

A QUALITATIVE STUDY OF MIDWIFERY PRACTICES DURING THE  
SECOND STAGE OF LABOUR.

Catherine Joan Hamilton

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*“To do nothing at all is the most difficult thing in the world,  
the most difficult and the most intellectual.”*

Oscar Wilde (1881, p.30).

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## Abstract

This qualitative study explores midwifery practice during the second stage of labour focusing specifically on whether midwives adopt a directed or physiological approach to maternal pushing. It was undertaken against the backdrop of research findings suggesting that there is no proven benefit to directing a woman's pushing efforts but anecdotal evidence suggests that this remains a routine and accepted part of midwifery practice in the United Kingdom (UK).

Semi-structured interviews were undertaken with ten midwives who had recent experience of caring for women during the second stage of labour, ten women who had recently given birth and four obstetricians. A form of thematic analysis was undertaken. Findings were viewed through a lens of critical social theory (CST) and drew on feminist principles to provide a deeper understanding of the emergent themes.

Findings indicated that a directed approach to second stage pushing was the norm in this UK Maternity Unit and was deeply embedded within the cultural context of what it meant to be a midwife that involved 'doing' rather than 'being'. Reasons explaining why midwives continue to use directed pushing were grouped into themes; '*time passing and watching the clock*', '*different worlds*', '*different women*', '*midwives take charge*', '*growth of confidence and changing practice*' and '*conflict*'.

When viewed from a CST perspective midwives undertaking directed pushing is seen as an example of institutionalised oppressive behaviour symbolising the way in which knowledge and rationality are disregarded in favour of a risk averse practice that is paradoxically the opposite of what evidence recommends. Midwives are identified as being oppressed by the dominant biomedical model to the extent that they do not view directed pushing as an intervention.

In order to promote a more physiological approach with its' associated benefits, a return to a social model of midwifery with a focus on salutogenesis rather than pathogenesis is called for. Recommendations for midwifery education, practice and research are provided in order to support the transformational shift in midwifery culture that is needed if such a change is to become a reality.

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I hope that this work will go some way towards enhancing the experience of birth for future generations of women.

## Abbreviations

<b>ARM</b>	Artificial rupture of the membranes
<b>BC</b>	Birth centre
<b>CST</b>	Critical Social Theory
<b>CS</b>	Caesarean section
<b>CTG</b>	Cardiotocography
<b>CAQDAS</b>	Computer assisted qualitative data analysis software
<b>DH</b>	Department of Health
<b>DS</b>	Delivery suite
<b>FHR</b>	Fetal heart rate
<b>ICM</b>	International Confederation of Midwives
<b>IV</b>	Intravenous
<b>NCT</b>	National Childbirth Trust
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NHS</b>	National Health Service
<b>NMC</b>	Nursing and Midwifery Council
<b>PMA</b>	Professional Midwifery Advocate
<b>RCM</b>	Royal College of Midwives
<b>RCT</b>	Randomised controlled trial
<b>SOM</b>	Supervisor of Midwives
<b>SVD</b>	Spontaneous vaginal delivery
<b>UK</b>	United Kingdom
<b>US</b>	United States

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**VE** Vaginal examination

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**WHO** World Health Organisation

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## Glossary

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<b><i>Antenatal</i></b>	Before birth.
<b><i>Apgar score</i></b>	A system used to give a numerical score to the condition of a neonate at the point of birth.
<b><i>Birth asphyxia</i></b>	A condition that occurs when a baby's brain and other organs do not get enough oxygen before, during or after birth.
<b><i>Birth Plan</i></b>	A written plan of a woman's preferences for care in labour.
<b><i>Cardiotocography (CTG)</i></b>	A method of electronically monitoring the fetal heart rate (FHR) and uterine contractions to assess fetal wellbeing.
<b><i>Cardiotocograph</i></b>	An electrical device used to monitor the fetal heart rate and the strength and frequency of uterine contractions.
<b><i>Cephalic</i></b>	Relating to the fetal head.
<b><i>Cervix</i></b>	The neck of the uterus where it opens into the vagina.
<b><i>Cervical</i></b>	Relating to the neck of the cervix
<b><i>Diaphragm</i></b>	A tough muscle separating the abdominal cavity from the chest.

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<b><i>Dilatation</i></b>	The process by which the cervix gradually opens during the first stage of labour.
<b><i>Effacement</i></b>	Shortening of the cervix resulting in loss of the cervical canal.
<b><i>Elective</i></b>	A clinical procedure that is planned as opposed to being an emergency.
<b><i>Electronic fetal monitoring</i></b>	See cardiotocography.
<b><i>Entonox™</i></b>	A gas consisting of a mixture of nitrous oxide and oxygen used as a form of analgesia during labour.
<b><i>Epidural anaesthesia</i></b>	The introduction of local anaesthesia into the epidural space to block selected nerves in the lower section of the spine.
<b><i>Episiotomy</i></b>	A surgical incision made into the perineum in order to expedite delivery.
<b><i>Eugenics</i></b>	The science associated with producing the perfect individual.
<b><i>Evolution</i></b>	The study of generic variation and change within generations.
<b><i>Expectant management</i></b>	The process of allowing pregnancy to progress with monitoring, but without medical intervention.
<b><i>Fetus</i></b>	An unborn human more than eight weeks after conception. Please note, this is the standard spelling for technical usage rather than 'foetus'.
<b><i>Fetal monitoring</i></b>	Assessing fetal wellbeing by intermittent or continuous auscultation of the heart.

<b><i>First Stage of Labour</i></b>	Stage of labour occurring from the onset of regular contractions accompanied by cervical dilatation to full dilatation of the cervix.
<b><i>Genome</i></b>	The total number of genes within a single organism.
<b><i>Gestation</i></b>	Refers to the normal period of time required for the fetus to develop sufficiently in order to live independently of the mother.
<b><i>Glottis</i></b>	The opening between the vocal chords in the throat.
<b><i>Gravid</i></b>	Pregnant
<b><i>Haemorrhage</i></b>	Excessive blood loss
<b><i>Hormone</i></b>	A chemical produced by an endocrine cell or gland which has an effect on another part of the body.
<b><i>Induction of labour</i></b>	The initiation of labour using artificial means.
<b><i>Inherent</i></b>	<i>Hereditary, having a genetic basis, innate.</i>
<b><i>Innate</i></b>	<i>Congenital, present from birth, behaviour that is instinctive rather than learnt.</i>
<b><i>Instrumental delivery</i></b>	Delivery of the fetus using forceps or Ventouse
<b><i>Intrapartum</i></b>	During labour.
<b><i>Intravenous</i></b>	Administered via a vein, usually in the hand or arm.
<b><i>Ischial spines</i></b>	Bony prominences on the lower part of the pelvic girdle which may be felt via vaginal examination and are used as landmarks to track the descent of the presenting part

<b><i>Latent phase</i></b>	The early period of labour during which the cervix is effacing and beginning to dilate. This phase may be symptomless or characterized by irregular cramping pains, restlessness and discomfort.
<b><i>Lower uterine segment</i></b>	The lower third of the body of the uterus.
<b><i>Morbidity</i></b>	A state of disease or ill health. Maternal morbidity refers to ill health as a result of pregnancy or birth.
<b><i>Mortality</i></b>	Relating to death associated with a particular event.
<b><i>Multiparous</i></b>	A woman who has given birth to one or more infants.
<b><i>Myometrial muscle</i></b>	Contractile muscle of which the uterus is comprised.
<b><i>Neonate</i></b>	A newborn baby in the first 4 weeks of life.
<b><i>Nulliparous</i></b>	A woman who has not previously given birth.
<b><i>Occiput</i></b>	A bone situated at the back lower aspect of the skull.
<b><i>Occipito posterior</i></b>	A fetal presentation in which the occiput is aligned with the mother's sacrum
<b><i>Oxytocin</i></b>	A hormone produced by the posterior pituitary gland stimulates uterine contractions and the myoepithelial that cells in the alveoli of the breast.
<b><i>Palpation</i></b>	Examining by touch
<b><i>Parity</i></b>	Refers to a woman's childbearing history usually expressed as a symbol E.g. P0 = a woman who has never given birth; P1 = a woman who has given birth to one child.

<b><i>Perinatal</i></b>	The period around the time of birth.
<b><i>Peripartum</i></b>	Another term for the period around the time of birth.
<b><i>Perineum</i></b>	The area comprising the pelvic floor and associated structures.
<b><i>Physiology</i></b>	The study of the function of living organisms.
<b><i>Posterior pituitary gland</i></b>	Part of an endocrine gland situated in the hypothalamus of the brain.
<b><i>Postnatal</i></b>	After birth
<b><i>Postpartum</i></b>	The period after birth.
<b><i>Precipitate delivery</i></b>	A rapid labour and delivery.
<b><i>Presentation</i></b>	The part of the fetus entering the pelvis first
<b><i>Presenting part</i></b>	The part of the fetus which presents at the cervical opening: usually the head.
<b><i>Primigravida</i></b>	Woman pregnant for the first time
<b><i>Primiparous</i></b>	Having born one viable child
<b><i>Progesterone</i></b>	A female sex hormone
<b><i>Rupture of membranes</i></b>	The breaking of the membranes surrounding the foetus which can occur spontaneously or artificially.

**Secondary powers** The abdominal muscles and the diaphragm contract forcefully to expel the fetus during the expulsive phase of labour.

