THE *KALEIDOSCOPIC MIDWIFE*: A CONCEPTUAL METAPHOR ILLUSTRATING FIRST-TIME MOTHERS' PERSPECTIVES OF A GOOD MIDWIFE. A GROUNDED THEORY STUDY.

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To my family

ABSTRACT

Background. The literature review reveals information about what makes a good midwife from several perspectives. However, there is a dearth of knowledge around women's perceptions of a good midwife in different birthplaces.

Aim. The aim of the study was to explore and explain first-time mothers' expectations and experiences of a good midwife during childbirth in the context of different places of birth.

Method. A qualitative grounded theory methodology was undertaken. Fourteen first-time mothers planning to birth in different settings in England (Home, Freestanding Midwifery Unit, Obstetric Unit) were recruited. Data were collected through two semi-structured interviews for each participant (before and after birth). Data analysis included the processes of coding and conceptualising data, with constant comparison between data, literature and memos. Ethical approval was gained. Informed consent was obtained from participants and women were free to decline participation or to withdraw at any time. Confidentiality was guaranteed.

Findings. The characteristics that the women expected and experienced of a good midwife were encompassed in four domains: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. When asked to describe the midwife's role, the women talked about skills related to the spheres of being and doing. Although the idea of a good midwife seemed not to influence the women's choice of birthplace, the planned place of birth was found to be associated with some women's expectations of a midwife's role and characteristics. In particular, women planning an OU birth seemed to be more focused on the 'doing' tasks of the midwife when compared with participants planning a FMU or home birth who were more concentrated

on her ‘being’ role. The majority of women did not expect the midwife to be physically present continuously throughout labour. The midwife’s presence seemed to be highly valued at transitions, such as early labour and the second stage. Some participants encountered midwives who demonstrated negative language and behaviours. The depersonalising behaviour of the midwife often resulted in the woman feeling dissatisfied with the care provided.

Discussion. The model named ‘The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers’ perspectives of a good midwife’ was developed. The model is dynamic and woman-centred, operationalised as the midwife’s characteristics that should adapt to each woman’s individual needs in the context of each specific labour, irrespective of the birth setting. The findings highlighted that midwives should not consider the planned birthplace as a straightforward marker of a woman’s attitude towards childbirth; this was the rationale for shifting away from the place of birth being analytically significant at the stage of data conceptualisation. Four pillars of care are encompassed in the care provided by a good midwife in the labour continuum: *promoting individuality*; *supporting embodied limbo*; *helping to go with the flow*; *providing information and guidance*. As a kaleidoscopic figure, a good midwife should be multi-coloured and ever changing in the light of the woman’s individual needs, expectations and labour journey (e.g. stage of labour and events occurring during childbirth), in order to create an environment that enables her to move forward despite the uncertainty and the expectations-experiences gap. The following elements are harmonised by the *kaleidoscopic midwife*: *relationship-mediated being*; *knowledgeable doing*; *physical presence*; *immediately available presence*.

Conclusion. The model presented has relevance to contemporary debates about quality of care and place of birth and can be used by midwives to pursue excellence in caring for labouring mothers.

Independently from the place of birth, when the woman is cared for by a midwife demonstrating the above characteristics, she is more likely to have an optimum experience of birth. Although this is a small qualitative study and its findings cannot be generalised, it is likely that the model will have explanatory power when applied to similar contexts. Recommendations for practice, education and research are elucidated. Future research is necessary to tease out individual components of the model in a variety of practice settings.

PUBLISHED PAPERS AND PRESENTATIONS

Borrelli S.E. (2013) What is a good midwife? Some historical considerations. *Evidence Based Midwifery,* 11(2): 51-59.

Borrelli S.E. (2014) What is a good midwife? Insights from the literature. *Midwifery,* 30(1): 3-10.

ORAL PRESENTATION: A literature review around the concept of good midwife. *Post Graduate Seminar 2012*. The University of Nottingham, United Kingdom. 23 May 2012.

POSTER PRESENTATION: How do we prepare good midwives? Insights from the literature (1st prize winner). *Research Away Day*. The University of Nottingham, United Kingdom. 19 July 2012.

POSTER PRESENTATION: What is a good midwife? Insights from the literature. *NICER Midwifery Conference*. The University of Nottingham, United Kingdom. 7/8 September 2012.

ORAL PRESENTATION: Exploring childbearing women's expectations and experiences of a good midwife: the influence of planned place of birth. *Seminar: Developing an international dialogue: UK and Italian midwifery practice, research and education*. The University of Nottingham, United Kingdom. 11 September 2012.

POSTER PRESENTATION: What is a *good midwife*? Insights from the literature. *Research Saturday*. The University of Nottingham, United Kingdom. 10 November 2012.

POSTER PRESENTATION: Childbearing women's expectations and experiences of a good midwife in the context of different planned places of birth. *Research Away Day*. The University of Nottingham, United Kingdom. 18 June 2013.

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ORAL PRESENTATION: What makes a good midwife? First-time mothers' expectations and experiences in the context of different birthplaces. *Research Saturday*. The University of Nottingham, United Kingdom. 26 April 2014.

ORAL PRESENTATION: Undertaking grounded theory in doctoral midwifery research. *Post Graduate Seminar 2014*. The University of Nottingham, United Kingdom. 30 April 2014.

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ABBREVIATIONS

UK: United Kingdom

ICM: International Confederation of Midwives

WHO: World Health Organization

FIGO: International Federation of Gynecology and Obstetrics

NMC: Nursing and Midwifery Council

DH: Department of Health

NHS: National Health System

NICE: National Institute for Health and Clinical Excellence

AD: Anno Domini

CMB: Central Midwives Board

OU: Obstetric Unit

MLU: Midwife-led Unit

AMU: Alongside Midwifery Unit

FMU: Freestanding Midwifery Unit

GT: Grounded Theory

GLOSSARY

Expectation - A belief that something should happen in a particular way, or that someone (*in this case the midwife during childbirth*) or something should have particular qualities or behaviours (MacMillan, 2015).

Experience - Something that happens to you or a situation you are involved in. *This study explores the experience of the woman with the midwife during childbirth* (MacMillan, 2015).

Childbearing - The process of being pregnant and giving birth to children.

Childbirth - The process of giving birth to a baby that includes both labour and birth.

Birth at term - Birth between 37 and 42 gestational weeks.

Third trimester of pregnancy - Pregnancy is divided into three trimesters, with the third trimester going from the 29th gestational week to birth.

Nulliparous woman - A woman that has never given birth.

Multiparous woman - A woman that has given birth more than once.

Obstetric Unit (OU) - An NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day (Rowe, 2011).

Midwife-Led Unit (MLU) - Units run by midwives without medical facilities. They can be next to a main hospital maternity unit or completely separate from hospital. They offer assistance to childbearing women from early in pregnancy to the post-partum period. However, if complications arise during pregnancy, labour or birth the woman is transferred to the hospital obstetric unit (Rowe, 2011).

Alongside midwifery unit (AMU) - An NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair (Rowe, 2011).

Freestanding midwifery unit (FMU) - An NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance (Rowe, 2011).

Role - The function assumed or part played by a person in a particular situation (Oxford Dictionaries, 2014).

Characteristic - Feature or quality belonging typically to a person and serving to identify him/her (Oxford Dictionaries, 2014).

Early labour or latent phase of labour - Period of time, not necessarily continuous, when there are painful contractions and there is

some cervical change, including cervical effacement and dilatation up to 4 cm (NICE, 2014).

First stage of labour - Regular painful contractions are present and there is progressive cervical dilatation from 4 cm (NICE, 2014).

Transition stage - The finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions (NICE, 2014).

Second stage of labour - The baby is visible, expulsive contractions (or active maternal effort in the absence of expulsive contractions) are present following confirmation of full dilatation of the cervix or other signs of full dilatation of the cervix (NICE, 2014).

Third stage of labour - Time from the birth of the baby to the expulsion of the placenta and membranes (NICE, 2014).

They were so caring, they were so warm and so like loving

and they just wanted to make sure that you were informed,

that you would constantly be cared for, prepared, spoken to, listened to.

(W1-HOME-OU)

PROLOGUE

With the submission of this work, a fabulous, fulfilling, rewarding, gratifying though arduous journey ends. I inevitably carried out my PhD project both as a novice researcher and a midwife. From the novice researcher's perspective, I found myself being constantly curious, enthusiastic of gaining meaningful insights and rigorous at the same time. As a midwife I am always empathetically involved in childbearing women's experiences and I became passionate about the stories of the fourteen mothers that contributed to this research. Although I am aware that my interpretation is not the only one, in presenting the data I tried to give voice to the women's expectations and experiences by reporting their words which I think are far more meaningful than any explanation made by me. I hope I gave the deserved merit to what the participants kindly shared with me and that the reader will be absorbed in their fascinating stories, feelings and experiences as I was.

1. INTRODUCTION

This PhD thesis reports a research project aimed at exploring first-time mothers' expectations and experiences of a good midwife in the context of different places of birth in England. The study started in December 2011 and was completed in March 2015, with data collected from June 2013 to January 2014.

The substantive theory named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife' was developed from the findings of the present study in the light of current evidence in the literature. The recommendations developed from the findings of this study are addressed to maternity services' providers, midwives and other healthcare professionals involved in the care of childbearing women and their families, with the purpose of inspiring a greater awareness of the importance of considering what is expected, valued and experienced by childbearing women.

The author's personal perspective, background of the study and structure of the thesis are included in this introductory chapter.

1.1 PERSONAL PERSPECTIVE

I am a midwife by background and my personal interest in what makes a good midwife comes mainly from my experience in midwifery practice, debates and discussions with colleagues around the topic and personal reflections on midwives' behaviors in their everyday clinical practice. My personal perception is that maternity services can be sometimes characterised by lack of empathetic and compassionate care for women and their families. Short-staffing, busyness and medicalised models of care may contribute to this perception, causing a shift of midwifery care from being woman-centred to being procedural-centred. Although recommendations for evidence-based practice are set and increasing attention is being paid to compassionate midwifery care by regulatory bodies (NHS, 2012; NICE, 2014; NMC, 2015), contemporary investigations of poor healthcare practice in the UK place a question mark on the quality and safety of maternity care services provided to women and their families. Examples of these are the recent Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and the Report of the Morecambe Bay Investigation (Kirkup 2015).

As women are the main actors of their childbearing event, I believe it is essential to capture what a good midwife means to them in the context of their labour and birth experience. Based on these reflections, the questions that guided the choice of the topic for this PhD project and the literature review to scope evidence gaps were: What are women's expectations of a good midwife? How to meet these expectations and how to improve the women's experiences of a midwife? How to support each woman's individuality to allow a good midwife-woman relationship? Other questions were whether the place of birth influences women's expectations and experiences of a good midwife or dictates how the midwife can provide care to labouring women. The possibility of choice given to women by the variety of places of birth offered in

England made this geographic area an ideal one to answer these questions.

1.2 BACKGROUND OF THE STUDY

In the light of the Changing Childbirth report (Cumberlege et al., 1993), there has been a growing interest in the last two decades in understanding what women want from maternity services in the United Kingdom (Walton and Hamilton, 1995). As a result, the role of the midwife has undergone a number of changes, mainly related to a growing emphasis on woman-centred care, both in policy documents (ICM, 2010; NMC, 2009; NMC, 2012; NMC, 2015) and in the literature (Fontein, 2009; Freeman et al., 2004; Leap, 2000). The National Service Framework for Children, Young People and Maternity Services (DH, 2004: 9) declares that its aim is to 'promote high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families', ensuring that childbearing women 'are involved in decisions about what is best for them and have choices about how and where they give birth'.

Woman-centred care is based on the recognition, acknowledgement and respect of the childbearing woman with her distinctive needs, ideas, thoughts, emotions and wishes about pregnancy, birth and motherhood (Fontein, 2009). However, these can vary widely between individuals and understanding what women expect from maternity care and midwives is a complex, multifaceted and constantly changing phenomenon. The White Ribbon Alliance (2011: 1) states: 'A woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma. Either way, women's memories of their childbearing experiences stay with them for a lifetime

and are often shared with other women, contributing to a climate of confidence or doubt around childbearing'. Similarly, Eliasson et al. (2008) argue that because giving birth is such a significant event in a woman's life, it could affect future behaviours of the whole family. Halldorsdottir and Karlsdottir (1996b) state that positive experiences are embedded in the memory if the midwife has been acting in a caring way. Women often value a midwife who cares for them as individuals, supporting their instinctive abilities in becoming mothers (Green et al., 1988). The constant presence of a midwife and good care during birth can also increase the woman's gratification with her birth experience (Waldenstrom, 1998). Therefore, it must be acknowledged that caregivers have a great deal of influence on how each woman will remember her experience. In addition to a safe outcome, the goal of positive memories should guide the provision of midwifery care (Simkin, 1991).

1.3 STRUCTURE OF THE THESIS

Chapter 2 reports a literature review about what makes a good midwife, including perspectives of regulatory bodies, historical considerations and contemporary findings from viewpoints of mothers, healthcare professionals and student midwives. A thematic analysis takes into consideration what childbearing women generally value in a midwife during labour and birth. Research questions were developed from the highlighted evidence gaps.

Chapter 3 discusses qualitative Straussian grounded theory as the research methodology best suited to answering the research questions and its philosophical underpinning. All stages of the research process are described including settings, sampling, recruitment, data collection tools, data analysis and ethical considerations.

Chapter 4 and **Chapter 5** report the research findings. Fourteen first-time mothers' expectations and experiences of childbirth, with particular focus on their perspectives on what makes a good midwife, are presented.

Chapter 6 includes the discussion of relevant findings in relation to the existing literature.

Chapter 7 presents the model named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife'. The process of data conceptualisation is explained. The author's reflexive accounts in analysing the data and developing the model are also highlighted.

Chapter 8 discusses the original contribution of this study. Strengths and limitations of the study are provided. Recommendations and implications for practice, education and future research are suggested.

2. LITERATURE REVIEW

This chapter firstly considers the perspectives of regulatory bodies on good midwifery practice. The multiplicity of meanings around the word *good* is then elucidated. Subsequently, historical considerations around the characteristics of a good midwife through the centuries in Europe are discussed (Borrelli, 2013). A focused review of six papers which explicitly investigated what makes a good midwife is included (Borrelli, 2014). Then a rationale is given for focusing on women's standpoint and a thematic analysis on what childbearing women generally value in a midwife during labour and birth is presented. The influence of the place of birth on childbearing women's experiences is also discussed. Finally, the evidence gaps and the research questions are outlined.*

* A substantial part of this chapter was published in peer reviewed journals and disseminated at international conferences:

Borrelli S.E. (2014) What is a good midwife? Insights from the literature. *Midwifery*, 30: 3-10.

Borrelli SE. (2013) What is a good midwife? Some historical considerations. *Evidence Based Midwifery*, 11(2): 51-59.

What is a good midwife? Insights from the literature. *NICER Midwifery Conference*, The University of Nottingham, United Kingdom. 7-8 September 2012.

Childbearing women's expectations and experiences of a good midwife in the context of different planned places of birth. *ICM 30th Triennal Congress*. Prague, Czech Republic. 1-5 June 2014.

The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers perspectives of a good midwife. *Normal Labour and Birth Conference*. Grange Over Sands, United Kingdom. 17 June 2015.

2.1 LITERATURE SEARCH

The literature search mainly focused on what makes a good midwife using the key words *good*, *ideal*, *exemplar**, *expert**, *competen**, *excellen*, experienced, optimum* combined with the terms *midwife*, *lab*r nurse, nurse-midwife*, *midwifery*, *midwifery practice*, *midwifery care* or *maternity care* (plurals were used as well). Women's perceptions and experiences of midwives and midwifery care in general were also sought. Secondary searches were related to midwifery education and how to prepare good midwives; regulatory aspects of quality of midwifery practice; the influence of the place of birth on women's experiences of childbirth; fathers' experiences of birth; what is considered to be a bad or uncaring midwife.

Textbooks, online databases, literature, reference lists and conference abstracts were searched to retrieve information. Expert colleagues and supervisors were asked about relevant references about the topic and grey literature was taken into account (e.g. unpublished theses). The databases searched were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstracts and CINAHL. The inclusion criteria included English language. Only the literature referring to high-income countries was taken into account, with the rationale to explore contexts similar to the United Kingdom (the country where the study was carried out). A full list of the search terms used is outlined in **Appendix 1**. The literature search was constantly updated throughout the PhD.

As the literature review process included different steps (historical considerations of a good midwife; contemporary insights on what makes a good midwife; thematic analysis on what childbearing women value in a midwife during childbirth), further details on inclusion and exclusion criteria for the specific literature searches are reported in the next headings.

2.2 WHAT DO REGULATORY BODIES SAY ABOUT GOOD MIDWIFERY PRACTICE?

A regulatory definition of the midwife is endorsed by the International Confederation of Midwives (ICM), the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO): 'the midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant'.

In particular, the International Confederation of Midwives (ICM) delineates the knowledge, skills and behavior that should characterise the domain of competencies of the midwife who is educated according to the international definition of the profession (Fullerton et al., 2011b). The ICM supports, represents and works to strengthen professional associations of midwives throughout the world. This organisation works with midwives and midwifery associations globally to secure women's right and access to midwifery care before, during and after childbirth. The document entitled *Essential Competencies for Basic Midwifery Practice* (ICM, 2010) is a core policy statement that defines the domains and scope of practice for those individuals who meet the international definition of midwife. The key concepts that define the unique role of midwives in promoting the health of childbearing women and their families are identified in the following areas: partnership with women and their families; respect for human dignity and rights; advocacy for women; cultural sensitivity; focus on health promotion and disease prevention that considers pregnancy as a normal life event (ICM, 2010).

As the proposed study took place in England, what the Nursing and Midwifery Council (NMC) states about good midwifery practice is taken

into account. The NMC is a regulatory body that sets standards of behaviors, performances and ethics for the midwives working in the country. The recently updated version of the code of conduct of NMC (2015) aims at inspiring the provision of high quality care. The central principles of the code are: prioritise people; practise effectively; preserve safety and promote professionalism and trust. The code is central to good midwifery practice, and all midwives must follow it in order to be able to work legally and safely. Any midwife must meet these standards and regularly demonstrate that they are meeting them, in order to remain on the register and be eligible to work in the United Kingdom. In regard to standards for midwifery education, the NMC (2012: 6) wrote the *Guidance on professional conduct for nursing and midwifery students*, referring to 'good health', 'good character' and 'fitness to practice' as cornerstones to be considered when educating future healthcare professionals.

Global (ICM, 2010) and national (NMC, 2015) regulatory bodies seem to acknowledge that sufficient theoretical knowledge and practical skills can guarantee only a minimum standard but do not encourage excellence. Indeed, they go beyond the idea of the healthcare professional performing a proficient minimum, recognising the importance of personal attitudes, moral/ethical values and possession of excellence instead of absence of incompetence (Sellman, 2007). In regard to encouraging excellence, Butler et al. (2008: 260) argue that 'models of midwifery competence should always include personal attributes and effective communication in addition to the competencies required to be able to practise safely, and there should be an explicit focus in curriculum content, skills training and assessment on attitudes and communication'.

2.3 THE TERM *GOOD* AND ITS 'SYNONYMS': MULTIPLICITY OF MEANINGS

In attempting to answer the question of what constitutes a good midwife, it is acknowledged that the word *good* could have different meanings and understandings. In fact, it can be defined in several ways, depending on the context and the subject or object it is referred to. For example, the adjective *good* can be defined as 'to be desired or approved of; having the required qualities; of a high standard; possessing or displaying moral virtue; giving pleasure; enjoyable or satisfying; thorough; valid' (Oxford Dictionaries, 2014).

The word *good* is commonly used in descriptions of healthcare professionals. A number of papers consider what makes a good midwife (Byrom and Downe, 2010; Carolan, 2010; Carolan, 2013; Halldorsdottir and Karlsdottir, 2011; Nicholls et al., 2011; Nicholls and Webb, 2006), a good nurse (Begley, 2010; Brady, 2009; De-Araujo-Sartorio and Campos-Pavone-Zoboli, 2010; Fagerstrom, 2006; Fealy, 2004; Randall et al., 2008; Rchaidia et al., 2009; Rush and Cook, 2006; Smith and Godfrey, 2002; Van der Elst et al., 2012) and a good doctor (Tonks, 2002). Tonks (2002: 712) affirmed that good professionals 'are not just better than average at their job' but 'they are special in some other way too: extra dedicated, extra humane or extra selfless'.

A variety of expressions is used in the literature to indicate good practice or good professionals, for example *excellent* (Bell, 2011), *ideal* (Lange and Kennedy, 2006), *exemplary* (Kennedy, 2000), *optimum* (Butterworth and Bishop, 1995), *expert* (Downe et al., 2006), *experienced* (James et al., 2003) and *competent* (Butler et al., 2008: 261).

Kennedy (2000) proposed a model of *exemplary* midwifery practice and Bell (2011) recently developed a conceptual model of midwifery *excellence*. Tooke et al. (2008) reported recommendations for medical

practitioners with the aim of 'aspiring to *excellence*', the Department of Health (2010) presented some National Health System (NHS) strategies aiming at striving for *excellence* and the National Institute for Health and Clinical Excellence (NICE) produces guidelines for *excellent* clinical practice. Mello (2012: S28) shaped a framework to 'energise' nurses and midwives for *excellence* in care, supporting 'safe and effective care delivery, creating positive patient and staff experiences'. Lange and Kennedy (2006) investigated the gap between *ideal* and actual midwifery practice and Butterworth and Bishop (1995) identified the characteristics of *optimum* practice. Downe et al. (2006) conducted a meta-synthesis on *expert* intrapartum care; the authors used the notion *beyond the ordinary* as shorthand of *expertise*, *exemplary*, *excellent* and *experienced*, referring to professionals involved in intrapartum care with a high level of knowledge or skill. James et al. (2003) described the integration of *expertise* and intuition by *expert* labour nurses, including the labour process' knowledge and letting the woman guide her labour.

The word *competence* has been used in the literature as a job-related term, referring to the knowledge, skills and experience required to be effective in a role (Scott, 1984) and to perform a job (Cowan et al., 2005; McMullan et al., 2003; O'Connor et al., 2001). Butler et al. (2008: 261) speak about *competencies* referring to 'essential attributes required at the point of registration for a midwife to perform successfully in his or her role'. Zhang et al. (2001: 469) describe *competency* as a person-related term, implying the 'underlying attributes of individuals that lead to effective and/or superior performance in a job'. The Nursing and Midwifery Council (2010: 11) states that '*competence* is a requirement for entry to the NMC register' and is defined as 'the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective […] practice and intervention'.

Although at a first instance, the words *excellent*, *ideal*, *exemplary*, *optimum*, *expert*, *experienced* and *competent* could be all considered equivalent to *good*, there are additional considerations required in order to understand the multiplicity of meanings beyond terminology. As some of these terms are not defined by authors, it is a complex process to discern meanings.

The terms *expert* and *experienced* might merely refer to professional components of the more complex notion of being a good professional, which involves personal and moral attributes as well. To give an example, an expert midwife could be considered a good midwife; however, also those not considered experts or experienced may be described as good practitioners. Therefore, expertise or experience might not be the only required attributes for being a good midwife.

The word *competence* is often used to describe fitness to practice and seems to be mainly related to satisfactory enough basic skills required to perform a job, without encouraging excellence. Thus, assuming that all healthcare professionals should be competent practitioner at the point of registration, *competence* might be considered as a necessary but not sufficient condition of being a good midwife. As some authors argue, 'there is something that makes a distinction between a competent and a good midwife' (Nicholls et al., 2011) and 'there is a value added factor that distinguishes a *good* midwife from one who is merely *competent*' (Nicholls and Webb, 2006: 415).

The terms *ideal*, *exemplary* and *optimum* may refer to professionals that conform to standards of conduct and regulatory perceptions of how a practitioner should be or behave. Moreover, these adjectives have often been used by authors in relation to practice or models of care (Butterworth and Bishop, 1995; Kennedy, 2000; Lange and Kennedy, 2006; Mello, 2012) rather than to the individual practitioner.

The term *good* seemed to be more in line with the purpose of the present study, as it is commonly used to refer to the characteristics of outstanding healthcare professionals rather than excellent practice. Additionally, the term seems not to be limited only to professional skills but can encompass personal and moral attributes as well. However, the definition of *good* was not decided at the beginning of the present research, as the author wanted to discover from the participants what a *good* midwife meant to them.

2.4 WHAT MAKES A GOOD MIDWIFE? HISTORICAL CONSIDERATIONS

This section examines historical considerations around the characteristics of a good midwife in relation to historical and professional factors, tracing changing concepts from ancient times until the end of the twentieth century in UK and Europe (Borrelli, 2013). Historical textbooks, databases (Medline, ASSIA, Maternity and Infant Care, CINAHL), European literature and reference lists were searched to retrieve information about the concept of a good midwife. Data from UK and some other European countries were considered and a range of primary and secondary sources in English language were included. This is not a systematic review but a descriptive historical overview from sources that are well known to midwives. It must be acknowledged that the historical sources reviewed were only those readily accessible by midwives and therefore not a chronological account from a range of settings. **Table 2.1** includes the timeline of the selected key references in relation to themes identified.

TIMELINE	SOURCE	COUNTRY	KEY THEMES
ANCIENT HISTORY	BIBLE: Genesis chapters 35-38, Exodus chapters 1-16-21		holy calling
	BOOK: Gynaecology (Soranus of Ephesus, 2nd Century A.D.)	Greece	suitable person, literate, with her wits about her, good memory, loving work, respectable, not unduly handicapped as regard her senses, sound of limb, robust, long slim fingers and short nails, soft hands, free from superstition, sympathetic disposition
	SECONDARY SOURCE: Pliny – 2nd century A.D. (Mayes, 1930)	Greece	nobility, calm, unobtrusive disposition
1500	BOOK: English Midwives (Aveling, 1967)	UK	age (not too young or too old), practical experience, moral appraisal (decent gravity and solidity, considerate, endued with resolution, presence of mind, sagacious and prudent), physical characteristics (strength and vigour of body), sensitivity, recognition of limits
	BOOK: De conceptu et generatione hominis – The expert midwife (Rueff, 1554)	Switzerland	wonderful knowledge of herbs, livestock and charms, faithful and diligent, helping poor and rich women, no incantation
1700	SECONDARY SOURCE: Dr Harvey – 1700 (Mayes, 1930)	UK	good reputation, professional success, knowledge, charity, patience, tender compassion, giving women cause to love, honour and esteem women, nature's servants

	BOOK: History of childbirth. Fertlity, pregnancy and birth in early modern Europe (Gelis, 1991)	UK	Skilful, punctilious, availability, right gestures, words of comfort and encouragement for labouring women, physical build (strong, sturdy, nimble, graceful, no bodily defects, long supple hands), spiritual or moral side (virtuous, discreet, prudent, good conduct, regular habits, zealous, mild and charitable)
	BOOK: Midwives and medical men (Donnison, 1988)	UK	doing only the 'easy' bits of midwifery, leaving the hard work to the doctors
	CHAPTER: Midwifery, 1700-1800: The man-midwife as competitor (King, 2012)	UK	recognition of limitations
1800	SECONDARY SOURCE: The London Obstetrical Society examination – 1872 (Mayes, 1930)	UK	certification of moral character, age (21-30), proof of having attended no fewer than twenty-five cases under supervision, proof of having attended a course of approved lectures, written and oral examination
	CHAPTER: Midwifery, 1800-1920: the journey to registration (Nuttall, 2012)	UK	regulated and trained professionals
	NOTES: Introductory notes on lying-in institutions (Nightingale, 1871)	UK	woman with scientific and practical training, intelligent, educated, trained, skilful, proficient in all aspects of obstetrics, who would consult with physicians only when necessary

1900	CHAPTER: Midwifery, 1800-1920: the journey to registration (Nuttall, 2012)	UK	good character, academic knowledge
	Midwifery Act (1902)	England, Wales	good character, equipment, clothing, standards of hygiene, continued education during professional practice
	BOOK: Midwives in history and society (Towler and Bramall, 1986)	United Kingdom	responsible for cleanliness and hygiene of the place of childbirth, securing the comfort of the woman, proper nutrition for the mother and child, cheerfulness, sympathy, empathy, high moral qualities, woman's satisfaction, effect upon the health of the nation, non-midwifery duties (domestic cleaning, clerical work), technological midwife of the '70s (assistant of the doctor, machine minder, technological handmaiden)
	BOOK: The midwife's tale. An oral history from handywoman to professional midwife (Leap and Hunter, 1993)	UK	pillar of society, autonomy, professionalism, good clinical skills, coping with emergencies, hard worker, accessible at all times, affection, passion, totally dedicated to her vocation
	REPORT: The Working Party on Midwives (1948)	UK	time, skill, attitude of mind
	REPORT: The Central Midwives Board report (1950)	UK	academic knowledge, psychological aspects, good and friendly midwife-woman relationship

BOOK: Delivered at home (Allison, 1996)	UK	dedicated to her calling, sense of her own worth, individual practitioner, duty to the public, accountable, sense of high professional status, high visibility in the community, respectable, informed choice, individualised midwifery care, woman centred care, support, continuity of care, responsibilities and limits, independence, holistic midwife, flexibility, practical experience, professional identity, importance of research
BOOK: Mayes' handbook for midwives and maternity nurses (Thomas, 1959)	UK	autonomy in conducting normal labour and in recognising abnormalities and complications, loyalty to medical profession, co-workers and public bodies
PAPER: The future role of the midwife (Department of Health and Social Security, 1976)	UK	extension of the midwife's role, emotional and psychological support in addition to physical care, team working
PAPER: Ethnography of technological competence in clinical midwifery practice (Crozier et al., 2007)	Northern Ireland	skills in using machines, decision-making, traditional midwifery skills
PAPER: Practice: a battlefield where the natural versus the technological (Sinclair, 2009)	Northern Ireland	specialist skills in technology and natural birth

Table 2.1 Historical considerations on what makes a good midwife - timeline of references and key themes.

2.4.1 Early sources

Midwifery is one of the oldest occupations in the world, if considered simply as the presence of a woman accompanying another woman during her childbearing event. In reviewing the subject of midwifery from its historical standpoint, the first recording occurs in the early chapters of the Bible and could be interpreted as a tribute to the midwives of that period. At that time, the Pharaoh's astrologers predicted that a Jewish male would have overtaken his throne. In the attempt of shortening the Jewish birth rate, he ordered all Jewish men to do hard labour as slaves. When the Jews continued to multiply, Pharaoh commanded the midwives Shifra and Puah to kill all newborn Jewish boys. Despite the danger, they decided to continue their 'holy calling', witnessing the miracle of life (Genesis; Exodus). The first textbook of midwifery is widely acknowledged to be that written by Soranus of Ephesus during the second century A.D. There were certain characteristics desired in a good midwife, as described by the physician in his work *Gynaecology*: '[A] suitable person, literate, with her wits about her, good memory, loving work, respectable, not unduly handicapped as regards her senses, sound of limb, robust, long slim fingers and short nails, soft hands, free from superstition' (translated by Tempkin, 1956: 1.1.3). Soranus also argued that the midwife should be of 'sympathetic disposition' (translated by Tempkin, 1956: 1.1.3). Pliny, another physician of that time, valued nobility, calm and unobtrusive disposition in a midwife (Mayes, 1930). These two ancient physicians appeared to consider that personal qualities, physical characteristics and moral values seem to overcome theoretical knowledge as it was not an option at that time. In fact, ancient Greek women probably did not have access to formal education at any level. Instead, midwifery knowledge was handed on from each generation to the next and from one midwife to another (Mayes, 1930).

2.4.2 The good midwife as considered in the 16th, 17th and 18th centuries: midwifery practice, superstition and male obstetricians

Mayes (1930) reported what was expected of English midwives in the 16th century. Qualifications of an ordinary midwife were mainly related to age ('not to begin to practise too young or to continue it until too old'); practical experience; moral appraisal ('being of decent gravity and solidity', 'being considerate', 'endued with resolution', 'presence of mind', 'being sagacious and prudent'); physical characteristics ('strength and vigour of body'); sensitivity and recognition of limits through the immediate recourse to 'the ablest practise in the art or the submission of thoughts to the discerning faculty of the more learned and skilful' (Mayes, 1930: 163).

The Swiss neonatologist Rueff wrote a practical handbook on midwifery in 1554, *De conceptu et generatione hominis*, that became the required reading for the midwives of Zurich. In 1637, an English translation was published with the title *The expert midwife*. This book is recognised as a record of superstition and magic associated with childbearing events of the period. However, since it was in Latin, it appears more likely to have been written for learned men of the period, rather than female midwives. The midwife of the 17th century was regarded as a wise woman (in France, the midwife was considered a 'sage femme' in the same period) and she was supposed to have a wonderful knowledge of herbs, livestock and charms, as much of her time was spent in preparing pills and potions with which to assist the labouring woman. In addition to this, she received many privileges; to give an example, she had free access to gardens, fields and livestock (Mayes, 1930). The belief that midwives were commonly persecuted as witches is widespread in the history of medicine (Harley, 1990). At that time, some clergymen exercised a tight control upon midwifery practice, giving their

approval to midwives that were licensed to practise by bishops. Midwives had to swear to practise faithfully and diligently, helping poor as well as rich women and to not use any kind of incantation. Midwives were also allowed to practise baptism in case of imminent death (Rueff, 1637).

The 18th century was a central period in the history of midwifery, during which scientific ideas brought into being new ways of seeing. However, superstition continued to play an important role. Referring to the good midwife of that period, King (2012: 118) recognises the importance of knowing her limitations and refers to Chapman's words: 'The best midwives commonly send for advice upon the appearance of danger'. Furthermore, Dr Harvey identified the following characteristics of a midwife: good reputation; professional success; knowledge; charity; patience; tender compassion; manifestation of her worth among women; giving women cause to love; honouring and esteeming them (Mayes, 1930). Experience was not seen as a guarantee of a midwife's competence (King, 2012). Gelis (1991) stated that the French midwife of the 18th century was expected to be skilful and very punctilious in her affairs, coming without delay when she was called. The midwife must have no other commitments and preferably no young children that would have reduced her availability. The author presented the image of the good midwife as an old mother of a large family who had become a poor woman living on public charity. The confidence inspired by the midwife was vital and a good midwife was reassuring and put people in their ease. She knew how to make the right gestures and she said words of comfort and encouragement which labouring women found helpful. The midwife was expected to have the physical build necessary for the work: she had to be 'strong, sturdy, nimble, graceful, with no bodily defects and with long supple hands' (Gelis, 1991: 105). The spiritual or moral side was no less important: she should be 'virtuous, discreet, prudent, of good conduct and regular habits, zealous, mild and charitable' (Gelis, 1991: 105).

By the end of the 18th century, the superiority of the male specialist was accepted everywhere in Europe. After that period, the midwife was often pictured as careless, meddlesome, dirty and stupid (Kloosterman, 1984). Harvey, a medical man of that period, argued that midwives were nature's servants, denouncing the meddlesome midwifery of his time: 'A midwife's duty in a natural birth is no more but to attend and wait on nature, giving woman and child necessary conveniences, having gentle proceedings with moderate warm keeping and having their endeavours dulcified with sweet words will best ease and relieve and soonest deliver their labouring women' (Mayes, 1930: 164). Paraphrasing the obstetrician's words, midwives were invited to do only the 'easy' side of midwifery, leaving the more complicated work to the doctors. However, it might also be interpreted more positively as describing the midwifery skills of 'masterful inactivity' (Jordan, 1993). The rise of male obstetricians caused some tensions, both in terms of how practice occurred and who was the best between midwives and obstetricians. Midwives were heavily criticised by many medical men who had their professional project to pursue (Donnison, 1988).

2.4.3 The good midwife of the 19th century: complementarity of scientific knowledge and practical skills

The London Obstetrical Society, a body of medical men interested in obstetrics founded in 1858, introduced an examination with the issuing of a diploma for midwives, with the explicit aim of improving their professional status. The qualifications for the examination were as follows: 'Certification of moral character, age not under 21 or over 30, proof of having attended no fewer than 25 cases under supervision satisfactory to the board of examiners, proof of having attended a course of approved lectures, written and oral examination' (Mayes,

1930: 166). This was the first recognition of the importance of theoretical and practical training and the dropping of superstition of previous centuries. The reflection that might arise is whether introducing a midwifery examination could be considered as a way to regulate and control dubious practitioners and the quality of midwifery practice, instead of improving midwives' conditions. In 1869, the London Obstetrical Society undertook a survey among doctors about midwives and their practice in the UK. A variable picture was outlined by respondents: 'Among the poor population of villages a large proportion, varying from 30% to 90%, is attended by midwives' (Nuttall, 2012: 136). Regarding training, few doctors believed their local midwives had had any instruction, referring to their ignorance and incompetence. Furthermore, some respondents argued about inequality between midwives and obstetricians in dealing with emergencies (Nuttall, 2012).

Despite the possibility of training, most midwives of the period still had no professional education and no diploma. Most old and untrained midwives continued to work as they had always done (Mayes, 1930: 166). Van Lieburg and Marland (2004) argue that, in the Netherlands as elsewhere, some women practised midwifery unsupervised and without any formal education throughout the 19th century, but not necessarily without informal preparation or inexpertly. The low social status of midwives often isolated them from the possibility of being officially trained (van Lieburg and Marland, 2004).

We can find a reference to the fictitious bad midwife in the 19th century: Mrs Sarah Gamp, a disreputable character from Charles Dickens' 1843 serialised novel *The life and adventures of Martin Chuzzlewit*. In the novel, she is an ignorant and drunken nurse-midwife of the lower classes of London, not infrequently defrauding people and certainly not caring for them as expected. Since Dickens' work became very popular, Sarah Gamp's caricature soon became representative of an uncaring nurse-midwifery practice.

Nightingale (1871) emphasised the complementarity of scientific knowledge and practical skills. However, she had a particular point of view, not necessarily widely shared. She was anxious to raise the standard of the midwife and her practice, writing her definition of midwife in *Notes on lying-in institutions and a scheme for training midwives* (Nightingale, 1871): 'A midwife is a woman who has received such training, scientific and practical, in order to undertake all cases of parturition'. Nightingale envisaged midwifery practice as continuing in the hands of 'intelligent, educated, trained and skilful women, proficient in all aspects of obstetrics, who would consult with physicians only when necessary' (Towler and Bramall, 1986:158).

Scientific knowledge and importance of training for being considered a good midwife were later encouraged and supported by the Midwives Institute (UK), founded in 1881 with the aim of improving the status of the midwife and proposing her legal recognition. The work of the Institute included lectures for midwives and various social activities, watching over the interests and progress of midwives. It possessed a good library and a rest-room with plenty of periodicals and also issued *The nursing notes and midwives chronicle*, a monthly journal with articles of interest and importance (Mayes, 1930), providing the means for professional communication throughout the country. Rosalind Paget was part of the small group of well-educated, middle-class women who provided the driving force behind the development of the institute. Her role was extremely important both at a professional level and regarding political strategies because of her determination in supporting the development and training of midwives (Hannam, 1997). However, it might be argued that the institute served a minority of middle-class career midwives who were not representative of most midwives. The push for professional legitimacy seemed to be aligned with acquiring scientific knowledge and technical skills, with the consequent apparent marginalisation of interpersonal or character attributes.

The end of the 19th century signposted the ‘transition from local community-based women, who mainly learnt their craft via apprenticeship and whose skills were of variable quality, to regulated and trained professionals, whose practice was tightly defined and monitored’ (Nuttall, 2012: 143).

2.4.4 The legal recognition and regulation of midwifery

The midwife of the 19th century was seen as a pillar of society, having an effect upon the health of the nation (Leap and Hunter, 1993). However, the legal recognition and regulation of midwifery can be observed only from the beginning of the 20th century in the greatest part of industrialised countries, with the aims of securing better training for midwives and regulating their practice.

The Midwives Act (1902) is taken in consideration as an example of professional regulation, although most midwives up until Second World War might have little idea of themselves as professionals. With the emanation of the Midwives Act (1902) in England and Wales, great attention was given to education and training, registration and certification, supervision and control of midwifery practice. Certain women that already possessed a recognised qualification in midwifery were automatically admitted to the ‘roll of qualified midwives’ under the Act; also, women of good character who had already practised as a midwife for at least one year could apply for admission (*bona fides* midwives) (Nuttall, 2012). Legislation laid down also several aspects of midwifery practice and rules concerning equipment, clothing and standards of hygiene considered essential for midwifery practice.

The question is whether the regulation of midwifery practice has truly recognised midwives’ characteristics of responsibility and autonomy, or has it been a strategic expedient to keep the profession under control?

It might be argued that there has always been a tension between professional regulation and boundary setting.

2.4.5 Being a good midwife in the UK prior to the National Health System

After state recognition of the midwife at the beginning of the 20th century, the purpose of training was primarily to improve basic knowledge and practical skills, requiring that midwives should be intelligent and thoroughly trained. However, it has been acknowledged that the importance of the midwife to such a major life event as birth far transcended the mere fundamental physical task of performing a safe delivery. Towler and Bramall (1986) argued that the midwife has always been required to possess attributes of cheerfulness, sympathy, and empathy in addition to high moral qualities. Such qualities might potentially make a significant contribution to the women's satisfaction of their childbearing experience, with both the short- and long-term future of mothers and their babies, which in turn would have its effect upon the health of the nation. During the Second World War midwifery was seen as a form of national service and midwifery-led homes were set up in rural areas, far away from bombarded cities. Despite the challenge of working during wartime, midwives described 'enjoying many aspects of their work in this period, particularly their increased autonomy' (Hunter, 2012: 156).

In the pre-NHS UK of the first half of the 20th century, the midwife was considered a practitioner in her own right who demonstrated the art of midwifery, exemplified by her professionalism, good clinical and practical skills with the ability to cope with emergencies (Allison, 1996; Gelis, 1991; Leap and Hunter, 1993). In oral history accounts, midwives describe they had no off-duty time, were hard workers and had to be

accessible at all times: midwives were called to a birth by a knock at their door and, in the daytime when they were out for postnatal visits, they would leave information on a slate outside the front door. Usual form of transport was either by bicycle or on foot until the 1950s and, although the work was demanding and not easy to organise in the days before cars and telephones, midwives describe it with affection, humour and passion. It was an era in which midwives were expected to be totally dedicated to their vocation as a pillar of society (Leap and Hunter, 1993). In addition, many non-midwifery duties were undertaken by midwives, such as domestic cleaning, sluicing of soiled linen and clerical work (Towler and Bramall, 1986). In the Midwives Act of 1936 the first post-basic education for midwives was provided, demonstrating the importance of continued education during professional practice.

Leap and Hunter (1993: 143) argue that 'in both home and hospital settings, birth was essentially natural' and the use of painkillers or medical intervention was avoided. However, the natural birth of pre-NHS days was far from the actual idea of natural childbirth. There is very little evidence of childbearing women's experiences of those times. Leap and Hunter (1993) collected some women's voices in their book, arguing that birth was often seen as a tremendously painful event. Furthermore, there were no expectations about having an emotionally fulfilling experience. A woman remembers giving birth to her first baby in Belfast in 1918: 'You weren't allowed to walk around. I was walking around and the doctor came like and "Oh, get into bed, get into bed." You weren't allowed to have a baby like you'd want to have it. […] they made you lie on the old iron bed. They bossed you around' (Leap and Hunter, 1993: 144). This demonstrates how the childbearing event was often 'very much managed by midwives and obstetricians and the woman was delivered of her baby by the birth attendant, whose job was to organise everything and tell the woman exactly what to do' (Leap and Hunter, 1993: 143).

2.4.6 Midwives of the National Health System

The National Health Service (NHS) came into being in the UK in 1948. In those years the Working Party on Midwives (1948) stated that the midwife's three assets of time, skill and attitude of mind were of immense value to the woman, recognising the unique service given by domiciliary midwives. The Central Midwives Board (CMB) defined the academic knowledge required for midwifery practice (Nuttall, 2012). The CMB report (1950) affirmed that the psychological aspects of the midwife's function were as important as the provision of physical care, stating that the importance of a good and friendly relationship between the mother and the midwife was vital to the subsequent and long-term relationship between the mother and her child. This foretells later research related to the influence that the midwife-woman relationship might have on labour outcomes and woman's satisfaction (Berg et al., 1996; Guilliland and Pairman, 1995; Hildingsson and Haggstrom, 1999; Tinkler and Quinney, 1998; Tumblin and Simkin, 2001). Furthermore, the CMB emphasised the significance of midwives in the foundation of a good maternity service.

Allison (1996) investigated activities and characteristics of district midwives in the UK during the 24 years following the implementation of the NHS. In that period, midwives mostly still made their visits on a bicycle and wore distinctive uniforms. District midwives were usually single and childless, dedicated to their calling, sacrificing their own chance of family life for caring for mothers and babies. Nevertheless, Allison (1996) observed that married women were always a substantial part of the district midwifery workforce, arguing that it may be that the greater number of unmarried midwives in the early part of the study had more to do with the death of young men in the war than the self-sacrifice of women to midwifery as a vocation deemed incompatible with family life. From interviews with 10 retired district midwives, it is clear that they had a sense of their own worth; they saw themselves as

individual practitioners, recognising that they had a duty to the public and were accountable to their supervisor. They gave examples of why they had this sense of high professional status. This was related to their high visibility in the community, the welcome they received in family homes, the kindness shown towards them by families, the fact that they were asked to be godparents many times, were recognised by families as ‘our midwife’ and the respect that obstetricians showed towards them (Allison, 1996). In a midwifery textbook of the time, Thomas (1959) recorded that midwives were entirely autonomous in conducting normal labour and in recognising abnormalities or complications of labour, showing loyalty to the medical profession, their co-workers and public bodies.

The particular organisation of maternal services of the 1950s highlights the importance for a good midwife of having both personal qualities and professional skills, an idea that can be found also in contemporary literature (Byrom and Downe, 2010; Halldorsdottir and Karlsdottir, 2011; Nicholls et al., 2011; Nicholls and Webb, 2006).

2.4.7 Technological midwives of the 1970s and re-assessment of the midwife’s role

The role of the midwife in the 1970s must be seen against a background of technological advances and increasing medical intervention. The childbirth revolution that took place in those years profoundly changed the clinical role of the midwife. Births in the UK began to take place in hospitals, at the expense of home births. Despite significant improvements in maternal and infant mortality, childbirth was increasingly seen as ‘a risky process requiring scientific control and management by obstetricians’ (Hunter, 2012: 152). A midwife who trained during this period was conditioned to see her role as that of an

assistant of the doctor, a machine minder or a technological handmaiden (Towler and Bramall, 1986). Sinclair (2009: 39) argues that 'the role of the midwife in the modern labour ward demands specialist skills in technology. These skills need to be clearly identified and appropriately addressed through curriculum development'. Crozier et al. (2007) undertook an ethnographic observation on the use of birth technologies. They suggest that confusion surrounding the use of technology should be addressed in both clinical practice and midwifery education. Furthermore, midwives should be educated to value traditional midwifery skills alongside those of machine skills. They argue that the development of a model about the appropriate use of technology is needed in midwifery.

In the 1970s the Department of Health and Social Security produced a paper about the changing role of the midwife, entitled *The future role of the midwife* (DH, 1976). It highlighted certain aspects of care and viewed them as an extension of the midwife's role within the following duties: pregnancy testing; contraceptive devices; advice and counselling in family planning; abortion and sex education. Emotional and psychological support, increasingly needed during technological childbirth, was emphasised in addition to physical care. Health education and parent-craft teaching were to become a specific part of the midwife's role. The hospital midwife was described as part of the obstetric team and the community midwife became part of the primary healthcare team. This political document revealed the difference between the hospital-based midwife, subject to obstetric authority, and the traditional community midwife, who was an autonomous professional practitioner trained to be able to provide antenatal, intrapartum and postnatal care on her own responsibility in normal cases.

The following ideas, linked to the concept of providing good midwifery practice, gained ground in the 1980s: informed choice; individualised

midwifery care; woman-centred care; support; continuity of care; responsibilities and limits; independence; holistic midwife; flexibility; practical experience; professional identity and importance of research (Allison, 1996). The 1980s probably slowly set down the basis for the new direction for midwifery care that found fuller expression in the 1990s with the reform of the maternity services in the UK (*Changing Childbirth*, 1993) and the related re-organisation of maternal facilities.

2.4.8 The on-going connections between the past and the present

The idea of a good midwife changed from the ancient midwife of second century A.D. to the 16th century's midwife; from the midwives practising at the time of the first Midwives Act to those at the institution of the NHS. The concept of being a good midwife evolved from the importance of possessing physical attributes, nobility of character and knowledge of herbs, to more contemporary notions including: importance of training; use of technology; woman-centred care; continuity of care; informed choice; holistic practice and midwifery autonomy. It might be argued that the idea of a good midwife inevitably evolved in parallel within the social, cultural, economic, political and historical contexts. However, this historical overview of the concept of a good midwife reveals common themes that have recurred over time. A connection between the past and present is apparent regarding what constitutes a good midwife in the ongoing focus on competencies and qualities required of a midwife.

The idea of the good midwife in the past sometimes appears to place greater emphasis on personal characteristics over theoretical knowledge, professional skills and practical experience (Aveling, 1967; Gelis, 1991; Leap and Hunter, 1993; Mayes, 1930). Concepts found in

contemporary literature (for example, communication skills and emotional intelligence) to some extent mirror these (Byrom and Downe, 2010; Nicholls et al., 2011; Nicholls and Webb, 2006). Other original requirements for midwives of the past are linked to the spiritual side that can be found until pre-NHS period. The good midwife should be virtuous, discreet, prudent, of good conduct and regular habits, zealous, mild, charitable and with religious convictions (Gelis, 1991; Leap and Hunter, 1993). It can be easily noted how the spirituality of a midwife in the past was strictly linked to religious convictions. In recent years, Hall (2001) reconsidered the notion of spirituality in a new light, with the modern concept related to ideas of listening skills, enabling midwifery, connecting relationships, understanding, self-development, intuition and caring approach.

The importance of theoretical knowledge and professional skills came later in the history of midwifery practice, from the beginning of the 19th century (King, 2012; Nuttall, 2012). From the 20th century onwards, authors recalled the importance of communication skills and personal qualities in combination with these professional competencies. The question is whether the midwife-woman relationship has always been one of the cornerstones of good midwifery care. According to the first books on midwifery practice of second century A.D., the answer seems to be affirmative as Soranus of Ephesus highlighted the importance of being a ‘suitable person’ and with a ‘sympathetic disposition’ in the relationship with the woman (translated by Tempkin, 1956: 1.1.3).

