its associated negative effects [36].

Continuity of midwifery care is established as being beneficial to women and babies of any risk [36,37], resulting in: fewer interventions, fewer preterm births, reduced infant mortality, and higher rates of physiological birth. Additionally, within the context of a trusting relationship, women are more likely to ask questions and articulate concerns, which facilitates more effective care [38]. The continuity of care model provides more opportunity for midwives to identify emerging problems over a series of visits thus, improving outcomes [39]. In addition to improved physical outcomes it has been identified that there is an association between this model and greater maternal satisfaction [40]. Trust and listening to women are important processes linking relational continuity of care with improved outcomes and experiences [41]: which can only be achieved if the midwife has adequate time. It is suggested that one of the principal mechanisms for the positive outcomes associated with this model of care may be the creation of calm [40]. Whilst there is little research about calm itself, they report on the body of work that demonstrates the relationship between anxiety in pregnancy, birth and the postnatal period, and negative health outcomes for mothers and babies, including: altered infant stress response at birth, delayed infant development, and impairment of breastfeeding. It is proposed that the release of stress hormones, when anxious or stressed, can result in the mother's immune system being compromised: predisposing her to infection and preterm birth [42]. Findings such as these support the need for the implementation of a model of care which is supportive and creates calm. Calmness is recognised to be an important aspiration for women, who will deliberately employ coping strategies during labour in order to feel calm and avoid panic [43]. Relational continuity of care is thus an ideal model for creating calm and its associated benefits [40].

The amount of time a midwife has in which to practise is closely linked to her professional autonomy and impacts the quality of care she can provide [33]. One study [12] reports that midwives working on a postnatal ward have little control over the time and space in which they practise, which has detrimental effects on the care they are able to provide. Another study [44] has found that hospital midwives have less professional autonomy or control over their working conditions compared with midwives working in case-loading models. It is argued that hospital-based midwives have little professional autonomy because national and local policies shape practice, to which midwives are expected to conform [45]. The necessity for midwives' professional autonomy has long since been highlighted by researchers [46] and

yet current evidence reveals midwives' ongoing lack of autonomy [45,47]. Having little control over their professional life is one reason midwives give for leaving the profession [48,49] and despite this, the situation for most midwives remains unchanged. Researchers [45] have linked high professional autonomy with low levels of burnout, leading to higher levels of midwifery retention and thus improved safety for women and babies.

A lack of time compromises the safety of women and babies. One study [50] found that when time is limited non-clinical aspects of work take priority over caring for women and babies, resulting in lower quality care. Another study, [51] reports that due to time pressures midwives adopt a strategy of manipulating communication to discourage women from asking questions. In doing so women are denied the opportunity to discuss issues of importance or concern which can reduce the safety of care and which will likely impact their sense of agency and ability to make informed decisions and ultimately result in their disempowerment. Educated and affluent women are more likely to assert themselves in this situation meaning that less advantaged women are most affected: further widening inequalities in health [52].

Time limits are described as risks in themselves [53], with reports of increased interventions when time is restricted and of lost opportunities to build trusting relationships, where women feel safe to divulge important information that may affect their care. Two separate studies [31,32] also identify lack of time as a factor associated with reduced quality of care. Midwives are aware of the impact a lack of time has on their practice [48,49] and cite inadequate time to give good quality of care as one of the main reasons for leaving, or wanting to leave, the profession. The inability to form relationships with their clients is another key factor in midwives' decision to leave [56], which is again related to the amount of time midwives have to provide care. Attrition of midwives naturally leads to low staffing levels, which is recognised as a key risk factor in maternity care [55]. Whilst the factors which cause midwives to leave their jobs are clearly evidenced within the literature little effective action has been taken to rectify the issues. This is in part a cyclical problem now. With too few midwives to provide high-quality care, midwives experience work-related stress and dissatisfaction with the job, and consequently leave the profession [49].

The amount of time spent providing on-call services and the unpredictable work pattern are often seen as negative elements of providing relational continuity of care and as a potential barrier to its implementation [56]. Increasing evidence about case-loading shows however that once midwives are working in the case-loading model the benefits outweigh the costs

[33,57] and enables them to achieve a sustainable work-life balance, with the caveat that they are effectively supported in their work.

Time plays an important role in women's autonomy: their sense of agency and ability to make informed decisions. Longer appointments are associated with increased levels of autonomy and involvement in decision-making, confirming that women need time to consider information and discuss their options before weighing up the best choice for themselves [58]. These findings support evidence that the increased time associated with case-loading facilitates informed decision-making [59]. Time however is not the only factor here, health professionals need to have the willingness to engage in discussions with women, rather than being prescriptive, and to respect women's rights to make their own decisions, no matter what those decisions are [58].