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**Second stage of labour** The time from full dilatation of the cervix to delivery of the fetus

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**Spontaneous labour** Labour which begins without any form of intervention.

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**Supervisor of midwives** An experienced midwife who has undergone further training to enable her to clinically supervise other midwives in accordance with the requirements of the Nursing and Midwifery Council. Removed from Statute in 2017.

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**Syntocinon™** The manufacturer's brand name of synthetic oxytocin used to induce or augment labour.

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**Transitional stage of labour** A phase of labour experienced by most women towards the end of the first stage of labour usually accompanied by intense physical sensations.

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**Valsalva manoeuvre** Performed by forceful exhalation against a closed glottis.

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## Definition of terms used in this thesis

**Birth attendant:** usually a midwife but includes any individual who supports a woman through birth including a lay person who may be her life partner.

**Birth centre:** a midwifery-led facility where women deemed to be at low risk of complications arising during birth are cared for. Birth centres can be attached to a general hospital (as was the one in the Trust where this study was undertaken) or stand alone and situated some way away from the main hospital. If complications arise during labour or medical intervention is required or if women request epidural anaesthesia they are transferred to a delivery suite.

**Consultant:** the title of a senior hospital-based doctor who has completed all of his or her specialist training and been placed on the specialist register in their chosen speciality. In this study this is obstetrics.

**Delivery suite:** an obstetrician-led facility contained within a general hospital where care is provided to women at high risk of complications arising during labour. Instrumental and operative deliveries are carried out by obstetricians and epidural anaesthesia is available.

**Directed pushing:** Midwives or other birth attendants provide instruction to women around pushing including when to start pushing, how to do it and when to stop. The Valsalva technique including a specific 'pushing mantra' is commonly used.

**Health care professional:** a midwife, nurse (in the USA) or doctor (usually an obstetrician) who provides care to a woman at some point during her pregnancy, birth and the postnatal period.

**Obstetrician:** in this study, a doctor of any grade specializing in pregnancy, childbirth and women's reproductive systems.

**Registrar:** a mid to high ranking doctor who is usually a few years away from becoming a consultant. The registrar in this study specializes in obstetrics.

**Spontaneous pushing:** women are left undisturbed to push as and when they wish with no intervention from a health care professional.

Please note: in order not to interrupt the flow of the writing I have referred to the midwife as 'she' throughout in recognition of the fact that, while there a number of male midwives, most are female.

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## 1. Introduction and Background

### Introduction

This study aims to explore how women are supported in their pushing efforts during the second stage of labour from the perspective of midwives, childbearing women and obstetricians. It will focus on how the second stage is 'managed' by midwives working in a United Kingdom (UK) based maternity unit. Walsh (2012) argues that the directed management of the second stage of labour where midwives take the lead in instructing women how to push their babies out, is a prime example of the disempowering impact that the biomedical model of maternity care has on childbirth. He believes that a midwife directing a woman's pushing efforts leads to an undermining of her innate ability to give birth without professional guidance (Walsh, 2012). It is argued that the practice of directed pushing also reflects the social construction of birth in the Western world where the technical knowledge of health care professionals is deemed to hold greater importance than the experiential knowledge of childbearing women (Davis- Floyd, 1992; Katz Rothman, 1996; Bergstrom, et al., 1997).

Traditionally the second stage of labour is defined as the period from full dilatation of the os uteri to the birth of the baby (Downe, 2011). It is further described as the 'expulsive' phase during which the fetus is delivered from its' mother's body. Physiologically, the second stage is accompanied by uterine contractions increasing in length, strength and frequency and leading to a marked retraction of the uterus that facilitates the descent of the fetus through the vagina. The expulsion of the fetus is assisted by the voluntary muscles of the woman's abdominal wall and diaphragm collectively known as the 'secondary powers'. The woman's instinctive urge to bear down (push) and use these muscles is usually instigated when the fetus reaches the maternal pelvic floor where nerve receptors are stimulated (Downe, 2011).

The National Institute for Health and Clinical Excellence (NICE) (2014) provides the following definition for 'active' second stage:

- The fetus is visible
- Expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix

- Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions'. (NICE, 2014, p.60).

'Passive' second stage of labour is distinguished from 'active' second stage as being when the woman does not experience involuntary expulsive contractions despite the os uteri being fully dilated (NICE, 2014).

NICE (2014) guidance recommends that women are informed that pushing in the second stage should be guided by their own instinctive urges. There is no suggestion that midwives should direct maternal pushing efforts. There is however, the recommendation that if a woman's pushing is deemed to be ineffective or if requested by the women, other strategies can be offered by the midwife such as 'support', change of position, emptying of the bladder and further encouragement (NICE, 2014). A definition of what constitutes 'ineffective pushing' is not included although time limits for the second stage are and this aspect will be revisited later.

A background to the study is included in this chapter, incorporating an historical and political overview of how midwifery practices have altered over the past century. Aspects of the conceptual framework underpinning the study will be presented followed by a personal reflection explaining my interest in this area. The chapter concludes with a brief summary of each of the subsequent chapters.

### The research question

The aim of the study, hereafter referred to as the Second Stage Study, was initially to explore general midwifery practices associated with the second stage; the main research question being 'what are the midwifery practices undertaken during the second stage of labour?' However once interviews had been completed and data analysis commenced, this came to be seen as midwifery practice encompassing a wide range of behaviours and strategies used by midwives whilst caring for women in labour. These included specific communication strategies midwives used during the intense expulsive phase, clinical practice involving physically supporting the woman's perineum during the birth or not touching it at all (the 'hands-on' versus 'hands-off' approach) and practices relating to maternal positioning to facilitate birth.

In order to undertake a rich, in-depth study, I decided at this point in the process, to focus on one key theme arising from the data; this being midwifery practice, behaviour and communication related to supporting women's pushing efforts during the second stage of labour. Indeed, this was seen to hold particular significance for all the midwives and women participants and appeared to be the primary focus of care during the second stage. A specific area of personal interest was midwifery practice associated with either leaving a woman to follow her own instinctive urge to push (as recommended by NICE, 2014) or directing her pushing efforts by providing explicit instructions on how and when to push. The research question was therefore modified to become: 'what midwifery practices are undertaken while supporting women to push during the second stage?'

### Use of the Valsalva technique of directed pushing

The encouragement of deep breath holding followed by forceful pushing against a closed glottis during the expulsive phase of labour, is widely known as the Valsalva technique after the 18th century doctor Antonia Valsalva who first described it (Perez- Botella & Downe, 2006). Hollins- Martin (2009) further described the technique as 'purple pushing' presumably because with prolonged breath holding the small blood capillaries contained within the woman's cheeks burst giving a purple tinge to the face. Way (1991) describes a similar technique to increase pressure in the Eustachian tube and as a result reduce blockage in the inner ear. Other terms used to describe this style of second stage management include: 'directed', 'coached' and 'closed glottis' pushing (Kopas, 2014).

It is argued that the Valsalva technique is an intervention into birth that is accepted as routine practice in Western culture (Cook, 2010; O'Connell et al., 2001; Peterson & Besuner, 1997). Indeed the intervention is cited by some, as an example of how midwives and obstetricians continue to override the physiological elements of childbirth by using practices that are not evidence based (Perez- Botella & Downe, 2006). It is of note that more than 50 years ago, the British obstetrician Beynon (1957) was critical of the Valsalva technique asking why health care professionals believed that an aspect of their role was to encourage a mother to force her baby through the birth canal as rapidly as possible.

The Valsalva technique differs significantly from physiological pushing which is when the woman responds to an instinctive urge to bear down also known as Ferguson's reflex

(Bosomworth & Bettany-Saltikov, 2006) and pushes spontaneously. The reflex is initiated as the fetal presenting part (usually the head) descends the birth canal and stimulates stretch receptors situated within the posterior vaginal wall. This in turn leads to an increase in oxytocin production which stimulates Ferguson's reflex eventually leading the woman to experience an involuntary urge to push (Roberts, 2002). When a woman feels this, a midwife who is aware of the physiology underpinning this reflex can be assured that the fetus is in an optimum position within the birth canal and that further progress followed by a spontaneous vaginal birth is likely. However, if a woman is extolled to push before she feels an involuntary urge to do so, obstetric conditions may not be optimal and extra strenuous pushing efforts may be needed if a vaginal delivery is to be achieved. This in turn may lead to exhaustion and additional stress for the woman and her fetus (Hamilton, 2016).

Despite this, since at least the beginning of the 20th Century most women in the Western world have been asked to follow specific instructions on pushing during the second stage (Thomson, 1993; Hanson, 2009). Historically these instructions were described extensively in the medical, obstetric and midwifery literature (Myles, 1964; Reeder & Mastroianni, 1980) where women were advised to take a deep breath and hold it for as long as possible and then push down into the rectum as though opening their bowels. The usual aim being for women to undertake three strong pushes per contraction (Bosomworth & Bettany-Saltikov, 2006).

The 'pushing' mantra will be familiar to midwives and is described as such by Cook (2010):

"You're fully dilated, you can push ..... Hold your breath.... Push .... Keep going ... keep going .... Chin on your chest .... Push down into your bottom .... Count to ten .... Quick... breathe in and push again" (p.76).