Historical considerations on what makes a good midwife reveal common themes that have recurred over time. A connection between the past and present is apparent regarding what constitutes a good midwife in the on-going focus on competencies and qualities required of a midwife. It is interesting to note how competing priorities of a good midwife are still relevant today. An example is the constant tension between personal qualities and professional competencies of midwives.

Is there any ‘bridge’ which could link these characteristics? And what is the central thread of midwifery practice? Professionals should be continuously challenged to reflect on the provision of good-quality midwifery practice through the recognition of the fundamental characteristics of a good midwife. Insights from the contemporary literature on what is considered to be a good midwife are outlined in the next section.

2.5 WHAT MAKES A GOOD MIDWIFE? INSIGHTS FROM CONTEMPORARY LITERATURE

In regard to the contemporary literature, the research in the area of interest over the past twenty-five years (1990-2014) was reviewed. In order to focus on the specific definition of what a good midwife is, a selection of papers resulting from the broader literature search was reviewed. The examined databases were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstract and CINAHL. Papers in English were considered. The inclusion criterion was the use of the term *good* or synonyms (*ideal*, *exemplar**, *excellen**, *optimum*) *and midwife* or *midwives* or *lab*r nurse** or *nurse-midwife* or *midwifery* in the title and/or in the aim of papers. The terms *expert*, *competent* and *experienced* were not considered in this case, as they might refer only to professional components of the more complex notion of being a good midwife, which involves personal and moral issues as well. Papers referring to midwifery models of care or maternity care were excluded as the review’s purpose was to focus on the individual professional (midwife). Different standpoints were considered (midwives, student midwives, women and their partners). Opinion papers were not included in this review. A total of six papers explicitly investigated what a good midwife means and were all included in the review (Borrelli, 2014). The details of the selected papers are reported in

Appendix 2. Given the dearth of evidence about the topic, the selection of these papers did not include a critical appraisal with the justification that the rigour of individual studies might be less important than the choice of undertaking a review as comprehensive as possible (Sherwood, 1997; Walsh and Downe, 2005).

Despite the time window of twenty-five years considered in conducting the literature search, the selected studies were undertaken over a seven years' period. The first paper on the topic was published by Nicholls and Webb in 2006 and the most recent is the one of Carolan (2013). Four empirical papers and two review papers were selected. Research approaches used were variously described as systematic integrative review (Nicholls and Webb, 2006), theory synthesis (Halldorsdottir and Karlsdottir, 2011), Delphi study (Nicholls et al., 2011) and qualitative thematic analysis (Byrom and Downe, 2010; Carolan, 2010; Carolan, 2013). The sample sizes of the empirical research varied from 10 to 226 participants. The selected papers and the related key-themes are reported in **Table 2.2**.

PAPERS	KEY THEMES	DOMAINS
What makes a good midwife? An integrative review of methodologically-diverse research (Nicholls and Webb, 2006)	Communication skills, compassionate, kind, supportive, knowledgeable, skilful	Theoretical knowledge Communication skills Professional competencies Personal qualities
"She sort of shines": midwives' accounts of "good" midwifery and "good" leadership (Byrom and Downe, 2010)	Skilled competence, emotional intelligence, caring approach, communication, empowerment, support, clinical ability, competent, knowledge, confidence, trust	Theoretical knowledge Communication skills Professional competencies Personal qualities Emotional intelligence
The good midwife: commencing students' views (Carolan, 2010)	Personal qualities, communication skills, belief in woman and natural birth, work ethic, passion/enthusiasm, life experience, cultural knowledge	Communication skills Personal qualities Moral values Beyond the call of duty
Establishing perceptions of a good midwife: a Delphi study (Nicholls et al., 2011)	Lifelong learning, individualised care, communication skills,	Theoretical knowledge Communication skills
The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery (Halldorsdottir and Karlsdottir, 2011)	Caring approach, competence, wisdom, interpersonal competence, personal and professional development.	Theoretical knowledge Communication skills Professional competencies Personal qualities Moral values
‘A good midwife stands out’: 3rd year midwifery students' views (Carolan, 2013)	Practical skills, caring, compassionate, beyond the call of duty	Professional competencies Personal qualities Beyond the call of duty

Table 2.2 Contemporary considerations on what makes a good midwife - papers, key themes and domains.

The focus of the included papers is on the midwife's role in general as they do not refer to specific professional duties in relation to different moments of childbirth (e.g. pregnancy, labour, birth, postnatal period or breastfeeding). According to the findings of these papers, several meanings and interpretations are related to the concept of what makes a good midwife.

After noting the lack of knowledge around the overarching question 'What makes a good midwife?' Nicholls and Webb (2006) carried out an integrative review of thirty-three methodologically-diverse research papers. The authors found that the principal attribute in these papers for being a good midwife was having good communication skills. Being compassionate, kind, supportive (affective domain), knowledgeable (cognitive domain) and skilful (psychomotor domain) also made major contributions. Being involved in education and research were necessary requirements, and midwives' abilities to treat women as individuals, adopting a caring approach and being there for women were essential. Furthermore, the authors argue that a good midwife can compensate for poor management systems.

Halldorsdottir and Karlsdottir (2011) introduced a descriptive theory on the empowerment of childbearing women, where the midwife's professionalism is central. According to the theory, the professional midwife cares for the childbearing woman and her family and is professionally competent. She/he has professional wisdom and interpersonal competence and is capable of empowering communication and positive partnership with the woman and her family. Furthermore, the professional midwife develops herself both personally and professionally.

Byrom and Downe (2010) explored the characteristics of a *good midwife* from the standpoint of midwives (n=10). The data analysis underlined two clear dimensions: skilled competence (knowledge, skills

and competencies) and emotional intelligence (personal qualities). This study suggests that knowledge ability and professional competencies were seen as a basic requirement for midwives; the added element contributing to a good midwife was emotional capability, defined by Salovey and Mayer (1990) as the ability to examine one's own and other's emotions, and to use the information to guide thinking and actions.

Nicholls et al. (2011) investigated the perceptions of a good midwife using a Delphi questionnaire and their sample included postnatal women, midwives and midwifery educators (n=226). The statements with the highest mean scores were related to lifelong learning, woman-centred care and again good communication skills. The authors found that being a lifelong learner and the development of good interpersonal skills are as important as technical competence in making a good midwife.

Student midwives' views (n=32) of a good midwife have been explored by Carolan (2010; 2013). The author found that first year students spoke of a series of key attributes they felt were important to the role of the midwife: personal qualities and attitudes, belief in women and natural birth, ethical concerns and possession of additional attributes (life experience, cultural knowledge and passion/enthusiasm). Students, early on in their course, showed a clear understanding of the affective attributes required of a good midwife but less understanding of requirements of knowledge and competence (Carolan, 2010). Two years later, Carolan (2013) explored third year midwifery students' view of a good midwife and it was evident that their perceptions were becoming aligned with the views of qualified midwives. Final year's students acknowledged the importance of safe practice at the same time as supporting women to make decisions. The author brings to light the importance of going 'beyond the call of duty', demonstrating 'passion and enthusiasm for midwifery profession (Carolan, 2013: 4).

According to the findings of the studies cited above (and therefore from a range of perspectives) a good midwife should possess several attributes related to five main domains: theoretical knowledge; professional competencies; personal qualities; communication skills and moral values. Going beyond the call of duty (Carolan, 2010; Carolan, 2013) and having emotional intelligence (Byrom and Downe, 2010) can be considered as added values to these attributes. The identified domains suggest that theoretical knowledge and professional competencies are seen as a basic requirement for midwives, but other essential 'ingredients' are needed in order to make a good midwife, as personal qualities, communication skills, moral values, going beyond the call of duty and having emotional intelligence.

The meaning of what makes a good midwife might change according to the ideas of the different actors involved in midwifery care and there is no agreement on the definition of what constitutes a good midwife. Furthermore, women and midwives' standpoints often overlap and it is difficult to make a clear distinction between them. For instance, Nicholls and Webb (2006) and Nicholls et al. (2011) included both women and midwives as participants in their studies; however, the different viewpoints cannot be disentangled from the results presented in the papers. It is therefore not clear if what women value in a good midwife corresponds to the midwives' perception of themselves as good professionals. In addition to this, conceptions around the idea of who is considered to be a good midwife must be regularly reviewed in the light of both current midwifery knowledge and cultural changes. The rationale for focusing on women's standpoint is outlined in the next section.

2.6 WHY FOCUS ON WOMEN'S STANDPOINT?

The importance of understanding women's perspectives of childbirth is underlined by Pembroke and Pembroke (2008), arguing that the woman is the principal actor who invites others to be with her as she gives birth. The authors introduce the concept of 'genuine hospitality', debating the appropriateness of referring to the midwife as a host. In fact, the midwife could be seen primarily as the invited guest to the woman's experience. However, there may be a place for the appellation 'host' in relation to the midwife's role: 'the midwife is called upon to mentally establish an open space that will be filled by the woman's needs and preferences' (Pembroke and Pembroke, 2008: 325).

Green et al. (1990) undertook a large-scale prospective questionnaire survey that included 825 women giving birth in six hospitals in England in 1987. The study was designed to assess the relationships between expectations, experiences and psychological outcomes of birth. After noting the lack of knowledge around the topic, Green et al. (2000a) undertook further research with the aim of examining changes over time (1987-2000) in women's expectations and experiences of intrapartum care and to relate these to psychological outcomes. The authors paid particular attention to the issues of decision-making, choice and control valued by the Changing Childbirth report (Cumberlege et al., 1993). The researchers found that after the Changing Childbirth report some changes in women's expectations occurred, mainly in the area of labour pain and decision-making. Women in 2000 were more likely to be anxious about pain in labour and to accept interventions. Green et al. (2000a) interpret this as related to the increased use of epidurals and to the diffusion of medicalised models of care. Furthermore, women in 2000 expected and became more involved in non-emergency decision making. They were more satisfied with the information received than women in 1987. Thus, it could be argued that decision-making and possibility of choice are closely associated with the quality and amount

of information that the women received from the caregivers. These findings also demonstrate how women's perceptions of maternity care evolve through the years; it appears therefore important that professionals' awareness of users needs constant updating.

National surveys of women's experiences of maternity care undertaken over recent years highlighted the importance of making the users' perspectives more central to services development (Birthrights, 2013; Redshaw and Heikkila, 2010). However, although large scale surveys provide some useful information, measuring quality in this way has been questioned by several authors (Avis et al., 1995; Speight, 2005; Staniszewska and Ahmed, 1999). In fact, surveys aim at investigating participants' perspectives on a large number of inter-related topics and therefore might be unreliable in providing accurate information. Moreover, the structured style of questions typical of questionnaires may seek to validate the current system of care, rather than look to discover insights from individuals (Edwards and Titchen, 2003). In regard to this, some authors argue that women usually value as best the care they received; for this reason, they suggest to pay attention in using surveys alone to evaluate satisfaction because often 'what is, must be best' for women (Porter and MacIntyre, 1984; van Teijlingen et al., 2003).

Another apparent problem seems to rely on the difficulty in introducing appropriate changes in organisations. In fact, while several authors published results on what users want from midwifery care, extensive changes in maternity services has not yet occurred and women might therefore be dissatisfied with their care (Homer, 2006). Despite the increasing interest in individualised approaches to maternity care which seek to promote women's informed choice (Carolan and Hodnett, 2007; Newburn, 2012; O'Cathain et al., 2002), woman centred care (Berg et al., 2012; Lundgren and Berg, 2007; Page, 2003) and the midwife-woman partnership (Fleming, 1998; Fontein, 2009; Freeman et al.,

2004; Guilliland and Pairman, 1995), the reality of care in the NHS is often far from this ideal (Madi and Crow, 2003; Mander and Melender, 2009). Some researchers argue that women's experiences of childbirth may be mainly dependent on their encounter with the individual midwife (Fraser, 1999; Kirkham, 2000), with Tinkler and Quinney (1998) suggesting that the midwife-woman relationship is an essential aspect of satisfaction which needs greater consideration. In regard to this, some authors agree on the fact that healthcare professionals and regulatory bodies should listen more to women and take into account what they expect from maternity services (Kitzinger, 2006; Oakley, 1980; Savage, 2007). It might be argued that, though it is obvious that women's expectations and experiences of midwifery care are of fundamental importance, maternity services and midwifery programmes sometimes seem more focused on competencies that the institutions and regulatory bodies require of healthcare professionals (Avery, 2005; Fullerton et al., 2011a; ICM, 2010; NMC, 2012). Therefore, this may result in the apparent paradox of encouraging informed choices which are often limited to what is considered suitable by care providers and organisations. Proctor (1998) conducted some focus groups with women and midwives with the aim of identifying and comparing health care staff and users' perception of quality in maternity services. Key differences were related to the midwives' underestimation of the importance of continuity during labour and women's need for control and confidence in adjusting to the maternal role and involvement of partners. This research brings to light how the staff and users' perception of quality of maternity care might differ. Hence, it is crucial to understand existing gaps between childbearing women and care providers' standpoints in order to offer a woman-centred individualised care (Proctor, 1998).

On the basis of the rationale explained, a thematic analysis explored what childbearing women value in a midwife during labour and birth.

2.7 WHAT DO CHILDBEARING WOMEN VALUE IN A MIDWIFE? A THEMATIC ANALYSIS

The aim of the thematic analysis was to understand what women generally value in a midwife during labour and birth. The databases searched were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstract and CINAHL. Search terms included *wom*n*, *mother**, *parent**, *perception**, *experience**, *encounter*, *relationship*, *labo*r*, *birth*, *delivery*, *childbirth*, *midwi**, *nurs**, *care*. The selection of the papers was done on the basis of the following inclusion criteria:

- methodological design: qualitative studies - more relevant for the aim of seeking to understand and explain phenomena (Walsh and Downe, 2005);
- focus of the studies: papers related to women's experiences of the midwife during labour and birth;
- sample: women as participants (no limit on sample size);
- studies conducted in high-income countries - most relevant to the author's work context;
- time window: 1990 - 2013;
- language: English.

Papers referring to childbirth experiences were excluded as the thematic analysis purpose was to focus on women's views of the midwife's role.

For the majority of papers, the titles indicated that they were either not relevant to the thematic analysis' topic or did not meet the inclusion criteria. The abstracts were reviewed for seventeen papers and eleven of them were excluded at this stage. Reasons for final exclusion are given in **Table 2.3**.

PAPER	DECISION	REASON FOR EXCLUSION
Anderson (2000)	Excluded	Focus on second stage of labour
Berg et al. (1996)	**Included**	
Bluff and Holloway (1994)	Excluded	Focus on one aspect of midwifery care: 'they know best'
Brown et al. (2009)	**Included**	
Butler et al. (2008)	Excluded	Focus on pre-registration midwife Sample: student midwives + midwives
Dahlen et al. (2010)	Excluded	Focus on childbearing experience
Fraser (1999)	**Included**	
Green et al. (1990)	Excluded	Focus on childbearing experience Questionnaires
Green et al. (2000a)	Excluded	Focus on childbearing experience Questionnaires
Halldorsdottir and Karlsdottir (1996a)	Excluded	Focus on childbearing experience
Halldorsdottir and Karlsdottir (1996b)	Excluded	Women's perceptions of healthcare professionals
Homer et al. (2009)	Excluded	Focus on midwife's general role Sample: women + midwives Multi-method approach
Leach et al. (1998)	Excluded	Women's perceptions of maternity carers
Kennedy (1995)	**Included**	
Kennedy (2000)	Excluded	Sample: women + midwives Delphi study
Mackey and Stepans (1994)	**Included**	
Walker et al. (1995)	**Included**	

Table 2.3 Thematic analysis on what women value in a midwife - abstract revision: final inclusion and exclusion.

After a full-text revision, the remaining six articles were included in the thematic analysis. The selected papers were critically appraised by the author through validated tools, in order to increase the methodological strength of this work. The quality assessment of the qualitative studies was done using the checklist developed by Walsh and Downe (2006). The details and critique of papers are reported in **Appendix 3**.

The studies were conducted over a fifteen year period (from 1994 to 2009) and the sample sizes vary from 6 to 61 participants. Women's partners were involved in two of the selected studies. Research designs were variously described as phenomenological (Berg et al., 1996; Kennedy, 1995), grounded theory (Walker et al., 1995) or descriptive/exploratory qualitative studies (Brown et al., 2009; Fraser, 1999; Mackey and Stepans, 1994).

The selected papers were read several times in order to grasp the essential features and to identify the main themes. The contents of the papers have been utilised to describe and explain the themes. It must be acknowledged that the authors of the selected studies had not explicitly asked women what they considered to be a good midwife. However, they relate to what women value in a midwife during childbirth. Details of the papers and identified themes and domains are presented in **Table 2.4**. Themes recurring in at least three of the total six papers have been considered by the researcher and developed as domains.

PAPER	KEY THEMES	DOMAINS
Berg et al. (1996)	Individualised care, trusting relationship, being supported and guided	Providing supportive and individualised care Establishing a trusting relationship
Brown et al. (2009)	Support, calming presence, giving information, educator, patient advocate, continuity of carer	Midwife's presence Giving appropriate information and possibility of choice
Fraser (1999)	Communication skills, interprofessional relationships, personal qualities, continuity of carer, individualised care, informed choice, inspiring confidence, psychomotor skills	Providing supportive and individualised care Establishing a trusting relationship Giving appropriate information and possibility of choice
Kennedy (1995)	Individualised care, informed choice and control, trusting relationship, calming presence, confidence, knowledge and ability, giving time, supporting normality of birth	Midwife's presence Providing supportive and individualised care Establishing a trusting relationship Giving appropriate information and possibility of choice
Mackey and Stepans (1994)	Positivity, acceptance, support, giving information, encouraging, presence, competence	Midwife's presence Providing supportive and individualised care Establishing a trusting relationship Giving appropriate information and possibility of choice
Walker et al. (1995)	Support, information, control, trusting relationship, someone to give confidence to, presence	Establishing a trusting relationship Giving appropriate information Giving possibility of choice and helping feeling in control

Table 2.4 Thematic analysis on what women value in a midwife - papers, key themes and domains.

From the papers identified in the literature review, it is clear that women tend to give a great importance to the relationship with their midwife and consider this as a cornerstone of midwifery care. In particular, the key themes emerging from the literature were: **a)** midwife's presence; **b)** providing supportive and individualised care; **c)** establishing a trusting relationship; **d)** giving appropriate information and possibility of choice. Conversely, healthy outcomes, professional competencies and theoretical knowledge seem to be less important to them than to the midwives (as identified in the focused review about what makes a good midwife). Each theme will be further discussed under the following subheadings. Some references to the papers of the broader body of the literature will be used to contextualize the recurring themes.

2.7.1 Midwife's presence

The midwife's presence seemed to be highly valued by the participants of the selected studies, not just in respect of continuity of care, but also in terms of *being with* the labouring woman (Brown et al., 2009; Kennedy, 1995; Mackey and Stepans, 1994). In particular, the women considered as reassuring the midwife's 'constant' and 'calming presence', with the 'ability to impart the belief that birth is a natural process' (Brown et al., 2009: 327-9).

A sense of availability and presence was felt even when the midwife was physically absent. Indeed, the women often appreciated the fact that the midwife was there for them, whether in the labour room, down the unit's corridor or accessible with a phone call (Kennedy, 1995; Mackey and Stepans, 1994). Findings from Mackey and Stepans (1994: 416) show that midwives were viewed positively by women because they 'were present only when needed' and 'did not overdo' examinations. The midwife should therefore facilitate the labour

unobtrusively in the background, allowing the right amount of privacy and space for the woman and her family (Kennedy, 1995).

There are quite a few references in the literature about the idea of midwifery presence, with authors considering the tension between *doing* and *being* in care provision. Several authors agree on the fact that the midwife's role is more about *being with* than *doing to* (Callaghan, 1996; Fahy, 1998; Flint, 1986; Kennedy, 2000; Leap, 2000; Propst et al., 1994). Leap (2000: 2) coins the concept of 'the less we do, the more we give' as an approach that 'minimises disturbance, direction, authority and intervention' and 'shifts power towards the woman'. Similarly, Fahy (1998: 14) states that 'midwives who want to fulfil their essential role of being with women are challenged to defend themselves against charges of doing nothing'. Kennedy (2000: 12) describes the art of 'doing nothing well', reporting that midwives 'articulate their ability to do nothing as perhaps more accurately termed to be present with the woman, intervening only when necessary'.

2.7.2 Providing supportive and individualised care

The caregivers were described as carrying out several important duties, which included providing supportive and individualised care (Berg et al., 1996; Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994). The participants of the selected studies were generally satisfied with the care delivered and how they were treated as individuals (Berg et al., 1996; Fraser, 1999; Mackey and Stepans, 1994).

The women highlighted the importance of being considered with respect and on the same level, without prejudices on their behavior during labour. When necessary, they desired to be guided by the midwife, but on their own terms, and a dialogue was required. The midwife should be able to meet each woman's individual needs, taking into

consideration that every person is different from the next one (Berg et al., 1996; Kennedy, 1995). Findings from Mackey and Stepans (1994), Kennedy (1995) and Berg et al. (1996) reveal that women appreciated when midwives empowered them about their instinctive capacity to manage the situation and cope with labour. Midwives were viewed favorably when telling childbearing women that their efforts, even if slightly, were contributing to the labour progress (Mackey and Stepans, 1994). As long as it appeared that women wanted to be seen as individuals, Kennedy (1995) suggests that they should always be considered within the domain of their significant others (e.g. partner, children, family).

Few women stated that their personal needs were not considered and reported examples of caregivers that appeared 'to be more rule oriented than concerned about meeting individual needs, or treated them as having no intelligence or views on their own' (Fraser, 1999: 104).

2.7.3 Establishing a trusting relationship

During the sensitive period of childbirth, the woman and the midwife often forge a special relationship built on mutual respect, confidence and partnership, going beyond the usual patient-carer rapport (Guilliland and Pairman, 1995; Kennedy, 1995). Some women reported that they developed a strong bond with the midwife during labour, characterised by a sense of sharing, even if they had never met previously (Kennedy, 1995; Walker et al., 1995). This looks to be greatly appreciated by the women interviewed, who wanted their midwife to be friendly, gentle, open, conveyor of safety, someone who increased their confidence and with interpersonal compatibility (Berg et al., 1996; Walker et al., 1995). Kennedy (1995) noted that a sense of safety might facilitate the woman's trust in the midwife's competence and knowledge. The midwife's intuition appeared to be important as

well and was described as identifying the woman's needs without any explicit verbal request from her (Berg et al., 1996). Together with a relaxed and homely atmosphere (Walker et al., 1995), all these characteristics helped the women feeling at ease and establishing a trusting relationship with their caregivers during childbirth (Berg et al., 1996). Indeed, if any of these was lacking the women had less confidence in the midwife, often resulting in communication problems (Berg et al., 1996). Fraser (1999) noted that if labouring women established a good relationship with the midwife, the change of caregiver and communicating with someone new as labour progressed made them feel more apprehensive.

2.7.4 Giving appropriate information and possibility of choice

As reported by authors, most women appeared to value the fact of being actively involved, having the possibility of choice and feeling in control of the process of care during childbirth (Brown et al., 2009; Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994; Walker et al., 1995). Having appropriate information was considered as a precursor to women's control over their birth experience (Walker et al., 1995) and the provision of information communicated clearly by the midwife enabled mothers and their families to exercise informed choices (Berg et al., 1996; Fraser, 1999). Furthermore, giving appropriate information might reduce fears and anxiety, enabling the woman to feel more confident in her own potential (Brown et al., 2009).

Feeling informed by the midwife seemed to be valued by women that gave birth both in midwife-led units (Berg et al., 1996; Walker et al., 1995) and hospitals (Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994). Midwives were described by women as 'teachers'

(Kennedy, 1995: 415), ‘educators’, ‘interpreters’, ‘coaches’ and ‘source of information’ (Brown et al., 2009: 328), contributing details that helped to be prepared to any eventuality during childbirth (Kennedy, 1995). A woman stated: ‘they are there to provide information, to answer questions, to be somebody who has time to discuss things with the couple about the birthing process’ (Brown et al., 2009: 328). The midwife should give information in the form of advice, guiding the labouring woman without being directive, letting her constantly know ‘where she’s at’ (Mackey and Stepans, 1994: 416) and ‘being astutely honest about situations as they unfolded’ (Kennedy, 1995: 415). However, women seemed to value not only receiving appropriate information from the midwife, but also the acknowledgment of their need for information, willingness to address this gap and giving information before questions were asked (Mackey and Stepans, 1994).

The participants of the selected studies highlighted the importance of having satisfactory information about what was happening or was going to happen and how to cope with it, expressing gratitude at being adequately informed at a personal level during labour (Brown et al., 2009; Walker et al., 1995). For women whose labour did not develop as expected, this was even more critical (Walker et al., 1995). However, it is not clear if the need for information when labour took an unexpected turn was impacted on by a change in the planned place of birth. Moreover, although the majority of women seemed to value being actively involved, it must be acknowledged that women sometimes prefer to give to professionals the authority to make important decisions, placing themselves in the hands of the caregivers (Walker et al., 1995). This recalls the fact that women want to be supported as individual persons with distinctive needs (Berg et al., 1996). The question that arises is whether and how the balance between the midwife’s suggestions and the woman’s choice/control can be addressed. Kennedy (2000: 12) articulates well an ideal balance, by reporting a woman’s description about her feeling of achievement in the

process of birth: ‘I’ve never played football, but if I had, giving birth with her was like catching a winning touchdown in the fourth quarter of a game against a rival, feeling tired and sore, but on top of the world’. The key message is that it was the woman who scored the touchdown, not the midwife, but together they were a team that moved toward an identified goal.

2.8 THE PLACE OF BIRTH AND WOMEN’S EXPERIENCES

The place in which women give birth has substantially changed over the past century. The most significant change in developed countries was the movement of the place of birth from home to hospitals (Kirkham, 2003). At the beginning of the last century the greatest number of births occurred at home; during the 1960s birth was mainly seen as a surgical procedure and by the end of the century almost all deliveries in high income countries occurred in hospital (Bonney, 1919; DeVries et al., 2001).

Does where a woman births impact on her views of what a good midwife means? The place of birth might shape the woman’s experience, determining who is in control and the way care is organised. To give some examples, in a home birth the midwife could be seen as a guest of the labouring woman, with high consideration of familiar values and customs. Homebirth midwives might be more supportive due to the trusting relationship they establish with the woman, their philosophy of care and their freedom from time restrictions and hospital procedures (Dahlen et al., 2010). Conversely, in a hospital birth the mother is often placed in a context characterised by the use of unfamiliar language and tools, and passively involved in ‘a routine event, accomplished with speed and efficiency’ (DeVries et al., 2001: 8).

2.8.1 Places of birth in England

In the early 1980s, demands for more choice in childbirth were growing in England, supported by a network of maternity consumer groups (Declercq, 1998). Since the early 1990s government maternity care policy included the aim of providing women with a real possibility of choice regarding the place of birth. The Changing Childbirth report (Cumberlege et al., 1993) encouraged significant changes in maternity care policy, including greater choice of birthplace for women, increased independence for midwives and greater continuity of carer. To address this, a range of NHS Trusts directed initiatives aimed at changing the organisation and delivery of maternity care, moving away from consultant-led care for women with straightforward pregnancy. In this context, midwife-led units and home birth services have become increasingly relevant to the configuration of maternity services currently under consideration in England (Hollowell, 2011).

The actual configuration of places of birth is well described by the map of maternity care recently provided by the Birthplace in England Research Programme (2011). A total of 148 trusts and 289 maternity units were identified at the end of 2010. Among these units, four types of places of birth were recognised: Obstetric Units (OUs), Alongside Midwifery Units (AMUs), Freestanding Midwifery Units (FMUs) and home. The main features of these different places for childbirth in England are now discussed.

An Obstetric Unit (OU) is an NHS clinical site in which care is provided by a team. Midwives deliver ‘care to all women, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth’. Obstetricians take ‘primary professional responsibility for women at high risk of complications during labour and birth’. Medical services (e.g. obstetric, neonatal and anaesthetic care) are accessible 24/7 on site

(Rowe, 2011: 12). An alongside midwifery unit (AMU) is an NHS clinical location in which midwives provide care for 'women with straightforward pregnancies during labour and birth, taking primary professional responsibility'. Medical services are available during labour and birth in the same building or in a separate building on the same site. Transfers are normally done by trolley, bed or wheelchair (Rowe, 2011: 12). Similarly to an AMU, a freestanding midwifery unit (FMU) is an NHS clinical site in which midwives provide midwifery care to 'women with straightforward pregnancies during labour and birth', taking 'primary professional responsibility'. The main difference is that medical services are not immediately available during labour and birth but are located on a separate site should they be needed. Transfer normally involves car or ambulance (Rowe, 2011: 12). The woman is also given the possibility to give birth at her own home in England. Antenatal visits and homebirth can be attended either by the midwives of midwife-led units and NHS community midwives, which are available 24/7 on call. All the women in good general health with a straightforward singleton pregnancy at term would be potentially eligible for homebirth (Rowe, 2011).

The Birthplace in England Research Programme (2011) declares a total of 621,312 women delivering in maternity units in England in 2007 (excluding births at home), with 95% of the women giving birth in an Obstetric Unit (OU). Nevertheless, it must be emphasised that many of the women that gave birth in an OU have received most of their care from midwives and more than half have received only midwifery care during labour and birth. Midwife-Led Units (MLU), both AMUs and FMUs, reported considerably fewer women giving birth compared with OUs. However, a considerable number of new FMUs (n=11) and AMUs (n=31) were planning to be opened within the next three years from 2010. The proportion of women reported to have given birth at home in England is quite small, with a percentage of 2.8%. However, the range of homebirths per trust varied between 0.45% and 22.2% (Redshaw et al., 2011). It must be acknowledged that, in case of planned midwife-led

units and home births, there is a quite high probability for nulliparous women of being transferred to a consultant unit during labour or immediately after birth (45% for planned home births, 36% for planned FMU births and 40% for planned AMU births). For multiparous women, the transfer rate is around 10% (Hollowell et al., 2011).

2.8.2 Places of birth, interventions and outcomes

Authors agree that non-traditional places of birth (home birth, freestanding birth centres and alongside midwife-led units) present advantages for low-risk women, when compared with hospitals. In particular, research bring to light a greater maternal satisfaction (Birthrights, 2013; Dahlen et al., 2010; Overgaard et al., 2012; Waldenstrom and Nilsson, 1993); the provision of woman-centred care (Overgaard et al., 2012); lower costs for maternity care (Stine et al., 2012; Toohill et al., 2012); better outcomes and a lower use of medical procedures without associated risks (Hodnett et al., 2010; Sandall et al., 2013; Sutcliffe et al., 2012).

In regard to birth outcomes, the allocation to freestanding or alongside midwife-led care settings seems to increase the likelihood of spontaneous vaginal birth, better breastfeeding rates and very positive users' views of care. In terms of medical interventions, women that start their labour in a midwife-led unit are more likely to have no epidural analgesia, oxytocin augmentation of labour, intrapartum caesarean section and episiotomy when compared to mothers labouring in an obstetric unit. The place of birth appears not to influence serious perinatal or maternal morbidity/mortality, other adverse neonatal outcomes or postpartum haemorrhage (Hodnett et al., 2010; Hollowell et al., 2011; Sandall et al., 2013; Sutcliffe et al., 2012).

Both freestanding and alongside midwife-led units appear to be safe and offer benefits to both the woman and her baby, even if FMU are slightly better than AMU on all outcomes (Hollowell et al., 2011). However, women should be informed of the relatively high probability of intrapartum transfer in these settings when choosing their planned place of birth (Hollowell et al., 2011). After having conducted a structured review of outcomes of FMU, Walsh and Downe (2004) encouraged the provision of midwife-led care for low-risk women. Their findings raise a question about the risk of increased morbidity for mothers who are eligible for such units but who labour and give birth in consultant-led units.

In respect to maternal satisfaction, midwife-led unit and home births seem to be related to more positive experiences (Birthrights, 2013; Dahlen et al., 2010; Overgaard et al., 2012; Waldenstrom and Nilsson, 1993). In particular, women who gave birth in birth centres reported more respectful care and greater choice and control, with more positive feelings about giving birth to other children in the future (Birthrights, 2013). Overgaard et al. (2012) found that the satisfaction with care was ranked more positively by mothers that gave birth in FMU rather than in hospital. Particularly, better results were associated with woman-centred care elements such as providing support, encouraging participation in decision-making, paying attention to individual needs and giving information. Similarly, a randomised control trial undertaken by Waldenstrom and Nilsson (1993) showed that women expressed greater satisfaction with psychological aspects of care in birth centres. Dahlen et al. (2010: 58) found that an ‘honouring relationship’ with the midwife based on trust and support was highly valued by women who gave birth at home.

2.8.3 Women's choice of place of birth

The Changing Childbirth report (Cumberlege et al., 1993) and the National Service Framework for Children, Young People and Maternity Services (DH, 2004) support the fact that women should be able to choose how and where they give birth. The Birthplace in England Research Programme (2011) shows how the National Health System is working towards the goal of offering a real choice for women giving birth in England. As mentioned above, the actual choices for women regarding place of birth are identified in Obstetric Units, Alongside Midwifery Units, Freestanding Midwifery Units and home. However, the reality of care seems to be far from this ideal. An example comes from a recent national survey of 10,000 women giving birth in England carried out by Redshaw and Heikkila (2010). Despite the perception of the quality of care during labour was high, the 80% of women were not aware of the four possible options for place of birth (home, FMU, AMU and OU). The question is whether women would have chosen alternative settings if they were fully informed about all the possibilities. On the basis of these findings, the continued provision of a home birth service and the expansion of the provision of FMUs and AMUs would provide a choice of birth setting for low risk women who do not wish to opt for a birth in a traditional hospital delivery suite.

Walsh (2010: 486) states that childbearing women's experiences of birth are often shaped in the 'uneasy space' between the 'biomedical model' and the more 'natural' approach of the midwife. In regard to this, women's expectations may significantly differ by where they choose to give birth. There is evidence that women giving birth at home or in birth centres are less likely to regard birth as a medical condition than labour-ward mothers (Cunningham, 1993). For example, having a predisposition to interventions and epidural may be more important for those who choose hospital. Conversely, midwife-led care more easily meet 'the needs of women who are interested in natural childbirth and

active involvement in their own care' (Waldenstrom and Nilsson, 1993: 3). Thus, it might be acknowledged that the place of birth is an important influencing factor not only for mothers' experiences of childbirth, but also for their expectations when planning where to give birth. However, there is no research on whether what women think of midwives' changes according to where they give birth.

2.9 SUMMARY OF LITERATURE REVIEW, EVIDENCE GAPS AND RESEARCH QUESTIONS

The idea of what makes a good midwife inevitably evolved through the years in parallel with the social, cultural, economic, political and historical contexts. Insights from contemporary literature reveal that a good midwife should possess several attributes: theoretical knowledge, professional competencies, personal qualities, communication skills and moral values (Byrom and Downe, 2010; Carolan, 2010; Carolan, 2013; Halldorsdottir and Karlsdottir, 2011; Nicholls et al., 2011; Nicholls and Webb, 2006). However, meanings might change according to different actors involved in midwifery care and there is no agreement on the definition of what constitutes a good midwife. Furthermore, it is not clear if what women value in a good midwife corresponds to the midwives' perception of themselves as good professionals.

According to the thematic analysis around what childbearing women value in a midwife during labour and birth, considerable importance is placed on their rapport with the midwife. In particular, frequent key-themes emerging from the literature were: midwife's presence; providing supportive and individualised care; establishing a trusting relationship; giving appropriate information and possibility of choice (Berg et al., 1996; Brown et al., 2009; Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994; Walker et al., 1995). Conversely, professional competencies and theoretical knowledge seem to be less

important to women. Given the earlier reflections on what a good midwife means from different perspectives, there appears to be a mismatch between women and midwives.

The literature review revealed general information about what is a good midwife from a range of perspectives and what childbearing women value in a midwife, but there is a lack of information around the mothers' perspectives of what makes a good midwife specifically during labour and birth, and even less around whether this changes according to the place of birth, though this is likely to be an important influencing factor. The planned place of birth might shape both women's expectations and experiences of birth, with impacts on maternal satisfaction (Birthrights, 2013; Dahlen et al., 2010; Overgaard et al., 2012; Waldenstrom and Nilsson, 1993), clinical outcomes and medical interventions (Hodnett et al., 2010; Sandall et al., 2013; Sutcliffe et al., 2012).

Although large surveys undertaken over the last two decades provided some useful information about women's experiences of maternity care (Birthrights, 2013; Brown and Lumley, 1994; Green et al., 2000a; Green et al., 1990; Redshaw and Heikkila, 2010), the use of questionnaires may seek to validate the current system of care because of the phenomenon of 'what's experienced is best' (Porter and MacIntyre, 1984; van Teijlingen et al., 2003). It is therefore essential to consider a more appropriate methodology to discover insights and understandings from individuals (Edwards and Titchen, 2003).

In regard to the sample population, most researchers studied women of mixed-parity (Berg et al., 1996; Brown et al., 2009; Fraser, 1999; Kennedy, 1995; Walker et al., 1995). However, nulliparous women's experiences are of particular importance as the first birth experience is known to shape future reproductive choices (Hauck et al., 2007).

The majority of the studies presented as part of the thematic analysis was retrospective, as they were exploring women's experiences of birth

in the postnatal period (Berg et al., 1996; Brown et al., 2009; Kennedy, 1995; Mackey and Stepans, 1994; Walker et al., 1995). The only longitudinal study was conducted over fifteen years ago by Fraser (1999), which interviewed women at three stages: during pregnancy, in the early postpartum period and a couple of weeks after birth. Green et al. (2000a) found that women's expectations changed in a period of thirteen years, from 1987 to 2000. Given that perceptions inevitably evolve through the years, the exploration of childbearing women's expectation before and after birth will offer useful information about current maternity care provision, with clear implications for midwifery practice.

The identification of the gaps in the literature provided the starting point and allowed the development of research questions and methodology for the present doctoral research. According to the outlined gaps in the evidence, the aim of this study was to explore and explain nulliparous women's expectations and experiences of a good midwife in the context of different planned place of birth. The research questions were:

1. What are first-time mothers' expectations of a good midwife during labour and birth?
2. What are first-time mothers' experiences of the midwife during labour and birth?
3. Does the birthplace influence women's expectations and experiences? If yes - how?
4. How can first-time mothers' perceptions of a good midwife be conceptualised?

3. METHODOLOGY AND METHODS

This chapter details the research methodology and methods that underpinned this study. The rationale for using a qualitative methodology with a grounded theory approach is given. After having illustrated the main features of the three grounded theory generations (Glaserian, Straussian and Charmazian), the choice of using a Straussian grounded theory approach among others is discussed in relation to the stages of the study. The core elements of Straussian grounded theory are then presented in heading 3.2.3. Despite the selection of Straussian methodology, references from other authors (e.g. Glaser and Charmaz) are used to explain shared points on grounded theory in this chapter. A discussion of the philosophical underpinnings is included in section 3.3. Then there is an exploration of the research methods, including the identification of the research sites, the sampling and recruitment process, the data collection and the data analysis. Ethical concerns and considerations on the researcher's reflexivity are finally outlined.[*]

[*] Part of this chapter was disseminated at international conferences:

Childbearing women's expectations and experiences of a good midwife in the context of different planned places of birth. *ICM 30th Triennal Congress*. Prague, Czech Republic. 1-5 June 2014.

The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers perspectives of a good midwife. *Normal Labour and Birth Conference*. Grange Over Sands, United Kingdom. 17 June 2015.

3.1 QUALITATIVE METHODOLOGY: DISCOVERING INSIGHTS

The development of evidence-based care has traditionally been associated with quantitative research. This challenges qualitative research, as it has not established the same strong position in health care decision making (Holloway and Wheeler, 2010). However, the qualitative and quantitative research paradigms aim at answering different types of questions. Furthermore, they are both pivotal in developing midwifery knowledge and practice (Rees, 2011). This is supported by Roberts and Dicenso (1999) who argued that no one research method is better than another; the choice of the method should be guided by the research question.

As discussed in the previous chapter, several quantitative studies were undertaken over the last years to investigate women's experiences and their satisfaction of maternity care (Birthrights, 2013; Brown and Lumley, 1994; Redshaw and Heikkila, 2010). However, the highly structured style of questionnaires and large surveys may be more useful to seek to validate the current system of care, rather than to discover insights from individuals which might re-envision current care (Edwards and Titchen, 2003).

According to the aim of this study, it seemed appropriate to use a qualitative approach to answer the specific research questions. The purpose of this research was neither to measure clinical outcomes nor to validate practices. Instead, the main aim was to explore and explain childbearing women's expectations and experiences in the context of different planned place of birth. Understanding women's perspectives is extremely relevant for midwifery decision-making, as midwives are affected by the woman's preferences and needs, as well as by their trust in normal birth, the professional team and the birth environment (Everly, 2012). Caregivers need therefore to understand how women

experience health care in order to provide a meaningful, sensitive and appropriate response to their needs.

3.2 GROUNDED THEORY: AN ITERATIVE, INDUCTIVE-DEDUCTIVE AND COMPARATIVE APPROACH

According to the purpose of this study, grounded theory appeared to be the appropriate qualitative methodology to answer the research question. The grounded theory method consists of 'a systematic, inductive and comparative approach for conducting inquiry for the purpose of constructing theory' (Bryant and Charmaz, 2007: 1). It was developed in the 1960s by two American sociologists, Glaser and Strauss. Instead of traditional approaches of testing assumptions from existing theories, they considered the possibility of developing theories through the fieldwork and interaction with data (Glaser and Strauss, 1967). During those years, developing theory started to be considered pivotal in providing healthcare professionals with 'relevant predictions, explanations, interpretations and applications' of health care (Glaser and Strauss, 1967: 1). In regard to this, the development and consideration of theories as guidance for professional practice is a central approach for midwifery (Bryar and Sinclair, 2011). Theory is important in both clinical and educational settings, as a guide to problem solving and knowledge building. For instance, midwives refer to theory to understand why particular interventions or behaviours should be implemented or not (Cragin, 2004). Within the nurse-midwifery field, the development of theory was initiated in the 1960s by Wiedenbach (1967), who presented a model on *Family-centred Maternity Nursing* in the US context. A substantial expansion of midwifery theories was observed from the 1990s onwards. Examples of relevant models developed in the last twenty-five years are the *Midwifery partnership* model by Guilliland and Pairman (1995); the *Model of exemplary*

midwifery practice by Kennedy (2000); the *Disintegrative and integrative ways of being* by Parrat (2008); the *Midwifery model of woman-centred childbirth care* by Berg et al. (2012).

Grounded theory is particularly appropriate when a topic or area of interest has already been extensively researched such that theory development becomes an important next step. The literature review showed that a number of aspects of what makes a good midwife have already been investigated, though gaps remain. Other approaches such as phenomenology or ethnography aim to describe and analyse a setting or culture or to add meaning and better understanding of a phenomenon as it appears. The purpose of grounded theory is to generate theory that seeks not only to explore but also to explain a phenomenon of interest, going beyond the simple description through the intention of justifying 'why things might take the form they do' (Birks and Mills, 2011; Rees, 2011: 52). On the basis of this intent, the researcher develops a theory that is grounded in the collected data; hence the term grounded theory (Rees, 2011).

3.2.1 Generations of grounded theorists: Glaser, Strauss and Charmaz

There is no agreement on what constitutes a grounded theory. Examination of the qualitative methodological literature reveals varying opinions and unsolved issues regarding the nature and process of grounded theory (Cutcliffe, 2000). For example, grounded theory is often erroneously considered by researchers as an analytical technique and not as a complete methodology (Weed, 2009). This may result from the fact that several interpretations have been developed by authors. In fact, there are various and conflicting answers to what makes a theory grounded. In particular, Strauss and Corbin (1998) offered a new

approach to grounded theory which deviated from the original method that originated in the 1960's (Glaser and Strauss, 1967). During the last decade, the sociologist Charmaz (2006) adopted a constructivist grounded theory methodology. The features of these three main branches of grounded theory are outlined in **Table 3.1** and described below.

	GLASERIAN GT	**STRAUSSIAN GT**	**CHARMAZIAN GT**
Research aim	Emergent; no initial literature review	Identification of a pragmatic experienced-based issue; initial literature review	Making sense of a social situation (specific context)
Theory development	Emergent	Interpretation	Co-construction
Relationship researcher-participants	Independent	Active	Co-construction
Data analysis	Comparing incidents; integrating categories and properties; theory delimitation; theory writing	Open coding; axial coding; selective coding; theoretical coding	Line by line conceptual coding; focused coding; theoretical coding

Table 3.1 Comparison of grounded theory generations

The seminal work of Glaser and Strauss (1967) indicates that the purpose of grounded theory is to generate a conceptual theory around the participants' main concern and explain how they react to it. The use of the literature in grounded theory is one of the most debated aspects of this research approach (Weed, 2009). Initially, Glaser (1978) discouraged a formal review of the literature in grounded theory in order

to avoid the influence of existing theories or knowledge on the research process and findings and to be totally sensitive to what might emerge from participants during the fieldwork. Nevertheless, it must be acknowledged that no researcher enters the field as a blank slate (Glaser and Strauss, 1967). A few years later, Glaser (1992) affirmed that the researcher should be engaged with the literature from the very beginning of the study, though reading around the substantive area exhaustively should be avoided. In regard to this, Glaser (1992; 1998) supports the positivistic premises of a neutral observer and an objectivist rendering of data. According to the concept of emergence, the original attitude to data analysis of Glaser (1992) is less structured if compared with the approaches adopted by Strauss and Corbin (1998) or Charmaz (2006).

Strauss and Corbin (1998) acknowledge a broader and more flexible vision of the purpose of grounded theory. They recognise that grounded theory techniques might be used beyond building a conceptual theory. The research aim is experience-based, related to an initial literature review and might be built on pragmatic reasons. The theory is developed through the interpretation of reality by both the researcher and the researched which actively create the theory together, as opposed to the Glaserian idea of mere emergence from participants. Thus, the investigator establishes an active relationship with the participants (Strauss and Corbin, 1998). An indication of procedures for data analysis is given by Strauss and Corbin (1998) and will be described in more depth in section 3.4.6.

Charmazian grounded theory aims at making sense of a given social situation and the developed theory is situated in a specific context (Charmaz, 2006). It is assumed that data and theories are neither discovered nor emergent, but are constructed by the researcher as a result of the interactions with the field. The interpretation of data is co-constructed by the investigator and participants, and enriched by the

researcher's perspectives, values, positions and reflexivity (Charmaz, 2006).

Several issues might arise in deciding which of the three grounded theory approaches should be adopted in undertaking a research project. However, few researchers consider this decision-making process when selecting a methodological approach (Cooney, 2010). Among published midwifery papers using grounded theory, authors do not usually distinguish between the three most common typologies of grounded theory, not even stating which approach they are referring to. Furthermore, the core elements of grounded theory are not usually reported in the methods' section.

It must be acknowledged that none of the presented approaches is better than others *a priori*. In fact, the methodology should fit the specific study in relation to the research aim and the researcher's purposes in developing the theory through the interaction with participants, data collection and analysis. The researcher might choose any approach as far as the reasons for methodological choices and related issues are clear and coherent with the research process (Whittemore et al., 2001). This will be further discussed in the next section in regard to the chosen approach.

3.2.2 The choice of Straussian grounded theory

The methodology of this study was guided by a Straussian grounded theory approach. The rationale for this decision was based on the following criteria: a) aim of the study and research questions; b) compatibility with contemporary thinking; c) compatibility with actual midwifery debates; c) flexibility; d) pragmatic issues related to doctoral work.

The research aim of this study appeared to be in line with the Straussian approach, as it was experience-based and guided by evidence gaps outlined by an initial literature review. The Straussian epistemological underpinnings appear to be compatible with the contemporary thinking, reflecting a shift toward interpretivism and considering the active relationship between the interviewer and the interviewee rather than aiming at letting the theory emerge from participants. The appropriateness within the actual midwifery debates is encouraged by the purpose of developing a theory which is relevant and able to guide action and practice. In fact, the broad goal of grounded theory should be to produce a theory that fits the situation (Strauss and Corbin, 1998). In regard to the pragmatic issues related to a doctoral study, Straussian grounded theory allows the PhD student (researcher) to conduct an initial literature review in order to inform the research aim, data collection and data analysis. Furthermore, Strauss and Corbin (1998) give considerable guidance on data analysis that might be helpful for a novice researcher.

The exclusion of a Glaserian approach was primarily related to the difficulties in adopting it within doctoral research. Glaser (1967) claims a theory should emerge from the participants' main problem and not from a pre-set research question. The author strongly recommends not undertaking any literature review before entering the fieldwork (Glaser, 1978), although this is regularly requested by examiners and Ethical Committees as part of a PhD project. In the specific case of this study, an in depth literature review was conducted before determining the methodology to be undertaken. Therefore, both the research aim and methodological approach were influenced by the literature. Furthermore, Glaser (1998) argues for openness in considering several different data collection methods and types of data, implementing a theoretical sampling technique (see section 3.2.3). However, the opportunities to do this are severely constrained in the timescale of a

doctoral programme. Furthermore, Glaserian grounded theory does not align with any particular philosophical position (Glaser, 1998).

Charmazian grounded theory appears quite similar to the Straussian one and, at a first instance, it would have fitted well to this study. The notions of constructivist ontology, making sense, co-constructing the theory and reflexivity were all embraced by the researcher. However, the Charmazian goal of situating the theory in the specific context was not appropriate in relation to the final purpose of this study. In fact, this research sought to generate a theory which might have explanatory power also for similar contexts (see heading 3.2.3 for explanatory power in similar settings). This is the reason why Charmazian grounded theory was not taken into consideration as suitable methodology for the study.

It must be acknowledged that Straussian grounded theory was identified as an approach among others which appeared to best fit for this study. The core elements of Straussian methodology will be considered in more depth in the next heading.