Allocating time to professional development was also identified as an essential element of independent midwifery practice and providing safe care. The participants spend considerable amounts of time developing and sharing new knowledge and skills with their colleagues, through professional meetings, their online forum and practical skills workshops. Providing individualised care means that clinical pathways are not routinely used in independent midwifery practice, instead a plan of care is devised with each woman, incorporating her choices. This requires the midwives to be aware of the evidence appertaining to their client's individual needs, critiquing the literature and guidelines and assessing the veracity of the evidence therein, so that they can fully discuss the issues and ensure the woman has all the knowledge she needs to make informed decisions.

Whilst there is a statutory requirement for ongoing professional development for midwives of 35 hours per three-year period [62], the participants spent much more time than this, attending conferences and workshops, and conducting literature reviews. The midwives also update themselves in clinical skills for cases such as twin pregnancies and breech presentations, in order to offer a safe service. In its remit to improve maternity care *Better Births* [26] has identified that NHS maternity staff have not had sufficient time to up-to-date their knowledge and skills. Its recommendations for all healthcare professionals to be given time to undertake professional development supports the Independent Midwives' strategy for ensuring the provision of safe care. Research has found that some community midwives are not given time to update their skills, despite policies requiring all staff to do so [50] which has clear implications for the safety of women and babies.

Conclusion

Time is critical to the provision of safe and sustainable maternity care. Having enough time enables midwives to safely serve the needs of those in their care by developing trusting relationships and providing individualised care. Time facilitates women's active participation in their care and the decision-making process enabling them to enact their autonomy. Lack of time is associated with lower quality of care, putting women and babies at risk. Midwives cite having a lack of time to provide the high quality of care they aspire to as a key reason for leaving the profession, compounding the problem and further increasing risks. With the NHS being so risk averse in its approach to health care it is surprising that little has been done to address the problem of inadequate time, and its negative consequences, that midwives report. The evidence demonstrates that having a lack of time is clearly a risk factor for women and babies and yet providing more time to reduce that risk has not been prioritised.

Learning from existing midwifery models which provide relational continuity of care may help service providers to improve the safety of maternity care, as recommended by *Better Births*, through the modelling and widespread implementation of such schemes.

Abbreviations

GMT, Greenwich Mean Time; NHS, National Health Service

Declarations

Ethical approval and consent to participate

Ethical approval was granted by the Bournemouth University Research Governance Committee (Reference Id 11510). Participants were provided with written information about the research and a consent form for them to sign prior to their inclusion in the study. Participants were made aware that they were under no obligation to participate and could withdraw from the study at any time. Each participant chose a pseudonym to conceal their identity and data were anonymised during transcription.

Consent for publication

Participants gave consent for their anonymised data to be published in peer reviewed journal publications.

Availability of data

Anonymised transcripts can be requested from the corresponding author.

Competing interests

The authors declare that they have no competing interests.

Funding

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Author contributions

MI conceived the study and together with EvT developed the design of the research. MI undertook data collection and analysis and drafting the manuscript. EvT assisted in the interpretation of the data and the drafting of the manuscript, and approved the final submission.

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Glossary of midwifery terms

(Glossary of terms used in this thesis)

Amniotomy: surgical rupture of the amniotic sac, usually using an amnihook. This procedure is commonly undertaken to induce or accelerate labour

Augmentation of labour: Acceleration of labour once it has commenced. It involves carrying out an amniotomy and/or an intravenous syntocinon infusion.

Caesarean section: the surgical delivery of a baby via the mother's abdomen.

Epidural analgesia: a form of anaesthetic or pain relief administered via an injection into the epidural space around the spinal cord.

Episiotomy: a surgical incision into the perineum during birth.

Foetal distress: the clinical manifestation of foetal hypoxia. It may be suspected in labour if the foetal heart rate is abnormal.

Haemodilution: an increase in the fluid content of blood leading to a lower concentration of formed elements.

Iatrogenesis: an injury or harm that occurs because of medical care.

Induction of labour: the process of starting labour artificially.

Instrumental birth: the use of forceps or ventouse to assist with birth.

Partogram: a graphical representation of the progress of labour. Practitioners document cervical dilatation and foetal descent onto the partogram. This document is used to inform decision-making regarding augmentation or an operative delivery.

Salutogenesis: an approach focusing on factors that support health and well-being rather than on factors that cause disease.

Syntocinon: a synthetic version of oxytocin, the hormone that initiates contractions of the uterus during labour. It is used to augment and induce labour, and following a post birth haemorrhage.