It remains unclear how the Valsalva technique came to be associated with maternal pushing during the second stage of labour (Perez- Botella & Downe, 2006). A possible reason could be the widely held belief amongst health care professionals that directed pushing leads to a shorter second stage of labour (Bosomworth & Bettany-Saltikov, 2006). Indeed, a prolonged second stage has long been considered hazardous for the

fetus with the potential for increased perinatal mortality and morbidity (Rossi & Lindell, 1986). The NICE (2014) guidelines suggest that second stage is considered to be prolonged if it has lasted more than 2 hours in a nulliparous women and 1 hour in a multiparous woman. When these parameters are reached, midwives are required to refer the woman to a healthcare professional trained to undertake an operative delivery if spontaneous birth is not imminent (NICE, 2014.) The intrapartum care guidelines used in the Trust where the Second Stage Study was undertaken were based on NICE (2014) recommendations and the wording used was identical.

Early studies investigating the use of Valsalva pushing did indicate that it led to a shorter second stage (Barnett & Humenick, 1982) and subsequently it was considered a safer way to manage labour than leaving women to push spontaneously which was perceived to take much longer. However, research began to emerge in the late 1980's that did not support this view and as further high quality research followed, this led to a recognition that there was no robust evidence to suggest that directing women to push conferred any advantage over leaving them to push spontaneously (Lemos et al., 2015).

Despite a lack of evidence to support its' routine use, the Valsalva technique continues to be a key element in modern midwifery practice (Royal College of Midwives (RCM), 2007; Hanson, 2009; Cook 2010). This led Cook (2010) to ask the question: "When will we change practice and stop directing pushing in labour?" (p.76.). This question remains unanswered seven years later as anecdotally UK midwives working in NHS (NHS) Maternity Units persist in their use of this intervention.

However, literature reviews undertaken during the course of this study failed to locate any published research exploring specifically what midwives were doing to support women's pushing efforts during the second stage, what they thought about using the Valsalva technique and why if they used it, they felt justified to do so despite the evidence recommending otherwise. Furthermore there was a paucity of research focusing on how midwives perceive their role and what they think about adopting a philosophy of just 'being' with a labouring woman rather than proactively 'doing' things to her as suggested by a number of midwifery theorists ( Leap,2000; Walsh, Kennedy, 2000; Anderson, T, 2000; Walsh, 2012). Walsh (2012) for example, based his arguments on the work of T. Anderson, ( 2000), stating that in order for childbearing women to

feel empowered and confident in their ability to give birth , midwives themselves must move from a stance of “control to facilitation, dominance to masterly inactivity, surveillance and monitoring to watchful expectancy, more to less”( p.113).

I also found that women’s voices were conspicuous by their absence from the literature. There were few studies asking women directly what expectations they held of the midwives’ role during the second stage or how they felt about being at the receiving end of either the pushing mantra or the suggestion that they should ‘listen to their bodies’ by following their innate pushing urges.

### The second stage study and current maternity policy

There has been growing concern in the UK over the past 30 years about the significant increase in the number of births by caesarean section (CS). The latest published UK maternity statistics for 2015.16 show that 60 % of births were classified as spontaneous vaginal deliveries whilst 27.1% were classified as CS and 12.9% as instrumental births (Health and Social Care Information Centre, 2016). To put this in context, in 1980 the spontaneous delivery rate was 75.5% and the CS rate was 9%. (NHS Information Centre, 2015). These statistics demonstrate a steady rise in the CS rate over the past three decades, representing an increasing amount of medical intervention into birth. Although obstetricians may argue that a medical model of childbirth, with the view that birth is ‘normal only in retrospect’, leads to improved safety for women and their babies, this increasing trend in childbirth by CS has not been accompanied by a measurable improvement in the health and well-being of the baby but has been associated with increased maternal mortality and morbidity when compared with vaginal birth (NHS, 2006).

In the UK, the steady rise in the medicalisation of birth appears to be linked to the inception of the NHS in 1948 that saw the development of maternity services based upon a paternalistic model maintained by a powerful medical hierarchy with obstetricians situated at the highest level (Lupton,2012; Martin, 2001). From the 1970’s onwards, birth in hospital became the norm and this led to increased power for the medical profession with a corresponding erosion of the autonomy of midwives and the voices of women being largely ignored (Kitzinger, 2005).

Opposition to the biomedical model started to emerge in the 1950's as middle class women began to challenge the power of the medical profession over birth and called for a return to a more woman- centred model where their choices were listened to and incorporated into maternity care (Oakley, 1993). Feminist writers continued the challenge throughout the 1970s, as evidence of women's growing discontent with the management of childbirth services became more apparent (Langan, 1998; Kirkham, 2004). In the 1980's this challenge was fuelled further by the work of 'active' childbirth supporters such as Janet Balaskas and Dr Michel Odent who offered an alternative vision of birth where women were empowered to cope with the accompanying powerful physical sensations in a natural way without the need to resort to drugs or technology ( Odent, 1984; Balaskas, et al., 1990; Balaskas, 1992).

Eventually in the UK, the Changing Childbirth report by the Expert Maternity Group (Department of Health( DH) (1993) set out it's overarching message that as childbirth in the Western world was relatively safe, maternity care no longer needed to blindly follow the medical model for all women but should instead stay focused on their individual needs. The report incorporated a call to return to a physiological model of birth and a move away from the hegemony of the medical model. At the time, this was welcomed as a chance for midwives to focus on providing woman- centred care and an opportunity for them to regain some of their perceived lost autonomy (Kirkham, 2004; Sandall, 1995; Walton & Hamilton, 1995).

The political agenda focusing on the promotion of normality in childbirth was further highlighted with the publication later of the National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004). This again emphasised the importance of women's choice and involvement in their care with a further focus on encouraging women to have as normal a pregnancy and birth as possible. The theme was repeated in Maternity Matters (DH, 2007a) and yet again in Midwifery 2020 (DH, 2011). More recently, Better Births ( National Health Service ( NHS) England, 2016) the five year forward vision for maternity care in England proposed more significant changes in the way modern maternity care should be delivered. Whilst key recommendations do not specifically mention the promotion of normality within childbirth there is a clear message that women should be placed at the centre of maternity services and that continuity of

carer is central towards providing a relationship based on mutual trust and respect where women are empowered to achieve the birth experience they are hoping for.

However, despite all these reports and subsequent recommendations, the fact remains that the physiological event of spontaneous vaginal birth is experienced by just 60% of women in the UK whilst over a quarter experience a medicalised birth. This continues to be a source of concern within the midwifery profession which has at its' core, the importance of the normality of childbirth (Downe, 2006). In 2005, the International Confederation of Midwives (ICM) added to their definition of the role of the midwife 'the promotion of normal birth' (ICM, 2005). Similarly, the Nursing and Midwifery Council (NMC) Standards for Pre-Registration Midwifery Education (NMC, 2009) state that the focus of educational programmes should be on enabling student midwives to develop the skills they need to support women during physiological childbirth.

In an attempt to address these concerns the Royal College of Midwives (RCM) launched its Campaign for Normal Birth in 2004 with the aim of supporting physiological birth practices to ensure that CS and other interventions are the last management choice for birth rather than the first (RCM, 2004). Indeed one of the first physiological practices promoted via this campaign was that of supporting women to push spontaneously rather than with direction (RCM, 2004). This campaign has latterly evolved into the Better Births Initiative (RCM, 2017) following publication of the Maternity Review (NHS England, 2016) with its focus on the provision of high quality maternity care for all women including the promotion of a physiological model of birth.

The current political and social agenda supporting a move away from the biomedical model of birth was a major driver behind the Second Stage Study. Midwifery theorists have long argued that for women to be empowered to take control of birth, midwives as key maternity care providers need to reconsider and redefine their own roles. (T.Anderson, 2000; Walsh, 2007). Leap (2000) suggests a philosophy of the "less we do, the more we give" (p.1). She discusses the potential for the empowerment of childbearing women through midwives relinquishing their control over birth and shifting power back towards women (Leap, 2000). The process of supporting normality during childbirth is described as the "art of doing nothing well" (Kennedy, 2000, p.12).

## Conceptual framework: medicalisation of birth and power relationships in maternity care.

As directed pushing represents an intervention into a physiological process it also reflects the medicalisation of birth where science seeks to gain control over nature. Within this conceptual framework comes the debate around what actually constitutes normal birth. It is suggested that a definition of 'normal' in the context of birth is both contentious and political (Kitzinger et al., 1990). Here, there are two competing models of birth: one historically embraced by midwives implying that birth is normal until proven to be abnormal. The other adopts the premise that every labour is potentially abnormal and can only be viewed as normal retrospectively, this being the obstetrician's domain.

It is argued however that normality is not a fixed concept for midwives. Kitzinger et al., (1990) identified two distinct ways in which midwives interpret 'normal labour' either as statistically common or 'natural'. In the first case, examples of common practices include artificial rupture of membranes, the use of oxytocin to augment labour and the use of directed pushing in the second stage. These are interventions into a natural process but are still classified by midwives as part of normal labour otherwise women with oxytocin infusions who have their membranes artificially ruptured would no longer be within the midwives' jurisdiction. Alternatively, normal defined as 'natural' implies no intervention into the birth process. In this context, a breech presentation or twin pregnancy can be classified as normal and it is only when the obstetrician intervenes by using forceps or recommending a CS that it is reclassified as abnormal.