3.2.3 The core elements of Straussian grounded theory

Grounded theory should be considered as a complete methodology, rather than simply an analytical technique. The core elements of Straussian grounded theory are: a) constant comparison; b) theoretical sensitivity; c) theoretical sampling; d) theoretical saturation; e) substantive theory; f) fit, understanding, generality and control. These elements are now explained in detail.

Grounded theory methodology is an iterative and inductive process based on the constant comparison between the literature, collected data, codes, categories and memos (see detailed definitions of code,

category and memo in headings 3.4.6 and 3.4.7). It is not a linear process as data collection and analysis proceed simultaneously in order to constantly check that developing insights are grounded in all parts of the analytical process (Strauss and Corbin, 1998). The basic process of data analysis includes an initial coding that seeks to describe phenomena and a second stage characterised by the conceptualisation of phenomena. This development from description to conceptualisation is facilitated by memo-writing, which helps the researcher in formally noting categories, analytical ideas and linkages (Strauss and Corbin, 1998).

Theoretical sensitivity acknowledges that the researcher should enter the fieldwork with a general awareness of the topic, but without any prejudice about what might be discovered (Strauss and Corbin, 1998). As mentioned in the previous section, Strauss and Corbin (1998) allow an initial literature review in order to identify the evidence gaps and the research question. However, the researcher should avoid having a pre-determined view of potential categories relevant to the emerging theory. The literature can also be used as a secondary source of data; after a category is noted, the researcher might contemplate the existing literature to establish if the same category has been reported by other authors and how. The Straussian approach considers the literature as a stimulus for theoretical sensitivity, by providing concepts and relationships that are compared with actual data. Moreover, it might inspire interesting questions during the analysis process (Strauss and Corbin, 1998). In this study, an in-depth literature review was done in order to scope the area of interest and this resulted in identifying more accurately the knowledge gaps and therefore a research aim and questions.

According to the notion of theoretical sampling, the constant comparison and the preliminary data analysis serve to direct the subsequent data collection, suggesting where to gain knowledge about

phenomena important to the construction of theory. In this way, the researcher is guided in refining and developing concepts through the encounter with meaningful and theoretically relevant facts. The main purpose of theoretical sampling is to uncover as many potentially significant categories and properties as possible, achieving the density and variation typical of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1998). Theoretical sampling can be considered as the only deductive moment of a grounded theory research, as the kind of data to be gathered are deducted from the already collected and analysed data. To allow the variation required by grounded theory methodology, women planning to give birth in different places of birth from different geographical areas were invited to participate in the study. Furthermore, the preliminary data analysis facilitated the identification of relevant topics for the participants, allowing appropriate adjustments in the interview guide for subsequent interviews.

As grounded theory is an iterative process, the point of theoretical saturation indicates when further interactions are no longer necessary. This means that the sample size should be determined by the saturation of concepts, when gathering data does not inspire new theoretical insights and does not reveal new properties of the core categories (Glaser and Strauss, 1967; Strauss and Corbin, 1998).

A model generated from a grounded theory research is not necessarily transferable to other contexts. However, it is likely that the model will have explanatory power when applied to similar contexts. This is facilitated by the fact that birth settings in England have quite similar models of care. Healthcare professionals can therefore make connections between their settings and the ones included in this study, extrapolating the elements of the model relevant for their practice. Although this is a small qualitative study and its findings cannot be generalised, the model developed from the present study may help explain the optimum role of the midwife in low risk women in similar

settings i.e. home, midwifery units, obstetric units, in other countries that have similar models of care. Substantive theory can contribute to formal theory when it is used to inform research less specific to group and place and applied to a wider range of issues across disciplines (Glaser and Strauss, 1967; Strauss and Corbin, 1998).

A well-constructed grounded theory should meet four central criteria for judging the applicability of the theory to a phenomenon: fit, understanding, generality and control. A theory fits if it is closely related to the phenomena explained and faithful to the everyday reality of the substantive area. Understanding is related to the comprehensibility of the theory to the target audience. Generality is ensured by a theory which is abstract enough, including sufficient variation to make it applicable to a variety of similar context. Control is provided by clearly declaring the conditions to which the theory applies (Strauss and Corbin, 1998). The applicability of the theory is usually ensured by constant comparison, theoretical sensitivity, theoretical sampling and theoretical saturation.

Birks and Mills (2011) identify procedural precision and methodological congruence as main determinants of the quality of a grounded theory research. These elements were considered in planning and conducting this study. Procedural precision is primarily related to the processes of generation, collection and analysis of data. In order to ensure procedural precision an audit trail was maintained and data and resources were rigorously managed. As suggested by Birks and Mills (2011), a track of the processes and methods used was developed and a structured mechanism to manage data was established to enhance the credibility of the study. The diligent use of memoing was considered as a fundamental part of the ongoing research, as it is one of the most significant factors in ensuring quality in grounded theory (Lempert, 2007). Methodological congruence is the basis of a good research project. It occurs when there is accordance between the research aim,

methodological approach and philosophical underpinnings (Birks and Mills, 2011). The rationale for the use of grounded theory to answer the research question and aim has been already addressed. The philosophical underpinnings will be explored in the next section.

3.3 PHILOSOPHICAL UNDERPINNING

This heading outlines the philosophical assumptions underpinning this doctoral project based on a qualitative research using a grounded theory approach. A definition of ontology and epistemology is given. The importance of methodological congruence between the research aim, methods and philosophical underpinnings is highlighted. The author reflects on the ontological and epistemological continuums outlined by Weed (2009), considering several theoretical positions supported by a range of grounded theorists. The main features of the constructivist ontology and interpretivist epistemology are defined. Finally, the rationale for utilising this theoretical standpoint in relation to the research questions and the methodology is provided.

The author compared and contrasted a variety of ontological and epistemological assumptions, questioning the reality to be explored and how the knowledge of it was reached in the context of the specific study.

3.3.1 Ontology and epistemology

Ontology and epistemology are two of the core areas of philosophy. Ontology is the study of the nature of existence and being, dealing with questions concerning truth and reality: What can be considered as true or real? How can existing entities be grouped and categorised? What is

the meaning of being? Are there multiple ways of being and are there multiple realities? Is reality stratified? (Benton and Craib, 2001). Epistemology is concerned with the nature, sources and limits of knowledge. The word epistemology derives from the Greek *episteme*, meaning knowledge, and *logos*, meaning theory; hence the phrase theory of knowledge (Benton and Craib, 2001). Crotty (1998: 3) argues that epistemology is 'a way of understanding and explaining how we know what we know'. Epistemology raises debates and reflections primarily related to the possibility of knowledge and its origin, limits, types and structure: where does the line run between the knowable and the unknowable? Is the source of knowledge reason or the senses? What are the presuppositions of knowledge – innate ideas, the situatedeness of the body or the language? What is the relationship between subjectivity and objectivity and what mediates this relationship? What can be acknowledged as truth? (Delanty and Strydom, 2003).

There is no agreement on the ontological and epistemological assumptions which should underpin grounded theory. Therefore, a variety of philosophical standpoints have been adopted by grounded theorists in conducting their research (Weed, 2009).

3.3.2 Methodological congruence

As previously mentioned, Birks and Mills (2011) argue that an important determinant in doing research is methodological congruence, which occurs when there is accordance between the research aim, the methodological approach and the philosophical underpinnings. If the researcher is not clear about this, he/she might undertake misleading and simplistic research. The basic idea which often underpins quantitative research in the midwifery field is that 'there is a straightforward cause-effect relationship in the physiology of childbirth'

(Downe and McCourt, 2004: 7). However, it must be acknowledged that the childbearing event cannot be reduced to only individual components that are systematically observed. The complexities of individuals (e.g. women and midwives), phenomena (e.g. labour and birth), interactions (e.g. midwife-woman relationship) and behaviours (e.g. decision making) need to be considered. Philosophical assumptions, which can be seen as the lens that the researcher wears in observing the phenomenon under investigation, are therefore an essential element in achieving methodological congruence. However, debates about ontological and epistemological underpinning of research approaches were not as prominent when Glaser and Strauss (1967) first developed grounded theory. In more recent years, a number of authors have addressed such assumptions and several variants of grounded theory have emerged, each underpinned by different ontological and epistemological assumptions (Weed, 2009). This point will be further developed in the next section.

3.3.3 Ontological and epistemological continuums: a range of philosophical underpinnings considered by grounded theorists

In regard to the range of philosophical underpinnings considered by grounded theorists, a continuum of assumptions for both ontology and epistemology can be identified. The extremities of the ontological continuum, which deals with questions about reality, are represented by realism and constructivism. The realist position assumes that a singular objective reality exists independently of individuals' perceptions of it (Sayer, 2000). On the other side, constructivists argue that reality is neither singular nor objective, but that multiple realities are constructed by individuals (Berger and Luckmann, 1966). The epistemological continuum deals with questions of knowledge and spreads from

positivist to interpretivist assumptions. Positivism is based on the assumption that direct knowledge of the world can be achieved through direct objective observation or measurement of phenomena (Comte, 1844). By way of contrast, the interpretivist epistemology claims that it is not possible to achieve the direct knowledge of phenomena; the observation and investigation of reality provide indirect explanations of phenomena, and thus knowledge is developed through a process of interpretation (Weber, 2003).

To cite a practical example, one side of the continuum (realist ontology and positivist epistemology) would consider the childbearing event as a linear and simplistic process of causes and effects where physiological processes are predictable, replicable and unaffected by context. However, this notion of cause-effect does not stand up to scrutiny when considering the complex interactions between individual women, their carers and the setting during labour and birth (Downe and McCourt, 2004). Instead, endless variations exist between labouring women which may more appropriately be described as representing a constructivist ontology and interpretivist epistemology.

According to these ontological and epistemological continuums, the different philosophical assumptions underpinning grounded theory variants will now be taken into consideration. Although ontology and epistemology seem not to be particularly underlined by Glaser and Strauss (1967) in their original work, the title ‘The Discovery of Grounded Theory’ might suggest ontological realist (the uncovering of an external reality) and epistemological positivist assumptions (accessed through observation and reason). More recently, Glaser (2002) argued that grounded theory is essentially ontologically and epistemologically neutral and the researcher should not be confined to any one lens, remaining open to adopt any epistemological perspective appropriate to the specific study. The second generation of grounded theorists (Strauss and Corbin, 1998) adopted an interpretivist

epistemology driven by an ontologically realist position, recognising that some aspects of the social world cannot be directly measured (embracing some interpretivist assumptions), although still believing in an objective reality (Weed, 2009). In more recent years, Charmaz (2006; 2011) suggested that grounded theory methodology might be underpinned by a constructivist ontology combined with an interpretivist epistemology. Constructivism rejects the notions of emergence and objectivity typical of realism and focuses on the contingent nature of reality that can never be fully known (Annells, 1996; Charmaz, 2006). Given this range of philosophical underpinnings which have been considered by grounded theorists, the ontological and epistemological position of this study will be clarified in the next section.

3.3.4 The philosophical assumptions underpinning this research: constructivist ontology and interpretivist epistemology

Benton and Craib (2001) argue that the social sciences are qualitatively different from the natural sciences, stating that the social world is made of human beings with self-consciousness and social groupings. This idea anticipates the interpretivist standpoint which argues that there are fundamental differences in the knowledge of the natural and social world. Therefore, the logic and methods used in natural science are not applicable to the understanding of social interactions (Delanty and Strydom, 2003). It is evident that the research strategy of this study did not seek to recognise any objective truth. Conversely, it acknowledged the presence of multiple and different women's expectations and experiences of a good midwife during childbirth. This research sought to discover local and particular truths; a truth-claim does not represent the whole reality but a particular context (Lyotard, 1984). The multiple truths of women were acknowledged in collecting and analysing data. In

regard to this, the analysis was characterised by a constant comparative analysis between data. The development of the theory remained tentative and revisable in the light of incoming data and new findings. According to this, the 'final' substantive theory sought to have explanatory power and relevance in similar contexts and not to be generically applicable.

Acknowledging the fact that the theoretical perspective is specific to each study, the philosophical underpinnings of this research combined constructivist ontology with interpretivist epistemology. The main features of constructivist ontology and interpretivist epistemology can be recognised within the proposed study, with regard to the concept of methodological congruence explained above. The main features of constructivism and interpretivism will now be explained, providing some considerations about their meaning-making in the specific context of this study.

3.3.5 Constructivist ontology

Although the author undertook a Straussian grounded theory methodology, different ontological underpinnings were considered for the present study, according to the research aim/questions and the researcher standpoint. Therefore, rather than the realist position adopted by Strauss and Corbin (1998), a constructivist ontology was undertaken.

Constructivists claim that reality is neither singular nor objective, but that multiple realities are constructed by individuals (Charmaz, 2006). As argued by Crotty (1998: 43), 'a meaning or truth cannot be described simply as objective'. The main features of the constructivist ontology can be recognised within the proposed study, which acknowledged the presence of multiple and diverse realities represented by women's expectations and experiences, as opposed to the existence of a

singular objective reality. According to grounded theory approach with its constant comparison method and data collection techniques (semi-structured interviews and memos), multiple realities were reflected in the ongoing conversations and interactions between data. Furthermore, the same conversation space was shared by the investigator and the participants; co-construction and reciprocity mainly drove the relationship between them.

3.3.6 Interpretivist epistemology

Interpretivism acknowledges that the social sciences may not be subject to the same methods of investigation as the natural world. Gerber and Macionis (1999) argue that researchers should reject empiricism and the scientific method in conducting social research. Instead, they should focus on understanding the interpretations that social actions have for the people being studied. Unlike the natural world, where a particular action constantly produces a given result, social actors do not homogenously react to stimuli (Benton and Craib, 2001). In particular, interpretivism claims that it is not possible to reach an in-depth understanding of social phenomena without considering how people interpret and make sense of their world, putting the emphasis on the distinctive nature of their beliefs, attitudes and perceptions (Gage, 2007).

In regard to the interpretivist rejection of the assumption of the uniformity of nature and linear causal models, Gage (2007) argued that interpretivists should employ different ways of investigating people's perceptions and attitudes, considering how these are shaped by cultural contexts and how they inform people's actions. Interpretivism has therefore encouraged a shift towards qualitative methods, which rely on ethnographic fieldwork, conversation/discourse analysis, focus groups and interviews. This shift in methods occurred because the research

aim/questions asked within an interpretivist paradigm differ from those asked within a positivist paradigm and, therefore, require different data (Craib and Stones, 2011). The same shift occurred in midwifery research, in which the use of qualitative methods is being predominantly applied according to the recognition of the importance of the complex social and human interactions underpinning the relationships between the woman, her family, the community and the midwifery profession. Downe and McCourt (2004) affirm that the best practice combines good quality data with professionals' competence and users' beliefs, knowledge and values.

Undertaking an interpretivist approach carries some implications for research. The researcher should adopt an exploratory orientation, with the intent to comprehend what is going on in each particular situation and to arrive at an understanding of the distinctive orientations of the people concerned. In regard to this, interpretivists argue that 'there is no absolutely objective scientific analysis of culture of social phenomena independent from special and one-sided viewpoints' (Weber, 2003: 111). Furthermore, the human beings' values and beliefs cannot be identified through an instrumental way (i.e. through techniques and measurement) but through meaning (Weber, 2003). This is reflected in the concept of woman-centred and individualised care which should characterise midwifery practice. As the midwife recognise, acknowledge and respect the individual woman with her unique needs, ideas, thoughts, emotions, expectations and wishes about the childbearing event (Fontein, 2009), the interpretivist researcher should adopt a multifocal view of the participants' meanings and perceptions of the reality under investigation.

The aim of this study reflected the idea of eliciting understandings and explanations of a good midwife from first-time mothers, birthing in different contexts, via the chosen data collection method (semi-structured interviews). The substance of the interviews was given

particular attention and underlining meanings and perceptions were shared during the conversation (Oliver et al., 2005). This research sought not only to explore expectations and experiences as they were lived by women, but also to explain them. The undertaken grounded theory methodology seeks to explain a phenomenon of interest, going beyond the simple description of the events by developing a theory that may have explanatory power beyond the specific context of this research (Birks and Mills, 2011; Glaser and Strauss, 1967; Strauss and Corbin, 1998). However, the theory did not seek to be generically applicable, unlike the assumptions behind a positivist epistemology. According to the aim of the study, interpretivism proposes an approach that would combine both the understanding of social action and the explanation of social events (Benton and Craib, 2001). On the basis of this rationale, also the context and broader factors were considered as valuable data (Strauss and Corbin, 1998).

2.3.7 The importance of declaring philosophical underpinnings

In explaining the main features of constructivist ontology and interpretivist epistemology and the rationale for this choice, the author developed a deeper understanding of the importance of declaring philosophical assumptions in undertaking a research project. However, as Glaser (2002) suggests, it must be acknowledged that there is not a unique way of combining a research methodology with specific philosophical assumptions. In other words, methodological congruence is not pre-set and the researchers develop their ontological and epistemological position in regard to the research question. This might vary from one researcher to another and this is demonstrated by the range of epistemological assumptions taken into consideration by the different grounded theorists' schools. Thus, the author is aware that

different philosophical positions may emerge. The theoretical position of constructivist ontology combined with interpretivist epistemology was done in congruence with the research aim, the type of knowledge to be sought and the research methodology undertaken in conducting the study.

3.4 RESEARCH METHODS

This section includes a detailed description of the research methods in regard to the planning and conduction of the study. In particular, information is provided on the identification of the birth settings and research sites, the phase of entering the research sites, the sampling and recruitment process, the data collection and analysis. Finally, considerations on reflexivity are presented and ethical issues are outlined. The challenges encountered by the researcher during the fieldwork are included in this chapter in relation to the different stages of the study.

3.4.1 Identification of birth settings and research sites

The configuration of maternity settings in England was considered in the section 2.8.1 of the previous chapter in order to contextualise this study. Childbearing women's expectations and experiences of a good midwife have not been investigated in relation to the planned place of birth. Despite that, the place of birth can be considered an important influencing factor. According to this rationale, women's perceptions were explored in the context of three different planned places of birth: home, Freestanding Midwifery Unit (FMU) and Obstetric Unit (OU). The study was conducted in England and these birth settings are representative of the possibility of choice for women in this country as

portrayed by the ‘Birthplace in England research programme’ (Redshaw et al., 2011).

The FMU was purposively chosen instead of an alongside birth centre, because women choose this birth environment during pregnancy, unlike some AMUs where women are allocated if they are low risk at the onset of labour. The hospitals were intentionally selected without an AMU for the same reason.

The researcher is aware that birthplaces are associated with different models of care that may influence women’s expectations and experiences. However, the model of care must be considered an intrinsic element of each birth place. This important issue was acknowledged in conducting the study.

Three NHS Trusts that offered women the possibility of giving birth in the identified birth settings (home, FMU and OU) were included in the study. The available options in each Trust are outlined in **Table 3.2**.

	OU	FMU	Home
Trust 1	✓	✓	✓
Trust 2	✓	✓	✓
Trust 3	✓		✓

Table 3.2 Birthplaces' options in the research sites

The next subheading will describe the phase of entering the research sites more in detail.

3.4.2 Entering the research sites

The lead midwife of each site was contacted first to assess the willingness to participate in the study. The researcher entered the research sites only after having had the ethical approval from the Research Ethical Committee and the respective Research and Development services (see heading 3.4.8 for ethical considerations).

The recruitment of women, data collection and analysis was simultaneously conducted in the three research sites. The study was presented in detail to the staff of each site during an initial meeting. Fliers were placed in each setting during the recruitment period to inform staff and users of the on-going project (**Appendix 5**). The researcher's contact details were available in case of need for clarification from both midwives and women. Furthermore, the researcher was available regularly at each setting during the recruitment period.

3.4.3 Sampling strategy: participants and sample size

A purposive theoretical sampling strategy was adopted and the sample size was determined by data saturation. The sample size was fourteen participants, with five women planning to give birth in an Obstetric Unit, seven in a Freestanding Midwifery Unit and two at home (one of these was undecided between home and the FMU). The difficulty in enrolling first-time mothers planning to give birth at home resulted in only two women recruited within this group. Each woman was invited to participate in two interviews: the first one in the third trimester of pregnancy and the second one four to ten weeks after birth.

The inclusion criteria for the first interview were that women were first-time mothers in good general health with a singleton straightforward

pregnancy anticipating a normal birth. Only women with a minimum age of eighteen were recruited. The rationale for recruiting women with a physiological pregnancy was related to the fact that this group had the widest choice of where they could give birth. The age of eighteen is a pragmatic criterion for simplifying the procedures for the informed consent. Participants needed to be able to read and speak English sufficiently to understand the information leaflet and to participate in the interview.

During the time span between the first and second interview, a physiological pregnancy might have turned into a pathological one. Moreover, the woman might have been transferred during labour from the planned place of birth to another setting (e.g. from the FMU or home to the OU). The second interview took place irrespective of whether a physiological pregnancy turned into a pathological one or transfer occurred during labour. In fact, what women think is a good midwife has to incorporate the experience of transfers between sites and models of care because that is the reality for a number of women, especially nulliparous. For this reason, more women were purposively recruited from the FMU to include a variety of experiences at the time of the second interview (e.g. same place of birth as planned, change of place of birth during pregnancy or labour). In regard to this, no intrapartum transfers occurred, but a change of place of birth (hospital) happened in seven of the nine women that were planning to give birth at home or in a FMU due to clinical reasons during the third trimester of pregnancy.

The exclusion criteria for the second interview were the woman's withdrawal or serious complications for the mother or the newborn (stillbirth, neonatal death, neonatal or maternal intensive care). Two out of fourteen women recruited and interviewed during pregnancy did not participate in the follow-up interview. One woman did not return the signed informed consent to be called by the researcher for the second

interview; one participant withdrew because her newborn was admitted to hospital few weeks after birth.

Data saturation was achieved for both antenatal and postnatal interviews independently from the place of birth. Within data analysis, the data collected were then compared and contrasted stratifying the participants by place of birth.

3.4.4 The recruitment process

The recruitment process lasted five months, from June to November 2013. Women were approached to participate in the study during the third trimester of pregnancy by the community midwives involved in their care. The midwives were fully informed about the study and were asked to help in giving brief information about the study to women and their families using the participant information sheet (**Appendix 6**). The researcher's contact details were available in case of need for clarification from both midwives and women. People who wanted to participate in the study could contact the researcher by telephone, text or email. Otherwise, the woman could leave her contact details with any midwife employed by the respective maternity unit, using the participant's contact details form (**Appendix 7**); in this case, the researcher called the woman back to talk about her involvement in the study and to arrange a suitable time to gain the first informed consent (**Appendix 8**) and do the interview. The study was also presented by both the researcher and midwives at antenatal classes in order to increase the pool of eligible women.

As the period following the birth of their babies is a time when women were making the transition to motherhood and had other priorities, the participants were given the possibility to contact the researcher after childbirth in order to arrange a suitable time and place for the second

interview. The women were sent a reminder letter two to three weeks after the expected date of birth and a stamped address envelope was provided for the second interview consent (**Appendix 8**).

3.4.5 Data collection: face-to-face semi-structured interviews

The data collection period lasted seven months, from June 2013 to January 2014. According to the research aim, face-to-face semi-structured interviews were conducted seeking women's expectations and experiences of a good midwife during childbirth. Two interviews for each woman were planned. The first interview took place in the third trimester of pregnancy, exploring expectations. The same woman was interviewed four to ten weeks after childbirth, with the rationale of giving her time to think about the birth experience. A total of twenty-six interviews were conducted, including fourteen interviews during pregnancy and twelve interviews after birth.

The time and place for the interviews were arranged with each participant, guaranteeing privacy and confidentiality. The researcher was as flexible as possible, in relation to participants' needs and requests. Twenty-five interviews were conducted at the women's own homes; one interview was done in a café. Other persons were present in six cases (persons in the café; partner; woman's own parents; mother-in-law; stepdaughter and her mum). Further considerations on this are outlined in heading 3.4.8.

The semi-structured interview is characterised by open-ended and non-judgemental questions that encourage the participants to share their stories. However, it also enables a balance between making the interview open and focusing on significant statements (Rees, 2011; Rose, 1994). In regard to this, some standard questions covering issues

or topic areas were discussed with participants, but the researcher was also flexible and open to investigate areas that seemed appropriate to the individual concerned. The interviews' topics were also guided by the previous data collection and data analysis, which allowed the continuous adjustment of the interview guide, according to the identified codes and topics that were meaningful to the participants. The changes in the interview schedule were tracked during the data collection period and seven versions resulted from this ongoing process. The first and last versions are reported respectively in **Appendix 9** and **Appendix 10**, including the information given to the woman prior and after the recorded dialogue. Before meeting with the woman after childbirth, the researcher re-read the transcript of the first interview. At the time of the second interview, references were made to the topics previously discussed with the participant, stimulating the comparison between expectations and experiences.

In line with the grounded theorists' approach, the researcher went into data collection with a particular interest in meaningful insights. Attention was given to the substance of the interview, emphasising meanings and perceptions created and shared during the conversation between the interviewer and interviewee (Oliver et al., 2005). Face-to-face interviews (e.g. instead of telephone interviews) allowed to observe other important issues such as the participant's non-verbal behaviour, the setting and the presence of other persons in the room.

Each interview was labelled with a reference code indicating the planned birthplace for first interviews and both the planned and actual birthplace for second interviews. The acronyms used were: OU for obstetric unit; FMU for freestanding midwifery unit; HOME for home. For instance, W1-HOME indicates an interview conducted with a pregnant woman planning to give birth at home; W2-FMU-OU refers to an interview with a mother that was planning to give birth in a FMU but ultimately gave birth in an obstetric unit.

The Policy and Guidance for the Safe Conduct of Fieldwork (UON, 2013) was taken into consideration in conducting one-to-one interviews.

3.4.6 Data analysis

According to grounded theory methodology, a preliminary data analysis proceeded simultaneously with the phase of data collection. The interviews were listened/re-listened to, fully transcribed and analysed before undertaking the next fieldwork.

The data analysis guided and informed the subsequent data collection by using ‘tentative theoretical categories’ (Charmaz, 2011). The data were jointly collected, coded and analysed by the researcher to determine what data to collect next and where to find them, with the aim of developing a theory grounded on the participants’ priorities (Glaser and Strauss, 1967; Strauss and Corbin, 1998). The ongoing development of the theory guided not only the subsequent data collection, but also what the researcher looked for in the previously collected data (Strauss and Corbin, 1998).

The analysis of data was manually performed, using an excel spreadsheet to organise codes and categories. Each row represented a participant and each column a category; the intersection cell contained the codes (quotes) from each woman in relation to the relevant category. Memoing was used as a complementary analytical technique. The purposes and features of memos are reported in heading 3.4.7.

The data analysis was undertaken on the basis of the following phases identified by Strauss and Corbin (1998): a) open coding; b) axial coding; c) selective coding; d) development of the theory. Theoretical sensitivity and a constant comparison between data, categories, memos and literature were maintained through all the stages. The data analysis’

process is summarised in **Table 3.3** and explained below in more details.

OPEN CODING	*Identification of codes* *Discovering categories* *Naming categories* *Building categories*	*DESCRIPTIVE LEVEL*	*CONSTANT COMPARISON*	*THEORETHICAL SENSITIVITY*
AXIAL CODING	*Linking categories*			
SELECTIVE CODING	*Identifying the core category/ies*			
THEORY DEVELOPMENT	*Developing the theory*	*CONCEPTUAL LEVEL*		

Table 3.3 Data analysis' process

The initial process of open coding aimed at identifying, naming, categorizing and describing the phenomena. Codes can be defined as the incidents, facts and concepts arising from the transcripts through the researcher's interaction with the data (Chenitz and Swanson, 1986). Each line, sentence and paragraph was read and re-read, repeatedly asking questions of the data: What is this about? What is the participant referring to here? The building of categories was supported by the constant comparative analysis and the understanding of the conceptual meanings behind the codes. Categories are defined by Glaser (1978) as 'mid-point indicators' and 'building blocks to theory'. In other words, categories are conceptual elements deriving from the abstraction of

codes, depicting the relationships between data and theory (**Figure 3.1**).

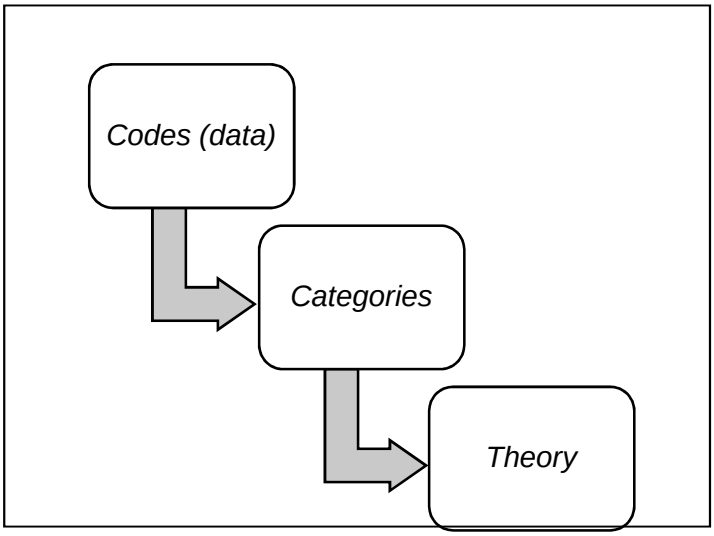


Figure 3.1 Categories: building blocks to theory

Properties are described by Strauss and Corbin (1998) as 'the attributes or characteristics pertaining to a category'. Properties can have dimensions which represent the degrees of a property along a continuum. This is well illustrated by the example of degree memo on the midwife's role as considered by women reported in heading 3.4.7.2.

Naming the categories was essential in order to remember, compare and analytically develop them. The chosen names were the most 'logically related' to the data they denoted, 'graphic enough to remind quickly the referents', and 'more abstract concepts' than the ones they represented (Strauss and Corbin, 1998: 67). Moving along in the coding process, original labels were changed with progressively more appropriate and conceptual terminology. **Table 3.4** gives an example of open coding in the present study in relation to the strategies implemented by women during pregnancy while waiting for labour and birth.

IDENTIFICATION OF CODES	QUESTIONING: What does the participant say? a) *'I've studied, I've looked at lot of different things, I've done the Hypno-birthing course'* b) *'I sort of banned myself from internet and from listening to people'* c) *'Millions of women have done it before!'*
DISCOVERING AND NAMING CATEGORIES	QUESTIONING: What is this code about? What is the participant referring to here? a) *'Studying the unknown'* b) *'Ignoring the unknown'* c) *'Other women successfully faced the unknown'*
CONSTANT COMPARISON	REFLECTION: These are all strategies employed by women while waiting for the unknown.
BUILDING CATEGORIES	CATEGORY: *Waiting for the unknown: coping strategies* *Properties: a) Preparing; b) Avoiding; c) Shared experience and maternal instinct*

Table 3.4 Waiting for the unknown: an example of open coding

The phase of axial coding sought to conceptualise the phenomena and it was guided again by constant comparison and memoing which allowed categories, notions and linkages to be formally noted and included in the iterative analytical process. The axial coding allowed the fulfilment of categories, characterised therefore by richness and density in terms of crucial properties, dimensions and associated relationships (Strauss and Corbin, 1998). The use of questioning played an important role and there were some basic questions that arose quite automatically in the interpretation of data, such as 'Who? When? Where? What? How? How much? and Why?' (Strauss and Corbin, 1998: 77). Going beyond these simple questions, Strauss and Corbin (1998) outlined a paradigm model to systematically think about data and enhance the conceptualisation of codes into categories. According to this model, important elements to be considered are the context, casual and intervening conditions, action/interaction strategies and consequences. Similarly, Glaser (1978) refers to causes, contexts, contingencies,

consequences, co-variances and conditions. Due to the interactive nature of events, Strauss and Corbin (1998) developed a conditional matrix that encompasses different levels of potential conditions and consequences to a phenomenon, such as international, national, community, institutional, group and individual levels.

The process of selective coding allowed the selection of core categories, which were systematically related to other categories and sub-categories (Strauss and Corbin, 1998). The core category is defined by Strauss and Corbin (1998: 116) as 'the central phenomenon around which all the other categories are integrated'.

The development of theory aimed at the creation of a substantive theory, 'translating' the analytical material (e.g. memos) clearly and effectively so that others can understand the developed model and benefit from it (Strauss and Corbin, 1998). As previously mentioned, a substantive theory is not necessarily transferable to all other contexts with factors that differ from the setting under research, such as low risk mothers in other countries or different groups of women (e.g. high risk). However, the theory is likely to have explanatory power when applied to similar contexts. Furthermore, a substantive theory should be modifiable and open to extensions or additional developments, considering new insights provided by future empirical investigations (Glaser and Strauss, 1967). A substantive theory can contribute to formal theory when it is used to inform research less specific to group and place and applied to a wider range of issues across disciplines (Glaser and Strauss, 1967; Strauss and Corbin, 1998). The considerable amount of data collected made necessary the selection of the most relevant categories in order to develop the theory.

The constant comparative analysis (see 3.2.3) held together the iterative process and the codification/conceptualisation of data. The comparison was between data, codes, categories and literature,

continually checking that the emerging insights were grounded in all parts of the analysis. This process continued until the data saturation of the area was achieved (Strauss and Corbin, 1998; Weed, 2009). Strategies implemented to enhance theoretical sensitivity (defined in section 3.2.3) are detailed in heading 3.4.9.

It must be acknowledged that the various steps of grounded theory are not necessarily taken in sequence and do not form a linear process. Strauss and Corbin (1998) declare that it is only for explanatory purposes that they distinguish between them.

3.4.7 Memoing

Memos were used as a complementary technique for data analysis, representing the researcher's engagement with data. Birks and Mills (2011: 40) introduce the concept of memoing as 'the cornerstone of quality' and 'the critical lubricant of a grounded theory machine', reinforcing the significance of memoing to the processes and outcomes of grounded theory.

Keeping memos means recording analytical thoughts, feeling, insights and ideas that emerge during the fieldwork. In other words, memos give the opportunity to interrogate data with the aim of developing concepts for the construction of theory (Glaser, 1978; Strauss and Corbin, 1998). The memoing technique can be allegorically described as a 'distillation process' through which the data are conceptualised into theory (Bryant and Charmaz, 2007). The researcher is assisted by memo writing in discovering conceptual patterns through organising, coding and analysing data (Charmaz, 2006; Strauss and Corbin, 1998).

In this study, memos were used to map methodological issues and analytical activities, maintain the audit trail of the study, record

reflections or questions and give the rationale for decision-making during interviews. Furthermore, memoing allowed the investigator to retain important details about interactions and immediate responses and to capture non-verbal behaviours that would not have been revealed through the transcript alone (Birks and Mills, 2011). Memoing were used also in listening/re-listening to audio recordings, transcribing the interviews and reflecting during the analysis phase. As required by grounded theory approach, the memos helped the constant comparative analysis.

Fifty-five memos were written by the researcher. As indicated by Strauss and Corbin (1998), memos varied in content and length; they evolved conceptually in complexity, clarity, density and accuracy as the study progressed. The later memos may 'negate, amend, support, extend or clarify the earlier ones' (Strauss and Corbin, 1998: 198). An example of memo development is included in **Appendix 11**. Each memo was sequentially numbered and dated; furthermore, it included references to the documents which it referred to (e.g. code number of the interview, reference from the literature, another memo). Short quotes or phrases were included in the memos as reminders of the data that inspired a particular analytical idea. Furthermore, important points were underlined or highlighted to allow quick reviews. As advised by Strauss and Corbin (1998: 203), the researcher tried to avoid 'rigid fixation on form or correctness' which may 'stifle creativity and freeze thought'.

Memos were audio recorded, manually or electronically written in different moments and places: before or after an interview; while transcribing or listening to an interview; during the coding process; while travelling to and from the participants' homes, in the office, at home or during everyday life. The memoing activity was not undertaken during interviews. The audio and manual notes were all electronically transcribed to consistently organise the memos.

By writing, reading, re-reading, sorting and integrating memos, the researcher was facilitated in identifying the core categories and the theoretical relationships between categories, contributing to the development of the substantive theory (Strauss and Corbin, 1998).

The memos took several forms: category memo, comparative memo, memo of degree, hypothesising memo, storyline memo, diagramming (Chenitz and Swanson, 1986). Examples of these are reported below.

3.4.7.1 Category memo

An example of category memo through which the sub-category of '*Negative language/behaviours of professionals: the meaning women make of it'* started to be developed is reported in **Figure 3.2**. This memo includes two quotations from an interview with an interpretation of what the incident might mean. The category was developed from these and other codes. By writing memos including both the participant's quotes and the researcher's interpretation, the author had quick access to the codes and could also compare them with new data.

NEGATIVE LANGUAGE/BEHAVIOURS OF PROFESSIONALS: THE MEANING WOMEN MAKE OF IT

The woman is dissatisfied and not believed – trivialising and patronising + midwife just representing the institution (not person to person, depersonalised)

'You are not in active labour yet'

By the labour ward I was at 4 contractions in 10 minutes and can't talk through them and I was assessed there and I was only 2 cm dilated. And the midwife said to me, first interesting point, 'Well, you're not in established labour yet, you can go home'. 'So, I live 35 minutes away and I am having 4 contractions in 10 minutes. When would you like me to come back?' And she said 'Well I am not convinced your waters are broken'. I said 'Well, let's put it this way, the pad I was wearing was completely full and I needed to go to the loo'. So unless I've developed a second bladder from somewhere… it wasn't like… I didn't need to go to the loo and it could have been me having an accident. So the registrar said to keep me in […] I think if they made a case by case assessment of me there, they would probably have gone 'Actually, she doesn't need the gas and air, she does need more attention'. (W3-OU-OU)

It had a real impact on me her saying 'You're only in early labour'. So I then went for another 2 hours thinking 'I am only in early labour, my Goodness how much more painful is this going to get?' (W3-OU-OU)

Figure 3.2 Category memo

3.4.7.2 Comparative memo

In the following comparative memo (**Figure 3.3**), the researcher reflected on the perception of safety of birthplace from the perspectives of women planning to give birth in different places. More incidents from several interviewees were included in this memo, with the purpose of making a comparison. This memo allowed the identification of the participants' viewpoints on the same topic (safety of birthplaces).

SAFETY OF BIRTHPLACES

Apparently, all women would prefer to have a normal birth. However, there is a **contrasting point of view in respect to being surrounded by medical staff** in relation to the place of birth.

Some women choose the **hospital** because they felt that being surrounded by a medical environment (obstetricians and other professionals) was a safer option. Safety=being surrounded by medical support

…not being a medical process but having that medical support immediately around you… so I guess oh this is a really bad analogy but It's like the skin of an orange… so the orange is 'I'm giving birth' but the skin of the orange is 'and I've got everything here that if anything were to go wrong people can reach out and grab immediately rather than having to take… call an ambulance and take 25 minutes… blue-lights… No! I would be stressed, that would make my adrenaline go through the roof, I would not be relaxed at all. (W3-OU-OU)

I think you do feel more safe in a hospital… not that I have ever been in hospital but I can imagine you would do. Seem to have everything there that you need whereas here. (W1-OU-OU)

W3-BC-BC felt that she was a 'central attention' in the **birth centre** (one-to-one care) and this made her feel relaxed about the fact that 'if anything happened they'd see it straight away'. Safety=one-to-one dedicated care

I don't really know what that would be like but I knew that I wanted it at the birth centre because I knew that it would be… I'd only be…if not maybe only one other one…so it did feel nice because it felt like I was a centre of attention which was nice, it felt like if something needed attention it would be done and that's what I liked, it didn't feel like their attention was taken elsewhere. So I knew that if anything happened they'd see it straight away. So it did just leave me feeling really relaxed. And because we'd seen this place beforehand… we've been there having a look around… it just felt really relaxed. (W3-FMU-FMU)

W1-HOME-OU completely trust her midwife's competencies and abilities in delivering her baby safely 'unless medical intervention is needed (splitting the 2 concepts of safety and medical support). Safety=complete trust in her midwife's expertise

…she knows exactly what I want so she knows I am not going to want to go down the route of induction or, you know, anything else and she'll try her best to be sure this baby is delivered, you know, safely and in the kind of the way that I want it to be delivered… unless medical intervention is needed. […] I'm expecting her to use her full professional judgement to assess me on a constant basis to make sure that everything is going smoothly and that I don't need to be rushed into hospital so… you know, to use her full expertise to make sure that both of us are safe! (W1-HOME-OU)

Figure 3.3 Comparative memo

3.4.7.2 Degree memo

The next example (**Figure 3.4**) is a degree memo showing the 'amount' of professionalism and emotional support that women would expect from a midwife in regard to the planned birthplace. This directed the researcher to consider this as a category of range, which can vary from women putting a greater emphasis on professionalism to women looking more for emotional support. The balance between the two characteristics indicates a good mixture of both (fifty-fifty).

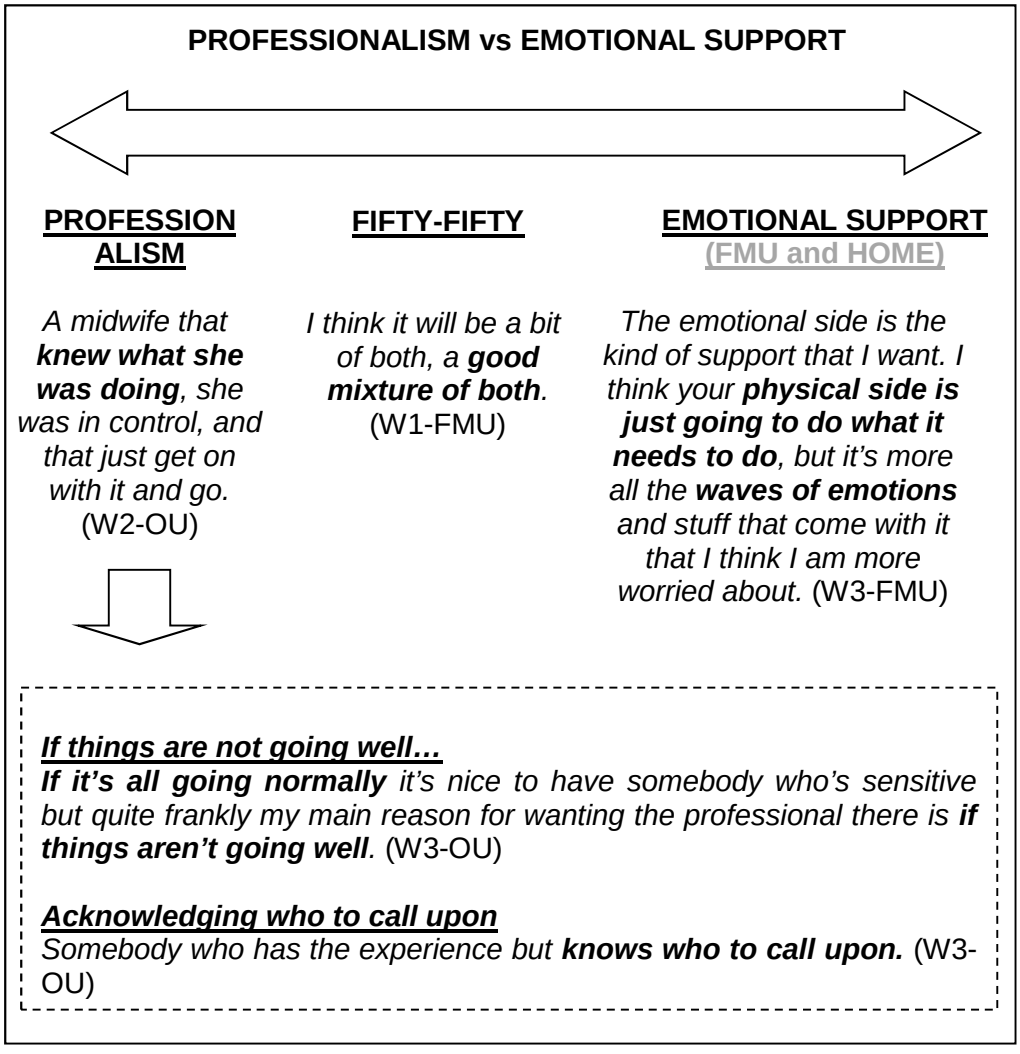


Figure 3.4 Degree memo

3.4.7.3 Hypothesising memo

In the hypothesising memo reported in **Figure 3.5**, the relationship between responsibility and the birthplace was considered. The memo reports two of the codes that were compared in order to allow the development of the hypothesis, which was underlined for emphasis.

RESPONSIBILITY AND BIRTHPLACE

I think it's very easy to be swayed by the hospital and what they insist that you should have according to them. (W1-HOME)

I feel like a bit more looked after whereas if I was doing it at home I'd be like… I'd feel like… I know that the midwife would be here but I just… it would be more my responsibility whereas if you go into the hospital I feel like I am going to get looked after. (W4-FMU)

My responsibility (HOME) vs. their responsibility (FMU, OU)

Figure 3.5 Hypothesising memo

3.4.7.4 Storyline memo

The memo in **Figure 3.6** is represented by a storyline on women's expectations, which denoted the researcher's attempt to bring together the previously written memos into a story aimed at recognising the core ideas of the phenomenon under study (Chenitz and Swanson, 1986). In writing this memo, the author was guided by the following questions: What is this about? What is happening here? What are the women's main concerns? Why? Although the focus was on what women expected from a good midwife, this storyline highlighted also other important topics from the participants' perspective, such as the recognition of the unknown and strategies to cope with it, influencing factors on women's choice of birthplace and safety of the birthplace.

According to the aim of a grounded theory methodology, the researcher remained open to the participants' concerns.

STORYLINE – EXPECTATIONS

A first-time pregnant woman acknowledges the unknown future situation of labour and birth. She therefore recognises that her expectations might be different from what she will experience. Women set different strategies to manage the unknown: a) studying and preparing; b) ignoring the unknown and banning herself; c) encouraging herself thinking that other women successfully faced the unknown. Women are aware that they are designed to go through childbirth and that 'the way you go into it' is essential. Women refer that they will 'go with the flow' as they don't know what to expect. Women see childbirth as a natural event and have really rough guidelines in their birth plans. Referring to the women's idea of a *good midwife*, they seem to value a midwife with both personal and professional qualities. Some of the recurring characteristics are: **a)** woman's self-affirmation (*someone 'like me', someone I can have a chat and a laugh with, making me feel it's my plan, having time for me, recognising I need different support from the next lady, someone I feel comfortable with, being excited with me*); **b)** interpersonal dynamics (*friendly, approachable, helpful, listening to me, giving information and answering questions, smiley, bubbly, plenty of communication*); **c)** personal attributes (*strong, proactive, confident, organised*); **d)** professional competencies (*experienced, they know what they are doing, professional, knowledgeable)*. While some participants place a greater emphasis on either the emotional or professional side, other women seek for a balance of these, mainly depending on labour's progression. Women do not expect the midwife to be always physically present with them throughout the labour. However, it is important that the midwife makes the woman feel relaxed and let her know that she is available. In case of shift changes women would expect the midwives to pass information to each other's, to let them know and to treat them with respect. All women agree that midwives *need to sleep* and it is better to have a *fresh midwife* caring for them. The presence of the midwife is considered really important not just at the moment of birth but also in early labour (e.g. they seek confirmation of being in labour from the midwife) which is when women are usually advised to stay at home. Women think that midwives are all *trained the same* and rated them as *good* independently from the place of birth. The difference between midwives might be influenced by the busyness of the birthplace environment, the individual midwife's personality and the birth outcomes. Beside the midwife, women feel that the presence of their birth partner is really important, being their *voice of reason*. Influencing factors on women's expectations are: family and friends' stories; TV programmes; society; hypno-birthing course. In relation to the place of birth, influencing factors on the birthplace's choice are: proximity, friends' and family's stories, media and TV programmes on birth, community midwife, medicalised/not medicalised environment, my responsibility VS their responsibility, idea of safety. In particular, TV programmes seem to influence women's choices in several and different ways. A woman planning to give birth in the hospital infers that she is scared about how things can go wrong so quickly as shown by TV programmes. Conversely, a woman planning to give birth at home argues that media show a frightening idea of what hospital birth is and this is exactly what she does not want. Women's choices of place of birth are also influenced by their idea of *safety* which is variously defined as: being surrounded by medical support (hospital); having a one-to-one dedicated care (midwife-led unit); having complete trust in an expert midwife that knows you (home).

Figure 3.6 Storyline memo

3.4.7.5 Diagramming memo

A diagramming memo is a visual representation of the author's analytical scheme in whole or in part (Chenitz and Swanson, 1986), showing the relationships between categories (Strauss and Corbin, 1998). The example provided in **Figure 3.7** is a diagram reporting the women's general attitude towards childbirth from pregnancy to the postnatal period. This was one of the first diagrams drafted by the author and therefore it changed in depth and integration as the theory developed.

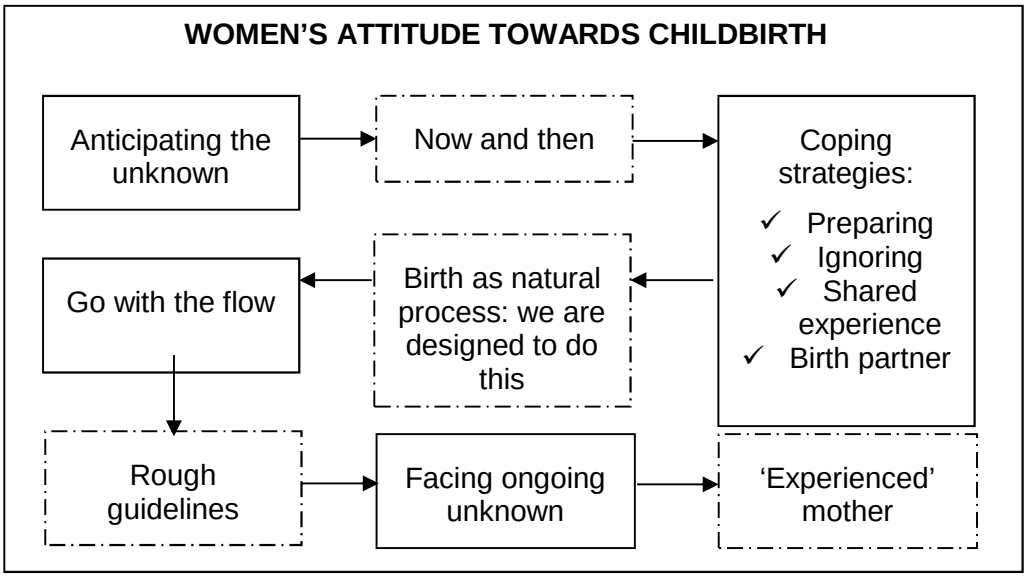


Figure 3.7 Diagramming memo

3.4.8 Ethical considerations

The researcher was committed to integrity, honesty, transparency, equality, and mutual respect in conducting this study. The ethical approvals were obtained from Multicentre Research Ethics Committee and the respective Research and Development services for the three NHS Trusts' sites. Regarding individual informed consent, permission to

conduct and tape-record interviews was obtained from each woman, after a detailed explanation of the study by the researcher. Respect for women's privacy and personal feelings was upheld, since the experience of childbirth is a very sensitive topic. Furthermore, the researcher avoided any judgmental statement in conducting the interviews. Women were free to decline participation or to withdraw at any time. Women will be offered copies of study findings on conclusion of doctoral studies. Pseudonyms are used in any reports, data are kept securely and data held on PCs or laptops are password protected.

Other ethical considerations were acknowledged before entering the research field. According to Harding (1991), recognising power imbalance means to understand that there is no value-free investigation and that any research has to be understood as a particular form of social relations. In regard to this, the researcher implemented some strategies to minimise the power imbalance between the interviewer and the interviewee. The time and place for the interview were agreed with each woman and the investigator was as flexible as possible, offering the option of conducting the interview at the participant's own home or in a place familiar and comfortable to her. The researcher was aware that privacy and confidentiality could not be totally guaranteed in giving the participants the option to choose a place suitable to them. In respect of this, other persons were present either in the same room or in the house in six cases, for the entire duration or for only a part of the interview (persons in the café; partner; mother and father; mother-in-law; stepdaughter and her mother). In this case, more attention was paid on what the woman wished to disclose in the presence of other people. The interviewer presented herself not only as principal investigator, but also as a midwife by background, and declared that English was not her mother-tongue. These strategies might have helped in reducing the power imbalance between the researcher and participants.

Although the interviewees were encouraged to express themselves openly and confidentiality was assured, the background of the researcher as a midwife may have influenced women's disclosure about their experience with the midwife during the interview (e.g. not feeling free to express bad feelings or unmet expectations). However, this appeared not to be the case as quite a few participants raised the negative language and behaviours of midwives. In the case women asked the researcher for advice related to clinical practice, they were encouraged to refer to their midwives.

As mentioned in heading 3.4.4, the postnatal period is a sensitive time when women make the transition to motherhood and have other priorities; for this reason, the participants were given the possibility to contact the researcher few weeks after childbirth. In the case the woman did not contact the researcher, she was sent a reminder letter two to three weeks after the expected date of birth and a stamped address envelope was provided for the second interview consent (**Appendix 8**). Once the investigator received the consent, she contacted the participant by phone to arrange the second interview.

These ethical concerns were acknowledged during the several phases of data collection, analysis and discussion. Further considerations on reflexivity are included in the next heading.

3.4.9 Reflexivity

My reflexive approach was congruent with the Heideggerian thinking (Heidegger, 1962). In accordance with the philosophical underpinnings of this research, I adopted a reflexive approach highlighting my role and horizons of interpretation. Heidegger (1962) argues that we do not exist as separate and disinterested beings but are fundamentally concerned with our 'being in the world' and this concern also revolves around our

being with others with whom we co-construct and interpret realities. Continuing the work of Heidegger, Gadamer (1975) states that no individual understands better than another; rather, individuals understand in diverse ways. Furthermore, understanding is derived from the researcher's personal involvement in a reciprocal process of interpretation with those being studied (Spence, 2001). According to this, my approach considered an active relationship between the interviewer and interviewees that co-constructed the theory. According to Gadamer (1975), interpretation is not about the uncovering of the intentions of another person. It is rather an encounter in which a fusion of horizons occurs, embracing the meaning held by the other.

In the present study, I did not seek to uncover meanings but to construct meanings through a situated encounter with the participants. I considered my personal and professional principles and beliefs as valuable resources in order to enhance reflexivity through the research process, including ethical issues, tensions, challenges, limitations of the study and possible future developments.

I acknowledged my main role as researcher within the fieldwork context. However, I also considered my personal experience as a woman and professional experience as a midwife both as important resources and potential limitations in conducting the study and analysing data. In fact, being a woman and midwife obviously influenced the different stages of the project, from planning the study (e.g. knowledge of the research area and identification of the research questions) to collecting data (e.g. conduction of the interview in terms of questions asked and interaction with the woman) and analysing them (e.g. interpretation of data).

In regard to the literature, having some familiarity with publications around the topic sensitised me to what was happening with the phenomenon under study (Strauss and Corbin, 1998). As argued by McGhee et al. (2007), the previous knowledge on existing evidence

should not preclude the iterative inductive-deductive approach, which is the heart of grounded theory methodology. I used reflexivity to minimise prior knowledge misleading my perception of data, stimulating questions during the phases of data collection and analysis.

In conducting the interviews, I considered the interaction between me and the interviewees as an essential factor finalised at co-constructing the theory (Cutcliffe, 2000; Hall and Callery, 2001). Some authors argue that a theory developed from qualitative methodology always imply reflexivity, referring to it as the researcher being part of, rather than distinct from, the world she/he is studying (Altheide and Johnson, 1994; Lipson, 1991). Specifically on grounded theory, Hutchinson (1994: 187) affirms that 'because grounded theory research requires interpersonal interaction, the researcher is inevitably part of his or her daily observations'. According to grounded theory methodology, I adopted a balanced approach between answering the specific research questions and remaining open to the participants' main concerns.

In regard to the analytic process, the insight and understanding of the phenomenon improved as I interacted with data. This was enabled by collecting and asking questions about the data, making comparisons, thinking in a reflective way, hypothesising relationships and developing preliminary conceptual frameworks of the theory (Strauss and Corbin, 1998). Theoretical sensitivity was implemented to enhance reflexivity on meaningful insights from the collected data. Theoretical sensitivity is defined by Strauss and Corbin (1998: 42) as 'the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't'. As suggested by Strauss and Corbin (1998), I periodically stepped back and questioned data, following the research process rigorously and maintaining an attitude of scepticism. In regard to the latter point, categories, properties and relationships among them were retained as provisional; they were constantly checked out, compared with incoming

data and never considered as facts. Theoretical sensitivity was facilitated from several sources, such as my professional background and personal experience, the literature and the constant comparative analysis. The memoing technique helped me in my reflexive journey through data collection and analysis.

3.5 SUMMARY OF METHODOLOGY AND METHODS

According to the aim of the study, a qualitative methodology using a Straussian grounded theory approach was undertaken. The core elements of Straussian grounded theory are: a) constant comparison; b) theoretical sensitivity; c) theoretical sampling; d) theoretical saturation; e) substantive theory; f) fit, understanding, generality and control. The philosophical underpinnings of this research combined constructivist ontology with interpretivist epistemology. The researcher adopted a reflexive approach highlighting the researcher's role and horizons of interpretation.

Women's perceptions were explored in the context of three different planned places of birth: home, Freestanding Midwifery Unit (FMU) and Obstetric Unit (OU). The sample size was fourteen participants, with five women planning to give birth in an OU, seven in a FMU and two at home (one of these was undecided between home and the FMU). Each participant was invited to attend two interviews: the first one in the third trimester of pregnancy and the second one four to ten weeks after birth. The inclusion criteria for the first interview were that women were first-time mothers in good general health with a singleton straightforward pregnancy anticipating a normal birth. Only women with a minimum age of eighteen and able to read and speak English were recruited. The exclusion criteria for the second interview were the woman's withdrawal or serious complications for the mother or the newborn (stillbirth, neonatal death, neonatal or maternal intensive care). A total of twenty-

six audio-recorded semi-structured interviews were conducted, including fourteen interviews during pregnancy and twelve interviews after birth. The preliminary data analysis proceeded simultaneously with the phase of data collection. The interviews were listened/re-listened to, fully transcribed and preliminary analysed before undertaking the next fieldwork. The data analysis was undertaken on the basis of the following phases identified by Strauss and Corbin (1998): a) open coding; b) axial coding; c) selective coding; d) development of the theory. Memos were used as a complementary analytical technique. The ethical approvals were sought from Multicentre Research Ethics Committee and the respective Research and Development services for the three NHS Trusts' sites. The informed consent was obtained from each woman before entering the study. Privacy and confidentiality were guaranteed. Women were free to decline participation or to withdraw at any time.

The next two chapters outline the findings of the study.

4. FINDINGS (1): EXPECTATIONS

This chapter presents first-time mothers' expectations of labour and birth, with particular focus on their perspectives on what makes a good midwife.*

The findings reported in this section emerged from the interviews conducted with fourteen women in their third trimester of a normal pregnancy (before the birth experience). The average age of the participants was twenty-nine years (range: nineteen to forty-three years) and the average gestational age at the moment of the first interview was 38^{+3} weeks (range: 36^{+1} - 40^{+1}). Five women were planning to give birth in an Obstetric Unit, seven in a Freestanding Midwifery Unit and two at home (one of these was undecided between home and FMU).

Where relevant, the influence of the planned place of birth on women's expectations is discussed in relation to the identified categories and properties. Extensive quotes from the interviews with the participants are included in order to demonstrate categories.

* Part of this chapter was disseminated at international conferences:

Childbearing women's expectations and experiences of a good midwife in the context of different planned places of birth. *ICM 30th Triennal Congress*. Prague, Czech Republic. 1-5 June 2014.

The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers perspectives of a good midwife. *Normal Labour and Birth Conference*. Grange Over Sands, United Kingdom. 17 June 2015.

According to grounded theory, as during the data collection phase, in presenting the findings the researcher adopted a balanced approach between answering the specific research questions and remaining open to the participants' perspectives. For instance, the women's expectations of labour and birth were taken into account in order to give a broader contextual picture rather than concentrating only on the women's views of a good midwife.

The women's expectations are reported as three categories:

1. ANTICIPATING THE UNKNOWN: GOING WITH THE FLOW;
2. CHOICE OF PLACE OF BIRTH;
3. EXPECTATIONS OF A GOOD MIDWIFE.

The three categories are now presented in greater detail.

4.1 ANTICIPATING THE UNKNOWN: GOING WITH THE FLOW

The category of 'anticipating the unknown: going with the flow' embodies the women's general attitude towards childbirth. Three sub-categories were identified: **a)** labour and birth: unknown territory; **b)** waiting for the unknown: coping strategies; **c)** going with the flow. The properties of each sub-category are outlined in **Table 4.1** and discussed in the respective headings.

CATEGORY	SUB-CATEGORIES	PROPERTIES
ANTICIPATING THE UNKNOWN: GOING WITH THE FLOW	LABOUR AND BIRTH: UNKNOWN TERRITORY	o *Every woman is different* o *Never done it before* o *Absence of guidelines on sequence of events* o *Uncertainty about emotional and physical reactions* o *Lack of control over events* o *Filling time* o *Now and then* o *Excitement*
	WAITING FOR THE UNKNOWN: COPING STRATEGIES	o *Preparing* o *Avoiding* o *Shared experience and maternal instinct* o *Relying on pain relief techniques* o *Birth partner(s) as voice of reason*
	GOING WITH THE FLOW	o *Childbirth: a natural process* o *We are designed to do this* o *The way you go into it* o *Going with the flow* o *Rough guidelines*

Table 4.1 Category one - Anticipating the unknown: going with the flow

4.1.1 Labour and birth: unknown territory

When thinking about labour and birth during pregnancy, the women acknowledged this was an unknown territory to them, independently from the planned place of birth. This perception was related to several beliefs. The most mentioned by the participants was that every woman is different and therefore has a unique childbearing experience:

> *I am not really sure what to expect to be honest. I don't know, I'm just going to see how it goes I think […] everybody's experience is different as well so I […] rather just sort of see what happens when it happens.* (W2-FMU)

> *Because it's my first time I don't know what to expect. It's just all sort of ifs and buts or maybes… until I am there I don't know because I've never done it before.* (W6-FMU)

In addition, as first-time mothers, they had some general expectations on labour and birth but did not have a clear idea on what to expect in terms of sequence of events and their reaction in response to them. Some women argued that this sense of unknown made them worry because they did not have any guideline to rely on and therefore did not feel in control over their childbirth experience. The participants generally reported the perceived absence of control over the events and birth outcomes, arguing that *things could be taken out of their hands completely*. In this case, some women intended to rely on what was going to be recommended by healthcare professionals attending their childbirth. The general feeling of unknown seemed not to be relieved by talking with mothers with previous birth experiences:

> *I don't know what to expect and that's worrying. I don't know when it's going to happen and how I am going to handle it. Someone could tell me that it will be fine, it is not going to hurt this much, explain it all, but because everyone is not the same they can't do*

that. I don't know what to expect [laughing]. I've never done it! That's the worst thing, not knowing. (W7-FMU)

Pain, tiredness, exhaustion, time consuming. I've got an idea but you don't know […]. It just depends… (W6-FMU)

It's just a worry of the unknown, isn't it? Once I've been through it, at least I have a guideline if I'll have one next time. (W2-OU)

You don't know exactly what's going to happen because things can be taken out of your hands completely. You know, if a baby becomes distressed and that kind of stuff that's different… then you have to have what those at the hospital tell you. (W1-HOME)

As mentioned above, the participants reported a sense of uncertainty in regard to their reactions to the events occurring during childbirth, both in emotional and physical terms. For this reason, they considered different routes and options when thinking about the birth plan (further discussed in heading 4.1.3):

I don't know how I am going to react or be so I don't know. Like in my book I've put stuff as and when needed or if I need this… (W6-FMU)

One interviewee perceived as difficult to imagine the social gathering surrounding her during labour and the way time will be filled while she will be having contractions, arguing for the need for finding something to do or say during that *spare time*:

But what I am going to be doing in those hours, what is going to happen in all those hours. It's crazy! What I am going to do in that spare time? Just sit there, talking to my mum, is there so much that you can talk about? [laughing] It's like a social gathering while I'm having contractions! I can't just see how it runs. (W2-OU)

The majority of participants predicted that their birth experience may be different to or conflicting with their actual expectations, in terms of what they wanted, what was going to happen and how they were going to cope with the situation. This idea is encompassed by the property of 'now and then':

> *Asking me now, I'll probably be like 'I really don't want that'. But at that time I'll probably be like 'I really don't care. Just get it out'.* (W7-FMU)

> *I think I am going to surprise myself after the labour. […] I'll probably find things that I am saying now is totally opposite to what actually happened and how everything was.* (W2-OU)

> *Normally I am quite outgoing, normally I am quite confident… but in that situation when I am in a complete unknown I'll go one way or the other. I'll either go completely into myself or I'll be absolutely 'right, this is my body, this is what's happening, this is how we're doing, this is what we're doing' and taking control… or I'll just go completely to the opposite extreme. I am probably more towards the confident side.* (W3-OU)

Despite the unknown terrain they were entering, some of the women planning to give birth in a FMU reported to be excited about their childbearing event:

> *I am really looking forward to the birth. I am just excited because I just think it's an amazing thing that's happening, you think growing this little thing for 8 or 9 months and you're going to meet it soon.* (W4-FMU)

> *I am always the only one in the antenatal class that is looking forward to it and they are 'You what?' [laughing]* (W2-HOME/FMU)

4.1.2 Waiting for the unknown: coping strategies

While waiting for the unknown, the women put in place a number of coping strategies in the course of pregnancy: preparing; avoiding; thinking about childbirth as a shared experience among women; relying on maternal instinct; relying on pharmacological pain relief techniques; considering the birth partner(s) as *voice of reason*.

The participants reported that they were preparing themselves for childbirth in several ways. The most common sources of information were reading/studying books, watching videos, attending antenatal classes and hearing stories about birth from other mothers. In regard to this latter point, one participant stated to have talked to people with positive birth experiences, as if she favoured and selected reassuring rather than discouraging comments about childbirth:

> *I've studied even before anyway. I've known quite a bit anyway just with my friends […] that have had babies quite young. So it's just hearsay really quite a lot of the stuff I know. It's just a lot of hearsay and with all the books that I had in the pack that I've got given at the beginning and then at the antenatal classes. So it's just all of these together.* (W6-FMU)

> *I think I've been talking a lot to people who have had positive experiences and read articles and videos. So I think most of it is covered in my head and then we'll see.* (W2-HOME/FMU)

Four women completed a DVD-hypno-birthing course. The learned relaxation and breathing techniques were seen as useful tools to prepare for natural birth and a reassurance of being able to cope with the pain during labour. One woman argued that, having practised through the whole pregnancy, she was not supposed to be in pain while having contractions:

I've been doing lots of relaxation and breathing techniques. When I had the contractions [during pregnancy] and I went to the hospital, […] the midwife said 'Oh, I am just going to get you some pain killers!'. I was 'I am not in pain! I am not supposed to be, I've been practising this for nine months, I am not supposed to be in pain!'. […] I've got all my tapes that I've been practising so I will be fine. (W2-HOME/FMU)

Some women adopted a strategy of avoidance, banning themselves from the internet and other women's narratives. The main reported reason was the fear of hearing negative recounting of birth that could have a daunting or frightening effect on them. One woman that did the self-hypno-birthing course and attended a yoga course talked about feeling as if she was in a *little protective bubble*, listening to and ignoring at the same time *bad stories* of childbirth:

I sort of banned myself from internet and from listening to people. I sort of go 'Yes, yes' and then just ignore it and just sort of have to listen to the midwife really. So yeah, I attempted to ignore other people. (W7-FMU)

It's almost put me into a little cocoon, like a little protective bubble. I do hear stories, I hear good stories and I hear bad stories but I am in my little hypno-birthing bubble so it's just rolling off me at the moment. (W4-FMU)

One woman stated that she was trying not to think about childbirth too much and avoiding high expectations in order not to be disappointed by her real birth experience:

I'm just trying to not think too much about it cause I think if you expect too much then you're bound to be disappointed either way. So I'll just kind of see how it goes when it comes to it! (W3-FMU)

Some participants felt reassured by the fact that childbirth is a shared and common experience among women all over the world. The interviewees pointed out that millions of women had given birth before and childbirth is typically considered such a natural event by women in third world countries, without significant concerns about pain relief. Participants also referred to the maternal instinctive ability of giving birth:

> *Millions of women have done it before! In third world countries they go onto the field 'Oh baby is coming, yeah, baby is born! I'll go and do the crops again or whatever!'.* (W2-HOME/FMU)

> *Up until the middle half of this century people did it without a great deal of pain relief. You go to other parts of the world and they get on with it and they're back out at work the next day.* (W3-OU)

> *I don't know how my body is going to react. I want such a natural thing. Your senses I think just change, like everything is so mumsy, you're more proactive, you just know what to do which I can't believe that until it's actually happening, just don't know.* (W2-OU)

One woman compared the current available pharmacological pain relief techniques with the absence of a good management of labour pain in the past. Although this was an isolated incident, it suggested that some women may rely on medical models of care and pharmacological pain relief techniques rather than on their innate ability of giving birth, considering pain during labour as something to be avoided:

> *All the stories back in the day when they just had their baby at their home on the sofa… you think 'God, really?'. No pain relief or anything! So if they can do it then… it's been investigated quite well, there's more things out there to help ladies going into labour, all the pain relief, all the new things that are coming out. One day*

> *the baby is just going to be like popping out and you're not going to be able to feel it and 'Here's the baby!'. You don't have to go through any pain […]. It's getting better and better compared to what it used to be like, isn't it?* (W2-OU)

All participants identified one or two birth companions to be present during labour and birth; all the women anticipated the presence of their partner/husband and few of them expected their mother to attend as well. Several women stated that they felt reassured by considering the birth partner as a *voice of reason* and advocate while they will be *away with the fairies*. Considering what the couple discussed and agreed during pregnancy, the partner/husband attending birth was supposed to speak up for the rights and wishes of the woman in the case she will not be able to make decisions or if there will be something the midwife is doing or not doing accordingly:

> *I think he will be of support to me and also my voice of reason.* (W1-FMU)

> *If he doesn't like something that the midwives are doing or not doing he will speak up […] which is good because I'll just be away with the fairies. I am quite confident about him.* (W1-OU)

> *Well, my husband is more of a vocal person so he will tell them if that's not what I want. He will be my advocate so anything that we agreed… if they want to do anything with me or to me, he'll be the one that say no or 'We'll discuss this and then if we agree then do it'.* (W2-HOME/FMU)

One woman used the allegorical word *co-pilot* to describe the way she expected her partner mediating the communication between her and the midwife. Unlike a midwife that she had never met before, the woman was confident in the fact that her birth companion knew what she did want and did not want for the birth of her baby:

> *He is my voice and he can speak for me because he would know what I do and don't want. But also the voice of reason and the communication between me and the midwife. So if it all got completely too much and I just can't really focus anymore, at least he can chat to the midwife and say 'She does want this so she doesn't want that' and communicate to the midwife for me. So just to be like my co-pilot, that's what we've described it as, we've said we're like Team Richards [a professional motorsport team] and I'm his co-pilot. That's what I am hoping for!* (W4-FMU)

Another participant compared the unknown territory of childbirth with an everyday life activity such as running. The woman expected her partner to know how to behave, giving a sort of quiet support during labour as when they go running together:

> *Everything I can relate it to is when we go running together… and when we go running and when I am at the limits of my ability to go any further, he knows that the thing to do is not to trying encourage me… it's just be there, quietly with me […]. So he knows how to sort of quietly support me. […] He absolutely knows that if he starts saying to me 'do this, try this, try that' he will get full force of the temper. But he also knows that just a hand on my shoulder is probably what I need, just to know he's there.* (W3-OU)

The apparently contradictory coping strategies of preparing and avoiding seemed to occur mainly in women planning to give birth at home or in a FMU. The interviewee that relied on pharmacological pain relief was going to give birth in an OU. The importance of the birth partner(s) and the consideration of childbirth as a shared experience were highlighted by the participants regardless of the planned place of birth.

4.1.3 Going with the flow

Irrespective of the planned place of birth, all the women interestingly perceived childbirth as a natural process. In the following quote, a participant claimed that a medicalised way-of-thinking is nowadays surrounding women encouraging them through this route; therefore, she argued for the need for a cultural change towards normality of childbirth:

> *Childbirth is a natural process, it's not a medical life frightening illness, which it's the way it now comes across in society. […] It would be nice if society changed and the first thing in the approach towards the pregnancy was not what pain relief you get. My friend from Australia […] cannot understand that I'm contemplating a birth without pain relief. They are completely reversed, they're like 'Right, what pain relief you're having?'. And this approach that is this horrendous experience. It would be nice if their thinking would change and that women today are encouraged to […] realise that actually it's a natural process'.* (W4-FMU)

However, the general approach of women towards medicalised models of care referred to in the above extract did not arise from the interviews and the participants' attitude seemed not to correspond to the stereotypical reality highlighted by W4-FMU. Indeed, all the women interviewed stated their intention to have a birth as natural as possible, particularly in regard to the avoidance of pharmacological analgesics. The approach of the participants towards birth is well represented by these two comments in respect to the consideration of the woman's body as *designed* to give birth, using its natural pain relieving system:

> *I am very much of the view that our bodies are designed to do this […].We weren't designed with the ability to have pethidine and epidurals and things. We were designed to get on with it.* (W3-OU)

> *I know it's not going to be the most comfortable experience and it's probably going to hurt but trying to get the body to use its own kind of pain relieving system is something that I would rather do.* (W1-HOME)

One interviewee made an interesting parallel between the body and mechanical engineering. She compared wrong engineering components with *being a patient effectively* and *lying prone on a bed*, both resulting in being an obstacle to the normal functions respectively of the mechanics and the body:

> *If things are fixed rigidly in place the mechanics can't do what they are designed to do. So by being up and keep moving around and not being a patient effectively and lying prone on a bed you are giving your body the opportunity to do what it's designed to do. If I put an engineering component in place and then ask it to do something that is not designed to do, by being constrained it will break and it will end up with more strain. Whereas if I put it into its natural environment and enable it to move and I help it, then things are going to happen more naturally. So moving around, giving the hormones and everything the chance to do what they are meant to do.* (W3-OU)

The perception of the body as *designed* to go through labour and birth naturally, seemed to be in contrast with the incident about relying on contemporary pain management practices from W2-OU (see heading 4.1.2). Even the same participant (W2-OU) showed inconsistency with her previous statement by saying:

> *I'd like to do it naturally if I can, just I don't want to be dosed up on drugs that I can't remember what is going on, I want to be able to see what is going on and feel the natural motion. I don't want to be out of my face.* (W2-OU)

The interviewees believed that the way women go into labour and how they look at it mentally could make a considerable difference in experiencing childbirth. Effective approaches to face the unknown territory of childbirth anticipated by the participants were: being relaxed; not focusing on pain; taking control over labour; being reassured by having the *knowledge's power*; concentrating on the idea of a manageable intense personal experience rather than thinking about birth as a *horrible ordeal* or a *degrading process*:

> *I think a lot of it is psychological. If you stop focusing on pain you can get past it a lot more easily.* (W3-OU)

> *I also get the feeling that sometimes the way you go into it, the way you personally feel about it, that makes a big difference. […] So using your own control and taking control over your own labour.* (W3-FMU)

> *The best approach you can have is to be quite, if you can, relaxed about it and I think that's half the battle won then. […] It's not a degrading process, it's not something that's a horrible ordeal. You can still have an intense personal experience. I think it's just a part of life and it's manageable. And I think if you've got knowledge's power. […] having an understanding and an awareness […]* (W4-FMU)

The property of 'going with the flow' emerged from a recurrent phrase used by women to describe their open-minded and flexible attitude towards labour and birth. This expression was used by the participants regardless of their planned place of birth, in terms of following both the course of events and their emotional and bodily response. They anticipated that they may constantly review their expectations in the light of their actual birth experience (recalling the property 'now and then' reported in heading 4.1.1):

I am quite open-minded and I am just going to go with the flow. (W2-OU)

I suppose I'll deal with it when I get there sort of thing so I really don't know. […] I'll just go with the flow! (W5-OU)

I am just going to take it how it comes really! Yeah, see how it is, if something needs to change I'll just do it! (W6-FMU)

In line with the idea of going with the flow, the women seemed to be quite flexible in regard to their birth plan and open to change if needed. They preferred to have just general guidelines with basic points such as who was the birth partner, what sort of labour and pain relief they wanted, how they wanted the placenta to be delivered and indications on Vitamin K injection. Together with the partner, the birth plan was considered as a beneficial tool to communicate their preferences to the midwife during labour:

I think I am kind of 'These are the things that would be ideal but I'm open to change if need be'. (W3-FMU)

I've got rough guidelines but I need to keep my mind open. Really I think just to keep my mind open and if I need pain relief just take it. You can't say no if you're not really coping with that. (W2-OU)

I think a birth plan is a great idea because at least then when you go into the hospital, if I'm too uncomfortable or too flustered to talk I can just give it to the midwife. (W4-FMU)

A couple of women stated they did not have a set birth plan because of the uncertainty of what may happen during childbirth. The fact that they could be upset or annoyed by unforeseen events or unmet expectations prevented them from writing a birth plan (recalling the property 'now and then' reported in heading 4.1.1):

I haven't really got a set birth plan because you don't really want to have rules if you like to go along to it because it might not go that way. (W1-FMU)

I haven't made a plan because I think that if it doesn't go to plan I might going to get annoyed or upset because it's not the way I planned it […]. So no birth plan, I just plan to have it, that's my plan! That's as far as my plan has gone! That's it, that's my plan! [laughing] (W7-FMU)

4.2 CHOICE OF PLACE OF BIRTH

The category of 'choice of place of birth' reports the considerations made by women in choosing the birthplace, including general influencing factors, the figure of the midwife in relation to different places of birth and the women's perception of safety of birthplaces. Three sub-categories were developed: **a)** influencing factors on the choice of birthplace; **b)** birthplaces, midwives and models of care; **c)** women's perceptions of safety of birthplaces. The properties of each sub-category are presented in **Table 4.2** and discussed in the following sections.

CATEGORY	SUB-CATEGORIES	PROPERTIES
CHOICE OF PLACE OF BIRTH	INFLUENCING FACTORS ON THE CHOICE OF BIRTHPLACE	o *Proximity* o *Normality of childbirth* o *Environment* o *Model of care* o *TV programmes* o *Recommendations from family and friends*
	BIRTHPLACES, MIDWIVES AND MODELS OF CARE	o *Midwives are all good* o *Midwives guaranteed by training standards and NHS* o *Positive experiences with the midwives so far* o *Birthplace environment and model of care*
	WOMEN'S PERCEPTIONS OF SAFETY OF BIRTHPLACES	o *Being surrounded by a medical environment* o *One-to-one dedicated care* o *Complete trust in the midwife's expertise*

Table 4.2 Category two - Choice of place of birth

4.2.1 Influencing factors on the choice of birthplace

The participants referred to the following influencing factors on the choice of the birthplace: proximity; normality of childbirth; environment; model of care; TV programmes; recommendations from family and friends.

One of the main reasons provided by the women for choosing a specific place of birth was its proximity, not for the couple alone but also for family members and friends. Moreover, the participants stated they would prefer to give birth in a local and familiar setting and did not want to worry about travelling at labour onset:

It's just closer to where I live for my family. […] It's a bit daunting going to the big hospital in the city rather than in local town especially for your partner's stuff and when you're in labour. I don't really want to be worrying about travel and birth. (W4-OU)

It's close, I mean, all of my family are close, all of my friends are close and I didn't want to have to travel a long way to have my baby. I want to be able to have my baby nearby. […] I wanted to be able to have my baby somewhere I feel familiar, somewhere that's close to friends and family and then just come home! (W3-FMU)

Some women were planning to give birth in a FMU because of their beliefs in the normality of childbirth. Having had a low-risk straightforward pregnancy so far, they did not see why they should give birth in a large medicalised hospital. Moreover, they supposed that a midwifery-led unit may give them the possibility of having the natural birth they wanted:

I haven't necessarily got any problems which are stopping me from going so I thought 'why not?'. (W1-FMU)

I don't need to be, touch wood, in a hospital […] because this is a low risk pregnancy. (W4-FMU)

I've chosen the birth centre because I am more likely to have the natural process that I want. (W4-FMU)

Independently from the chosen birthplace, the interviewees expressed their desire of giving birth in a nice, friendly, clean and tidy environment. The women planning to give birth in a FMU talked about a like-home, quiet and relaxed setting. Some of the participants felt more confident after having visited the place of birth during pregnancy. The search for a labour room with a birthing pool played an important role in some cases:

It made me feel even more confident when I went a couple of weeks ago and everything was lovely. The hospital was really clean, tidy. (W2-OU)

I'm hoping that the birth centre will be nice because I'm not keen to go somewhere […] that's really big. I wanted somewhere that's a little bit more comfortable and more familiar I think, so which is why I've gone for the birth centre. [...] I liked the fact that every time I go there it feels quite familiar. […] It just feels like a bit more relaxed. (W3-FMU)

I quite like the idea of the pool and the birth centre has a pool so… (W2-FMU)

One woman reported that she searched for information and watched videos on the internet about different hospitals and found this very helpful in order to choose the place of birth:

I've looked on the internet as well, I did some research about what hospitals and they had a video about that, that shows you about the hospital and gives you information about it which I really liked, that was nice. (W2-OU)

The characteristics of the model of care, especially the provision of one-to-one individualised woman-centred care, played an essential role in the choice of a FMU as birthplace. Other important factors were knowing the midwives' team during pregnancy and having the midwives available to come home in early labour:

It's generally just a one-on-one anyway, there's a birthing pool, it's quiet and it actually sounds nicer than being in a big ward in a big hospital where I don't know many of the midwives so it's just that more personal quiet touch. […] I just think that at the minute the birth centre is giving you that individual attention so it's nice. (W7-FMU)

They come out to you instead that you go into them and then being sent away. I don't know, I think that was maybe a factor for us that was kind of another reason. (W1-FMU)

They send you the midwife to see you when you go into labour or you have any problems, whereas if you're booked at the hospital you have to go all the way there for any kind of assessment that I need and any check. (W2-FMU)

I think […] it's more likely to be somebody that I know or have seen, seen around anyway. (W2-FMU)

Watching childbirth-related TV programmes seemed to offer a negative picture of birth and to influence the women's choices of the place of birth in several and different ways, bringing up divergent choices among the participants of this study. For instance, some women were scared about how *things could go wrong so quickly* and therefore chose to give birth in an OU to have a medical backup immediately available:

I suppose it was watching that one programme that is why we're going to the hospital. Realising how quickly it can go wrong and needing that medical back up at that speed is why we are going to the hospital and not to the birth centre. (W3-OU)

Some women planning to give birth at home or in a FMU referred that the TV programmes showed them a negative idea about hospital birth and this was exactly what they did not want for their labour and birth. Although they were still planning to give birth in a FMU, the TV programmes scared some women off having a home birth:

I guess that's kind of my understanding of what the hospital ward would be like if I was there which is another reason why I don't want to do it. […] I just think it looks like a horror story [laughing]. It's just your worst possible nightmare and that's probably, you

know, one of the reasons why I categorically do not want that experience for me and for this little one. (W1-HOME)

I've watched, obviously, all these midwives at 'One born every minute' but I've only watched them so I know what not to do, what I don't want to do. […] Yeah, it was a good programme because you get to know what you don't want. (W2-HOME/FMU)

I think some of them [TV programmes] are what scared me off having a home birth. (W3-FMU)

Finally, some women referred to recommendations from family and friends based on personal experiences as a quite significant influencing factor in deciding where to give or not give birth:

Stories and just recommendations from people. People tell you a lot about all different hospitals. And I didn't have really a bad word to say about this hospital. (W2-OU)

Well, a couple of my friends have already had their babies at the birth centre and all of them have had a good experience whereas some other people that I know have been to other hospitals. It's been a variety of comments and feedbacks. (W6-FMU)

4.2.2 Birthplaces, midwives and models of care

Whether the women were planning to give birth at home, in a FMU or OU, they thought that there was no difference between midwives practising in different settings; therefore, their idea of a good midwife seemed not to influence their choice of birthplace. The participants reported that they did not choose where to give birth in relation to seeking specific qualities in the midwife during childbirth. The women assumed that midwives are quite good anyway and would *not get very*

far if they are not doing their job properly. In regard to this, the interviewees stated that *midwives are all good* independently from the birthplace they work in. In particular, the participants raised the point that the midwives' ability to practise competently and safely is guaranteed by academic and NHS standards. The women also reported to have had positive experiences with the midwives so far during pregnancy, so they were wondering why they should have a negative encounter with the midwife at the moment of labour:

> *The midwives that I've seen in the hospital are all been so nice and friendly. I'm assuming that most midwives will be sort of quite good anyway. I'm assuming that midwives won't get very far if they're not doing their job properly.* (W3-FMU)

> *I guess if you have been assigned a midwife then you assume automatically that they would have been trained at certain standards. So you assume that when they are allocated to you they're fully trained and that's it! […] It's an automatic assumption that the person that you've got is properly trained and qualified, and given the NHS has a lot of kind of sway in how qualified the midwives are, they're not going to give you somebody that's substandard and that's not qualified to come and look after you at such a critical time.* (W1-HOME)

> *You expect them to be bubbly, friendly. Especially because I haven't had a bad experience as of yet with the midwives.* (W2-OU)

A number of participants made an apparent distinction between the midwife, the birthplace and the model of care. In respect of this, the choice of the women planning to give birth at home or in a FMU seemed to be more related to the general atmosphere and environment of the place of birth and to the model of care rather than the midwife. Specifically, the women recognised that the difference of birthplaces

rely more on the care they will receive and the time the midwife will be able to dedicate to them in relation to contingent factors such as the unit size, the ward busyness (e.g. number of births and women in the labour ward) and short staff issues. The presence or absence of models of care allowing one-to-one individualised woman-centred care and paying attention to natural childbirth were considered as one of the main differences between FMUs and OUs:

> *It's a midwife-led unit and it's a quiet unit and it's a small unit and they're not dealing with the volume of women that they do at the hospital. So then you've got, you know, you've got that attention, you've got that one midwife that is looking after you. So she's going to provide brilliant care. […] At the hospital, I think you would still get excellent care, you would still get a good midwife, but I think instead of you having that dedicated one midwife or that midwife that can spend a lot of time with you… I think you would still be cared for and it would still be fine but you are not the only one in the ward, you're probably one of, I don't know however many of the many other women. And there won't be a lot of midwives that can be stretched. So as much as they are going to offer you a very good care and you'll be looked after, it would be in a different way I think.* (W4-FMU)

> *Well, I don't know if [being in a birth centre would be] better than in the hospital. But I know that their approach to natural birth is… they believe in no intervention. […] If a midwife is not personally interested in natural birth and ends up in a big hospital, there's nothing they can do so I don't blame them. That's the way it is for them, that's just the way it is. […] That's why I think doulas and private midwives are getting more and more popular, because it's their choice then if they want to escort mums with natural birth and aromatherapy and different healing.* (W2-HOME/FMU)

4.2.3 Women's perceptions of safety of birthplaces

The women's perceptions of safety of birthplaces varied accordingly to their planned place of birth. A number of participants reported that their chosen birthplace was an OU because they felt that being surrounded by a medical environment was a safer option than giving birth in a midwifery-led unit or at home. Therefore, to them safety meant having a medical backup immediately around them. However, the women argued for a medical support to be external to their childbearing event and for obstetricians or other professionals (e.g. neonatologists) to intervene only if anything was going to deviate from normality:

> *Not being a medical process but having that medical support immediately around you. It's like the skin of an orange. The orange is 'I'm giving birth' but the skin of the orange is 'and I've got everything here if anything goes wrong'.* (W3-OU)

> *I think you do feel more safe in a hospital. Not that I have ever been in hospital but I can imagine you would do. Seem to have everything there that you need.* (W1-OU)

The interviewees planning to give birth in a FMU felt they would be safe because they were going to be the centre of attention in the context of a one-to-one, individualised and woman-centred model of care. This made them feel relaxed about the fact that if anything happened the midwife would notice it *straight away*. In this case, the safety perceived by the women was associated with the provision of one-to-one attentive individualised care:

> *I feel like their attention is not taken elsewhere. I know that if anything happen they'd see it straight away.* (W3-FMU)

> *I think I trust the midwife more than doctors. The midwife has got more an idea of what is going on.* (W7-FMU)

The participant that choose home as place of birth, placed her complete trust in the midwife's expertise and ability to *deliver her baby safely* and in the way she wanted unless medical intervention was needed. The woman-midwife relationship established during pregnancy played an important role in this case. As opposed to the first two quotes in this heading from W3-OU and W1-OU, in the following the two concepts of safety and medical support/environment seemed to diverge, with safety being entirely related to the midwife's competence in providing the best care for the woman and her baby during labour and birth:

> *She knows exactly what I want […] and she'll try her best to be sure this baby is delivered safely and in the kind of the way that I want it to be delivered unless medical intervention is needed. […] I'm expecting her to use her full professional judgement to assess me on a constant basis to make sure that everything is going smoothly and that I don't need to be rushed into hospital so to use her full expertise to make sure that both of us are safe.* (W1-HOME)

4.3 EXPECTATIONS OF A GOOD MIDWIFE

The category of 'expectations of a good midwife' includes the women's anticipation of a good midwife's characteristics and role during childbirth. Seven sub-categories were identified: **a)** characteristics of a good midwife; **b)** the midwife's role; **c)** dealing with an unknown midwife; **d)** continuity of carer; **e)** midwife and labour stages; **f)** midwife and birth partner(s); **g)** what I would not expect from a good midwife. The properties of each sub-category are outlined in **Table 4.3** and discussed in the following headings.

CATEGORY	SUB-CATEGORIES	PROPERTIES
EXPECTATIONS OF A GOOD MDIWIFE	CHARACTERISTICS OF A GOOD MDIWIFE	o *Empathic way of being* o *Interpersonal dynamics* o *Personal attributes* o *Professional competencies*
	THE MIDWIFE'S ROLE	o *Balancing being/doing* o *Being there* o *Doing nothing* o *Doing checks* o *Delivering the baby*
	DEALING WITH AN UNKNOWN MIDWIFE	o *As long as…* o *Importance of knowing the midwife*
	CONTINUITY OF CARER	o *People have lives and need to sleep* o *Not too many different midwives* o *Competent midwives* o *Understanding midwives* o *Proper handover*
	MIDWIFE AND LABOUR STAGES	o *Popping in and out* o *Crucial stages: transition, birth, after birth* o *Staying in the room*
	MIDWIFE AND BIRTH PARTNER(S)	o *Involving* o *Respecting* o *Explaining* o *Reassuring* o *Help them to help me*
	WHAT I WOULD NOT EXPECT FROM A GOOD MIDWIFE	o *Negative personal, interpersonal and professional attributes* o *Patronising and dismissive manners* o *Procedures' or rules' oriented*

Table 4.3 Category three - Expectations of a good midwife

4.3.1 Characteristics of a good midwife

The subcategory ‘characteristics of a good midwife’ encompasses the four properties reported in **Figure 4.1**: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. The attributes expected of a good midwife included in these four areas seemed to be similarly raised by the women interviewed, independently from their planned place of birth.

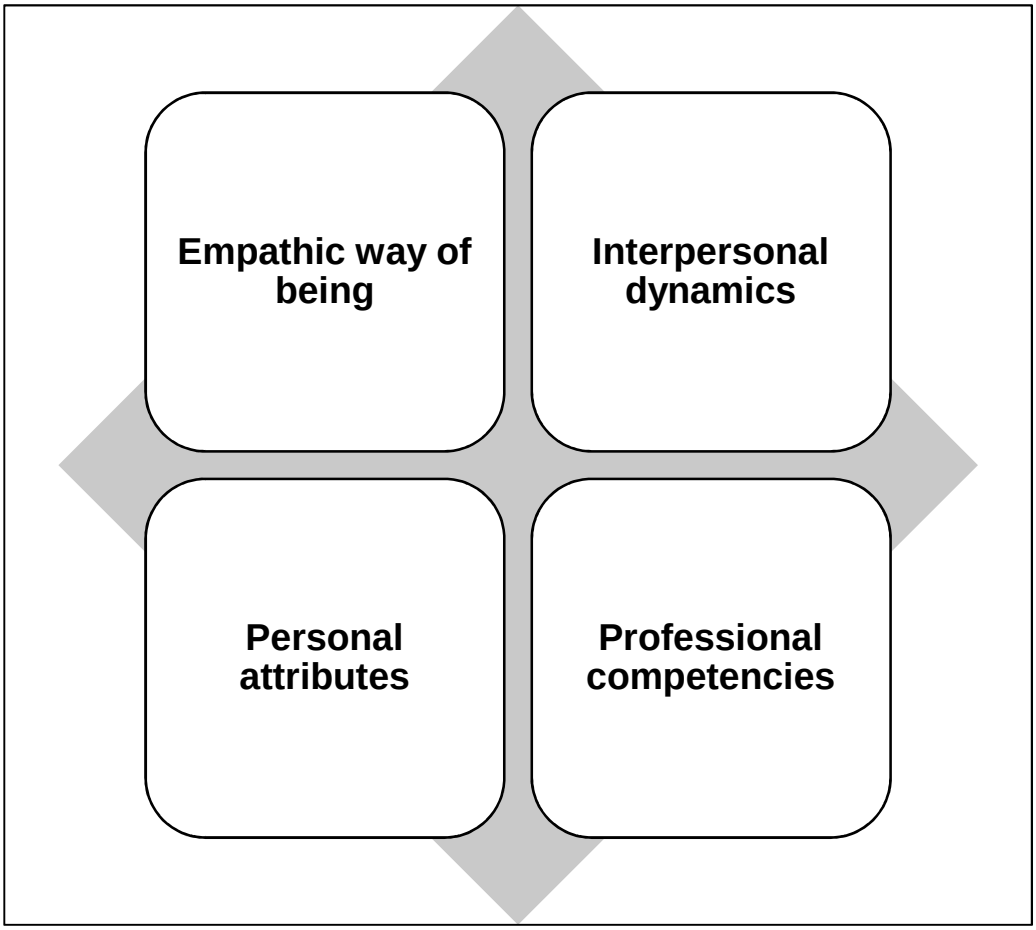


Figure 4.1 Characteristics of a good midwife:

The expected characteristics of a good midwife reported by the women are outlined in **Table 4.4** in respect of each property.

Empathic way of being
Someone 'like me'; someone I feel comfortable and I can get along with; coping with me as a person; someone I can have a chat and a laugh with; making me feel it's my plan; trying to stick to what I want; having time for me; being there for me; listening to me; being excited with me; caring; understanding what I am going through; making me feel relaxed and not panicky or worried; telling me it's normal (don't make me feel like an alien); involving me; making me feel in control; being able to assess individual needs and adapting to the person; recognising I need different support from the next lady; emotional reassurance; compassionate; establishing a trusting relationship to work together.
Interpersonal dynamics
Approachable; helpful; giving information and answering questions; explaining things (how and why); smiley; bubbly; chatty; good communication; saying the right words; balance between giving options and advising what to do (how about trying this?).
Personal attributes
Friendly; nice/kind; sweet/warm; calm; strong/stern/forceful; nasty when needed; fun; proactive; thinking ahead; confident (willing to make decisions; taking control of the situation if needed); organised; positive; open; down-to-earth; not too bossy; motherly figure / mumsy; being themselves.
Professional competencies
Experienced; they know what they are doing; professional; knowledgeable; making sure the mum and her baby are healthy; good at her job; capable; empowered; knowing who to call upon; recognising professional fallibilities and limits.

Table 4.4 Characteristics of a good midwife: description of properties

The majority of the qualities of a good midwife highlighted by the participants were included in the domain of 'empathic way of being'. In particular, a good midwife should be able to recognise individual needs; understand what the labouring woman is going through; make her feel

relaxed and in control of the situation; cope with her as a person; respect choices; dedicate time; be excited with the couple; be a good listener, caring and compassionate; provide emotional reassurance and establish a trusting relationship to work in partnership:

> *I want somebody that is going to have time for me […] I want somebody that is going to be there when I need them […] and that know what I am going through.* (W2-OU)

> *Recognises that I need different support than say the next lady. I would need to handling in a different way to the next lady* (W3-OU)

> *If you take the midwife job up, you want to match that criteria, you want to know that they're willing to be a midwife, it's not just a job, is it? It's not a job like others, like working in the supermarket! You need to have that relationship with the person.* (W2-OU)

> *Somebody listening to you and understanding and, you know, hearing what you're saying and all that kind of stuff. I think it makes a big difference.* (W1-HOME)

Some of the attributes reported by the participants were related to the area of 'interpersonal dynamics', such as being approachable, helpful, smiley, bubbly and chatty; giving information and answering questions; explaining things (how and why); having good communication skills; saying the right words; maintaining a balance between giving options and advising what to do:

> *A midwife who advises me, gives me the information, says that this might be a better way of looking at it or 'how about trying this?', lets me try it and then works with me to say 'ok, how about trying this?' rather than say 'this is what you must do', 'you must stay in this position', ' you must do this, you must do that'.* (W3-OU)

To be informed and then to choose, but somebody that you know that if you ask them for a straight answer they'll give you the straight answer and will give you advice based on their experience and what they recommend for you. (W1-HOME)

Some of the midwives' characteristics expected by the women were embraced by the property of 'personal attributes'. These included being friendly, nice, warm, calm but strong, not too bossy, confident, organised, open-minded, down-to-earth; having a positive and proactive attitude; representing a motherly figure; being themselves:

I suppose just somebody quite friendly, somebody who doesn't take things too seriously and that is generally quite supportive almost like a motherly sort of figure. (W3-FMU)

I think friendly and approachable so you can kind of say anything to her and not feel like, 'Oh, God what are they going to think about me for doing that or whatever' and I think also professional but also kind of to be a friend at the same time. (W1-FMU)

Friendly, […] just down-to-earth really, not too bossy. Just friendly and someone I can get along with. (W1-OU)

Friendly, […] someone that is chatty […], caring, […] very smiley and bubbly. I can't have a grumpy midwife that really can't be bothered to be there, she doesn't want to be there, she's just there because she's getting paid. I'd hate that! (W2-OU)

Friendly but kind of stern at the same time […]. Just someone that is so friendly but forceful, that enjoys what they do because I think that really actually makes the difference. (W7-FMU)

The last domain of attributes expected of a good midwife was represented by 'professional competencies', which comprised being professional, experienced and knowledgeable; knowing what she/he is

doing; providing care in a safely manner and guaranteeing the mother and baby's health; being capable and good at her job; acknowledging professional limits and knowing who to call upon if needed:

> *I want somebody that I can feel confident with, […] that knows what is doing. I don't want somebody that […] doesn't have enough conviction in her decisions. […] I want a good midwife, I want an experienced midwife, someone that delivered a lot of babies and is experienced* (W4-FMU)

> *Professional, definitely, so they know what they're doing. Organised, proactive, so thinking ahead.* (W2-OU)

When asked to compare the significance of the midwife's personality and way of being with the importance of professional attributes, the participants variously placed emphasis either on one of the two or argued for a balance between them. The prominence of the areas of personal qualities, interpersonal dynamics and empathic way of being was mostly highlighted by women that choose a FMU or home as place of birth:

> *The emotional side is the kind of support that I want. I think your physical side is just going to do what it needs to do, but it's more all the waves of emotions and stuff that come with it that I think I am more worried about.* (W3-FMU)

> *I'd rather choose a midwife with few years of experience but really sensitive and compassionate. […] If you've got somebody that you feel completely comfortable with and that you trust and he is sympathetic and understanding […], it makes a massive difference. I think personality has got a lot to do with it and makes a massive difference in the way that they behave towards you and how you react as a result, so I think it's a whole package. It's how*

well they're trained but also how understanding and how compassionate they are and supportive. (W1-HOME)

A number of participants recognised professional competencies such as experience, knowing what to do, capability and confidence in the decision-making as crucial characteristics in a midwife, when compared to the subordinate areas of personal qualities, interpersonal dynamics and empathic way of being. The midwife's knowledge and professional skills seemed to be valued more by women planning to give birth in an OU, especially in the case of deviation from normality. These women seemed to delegate the emotional support to the birth partner(s) rather than to the professionals:

I think for my first time I'd prefer somebody that has got more experience that is just there for me. If they're not going to have the right attitude and we don't get on… as long as she knows what she's doing and everything is going smoothly, I've still got my mum and my partner there. (W2-OU)

If it's all going normally it's nice to have somebody who's sensitive but quite frankly my main reason for wanting the professional there is if things aren't going well. (W3-OU)

If I had to have a midwife that knew what she was doing, she was in control, and have somebody that's just get on with it and go I'd rather have somebody like that than somebody that don't know what they're doing but really nice and friendly and bubbly. (W2-OU)

4.3.2 The midwife's role

When asked to describe the midwife's role, the importance of a midwife's ability to balance the spheres of being and doing was

reported by a number of women, independently from the planned birthplace. The participants specified that the midwife's role should include all the following spheres of skills: being there (providing moral support); doing nothing (staying in the background-ish and doing nothing until needed); delivering the baby safely; doing checks (having the knowledge to understand when/how to monitor and intervene):

> *Just that they'll be there for you hopefully and, obviously, deliver the baby safely. Then […] if they're worried or anything they'll know when to intervene.* (W4-OU)

> *I think kind of being there and kind of stepping in and telling me what to do and encouraging you but also not taking over but taking over when they have to. […] They'll kind of being in the background-ish, but keeping an eye and then step in.* (W1-FMU)

> *I imagine that the midwife will just be there to support me really and to check on me, check my vital signs like my blood pressure and that sort of things and check the baby's heartbeat. And just kind of be there as a support without any medical intervention but being aware of what's happening. And looking after me medically without intervening*. (W4-FMU)

This woman (planning to give birth in an OU) recognised 'being there' as the main role of the midwife, that should constantly guide, reassure and support the labouring woman:

> *I want the midwife there constantly guiding me through what's going to be happening next so then I know what's coming so I can plan myself.* (W2-OU)

Concerning the property of 'doing nothing', a woman planning to give birth at home or in a FMU emphasised the importance of receiving moral support rather than checks and interventions from the midwife:

Just moral support rather than clinical support. I don't want any intervention at all. […] Well, we did ask for not checking. In the birth plan we said if when they come to me they really want to do a first examination that's fine but no after. And if they want to listen to baby, fine. Not every 15 minutes because that would just bring you back to reality and that's when you'll start feeling pain. […] So it's more like the moral support for them to be there for me other than doing checks. (W2-HOME/FMU)

'Delivering the baby' was identified by some women planning to give birth in an OU as a midwife's job, rather than considering themselves as fully responsible for and capable of giving birth:

I just know that they're there to deliver your baby as safely as they can. (W4-OU)

Just get her out as quickly as possible [laughing]. (W5-OU)

Quite a few participants confined the midwife's role to the area of 'doing checks'. In particular, the interviewees argued that the midwife should monitor the woman and the baby, watch over the progression of labour and do the necessary examinations. On the basis of these elements, the women expected the midwife to take control over the situation and tell them what to do if needed, delegating decisions to the professional. The property of 'doing checks' emerged mainly from the interviews with women planning to give birth in an OU (apart one quote from a woman that was going to give birth at home):

Monitoring me, making sure that as a whole process it's all going according to some sort of plan […]. Making sure that it's progressing and taking control when is not […]. Doing all the sort of examinations and things and making sure things are ok [...] and progressing things in a different way if they need to go in a different way. (W3-OU)

I would expect her to be monitoring the baby's heartbeat, to be checking me, to make sure that I'm dilating normally, that there's nothing for me to worry about. (W1-HOME)

Check it's progressing how it should be and if not then they obviously then have to […] decide what is best. (W4-OU)

Just get around and make sure I am alright, make sure she is alright and tell me what I need to do basically. (W5-OU)

4.3.3 Dealing with an unknown midwife

When talking about not knowing the midwife that was going to assist their labour and birth, the majority of the women did not seem to be too concerned by this circumstance. In regard to this, the property of 'as long as…' was developed; the women ended this clause in different ways in relation to the planned place of birth.