Kitzinger et al., (1990) argue that this 'natural' interpretation of 'normal' can be used in two ways; to justify midwives' resistance to accepting medical intervention into the birth process and to support the fact that they are also able to care for women expecting twins or with breech presentations. In this way midwives are able to define their role as the attendants of normal labour as well as the guardians of natural labour. When viewed in this context, the continued use of directed pushing by midwives suggests that they are not always acting as guardians of natural labour but are practising within a biomedical framework. Directing pushing is seen as common, routine practice and therefore 'normal' although it is not 'natural' in that women are being instructed to behave in a way that does not always come naturally to them.

Power relationships inherent within maternity care are a further area of interest associated with directed pushing. A biomedical model implies that health care professionals have the power to control the birth process by telling women when to push. This is in stark contrast to a social model of birth suggesting that it is a normal everyday event in a woman's life that progresses in a manner determined by the woman over which health professionals have no control.

These concepts will be explored further throughout this study in order to understand why midwives care for women as they do and how childbearing women perceive the care midwives provide. Additional notions of 'birth territory' and 'midwifery guardianship' are drawn from the work of Fahy et al., (2008) and used as a basis on which to explore the promotion of a woman-centred birth environment in modern maternity care. The aim being to consider how midwives can enable an environment in which women are supported to give birth physiologically within the organisational constraints afforded by the NHS.

As I considered the impact that power relationships within maternity care may have on the way that midwives care for women during the second stage, I recognized that critical social theory (CST) could be utilized as the theoretical perspective underpinning this work. CST as a philosophy, emerged from Germany in the early 20<sup>th</sup> Century and incorporated research aimed at investigating power relationships and seeking transformation as a result (Savin-Baden & Howell Major, 2013). CST is particularly critical of positivist research but complementary to interpretive research (Holloway & Wheeler, 2010). Critical theorists such as Horkheimer, Adorno and Habermas were sceptical about the positivist approach that dominated social science research in the 20<sup>th</sup> Century and argued that an adherence to rigid rules stifled creativity and innovative thinking (Holloway & Wheeler, 2010). Alternatively, CST combines humanistic values and interests with ethical and critical thought.

Key beliefs of CST include the concept that researchers should examine power and the way it is constructed, that individuals should participate in discussions as equal partners and that ideology informs and affects research (Kincheloe et al., 2011; Savin-Baden & Howell Major, 2013). The suggestion is that there is a reality that has been created by forces like, gender, race and class that are taken for granted but actually warrant further

exploration. (Horkheimer & Adorno, 1972). According to Kincheloe et al. (2011), critical theorists use their work as a form of social or cultural criticism based on the premise that the relationship between a concept and an object is never fixed but frequently mediated by the social relations of capitalist production and consumption. Critical theorists do not only seek to understand a particular phenomenon but also strive to challenge it on the grounds that the distribution of power may lead to the oppression of some societal groups and that transformative action is needed to change and improve things (Crotty, 1998). Kincheloe et al. (2011), argue that research rooted in CST can best be understood in terms of the empowerment of individuals or groups. Such inquiry needs to be seen as an attempt to confront injustice identified within a particular societal sphere by researchers seeking to raise the emancipatory consciousness of oppressed individuals or groups.

The seminal work of the post-Marxist educationalist Freire (1970) was instrumental in the development of a research approach that contributes to the struggle for a better world for all. Freire (1970) introduced the concept of 'critical consciousness'. This focuses on individuals achieving a deeper understanding of the world through the exposure of various social and political contradictions. Freire (1970) argued that as individuals become increasingly aware of the social and historical reality that influences the way they live, they are more able to take action to change it. According to Freire (1970), human beings require 'emancipatory knowledge' in order to achieve freedom and autonomy, overcome social challenges and transform power relationships by the removal of oppressive forces. I considered the relevance of this within the sphere of maternity services and a perceived power imbalance where obstetricians dominate the service, midwives work under their jurisdiction and women's embodied knowledge goes largely ignored as they are told how to push during the second stage of labour.

This philosophical stance also fitted with the study's objective that was to explore aspects of midwifery practice during the second stage of labour. Inevitably this will involve some consideration around who holds the power in the birthing room; the midwife who directs the woman to push or the woman with her embodied knowledge of the right time to push. There was also a commitment to include participants as equal partners ensuring that a safe environment was provided allowing them to voice their opinions and finally an

interest in exploring the competing ideologies of the social versus the biomedical model of birth. Later in the thesis I will provide further justification as to why I have drawn on certain philosophical aspects of CST to inform the theoretical perspective of this study.

### Personal reflection

My interest in routine use of the Valsalva technique arose from my personal experiences of caring for women during the second stage of labour at a time when the biomedical model of birth was seen as the norm.

I began my midwifery career in the mid - 1980s having initially undertaken my nurse training. This was at a time when maternity care was highly medicalised, pregnancies and labours were monitored closely and birth managed in maternity units by midwives and obstetricians. There was increasing use of technology throughout pregnancy and birth. This included medical interventions such as continuous cardiotography (CTG) for all labouring women, biochemical analysis of fetal blood samples, epidural anaesthesia, artificial rupture of membranes, induction and routine augmentation of labour using synthetic oxytocin.

Homebirth was infrequent and I attended only one woman at home during my training. This was against medical advice as she was nulliparous woman and the general consensus amongst the midwives was that she would be 'safer in hospital'. She laboured at home but was transferred into the Maternity Unit with a diagnosis of 'lack of progress' after pushing at home for an hour with no sign of an imminent delivery

This was also the time when the Irish obstetrician O'Driscoll pioneered a policy of 'active management' of all labours at the National Maternity Hospital in Dublin (O'Driscoll & Meagher, 1980). Elements of this policy were being adopted in English maternity units including the one where I was undertaking my training. 'Active' according to O'Driscoll, related to obstetricians and the nature of their involvement in the management of labour rather than that of a woman 'actively' giving birth. O'Driscoll's regime was described as inflexible and dogmatic by feminist commentators (Oakley, 1984). It involved all women having artificial rupture of membranes one hour after the onset of labour had been confirmed followed an hour later by intravenous (IV) oxytocin used to speed up the uterine contractions. The premise of active management was that no labour would last

longer than twelve hours and that every woman would be guaranteed one to one care by a midwife throughout the labour. It proved popular because it removed some of the uncertainty of birth; women and midwives working within this regime knew what to expect and could prepare themselves accordingly.

As a nurse coming into midwifery, I embraced the concept of active management as it fitted well with the routine way of working I was accustomed to on the general hospital wards. I liked the way that it took away some of the uncertainty of birth and represented health professionals harnessing control over a natural process. Most of my colleagues were also nurses and we felt comfortable viewing birth through the biomedical lenses that we were accustomed to.

Instructing women to undertake directed pushing during the second stage was the norm and as a student midwife I took pride in learning by rote the 'pushing mantra' previously described. Women were told to put their chins down on their chests, legs up, usually on the midwives hips or sometimes in lithotomy poles and then push hard; 'push like you've never pushed before..', 'push away the pain', 'get angry with it' 'get three good long pushes in with each contraction'. These were the words and phrases I heard uttered frequently and soon began to use myself. All the births I attended involved use of this technique and I became increasingly more confident to use it myself as I completed my training and began practicing as a qualified midwife. I then became a role model for students and taught them the same approach and was satisfied to hear them become confident in using the same mantra.

This situation began to change in the 1980s as evidence began to emerge suggesting that it was preferable to encourage women to push spontaneously during the second stage. It appeared that directed pushing did not have any significant effect on the duration of labour and might have some adverse effects on both the woman and her baby. (Caldeyro-Barcia et al., 1981; Yeates & Roberts, 1984; Enkin et al., 2000; Aldrich, et al., 1995).

Having read the published research, I decided to amend my practice and leave women to be led by their own instinctive pushing urges. The first woman I tried this approach with was a healthy primigravida with no risk factors who was expected to give birth spontaneously without the need for intervention. Instead of instigating the familiar

Valsalva technique when she approached the expulsive phase of the second stage, I encouraged her to 'listen to her body' and push how and when she wanted. This continued for at least two hours and while the woman was indeed pushing as and when she wanted to, there was no sign of progress in terms of her baby moving down the birth canal to be born. I encouraged her to stand up and move around and to adopt whatever upright position was comfortable but still there were no tangible sign indicating any progress.

The senior midwife in charge began knocking on the door after two hours of pushing had elapsed asking if the woman had delivered yet and also wanting to know what I was doing to facilitate the birth. 'Get her pushing' was the advice from the senior midwife and the obstetrician. The woman and her partner became despondent with their perceived lack of progress and the woman in her exhausted state implored me to tell her what to do. At this point in desperation, I reverted back to a practice I felt most familiar with; I told her to take a deep breath, put her chin on her chest and push as hard as she could. Within just 20 minutes of undertaking the Valsalva technique, a healthy baby was born without complication and all was well. 'At last' was the comment of the senior midwife, 'you see, all you had to do was get her pushing.'

Following this experience I reflected on how I had tried to support this woman in an evidence based way by encouraging her to follow her instinctive urge to push but how in my mind this had not worked. It seemed to take too long to see any results and labour ward policy stated that the second stage of labour should last no longer than two hours. If labour was deemed to be prolonged, then the midwife was required to refer to the obstetrician who was qualified to undertake an instrumental delivery. The evidence base recommended that I should leave women to push spontaneously but despite this I had felt compelled to do something to help the woman and to appease the senior midwife who wanted me to 'get on with it' so the room could be freed for the next labouring woman.