For births planned in an OU, the women reported that they would accept a midwife that they did not know as long as she/he behaved in a respectful manner; was competent at his/her job; the baby was delivered safely and the birth partner(s) were present:

It doesn't really bother me to be honest with you. As I said, as long as she comes out okay and we are both fine, then I don't really mind who is there. […] I would be okay with any midwife as long as they know what they know what they're doing. […] And as long as I've got my mum on one hand and my partner in the other I am not really bothered. (W5-OU)

For FMU and home births, the interviewees stated that they would accept to be assisted by a midwife that they did not know as long as

they could trust her/him; they established a special bond and she/he made them feel comfortable:

> *I think I will be fine. I'll just start to get to know them at the beginning anyway so hopefully will have to get like a bond, a friendship. Hopefully it will be okay.* (W6-BC)

A woman planning to give birth in a FMU expressed a feeling of disappointment for not knowing the midwife that was going to be present at her birth, nostalgically recalling how the midwifery profession used to be in the old days, when the woman and the midwife were usually able to build up a relationship and get to know each other's antenatally:

> *I am a little bit disappointed. I think in the old days […] you had a midwife that saw you through the whole nine months and then delivered your baby. And I really think it would be nice if it was like that today because over those nine months you build up a relationship with the midwife and then you see her really often, really regular but it's not lots and lots. During that time, she gets to understand you and know you. […] One of those things that will make you feel more reassured or relaxed is when you get there you know your midwife is there who you've known for the last nine months. […] If I would knew that my midwife now was going to deliver my baby I could be chatting to her about the sort of birth that I want and what my expectations are.* (W4-FMU)

A woman planning to give birth at home with her community midwife highlighted the positive aspects of being allocated a midwife from the beginning of pregnancy to birth:

> *She knows me personally from me being 6 weeks pregnant and I think that makes a massive difference if you're allocated a midwife and then she knows you right the way through from that kind of*

point right the way through to birth. She kind of knows, she knows how you react to things, she knows what and how to ask you, she knows you very personally. (W1-HOME)

In regard to the woman-midwife relationship, the following category describes the women's perspective about continuity of carer.

4.3.4 Continuity of carer

As for being assisted by a midwife that they did not know, the women seemed not to be generally disappointed by the possibility of having different midwives during labour and birth, agreeing on the fact that professionals *have their own lives* and *need to sleep*. One interviewee stated that she would prefer to have a *fresh* midwife rather than a tired one:

People need to sleep [laughing]. […] And to be honest I know what I am like at the end of a travailed shift. I can much rather have somebody who is fresh and that has had some rest and who is able to make those informed decisions than somebody who is exhausted… yeah, so people need to sleep, that's normal [laughing]. (W3-OU)

The participants were expecting to meet different midwives due to shifts and they accepted that as long as they were not too many different ones, they knew what they were doing and understood how the woman was feeling (emphasising the importance of empathy):

Not too many different ones. I understand obviously they'll have to swap over through shifts and staff but no, I don't want to see a different face every time. (W1-OU)

I am not bothered too much about it being a specific midwife. Yes, it's nicer to think that maybe it's not going to be hundreds of different midwives coming in and out. (W3-FMU)

As long as they know what they're doing and they communicate and know how I am feeling and stuff like that. (W5-OU)

During a shift's transition, the women expected the midwives to behave properly, passing the information/notes and communicating to each other, anticipating the shift's change to the woman, introducing the woman to the new midwife and treating the mother in a respectful manner:

[During the change I would expect them] to let me know, I wouldn't want just a midwife to go and not knowing that they've gone. It would be nice if they notify what is going on. Communicate with each other so that they know where and what stage I am at, what's going to happen. Introduce themselves, probably both of them being there at the same time just having a chat with me saying 'I have finished my shift, I am going to swap now, this is so and so'. Just to welcome them in a little bit more and it should be okay. (W2-OU)

It would be nice if they told me. If they said, you know 'Hi, I am your midwife for now, I am here till 10 o'clock and then unfortunately my shift is changing, a new colleague coming in, this is her, she's really nice'. Rather than disappearing and a new face is coming 'Oh, hello! Who are you?'. That wouldn't be very nice. (W4-FMU)

Apart from the importance of having midwives that knew what they were doing highlighted by the women that choose an OU as birthplace, the other properties of this category (not too many different midwives;

understanding midwives; proper handover) emerged from participants independently of their planned place of birth.

4.3.5 Midwife and labour stages

The majority of women did not expect the midwife to be physically present in the labour room with them all the time. The participants argued for a midwife 'being there' even if not actually staying in the room; they rather preferred a midwife going in and out from the labour room, making the woman feel relaxed and letting her know that she was out there if needed. Some participants were willing to stay in the room with the birth partner(s) alone for most of the time. The midwife's presence seemed to be highly valued by interviewees during the transition stage, at the moment of birth and in the first few hours after the birth of the baby:

> *I'd like I think just to be mostly with my husband, at least in the early part of it and like they just pop in when she's needed or be around if I need her extra time. […] Maybe just popping in and out in the first few stages that's not so intense [laughing].* (W2-FMU)

> *I don't think it needs to be with me cause I've got my husband with me so there'll be that support. It will be nice to have some time alone with my husband so I wouldn't necessary need somebody literally sat in the room with me, but it would be nice to know they were sort of coming in every once in a while just checking everything was okay. I suppose it's just knowing that they were there just down the hall as well if you needed them.* (W3-FMU)

> *At the start of labour, the first stage, you kind of do it on your own I think [laughing]. But then in the transition and pushing I think that's where she's really really important. […] Not just until after the third*

stage but checking that I am okay after the birth […], checking the baby is okay, helping me to breastfeed, making me feel comfortable and confident in looking after this tiny little baby and then to be able to come home feeling confident and happy (W4-FMU).

One woman foresaw the possibility of her either feeling calm, relaxed and in control of the situation or struggling, panicking and not feeling comfortable; depending on her way of coping with the labour, she expressed the desire to have the option of choosing to have the midwife in the room all the time or not. This is linked with the previous property of 'now and then' (see heading 4.1.1):

I'd like to know that she's there if I need her. If I feel really calm and relaxed and everything is okay and I feel in control and me and my husband are doing this okay, that's fine. I'd rather like to be able to know that I can buzz her or shout for her and she comes to me if I need her. I don't want to feel abandoned which I don't think I would. So it depends on how it's going. If I'm struggling or starting to panic or I don't feel comfortable anymore I'd like her to stay with me enough for that reassurance and help me through it. But if everything is going okay I am happy to be left alone and she just pops in and checks on me and if I need her I can get her. (W4-FMU)

One participant referred to the fact that she would be distracted by the midwife coming into the room too regularly, interfering with her being into her *little bubble*, concentrating on breathing and listening to her body:

Probably if they are out, not coming in too regularly because I will have my headphones so I don't want to hear much. […] I just want to get into my little zone, my little bubble and concentrate on my

breathing and listen to my body. So as long as they're not too far [laughing] that's fine! (W2-HOME/FMU)

Few women argued for the importance of the midwife's both physical and emotional presence in the room all the time and all the way through labour and birth. The main reasons given by women planning to give birth in an OU for wanting the professional there were related to their looking for a midwife providing a constant reassurance, monitoring the mother and baby's health and checking on labour's progression in order to be able to spot any deviation from physiology:

I think all the way through … I think if things are all progressing as they should and you're coping, then it's about emotional reassurance until the point of birth and then it's making sure the mum and baby are both healthy. I think if you don't have that emotional… if you don't have that confidence that somebody who knows what's going on is happy and content, that can probably make the whole experience a lot more difficult. So let's say if it's all normal, equal across before birth and birth… but clearly if something goes wrong at the point of birth, then absolutely critical to be there at the point of birth. (W3-OU)

All the way through really, cause obviously if something it's not progressing then they need to be there and solve it. (W4-OU)

Recalling the previous findings about the sub-category 'dealing with an unknown midwife', some women planning to give birth in a FMU wanted to establish a trusting relationship with the midwife participating in their childbearing event right from the first stage of labour to birth:

No, I think they're important all the way through because if I am not speaking to them or seeing them for the whole of it and then they're there at the end 'Oh come on, you've got to push now!'. I think that would make me feel like they're just waiting for the baby

[…]. Whereas if they're there all the way through then it makes me feel like they want to go through it as well to help you out from the start rather than just at the end. (W6-FMU)

4.3.6 Midwife and birth partner(s)

As mentioned in section 4.1.2 on strategies for coping with the unknown, the women interviewed highlighted the importance of the presence of birth partner(s) and of the moral support provided by them. The participants identified one or two birth companions to be present during labour and birth; all the women anticipated the presence of their partner/husband and few of them asked their mother to attend as well. The interviewees expected a good midwife to involve the birth companion(s), being respectful to him/them, explaining what is happening at different labour stages to him/them and keeping him/them calm and confident:

I expect the midwife to keep them calm and confident, let them know what's going on as well. As long as they know what's going on they can keep calm for me. Make sure they're relaxed as well, make sure they've got a drink and just provide them with, you know, just make sure they know what they're doing so they can feel calm like me. I'd hate it if everyone stressed out and everyone was panicking because no one knew what was going on. (W2-OU)

Support us both and be as respectful to him as she is to me because he's just as important in that room. Whatever he is saying or doing is what we've discussed that we want so I want her to listen to him and know that yes he does understand what's going on. (W4-FMU)

Including him, cause yes it's my body but actually is both of our baby and I am his wife so he is to not being left to worry and ignored effectively. […] It's still not happening to him, he would feel quite out of control, there's nothing he can do about it and I think recognising that and being able to support him as well. (W3-OU)

One woman used the phrase *help them to help me* to indicate the desired midwife's attitude towards her partner and mother:

Help them to help me because my partner doesn't like situations like this so if you cry in front of him he'll just stand there and going 'Oh my God, what I've got to do?'. So if he gets the help to help me I think he will feel better. And obviously my mum has been there before and obviously times have changed so they probably do a load of things differently from what she experienced. So she will need telling and help and stuff like that. So just help them to help me really. (W5-OU)

4.3.7 What I would not expect from a good midwife

As opposite to the qualities expected of a good midwife, the participants highlighted negative characteristics that they would not like to find in a midwife. The women would not expect a good midwife to be rude; impatient; not understanding; not listening; stressed out; not able to cope with the mother; not cooperating; not caring; not capable; loud; busy; hesitant and not confident enough in her decisions:

Impatient, stressed out, can't cope with me [laughing]. And just somebody that is not going to really cooperate. […] It would be horrible to have somebody that just really don't care. I'd say is just there because they get paid. (W2-OU)

If you think something has happened like your waters breaking and they are like 'no, it hasn't'… you'd like them to listen to you. (W4-OU)

I don't want somebody that is a bit (mmm…what's the word?) shy or timid or isn't confident enough or just not have enough conviction in her decisions. I don't want hesitation, I just need to be honest feel confident and know that they know what they're doing. (W4-FMU)

Both the two extremes of having patronising and dismissive manners were considered by the women undesirable behaviours of a midwife. Being too sweet and lacking energy were also not seen as positive attributes:

Somebody that wants… the midwife wants you to go their way and not my way or the way my body is telling me to go. (W2-OU)

Well, somebody who is saying 'You have to do this' and somebody who is not saying anything, both of which I am going to get frustrated with. […] The extremes, someone who is a bit of a limp lettuce who is going to just give me a hug and say 'it's alright dear'… I wouldn't cope with that. And also somebody who's (when it's without telling me why) saying 'this is what you must do' because that's how they prefer it to be done. It isn't a medical procedure, it's a part of life […]. If it's all going reasonably well, I don't need ordering how to do things, I just want to be given information to work together. So, yeah, the two extremes, that would drive me insane [laughing]. (W3-OU)

One of my friends' midwife… she says that she has a midwife voice and it's like, you know 'oh, come on, yes, hold on, keep doing that' [sweet voice] and I was thinking I'd go ape if someone was like that the all way through. (W1-FMU)

In addition to unfriendly, uncaring and dismissive manners, being procedures' or rules' oriented with no flexibility in regard to the woman's needs and desires was another negative attitude raised by the interviewees:

> *If they are going to be rude or dismissive of you, that they won't listen to you, that they think that you've got to follow what the hospital say* (W1-HOME)

Negative language and behaviours of midwives experienced by some participants are reported in the next chapter (see heading 5.2.6).

4.4 SUMMARY OF FINDINGS (1): EXPECTATIONS

The women's expectations are reported as three categories: 1) anticipating the unknown: going with the flow; 2) choice of place of birth; 3) expectations of a good midwife.

When thinking about labour and birth during pregnancy, the women acknowledged this was an unknown territory to them, independently from the planned place of birth. While waiting for the unknown, the women put in place a number of coping strategies during pregnancy: preparing; avoiding; thinking about childbirth as a shared experience among women; relying on maternal instinct; relying on pharmacological pain relief techniques; considering the birth partner(s) as *voice of reason*. The property of 'going with the flow' emerged from a recurrent phrase used by women to describe their open-minded and flexible attitude towards labour and birth. They anticipated that they may constantly review their expectations in the light of their actual birth experience.

The participants referred to the following influencing factors on the choice of the birthplace: proximity; normality of childbirth; environment;

model of care; TV programmes; recommendations from family and friends. Whether the women were planning to give birth at home, in a FMU or OU, they thought that there was no difference between midwives practising in different settings; therefore, their idea of a good midwife seemed not to influence their choice of birthplace. The choice of the women planning to give birth at home or in a FMU seemed to be more related to the general atmosphere and environment of the place of birth and to the model of care rather than the midwife. The women's perceptions of safety of birthplaces varied accordingly to their planned place of birth.

The attributes expected of a good midwife were included in the following four areas: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. Women planning an OU birth seemed to be more focused on the 'doing' tasks of the midwife when compared with participants planning a FMU or home birth who were more concentrated on her 'being' role. The participants were expecting to meet different midwives due to shifts and they accepted that as long as they were not too many different ones, they knew what they were doing and understood how the woman was feeling (emphasising the importance of empathy). During a shift's transition, the women expected the midwives to behave properly, passing the information/notes and communicating to each other, anticipating the shift's change to the woman, introducing the woman to the new midwife and treating the mother in a respectful manner. The majority of women did not expect the midwife to be physically present in the labour room with them all the time. The participants argued for a midwife 'being there' even if not actually staying in the room; they rather preferred a midwife going in and out from the labour room, making the woman feel relaxed and letting her know that she was out there if needed. Some participants were willing to stay in the room with the birth partner(s) alone for most of the time. The interviewees expected a good midwife to involve the birth companion(s), being respectful to him/them, explaining

what is happening at different labour stages to him/them and keeping him/them calm and confident. The midwife's physical presence seemed to be highly valued by interviewees during the transition stage, at the moment of birth and in the first few hours after the birth of the baby.

5. FINDINGS (2): EXPERIENCES

This chapter presents first-time mothers' experiences of labour and birth, with particular focus on the midwife's characteristics and role.[*]

The findings reported in this section emerged from the follow-up interviews conducted with twelve mothers in the postnatal period, four to ten weeks after the birth of their baby. No intrapartum transfers occurred, but a change of place of birth (OU) happened for seven of the nine women that were planning to give birth at home or in a FMU due to clinical reasons that occurred during the third trimester of pregnancy. All the women gave birth to healthy babies at term, with eight vaginal births (VB) and four caesarean sections (CS). The relevant sample characteristics are reported in **Table 5.1**.

[*] Part of this chapter was disseminated at international conferences:

Childbearing women's expectations and experiences of a good midwife in the context of different planned places of birth. *ICM 30th Triennal Congress*. Prague, Czech Republic. 1-5 June 2014.

The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers perspectives of a good midwife. *Normal Labour and Birth Conference*. Grange Over Sands, United Kingdom. 17 June 2015.

Participant	*Planned place of birth*	*Place of birth*	*Gestational age at birth*	*Type of birth*	*Weeks+days from birth at the interview*
W1-OU-OU	*OU*	*OU*	*40+4*	*VB*	*10*
W2-OU-OU	*OU*	*OU*	*39+4*	*VB*	*4+5*
W3-OU-OU	*OU*	*OU*	*40+3*	*CS*	*9*
W5-OU-OU	*OU*	*OU*	*39+4*	*VB*	*4*
W1-FMU-FMU	*FMU*	*FMU*	*40*	*VB*	*8*
W2-FMU-OU	*FMU*	*OU*	*40+3*	*CS*	*8+2*
W3-FMU-FMU	*FMU*	*FMU*	*38+3*	*VB*	*8+4*
W4-FMU-OU	*FMU*	*OU*	*40+3*	*VB*	*6+4*
W5-FMU-OU	*FMU*	*OU*	*40+3*	*CS*	*4*
W6-FMU-OU	*FMU*	*OU*	*40*	*VB*	*4+5*
W1-HOME-OU	*HOME*	*OU*	*41+3*	*CS*	*10+5*
W2-HOME/FMU-OU	*HOME/FMU*	*OU*	*39+6*	*VB*	*7*

Table 5.1 Sample characteristics (second interview)

Due to the fact that the majority of the mothers interviewed gave birth in an OU (n=10/12), it was difficult to appraise the influence of the actual place of birth on women's experiences of the midwife. Extensive quotes from the interviews with the participants are included in order to demonstrate categories.

As previously mentioned, according to grounded theory methodology, the researcher embraced a balanced approach between answering the

research questions and remaining open to the participants' viewpoints in presenting the findings. In this chapter, the women's experiences of childbirth were considered to give a larger contextual picture rather than focusing only on the women's experience of the midwife during labour and birth.

The women's experiences are reported as three categories:

1. FACING THE ONGOING UNKNOWN: LET IT HAPPEN;
2. REFLECTING ON THE EXPERIENCE OF THE MIDWIFE IN THE LIGHT OF BIRTH;
3. REFLECTING ON THE BIRTH EXPERIENCE, THE CARE PROVIDED AND THE PLACE OF BIRTH.

The three categories are now presented in greater detail.

5.1 FACING THE ONGOING UNKNOWN: LET IT HAPPEN

The category of 'facing the ongoing unknown: let it happen' includes the women's attitude towards labour and birth during the actual experience of childbirth. Three sub-categories were identified: **a)** women's perception of time; **b)** facing labour and birth: the ongoing unknown; **c)** facing the unknown: coping strategies. The properties of each sub-category are outlined in **Table 5.2** and discussed in the respective headings.

CATEGORY	SUB-CATEGORIES	PROPERTIES
FACING THE ONGOING UNKNOWN: LET IT HAPPEN	WOMEN'S PERCEPTION OF TIME	o *Marking time* o *Actual time vs time in TV programmes* o *Duration: shorter vs longer*
	FACING LABOUR AND BIRTH: THE ONGOING UNKNOWN	o *You do not really know until you get there (living it yourself)* o *Every woman is different: no carte blanche rule* o *Am I in labour or not?* o *Expectations-experiences gap* o *How much more painful is this going to get?*
	FACING THE UNKNOWN: COPING STRATEGIES	o *Let it happen* o *Relying on professionals* o *Baby will be born one way or another* o *Me encouraging myself empowered by inner strength*

Table 5.2 Category four - Facing the ongoing unknown: let it happen

5.1.1 Women's perception of time

Although the women were interviewed quite a few weeks after the birth of their baby, a number of participants reported the exact times and duration of the events occurring during labour and birth. In particular, they referred to when the uterine contractions started (and their frequency) or the waters broke; when they phoned the midwives and reached the place of birth; at what time vaginal examinations were done; when the second stage of labour started; the duration of the pushing phase and of the whole labour. The women seemed to signpost the key stages of labour and birth by indicating the exact time and duration of these:

> *Left another hour and then phoned the hospital and they said 'Oh just pop in at 9, half past 9'. So waters broke at 5 in the morning and just popped in at half past 9. [...] By the time we got to the hospital I was having 3 contractions in 10 minutes and couldn't talk through them. [...] I literally had 30 seconds, 20 seconds between contractions. [...] About half an hour later a student midwife was brought in to stay with me. [...] after about another half an hour she was struggling to find his heart rate using the band. So she monitored me for another… not very long, about 20 minutes and then said 'I think you're pushing'. [...] So it was about 3 hours total and I was fully dilated. [...] I was pushing for 45 minutes.* (W3-OU-OU)

> *I had gas and air and I was on that for about an hour apparently and then I was obviously pushing her out and she came out 27 minutes later.* (W5-OU-OU)

> *The labour was 6 hours 48 minutes.* (W4-FMU-OU)

> *At half twelve I was 3 centimetres dilated, at half four I've got examined and I was still 3 centimetres but the wall was a lot*

thinner. And so that's why they gave me the drips trying to speed everything else along. And then it took forever, it took another 4 hours and then I asked for Diamorphine because I couldn't deal with the pain. And then literally pretty much 5 minutes after the Diamorphine I was ready to push [laughing]. So that was lucky! It kicked in just before I had to push and that was good. They class my proper active labour 45 minutes and then 24 minutes pushing. (W6-FMU-OU)

One woman reported the importance of having a midwife that helped her in managing expectations about times of labour:

And she gave me specific times as well I think to kind of work I kind of knew how long I had to think about the next stage. It was nice and she was always coming in a bit earlier than she said so that I wasn't constantly waiting for her. (W3-FMU-FMU)

Some participants made a comparison and highlighted the discrepancy between the times experienced during their actual labour and the ones showed by childbirth-related TV programmes. The women considered the media as giving a misleading idea of the progression of events during labour, resulting in the ambivalent perceptions of childbirth being faster or shorter than imagined. One interviewee appreciated the fact that she surprisingly had plenty of time to gradually realise what was happening at each stage of labour:

It is not like when you see women on the TV when their waters broke and they start having contractions and that's it! You have to go to the hospital right now! It wasn't like that at all, it was really nice and relaxed and even though it was actually quite a short labour I felt like we had plenty of time to sort of getting an idea. It wasn't really rushed and I didn't feel like I was being dragged on to the next bit. Yeah, it was good. (W3-FMU-FMU)

Literally I was sat on that ball and I thought to myself 'God, I feel like I need to push here' and I said it to my husband, because the midwife wasn't there at the time, she was gone somewhere. And he was like 'No, you don't, you don't need to push, you've seen all those programmes, it can't be this fast!' [laughing]. And literally I was pushing on this ball, I remember pushing while we were talking! And then I was like 'I need to push!' and my waters just went on that ball and then she was like 'Get on bed'. And I was like, 'I can't move!' Because it was all that fast she was like 'Oh, quick get on the the bed!' (W1-OU-OU)

The following quote shows how a midwife reframed the woman's expectations about time, referring to TV programmes to explain what the progression of the second stage was not like:

There was a moment at the very beginning of the second stage... She got hold on my hand and she said 'Right, this isn't like on television, it isn't 3 pushes and he's out, we could be here for some time'. And that was important because in my mind it was going to take about half an hour and she just said to me 'It takes some time'. It kind of managed my expectations so I was like 'Okay!'. (W3-OU-OU)

As mentioned above, the women's perception of time in terms of shorter or longer duration varied among participants. While quite a few participants felt as if labour went so fast and did not seem that long, some interviewees referred that labour was definitely longer than expected:

To be honest it went so fast, I don't really know how long I was in the room before I was pushing but it felt like about 20 minutes. (W1-OU-OU)

It was really good actually, yeah, it was fine. It felt like you didn't feel like 13 hours in the labour ward. It felt like 2 hours [laughing], you know what I mean, really quickly! I mean, it was really good. (W2-FMU-OU)

I wasn't in labour that long. I got there at 8 o'clock in the evening and I've had him by 4.30 in the morning. So to me that didn't really seem that long. Probably to mum and my partner it did because they were just sat there waiting [laughing]. (W2-OU-OU)

[The labour] was a lot longer. I think I knew that labour can be a long process because obviously I've been told another people have had quite a long labours but I was like thinking to myself 'Oh, no, I think I'll be alright, I think I'll be quick and everything'. But no, it wasn't. (W6-FMU-OU)

However, having a shorter labour than expected did not automatically mean having a better experience. For instance, this woman would have preferred to have more time to adapt to and manage the unknown territory of labour and birth:

That was on the basis of thinking I was going to be having this gradual birth which gave me time to have my kind of zoning out time. […] I was kind of thinking 'Alright, you go into hospital and you've got 3 minutes apart, so I was still expecting to have that time between the contractions and still be able to manage it but because it all happened so quickly I didn't have any of that. (W3-OU-OU)

5.1.2 Facing labour and birth: the ongoing unknown

Facing unknown territory was considered by the women as an ongoing condition through the entire duration of labour and birth. The

overarching idea highlighted by the participants was that they did not really know what to expect until they were actually in labour themselves:

> *Well, you don't know what to expect, do you? Well, it's just completely different when you actually get there. […] I think you don't really know what to expect. Although you read and you hear a lot of stuff about it you don't really know what to expect until you get there! [laughing]* (W2-FMU-OU)

> *I mean, you don't really know until you're actually in labour yourself what it's going to be like.* (W1-HOME-OU)

The property of 'every woman is different' mentioned in the previous chapter in relation to interviews conducted in pregnancy (see heading 4.1 on 'anticipating the unknown: going with the flow') was raised by some participants during the follow up interview as well. In particular, the interviewees stated that there is no *cart blanche rule* for labour and birth and that the women's bodies react in different ways. Furthermore, despite listening to other people's experiences and reading helpful information, the women confirmed that they felt as if nothing could prepare her for going through labour for the first time:

> *You know, you can listen to other people's personal opinions and perspectives but ultimately your experience will be your experience and, you know, they're not all the same. So there is no cart blanche rule that says because this has happened to somebody else, that's the way it's going to be for you. I mean, my mum was in labour for 36 hours with my brother and 30 hours with me but she delivered both of us naturally. I had 3 days and had a c section, you know. I could have listen to my mum and thought that that was what was going to happen to me but it didn't so… you know, every woman's perspective and experience is different.* (W1-HOME-OU)

All the leaflets they've got given and the advice from your friends and family… it was all nice to be able to take that in but you realise that everyone is different. People say that and you don't really believe it, you think 'Well, labour is labour'. But everyone has different experiences and the body is different and handle things in a different way. So it's nice but I thought it was a quite personal thing for me to experience it myself. Now I can tell my stories! [laughing] Nothing can prepare you for going through it for the first time, you just have to get on with it. (W3-OU-OU)

The uncertainty about what to expect is indicated by the words of this woman in relation to the appearance of uterine contractions that characterise the early labour phase. Her crucial doubt was 'Am I in labour or not?' and she Googled what contractions were like to have an answer to her question:

And then it went and then came back and then I thought 'No, no, no, it's not contractions yet'. And then I Googled what contractions feel like and everyone said 'Period!'. I was like 'Right, okay then'. (W2-HOME/FMU-OU)

Some women reported a gap between their expectations and experiences, confirming the property of 'now and then' included in category one explained in the previous chapter (see heading 4.1 on 'anticipating the unknown: going with the flow'). The main point raised by the participants was in relation to the fact that they reacted in a totally different way to labour to how they were anticipating, especially in relation to coping with pain:

I said I didn't really want any pain relief and stuff. It was okay to start with, I think I don't know how far I've got but I didn't have any pain relief. She got a rocking chair for me and just had the lights low and my music on. And that was great! But then I think I've probably relaxed a little bit too much and slow the labour down

and then it just got really painful. So I did ask for some drugs. (W4-FMU-OU)

I reacted totally differently to labour to how I thought I would. […] It wasn't how I expected it to be, I didn't move around that much. I think it was because it was my first one and you just don't know what to expect and don't know how you are going to react to things and pain was just horrendous! [laughing] (W2-FMU-OU)

A number of participants raised a critical uncertainty in relation to the progression of labour and their ability to cope with pain. In regard to this, the series of concerns reported by women were: *how much more painful is this going to get? If this is bad now, how bad is it going to get? If it's getting worse than this, then I am not going to be able to cope*:

I was thinking 'God, if it gets any worse…I hope to God he's coming'. That's what I thought, I felt like it was coming but I thought 'If it's not, then it's getting worse than this, then I am not going to be able to cope!' [laughing]. (W1-OU-OU)

That made me think 'Right, this is going to get a lot worse, I am in early labour, I can't have gas and air yet'. […] 'Oh Goodness, if this is as bad… if this is bad now, how bad is it going to get?'. […] 'I am only in early labour, my Goodness how much more painful is this going to get?' Do you know what? It didn't get any more painful! It was there! [laughing] (W3-OU-OU)

This mother recounted a feeling of relief when the midwife told her she was three centimetres dilated and therefore in labour, relieving the general sense of unknown around childbirth:

It was such a relief when she told me that I was 3 centimetres dilated. It was such a relief that I actually was in labour and that the pain was for a reason. I was quite relieved to find that out. (W3-FMU-FMU)

5.1.3 Facing the unknown: coping strategies

While facing the unknown, the women put in place the following coping strategies: let it happen; relying on professionals; baby will be born one way or another; me encouraging myself empowered by inner strength.

Some participants referred to the importance of being open minded during labour and birth and let it happen, recalling the property of 'going with the flow' previously discussed in relation to the interviews conducted before the birth experience:

> *You kind of go into your own little world, you're not focused on what is going on around you, you're just concentrating on the contractions and getting the baby out. I just went with the flow! I just let my body take over and I listened to my body. That's the best advice anyone have ever given me. Because if you thought it, if you fight the feeling I think I would have been more in pain. Definitely, just let it happen.* (W2-OU-OU)

> *I didn't really feel like I knew what was going on but I just kind of just seems sort of flow one stage into the next so that was really nice.* (W3-FMU-FMU)

In regard to the coping strategy of relying on professionals, a woman that gave birth in a FMU stated that she felt quite relaxed during labour because the midwives were relaxed about it and it felt as they went through it quite several times before:

> *I think because I was generally quite relaxed about it and they were all quite relaxed about it, they were all just like 'Oh, come on in, get it sorted'. Yeah, it was nice that it was not a sort of urgency but that was no stress about it, it was all just quite laid back and quite relaxed and I obviously felt like they did it hundreds of times before and it was just very normal.* (W3-FMU-FMU)

This participant seemed to completely delegate decisions on labour and birth to the midwife:

> *I didn't really have a birth plan really so she [the midwife] just kind of went with however, whatever was easier.* (W5-FMU-OU)

Another interviewee reported the importance of relying on the medical team (instead of the midwives referred to in the previous quotes from W3-FMU-FMU and W5-FMU-OU) and to the fact that the baby will be born in one way or another. It is interesting to note that this woman was planning to give birth at home and actually gave birth in an OU, with a change of perspective on medical background (from an obstacle for natural birth to a helpful support to the birth of her baby):

> *I think you can take on board what other people say but ultimately you need to just go into it with some kind of open-mind and know that, you know, the medical team they're going to look after you and that the baby will be born in one way or another. But it will be what it will be!* (W1-HOME-OU)

Alongside the birth partner(s) and professionals' support, the women were trying to encourage themselves and harness their inner strength in order to overcome the moments of fear and anxiety that happened in stops and starts during labour:

> *To be honest, I sort of told myself I needed to do it. […] When I sort of got a bit scared I had a word with myself really and I just thought 'Come on, you can do this!' and I think he [my husband] told me as well 'You can do better than this!'* (W1-OU-OU)

> *By that point I was in a bit of frenzy. I was… in my mind I was like 'I can't cope with this pain but I've got to cope with this pain'.* (W3-OU-OU)

I've lost it a tiny bit but I've got over that quite quickly, I said 'I can do this'. [...] I didn't need anybody to snap me back into it, I did it by myself! Luckily I didn't need the midwife doing it but I think she would have if I lost control, I think she would have quickly got it back. Luckily I didn't need to. (W6-FMU-OU)

5.2 REFLECTING ON THE EXPERIENCE OF THE MIDWIFE IN THE LIGHT OF BIRTH

The category of 'reflecting on the experience of the midwife in the light of birth' embraces the women's perspectives of a good midwife based on the relationship established with the actual midwife/midwives that she encountered during labour and birth. Seven sub-categories were identified: **a)** I had a good midwife; **b)** dealing with an unknown midwife; **c)** continuity of carer; **d)** midwife and labour stages; **e)** midwife and birth partner(s); **f)** negative language / behaviours of the midwife: the meaning the women make of it; **g)** women giving advice to midwives. The properties of each sub-category are outlined in **Table 5.3** and discussed in the following headings.

CATEGORY	SUB-CATEGORIES	PROPERTIES
REFLECTING ON THE EXPERIENCE OF THE MIDWIFE IN THE LIGHT OF BIRTH	I HAD A GOOD MIDWIFE	o *Empathic way of being* o *Interpersonal dynamics* o *Personal attributes* o *Professional competencies*
	DEALING WITH AN UNKNOWN MIDWIFE	o *A bit awkward? No* o *Familiarity and connection* o *Initial concern VS brilliant midwives* o *Good relationship*
	CONTINUITY OF CARER	o *Similar and good midwives* o *Shift change: confusion and relief* o *Shift change: breaking continuity*
	MIDWIFE AND LABOUR STAGES	o *Straightaway and all the way through* o *Early labour* o *Towards the end* o *Pushing stage* o *Contractions getting stronger* o *Deviation from normality*
	MIDWIFE AND BIRTH PARTNER(S)	o *Emotional support* o *Concrete involvement*
	NEGATIVE LANGUAGE / BEHAVIOURS OF THE MIDWIFE: THE MEANING THE WOMEN MAKE OF IT	o *You are not in active labour yet / You are only in early labour* o *Not staying with me* o *Just doing a routine work* o *Perception of inflexibility (procedure vs choice)* o *General attitude* o *Impact of language*
	WOMEN GIVING ADVICE TO MIDWIVES	o *Empathic way of being* o *Interpersonal dynamics* o *Personal attributes* o *Impact of what is said* o *Attitude of being a midwife*

Table 5.3 Category five - Reflecting on the experience of the midwife in the light of birth

5.2.1 I had a good midwife

The subcategory ‘I had a good midwife’ refers to the characteristics of the midwives that attended the women’s labour and birth that were considered as good by the participants. This subcategory encompasses the same four properties that were presented to describe the subcategory ‘characteristics of a good midwife’ (see heading 4.3.1) in regard to women’s expectations: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. Slight variations from the first round of interviews were identified in terms of the characteristics reported by the women to describe these four properties. The characteristics of midwives valued as good by the women during labour and birth are outlined in **Table 5.4** in respect of each property.

Empathic way of being
Human beings 'like me'; understanding; compassionate; caring; supportive; establishing a trusting reciprocal relationship; staying with me; being there for me; involving me; making me feel in control; focus on me; someone I can talk and have a laugh with; making me feel relaxed; making me enjoy the moment; part of my family (like I've known her for ages); having that connection with me; being excited with me; listening to me; making me feel home and welcomed; making me feel relaxed; reassuring me; treating me as individual; taking on board my feelings; making sure I was informed / cared for / prepared / spoken to / listened to; supporting my choices; caring for me all the way through and afterwards.
Interpersonal dynamics
Good listener; chatty; bubbly; balance between giving options and advising me what to do (how about trying this?); explaining things step by step (how and why); having normal everyday conversations; friendly pushy; instructive when needed; telling me off when I said 'I can't do it'; helpful; giving information and answering questions; accommodating; involving birth partner(s); speaking eye-to-eye level.
Personal attributes
Friendly; warm; lovely; kind; calm; strong/strict/firm; funny; polite; crazy in a lovely way; passionate about her job.
Professional competencies
Experienced; they know what they are doing; knowing exactly what is going on and when; professional; knowledgeable.

Table 5.4 I had a good midwife: description of properties

A number of attributes reported by the participants were related to the area of 'empathic way of being', such as being there; recognising individual needs; focusing on the woman, involving her and make her feel in control; making the woman feel at home and welcomed; supporting the woman's choice; taking on board feelings and providing emotional reassurance:

> *I think that's important as well as they don't just talk at you but they listen to what you are saying and they take on board your feelings and what you think and what you like.* (W1-HOME-OU)

I felt definitely in control. But then if I needed her there I could ask her, if I wanted anything she was there for me. It worked both ways which was nice. (W2-OU-OU)

In regard to the property of 'empathic way of being', a number of women highlighted the importance of establishing a trusting reciprocal relationship with the midwife:

We were talking about all sorts in there, we weren't talking about anything to do with the labour and stuff afterwards. It was all like just friendly chit chat. [...] It's important for you to feel like, you know, they are just like human beings, they are not these machines! [laughing] [...] You know, they are just like you, aren't they? (W1-OU-OU)

I got to know her quite well, she brought in cakes and tea and coffee and toast afterwards. […]It did feel like a social gathering but with my family, I didn't feel awkward like I was in a room full of strangers or doctors. So it was nice, it was just a casual 'I'm in labour'! [laughing] (W2-OU-OU)

She was telling us a bit about her as well so we didn't feel like it was all us. We kind of knew about her, like she had dogs and… I don't know, it's just kind of get to know them a bit more because it's someone that you are never going to forget. She's a very important person now, especially to us, so I think it's more friendly and more involved than what I thought before. [....] Yes, so that you know a little bit more about her rather than her just knowing everything about you and you just kind of show her everything and you don't know anything apart from her name [laughing]. So it was just a general conversation while we were here [home], just that she has dogs and children. (W1-FMU-FMU).

I think I liked her telling me a bit more about her… I think that's kind of what I didn't expect but it was kind of a nice extra to what I expect a good midwife to be. (W1-BC-BC)

The qualities highlighted by the participants included in the domain of 'interpersonal dynamics' were: being a good listener and communicator, chatty, bubbly, helpful and accommodating; giving information and answering questions; explaining things step by step; maintaining a balance between giving options and advising what to do; involving birth partner(s); having normal everyday conversations and speaking eye-to-eye level:

I think it was just the fact that they were so caring, they were so warm and so like loving and they just wanted to make sure that you were informed, that you would constantly be cared for, prepared, spoken to, listened to. (W1-HOME-OU)

She spoke through everything that was going on, she told me what was going to happen, what just happened, what she could see so she kept me up to date very well. And I had her through the whole labour so it was nice. [...] She asked me everything. She just did what I said. (W2-OU-OU)

Some of the qualities reported by the participants were related to the area of 'personal attributes', such as being friendly, warm, lovely, calm but strong, funny, polite and passionate about her job:

I just had exactly what I wanted, she was lovely, she was bubbly, friendly, anything I could have asked for. (W2-OU-OU)

She was calm and sat right away watching and when it came the time to do the business they were quite hands on in and anyone knew what to do. (W1-OU-OU)

Other characteristics valued by the women were embraced by the property of ‘professional competencies’. In particular, a good midwife should be experienced, knowledgeable and professional; know what she is doing and what is going on and when:

> *She was very knowledgeable about everything and I just kind of put everything onto her.* (W1-FMU-FMU)

> *She made me feel like she knew what was going on, like she was in my position and doing it for me. It was strange how she knew exactly what was going on and when.* (W2-OU-OU)

> *I felt I had confidence in her and trust in her, she was very accommodating and I felt quite safe around it that she knew what she was doing, she looked pretty experienced and knew what was what. I liked the way she kept such a close eye on us. We were always being checked and I just felt that she knew what she was doing, she was very professional.* (W4-FMU-OU)

When asked to evaluate the importance of their midwife’s personal attributes and way of being when compared with the value of professional competencies, the participants highlighted either one of the two characteristics or sought for a balance between them. Some women reported to have changed their mind about this after their birth experience. The following quotes underline the significance of having had a midwife with good personal qualities and a friendly manner:

> *I probably wouldn’t say professional now. I said professional before [birth] I think. I would say… I am trying to pinpoint everything all down to one word… personality and friendly. […] Personality as they’ve got to be open-minded and they’ve kind of match your personality so you have a connection and an understanding of each other.* (W2-OU-OU)

I think the compassionate and the understanding rather that somebody that's very stiff upper lip […]. I think I would far rather have somebody like that because it leaves you with a better overall kind of feeling about it. And it is a big thing, having a baby is a big thing. And it's a very personal, a very humbling experience but as I said also… you know, in some way it's kind of a bit humiliating and you're very vulnerable so I think it helps when you've got somebody there that kind of knows that and feels it and understands it and is very compassionate and caring towards you. It's the care really. (W1-HOME-OU)

The midwife's professional side seemed to be more important for the women in the crucial stages of labour (e.g. pushing phase) and when medical interventions were needed:

[Being knowledgeable] it's a kind of a given, yeah. […] Obviously the knowledge side when it comes to it, that is the kind of crucial part. But I think in between, I think it's the personal part. (W1-FMU-FMU)

I think now on the professional, with having had a caesarean just because I knew what they were doing. But it was all going naturally, then maybe the caring side. (W2-FMU-OU)

The years of experience of the midwives did not appear to be a concern for women. The participants believed that the midwives were all been trained and qualified at the same level, regardless of the duration of their professional career:

I don't think it makes a difference because like I said I had one that was qualified and one that was still a student and was due to qualify. So it didn't really make a difference because they're all from same level anyway. She did ask a few questions to the other midwife but that was just based on paperwork and things like that.

Other than that, she knew what she was doing anyway so it didn't really matter. It didn't make a difference to me anyway. (W5-OU-OU)

I think the years of experience are not really important because I suppose you've all done your training so everyone knows. They have just done more, that's all. So it wouldn't really bother me if there was a young one. (W5-FMU-OU)

Contrary to the views on the years of professional experience, some women believed that a midwife with children herself could understand more what they were going through. Having children was not seen as an essential characteristic of a midwife, but quite a few women agreed that this may be an added value that could help midwives in caring compassionately for labouring women:

Yeah, I think [it's important for the midwife having had kids herself] because they understand more of what you are going through. People that haven't got children, they're giving you information and advice that take from a manual, a book, they've been to uni or whatever and read a book. Sometimes this is not the right way to do things for your baby. I've noticed that quite a lot. They give you instruction. (W2-OU-OU)

She got a little girl that was two herself so she knew what it was like and she'd ended up with a c section, she'd been induced so she understood herself what it was like to go through the labour etcetera. Whereas I think some of the other midwives didn't necessarily, although they were very empathetic and compassionate and they did their jobs but they didn't know how it was like to actually go through the experience themselves. So I think that always helps when you've got somebody that you are dealing with that has been through those experiences. I think it just adds a different layer of understanding when they've been through

that experience themselves. […] You know it's very easy for them to talk about things in theory but in practice obviously it's very different. […] So I do think it makes a difference. I am not saying it's something that they necessarily need and it's certainly something that they'd have to have. I just think it helps. (W1-HOME-OU)

A number of participants argued for the importance of having had a midwife with a good mixture of personal and professional characteristics:

I think you definitely need the two [professional and personal attributes]. If you have somebody who is really friendly and so laid back but didn't really seem to know what they are doing you would be a bit worried. At the same time if I'd had a just had her barking orders at me and not making me feel relaxed I think it would have been a completely different labour. Yes, she had a nice mixture of the two. (W3-FMU-FMU)

5.2.2 Dealing with an unknown midwife

Regardless of their planned place of birth, the women interviewed stated that they were not concerned about dealing with a midwife they had never met before. Some participants were anticipating it to be a bit embarrassing with childbirth being a very intimate moment, but they reported that the midwives were generally really professional and friendly and managed to put them at ease:

I kind of expected it would maybe be a bit awkward because I hadn't ever met her and this was very intimate [laughing] but then it was amazing and she was really nice and really put you at ease. […] That definitely helped with us especially because we didn't

know K [the midwife] at all and then by the end of it, by the time you are leaving, not even 12 hours after meeting her, you're kind of be attached. [laughing] (W1-FMU-FMU)

I had thought 'oh I wonder if it would be a bit awkward maybe with somebody that you don't know' but it really wasn't. (W1-FMU-FMU)

Fine, yeah. I think once I was in there… before I might have said it differently but when I was in there I was just like 'Whatever!' [laughing]. (W1-OU-OU)

Some interviewees were surprised by the familiarity and immediate connection they experienced between themselves and their midwives after meeting them for the first time:

Yeah, I was alright. I think I was alright because the second I saw her she was so friendly and it felt like I'd already seen her like a hundred times. (W3-FMU-FMU)

I just felt really comfortable with them all although I had only just met them. They're so professional, you just have to get on with it. I thought I would be shy because I did a lot of examinations and things like that that were really awful but it actually wasn't that bad at all because they are so professional over there. (W2-FMU-OU)

The midwife I felt like I've known her for years, she actually felt like a part of my family which was really strange. Honestly, that was strange. So she kind of did more of what mum and K did. They just sat and watched which I felt relaxed about because I felt that connection with the midwife which was lovely. (W2-OU-OU)

Two women that were planning to give birth respectively in a FMU and at home and that were admitted to an OU, were initially concerned about not knowing the midwives at the hospital; however, they later

recognised that the midwives *were all brilliant*, even if they did not get to know them during pregnancy as they did with the community midwives:

> *I'd tell my community midwife right from being 6 weeks pregnant and I really wanted her to be there because I trusted her and I knew her, I knew how she reacted, I knew what she would expect of me and also I knew that she would know what to say to me to get the best out of me to encourage me and things like that.* […] *I was concerned that the midwives in the hospital because they didn't know me they wouldn't give me the care, that they wouldn't really be bothered that much because they see so many different women. But they were all brilliant! I couldn't have asked for better care than I got.* (W1-HOME-OU)

> *It's a bit like 'Oh, I am not going to know anybody, I don't know the hospital, I don't know anything, where anything was' whereas at the birth centre I know it as the back of my hand. But when I got there it just went all smoothly so it was good.* (W6-FMU-OU)

Overall, as long as a good relationship was established, the women were satisfied by the care they received, even if they did not get to know the midwife before the labour. In regard to the woman-midwife relationship, the following category describes the women's experiences of continuity of carer.

5.2.3 Continuity of carer

As for the previous property about dealing with a midwife that they did not know, the women seemed not to be generally disappointed by having been assisted by different midwives during labour and birth. The following quote is from a participant that gave birth in an OU and evokes the properties of 'now and then' (see heading 4.1.1) and 'as

long as…' (see heading 4.3.3) discussed in the previous chapter. In particular, she seemed to consider safety as a fall-back position in the absence of intimacy with the midwife:

> *I had three in total but they were all very nice. […] I think I said that I wanted to see the same person but no, it didn't bother me at all. […] To be honest I don't think you really care when you're in that… you don't really know what's up! Just as long as they get him out safe, I think that's all that you are really bothered about!* (W1-OU-OU)

The women appreciated the fact that, even if a change of midwife occurred during their labour, the midwives were all very *similar* and good, describing them as *friendly*, *bubbly*, *polite*, *brilliant* and *fantastic*:

> *They were very similar, they were both friendly, bubbly, polite. They were very similar which was nice.* (W2-OU-OU)

> *I think I went through four or five different shifts of midwives so because obviously it was such a long time as I said. […] All of them that were in there were fantastic. […] They were all absolutely brilliant the midwives in the hospital.* (W1-HOME-OU)

The shift change might be perceived as a moment of additional confusion and concern in the context of the unknown terrain of labour and birth, especially when not previously explained by professionals and therefore not foreseen by the labouring woman. However, this participant reported a feeling of relief when she finally met the next midwife at the moment of the shift change and realised she was as good as the previous one:

> *I didn't expect that, when I first got there I thought that she was the one that would have looked after me into labour and I would have had her. I didn't realise that they were going to swap over or have a different midwife actually when I moved upstairs. So I was a bit*

worried first but then when I met her and obviously saw what she was like and how she was I felt a lot more relieved. (W2-OU-OU)

Interestingly, the shift change was considered as a positive moment by this woman because she went from being assisted by a midwife she was not getting along with to meeting other two *nice* and *lovely* midwives:

The first one, I just wanted to strangle her [laughing]. […] Then I had an Irish lady and she was lovely, very very nice. And then there was V after, who was there when I delivered and she was lovely. (W2-HOME/FMU-OU)

Although the majority of the interviewees described the different midwives they were cared by as very good, it was argued that a change of shift may break the continuity because the woman and the new midwife need to go through the whole process of getting to know each other. Moreover, one participant stated that it would be good if continuity of carer was guaranteed, with the woman being allocated to the same midwife throughout pregnancy, labour, birth and the postnatal period:

I was really kind of concerned about that because of the continuity. […] At the end of the day you've got to be okay with it because you can't expect them to be there with you the whole time you know… they're there to do their job, they're there to help you and they've got various other ladies besides me to look after and they can only do so much on one shift. And, you know, yes it breaks the continuity because you're having to go through the whole kind of learning thing with the new midwife but if you had a short labour then that wouldn't be the case (W1-HOME-OU)

It has been different midwives. Anything wrong with that! They were all absolutely brilliant, I can't fault them but it would just be

nice if you just had the same person […] I think you should always have the same midwife. (W4-FMU-OU)

5.2.4 Midwife and labour stages

In the light of their birth experiences, some first-time mothers argued that the midwife's presence was important straightaway and all the way through in order to reassure the woman on the normality of labour's progression, explaining what was happening, what was going to happen and why:

I would probably say there are not stages more important than others for the first time, not if you haven't had a baby before. I think all of it is really important the midwife for the first time because you need them to explain what is going to happen and what's happening now, why it's happening. So then you feel at ease like it was normal, this is supposed to be happening. So I think first time in my experience I definitely wanted them there all the way through. (W2-OU-OU)

All the way through it, yeah. I kind of got there and I just felt we just needed to be looked after and someone to make sure everything was okay. (W4-FMU-OU)

Quite a few participants highlighted the labour stages during which the physical and emotional presence of the midwife was much needed: early labour; towards the end; the pushing stage; when contractions got stronger; in the case of deviation from normality. The most mentioned were the early labour phase and the second stage of labour (pushing phase).

The presence of the midwife during the latent phase was highly valued by the women that were seeking for support, reassurance and provision of information around progression of normal labour.

In the case of FMU births, the women referred very positively to the home visit by the midwife during early labour. In the case of an OU birth, some participants reported a greater sense of control and a reduction of anxiety following admission to hospital and allocation to a midwife in early labour, if compared with the time spent at home with the birth partner(s) without the midwife:

> *I mean, initially when you're first going into labour and you don't know what it's going to be like so… You know, when you're first going into labour you're kind of gauging from them 'Is this normal? Is this alright? Am I… is everything okay?'. And then as long as they check you sporadically through your labour to make sure everything is okay.* (W1-HOME-OU)

> *Because the midwife was there I felt more relaxed, I wasn't in a so much pain as I was when I was at home I just panicked. [...] I was panicking very much at home. Really panicking. And no one knew what was going on, no one could understand what was happening so it was just me feeling that feeling.* (W2-OU-OU)

> *I went to the assessment centre and they immediately sent me up to the labour ward. By the labour ward I was at 4 contractions in 10 minutes and can't talk through them and I was assessed there and I was only 2 cm dilated. And the midwife said to me, first interesting point, 'Well, you're not in established labour yet, you can go home'. 'So, I live 35 minutes away and I am having 4 contractions in 10 minutes. When would you like me to come back?'* (W3-OU-OU)

Conversely, this woman chose to stay home for as long as possible in order to avoid medical interventions at the OU:

> *We got there at 6 in the morning but by the afternoon my contractions really slowed down so we came back home. They slowed down but they never stopped so then because my waters broke at 3 o'clock they wanted us to go back by 3 the following morning. At about 1 o'clock I said to my partner 'I don't want to go!' and he said 'I know, and I don't want either'. Because we knew that if we did, they would get baby out because my waters were gone.* (W2-HOME/FMU-OU)

Other crucial phases in which the women claimed for the importance of the midwife's presence and support were towards the end and the pushing stage, considered as the most worrying and hard stages of labour:

> *I'd probably say at the pushing stage because that's when it's harder and you start to get a bit worried then. So for them to be there and talk you through it again, I think that's the most important bit. That pushing stage.* (W1-OU-OU)

> *When it got to that stage when I was literally about to start pushing I was expecting that the midwife would be there the whole time.* (W3-OU-OU)

> *They need to be with you at the end because I think that is a pretty scary time. […] You're never more vulnerable and exposed then that point in your life. […] It's certainly important that the midwife is there to just reassure you really, just check you and reassure you […]. So, I think it's essential at certainly the latest stages, before you're due to actually push and deliver. But the midwife is there and you've got some kind of consistency there.* (W1-HOME-OU)

Definitely towards the end I think the midwife is really important. In the first couple of hours nothing really was happening and it wasn't very painful anyways. But when it was more painful and more intense, yeah, it was good to have her there at all time. (W2-FMU-OU)

Conversely to what happened (the midwife was not there to support the woman), one participant underlined the significance of the midwife being present to empower and encourage her when she entered a stage during which she was not able to relax between contractions:

I think once you get to the stage you haven't got time to relax between contractions you need them there to help you and to almost tell you off that when you getting into the frenzy and say 'Right, come on!'. If she had said to me 'Look, you've got to calm your breathing down, your baby's heart rate isn't recovering' I probably would have snapped. It would have helped me snap out and have something else to focus on. But as it was I was just focusing on 'My Goodness, that really hurts and I've got another one coming immediately'. Yeah, but she wasn't there. (W3-OU-OU)

For a few interviewees the midwife's presence was essential when the events deviated from normality, in order to act accordingly and to explain both the reasons and implications of the actions taken:

I'd probably say [that the midwife was really important] when they found that he was stuck that they pushed it along a lot faster. I'd probably say then. (W5-FMU-OU)

[I felt that the midwife's presence was important] when they did things to me like putting me on the drip because I wanted to know what was going on. (W2-HOME/FMU-OU)

Some participants emphasised the need for the midwife to balance her behaviour in accordance to different labour stages. In particular, they seemed to appreciate a calm and friendly midwife that put them at ease and stayed in the background during the first phase of labour and a more strong and motherly midwife in the pushing stage:

> *She was calm and sat right away watching and when it came the time to do the business they were quite hands on in and anyone knew what to do. And she spoke me through it every step of the way. I am just remembering bits now, like when to 'Slow down your pushes'. I remember she was really good.* (W1-OU-OU)

> *She wasn't as motherly as I'd expect her to be but she was really nice. She sort of like let me feeling really comfortable and she was really friendly. [...] The other midwife I suppose was maybe a bit more motherly because […] she was telling me all the things that maybe I expect my mum to sort of say in that situation and she was guiding me. So I suppose she was more of a motherly figure which is maybe why I needed her in that situation when I actually came to the pushing. That's when she sort of came in and took more control.* (W3-FMU-FMU)

5.2.5 Midwife and birth partner(s)

All the participants interviewed reported that their male partner/husband attended labour and birth; for some women, the woman's own mother was present as well. The participants described the midwives as very supportive to the birth companion(s), in terms of getting them involved; talking to them and explaining what was happening; allowing them to ask questions; making them feel relaxed; suggesting them what to do for the woman; guiding them throughout labour and birth; encouraging

them to encourage the labouring woman; helping them to enjoy the moment:

> *And she was also there to be talking to my husband so it wasn't all on me. […] She was really good with updating my husband and kind of talking to him about what he could be doing and what he should be doing and why things were happening so he didn't feel completely out of it.* (W1-FMU-FMU)

> *I think she was very nice, with N she just told him what to do and he just did what he was told [laughing] […]. I think he was quite happy with just being told what to do and I think she kind of knew that and she was like 'Do you want to then?' And it was almost like she gave him permission to do the things that he was going to do next so that was quite nice because then I felt like he knew what he was doing because she was just guiding him to like 'Do you want to do this?' and he'd go 'Yeah, yeah I do actually!' [laughing]* (W3-FMU-FMU)

> *She was talking to him and saying to him 'We need to get her out of the toilet'. And so then he was helping me and trying to persuade me what it was we needed to do and so she was involving him in getting me to do things.* (W3-OU-OU)

> *She talked to them, she told them what was going on. If they had any questions, the midwife made them feel relaxed enough to ask them. I thought, you know, 'I just want you to do everything'. To the midwife they were just there to enjoy the moment and see what was going on and appreciate the baby when it came out.* (W2-OU-OU)

The women appreciated when the midwife encouraged the concrete involvement of the birth partner(s), such as supporting the woman with the use of the hypno-birthing techniques learned during pregnancy and

making sure the woman's energy levels were kept up. Cutting the cord and telling the sex of the baby were seen by the women as an opportunity for the birth partner of being hands on and feeling in control:

> *I think she just helped us, she kind of reminded us different things. They were aware that we've done the hypno-birthing so they knew that we were doing the hypno-birthing techniques so they encouraged us to use those and encouraged him really as well to make sure I was drinking and all those sort of things, that I got buckets of Lucozade and cereal bars and those sort of things. So they were kind of reminding him to make sure that my energy levels were kept up. I mean they were very very supportive, obviously they were explaining things to him. They were explaining things to him as well and encouraging him to encourage me.* (W1-HOME-OU)

> *I think she could tell what my husband involvement was going to be and he was going to be very hands on and just kind of in control of things. They were really respectful of that and very good. I said that I wanted him to tell me the sex of the baby so they did that and they said 'Do you want to cut the cord?' because we said that he might want to. So they did all of that and yeah, they were good. You know, obviously S and me were their priority but they were really accommodating as well with my husband.* (W4-FMU-OU)

5.2.6 Negative language / behaviours of the midwife: the meaning the women make of it

As opposed to the women that listed the positive attributes of the midwife who provided care during labour and birth, some participants encountered midwives with negative language and behaviours. This

property was developed from the quotes of five women that were planning to give birth in different places (OU, FMU, HOME/FMU) and that finally gave all birth in an OU. The characteristics of the participants that reported negative language / behaviours of the midwife are reported in **Table 5.5**.

Participant	*Planned place of birth*	*Place of birth*	*Gestational age at birth*	*Type of birth*	*Weeks from birth at the interview*
W2-OU-OU	*OU*	*OU*	*39+4*	*VB*	*4+5*
W3-OU-OU	*OU*	*OU*	*40+3*	*CS*	*9*
W4-FMU-OU	*FMU*	*OU*	*40+3*	*VB*	*6+4*
W6-FMU-OU	*FMU*	*OU*	*40*	*VB*	*4+5*
W2-HOME/FMU-OU	*HOME/FMU*	*OU*	*39+6*	*VB*	*7*

Table 5.5 Characteristics of participants reporting negative language / behaviours of the midwife

A couple of interviewees reported the negative language of midwives in relation to the early labour stage. Some of the midwives were described as labelling the woman as being *only in early labour* and *not in active labour yet*. The participants derived their own meaning of the language used by the midwives, considering the latent phase as an ineffective and static stage of labour, where no evident progression was present. Moreover, they felt that their individual needs and the pain they were actually in were not understood by the midwife. One woman said that the midwife was concerned more about the cervical dilatation rather than looking at her as a whole and at how she was coping with the contractions. Words such as *only* and *yet* seemed to make them worry about the duration of labour:

It had a real impact on me her saying 'But you're only in early labour, you can't have gas and air yet'. So I then went for another 2 hours thinking 'I am only in early labour, my Goodness how much more painful is this going to get?'. […] So yeah, let's say think how you say things to people, think about the impact of what you say, that you don't necessarily think. (W3-OU-OU)

On the first phone call they were kind of like 'There's nothing we can do, you're not in labour, you've just got to wait'. So that makes you feel uncomfortable because you're the one actually having to put yourself throughout pain, you've got to sit there and go through it! And there's nothing you can do, it's like you just got to do it, it's horrible, it's horrible, that's the worst! (W2-OU-OU)

When I walked into the hospital… I am very bubbly myself so I was quite calm and relaxed even though I'm in pain, I still think it's polite to say 'Hello, thank you'. Just because I am in labour it's not like 'I'm in labour, I'm going to ignore you, don't talk to me!'. I am not that kind of person, I am not ignorant. And when I went into the hospital they all looked at me and said 'What are you doing here?' and I felt really uncomfortable and it was all young midwives. 'You're not in labour because you're smiling' and I was like 'That's just me!'. […] I was kind of like 'God, I don't want a midwife like that'. (W2-OU-OU)

When she assessed me I was only 2 cm dilated but I was quite clearly having contractions pretty frequently and she'd already asked me 'How far away do you live?' and said I can go home and I was like 'Look at me! Really? I can go home like this? Do you think?' [laughing] (W3-OU-OU)

It was always like it was the 'Oh, you're not even 3 cm dilated yet so we're going to send you home' rather than look at the patient, look at how I was doing… and the fact that I had already told her I

had taken two paracetamol and I'd taken them 2 hours ago and I was already in that state. And yes, okay, I could have had a really low pain threshold but it was quite clear that I couldn't have gone home! (W3-OU-OU)

Some women were disappointed by the fact that the midwife was not present in the labour room for the expected amount of time and not assessing them step-by-step as persons with individual needs. For these reasons, the participants did not feel entirely understood, believed and listened to in some cases. The absence of the midwife towards the end of labour was reported by W6-FMU-OU as causing a greater level of anxiety and worry:

She came in pretty much every fifteen minutes, so she did come in regularly but she kept going out and in, out and in, rather than staying for a little bit and then going out and coming back kind of thing. [...] And then obviously I think towards the end when she kept going out, it was a bit more nerve-wracking because I knew that it was coming to the end. (W6-FMU-OU)

I wonder whether if they were coming in to see me more frequently […], if they made a case by case assessment of me there, they would probably have gone 'Actually, she doesn't need the gas and air, she does need more attention'. The midwife didn't believe I was having such as intense contractions as I was. […] Had she reassessed me half an hour later properly and I don't mean her just sticking her head in the door and saying 'We need to move you rooms'. If she reassessed me, had spent 5 minutes with us she would have probably gone right. […] I didn't like the fact that she basically looked at one small part of a patient, she didn't look at the whole picture. And didn't reassess that picture enough for her to be able to really understand what was happening with me because I think if she had I think she would have dealt with it

differently. Yeah, because the change was so quick between where I was and then where I was half an hour later. She wasn't aware of that, she can't because wasn't with us. I just think she would have managed it differently. (W3-OU-OU)

She could have coming in, sat in the room rather than just stand. That's the only thing really. She was just standing so it felt like […] she was still ready to go back out. Whereas if she sat down for a little bit, that would have been a bit more one-to-one. (W6-FMU-OU)

In opposition to the interviewees that reported to have established a trusting woman-midwife reciprocal relationship which transgressed traditional client-professional boundaries (see heading 5.2.1), few participants felt that the midwife was neither professional nor friendly, being there just to do her job, doing only quick *routine checks* and acting like the woman was *just the client*:

I don't know if it is down to the midwife but I felt like she wasn't very professional, she wasn't that friendly, she kind of made you feel like you were just the client, she was just doing a routine check that she normally does like 15 times a day. She didn't ask anything about myself or my family, she didn't get to know me or even try. I don't know if it was because she was a young midwife, I don't know but it kind of came across like she was just there to do her job and she didn't really get to know you. It's like you're there, you're not in labour so I'll leave you there. (W2-OU-OU)

Some participants argued that the midwife was quite *quick to go* when her shift finished. Moreover, some interviewees agreed that the care appeared sometimes to be more dictated to the routine tasks required by the ward's workload rather than shaped on each individual woman's needs. This depersonalising behaviour often resulted in the participants feeling dissatisfied with the care received:

The midwife who met us out of theatre, she was all a bit 'Right, you've got an hour here and then we'll take you down to the ward, get him dressed'. It was all very much of the fact they were moving you off the labour ward to take you down to the postnatal ward, you've got an hour here, crack on! (W3-OU-OU)

She was quite quick to go when her time was up so that was a bit disappointing. [...] So it was quite good we had that quick little chat but then she was like 'Ok, I've got to go now, bye!' straight after. And then from then I hardly saw anyone. (W6-FMU-OU)

Just said 'I'm done, here's the next!' [laughing] It was more like 'I'm off, there you are'. It would have been nice if they said goodbye to you. I don't know, it's just not personal. Not what I expected, that's it. (W1-HOME/FMU-OU)

Some interviewees reported to be annoyed by the perceived inflexibility of the midwife, especially in terms of inconsistency between the protocols and guidelines referred to and the provision of woman-centred care based on individual needs. In regard to this, the participants felt as if their possibility of choice was overwhelmed by procedural issues. In some cases, what women were expecting appeared to be far from routine care, such as vaginal examinations done inflexibly every four hours or strict criteria for being admitted to the AMU. When this was the case, the participants felt as if the healthcare professionals were not willing to modify their procedures to meet women's expectations:

They did one examination when I went in and I was about 3 centimetres and they when they looked again I was like 6 and I've been stuck at 6 for a little while. And it was then when I said 'Would you look again?'. Probably it was an hour or something, a couple of hours, because they said 'We only do it every 4 hours'. And I've just thought 'I don't care that you only do it every 4 hours, I am not a statistic, I want you to do it'. But they didn't and I think

that's what annoyed my husband, because it would have been a bit better if I've known. [...] Looking back on it now if they had done what we'd asked, I probably wouldn't have been begging for an epidural. (W4-FMU-OU)

They didn't let me onto the midwifery-led unit. So they put me on the ward and I just got so upset, I was crying and I said 'Please just let me in, is it busy?' and they said 'No, no one is giving birth yet now'. Then I said 'Why don't you let me in then? Please let me just go. I don't want any clinical medical… nothing'. […] They checked his heartbeat and he dropped once so she said 'Right, that's it, we have to monitor you because baby's heartbeat has dropped and we can't risk obviously his life'. And I thought 'Yeah, fine, okay, so that means: on the bed, constantly under monitor, no moving, no dilating, that's it!'. […] I was sobbing my heart out because I knew that they were going to put me on the drip. If they put you on the drip that's epidural because there's no way you can do about it. If they put you on the drip you have problems with breastfeeding, just because the oxytocin you can't match it with the drip. So I was crying nearly all the way and it was horrible, horrible, horrible because it just felt so unnatural with the drip. I hated it and I was just crying and crying. (W1-HOME/FMU-OU)

When I said 'Look, this is what I wanted so just please do this' she was like 'Oh, you know what you want!'. I said 'Yeah, I do'. Just because it's not how they do it, because it's different, don't judge me for it, just respect it! (W1-HOME/FMU-OU)

In regard to possibility of choice, one woman reported that the midwives completely ignored her birth plan and therefore she felt that her perspective was not respected. Even if she was planning to give birth in a FMU and then she was admitted to an OU, she argued there were still choices that they could have made according to her initial birth plan.

She was disappointed by the fact that she was not offered the possibility to go through her birth plan with the midwife at any stage of labour:

> *Did they really respect my decisions or how I wanted things? They completely ignored my birth plan. They knew that I wanted a natural birth and it wasn't natural but there were still things that they could have done differently or I could have done according to the birth plan. [...] Once they put me on the drip I thought 'Well, birth plan is out of the window, that's it!'. But there were things that we could have still done. […] I would have appreciated if they said like 'Okay, look, I know how you wanted it, let's just have a chat about it, I know how you wanted it and I know what you're doing, let's just check baby and then I'll go and check if you can get in the water bla bla bla bla bla'. No.* (W1-HOME/FMU-OU)

One interviewee indicated that she was bothered by the midwife's general attitude, mainly due to the language used and the way of speaking to over-talk the woman's voice rather than concentrating on and listening to her:

> *The first one, I just wanted to strangle her [laughing]. I am not saying that it's because she was young but she was a young, cocky… when his heart rate dropped she said 'Oh, babies are so stupid because they can just hold on to the cord and that's what causes the heart beat drop'. I was like 'You're fucking stupid, not my baby!'. You can't say that! […] It wasn't her experience that bothered me. She must have been experienced if she was there on her own. It never bothered me, it's her attitude. It was really her way or no way.* (W1-HOME/FMU-OU)

> *When I was holding on to the hand-rail and I had my contraction, rather than the midwife concentrating on me, she tried to speak louder to over-talk my voice. I wasn't screaming but obviously I*

was doing my breathing and it was just so strong. She over-spoke my voice to my partner and I just thought 'Really? Just shut up and concentrate on me!'. (W1-HOME/FMU-OU)

The impact that the midwives' words may have on the woman's experience and feelings (e.g. causing worries) is highlighted by the following quotes:

As soon as they said his heart rate was dropping, that's when I was like 'Oh, God!'. I just tried to keep calm really and do my job! (W1-OU-OU)

Because they explained to us that they didn't want her to cry on her way out, they wanted to check her over first to make sure that she didn't inhaled any of the poo or anything like that basically. So I felt her come out and within a few minutes she cried on her own so in my head I've thanked God for that. But then I thought 'Well, they didn't want her to do that'. But luckily she was fine. (W5-OU-OU)

5.2.7 Women giving advice to midwives

When asked if they had a piece of advice for midwives, the women focused mainly on the areas of personal attributes, interpersonal dynamics and empathic way of being (see heading 5.2.1). Conversely, they hardly referred to professional competencies.

Quite a few participants would suggest the midwife to be friendly, understanding, caring and approachable, making women feel comfortable and talking through the different stages of labour:

Concentrate on having a good bedside manner and being friendly and approachable to the patients because it makes you feel comfortable when you are there. (W2-FMU-OU)

You want someone that talks you through it and nice. (W5-FMU-OU)

Just to come across this really caring and understanding and looking after the woman. (W4-FMU-OU)

The importance of establishing a trusting relationship with the client was raised by participants that would suggest to the midwives to be themselves, look at the whole situation and consider each woman as a person with individual needs:

I think getting to know the person, what the person is like definitely. Just having that boundary with your client and making it personal to them. (W2-OU-OU)

Look at the whole situation, don't make the assessments on one 5 minutes conversation and one examination, make sure you do the initial assessment, the main assessment over the course of half an hour – 45 minutes and how things are changing because some people won't follow the norm and some people will not fit with that way you think they are. (W3-OU-OU)

I think just say to them of being themselves and not pretend to be somebody… cause I think being themselves and being quite open about themselves like I have experienced with my midwife, then the amount of years and experience they might have doesn't matter, it becomes irrelevant because you feel like you kind of know them. But if they're pretending to be somebody else, then it all, you know, get a bit messy. (W1-FMU-FMU)

Besides establishing a good bond, this participant would advise to the midwives to be there to reassure, listen and support the labouring woman since she is going through a very vulnerable and scary moment:

Listen and take on board what your lady said to you, but to be there because she needs you. No matter what, she still need your knowledge and your expertise and although she has her own personal perspectives and picture, you know, she needs you there to hold the hand because it's pretty scary. You know, it is a situation when you fell very vulnerable and it's quite scary and ultimately she just need to know that you're there holding hand. You know, bottom line, that's what all women need. They just need that 'You're going to be alright' kind of thing. That would be my advices… to just be there every step of the way and to just listen and support. (W1-HOME-OU)

Making the woman feel everything is normal, she is doing well, she is in safe hands and having a positive attitude are other advice given by some participants. In the case something deviates from normality, one interviewee would suggest the midwife to deal with critical situations professionally, remaining in control of the situation and not letting the woman or her birth partner(s) panic:

Making them feel like everything is… this is a normal procedure, this is supposed to happen, you're doing well, probably being positive. (W2-OU-OU)

Making them feel that they're in safe hands and it's okay and they're being looking after and it's all going to be okay. And when things happen 'Yes this is normal, this is okay, things are going on alright'. That sort of things. And if there's a problem […] you need somebody that even though they might be thinking 'Oh, God, this isn't good!' they can't let that come across. […] And dealing with things professionally. (W4-FMU-OU)

After having reported the negative language / behaviour of their midwives (see heading 5.2.6), these two interviewees would advise to think about the impact of what is said and listen to the woman,

respecting and supporting her decisions rather than convince her otherwise based on hospital procedures:

> *Think how you say things to people, think about the impact of what you say, that you don't necessarily think.* (W3-OU-OU)

> *Listen more to the lady and respect her […]. Respect their decisions and support them in their decision, not try to convince them otherwise.* (W2-HOME/FMU-OU)

One participant believed that there is nothing that should be advised to midwives because it is assumed they already have the attitude of being good:

> *I think if they wanted to be a midwife, they're already going to have the attitude of being a midwife so there's not really anything that you can tell them to do.* (W6-FMU-OU)

5.3 REFLECTING ON THE BIRTH EXPERIENCE, THE CARE PROVIDED AND THE PLACE OF BIRTH

When the women reported their satisfaction with the childbirth experience, they made a distinction between **a)** the birth experience; **b)** the care provided; **c)** the place of birth. The properties of each of these sub-categories are outlined in **Table 5.6** and discussed in the following headings.

CATEGORY	SUB-CATEGORIES	PROPERTIES
REFLECTING ON THE BIRTH EXPERIENCE, THE CARE PROVIDED AND THE PLACE OF BIRTH	THE BIRTH EXPERIENCE	o *Better than expected* o *Worse than expected* o *From disappointment and failure to resignation: a mixture of emotions*
	THE CARE PROVIDED	o *Good care* o *Variable care* o *Room for improvement*
	THE PLACE OF BIRTH	o *Difficulties in comparing places of birth* o *The midwife working in different settings* o *Upset vs grateful for giving birth in an OU: myths to dispel* o *Better care at home and FMUs?*

Table 5.6 Category six - Reflecting on the birth experience, the care provided and the place of birth

5.3.1 The birth experience

Some interviewees evaluated their birth experience as better than expected, especially in terms of duration of labour and management of pain:

> *I thought it was going to be a lot worse. I mean, it's not pleasant but it's bearable. It had only been a half an hour and I couldn't wait to do it again! Can we have another one?* (W1-OU-OU)

> *I had a much better experience than expected. The midwife told me that I was the only woman she assisted that was smiling and laughing throughout all her labour.* (W1-FMU-FMU)

> *It's been a really good experience and I had, as much as labour can be a good thing, the most amazing labour ever! I was very very happy actually with the whole labour. [...] I think I knew*

beforehand the kind of labour I wanted and I was just very lucky that I ended up getting that kind of labour. […] I think I'd say it was such a nice experience and I was really suddenly surprised by what a nice experience it was. (W3-FMU-FMU)

On the contrary, other participants recounted their labour and birth as more painful and longer than expected; one of them said that she and her birth partner were not able to use the pain relief alternative techniques learnt during pregnancy (e.g. yoga postures and hypno-birthing techniques). These ambivalent perceptions recall the property 'every woman is different' (see heading 4.1) emerged from the interviews on expectations conducted before birth:

It was more painful than expected [laughing]! But I don't think you really realise how painful it's going to be. […] I was just glad when they got her out [laughing]! (W2-FMU-OU)

To be fair, I thought it would have been like 'Oh, yeah, I'm in labour, let's go to the hospital, right, have this baby, right, let's come home'. That's originally what I thought but no, like I said I had contractions for ages until actually I had to go to the hospital. […] Well, I knew what was going to happen and I knew there's pain involved but I didn't actually grasp how… because normally I deal with pain quite well so I thought I would have been fine and I did cope okay with the pain but I didn't realise how strong it could actually be. (W6-FMU-OU)

During the labour I did my yoga breathing but I didn't do any yoga postures because it was just too painful to move so I was just on the rocking chair for a lot of the time. And I know if I could have been more active I think it would have helped. And the hypno-birthing I think it helped at the beginning up to about 6 centimetres and then the only other time it helped I think it was when I had suddenly stitches and I was kind of went to a bit of a zone. As it's

said on the cd, it just flies out, it's a sensation, it's not a pain… for me that didn't happen, it was just terrific pain! (W4-FMU-OU)

In regard to the fact that the labour they were experiencing was not meeting their expectations, a couple of women reported a mixture of emotions, from disappointment and failure to resignation. One interviewee argued that she tried her best to get the kind of birth she wanted, even though she ran out of options through labour, realising later that she was never going to have what she was expecting:

Obviously I was hoping that I would have a natural birth […]. So obviously I've tried everything that I could to have a as calm, peaceful, natural birth as possible but as it turned out… everything that we've tried before had failed […] because he was just basically in the wrong position, he was brow presented so everything I tried didn't work which was obviously frustrating for me but you understand it all afterwards because that makes sense. [...] It sounds like you can feel a bit of a failure in a way because you've not being able to deliver it naturally. […] So a mixture of emotions. Disappointed, you kind of feel a bit like you've let yourself down and let him down, but then ultimately just overjoyed that he's here and everything is fine and he's gorgeous. [...] As far as the birth was concerned, I guess I'd tried my best to get the kind of birth that I wanted but ultimately I was never going to get that because he was just the wrong way around. […] I wanted the homebirth but when you look back it was never ever going to happen. […] I was given options but ultimately the further I got through the labour, the narrower those options were because you just run out of options. (W1-HOME/FMU-OU)

I think my labour was the way it was and we couldn't change that. Yes, I know that labour and childbirth is meant to be the most

natural process ever but we needed to be monitored otherwise we didn't know what was happening with him. (W4-FMU-OU)

5.3.2 The care provided

As for the birth experience, the women evaluated the care provided by the midwife in different ways. The majority of participants considered the care received excellent and better than expected. The interviewees related the high standard of care provided to several factors, such as the midwife's qualities and competencies, the low number of births occurring at that time and the excellent monitoring in case of a high risk birth:

Higher than my expectations. […] Because of the midwife, more than anything. […] I just had exactly what I wanted, she was lovely, she was bubbly, friendly, anything I could have asked for. (W2-OU-OU)

I am glad I went into labour at that time as well because the hospital was dead. We had amazing service because there was only twelve or it was quite a low number anyway of birth. […] I wouldn't change anything! They were brilliant, they were all amazing. (W1-OU-OU)

[The care was] very good. […] I just felt like I was really looked after and that at no point it was me or my baby compromised. […] I think because it was like a risky delivery they were absolutely brilliant, they didn't leave us and we were in a nice private room, we had one midwife with us at all times. […] I couldn't have asked anything different during the delivery, they were excellent. (W4-FMU-OU)

The care was to a T really. […] Everything that needed to be done, was done! Everything was spot on. (W6-FMU-OU)

I know that they see different types of people and things like that but they were fantastic! They were very caring, very supportive. And they were really rushed off their feet, they were so busy. And I now there's a shortage of midwives but, to be honest, I've got really good care. (W1-HOME-OU)

The care was defined by the participants as variable in some cases, with the midwife being present and providing support to the woman intermittently (see heading 5.2.6):

[The care was] variable. From the hospital as a whole better, from the midwife specifically worse. Including midwives, once they realised things weren't going to plan and that we needed to take alternative actions they were fantastic! But until that point… (W3-OU-OU)

This woman argued there could be room for general improvement in some areas of maternity care, claiming that in her opinion problems seemed to occur at a NHS level rather than in relation to the single midwife or the place of birth:

I think on the whole it was harder than I expected, I was disappointed I didn't go to the birth centre, I think there are shortcomings with the NHS in terms of the maternity support and services they provide, I think it is a good hospital and I couldn't really fault the care that I received although there are areas that could be improved. […] [The problem is in the system and not in the single midwife]. That's exactly it, yes. I think it's just bound up with red tape and stuck in a system but when it comes down to it, the actual care that I received was very good. And I think there are rooms for improvement. (W4-FMU-OU)

5.3.3 The place of birth

The participants found it difficult to compare different places of birth. As all the interviewees were first-time mothers that did not experience any in-labour transfer, their birth experience was associated with only one setting (in this case, OU or FMU):

> *I can't really say much about the birth centre now because I've not had the experience whereas if I've already had one at the birth centre and then went to the hospital I could have probably compared better.* (W6-FMU-OU)

> *I don't know because I've never seen any of the midwives from other places. I mean for not having been at the hospital I don't really know what that would be like.* (W3-FMU-FMU)

Some women felt that the midwives had all the same skills and experience and had been all trained the same, independently from the birth setting that they work in:

> *From the ones that I've seen at the community site and the ones that I've seen in the hospital, they're all of the same attitude, they're all of the same experiences and obviously they're all been trained the same.* (W5-OU-OU)

One interviewee acknowledged that a FMU is not a busy OU and the dedicated time for the woman may vary accordingly; however, she said that a midwife is a midwife independently from the birth setting:

> *I think that the birth centre isn't a busy hospital so midwives have probably got more time for you. But saying that, there wasn't any one point where I thought 'I'm not being looked after properly'. I always had the same midwife, she didn't rush off anyway, I didn't ever feel like she'd gone to look after someone else and not being with me. I know that some of the midwives at the birth centre are*

perhaps trained in the hypno-birthing and that sort of things, whether that would be any different. But I do know that midwives do transfer between the birth centre and the hospital so I think obviously they are going to have the same skills and that sort of things. Yeah, I think that a midwife is a midwife. (W4-FMU-OU)

One interviewee stated that the difference relies more on each individual midwife rather than the birthplace while another woman argued that the place of birth dictates how the midwife can care for mothers:

I don't know, I wouldn't say that. I'd say it's more on the actual midwife rather than where they work. I'd say, do you know what I mean? They are all individuals so if you're nice, you're nice and if you're not, you're not. (W5-FMU-OU)

I think that the location about where you're having the baby so dictates how the midwife can care for you. So that's why the birth centre was such a big deal for me, it wasn't that I thought that the midwives at the hospital would going to be horrible but I just… I knew that at the birth centre they got the ability to be more relaxed and that's what I was after really. (W3-FMU-FMU)

Some participants that were planning to give birth at home or in a FMU reported to be upset about the fact that they ended up to give birth in an OU, even though it was a decision *out of their hands* and *necessary for the baby's safety*. To them this meant being surrounded by a medical environment interfering with the natural birth they were planning to have:

I was pretty upset because I didn't want to go to the hospital, I wanted to be at the birth centre for my natural delivery and I didn't want to be interfered with… and because they started talking about induction, they seem quite quick to offer an induction and it's

only because me and my husband said 'What are other options? Do we have to have an induction?'… […] I was upset that I had to go there but I had just to say 'Well, I've got to put my baby first and all the facilities that we would need are at the hospital'. And it's a decision out of my hands. (W4-BC-OU)

I still believe that it's because I was in a medical environment and I couldn't relax, that's why I wasn't dilating. So if I was probably in the birth centre in water, nice and calm… I know it's a lot of 'what ifs' but I don't know. […] I couldn't enjoy it because I hated where I was (W2-HOME/FMU-OU)

Other women felt grateful they were in an OU and surrounded by a medical background. One interviewee referred to be less worried because of the presence of doctors compared to being in a FMU with midwives alone:

They made the decision incredibly quickly which I am grateful for because having gone to the birth centre I am not sure he would be here. […] And when they actually they did get him out when they checked the blood gasses […] the registrar said 'Oh Goodness, he was properly into distress, good job that we got him out when we did!'. So I know that it would have made it a lot more difficult having been at the birth centre [...] All the things that we hypothesised came true for him so it was a good job we've made the decision we had. (W3-OU-OU)

Yes, I think I felt less worried because of the presence of consultants at the hospital compared to being at the birth centre with just midwives. [...] (W2-FMU-OU)

Quite a few women that were planning to give birth in a FMU but finally gave birth at the hospital reported their positive experiences

accompanied by some myths to dispel about OUs, such as lack of one-to-one care and continuity of carer due to the ward's workload:

> *[Things that are usually said about the hospital like the business] didn't affect me at all. When we've got there, we went into one ward and I was checked over and then they said 'Yeah, you're ready, you can go to the delivery suite'. And then from the moment I walked into the delivery suite, I met with a really nice lady, she introduced me to one midwife and that was it! I was in my room.* (W4-BC-OU)

> *I haven't experienced it at the birth centre but I don't see how it could have been too different in the sense that I was… if you've got the 2 places of birth [OU and FMU], you've got your room for each place. I would still be in a private room, I'd still have a midwife. Yeah, I think it was very very similar. [...] But then I am saying that with no experience at the birth centre.* (W4-BC-OU)

> *Everything that happened is what I expected the midwife to do. All the midwives that I had were good prior and in labour. They were really good, extremely good.* (W6-FMU-OU)

A fascinating ambivalence was noted between the women's expectations and experiences of birthplaces. On one hand, a participant that chose to give birth in an OU because of the presence of medical support supposed that home or a small FMU are probably the places with the best midwife experience. On the other hand, a person that was planning to give birth at home and then was referred to an OU assumed that being cared by the midwife at home would not necessarily be better; instead, she believed that the care would change according to the options available due to each woman's actual birth experience:

> *Homebirth I think it will be [better] because it would be so focused on you and you have the dedicated midwife there, an experienced*

midwife and it would be so focused. Yes, I think midwife care at home would be absolutely the best that you could have. And I think at the birth centre would be brilliant because there are so few birth that happen there, you get a really focused attention. Would it be any difference if the birth centre is busier? I don't know! I think homebirth… if you wanted the best midwife experience you could have, I think homebirth or a very small midwife-led unit. (W3-OU-OU)

As far as the care is concerned, I don't think that that can be compared really because I think ultimately you still get the same care wherever you are, it's just that your experience and the actual birth itself and the different things that happen are not the same when you end up with a caesarean section compared to having a pool birth at home. But the care will be no different. (W1-HOME-OU)

An interviewee argued that she would not expect the provision of a better intrapartum care at home. In her opinion the woman would probably feel more comfortable but the midwife might not be familiar with the place. The participant identified the labour ward as the *midwives' home*:

No, no. I don't think [you would receive a better care at home] because they're coming to your home. I'd say it's comfortable because you're in your own home, you know where everything is but the midwife doesn't. So it's a bit panicky, it will be unorganised I think. Because if the midwife is coming in here, she doesn't know where anything is, if she wanted anything she'd be like 'Where is this, where is that?'. You know, it's difficult but when you're actually in a hospital, that's their home! You've got your profession held there. You've got other members of staff, you've got all the equipment, you've got everything in the hospital. [You want the

midwife to be comfortable] because you rely on them, you trust them, don't you? You rely on them to do their job! (W2-OU-OU)

Quite a few women believed that a better care would be provided in FMUs when compared with OUs and raised several positive factors related to the model of care adopted in FMUs. These were support for natural birth; establishment of a connection and a trusting relationship with the midwife; one-to-one individualised woman-centred care; possibility of visiting the place beforehand; workload of the unit; familiar and nice environment:

It's more the model of care because they are so supportive of natural birth in the birth centre. But then also is the individual as elsewhere because if you're not supportive of natural birth then you would just tell the person 'Yeah, okay, you're not dilating, we'll take you to the hospital'. Whilst some of them 'Ok, look, you're not dilating, here are the things we can do to give you another hour or two hours'. So they actually give you the options. (W2-HOME/FMU-OU)

Yeah, I think that was the nice thing about the birth centre because it's not many people having babies there I think we were the only people that had their baby there that day. It was really nice and I actually felt like […] we were like a little team really. […] I think they've got the opportunity to sort of to be more one-to-one and be more friendly and get more of a rapport. […] It must be quite difficult I think if you're a midwife somewhere where there's lots of women who are having babies because all the women want your attention all the time. (W3-FMU-FMU)

I'd like to go to the birth centre. I'll always maintain that. The rooms are nicer. You could say more one-to-one care. (W4-FMU-OU)

Because we'd seen this place beforehand… we've been there having a look around… it just felt really relaxed. (W3-FMU-FMU)

5.4 SUMMARY OF FINDINGS (2): EXPERIENCES

The women's experiences are reported as three categories: 1) facing the ongoing unknown: let it happen; 2) reflecting on the experience of the midwife in the light of birth; 3) reflecting on the birth experience, the care provided and the place of birth.

Facing unknown territory was considered by the women as an ongoing condition through the entire duration of labour and birth. The subcategory 'I had a good midwife' refers to the characteristics of the midwives that attended the women's labour and birth that were considered as good by the participants. This subcategory encompasses the same four properties that were presented to describe the subcategory 'characteristics of a good midwife' in regard to women's expectations: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. As opposed to the women that listed the positive attributes of the midwife who provided care during labour and birth, some participants encountered midwives with negative language and behaviours.

Regardless of their planned place of birth, the women interviewed stated that they were not concerned about dealing with a midwife they had never met before. Also, the participants seemed not to be generally disappointed by having been assisted by different midwives during labour and birth.

In the light of their birth experiences, some first-time mothers argued that the midwife's presence was important all the way through in order to reassure the woman on the normality of labour's progression, explaining what was happening, what was going to happen and why.

The labour stages during which the physical and emotional presence of the midwife was much needed were: early labour; towards the end; the pushing stage; when contractions got stronger; in the case of deviation from normality. The most mentioned were the early labour phase and the second stage of labour.

The participants described the midwives as very supportive to the birth companion(s), in terms of getting them involved; talking to them and explaining what was happening; allowing them to ask questions; making them feel relaxed; suggesting them what to do for the woman; guiding them throughout labour and birth; encouraging them to encourage the labouring woman; helping them to enjoy the moment.

The majority of participants considered the care received excellent and better than expected. They felt that the midwives had all the same skills and experience and had been all trained the same, independently from the birth setting that they work in. The interviewees related the high standard of care provided to several factors, such as the midwife's qualities and competencies, the low number of births occurring at that time and the excellent monitoring in case of a high risk birth.

6. DISCUSSION

At the beginning of this chapter, a brief summary of the findings is provided. Relevant findings are then discussed in relation to the existing literature, including the following main topics: supporting the woman's uncertainties; birthplace decision-making; midwife's relationship-mediated being and knowledgeable doing; midwife's immediately available presence and physical presence; respectful handover and midwife's negative language and behaviours.

6.1 SUMMARY OF FINDINGS

The main aim of this study was to explore and explain the process of first-time mothers' expectations and experiences of a good midwife during childbirth in the context of different planned and actual places of birth, in order to answer the first three research questions (*What are first-time mothers' expectations of a good midwife during labour and birth? What are first-time mothers' experiences of the midwife during labour and birth? Does the birthplace influence women's expectations and experiences? If yes - how?*). The main categories explaining the development of women's expectations and experiences are reported in **Figure 6.1** and the process is summarised below.

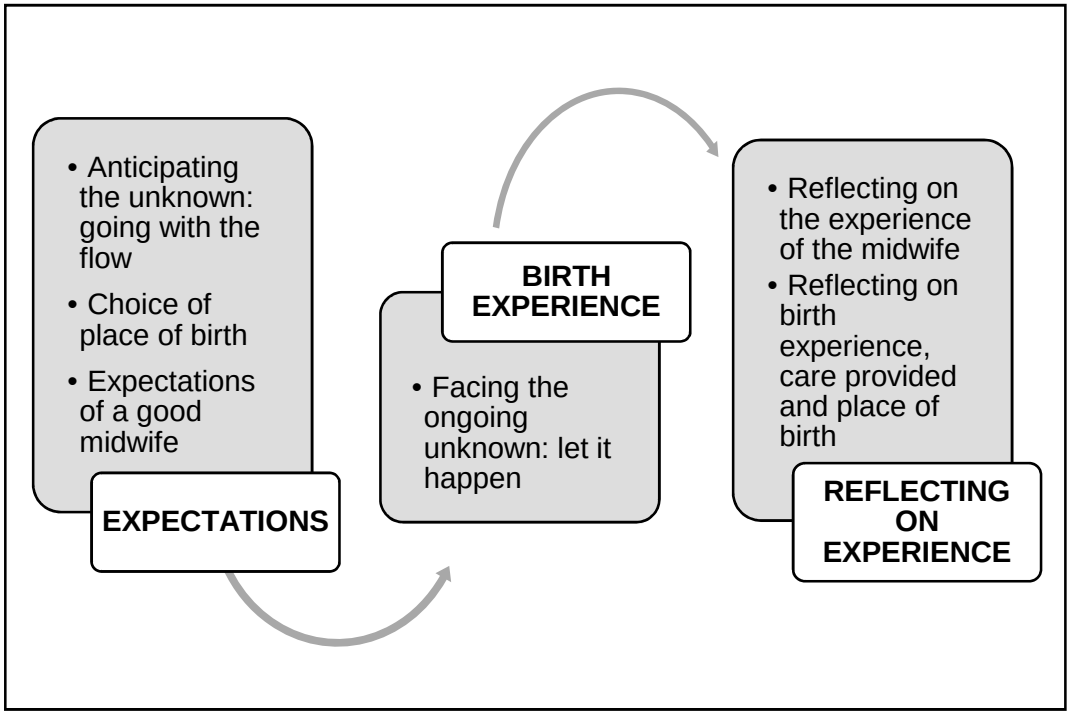


Figure 6.1 Development of first-time mothers' expectations and experiences of a good midwife

Pregnant women acknowledged that labour and birth was unknown territory to them, wherever they planned to give birth. While waiting for this unknown, the women put in place a series of coping strategies: preparing; avoiding; thinking about childbirth as a shared experience; relying on pain relief techniques; considering the birth partner(s) as *voice of reason*. The expression 'going with the flow' was used by the women to describe their open-minded and flexible attitude towards childbirth.

Women thought that there was no difference between midwives practising in different settings, regardless of their planned place of birth; their idea of a good midwife seemed not to influence their choice of place of birth. The choice of the women seemed to be more related to the proximity, to the general atmosphere and environment of the place of birth, to the model of care and to their perception of safety of the birthplace. Women's perceptions of safety varied according to their planned place of birth. Safety was variously defined as: having a

medical backup (OU); receiving a one-to-one, individualised and woman-centred model of care (FMU); having complete trust in the midwife's expertise and ability to deliver their baby safely and in the way the woman wants (home). The women's perceptions of safety associated with FMUs and home clearly highlighted the woman-midwife relationship and woman-centred care as fundamental components of safety.

The characteristics that the women expected of a good midwife were encompassed in four domains: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. When asked to describe the midwife's role, the women talked about duties related to the following spheres of skills: being there; doing nothing; doing checks; delivering my baby; balancing being/doing. The majority of the women did not seem to be too concerned by not previously knowing the midwife assisting their labour and birth. The participants were expecting to meet different midwives due to shifts and they accepted that as long as they are not too many different ones, they have professional competence and are empathic. During a shift handover, the women expected the midwives to behave professionally; this was defined as passing the information/notes and communicating to each other, alerting the woman to the change of shift, treating mothers in a respectful manner, introducing the woman to the new midwife and saying goodbye when leaving. The majority of women did not expect the midwife to be physically present continuously throughout labour. The midwife's presence seemed to be highly valued by interviewees during the transition stage, at the moment of birth and in the first few hours after the birth of the baby.

Facing unknown territory was considered by the women as an ongoing condition through the entire duration of labour and birth. Some women reported a gap between their expectations and experiences. When facing the unknown territory of childbirth, a number of participants

experienced uncertainty in relation to the progression of labour and their ability to cope with pain. To overcome this, the women put in place the following coping strategies: let it happen; relying on professionals; baby will be born one way or another; me encouraging myself and empowered by inner strength.

The participants referred to the characteristics of good midwives that attended their labour and birth. As for women's expectations, the four domains that emerged were: empathic way of being; interpersonal dynamics; personal attributes; professional competencies. The participants believed that the midwives had all been trained and qualified at the same level, regardless of the duration of their professional career. Having children was not seen as an essential characteristic of a midwife, but quite a few women agreed that this may be an added value that could help in caring for labouring women. In the light of their birth experience, a number of participants argued for the importance of having had a midwife with a mixture of personal and professional characteristics. The participants described a good midwife as being very supportive to the birth companion(s). Regardless of the planned place of birth, the women interviewed stated that they did not have any problem in dealing with a midwife they had never met before. Similarly, women seemed not to be generally disappointed by having been assisted by different midwives during labour and birth. In the light of their birth experiences, some first-time mothers argued that the midwife's presence was important from the beginning and all the way through in order to reassure the woman on the normality of labour's progression, explaining what was happening, what was going to happen and why. The participants highlighted the periods of labour during which the presence of the midwife was particularly needed: early labour; the pushing stage; when contractions get stronger; in the case of deviation from normality. The presence of a midwife during the early labour phase and the second stage of labour were featured most strongly. Some participants raised the issue of having encountered midwives who

demonstrated negative language and behaviours. The depersonalising behaviour of the midwife often resulted in the woman feeling dissatisfied with the care provided.

6.2 DISCUSSION OF FINDINGS

The findings of this study highlighted that what women expect from maternity care and experience with their midwives in different places of birth is a complex and multifaceted phenomenon. Data on the women's childbirth journey and on the birthplace decision making are included as they played an important role in contextualising, building and shaping the final model on what makes a good midwife. Gaps between women's expectations and experiences, ambivalence and nuances among the participants' perspectives were identified. This may be due to the fact that childbearing women approach labour and birth from a variety of starting points and with different attitudes and expectations (Raphael-Leff, 2001). Therefore, each individual experience of labour and birth should be considered as personal, subjective and a particular life event; this is situated within specific psychosocial, environmental, organisational and policy contexts that can have a strong impact on the understanding of what women want and what they see as important (Larkin et al., 2009). 'The lived experience of giving birth is a powerful life experience which is coloured by circumstances and expectations of the woman, her sense of self during the journey and the journey itself' (Halldorsdottir and Karlsdottir, 1996a: 48).