Following this incident, future births I attended were always accompanied by my use of the Valsalva technique and I saw none of my midwifery colleagues adapting their practice to become more woman-led. The only time women were seen to follow their instinctive

pushing urges were in so called 'born before arrival' cases when they gave birth spontaneously often on the way to the Maternity Unit with no midwife in attendance.

A few years later I made a career move into higher education but retained my interest around the question of why midwives remained reluctant to adapt their practice in relation to directed pushing and why there was a preference for midwife-led pushing rather than woman-led pushing. After all, the role of the midwife is supposed to be 'with woman' and associated with the promotion of a physiological approach to the birth process. Why is it then that we feel the need to intervene into a woman's experience by directing her pushing in such a ritualistic way? It would seem more likely that midwives would favour a physiological approach and be grateful for an evidence base that supports them in this. However despite the fact that the evidence relating to pushing emerged over 25 years ago, as previously highlighted midwives have generally been slow in supporting a woman led approach to pushing.

Although I am no longer in clinical practice, student midwives inform me that use of the Valsalva technique is widespread in the maternity units in which they are undertaking their training and it would seem that it is still seen as a routine part of midwifery practice. It is certainly a key feature of births shown in the media. It was this, along with my own experience of using the Valsalva technique in my professional practice that inspired me to explore the issue for my doctoral studies with the intention of discovering why midwives persist in directed pushing despite the evidence that states that it should not be routine practice.

### [Justification for this study](#)

The Second Stage Study aims to address a gap in the literature by finding out what midwives in a UK based maternity unit are doing in relation to directed pushing during the second stage of labour. Anecdotally it is suggested that midwives do still direct pushing but the Second Stage Study will aim to find out what is actually happening behind the closed doors of the delivery room. If midwives are continuing to direct pushing despite the evidence, then reasons for this will be explored as will their feelings about the type of care they provide to labouring women and whether adopting a 'being' rather than 'doing' approach is something they feel comfortable with. The views of

women will also be explored in order to find out how they expect the midwife to support them during the second stage and whether their expectations have any impact on the manner in which midwifery care is provided.

As I am utilising a CST approach, these issues will be reviewed in the context of the environment that midwives find themselves working in the modern NHS and how the culture of medical dominance influences and to an extent, oppresses midwifery practice. As Brodie and Leap (2008) argue, it is imperative that midwives explore the tension which exists between how they define their role as guardians of normality and how this is played out in the institution of the hospital if they are ever to successfully implement major reforms in the organisation of maternity services.

The methodology chosen for the Second Stage Study reflects the epistemological view that in order to understand midwives and women's experiences of the second stage (and in accordance with a CST approach) their own voices need to be heard. For this reason a qualitative approach was considered most appropriate. The data collection method allows participants to focus on elements of the topic that hold most significance for them (Rogers, 2008) and having three participant groups (midwives, women and obstetricians) permits a convergence of data from their differing perspectives. Results from the study will provide evidence that will be of relevance to midwives and to those responsible for planning and implementing maternity care as well as to future generations of childbearing women so that they may be supported to experience birth in a positive life affirming way. As Katz- Rothman (1996) argued, whether she gives birth with or without medical intervention, a woman who feels powerful, aware of her own inner strength and able to trust her bodily instincts is well placed to take on the role of new mother.

### [Aim of the second stage study](#)

The overall aim of this study was to undertake a qualitative study exploring midwifery practices during the second stage of labour. For the purposes of this doctoral thesis the focus is on midwifery practice in relation to directed pushing during the second stage.

### [Objectives](#)

- To explore how midwifery practices during the second stage of labour relate to the current evidence base around directed pushing.

- To discover what factors underpin midwives decision making in relation to practices during the second stage of labour.
- To explore how midwives perceive their role while supporting women during the second stage of labour.
- To explore women's experiences during the second stage in relation to pushing.
- To discover how obstetricians view midwifery practice during the second stage in relation to pushing.

## Summary

In this chapter, midwifery practices undertaken during the second stage of labour have been framed within the relevant historical and political context. A rationale has been provided for why the focus of this study is on midwives use of directed pushing despite the fact the current evidence base recommends that women should push spontaneously during the second stage of labour.

CST as a potential theoretical framework for the study has been introduced and a rationale for its use provided. Concepts of interest including power relationships and the medicalisation of birth have been presented followed by a reflection on my own experience of caring for women during the second stage to explain why this is an area of personal interest. A justification for the study has been offered and the overall aim and objectives defined. The chapter now concludes with a brief overview of the remaining chapters;

## Chapter 2 Literature review

This chapter includes a review and critique of literature appertaining to the use of directed pushing during the second stage. The aim is to examine the evidence on which the NICE (2014) intrapartum care guidelines are based in order to show why the current recommendation is that women should be supported to push spontaneously during the second stage.

## Chapter 3 Physiological birth

This chapter presents an overview of literature relating to the physiology of birth when it is left undisturbed and the benefits that this has been found to bestow on the health and

wellbeing of women and their babies. The aim is to demonstrate why it is still considered of importance to the individual woman and to society, to promote physiological birth in a culture where medical intervention into birth is ever increasing.

#### Chapter 4 Medicalisation of birth

This chapter aims to demonstrate how the culture of giving birth in the Western world has changed over the past 100 years from being an everyday private event where women cared for each other in the domestic setting into a risk averse medical event taking place in the public arena of the hospital institution.

#### Chapter 5 Power and control: relationships in maternity care

In accordance with a CST approach, this chapter examines the literature around power relationships inherent within maternity care and the potential influence these may have on midwifery practices during the second stage. Two theories of power as defined by Lukes and Foucault are outlined and their relevance to maternity care provided by midwives working in the NHS are discussed. Birth Territory Theory, with its notion of optimising the birth environment to facilitate physiological birth and the part midwifery guardianship plays in enabling this environment is introduced as a potential framework on which midwifery practice during the second stage could be based.

#### Chapter 6 Theoretical perspectives

This chapter discusses CST and feminist theory as theoretical perspectives underpinning the study. CST works on the principle that transformation can only occur when individuals are made aware of the historical and social context in which they are working. The concepts of oppression and emancipation are introduced in the context of maternity care. The potential for the study findings to emancipate women and midwives from the dominance of the medical model so enabling them to promote a more physiological model of birth is considered.

#### Chapter 7 Methodology

This chapter presents the rationale for the chosen methodological approach in relation to the aims and objectives of the research question and the overarching philosophical stance. The rationale for the final method of data collection is explained with a focus on

the various ethical issues raised by this research. A description of how data analysis was undertaken is included with a specific focus on how academic rigour was maintained.

#### Chapter 8 Findings 1: Midwifery practice during the second stage

This chapter presents findings relating to the three participant groups perspectives of midwifery practice and directed pushing.

#### Chapter 9 Findings 2: Factors affecting midwifery practice.

This chapter highlights themes relating to midwives' practice during the second stage. These themes are: 'time passing and watching the clock' 'different worlds' , 'different women', 'midwives take charge', 'growth of confidence and changing practice' and 'conflict'.

#### Chapter 10 Discussion.

This chapter discusses key themes emerging from analysis of the data in order to explain the rationale behind midwives persistence in directing pushing despite unequivocal evidence suggesting that it should be woman - led. Findings are viewed through a CST lenses to consider power relationships inherent in the birth room and how this impacts on the midwifery practices that take place there. Implications of findings for the care midwives provide during the second stage are explored along with their significance for midwives' educational and continuing professional development needs. Finally limitations of the current study are acknowledged.

#### Chapter 11 Conclusion

This chapter demonstrates how the aims and objectives of the study have been met using a CST perspective to offer an explanation for the way midwives construct their practice and how these findings make a unique contribution the current body of knowledge. Suggestions for further research around the topic of midwifery practices during the second stage of labour are included.

## 2. Literature review

### Introduction

This chapter will review the literature relating to use of the Valsalva technique to direct a woman's pushing efforts during the second stage of labour. A narrative literature review was undertaken, the overall aim being to examine the evidence on which the current NICE Intrapartum Care guidelines (NICE, 2014) are based and to undertake a critical and comprehensive analysis of the current knowledge associated with this topic area. Green et al. (2006) describe a narrative review as being a comprehensive synthesis of previously published literature that reports the author's findings, summarising content in a condensed form. Onwuegbuzie and Frels (2016) define a narrative literature review as being an overview of the most significant aspects of the current knowledge base associated with a specific topic. The review then forms the basis of the introduction to a thesis and should be defined by the research objective, the underlying problem being explored or the researcher's argument. Some researchers maintain that a narrative review should also include a critique of each included study (Gastel & Day, 2016), others argue that this is not always necessary (Helewa & Walker, 2000). Green et al. (2006) suggest that it is up to the author of the review itself to decide the approach to adopt. In my case, I opted for the former and included a critique of the research methodology so highlighting strengths and limitations of the reviewed studies where appropriate.

The literature review was undertaken prior to data collection meaning that at the start of the data collection process, I was aware of the recommendations for care during the second stage as supported by the research evidence. This information assisted me in the formulation of an interview schedule.

The search strategy is described to demonstrate how the most pertinent information relating to the research question; 'What are midwives' practices in relation to directing pushing during the second stage of labour?' was retrieved. Where relevant, a critique of the literature is included to help judge its reliability and validity in relation to the current evidence base.