6.2.1 Supporting the woman's *embodied limbo*

6.2.1.1 Embodied limbo

The findings suggested that women considered childbirth as a new unknown event, regardless of the planned place of birth. However, it appeared that they had at least a general idea of childbirth as a result of a number of impressions from various sources such as healthcare professionals, family and friends, society and media. Therefore, although women may not have overt expectations about labour and birth, the women's state of mind could be better conceptualised as *embodied limbo* rather than complete unknown of the labour and birth phenomenon. The woman's *embodied limbo* is defined as a period characterised by uncertainty while awaiting childbirth. This state of uncertainty was considered by participants as an ongoing condition through the entire duration of labour and birth. In particular, interviewees stressed their insecurity about emotional and physical reactions during labour and birth. Later, when recounting their childbirth experience, a number of women raised ongoing critical uncertainties in relation to the progression of labour and their ability to cope with pain. Similar to the findings of this research, Dahlen et al. (2010) found that first-time mothers' experiences of birth at home and in hospital were all linked by the common process of reacting to the unknown. Three decades ago, Greer (1984: 12) wrote 'women who want the experience of childbirth are in the curious position of desiring the unknown' and Rubin (1984: 52) argued that labour and birth involve the woman exchanging 'a known self in a known world with an unknown self in an unknown world'. The women's *embodied limbo* often resulted in a gap between expectations and experiences of childbirth.

6.2.1.2 Expectations-experiences gap

The process of approaching their forthcoming birth experience was accompanied by individual expectations and beliefs. A number of participants anticipated during pregnancy that their birth experience might be different to what they were expecting. In line with this, during the follow-up interviews after birth, some women reported a gap between their expectations and experiences. In particular, the interviewees stressed the fact that they did not know what to expect until they were actually in labour and that they reacted to labour in a totally different way to how they were anticipating, for instance in relation to coping with pain. It must be acknowledged that the relationship between the woman's expectations and her actual birth experience may influence the woman's overall satisfaction with childbirth, maternity care and caregivers (Heaman et al., 1992). Although beliefs and subsequent expectations significantly differed between participants, the women whose expectations were met were more likely to be happy with their childbirth experience, supporting data from previous research (Goodman et al., 2004; Hauck et al., 2007). Conversely, when expectations were unfulfilled, maternal dissatisfaction occurred (Tumblin and Simkin, 2001). When expectations were not met, the participants interviewed for this study described feelings of disappointment, failure and resignation, with potentially increased risk of adverse psychological outcomes (Shub et al., 2012). In regard to parity, Hauck et al. (2007) reported that unsatisfactory birth experiences due to unmet expectations may frequently occur in first-time mothers. First-time mothers could develop unrealistic expectations due to several reasons: they have no previous experience of labour and birth; appropriate preparation and information are not always provided; they do not feel supported in readapting expectations to the actual experience; unrealistic expectations are usually not recognised and addressed properly (Dahlen et al., 2010). The difference between unrealistic and high expectations requires clarification. In fact, having

high expectations does not necessarily mean they are unattainable. In regard to this, Green et al. (1990) interestingly found that higher expectations had a positive impact on women's experiences of childbirth, while lower expectations contributed to a worse experience. In the present study, some women adjusted expectations when prior expectations were unfulfilled to avoid disappointment. Accepting changes as a coping strategy can be considered as a beneficial post-hoc adjustment, as highlighted by Parrat (2008) in her theory entitled 'Integrative and disintegrative ways of being'. By doing this, old expectations and ways of being are released, 'making room for new ways of being that are most appropriate to the context' (Parrat, 2008: 48). This is illustrated by the following concept of *going with the flow*.

6.2.1.3 Going with the flow

The findings of this study highlighted that a number of participants expected labour and birth to be easier than it was while others anticipated it to be worse; some mothers were frightened by labour and birth, but for other women childbirth turned out to be a pleasant surprise and not as hard or even better than hoped. In both cases and irrespective of the planned or actual place of birth, a natural consequence of the *embodied limbo* was *going with the flow* in terms of physical perceptions, emotional state and labour events. *Going with the flow* was a recurrent expression that many women used to describe their open state of mind towards labour and birth. This inclination seemed to be in line with the participants' flexibility in regard to their birth plan and openness to change if needed. A woman's state of mind during childbirth may set the stage for her satisfaction with the birth experience. For instance, a mind that remains open and accepts the inner experience is usually accompanied by a more positive recounting of the labour experience (Whitburn et al., 2014). Irrespective of type of

birth and labour related events (e.g. medical interventions such as labour induction or augmentation), the majority of women involved in this research were able to ‘go with the flow’ when felt cared for by a good midwife.

In this study the idea of *going with the flow* appeared to be distinctly paired with the woman’s need for information and advice from the midwife to be in control of her childbirth experience. Although knowledge could be a source of anxiety for women (Melender, 2002), in this case its ability to reduce fear was of greater value. The reassurance derived from information provided on the normal progression of labour helped the women to go with the flow.

6.2.1.4 The midwife’s role in supporting the woman’s embodied limbo

Uncertainties, doubts and fears preceding and accompanying the birth experience have been highlighted by the findings of this study and by a number of other researchers (Dahlen et al., 2010; Elvander et al., 2013; Haines et al., 2012; Laursen et al., 2008; Melender, 2002; Stenglin and Foureur, 2013). Although Howell-White (1999) argued that childbirth satisfaction is influenced more by the woman’s own expectations than by the care received, this research revealed that one of the most powerful influencing factors is the support provided by caregivers, reflecting previous research findings (Beaton and Gupton, 1990; Heaman et al., 1992; Hodnett, 2002). The women involved in this research relied on their midwife as essential provider of trustworthy information, advice and emotional support during childbirth. Similarly, Dahlen et al. (2010) argued that the way first-time mothers’ respond to the state of uncertainty that characterises childbirth is influenced by the mediating factors of preparation, support, communication and information from caregivers. It emerged that participants appeared to be

more satisfied with their labour and birth experience when assisted by caring and supportive midwives that were advocating the woman's individuality, while they showed disappointment when encountered unsupportive caregivers. Moreover, the supportive behaviours of midwives helped the women to evaluate their birth experience as positive even when expectations could not be achieved. Therefore, caregivers may become even more important when childbirth expectations cannot be realised (Hauck et al., 2007).

Although the perception of birth as mysterious event was still present, the findings of this study suggest that women appreciated receiving accurate and realistic information from their midwives starting in pregnancy and continuing during labour and birth to alleviate the uncertainty state typical of the childbearing event. To promote realistic expectations of childbirth and to assist women in meeting their expectations, midwives should listen to the woman and be aware of her wishes. Being aware of and getting to know a woman's expectations during childbirth assist the midwife in her advocacy role (Hauck et al., 2007) and in providing woman-centred individualised care. Raines and Morgan (2000) reinforced the implications of being culturally sensitive when considering women's beliefs and expectations about childbirth. Although commonalities may emerge among mothers' expectations, the cultural meaning placed upon issues (such as pain and pain relief) can generate several discrepancies within childbirth expectations. Discrepancies can occur among women of different cultural backgrounds as well as within the same socio-cultural setting or they may even be present in the same woman at different labour stages. The ambivalences and nuances that emerged from the findings of this research highlighted the uniqueness of each woman's expectations and experiences. For instance, the participants reacted to the uncertainties of childbirth by putting in place different strategies, from preparing and studying to avoiding information about the childbearing event; some women placed greater emphasis on a midwife's personal and

interpersonal characteristics while others on professional competencies. It is essential that midwives recognise these when caring for mothers to support them through uncertainty and promote their individuality. Some women claimed that the birth plan should be revised by the midwife and woman together if they cannot refer any longer to the original one. The midwife should therefore constantly reshape her way of supporting the woman's individual *embodied limbo* in the light of the changes of the woman's needs in the labour continuum rather than offering one-way answers to her initial expectations, in order to create an environment that enables her to move forward despite the uncertainty and the fluctuating gap between expectations and experiences. Midwives should be able to recognise the woman's needs and act accordingly by employing a range of skills related to the various domains of characteristics identified (interpersonal attributes, personal qualities, empathic way of being and professional attributes).

6.2.2 Birthplace decision-making

During the first interview conducted in the third trimester of pregnancy, it was found that the participants had a clear idea of where they wanted to give birth. Overall, they referred to the birthplace decision-making as a choice on a personal level rather than as a decision made together with the partner or the family. In regard to this, recent research established that women usually perceive themselves as the main birthplace decision-makers (Grigg et al., 2014), with choices made generally before pregnancy or during the first trimester (Murray-Davis et al., 2014). The reasons behind the choice of place of birth emerged quite clearly in this study. Some shared general motives across different birthplaces were identified, while specific reasons were referred to by women planning to birth either in an OU, in a FMU or at home.

6.2.2.1 Reasons behind planned birthplace

Regardless of the planned birthplace, the women's decision making on the place of birth was generally influenced by proximity to home, friendliness, cleanliness and tidiness of the birth setting, often referring to recommendations from family and friends. As proximity was highlighted by the participants as one of the main driving factors for choosing OUs, it must be acknowledged that women's choice of place of birth might be directly affected by the variable geographical location, distribution and accessibility of midwife-led units across the country.

Watching TV programmes seemed to influence women's choices in several different ways and resulting either in choosing an OU, a FMU or home as place of birth. The women that mentioned the TV programmes referred to them as providing a negative picture of birth and caregivers. In the current technological era, the power that media and the internet may have on childbearing women should not be underestimated by caregivers. The media have contradictory impacts for women; in fact, although they are often reassured and helped through decision-making, distress might come from watching and listening to negative stories as reported by some participants of this study (Morris and McInerney, 2010).

Grigg et al. (2014) and Murray-Davis et al. (2014) recently found that books and research are generally seen as important sources of information by women when shaping their ideas about a preferred birthplace. The women's expectations of a good midwife were not reported as an influencing factor on the choice of the place of birth, as the interviewees mainly defined all midwives as good by default and independently from the work setting. The participants' perceptions on the differences between birthplaces were rather related to the environment atmosphere and model of care.

Women planning to give birth in a FMU expressed their preference for a home-like, quiet and relaxed setting which would promote normal childbirth and one-to-one individualised woman-centred care. This seemed to be strictly related to the importance of establishing a good trusting relationship with the midwife during labour and birth reported by women and further discussed in heading 6.2.3.1. Similarly, a woman who preferred homebirth wanted to avoid interventions and felt most relaxed in her familiar setting. In regard to this, Walsh (2006: 228) argued that 'intuitive nesting-related behaviours' appeared to be evoked by women in their evaluation of the appropriateness of the place of birth. Proximity, ease of access, environment atmosphere and avoidance of unnecessary medical interference have all been identified as influencing factors among women planning to birth in a FMU or at home (Grigg et al., 2014; Murray-Davis et al., 2014).

6.2.2.2 Safety: medical backup versus individualised one-to-one care and trust in the midwife's expertise

Expectations, beliefs and values about childbirth played a substantial role within women's decisions on the place of birth; however, these seemed to be often balanced with perceptions of safety. Although safety and appropriateness of birthplaces with relative benefits and risks of birth in different settings have been widely debated in recent years (Hodnett et al., 2010; Hollowell et al., 2011; Janssen et al., 2009), there is a dearth of information on what safety of place of birth means to childbearing women. Although the participants of this study declared their preference for a birth as natural as possible with no medical interventions, they reported various perceptions of safety of childbirth in different places of birth, providing a new insight in this area.

The women generally believed that their planned place of birth was the right and safe place for them. Women planning an OU birth conceived

safety as having medical backup readily available if needed. Even though the women planning to give birth in an OU reported to feel safer in the presence of accessible medical staff, they expected to receive midwifery care and make use of consultant care only if necessary. Similarly, Houghton et al. (2008) claimed that women in the north-west of England often assume birth would take place in the hospital environment, feel more at ease when birth occur in a OU and perceive it to be a safer environment. Other evidence suggests that accessing a specialist facility and having access to pain medication were named as the most important factor by women planning a hospital birth (Grigg et al., 2014; Murray-Davis et al., 2014). For women planning a FMU birth, safety meant receiving one-to-one, individualised and woman-centred care. In the context of homebirth, safety was considered as having complete trust in the midwife's expertise and ability to deliver the baby safely and in the way the woman wants, as if the competence and presence of the midwife would create a 'safe haven' at the woman's own home, characterised by the midwife's 'safe hand', 'caring approach' and 'peaceful presence' (Sjöblom et al., 2014: 100). Whatever the planned place of birth, 'the mother needs to feel safe and protected and so the birthing place must be perceived as safe and welcoming' (Moberg, 2015).

6.2.2.3 Should midwives consider planned birthplace as marker of a woman's attitude towards childbirth?

The choice of the place of birth and the perception of its safety seemed to reflect some women's expectations and attitude towards childbirth. For instance, in this research it was observed that the woman's perception of safety of childbirth played an essential role in the birthplace decision-making. The planned place of birth was found to have an influence on some women's expectations of the midwife's role

and characteristics. In particular, women planning an OU birth seemed to be more focused on the 'doing' tasks of the midwife when compared with participants planning a FMU or home birth. In regard to this, the women that choose an OU as birthplace appeared to be more concerned about complications that may occur during childbirth and often reported the eventuality of something going *wrong*, which appeared to be the main reason for wanting a medical backup readily available. However, this decision seemed to be due to a greater sense of safety rather than going into labour with the pre-set idea of resorting to medical interventions.

Authors have often associated women that choose FMUs and home birth with more non-technological approaches to childbirth (Van Der Hulst et al., 2004) and greater desired levels of choice and responsibility within the childbirth experience (Cohen, 1981; Coxon et al., 2014; Dahlen et al., 2010; Fullerton, 1982; Hodnett et al., 2010; Neuhaus et al., 2002) when compared with women planning to birth in hospital settings. Viisainen (2001: 1109) suggested that 'two competing cultural models of childbirth, the biomedical/technocratic model and natural/holistic model, mediate women's choices and preferences for the place and caregiver in childbirth'. However, the findings of this study challenge this tendency as even when choosing to birth in an OU, women still preferred to have a natural birth and sought active participation in their birth experience, with control being an essential component of expectations. Moreover, the women's overall perception of childbirth as natural process and the discontent reported following medicalised birth calls into question the idea that medical technology in childbirth seems to be frequently accepted as the norm (Johanson et al., 2002).

Each woman's expectations and approach to birth should be explored beyond her planned birthplace, as these are often influenced by the intersection of various factors as demonstrated by the findings of this

study. Discussing the need to consider the complexity of maternity care, Enkin (2006: 268) wrote: *'*it is not simply the woman or the setting, the attendant or the policies that influence the outcome. Rather, it is the complex interrelationships among these separate elements*'.*

6.2.3 Relationship-mediated being and knowledgeable doing

Although in presenting the findings the role and characteristics of the midwife have been considered as distinct spheres, they are now conceptualised together in the two notions of *relationship-mediated being* and *knowledgeable doing*. These concepts originated from women's expectations and experiences of a midwife's role and characteristics. The present research shows how a midwife's role and attributes are intertwining elements. For instance, a woman that anticipates the role of the midwife as 'being there' or 'doing nothing', may expect that a good midwife would be empathic, establish a trusting relationship with the labouring woman and stay in the background; conversely, a person that is anticipating the role of the midwife as 'doing checks' or 'delivering my baby', may expect that a good midwife would have mainly excellent clinical skills and professional knowledge. The integration of a midwife's role and characteristics can be explained by Hunter et al. (2008: 134) who observed that different elements of care are often 'interwoven and interlinked, like threads in a tapestry' and therefore 'it is not possible to address any one in isolation'.

6.2.3.1 Relationship-mediated being

In the context of the study findings, the notion of *relationship-mediated being* is defined as the combination of a midwife's being role and her

personal, interpersonal and empathic characteristics. *Being* is identified as the provision of both emotional and physical presence by the midwife. The *relationship-mediated* component indicates the midwife's ability in using her personal and interpersonal resources to establish a relationship with the woman as a basis for providing the support needed.

The participants placed great emphasis on the importance for a midwife to 'be there' with the woman and 'do nothing' unless needed. Due to the multidimensional way of being with the labouring woman highlighted by the findings, it is acknowledged that 'being there' encompasses both the emotional and physical levels (Dickson, 1997). The majority of characteristics attributed to a good midwife by the interviewees was related to emotional and informational support, confirming previous data from a survey undertaken among North-American nulliparous pregnant women concerning their perception of the midwife's role during childbirth (Tumblin and Simkin, 2001). Some women that gave birth in OUs interviewed for the present research perceived that their midwife spent little time providing physical comfort, emotional and informational support, confirming that the issues raised by authors in the 1990s about provision of sensitive intrapartum care are still relevant today (Beaton and Gupton, 1990; Gagnon and Waghorn, 1996; McNiven et al., 1992).

The midwife's role of 'being with' or 'being there' appeared to be connected with the notion of 'doing nothing'. Similarly, Kennedy (2000) described the midwifery art of 'doing nothing well' while supporting the normalcy of childbirth. Supporting the perception of a midwife's role of the women involved in the present study, the midwives' ability to do nothing is defined by Kennedy (2000: 12) as 'being present with the woman, intervening only when necessary'. Some women in the current research argued that they expected a good midwife to stay in the background and maintain the right amount of distance during childbirth. In regard to this, Leap (2000: 2) argued that the less the midwives do,

the more they give to labouring mothers, suggesting an approach that ‘minimises disturbance, direction, authority and intervention’ and ‘shifts power towards the woman’. Similarly, Carlson and Lowe (2014: 518) refer to ‘watchful waiting’ defined as ‘providing calm, non-invasive therapeutic support to a woman in labour’. In fact, although a midwife is involved in caring for mothers during childbirth, involvement does not always mean activity. The ideal attitude of a midwife was described as ‘masterly inactivity’ (Haraldsdottir, 2007), where the key element is the disposition of ‘being with’ combined with the wisdom/intuition to know when to act. ‘Masterly inactivity’ does not mean passivity but an alertness and receptiveness to the nuances of the situation.

The women of this study expected and valued a midwife with an empathic way of being and good personal qualities. These are conceptualised as *relationship-mediated* attributes. In the light of their childbearing experience and independently from the actual place of birth, the majority of participants emphasised the importance of establishing a trusting reciprocal relationship e.g. getting to know the midwife’s own life and personality thus transgressing traditional client-professional boundaries considering it as more important than knowing the midwife before labour. Similarly, Halldorsdottir and Karlsdottir (1996a) identified the women’s desire of a good relationship with the midwife during childbirth and Dahlberg and Aune (2013) highlighted the quality of the woman-midwife relationship as a very important factor facilitating mutuality and trust during childbirth. From some women’s perspectives, it appeared essential to create a two-way encounter, where both the midwife and the mother were sharing their views and experiences. The satisfaction of the women interviewed for this study seemed to be mainly related to the relationship established with the midwife during childbirth, rather than the place of birth, continuity of carer, medical interventions or maternal and neonatal outcomes. Therefore, the findings reflect that the midwife has the potential to mediate positive childbearing women’s experiences. As argued by Fahy

and Hastie (2008: 22), midwives are ‘guardians’ who ‘create and maintain harmony between themselves and the woman and within the birthing room’, with the desired outcome of having a satisfied woman even if the birth is not as she had wished or planned. The conceptual model ‘intelligent guardianship’ developed by Baston (2006: 208) comprises ‘engagement’, ‘perceived competence’ and ‘demeanour’ to provide care that meets the woman’s clinical, emotional and social needs. Although Baston (2006) explored women’s experiences of emergency caesarean section retrospectively (three years after childbirth), some elements of her model are similar to some of the findings of this study. For instance, the interpersonal skills and the manner in which care was given were highly valued by women in addition to the midwives’ clinical proficiency. Jenkins et al. (2014) recently conducted a qualitative study that aimed at investigating the aspects of maternity care considered by women as most important. Overall, first-time mothers seemed to be more concerned with staff and relational issues than facilities, highlighting woman-focused care, staff qualities and provision of information among the most important aspects (Jenkins et al., 2014). Hunter et al. (2008: 136) argue that ‘without good-quality relationships the tapestry of maternity care is compromised and weakened and it is highly unlikely that any new interventions, policies or systems will be effective or sustainable, or that high-quality care will be provided’. Moreover, they raise the urgent need ‘to pay real attention to the significance of relationships, and consider how best these can be developed, nurtured and sustained’ (Hunter et al., 2008: 136).

The interviewees also indicated that a good midwife should use her *relationship-mediated being* to support, involve, inform, respect, and reassure the birth companion(s) as well as the labouring woman. As reported by the interviewees in this study, first-time fathers often feel apprehensive and anxious during childbirth, principally due to their emotional involvement (Chandler and Field, 1997; Finnbogadóttir et al.,

2003; Premberg et al., 2011), struggling to find a role in the labour room (Longworth and Kingdon, 2011). Fathers, when present during childbirth, expect to be supported as part of the labouring couple (Bäckström and Hertfelt Wahn, 2011; Darling, 2011; Draper, 2002; Hildingsson and Haggstrom, 1999). In particular, the participants of this research reported that the birth partners expected and valued receiving support during childbirth from a midwife who should be respectful to them, explain what is going on and keep them calm and confident. Bäckström and Hertfelt Wahn (2011) found that fathers perceived having received support during their partner's labour when they were allowed to ask questions, had the opportunity to interact with both the midwife and their partner and when they could choose their level of involvement. If fathers are not considered, they may feel helpless, resulting in a sense of panic that could undermine their supportive role as birth partners (Bäckström and Hertfelt Wahn, 2011). Both the findings of this and previous research highlight that a good midwife should promote the involvement of fathers and/or the woman's significant others in the labour room as part of their *relationship-mediated being* role.

The participants of this study highly desired and valued a midwife's 'being' role, personal qualities and interpersonal attributes. The capacity of the midwife to establish a good trusting relationship was seen as pivotal by women. Therefore, the findings support the importance of the midwife nurturing the *relationship-mediated being* concept. The thematic analysis undertaken before this research similarly identified that childbearing women emphasised the midwife's presence; the establishment of a trusting relationship; the provision of supportive and individualised care, appropriate information and possibility of choice (Berg et al., 1996; Brown et al., 2009; Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994; Walker et al., 1995). Fahy (1998: 15) argued that 'being a midwife […] means re-humanising childbirth for women and for families […] putting our emphasis on being supportively,

attentively, with woman rather than doing anything to them at all'. According to the findings of the present study and contemporary literature, it is acknowledged that *relationship-mediated being* should be put 'at the heart of maternity care' (Campling, 2015:15) and considered as a central concept in caring for women in labour (Hunter, 2002; Kennedy, 1995).

6.2.3.2 Knowledgeable doing

As opposed to *relationship-mediated being* and in addition to the emotional and informational support highlighted by the thematic analysis about what childbearing women generally value in a midwife (see heading 2.7), the concept of *knowledgeable doing* emerged in this study. It is defined as the combination of a midwife's doing role and professional competencies. *Doing* is identified as the provision of clinical tasks by the midwife. The *knowledgeable* element designates the midwife's adequate theoretical knowledge, capability and expertise to provide labouring women with good clinical care during childbirth.

When asked about their perceptions of a midwife's role, the participants talked about duties related to doing checks, monitoring the labour progress and delivering the baby safely. Although women considered birth as a natural process, those that were planning to give birth in an OU identified the midwife's role as doing checks on her, her baby and the labour progress. Although the majority of women seemed to be reassured by the midwife checking to safeguard the mother's and baby's health, flexibility in approach seemed to be also important to them. In regard to the midwife's role of delivering the baby identified by the interviewees planning to birth in an OU, few women appeared to refer to birth as a midwife's task. Rather, it was a personal achievement (Jordan, 1993). Although from these findings it seemed that divergent levels of responsibility were accepted by women planning to birth in

different places, the majority of them sought for active participation in their birth experience regardless of the birthplace.

Professional competencies seemed to be more valued by some pregnant women planning to birth in an OU, with emotional support delegated to the birth partner(s). This may possibly be associated with both the women's perception of safety of the birthplace and the busyness of the midwife. In the light of their birth experience, the midwife's professional skills were considered as essential for the majority of women during crucial moments or in the case of deviation from normality, in relation to the labour phase and to eventual interventions required. Professional skills were often taken for granted by the participants of this study because of the completion of the mandatory training, regardless of the years of experience. In regard to the attributes of *knowledgeable doing* that emerged from the conceptualisation of findings, Byrom and Downe (2010) argue that clinical skills, competence and experience are considered by midwives as part of a fundamental professional base. As highlighted by the present research, Halldorsdottir and Karlsdottir (1996b) found that when the midwife was perceived as highly capable and self-confident, the labouring woman was usually instilled with greater confidence.

6.2.3.3 Complementary roles and characteristics

From an historical viewpoint, the importance of a midwife's *relationship-mediated being* can be recognised in the characteristics required to be a good midwife in the past (see heading 2.4), for instance in the sympathetic disposition of the traditional midwife (Tempkin, 1956) or in the tender compassion of the 18th century midwife (Mayes, 1930). It appears that the midwife-woman relationship has always been one of the cornerstones of good midwifery care. If compared with the midwife's being role, the importance of theoretical knowledge and professional

skills came later in the history of midwifery practice, from the beginning of the ninetieth century, when the first schools for midwives were instituted (King, 2012; Nuttall, 2012).

The findings emphasised the tension between professional versus personal characteristics and being versus doing roles required of a midwife, which have been conceptualised as *relationship-mediated being* and *knowledgeable doing*. In the context of this research, the concept of *relationship-mediated being* encompasses the idea of emotional intelligence, personal qualities and communication skills while the notion of *knowledgeable doing* embraces the midwife's theoretical knowledge and skilled competencies. The connection and complementarity of these two elements emerge quite strongly from both the findings and the literature. The importance of balance between *relationship-mediated being* and *knowledgeable doing* was advocated by a number of participants, highlighting that a good midwife should emphasise her being role, communication skills and personal qualities in combination with her doing role and professional competencies. The 'Compassion for practice' report (NHS, 2012) demonstrates the importance of the complementarity of competence and compassion when caring for service users, highlighting the six enduring values and behaviours that should underpin health care, known as the '6Cs': care; compassion; competence; communication; courage and commitment. Similarly, the NMC Code for nursing and midwifery practice (2015) refers to both professionalism and individualised compassionate care. The four topics on which it focuses are: prioritise people; practise effectively; preserve safety and promote professionalism. Guidance is provided including how to treat people with compassion; how to ensure the holistic needs of people; how to consider people as individuals and uphold their dignity; how to listen to people and respond to their preferences and concerns (NMC, 2015). The recommendations of the Francis' (2013) report also reinforces the importance of compassionate, considerate and respectful care beside professional competence.

Whilst the literature review carried out at the commencement of this research drew on the perspectives of a range of participants, it was identified that theoretical knowledge and professional competencies are seen as a basic requirement for midwives, but other crucial characteristics are needed in order to make a good midwife, such as personal qualities, communication skills, moral values, going beyond the call of duty and having emotional intelligence (Byrom and Downe, 2010; Carolan, 2010; Carolan, 2013; Halldorsdottir and Karlsdottir, 2011; Nicholls et al., 2011; Nicholls and Webb, 2006). In regard to this, Byrom and Downe (2010: 126) talked about the importance of having 'emotional intelligence' beside 'skilled competencies', with the first being increasingly recognised as key quality for healthcare professionals. Emotional intelligence is defined by Coleman (2008) as the ability to recognise one's own and other persons' feelings, to distinguish between different emotional states and label them properly, and to use emotional information to guide thinking and behaviour. Nicholls and Webb (2006) pinpointed the difference between a competent and good midwife, suggesting that a good midwife should possess more than practical skills and that being compassionate and caring is the added dimension of being good. Although some women seem to place greater importance on the midwife's *relationship-mediated being*, it is apparent that some mothers' and midwives' perspectives of a good midwife are analogous while others are dissimilar, creating a mismatch between the two. For instance, from previous research that included professionals' perspectives, having moral values and good inter-professional communication were raised as essential characteristics of a good midwife (Carolan, 2010; Halldorsdottir and Karlsdottir, 2011), but this was not mentioned by the women interviewed for this study.

Fraser (1999) found that women desired a special relationship with the midwife and considered her both as friend and knowledgeable professional. In the findings of the present study and in the literature, discontent was expressed by women when the balance mentioned

above was not present and midwives concentrated more on clinical tasks rather than on 'being' with them (Kirkham et al., 2002). None of the interviewees reported a lack of professional knowledge (reinforcing their belief in the midwives' competency) or difficulties related to an excessively friendly midwife (emphasizing the importance of a midwife's *relationship-mediated being*).

Pregnant women that chose FMU or home for birth placed more prominence on personal qualities, interpersonal dynamics and empathic way of being while women planning to birth in an OU seemed to value more the midwife's professional competencies. However, it was overall observed that the participants were satisfied with their childbirth experience when they encountered a midwife with balance between characteristics and roles related to *relationship-mediated being* and *knowledgeable doing*, regardless of the place of birth. Midwives are therefore encouraged to establish a flexible relationship with women during childbirth, harmonising the spheres of *relationship-mediated being* and *knowledgeable doing*.

6.2.4 Immediately available presence and physical presence

6.2.4.1 Immediately available presence in the labour continuum

Many studies have reported that the midwife's constant presence in the labour room is an important aspect of support (Probst et al., 1994; Tumblin and Simkin, 2001) and the notion of continuous support has become an established requirement of gold standard maternity care (Cumberlege et al., 1993). However, in this study the majority of participants valued more a midwife 'being there' for them if needed, thus being intermittently present, once an initial trusting bond was established. This type of presence is conceptualised as *immediately*

available presence of the midwife in the labour continuum. Some women seemed also to appreciate a midwife stepping back at times and allowing the couple to be alone. The constant physical presence was mainly perceived by the women as part of the birth partners' role, which are often viewed as the 'orienting agents who would tell the woman what is going on and act as a go-between for her with the hospital staff' (Beaton and Gupton, 1990: 136). Therefore, when continuous presence cannot be guaranteed (e.g. due to the unit's workload), reassurance that the midwife is free of other direct care responsibilities, immediately available if needed and going in and out from the labour room regularly may help women maintain a sense of support. The participants conceptualised the midwife's presence as going beyond the mere physical presence of the professional, including emotional and spiritual levels, as discussed in heading 6.2.3.

6.2.4.2 Physical presence at transitions

Having said that participants preferred the midwife's *immediately available presence* in the labour continuum, the midwife's constant physical presence in the labour room was required by women at transition points. These were identified as early labour (transition between pregnancy and labour); the transition stage (between first and second stage of labour); in the case of deviation from normality (transition between physiology and pathology); the second stage or pushing phase (transition between pushes and birth of the baby) and the first few hours after the birth of the baby (transition to parenthood). Therefore, a good midwife is expected to support transitional moments during labour to help women to cope with the heightened insecurity at these times.

The times during labour when the midwife's physical presence was particularly needed were early labour and the second stage of labour.

However, different supportive behaviours were valued by participants according to different labour stages. For instance, they appreciated a calm and friendly midwife that put them at ease and stayed in the background during the early phase of labour and a more actively involved midwife in the pushing stage. While the midwife is ordinarily present throughout the second stage of labour, the physical presence of a midwife during periods of early labour is less well accepted. An example is given by the recent NICE (2015: 16) guidelines on safe midwifery staffing for maternity settings stating the importance of allowing 'one-to-one care during established labour or more than one-to-one care during established labour if circumstances require it'; the latent phase of labour was not mentioned in the document. This is in contrast with the findings of the present study, which emphasised the importance of the midwife's physical presence and guidance during early labour. Midwives need to be aware that their physical presence is highly valued by women at these particular transition points of labour.

6.2.4.3 Early labour support: ideal and actual care

A number of women that planned or were referred to give birth in an OU struggled to find proper support during the latent phase of early labour. The definition of early labour as a 'time of conflict' between a woman's perceived need to be cared for and the caregivers' conviction that 'best practice means keeping women out of hospital' (Janssen and Desmarais, 2013: 190) offers an explanation for some of the study's findings. While women and partners often seek hospital admission (Cheyne et al., 2007), healthcare professionals tend to avoid women's admission to hospital in early labour to prevent unnecessary medical interventions (Bohra et al., 2003; Holmes et al., 2001; Klein et al., 2003; McNiven et al., 1992). However, without guaranteed home visiting from the midwife, it is not obvious that for women home is the best place to

be in early labour. In fact, this may lead them to look for support elsewhere often coming and going to hospital several times before being finally admitted in established labour (Iannuzzi and Borrelli, 2014). This could be partly due to the need for confirmation of being in labour (Cheyne et al., 2007), as reported by some participants of this study which were uncertain whether their labour had started and also about their ability to deal with it. Therefore, the midwife's role at this transition point should be reviewed. In assessing the woman, it is essential that the midwife understands not only the woman's clinical needs but also her psychosocial condition as feelings of uncertainty pervade much of the women's experiences of first time labour. Midwifery reassurance that labour appears to be progressing normally is a key factor in helping women to cope with the early stages of labour at home (Cheyne et al., 2007). It must be acknowledged that the authors of a large trial conducted in UK claim that home visits during early labour did not reduce operative and instrumental births and did not delay the stage of labour at the point of final admission (Spiby et al., 2008). This means that home visiting may not have a protective effect against the cascade of interventions during labour. However, the presented findings suggest that the physical and emotional presence of the midwife during early labour may have positive impact on women's satisfaction and sense of control during early labour.

6.2.5 Respectful handover

Continuity of carer is defined as 'fewer caregivers, either overall or during pregnancy, or as a known caregiver in labour' (Green et al., 2000b). This concept should be considered as different from continuity of care, which is concerned with the quality of care over time (Gulliford et al., 2006) and includes aspects of co-ordination, access or barriers to

accessing services and the availability of services during all stages of the women's pathway (NICE, 2014).

Regardless of the planned place of birth, the participants of the current research stated that they did not consider it problematic to be cared for by a midwife they had never met before. Having a known midwife during labour was found to be a relatively low priority and there seemed to be no evidence that labouring women who are cared for by a midwife that they have already met are more likely to be satisfied than those who are not. This is supported by Waldenstrom (1998) and Green et al. (2000b) who observed no significant differences in satisfaction between women who experienced and not experienced a known intrapartum carer. However, recalling the idea of 'what is, must be best' (Porter and MacIntyre, 1984: 1197), the women might have expressed a preference for what was actually experienced; therefore, women that had a known midwife may believe that this was very important, while those who did not have a known caregiver could evaluate it as unimportant. Moreover, in regard to the place of birth, continuity of carer may be less central for women planning to birth in a midwife-led unit, where the woman's satisfaction is probably more affected by the carers' attitude, the philosophy of care and the friendly atmosphere rather than by knowing the individual midwife (Waldenstrom, 1998).

The findings of the present study highlighted the importance of the first meeting between the labouring woman and the caregiver, considered as central by Aune et al. (2014). Therefore, the midwife should dedicate enough time to establish a trusting relationship and to inspire confidence in the woman and the birth partner(s). Although this is a time-consuming process, it should be repeated for each midwife that is called to assist the woman when continuity of carer cannot be guaranteed as the 'projection of a confident, self-assured image during initial contacts with the woman and her family will help reassure them that she is in good hands' (Bowers, 2002: 752).

Fraser (1999) and Hanson et al. (2001) debated that changing caregiver can be felt by some women as a source of increased anxiety due to the anticipated difficulty of establishing a new relationship with another midwife as labour progressed. However, the participants of the current research were expecting to meet more than one midwife due to shifts. Although most women would prefer to have the same midwife throughout labour, they believed that midwives being friendly and capable were acceptable alternatives.

At the time of shift changes, women expected midwives to behave properly, passing the information/notes and communicating to each other, explaining the shift change in advance, introducing the woman to the new midwife and treating the mother in a respectful manner. Fraser (1999) observed that women placed great importance on the fact that all the midwives caring for them should know about them and read their notes in detail, after being informed by previous colleagues. The author also reported as essential midwives communicating with them when a change would occur and to introduce the new carer.

In the light of the findings, although a number of authors claim that greater maternal satisfaction and better outcomes are achieved when continuity of carer is provided (Hicks et al., 2003; Hodnett et al., 2013; van Teijlingen et al., 2003), when continuity of care cannot be guaranteed a good alternative may be represented by midwives paying attention to how a handover is done, how information is passed over to new colleagues and how this is communicated to the labouring woman and her significant other(s) present in the room. In other words, a handover should actively involve the mother and the birth partner(s) and be essentially respectful of their needs.

6.2.6 Negative language and behaviours

Women who participated in this research raised the significance of being assisted by a midwife with caring behaviours and stressed the importance of the way in which information is provided to women during childbirth. During the first interviews, participants identified the following attitudes as being undesirable: being procedures and rules' oriented rather than considering individual needs; not establishing a relationship with the woman; demonstrating depersonalised behaviour; just doing her job and routine checks and being quick to go; not staying with the woman for as long as she needs; not listening, nor understanding, nor believing her; using negative language.

Although all participants had high expectations of the midwives and assumed that all midwives are good because they are usually driven by enthusiasm and passion for a special job, some participants of the present study reported being cared for by midwives with negative language and behaviours. The caregivers' attitudes were sometimes considered as dismissive by women who stated that their desires and emotions were not acknowledged. In particular, some participants reported that their individual needs and the pain they were experiencing were not understood or believed by the midwife, especially during early labour. When this is the case, women may feel humiliated and ignored (Eliasson et al., 2008). A few interviewees felt that the midwife was neither professional nor friendly, being there just to do her job and doing only quick routine checks. Inflexibility with procedures was experienced at times, resulting in a 'superficial', 'routinized', 'related to tasks' professional-client interaction mostly controlled by the carer (Hewison, 1995: 75). Fraser (1999) found that some women defined midwives as being more rules oriented rather than considering meeting individual needs and treating mothers as not being clever enough or not having their own opinions.

The impact that midwives' words may have on the woman's experience and feelings is highlighted by both the present findings and in the literature. It is evident that the participants of this study made their own interpretation of the language used by the midwives. For instance, the phrases *you are only in early labour* or *you are not in active labour yet* were interpreted negatively by women and resulted in them feeling discouraged and disempowered. Fenwick et al. (2003: 10) reported that the language used by healthcare professionals was termed by mothers as 'abusive', 'aggressive' and 'misleading', particularly when routine practices were questioned by women. Simkin et al. (2012: 157) cited some examples of caregiver's language that could be easily interpreted as something is deviating from normality, for example 'You're going to be too exhausted to push if you continue that way' or 'You're pushing the wrong way'.

The negative language and depersonalising behaviour of the midwife often result in the woman feeling discouraged from speaking or asking questions (Bowers, 2002; Halldorsdottir and Karlsdottir, 1996b) and dissatisfied with her birth experience (Fowles, 1998). When this was the case in the present study, negative feelings seemed to be related to individual caregivers more than the type of care received. Unless women established a trusting rapport with the caregiver, they seemed to have a tendency to hold back, not listen to what was advised or feel unhappy with the care received. These results are quite concerning as partnership and empowerment are key principles of maternity care provision in England (DH, 2012). Midwives should keep in mind that the caregiver who satisfies a woman's need for caring during labour and birth is more likely to be effective in meeting midwifery care goals than the professional who is perceived as uncaring (Halldorsdottir and Karlsdottir, 1996b). Negative language and behaviours should be therefore avoided by midwives as language and non-verbal behaviours are powerful tools of communication. With this in mind, midwives are encouraged to think of more positive ways to communicate with

labouring women, choosing nonthreatening language that is likely to be interpreted in a positive way without compromising honesty (Simkin et al., 2012).

6.2.7 Definition of (good) midwife

The international definition of ‘midwife’ (ICM, WHO and FIGO) includes the phrase: ‘[…] works in partnership with women to give the necessary support, care and advice […]’. Midwives should therefore be encouraged to reflect the woman-centred care philosophy based on mutual respect encompassed in the definition of midwife. The women interviewed for this study had the opportunity to freely convey their expectations and experiences of a good midwife during childbirth. Their perceptions of the midwives who cared for them during labour highlighted the need to be cared for by a midwife who integrates several roles, behaviours and characteristics with the aim to adapt to each individual woman and labour. Since mothers are the main actors in their childbearing event, their voice should be considered in defining what makes a good midwife. Renfrew et al. (2014) have recently developed a framework for quality maternal and newborn care synthesising findings from systematic reviews of women's perspectives and experiences, effective practices, and maternity care providers. In line with the presented findings, the authors state that ‘supportive [midwifery] care that works to strengthen women's capabilities in the context of respectful relationships is tailored to their needs’ and ‘focuses on promotion of normal reproductive processes’ (Renfrew et al., 2014: 1129).

It would appear appropriate that both relational (*relationship-mediated being*) and professional (*knowledgeable doing*) elements are captured in the definition of a midwife’s role and characteristics, together with the balance between *physical presence* and *immediately available*

presence. Other key components that should be included in the role of a midwife are: *promoting individuality*; *supporting embodied limbo*; *helping to go with the flow* and *providing information and guidance*. All these elements are explained in more detail in the next chapter.

7. THE *KALEIDOSCOPIC MIDWIFE*

In this chapter the process of data conceptualisation is explained according to the chosen methodological approach (grounded theory). The author's reflexive accounts during data analysis and model development are also highlighted. The model named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife' is finally presented in the light of the findings and literature evidence. The harmonisation of the midwife's characteristics, roles and types of presence when providing intrapartum care is discussed, including the following components of a good midwife: *promoting individuality*; *supporting embodied limbo*; *helping to go with the flow*; *providing information and guidance; relationship-mediated being*; *knowledgeable doing*; *physical presence*; *immediately available presence*.[*]

[*] A substantial part of this chapter was disseminated at an international conference:

The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers perspectives of a good midwife. *Normal Labour and Birth Conference*. Grange Over Sands, United Kingdom. 17 June 2015.

7.1 DATA CONCEPTUALISATION

Following the exploration and description of women's expectations and experiences of a good midwife, the findings of the present study were compared with the existing evidence and brought to the next level of data conceptualisation in order to answer the last research question (*How first-time mothers' perceptions of a good midwife can be conceptualised?*). The substantive theory named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife' is the 'end-product' of the further interpretation of findings in the light of existing literature.

Grounded theory approach shaped the representation and presentation of descriptive findings (chapters 4 and 5) and conceptual findings (chapter 7). Categories, sub-categories and properties were brought from a lower level of abstraction, in which case they function as descriptive labels, to a higher level of conceptualisation (Strauss and Corbin, 1998). For instance, references to 'empathic way of being', 'interpersonal dynamics', 'personal attributes' and 'professional competencies' were grouped together under the sub-category 'characteristics of a good midwife'. Similarly, 'balancing being/doing', 'being there', 'doing nothing', 'doing checks' and delivering the baby were all clustered under the sub-category 'the midwife's role'. As grounded theory analysis progressed, analytic rather than descriptive categories were identified, interpreting rather than simply labelling instances of phenomena. For example, the sub-categories 'characteristics of a good midwife' and 'the midwife's role' were finally categorised as 'relationship-mediated being'. Memo writing supported the analytic process (see heading 3.4.7).

After discussion of how the researcher's reflexivity and personal perspective shaped data analysis and conceptualisation, the conceptual model is presented in the light of existing literature and study findings.

7.2 REFLEXIVE ACCOUNTS

Qualitative data analysis is inevitably influenced by a researcher's personal and professional background, cultural beliefs, institutional influences, pre-conceptions and pre-suppositions (Ibrahim and Edgley, 2015; Mauthner and Doucet, 2003). In this heading I will try to illustrate my reflexive accounts during data analysis.

I think my education and professional background as a midwife and researcher has helped me to be fairly open and discard stereotypes, pre-conceptions and pre-suppositions. My personal experience of living abroad in a foreign and multi-ethnic country has also contributed to reshape my system of values and cognitive structure. In the last few years I realised how important is to look at events, people and situations with a flexible mind. Within the present study, I tried to translate these attitudes into openness to data and theoretical sensitivity. This recalls the participants' attitude of *going with the flow*, having expectations but at the same time preserving an open mind about what may happen next. Similarly, during data collection and analysis I remained open to *go with the flow* of ideas, expectations and experiences disclosed by the women I interviewed, trying to limit my pre-conceived thoughts (though I inevitably used my 'midwifery lens' in reading the data).

When building properties, sub-categories and categories from codes, I reflected on the entire stories recounted by women rather than considering individual quotes 'detached' from the woman's expectations and experiences as a whole. According to grounded theory approach, I also constantly compared different incidents within the same and different interviews. In this way, the interview's components were put into context and grounded in the whole data. For example, a woman summarised her childbearing experience as follows:

> *I was concerned that the midwives in the hospital because they didn't know me they wouldn't give me the care, that they wouldn't really be bothered that much because they see so many different women. But they were all brilliant! I couldn't have asked for better care than I got.* (W1-HOME-OU)

The background story of the woman is essential here to understand the 'real' meaning of these words. She was planning to give birth naturally at home with her known community midwife but she actually had a caesarean section in an OU, after a long induced labour during which she encountered five different midwives. These 'behind the scenes' information reveal that the actual place of birth, continuity of carer and type of birth probably did not play such an important role as expected by the woman (and by me!). This tendency was noticed across all the cases, where the relationship established with the midwife tended to be the most important factor in facilitating a good birth experience. By wearing my 'midwifery lens' and having read literature around the influence of the place of birth and the significance of provision of continuity of carer, I would have expected these to be two crucial elements within childbearing women's experiences. In regard to the place of birth, I also anticipated women's general expectations of childbirth to diverge in relation to different planned birth settings. However, all women referred to birth as a natural event, not expecting to require consultant-led care or pharmacological pain relief even when planning to give birth in an OU. They still wanted to be cared for by a midwife and the medical back-up to intervene only if necessary. The fact that I was surprised by these findings made me realise that I may have been judgmental prior to this study and I should not consider the planned birthplace as straightforward marker of a woman's attitude towards childbirth in the future. Although minor differences amongst women planning to birth or giving birth in different birthplaces were highlighted in the findings' chapters (e.g. midwife's being and doing roles), this was the rationale for shifting away from the place of birth

being analytically significant at the stage of data conceptualisation. In terms of the sample characteristics, it is surprising that there were so many changes of birth setting from FMU/home to OU during pregnancy; I therefore acknowledge that the sample of this study may be rather atypical when compared to the general population of first-time mothers.

Although the main focus of my study was exploring and explaining what makes a good midwife, I did not automatically assume participants encountered good midwives during labour and birth by default. Having had a positive experience with their midwife was not an inclusion criterion for the second interview and I remained open to listen to both positive and negative experiences. As I declared that I am a midwife before the first interviews, I acknowledged women may have had difficulties in sharing negative experiences with the midwives. However, this was disconfirmed by quite a few participants recounting midwives' undesirable language and manners.

Disconfirming data and subtleties were sought and highlighted within the findings and discussion chapters. An example of dissonant data is clear in the following quote, where a participant compared the current available pharmacological pain relief techniques with the absence of a good management of labour pain in the past:

> *All the stories back in the day when they just had their baby at their home on the sofa… you think 'God, really?'. No pain relief or anything! So if they can do it then… it's been investigated quite well, there's more things out there to help ladies going into labour, all the pain relief, all the new things that are coming out. One day the baby is just going to be like popping out and you're not going to be able to feel it and 'Here's the baby!'. You don't have to go through any pain […]. It's getting better and better compared to what it used to be like* (W2-OU)

Although this was an isolated incident about this topic and conflicts with other quotes on the 'body's innate ability of giving birth' and the concept of 'going with the flow', it suggests that expectations and experiences are individually shaped around the person concerned. This quote also has some clashes with other quotes from the same woman; this is an example:

> *I want such a natural thing. Your senses I think just change, like everything is so mumsy, you're more proactive, you just know what to do.* (W2-OU)

This made me understand the importance of exploring each woman's preferences and beliefs meaningfully and not superficially during data collection and analysis, similarly to what a midwife is called to do when caring for childbearing women. It also highlighted that expectations and experiences may quickly evolve and change even within the same woman. This reflection had an impact in refining my conceptual model, which at first sight may seem obvious and very generic but it was actually designed keeping in mind the nuances and dynamism needed to address individual women's expectations and experiences of a good midwife in the context of each specific labour.

7.3 THE CONCEPTUAL MODEL

The conceptual model identifies the intrapartum care priorities that enable first-time mothers to feel supported and assisted by midwives who fit the criteria of good during labour and birth across different birth settings. The synthesis of the attributes, types of presence, roles and behaviours of a good midwife included in the model allow the woman to trust that the carer is focused on her as an individual, is competent and conveys respect. If any one of the model's features is absent or underdeveloped, there is the potential for the woman to feel that the

care provided by the midwife was not ideal. Negative language and behaviours that could lead to dissatisfaction with the birth experience and do not contribute to the model are also highlighted. The model is dynamic and woman-centred, operationalised as the midwife's characteristics adapting to each woman's individual needs in the context of each specific labour, irrespective of the birth setting.

The model is represented in **Figure 7.1**. Each side of the external square indicates one of the four pillars of care provided by a good midwife in the labour continuum. The central part of the figure portrays the different coloured sections that form a kaleidoscopic figure, which is the metaphor used to describe a good midwife's characteristics, roles and behaviours. Each coloured section indicates one of the main elements encompassed in a good midwife highlighted by the findings of this study. The central circle includes the labouring woman as she is considered as the starting point for the midwife to balance her characteristics and presence and to shape the elements of intrapartum care on individual needs. The harmonisation and balance between different characteristics and types of presence is pointed out by the arrows between the coloured circles of the kaleidoscopic figure.