The initial literature review around second stage practices showed that there were a vast number of papers and studies appertaining to this topic area. To make the volume of

literature more manageable, the section has been broken down further into specific themes. Articles relating to each theme are then discussed and included under each heading.

The focus of this chapter is a review of the literature specifically around directed pushing during the second stage. Further reviews of the literature relating to other aspects of the study's conceptual framework, namely the physiology of normal birth, the medicalisation of the childbirth process and power relationships in maternity care, will be presented in subsequent chapters.

### Conducting the literature search

As an experienced midwife, educationalist and mother, I already possess much personal and professional knowledge relating to midwifery practice and have witnessed how intrapartum midwifery practices have evolved over time. This has inevitably shaped my reflections and approach to the subject. In this context, the purpose of a literature review prior to collecting data is to examine, in a systematic way, the available evidence on which midwives base their practice and to identify gaps in current knowledge which might benefit from further exploration (O'Leary, 2010). Holloway and Wheeler (2010) also recommend that qualitative researchers review the literature in the early stages of a study to confirm the need for the particular approach to be adopted. Themes identified from the initial review also guided the development of questions used during the semi-structured interviews. One of the secondary objectives of the study was to explore the extent to which evidence shapes the reality of everyday midwifery practice. In this context I needed knowledge of the evidence base in order to facilitate development of the interview questions.

As this doctoral study spans a period of six to seven years, an initial literature review was undertaken prior to data collection and then repeated at regular intervals during and following completion of data collection to discover if further relevant studies had been undertaken in the interim. This is the approach recommended by Holloway and Wheeler (2010) who suggest that researchers compare and contrast their own findings with those of other studies as their work progresses.

Searches of the literature were undertaken using the following search engines: Google Scholar, PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Knowledge, Scopus, and the Cochrane Database.

A number of search terms were used in different combinations using Boolean operators and truncation to broaden the search and link different themes (O'Leary, 2010). An early review of the literature showed that relevant literature appeared to span several decades, so no date or country filter was applied in order to ensure that papers of interest to the topic area were not missed. All studies and articles written in English were considered. The search strategy was further enhanced by carrying out hand searches of the reference lists attached to specific articles as well as contents lists of specific journals to see if other relevant articles could be found. This approach is recommended by Greenhalgh and Peacock (2005) who highlight the importance of using a number of different approaches to identify relevant literature when carrying out a review. They argue that systematic reviewers should not rely solely on computerised databases to retrieve all the information they require. They describe an approach known as 'snowball sampling'. This search strategy develops as the study progresses and is responsive to literature already retrieved (Greenhalgh & Peacock, 2005). For example, if a journal contains several relevant studies, then other editions of the same journal are hand searched to look for further material of interest.

Using a combination of search strategies increases the likelihood of locating articles relevant to the research question. However, as Aveyard (2014) argues, it is impossible to state categorically that ALL information has been found so reviewers should only ever state that no further literature relating to a particular topic area has been identified rather than implying that no such information exists.

Initial key search terms were 'pushing', 'second stage', 'labour', 'Valsalva', 'directed', 'spontaneous pushing', and 'childbirth'. These were used to gain a general understanding of the topic. The search terms were further revised to include 'coached pushing', 'uncoached pushing', and 'physiological pushing'.

The following inclusion criteria was used; studies using English language, published research, and studies recruiting women with uncomplicated labours. The exclusion

criteria used was; non-English language studies, unpublished research, studies allowing epidural use, and studies recruiting women with complicated labours.

Initially literature studies including women using epidural analgesia were excluded from the review the idea being to focus specifically on midwifery practices during physiological birth with minimal medical intervention. Use of epidural analgesia will inevitably affect physiological second stage as it inhibits the spontaneous pushing reflex (Odibo, 2007). As Downe (2011) highlighted there is a lack of research exploring pushing in the second stage for women with epidurals *in situ*, but the likelihood is that they do require some direction from a midwife because the anaesthesia used blocks the sensation of needing to push. However, during the search some studies were retrieved where women with epidurals had been included alongside women without epidurals. An example being the systematic review undertaken by Lemos et al., (2015) where such articles included the generation of knowledge considered of relevance to the research question this literature was included. Another example was the Second Stage of Labour project (Roberts et al., 1989) carried out in the United States (US) in the mid-eighties. It explored social and behavioural aspects of women and their birth attendants during the second stage. This study had originally also intended to exclude women with epidurals. However, the number of women in the US requesting epidural analgesia during labour at the time of the project was so high that it was decided to include them. Information gleaned from the secondary analysis of data produced from this project (for example Bergstrom et al., 1997; Roberts et al., 2007; Bergstrom & Roberts, 2010) is considered of relevance to the research question for my doctoral study.

Literature obtained from the initial search was further categorised as; highly relevant to the topic, supports understanding of the topic, or mainly irrelevant to the topic. All studies considered relevant were separated into either quantitative or qualitative. This aspect of the search revealed a lack of contemporary qualitative literature relating to directed pushing and care of women during the second stage. In addition there is a paucity of literature exploring midwives' views of their practice during the second stage of labour and/or why they made the decisions they did to undertake specific practices. However, a body of literature acknowledging, and challenging midwives continued use of

directed pushing was identified. (Cook, 2010; Perez-Botella & Downe, 2006; Hollins-Martin, 2009). See Appendix 1 for a summary of the reviewed studies.

The literature search also revealed a lack of contemporary UK studies. Thomson (1993) undertook a randomised controlled trial (RCT). However, research since this time has predominantly been undertaken in other countries, mainly the US.

The following key themes associated with maternal pushing during the second stage of labour were identified from the initial literature review. These were;

- Directed pushing: effect on maternal outcomes
- Directed pushing: effect on fetal outcomes
- Second stage practices: birth attendants support

These themes will be considered in more detail in relation to the associated evidence base.

### [Directed pushing: effect on maternal outcomes](#)

This section will present findings of the literature review appertaining to whether directing a woman's pushing efforts has any effect on duration of the second stage and/or on her general health, sense of well-being and satisfaction with her experience of giving birth.

Hollins Martin (2009) in her review of second stage pushing techniques argues that directing pushing during the second stage of labour can cause unnecessary distress to women and may have an adverse effect on their future health. She challenges the continued use of directed pushing by midwives, suggesting that it is an unnecessary intervention into the natural birth process (Hollins Martin, 2009). Bergstrom et al., (1997) also highlight the distress women felt when they were made to hold back on their instinctive urge to push before full dilatation of the cervix had been confirmed by the midwife. This view is echoed by Kopas (2014) who, on reviewing second stage practices, argues that directing a labouring woman on how and when to push is an intervention which should only be used on those occasions when the benefits are believed to outweigh the risks (Osbourne & Hanson, 2012).

Directed pushing is in direct contrast to the spontaneous, physiological style of pushing adopted by women when responding to their instinctive urges (Bosomworth & Bettany-Saltikov, 2006). A study by Rossi and Lindell (1986) observed both the breathing style and positions adopted by 50 women classified as being low-risk and giving birth in a non-prescriptive environment. They found that when left to their own devices, women tended to undertake spontaneous open glottis pushing. Later studies by Roberts et al. (1987) and Thomson (1993, 1995) demonstrated similar results. Instinctive pushing differs from directed, Valsalva-style pushing techniques in that women do not take a deep breath in at the start of a push, they do not start to push as soon as they feel a contraction and they use an individual combination of open and closed glottis pushing (Thomson, 1995). Rather than holding their breath for the duration of a contraction, women tend to undertake several short, strong pushes during the contraction characterised by a deep breath before each pushing effort (Roberts et al., 1987).

Schneider et al. (1990) investigated the correlation between women's pushing during the second stage of labour and maternal and fetal blood lactate levels. They demonstrated that the concentration of maternal lactate at birth significantly correlates with the number of pushing efforts the woman had undertaken. Similarly Nordstrom et al. (2001) monitored maternal blood lactate concentrations during the second stage and demonstrated that the length of time that the woman was actively pushing for was significantly associated with an increase in maternal blood lactate as the fetal head delivered. The significance of this finding is that increased lactate leads to increased acidity in the fetus, the acidaemia becoming more pronounced with longer duration of expulsive efforts. This led Nordstrom et al. (2001) to speculate that a fetus already at risk of birth asphyxia could change from a compensated to a decompensated state with this degree of hypoxic stress.

Williams et al. (1998) investigated the effect of pushing during the second stage of labour on maternal cerebral blood flow. Women's middle cerebral blood flow velocity was monitored continuously during labour using transcranial Doppler ultrasonography. Measurements were taken at the height and trough of a contraction and during the pushing phase of the second stage. It was demonstrated that whilst a woman was pushing her cerebral blood flow speed fell, her pulse rate increased by 16 beats per

minute but there was no corresponding alteration in blood pressure. This was a small study involving only 15 women but it suggests that directing pushing does not expose women to the risk of a middle cerebral vasospasm. However, these findings are in marked contrast to another study using similar technology (Tieks et al., 1995) which demonstrated that the Valsalva technique **does** cause characteristic changes in systematic blood pressure as well as an increase in flow velocity in the middle cerebral artery. This study was also small involving 10 healthy adults and was not conducted on women in labour. These two studies suggest that further research is needed in this area to produce conclusive results.

Barnett and Humenick, (1982) studied the effect of directed pushing on the duration of the second stage. They conducted a small scale RCT including 10, low risk multigravida women randomly allocated to either a directed pushing or spontaneous pushing group. No significant difference in duration of the second stage was found between these two groups. Similar results were obtained by Yeates and Roberts (1984), and Parnell et al., (1995) although the latter study, which was conducted in Denmark, also included women who had previously given birth by caesarean section, which means that these studies are not directly comparable. In each of these studies, no significant difference in the overall duration of the second stage of labour between the groups was found. Parnell et al., (1995) however, did not allocate the method of pushing (spontaneous pushing versus forced breath holding and directed pushing) until the baby's head was visible at the vulva. Up until that point, the women pushed as they wished with no direction from the midwife. Recruitment of eligible women into this study was poor as some women did not want to be allocated to the spontaneous pushing group as they perceived that this implied no further support from the midwife. Other women were lost from the study because they gave birth by caesarean section. The authors admit that although no significant differences in terms of length of second stage, condition of baby at birth, mode of delivery or perineal trauma were found in the two groups this could have been due to non-compliance with the allocated pushing technique. Oxytocin used frequently in both groups to accelerate contractions, and there was a similarly high episiotomy rate in both groups. These factors may have contributed to the overall results and so undermine the reliability of the findings (Parnell et al, 1995).

A much larger RCT by Bloom et al., (2006) studied the effects of active coaching of maternal pushing efforts on the duration of the second stage. Over 300 women were recruited to take part with 163 randomly allocated to a coached, directed pushing group and 157 allocated to a control group which required them to respond to their own instinctive urges to push. In this study, the mean length of the second stage was significantly shorter in the directed pushing / coached group in comparison to the group of women who pushed spontaneously; 46 minutes versus 59 minutes respectively. However, there was no increased incidence of prolonged second stage of labour (defined as lasting longer than 2 to 3 hours in total) in the spontaneous pushing group. In addition there were no further variations between the two groups in terms of other outcomes such as type of delivery, perineal trauma, Apgar scores or admission of the baby to the neonatal intensive care unit (NICU). The clinical significance of achieving a shorter second stage of labour through directing pushing, of just 13 minutes is also debateable.

When a subset of 128 women from this study agreed to have their pelvic floor and urinary function tested postnatally (Shaffer et al., 2005) a significant number of women in the coached pushing group demonstrated decreased bladder capacity and increased pelvic floor descent 3 months following delivery compared with women assigned to the uncoached group. Conversely though, a later study (Low et al., 2013) found that spontaneous pushing did not reduce the incidence of postpartum urinary incontinence at one year following delivery. It is of note however that these authors did identify various limitations to their research including a particularly high attrition rate and a high rate of crossover between the randomised groups, which should be taken into account when considering the validity of these results from both studies.

A more recent albeit still relatively small RCT involving 100 primigravid Turkish women (Yildirim & Beji, 2008) found that women using a directed pushing technique during the second stage of labour experienced a significantly longer second stage (mean 50.1 minutes versus 40.8 minutes respectively) and a longer period of active pushing (14.8 minutes versus 9.6 minutes respectively). They also reported less satisfaction with their overall birth experience than did those randomly assigned to the group that was asked to push spontaneously. Similarly another small, quasi-experimental study undertaken in Taiwan by Chang et al., (2011) compared the experiences of 66 women assigned to either

a directed pushing 'usual care' group or an experimental group where they were supported to push as they wished in an upright position. Again, the second stage of labour was significantly shorter in the spontaneous pushing group and women reported less tiredness, less pain and an increased satisfaction with their experience of birth.

Co Lam and McDonald (2010) conducted a similar RCT and measured maternal fatigue as an outcome during and following labour in Chinese women randomly assigned to either a directed pushing or spontaneous pushing group. Nearly 400 primigravid women were recruited to participate but there was a high dropout rate when women withdrew from the trial to receive epidural analgesia or felt unable to complete the required data collection tool assessing their levels of energy and fatigue during labour. Results showed a slight increase in the length of the second stage in the spontaneous pushing group but this was not statistically significant, obstetric and neonatal outcomes were the same in both groups. Women in the spontaneous pushing group reported less fatigue and recovered more quickly than did those in the directed pushing group, but again results were not statistically significant. The only statistically significant result related to type of delivery was that the women in the directed pushing group had more instrumental deliveries than those in the spontaneous pushing group. These results are interesting but must be viewed with caution as due to the high attrition rate only 38 women in the directed pushing group and 35 in the spontaneous pushing group actually took part, so overall numbers are very small.

Conflicting results were obtained from an RCT conducted in Iran (Jahdi et al., 2011). The intervention in this study involved midwives supporting women to push how and whenever they felt the urge to do so while adopting an upright position. The control or usual care group were coached by midwives to use closed glottis pushing with pushing being directed in the Valsalva style. The mean duration of the second stage of labour for both primigravid and multigravida women was significantly shorter in the spontaneous pushing group. In common with Co Lam and Macdonald (2010) however, other outcomes including type of delivery and Apgar scores showed no significant differences.

The difference in the two study designs of Chang et al., (2011) and Jahdi, et al., (2011) compared with others is that the intervention specified that women should push spontaneously in an upright position. This means that it cannot be determined whether it

was the fact that women were pushing instinctively and spontaneously or that they were giving birth in an upright position that led to the shorter duration of the second stage of labour. A systematic review (Gupta et al., 2012) did demonstrate a trend, albeit a statistically non-significant one, towards a shorter second stage when an upright position was adopted.

It is acknowledged that the rationale behind directing pushing during the second stage of labour lies in the widely held belief that it would shorten the duration of the second stage and consequently the perceived hazards to both the woman and baby associated with a prolonged second stage (Bosomworth & Bettany-Saltikov, 2006; Peterson & Besuner, 1997; Rossi & Lindell, 1986). Barnett & Humenick (1982) suggest that limiting the duration of the second stage minimises risk to the fetus. However, this view is challenged by more recent research (Myles & Santolaya, 2003; Cheng et al., 2004).

Myles and Santolaya (2003) carried out a retrospective analysis reviewing the labours of nearly 8,000 women who gave birth at a hospital in Chicago over a three-year period. They found that a prolonged second stage of labour is associated with a high rate of vaginal delivery with over 96% of the women who reached the second stage of labour giving birth vaginally (as opposed to operatively) within four hours. Indeed more than 65% of women with a very prolonged second stage of labour lasting more than four hours also gave birth vaginally without any increase in risk for the baby. Maternal morbidity in terms of increased use of episiotomy, higher rates of perineal trauma, uterine infection and postpartum haemorrhage was however increased when second stage of labour was prolonged. The authors acknowledged the limitations of their study as it was retrospective in design but concluded that although a prolonged second stage of labour may be associated with a higher rate of maternal complications, there was no increasing risk to the fetus. (Myles & Santolaya, 2003).

Cheng et al., (2004) undertook a similar retrospective study spanning the period from 1976 to 2001, examining the outcomes for over 15,000 women delivering in California. They found similar results in that a prolonged second stage of labour, while associated with increased maternal morbidity, did not show a corresponding increase in poor neonatal outcomes. This is another retrospective study undertaken over a very long time period during which hospital guidelines and practitioners will invariably have changed.

Another limitation is the authors did not provide a specific definition of the second stage of labour. This may impact on the reliability of results as it is unclear what is actually being measured or what is meant by the second stage of labour (i.e. from when full dilatation of the cervix is diagnosed, when the presenting part of the fetus is visible or when the woman starts to experience expulsive contractions (Holvey, 2014). However, results from both studies suggest that it is actually medical intervention undertaken when second stage becomes prolonged that causes maternal morbidity rather than the fact that labour is taking longer than guidelines recommend.

As Hollins Martin (2009) highlights, perineal trauma is another important factor to consider when assessing the effectiveness and safety of directed pushing. Bosomworth and Bettany-Saltikov (2006) suggest that perineal tears could be considered a measurable outcome as they can usually be classified in terms of severity as first, second, third degree tears, and episiotomy.

Indeed, the earliest study found for this review was conducted by Beynon (1957) who compared the outcomes of 100 women who pushed spontaneously with 393 women in a control group who delivered in the same hospital in the same time period and were directed to push during contractions. It was found that directed pushing did increase perineal trauma and the instrumental delivery rate. However, results from this study do need to be treated with caution as this was not a RCT and there is a discrepancy in the number of women included in each arm of the trial, and the intervention group included only women under the care of one obstetrician so an element of bias cannot be excluded. This is not highlighted as a limitation in the study (Beynon, 1957). Also the frequency of perineal suturing required was included as a measure of the degree of perineal trauma sustained but there was no clear indication of what actually constituted a need for suturing, so again this outcome is subjective and open to bias.

Sampsel and Hines (1999) retrospectively asked 39 primigravid women who had given birth vaginally about the perineal trauma they had sustained during delivery. The information the women provided was then matched with the description of their perineal trauma as recorded in their medical records. Women who had had a spontaneous vaginal birth within the past 9 to 14 months were asked about the type of pushing (spontaneous or directed) they had used during the second stage as well as the levels of pain they had

experienced in the perineal and vaginal area during the first postpartum week. Results from this retrospective study need to be treated with caution as they rely on participant's memory of their birth experience which, while may be accurate, will be subjective. However, a positive aspect of the study is that it is based on women's own embodied experience of birth. Indeed as the authors highlight, a study by Simkin (1992) found considerable agreement between the short and long-term memory recall of women describing their first birth experience. Birth is such a significant event in any woman's life that memory is likely to be accurate. Whatever its' acknowledged limitations, findings from this study (Sampsel & Hines, 1999) suggested that women who pushed spontaneously sustained less perineal trauma than those who were directed. They were less likely to have episiotomies or sustain perineal lacerations. Other variables such as birthweight of the baby, woman's age and duration of the second stage showed no significant difference to the extent of perineal trauma sustained.