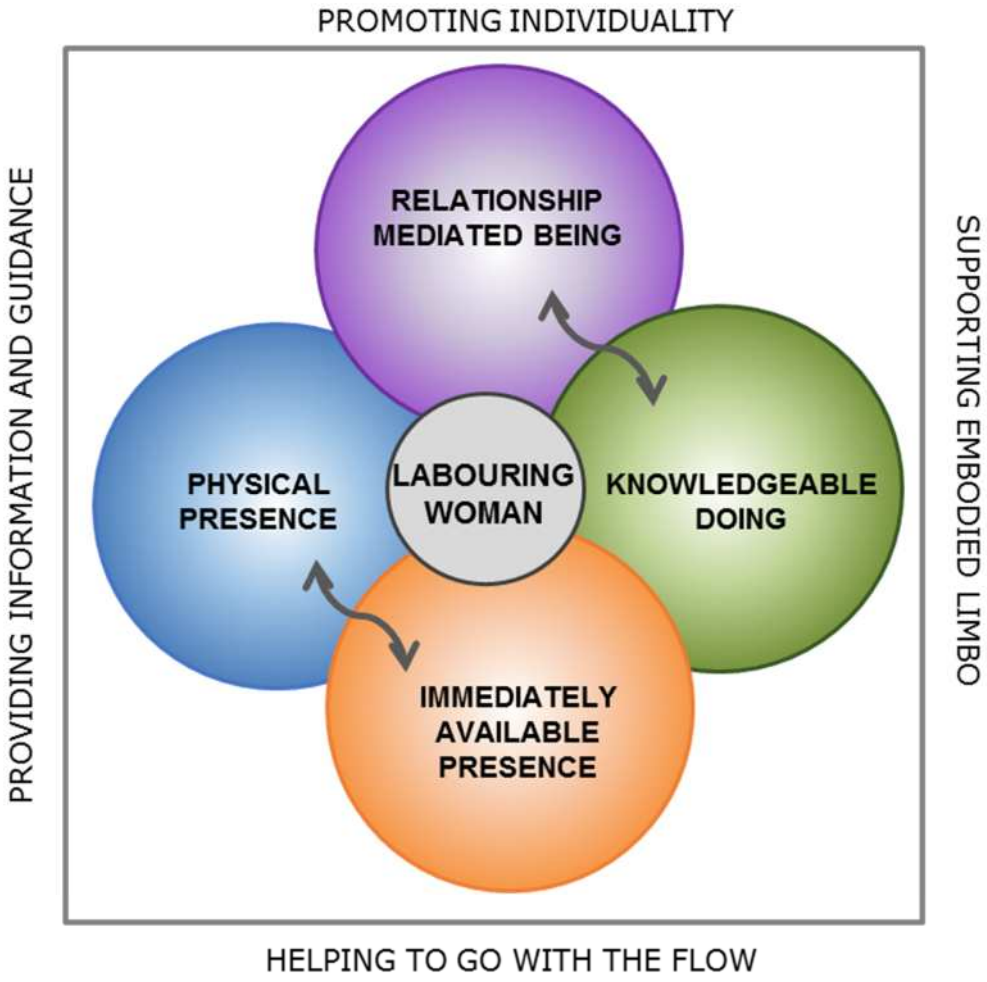


Figure 7.1 The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife.

7.3.1 Pillars of intrapartum care

The four pillars of care that should be provided by the midwife in the labour continuum derive from the identified first-time mothers' needs during labour and birth which were: being treated as individuals; solving their sense of uncertainty about childbirth; being able to 'go with the flow' and receiving accurate information and guidance about the labour progress. Therefore the following elements should be taken into account by the midwife in the labour continuum: ***promoting***

individuality; ***supporting embodied limbo***; ***helping to go with the flow*** and ***providing information and guidance***. These are essential to meet first-time mothers' needs and feelings during childbirth and to maximise the potential of her having an optimal birth experience whatever the setting and the circumstances. As the process of approaching the forthcoming birth experience is inevitably accompanied by personal and subjective expectations and beliefs, the midwife is called to promote individuality by acknowledging the uniqueness of each woman's needs, beliefs, expectations and events occurring during labour (Berg et al., 2012; Fraser, 1999; Halldorsdottir and Karlsdottir, 1996a; Larkin et al., 2009):

> *Getting to know the person, what the person is like. Just having that boundary with your client and making it personal to them* (W2-OU-OU).

> *They don't just talk at you but they listen to what you are saying and they take on board your feelings and what you think and what you like* (W1-HOME-OU).

The uncertainty about childbirth that characterises first-time mothers is ongoing through the entire duration of labour and birth; a good midwife supports the woman's *embodied limbo*, especially in regard to insecurity about the labour progress, and care for her throughout the emotional and physical reactions during childbirth (Haines et al., 2012; McNiven et al., 1992; Seefat-van Teeffelen et al., 2011), including her ability to cope with pain (Hodnett, 2002; Kannan et al., 2001):

> *Because it's my first time I don't know what to expect. It's just all sort of ifs and buts or maybes… until I am there I don't know because I've never done it before* (W6-FMU).

I don't know what to expect and that's worrying. I don't know when it's going to happen and how I am going to handle it. […] That's the worst thing, not knowing (W7-FMU).

As there is often a gap between the woman's expectations and experiences of childbirth, the midwife helps the woman to go with the flow, following the labour events and constantly adapting ideal expectations to the actual birth experience:

I just went with the flow! I just let my body take over and I listened to my body. That's the best advice anyone have ever given me. Because if you fight the feeling I think I would have been more in pain. Definitely, just let it happen (W2-OU-OU).

Helping the woman to 'go with the flow' is paired with providing appropriate information on labour progress and guidance on how to go through the labour journey, supporting her to actively participate in the childbirth experience. The reassurance resulting from information provided on the normal progression of labour is highly appreciated by women (Brown et al., 2009; Dahlen et al., 2010; Fraser, 1999; Kennedy, 1995; Mackey and Stepans, 1994; Walker et al., 1995):

She spoke through everything that was going on, she told me what was going to happen, what just happened, what she could see so she kept me up to date very well (W2-OU-OU).

7.3.2 The *kaleidoscopic midwife*

The metaphor of a kaleidoscopic figure is used for the central part of the model, where the key features of a good midwife that underpin the four pillars of intrapartum care mentioned above are represented. As a kaleidoscopic figure, a good midwife should be 'multi-coloured' and ever changing in the light of the woman's individual needs, expectations and

labour journey (e.g. stage of labour and events occurring during childbirth). In relation to these factors, as a beautiful kaleidoscopic shape is always created as a result of the turning movement of a kaleidoscope, a good midwife is required to constantly adapt her role, characteristics and behaviour to the labouring woman and her childbearing event. The *kaleidoscopic midwife* should therefore constantly reshape her way of supporting the woman in the light of the changes of the woman's needs in the labour continuum, in order to create an environment that enables her to move forward despite the uncertainty and the expectations-experiences gap. The following elements are encompassed by the *kaleidoscopic midwife*: ***relationship-mediated being***; ***knowledgeable doing***; ***physical presence*** and ***immediately available presence***.

7.3.2.1 Physical presence and immediately available presence

For a midwife to engage with a labouring woman, she must provide some ***physical presence***, especially at transitional points such as the early labour phase (Cheyne et al., 2007; Iannuzzi and Borrelli, 2014; Janssen and Desmarais, 2013), the second stage of labour (Anderson, 2000) and the immediate postpartum period (Baker et al., 2005):

> *Initially when you're first going into labour and you don't know what it's going to be like so… You know, when you're first going into labour you're kind of gauging from them 'Is this normal? Is this alright? Am I… is everything okay? And then as long as they check you sporadically through your labour to make sure everything is okay* (W1-HOME-OU):

> *I'd probably say at the pushing stage because that's when it's harder and you start to get a bit worried then. So for them to be there and talk you through it* (W1-OU-OU).

Diverse supportive behaviours might be valued by women according to different labour stages. For instance, they may appreciate a calm and friendly midwife that puts them at ease and stays in the background during the early phase of labour and a more proactive midwife in the pushing stage:

> *She was calm and sat right away watching and when it came the time to do the business they were quite hands on in and anyone knew what to do* (W1-OU-OU).

Once a trusting bond is established between the midwife and the woman, reassurance that the midwife is free of other direct care responsibilities and therefore ***immediately available*** if needed helps the woman maintain a sense of support (Bowers, 2002):

> *I don't think it needs to be with me cause I've got my husband with me so there'll be that support. […] but it would be nice to know they were sort of coming in every once in a while just checking everything was okay. I suppose it's just knowing that they were there just down the hall as well if you needed them* (W3-FMU).

7.3.2.2 Relationship-mediated being and knowledgeable doing

Being physically present in the room with the labouring woman does not necessarily mean that the midwife understands how she feels or what her support needs are. It is the midwife's way of being that accomplishes this explained here as ***relationship-mediated being***. This combines personal qualities, interpersonal attributes and an empathic disposition (Byrom and Downe, 2010; Carolan, 2010; Fahy, 1998; Hunter, 2002; Page, 2003; Pembroke and Pembroke, 2008). It is the *relationship-mediated being* that enables the establishment of a trusting relationship with the woman such that she feels listened to and

understood (Berg et al., 1996; Dahlen et al., 2010; Fraser, 1999; Lundgren and Dahlberg, 2002):

> *Good communication and adapt to the person. Good listener, understanding and give you support* (W4-HOS).

> *It helps when you've got somebody there that […] understands it and is very compassionate and caring towards you* (W1-HOME-OU).

The *relationship-mediated being* includes also a respectful handover between the midwives. The midwife informs and prepares the woman for the shift change and introduces the new midwife to her. Notes should be passed over to the new midwife that is called to establish a new trusting relationship with the mother (Fraser, 1999):

> *[During the change I would expect them] to let me know, I wouldn't want just a midwife to go and not knowing that they've gone. It would be nice if they notify what is going on. Communicate with each other so that they know where and what stage I am at, what's going to happen. Introduce themselves, probably both of them being there at the same time just having a chat with me saying 'I have finished my shift, I am going to swap now, this is so and so'* (W2-OU).

In addition to personal and interpersonal qualities, a good midwife should possess also ***knowledgeable doing*** competencies in order that the woman can be confident in the professional's abilities to provide safe care (Halldorsdottir and Karlsdottir, 2011; Halldorsdottir and Karlsdottir, 1996b; Pope et al., 1998). The *kaleidoscopic midwife* properly interprets knowledge, recommendations and guidelines in the light of each woman's individual preferences. The midwife must also use her professional competence to accept the uncertainty typical of childbirth and employ a behavior of 'watchful waiting' (Carlson and

Lowe, 2014: 514). A certain degree of flexibility, intuition and tolerance of events happening in different ways is needed to do this:

> *A midwife who advises me […] 'how about trying this?', lets me try it and then works with me to say 'ok, how about trying this?' rather than say 'this is what you must do* (W3-OU).

7.3.2.3 Undesirable attitudes

From this research, the following attitudes of a midwife are considered as undesirable and therefore do not contribute towards the model of being a *kaleidoscopic midwife*: being procedure and rule oriented; accomplishing routine tasks as an end in itself; demonstrating incompetence; using negative language; having a depersonalising and unfriendly behaviour and being rushed. These findings reflect earlier research on the topic (Eliasson et al., 2008; Fraser, 1999; Halldorsdottir and Karlsdottir, 1996b; Pope et al., 1998). As opposed to the characteristics of a good midwife, these can be in contrast summarised as the attributes of a robotic, detached, uncaring and unresponsive midwife.

7.4 OPERATIONALISATION OF THE MODEL

Although constantly maintaining the pillars of care in the labour continuum, the *kaleidoscopic midwife* is dynamic and continuously adjusts the balance between *physical presence* and *immediately available presence* for each woman in the context of each specific labour. Moreover, a good midwife aims at harmonising the spheres of *relationship-mediated being* and *knowledgeable doing*. It is important that the *kaleidoscopic midwife* considers all the aspects together to provide care that meets the woman's physical and emotional needs.

The model presented can be used by midwives to pursue excellence in caring for labouring mothers across different birth settings. Independently from the place of birth and mode of birth, when the woman is cared for by a supportive caregiver, it is more likely that she will be satisfied with her experience. Since there are numerous nuances in women's perceptions of a good midwife's role, behaviour and characteristics, midwives should acknowledge that each woman requires first of all the establishment of a positive rapport from which one-to-one individualised care can flow. This is fundamental to improving women's satisfaction with their caregivers during labour and birth. As this is a dynamic model, midwives are called to adapt it to individual women, labour experiences, settings and contexts.

A more detailed operationalisation of the model is included in the next conclusion chapter when recommendations for practice and education are suggested (see headings 8.2.1 and 8.2.2).

8. CONCLUSION

This last chapter reports the conclusions of the presented research. Strengths and limitations of the study are highlighted. The operationalisation of the model is reported within recommendations and implications for practice and education. Future research is suggested.

8.1 STRENGTHS AND LIMITATIONS OF THE STUDY

Whilst some findings of this grounded theory study reflect existing literature, other findings have not been previously identified or have been addressed by few researchers, including the identification of a good midwife's role and characteristics from first-time mothers' perspectives; the midwife's physical presence at different labour stages; coping strategies adopted by women before and during the unknown territory of childbirth; women's birthplace decision-making with particular focus on their perception of safety and the actions to be taken by a midwife during a handover.

The use of semi-structured interviews allowed the exploration of the participants' views, encouraging them to share their main concerns and thoughts while maintaining a focus on the research questions. Individual differences between cases and nuances in the women's expectations and perceptions were identified and highlighted. The broad consideration of women's views of their childbearing experience

allowed the contextualisation of their idea of a good midwife. The participants' main concerns about the midwife providing intrapartum care were captured, together with the influencing factors on their birth expectations and experiences.

Saturation of data was used to indicate when further interactions with the participants were no longer necessary. The sample size was determined by the saturation of concepts, when gathering data did not inspire any new theoretical insight and did not reveal any new property of the core categories. A high follow-up rate was maintained as twelve of the fourteen women that were recruited agreed to take part in the second interview. This might confirm that the participants felt comfortable with the interviewer after the first interview and were willing to share their birth experiences in the second interview.

Although English was not the researcher's first language, no major difficulties were encountered in communicating with and understanding the interviewees. In regard to semi-structured interviews, at the beginning it was challenging to simultaneously listen to what the person was saying, noting interesting issues to further explore and following the interview guide. However, after the first few interviews and suggestions from supervisors, the researcher felt more confident and 'efficient' in conducting interviews. An exercise that helped in this was listening, re-listening and transcribing interviews in order to understand if, how and where further questions could have been asked in order to get the most from the interviewer in the available time.

This research was conducted in two regions in England and three NHS Trusts covering home birth and free-standing midwifery units. In regard to the population characteristics, the study conducted did not include women from minority ethnic groups. Furthermore, women with a pathological pregnancy were not enrolled as they would be automatically referred to an OU for labour and birth and hence would

not have choice on where to give birth. Therefore the applicability of the findings to these groups is limited.

Due to the fact that few first-time mothers usually plan a homebirth, the researcher managed to recruit only a limited number of participants planning to birth at home. Sampling was weighted in favour of women planning to give birth in an FMU. However, five women experienced a change of planned place of birth during the third trimester of pregnancy and no in-labour transfers occurred. Only two women had a FMU birth (compared with ten women who experienced an OU birth), resulting in the difficulty of comparing women's experiences of diverse birthplaces in regard to the data collected with the follow-up interviews after birth. Due to a high transfer rate of birthplace during pregnancy, it was not possible to explore in depth the experiences of women giving birth where they planned to both for home birth and FMUs birth.

8.2 RECOMMENDATIONS FOR PRACTICE, EDUCATION AND RESEARCH

The experiences described by women in this study demonstrated that a number of mothers met midwives they perceived as good during labour and were satisfied with their birth experience. However, some negative experiences suggest that there is room for improvement within the provision of midwifery care in England. Therefore, more work is needed at several levels including clinical practice, midwifery education and future research, in order to facilitate the development of good midwives as main providers of care during childbirth in different birth settings.

8.2.1 Recommendations for practice

The findings of the current study provide useful insights that should be considered when local, national and international maternity care guidelines and protocols are planned and developed.

Accurate and realistic information about labour and birth should be provided to women starting in pregnancy and during labour to address the experience of *embodied limbo*. For instance, this may include talking about all the birth settings, the likelihood of transfer for a woman planning homebirth or FMU birth and likely interventions that might result after transfer (e.g. oxytocin augmentation if transfer is required for slow labour and how this might impact on pain intensity). Midwives should take the time to discuss adjustments in women's birth plans when antenatal or intrapartum transfers are required. These adjustments should be agreed with women and may include practices that maximise birth physiology, given the changed situation. For instance, when continuous fetal monitoring is required, the utilisation of wireless monitors should be offered so that mobility can be maintained. In other words, maternity care provision should be constantly reshaped in the light of a woman's desired birth plan rather than the woman's preferences needs fitting around maternity care policies.

Future maternity care policies should promote the need for women to be cared for by midwives who are able to complement and balance 'being' qualities and 'doing' skills. The kaleidoscopic model developed from this work should be extended to all the birthplaces, including OUs, AMUs, FMUs and home. Practical recommendations include the implementation of monthly clinical case reviews where the midwife's roles are examined and discussed by practising midwives; the development of examples that demonstrate the enactment of these roles and the discussion of exemplars at practice meetings.

Midwives should also be able to alternate physical and immediately available presence in any birth setting, according to when the woman wants the midwife to be in the birth room rather than on the sole basis of when the midwife thinks she should be there. The findings of this study highlighted that labouring women may prefer to have some privacy and time with their birth partners with no interference from healthcare professionals. In order to guarantee immediately available presence, it is recommended that midwives caring for a labouring woman are responsible for providing care only for one client at a time and free of other direct care responsibilities. It is suggested that the midwife goes in and out from the birthing room regularly to help the woman maintain a sense of support, utilising the time outside the room to undertake activities which can be easily interrupted and restarted later (e.g. administrative tasks). However, it is acknowledged that this might be more difficult in busy OUs where task completion and time are key regulators.

Rather than continuity of carer models in the labour continuum, respectful and efficient handovers between midwives were considered as crucial in guaranteeing a high level of continuity of care. Continuity of information at handover must therefore be done in such a way as to maximise information exchange and undertaken in a way that is respectful of the woman and the birth partner(s). It is suggested that the midwife dedicates 15 minutes to sit down with the woman and the new midwife having prompt questions for the woman regarding her needs from the current stage of labour onward with this new midwife. It is recommended that the new midwife dedicates the necessary time to establish a trusting rapport with the mother in a friendly manner, possibly over a cup of coffee or tea if the woman wishes to.

8.2.2 Recommendations for education

The development of the attributes of a *kaleidoscopic midwife* should be promoted and discussed in undergraduate and postgraduate midwifery training and continuous professional education. The values-based recruitment and selection of future student midwives is recommended to ensure that they have good personal qualities and communication skills and demonstrate caring and compassionate behaviours. In order to educate student midwives, it is proposed that midwifery programmes should place more emphasis on the following: ideal exemplars from practice of a midwife's role demonstrating integration of 'being'/'doing' skills and balance between physical and immediately available presence; respectful handover as part of continuity of care; how to develop personal qualities and communication skills to establish a trusting woman-midwife relationship using several teaching strategies (e.g. actors doing simulations of rapport building and use of technology and media in teaching); providing realistic information on choices available to women during childbirth; examples of positive and negative language, phrases and words; clinical placements in different birthplaces. In regard to this last point, it is recommended that all student midwives have a meaningful exposure to women labouring in different birth settings (home; FMUs; AMUs and OUs), also experiencing intrapartum transfers and change of the birthplace previously planned by the woman due to various reasons.

During clinical placements, teachers and mentors should encourage student midwives to develop their 'being' and 'presencing' role likewise their clinical abilities and theoretical knowledge. An example of this might be learning from good role models how to engage in 'watchful waiting' (Carlson and Lowe, 2014) on the rhythms of labour and tolerate uncertainty, rather than repeating vaginal examinations or intervening to speed up labour. In order to facilitate the development of such behaviours, student midwives should be stimulated to participate in the

revision and discussion of case studies from practice illustrating examples of these. This is required in different places of birth as the observant attendance of the midwife could be easier to witness in settings such as midwife-led units or home when compared to OUs. Among other alternative educational strategies, caseloading (defined as a group of women for whom the student provides care and support from early in pregnancy and during the childbearing event) might be an efficient approach to help the development of the student's characteristics aimed at establishing a good woman-midwife rapport as these can be meaningfully 'caught' in action, not taught (McIvor, 2013). It is therefore recommended that all student midwives take part in a number of caseloadings experiences during their educational programme.

8.2.3 Recommendations for future research

The study presented in this PhD thesis raises questions for future research that is necessary in several areas to tease out individual components of the model in a variety of practice settings. The novel elements in the model indicate that it is worth investigating markers of *relationship-mediated being* like 'knitting' in the birth room (Odent, 1996; Pembroke and Pembroke, 2008; Wickham, 2013), 'drinking tea intelligently' (Anderson, 2004) or being 'present yet unobtrusive' (Anderson, 2000: 101). Research is needed to identify the strategies engaged by midwives to use their reflexivity and intuition to be *kaleidoscopic* and what are the factors that may contribute to and facilitate or hinder the midwife's continuous adjustment to the woman's individual needs, expectations and labour journey. Moreover, the exploration of the best ways to support students to develop *relationship-mediated being* during midwifery programmes is needed, including the understanding of whether relationship-mediated characteristics are

easier to be cultivated in particular settings (e.g. home or MLUs versus OUs) or models of care (e.g. caseloading schemes). Beside this, examples of women's *embodied limbo* through the childbearing event from pregnancy to after birth and how midwives can appropriately support these should be further explored. These could be addressed through qualitative designs like ethnography, narrative story-telling and phenomenology.

Potential differences in perceptions between nulliparous and multiparous women at different stages of both physiological and pathological pregnancies and among women from rural and remote compared to urban settings highlight the need to include women with a diversity of experience when trying to understand what makes a good midwife. Further data are needed to understand perceptions of women who are low risk but choose an OU as planned place of birth. Moreover, the data collected for this study did not include the perceptions of first-time mothers who planned to give birth at home and had a home birth and few data were collected from women who chose an FMU as place of birth and had an FMU birth. Finally, it is necessary to look at the expectations and experiences of vulnerable groups (e.g. young women or women from minority communities) particularly in relation to decision-making, support and cultural sensitivity during labour and birth.

The present study suggested that women may look for different levels of presence and attributes of the midwife at different labour stages. More research is needed to further explore the midwife's presence and characteristics at different labour stages, especially at transitional points such as the latent phase, the second stage of labour and the immediate postpartum period. In particular, questions to develop models and to test ideas regarding the early labour stage emerged. A more robust maternity triage system should be designed and dedicated spaces in birth units for women in early labour and their birth companion(s) should be made available. A feasibility and acceptability pilot study should

investigate home visiting during early labour offered by some 'floating' midwives available to be with women wherever they are when they need a carer's presence in early labour, be that at home or on a maternity unit ward.

8.3 CONCLUDING COMMENTS

According to the evidence gaps highlighted by the literature review, the grounded theory study reported in this thesis explored what makes a good midwife from first-time mothers' perspectives in the context of different places of birth. Starting from women's expectations and experiences, the findings were then expressed in a more abstract level in order to conceptualise first-time mothers' perceptions of a good midwife. The central original contribution of this study is the substantive theory named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife'. Implications for practice, education and research have been provided to support midwives in acting as *kaleidoscopic* healthcare professionals during childbirth. Since this is a dynamic model, it has the potential to be adapted to women with various childbirth expectations and experiences labouring in different contexts and birth settings. Although further research is required to confirm this, it is anticipated that the findings of this study may be applicable beyond first-time mothers as women's needs and uncertainties could be similar for subsequent births. Moreover, although this research was carried out in England, it is likely that the recommendations provided have relevance for maternity services, midwifery education and research internationally.

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APPENDIXES

Appendix 1 - Literature search

(good or ideal or exemplar or exper* or competen* or excellen* or optim*) adj5 (midwi* or midwifery care or midwifery practice)*
(good) and (midwi or midwifery care or midwifery practice or maternity care)*
(ideal) and (midwi or midwifery care or midwifery practice or maternity care)*
(exemplar) and (midwi* or midwifery care or midwifery practice or maternity care)*
(exper) and (midwi* or midwifery care or midwifery practice or maternity care)*
(competen) and (midwi* or midwifery care or midwifery practice or maternity care)*
(excellen) and (midwi* or midwifery care or midwifery practice or maternity care)*
(optim) and (midwi* or midwifery care or midwifery practice or maternity care)*
(qualit) adj5 (midwi*)*
(skill or attribute* or attitude*) and (midwi* or midwifery care or midwifery practice or maternity care)*
(support) and (midwi* or midwifery care or midwifery practice or maternity care)*
(essen) and (midwi* or midwifery care or midwifery practice or maternity care)*
(potential or skill or competence* or attribute* or characteristic* or qualit*) and (midwi*)*
(perception or experience* or relationship or encounter) and (wom*n or mother* or parent*) and (midwi* or nurs* or care or lab*r or birth or delivery or childbirth)*
(father) and (midwi* or midwifery care or midwifery practice or maternity care or lab*r or birth or childbirth)*
(potential or skill or competence* or attribute* or characteristic* or qualit*) and (midwi*) and (student*)*
(bad or worse or worst or poor or incompetent or uncaring or lack in competence) adj5 (midwi or midwifery care or midwifery practice or maternity care)*
(bad quality) and (midwi or midwifery care or midwifery practice or maternity care)*
(education or educational strateg* or program* or university program* or university education or selection criteria or selection or post qualification) adj5 (midwi*)*

Appendix 2 - Summary of contemporary papers on what makes a good midwife

PAPER	AIM	DESIGN	SAMPLE	SETTING
NICHOLLS L., WEBB C. (2006) What makes a good midwife? An integrative review of methodologically-diverse research. Journal of Advanced Nursing, 56: 414-429.	Identifying a research-based definition of a good midwife that could be used as an operational definition in research and as a basis for curriculum development.	Integrative review.	33 methodologically diverse research-based papers (1993-2006)	United Kingdom.
BYROM S., DOWNE S. (2010) "She sort of shines": midwives' accounts of "good" midwifery and "good" leadership. Midwifery, 24: 126-137.	Exploring midwives' accounts of the characteristics of "good" leadership and "good" midwife.	Qualitative research, phenomenological approach, semi-structured interviews.	10 qualified midwives (senior and junior grades).	2 NHS maternity departments in England (North West).
CAROLAN M. (2010) The good midwife: commencing students' views. Midwifery, 27: 503-508.	Exploring commencing midwifery students' views of the good midwife.	Qualitative research, demographic questionnaire + written essays (2 open text questions), thematic content analysis.	32 commencing midwifery students.	University of Melbourne, Australia.
NICHOLLS L., SKIRTON H., Webb C. (2011) Establishing perceptions of a good midwife: a Delphi study. British Journal of Midwifery, 19: 230-236.	Investigating what makes a good midwife.	Delphi study, questionnaire.	Postnatal women, midwives and midwifery educators (n=226).	United Kingdom.
HALLDORSDOTTIR S., KARLSDOTTIR S. (2011) The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery. Scandinavian Journal of Caring Sciences, 25: 806-817.	Introducing an evolving theory on the empowerment of childbearing women, where the midwife's professionalism is central.	Theory synthesis.	9 datasets and scholarly work + more than 300 studies reviewed for clarification and confirmation.	Iceland.
CAROLAN M. (2013) 'A good midwife stands out': 3rd year midwifery students' views. *Midwifery,* 29: 115-121.	Exploring third year midwifery students' views of the good midwife.	Qualitative research, demographic questionnaire + written essays (2 open text questions), thematic content analysis.	30 third year midwifery students	University of Melbourne, Australia.

Appendix 3 - Thematic analysis on what women value in a midwife: summary and quality assessment of papers

PAPER	STUDY AIM	DESIGN	SAMPLING	ANALYSIS	INTERPRETATION	REFLEXIVITY	ETHICS	RELEVANCE / TRANSFERABILITY
BERG M., LUNDGREN I., HERMANSSON E., WAHLBERG V. (1996) Women's experience of the encounter with the midwife during childbirth. *Midwifery,* 12: 11-15.	Describing women's experience of the encounter with the midwife during childbirth. Clear focus and purpose, explicit purpose, link between research and existing knowledge NOT stated.	Qualitative phenomenological approach, tape-recorded unstructured interviews 2-4 days after delivery. Brief section about literature review, some literature used to contextualise the findings, rationale given for use of qualitative design and phenomenology, NO discussion of philosophical underpinnings, clear setting.	Purposive sample, 18 mixed-parity women (midwife-led unit birth). Sample and sampling method appropriate.	Phenomenological approach. Analytic approach clear and appropriate.	Poor description of the context, consideration of alternative explanations of the phenomena, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	NO discussion of relationship between researcher and participants during fieldwork, NO researcher's influence on stages of research process, NO documentation of effects of the research on researcher, NO evidence of how problems/complications were dealt with.	Demonstration of sensitivity to ethical concerns, NO recording of ethical dilemmas met.	Poor consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for practice outlined, NO further directions of investigation.

BROWN J., BECKHOFF J., STEWART M., FREEMAN T., KASPERSKI M. (2009) Women and their partners' perceptions of the key roles of the labor and delivery nurse. *Clinical Nursing Research,* 18: 323-335.	Examining the perspectives of women and their partners regarding key roles of the labour and delivery nurse during labour and birth. Clear focus and purpose, explicit purpose, link between research and existing knowledge demonstrated.	Descriptive qualitative study, tape-recorded semi-structured in-depth interviews after birth. Clear literature review, literature used to contextualise the findings, rationale given for use of qualitative design, NO discussion of philosophical underpinnings, clear setting.	Purposive sample, 10 couples (different places of birth). Sample and sampling method appropriate.	QSR International's (2007) Nvivo + further interpretations of the themes by the autors. Analytic approach clear and appropriate.	Description of the context, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	NO discussion of relationship between researcher and participants during fieldwork, NO researcher's influence on stages of research process, NO documentation of effects of the research on researcher, NO evidence of how problems/complications were dealt with.	Demonstration of sensitivity to ethical concerns, NO recording of ethical dilemmas met.	Consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for practice outlined, NO further directions of investigation.
FRASER D. (1999) Women's perceptions of midwifery care: a longitudinal study to shape curriculum development. *Birth,* 26: 99-107.	Enabling views and experiences of local women to influence curriculum development in a large university in England. Clear focus and purpose, explicit purpose, link between research and existing knowledge demonstrated.	Descriptive longitudinal qualitative study, semi-structured and unstructured interviews (in pregnancy, early postpartum period, 2-3 weeks after birth) + data from maternity records. Clear literature review, literature used to contextualise the findings, rationale	41 mixed parity women (hospital birth). Sample and sampling method appropriate.	Textbase Alpha software package and computer database, grounded theory data analysis. Analytic approach clear and appropriate.	Description of the context, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	Discussion of relationship between researcher and participants during fieldwork, researcher's influence on participant's disclosure of negative experiences, NO documentation of effects of the research on researcher, NO evidence of how problems/complications were dealt with.	Demonstration of sensitivity to ethical concerns, NO recording of ethical dilemmas met.	Consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for practice outlined, further directions of investigation.

		given for use of qualitative design, NO discussion of philosophical underpinnings, clear setting.						
KENNEDY H. (1995) The essence of nurse-midwifery care. *Journal of Nurse-Midwifery,* 40: 410-417.	Discovering the experience of the woman cared by a nurse-midwife. Clear focus and purpose, explicit purpose, link between research and existing knowledge demonstrated.	Qualitative, phenomenological approach, semi-structured interviews after birth. Clear literature review, literature used to contextualise the findings, rationale given for use of qualitative design, discussion of philosophical underpinnings, clear setting.	8 mixed parity women (hospital birth). Sample and sampling method appropriate.	Colaiazzi's phenomenological method. Analytic approach clear and appropriate.	Description of the context, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	Discussion of relationship between researcher and participants during fieldwork, researcher's influence on participants, NO documentation of effects of the research on researcher, NO evidence of how problems/complications were dealt with.	Demonstration of sensitivity to ethical concerns, NO recording of ethical dilemmas met.	Consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for practice outlined, further directions of investigation.
MACKEY M., STEPANS M. (1994) Women's evaluation of their labor and delivery nurses. *Journal of Obstetric, Gynecologic and Neonatal Nursing,* 23: 413-420.	Documenting women's evaluations of their labour and delivery nurses. Clear focus and purpose, explicit purpose, link between research and existing	Exploratory qualitative study, open-ended intensive tape-recorded interviews in the postnatal period (0-5 days postpartum). Clear literature review, literature used to	61 Lamaze-prepared, married, multigravidae women aged 21-37 years (hospital birth). Sample and sampling method appropriate.	Qualitative thematic analysis. Few information about analytic approach.	Description of the context, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	NO discussion of relationship between researcher and participants during fieldwork, NO researcher's influence on stages of research process, NO documentation of effects of the research on researcher, NO evidence of how	NO information about ethics, NO recording of ethical dilemmas met.	Consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for

	knowledge demonstrated.	contextualise the findings, rationale given for use of qualitative design, NO discussion of philosophical underpinnings, clear setting.				problems/complications were dealt with.		practice outlined, further directions of investigation.
WALKER J.M., HALL S.M., THOMAS M.C. (1995) The experience of labour: a perspective from those receiving care in a midwife-led unit. *Midwifery,* 11: 120-129.	Elucidating the experience of labour for those receiving any aspect of care in a midwife-led unit. Clear focus and purpose, explicit purpose, link between research and existing knowledge demonstrated.	Qualitative grounded theory, tape-recorded in-depth focused interviews during the postnatal period before discharge or 3-5 months after birth. Clear literature review, literature used to contextualise the findings, rationale given for use of qualitative design, NO discussion of type of grounded theory adopted, NO discussion of philosophical underpinnings, clear setting.	Purposive sample, 32 women, 6 partners, 1 friend (midwife-led unit birth). Sample and sampling method appropriate.	Grounded theory. Analytic approach clear and appropriate.	Description of the context, extensive use of verbatim interview quotes in discussion of findings, clear exposition of how interpretation led to conclusions, clear audit trail given.	NO discussion of relationship between researcher and participants during fieldwork, NO researcher's influence on stages of research process, NO documentation of effects of the research on researcher, NO evidence of how problems/complications were dealt with.	Demonstration of sensitivity to ethical concerns, NO recording of ethical dilemmas met.	Consideration of limitations of the study, results/conclusions supported by evidence, plausible interpretation, the study provides new insights and increases understanding, implications for practice outlined, NO further directions of investigation.

Appendix 4 - Ethical approval

Modified 01/05/2013

NHS
Health Research Authority

NRES Committee East Midlands - Leicester
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839437

23 April 2013

Dr Denis Walsh
The University of Nottingham,
Academic Division of Midiwfery,
School of Nursing, Midwifery & Physiotherapy
A Floor, Medical School, Queen's Medical Centre
Nottingham
United Kingdom
NG7 2HA

Dear Dr Walsh

Study title:	**Women's expectations and experiences of a good midwife during childbirth: the influence of planned place of birth**
REC reference:	**13/EM/0116**
Protocol number:	**13015**
IRAS project ID:	**121323**

Thank you for your letter of 22 April 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Maria Morledge, NRESCommittee.EastMidlands.Leicester@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Modified 01/05/2013

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Advertisement		11 February 2013
Advertisement	1.0	11 April 2013
Covering Letter		22 April 2013

Evidence of insurance or indemnity	Henderson Corporate	25 July 2012
Interview Schedules/Topic Guides	1.0	04 February 2013
Investigator CV	Denis Walsh	
Investigator CV	Helen Spiby	
Investigator CV	Sara Borrelli	
Letter from Sponsor	University of Nottingham	12 February 2013
Other: Participant's Contact Details	1.0	04 February 2013
Other: Second Interview Letter	1.0	11 April 2013
Participant Consent Form	1.0	04 February 2013
Participant Consent Form: first Interview	1.0	11 April 2013
Participant Consent Form: Second Interview	1.0	11 April 2013
Participant Information Sheet	1.0	11 April 2013
Protocol	1.0	11 April 2013
REC application	3.4	05 February 2013
Response to Request for Further Information		22 April 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Modified 01/05/2013

Further information is available at National Research Ethics Service website > After Review

13/EM/0116	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

pp

Keith Lackenby
Chair

Email:NRESCommittee.EastMidlands.Leicester@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Angela Shone*
Dr Samuel Kemp, Sherwood Forest Hospitals NHS Trust

Appendix 5 – Flier for recruitment

ARE YOU A WOMAN EXPECTING HER FIRST BABY?

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

YOU MIGHT BE INTERESTED IN THIS...



Hello! My name is Sara Borrelli. I am an Italian midwife and PhD student at the School of Nursing, Midwifery & Physiotherapy of the University of Nottingham (UK). My supervisors are Dr Denis Walsh and Prof Helen Spiby.

I am conducting a study exploring childbearing women's expectations and experiences of a *good midwife* in the context of different planned places of birth.

If you meet the following conditions...

- **Expecting your first baby**
- **In good general health**
- **Having a straightforward pregnancy**
- **Expecting one baby**
- **Planning a normal birth**
- **Age 18 years or over**

... you are eligible to take part in this study.

Your contribution may help future care for women and professionals!

What will happen if you decide to take part?

You will be asked to take part in two interviews. The first interview will take place from about the 30th week of your pregnancy onwards; the second one will be done 4-6 weeks after the birth. Each interview will last approximately one hour and be conducted by the same researcher (Sara Borrelli). We will organise the time and place for the interview according to what is convenient for you and will usually be at your home or the maternity unit where you are planning to give birth / gave birth.

If you would like further information about the study, please collect the information sheet from the folder near this poster. If you have any question about my research or wish to participate, please do not hesitate to contact me either by email, text or phone. I will be pleased to talk with you.

You could see me around on these days:

CONTACTS

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Women's expectations and experiences of a good midwife during childbirth: the influence of planned place of birth
Poster – Draft 1.1 - Final Version 1.0 – 11 April 2013

Appendix 6 - Participant information sheet

Women's expectations and experiences of a *good midwife* during childbirth: the influence of planned place of birth

PARTICIPANT INFORMATION SHEET

(Draft 1.1 - Final version 1.0 – 11 April 2013)

Name of Researcher(s): Sara Borrelli, Dr Denis Walsh, Prof Helen Spiby

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. You could talk to others about the study or alternatively ask us if there is something that is not clear.

What is the purpose of the study?
This study aims at exploring and explaining first-time mothers' expectations and experiences of a *good midwife* during childbirth. This will be explored in the context of different planned places of birth: home, freestanding birth centre, traditional labour suite. This work is being conducted as part of a PhD.

Why have I been invited?
You are being invited to take part because you are a woman (aged 18 years or over) in good general health expecting her first baby, with a straightforward pregnancy planning a normal birth in one of the places of birth involved in this study (home, freestanding birth centre, traditional labour suite). We are inviting 24-30 women to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?
You will be asked to attend two audio-recorded interviews. The first interview will take place from about the 30th week of your pregnancy onwards; the second one will be done 4-6 weeks after the birth. Each interview will last approximately one hour and be conducted by the same researcher (Sara Borrelli). Time and place for each interview will be agreed with you and will usually be within your home or your clinical site. You will be given the possibility to contact the researcher after childbirth in order

to arrange a suitable time and place for the second interview. Otherwise, you will be contacted by the researcher 2-3 weeks after the birth.

Expenses and payments.
Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?
We do not anticipate any disadvantage or risk in taking part in this research. You will only share what you are comfortable with and will keep the interview confidential.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help future care for women and professionals.

What if there is a problem?
If you have any question you can speak with Sara Borrelli. If you have a concern about any aspect of this study, you should ask to speak to Dr Denis Walsh. The researchers contact details are given at the end of this information sheet. If you remain unhappy after the response you are advised to contact the Patient Advice and Liaison Service (PALS) at XXX.

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant. All information which is collected about you during the course of the research will be kept <u>strictly confidential</u>, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the site will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it. Your personal data will be kept for 12 months after the end of the study so that we are able to contact you about the findings of the study *and possible follow-up studies* (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data. Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

Involvement of the General Practitioner/Family doctor (GP)
It is not necessary to inform your GP about your participation in this project. Therefore, unless requested by you, the research team will have no direct contact with your GP.

What will happen to the results of the research study?
This project is part of a PhD and results will be published as doctoral thesis around middle 2015. Findings will also be presented at conferences and submitted for publication in peer-reviewed journals. A summary of the results will be available to the participants. Anonymity and confidentiality will be maintained in any report.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is a self-funded study.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES Committee East Midlands - Leicester and the respective National Health Service (NHS) Research & Development (R&D) departments.

Further information and contact details

Sara Borrelli
RM, BMid, MSc, PhD student in Health Studies - The University of Nottingham, School of Nursing, Midwifery & Physiotherapy, Room B33, Medical School, Queen's Medical Centre, Nottingham NG7 2HA (UK)
Email: XXX
Mobile: XXX

Denis Walsh
RGN, RM, DPSM, MA, PGDip Ed, PhD, PG Cert (Sup), Associate Professor in Midwifery - The University of Nottingham, Academic Division of Midwifery, School of Nursing, Midwifery & Physiotherapy, A Floor, Medical School, Queen's Medical Centre, Nottingham NG7 2HA (UK)
Email: XXX
Tel: XXX

Appendix 7 - Participant's contact details form

Women's expectations and experiences of a *good midwife* during childbirth: the influence of planned place of birth

PARTICIPANT'S CONTACT DETAILS

(Final version 1.0 – 4 February 2013)

I am happy with the information I received about the research and to give my details to be contacted for the study.

Name and surname…….

Your date of birth……...

Email……....

Telephone…….

Address…….

Expected date of birth ……..

Planned place of birth……..

Date _____

Signature _____

Your contact details will be kept in total security and confidentiality for no longer than 12 months after the end of data collection.

Thank you for your help.

Appendix 8 - Informed consent

Women's expectations and experiences of a *good midwife* during childbirth: the influence of planned place of birth

CONSENT FORM – FIRST INTERVIEW

(Draft 1.1 - Final version 1.0 – 11 April 2013)

REC ref: 13/WM/0083
Name of Researcher: Sara Borrelli
Name of Participant: _____

Please initial box

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that my data collected in the study may be looked at by authorised individuals from The University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. My identifiable data can be removed if I decide to withdraw. ☐

4. I understand that the interviews will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I consent to be contacted by the researcher 2-3 weeks after childbirth to arrange a suitable time and place for the second interview. ☐

6. I would like to have a summary of the study findings (optional). ☐ ☐

7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____

2 copies: 1 for participant, 1 for the project notes

Appendix 9 - Interview guide (first version)

INTRODUCTION Thank the interviewee for the participation; Presenting myself (background as midwife); Establishing a relationship with the woman; Aim of the study and importance of participant's contribution; The interview will be tape-recorded (accuracy for the data analysis and possibility of using quotes).

1ST INTERVIEW

- Definition of a good midwife
- Expectations of a good midwife during childbirth
- Most important attributes of a good midwife
- Professional competencies vs personal qualities
- Place of birth (with links to midwife)

2ND INTERVIEW

- Remind topics of the previous interview
- Experience with the midwife during childbirth
- Gap expectations/experiences of a good midwife
- Place of birth
- Most important attributes of a good midwife
- Professional competencies vs personal qualities
- In-labour transfer / change of place of birth (?)

CLOSURE Thank the interviewee for the participation; After the first interview: info about the second interview; Development of the research and use of data collected; Possibility to receive a summary of findings at the end of the study; Useful contacts.

Appendix 10 - Interview guide (last version)

1ST INTERVIEW

INTRODUCTION Thank the interviewee for the participation; Presenting myself (background as midwife); Establishing a relationship with the woman: background, age, pregnancy, partner…; Aim of the study and importance of participant's contribution; No right/wrong answer, time to answer; The interview will be tape-recorded (accuracy for the data analysis and possibility of using quotes).

MAIN TOPICS

Experience with the community midwife

Labour and birth expectations/concerns (e.g. birth plan, pain relief, normal birth?)

Sources of information on labour and birth during pregnancy

TV programmes / media

Unknown midwife

Midwife with children or male midwife

Continuity of same carer throughout childbirth

Handover

Midwife's role during labour and birth

Midwife's physical presence in the labour room

Definition of a good midwife

Expectations of a good midwife during labour and birth

Professional skills vs personal qualities

Control and choice over labour and birth

What women would NOT like in a midwife

Birth partner's role during labour and birth

Midwife's role in supporting the couple

Place of birth (choice, safety, midwife in different places of birth)

Family and friends' experiences

Anything else to add?

CLOSURE Thank the interviewee for the participation; Info about the second interview; Development of the research and use of data collected; Possibility to receive a summary of findings at the end of the study; Useful contacts.

2ND INTERVIEW

INTRODUCTION Thank the interviewee for the participation; Presenting myself (background as midwife); Aim of the study and importance of participant's contribution; Remind topics of the previous interview; The interview will be tape-recorded (accuracy for the data analysis and possibility of using quotes).

MAIN TOPICS

Woman's experience of labour and birth (a bit…)

Sources of information on labour and birth during pregnancy compared with actual experience

Birth plan and midwife's support

Experience with the midwife during labour and birth

Unknown midwife

Continuity of same carer throughout childbirth

Handover

Midwife's role during labour and birth

Expectations/experience gap (if any)

Midwife's physical presence in the labour room

Stages of labour and midwife's role/presence/characteristics

What did you like of your midwife during labour and during birth?

Can you remember anything that the midwife said that was really important for you?

Information provided + choice and control

What women did NOT like in their midwife (if anything)

Birth partner's role during labour and birth

Midwife's role in supporting the couple

Definition of good midwife

Expectations/experience gap (if any)

Most important characteristics of a good midwife

Professional skills vs personal qualities

Place of birth

Piece of advice for midwives

Piece of advice for first-time childbearing women

In-labour transfer / change of place of birth (?)

Anything else to add?

CLOSURE Thank the interviewee for the participation; Development of the research and use of data collected; Possibility to receive a summary of findings at the end of the study; Useful contacts.

Appendix 11 - Memo development

MEMO 16 - 07 October 2013

SOCIETY

TV programmes

Family & Friends

Partner

Community midwife

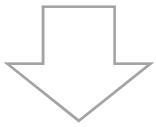
Pregnancy

→ **FIRST-TIME PREGNANT WOMAN**

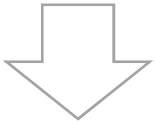
LABOUR AND BIRTH → THE UNKNOWN → GOING WITH THE FLOW

GOOD MIDWIFE

CHOICE PLACE OF BIRTH



LABOUR AND BIRTH EXPERIENCE



FIRST-TIME MUM

MEMO 53 - 28 April 2014

CATEGORIES	*SUBCATEGORIES*	*PROPERTIES*
ANTICIPATING THE UNKNOWN: GOING WITH THE FLOW	*ANTICIPATING THE UNKNOWN*	*Everyone is different* *I've never done it before* *Now and then: speak to me afterwards!* *Excitement – looking forward to it!*
	WAITING FOR THE UNKNOWN: COPING STRATEGIES	*Preparing* *Avoiding* *Shared experience* *Birth partner as guardian of the woman's rights and her voice of reason while she is 'away with the fairies'*
	GOING WITH THE FLOW (body, events, responses to experience)	*The way you go into it* *We are designed to do this* *Labour and birth: a natural process* *Birth plan: rough guidelines*
EXPECTATIONS OF A GOOD MIDWIFE	*GOOD MDIWIFE'S CHARACTERISTICS*	*Empathic mood* *Interpersonal dynamics* *Personal attributes* *Professional competencies*
	THE MIDWIFE'S ROLE	*Being vs doing* *Being: being there, guiding me, reassuring me, moral support* *Doing: monitoring me as a whole person, doing checks, telling me what to do and taking control* *Being & doing: balance* *Professionalism vs emotional support* *Professionalism* *Emotional support* *Fifty-fifty* *If it's all progressing well / if something goes wrong…* *Experience does not matter: moving quickly through roles, recognising fallibility and knowing who to call upon*

		Experience: every day you learn new things *Uncertainties about the midwife's role*
	DEALING WITH A MIDWIFE THAT I DON'T KNOW	*As long as …* *Disappointment* *Importance of knowing the midwife that will assist my birth*
	CONTINUITY OF CARER	*Not too many different ones* *As long as they know what they're doing* *People have their lives and need to sleep* *Same midwife* *Back in the days* *Shift's transition*
	MIDWIFE AND LABOUR STAGES	*Popping in and out* *Out to have some 'private moments'* *In during important stages* *Staying in the room*
	MIDWIFE AND BIRTH PARTNER(S)	
CHOICE OF PLACE OF BIRTH	*WOMEN'S CHOICE OF BIRTHPLACE*	*Influencing factors*
	MIDWIVES AND BIRTHPLACES	*Midwives are all good* *Positive experiences so far* *Midwives trained at certain standards* *Differences of birthplace are more related to the model of care and environment*
	WOMEN'S PERCEPTION OF SAFETY OF BIRTHPLACES	*Being surrounded by medical support* *One-to-one dedicated care* *Complete trust in the midwife's expertise*
INFLUENCING FACTORS ON WOMEN'S EXPECTATIONS	*FAMILY AND FRIENDS' STORIES*	
	MEDIA	

	SOCIETY	
	ANTENATAL CLASSES (SELF HYPNO-BIRTHING)	
FACING THE UNKNOWN	*TIME PERCEPTION*	
	ONGOING UNKNOWN	*You don't know until you get there (living it myself)* *Is it getting worse than this?*
	COPING STRATEGIES	*LET IT HAPPEN* *ME ENCOURAGING MYSELF*
REFLECTING ON THE EXPERIENCE WITH THE MIDWIFE IN THE LIGHT OF BIRTH	*I HAD A GOOD MIDWIFE*	*Woman's self-affirmation* *Interpersonal dynamics* *Personal attributes* *Professional competencies*
	THE MIDWIFE'S ROLE	*Professionalism vs emotional support* *Professionalism* *Emotional support* *Fifty-fifty* *If it's all progressing well / if something goes wrong…* *Years of experience: old and young midwives*
	DEALING WITH A MIDWIFE THAT I DON'T KNOW	*Fine as far as a good relationship was established*
	CONTINUITY OF CARER	*Okay with different midwives as far as a good relationship was established*
	MIDWIFE AND LABOUR STAGES	*Pushing stage* *Towards the end – the crucial stage* *Straightaway and all the way through* *Stronger contractions* *If something happens…* *Early labour* *Home or hospital?* *I didn't think I was in labour*

		Relieved when they told me I was in labour (opposite to the unknown) *Popping in and out vs staying in the room* *Being there even if not physically present in the room all the time* *A bit of privacy* *She could have stayed a bit more with me…* *The right amount of distance*
	MIDWIFE AND BIRTH PARTNER(S)	
	NEGATIVE LANGUAGE/BEHAVIOURS OF PROFESSIONALS AND THE MEANING WOMEN MAKE OF IT	*Causing worries* *You're not in active labour yet* *Not reading my notes* *Not staying with me* *Just doing her 'job'* *Not listening to me* *Perception of inflexibility (procedure vs choice)* *Attitude*
<u>THE 'EXPERIENCED' MOTHER</u>	*THE OVERALL EXPERIENCE*	
	THE NEXT TIME	
	GIVING ADVICE…	*…to first time mothers* *…to midwives*