The RCT conducted by Yeates and Roberts (1984) demonstrated similar results in that women who undertook directed pushing sustained more perineal lacerations than did those who pushed spontaneously. In contrast Thomson (1993) measured perineal outcome in relation to whether suturing was undertaken and found that 73.3% of women who pushed spontaneously required suturing compared to 58.8% of women in the directed pushing group although again this difference was not statistically significant.

It is argued that the reliability of the results in relation to perineal damage across these RCTs does depend on inter-observer reliability (Bosomworth & Bettany-Saltikov, 2006) and that several studies considering this outcome (Yeates and Roberts, 1984; Thomson, 1993; Sampsel & Hines, 1999; Beynon, 1957) do not provide clear definitions of perineal trauma or include guidelines relating to what degree of perineal trauma constitutes a need for suturing. Therefore the possibility that inter-observer errors have influenced the results needs to be acknowledged.

RCTs undertaken by Bloom et al. (2006) and Yildirim and Beji (2008) and a systematic review evaluating interventions to prevent perineal trauma during childbirth (Eason et al., 2000) found no significant differences between women who were directed to push versus those who pushed spontaneously in terms of perineal trauma sustained. A more recent systematic review by Prins et al. (2011) concurred that although a trend towards less

perineal trauma was apparent in the spontaneous pushing group there was no statistically significant difference when results from a number of RCTs including this outcome were compared. Another systematic review (Lemos et al., 2015) evaluated seven RCTs involving 815 women and comparing spontaneous with directed pushing with or without an epidural. Again no significant differences were found in the two groups in terms of perineal laceration risk.

It has also been noted that some women will instinctively push before their cervix is fully dilated and so before the second stage of labour has been reached (Reed, 2015). Some birth attendants will treat this as a complication and will encourage women not to push so as not to cause damage to their cervix (Reed, 2015). This is another example in which the intervention of professionals in the physiological process of birth could potentially undermine the woman's belief in her ability to give birth unassisted. (Walsh, 2007; Downe, 2010; Reed, 2015). However, there does not appear to be evidence to support this perceived risk (Reed, 2015). Indeed, the distress this causes women is highlighted graphically by Bergstrom et al., (1997) in the title of their research article 'I gotta push, please let me push'.

An Italian study conducted by Borelli et al. (2013) found that 7.6% of women (60 out of 769 women who gave birth during the period of the study) experienced an urge to push before their cervix was fully dilated. This was more common in primigravid women (73%) and 41% of cases occurred in women whose babies were lying in an occipito-posterior position in the uterus. An earlier survey by Downe et al. (2008) produced similar results although the incidence of women expressing an early pushing urge was much higher at 20% and this study did not demonstrate a clear correlation between an early urge to push and parity.

The authors acknowledge limitations in their studies due to the small sample sizes, the low response rate (only 42%) in the Downe et al. (2008) survey, and the fact that hospital policies and individual practitioner's responses will vary so results may not be transferable and comparable. For example, Borelli et al. (2013) found that the earlier a midwife performed a vaginal examination in response to a woman's urge to push, the more likely it was that a cervix which had not reached full dilatation would be found. If examination was delayed, then a fully dilated cervix was more likely to be found. Despite

these acknowledged limitations, Borelli et al. (2013) highlight findings that contribute to the body of knowledge around this topic area, and which has not been explored in depth previously. Indeed these studies suggest that an urge to push prior to full dilatation of the cervix may be a normal variation of labour and may actually aid the physiological process. Reed (2015) suggests that the extra downward pressure as the woman pushes may help to turn the posteriorly positioned fetus into an anterior position or may assist with dilatation of the cervix.

### Directed pushing: effect on fetal outcome

Early research into the use of directed pushing during the second stage demonstrated an adverse effect on the wellbeing of the fetus. For example, Caldeyro-Barcia et al. (1979) and Bassell et al. (1980) demonstrated that prolonged closed glottis pushing caused fetal hypoxia, fetal acidosis and an increase in pathological decelerations of the fetal heart rate during labour. However as Bosomworth and Bettany-Saltikov (2006) note, although frequently cited in articles highlighting the risks associated with directed pushing (for example more recently Hollins Martin, 2009; Cook, 2010) the very small sample sizes involved leads to a low external validity.

Another study by Aldrich et al. (1995) compared levels of fetal cerebral oxygenation and cerebral blood volume both prior to and during the pushing phase of labour. Ten women participated in this study where the fetal heart rate was monitored continuously throughout labour using CTG. An optical probe was used to monitor oxygen saturation in the fetus. Following the birth of the baby, umbilical cord blood was obtained and tested for pH, base excess and haemoglobin. Results demonstrated a significant decrease in fetal cerebral oxygenation when sustained maternal pushing was undertaken. Fetal outcomes were assessed by measuring umbilical blood gases in the Barnett and Humenick study (1982). This research demonstrated no significant difference between the closed glottis, forceful pushing group and the open glottis spontaneous pushing group. Of interest here though is that umbilical vein pH was found to be significantly higher in the spontaneous pushing group suggesting that directed pushing against a closed glottis does increase fetal acidosis by lowering pH levels.

Mayberry et al., (1999) studied the physiological effect of women becoming fatigued during labour. Muscle fatigue is the result of continued sustained shortening of muscle fibres which can occur during the strenuous closed glottis pushing characteristic of the Valsalva pushing technique. Mayberry et al., (1999) suggested that the diaphragmatic muscle can become fatigued during directed pushing leading to a reduction in adequate oxygenation in the woman and subsequently affecting her fetus.

Yildirim and Beji (2008) found that babies born to women in the spontaneous pushing group were born in significantly better condition with higher Apgar scores than were those in the directed pushing group. Umbilical cord arterial pH was also significantly higher in the spontaneous pushing group. However, Jahdi et al., (2011) found no significant differences in Apgar scores between the two groups

Similarly Yeates and Roberts (1984) noted no significant difference in the Apgar scores in babies born in either group. However, their sample size was small and although the Apgar score is based on set criteria, it has been argued that there still scope for subjectivity (Bharti & Bharti, 2005). As Bosomworth and Bettany-Saltikov (2006) argue, in order for the Apgar score to be reliable as a measurement tool, the individual recording needs to be blinded to the group the participant was assigned to. In the case of these studies this was not possible and should be viewed as a limitation of most research in this area.

The pilot RCT conducted by Thomson (1993) assessed fetal outcome by measuring venous cord blood pH and the need for resuscitation following birth. In the directed pushing group, a negative correlation between the length of the second stage and cord blood pH was noted whilst there was no significant effect found in the spontaneous pushing group. However, the small number of participants and the fact that the author classified this as a pilot study means that external validity is low.

The two studies by Nordstrom et al. (2001) and Schneider et al. (1990) have already been discussed in relation to maternal outcomes. Nordstrom et al. (2001) measured fetal and maternal blood lactate levels throughout labour and found that the length of time of active pushing was significantly associated with an increase in fetal blood lactate as well as maternal blood lactate. Nordstrom et al. (2001) suggests that this is due to the fetus undertaking anaerobic metabolism during periods of sustained pushing by the woman.

Similarly Schneider et al. (1990) found that fetal blood lactate levels increased significantly when correlated with the number of pushing efforts made by the woman during the second stage.

### Second stage practices: birth attendant support

This section uses the term 'birth attendant' rather than 'midwife' in recognition of the fact that the midwife is not the main care giver during birth in all Western societies. For example in the US, labouring women tend to be cared for by obstetric nurses with obstetricians being called to conduct the delivery of the baby.

The literature review confirmed that most of the published literature around directed pushing during the second stage is quantitative and has focused on physiological issues and the effect that pushing technique has on the woman, the fetus and length of second stage. However, in the 1980s the Second Stage Labour Project (Roberts et al., 1989) was undertaken in the US with a focus on the social and behavioural aspects of birth attendants (usually nurses) and women during the second stage. The study consisted of 23 women who were between the ages of 18 and 36, of mixed parity with low risk pregnancies who along with their birth attendants consented to being filmed during the second stage. The overall aim of the National Institute of Health funded project was to describe care during the second stage of labour in order to develop detailed protocols which would then be taught to health care professionals and studied in further depth to discover any effect on clinical outcomes. The full experimental phase of the project was never completed. However, several social and behavioural aspects of care during the second stage were analysed including specific social interactions between women and their birth attendants, women's perceptions of labour and their birth attendant's interpretations of the vocalized sounds women made during the second stage (Bergstrom et al., 2010).

In their part of the study, Bergstrom et al. (2010) used linguistic and observational methods to review the original films generated from the project. They produced micro-analytical descriptions of the interactions between women and their birth attendants. They found that talk and behaviour occurring during the second stage of labour consisted of a limited repertoire of words, phrases and actions; the main task being to assist the

woman to push and deliver her baby. Two quite distinct styles of 'birth talk' were identified; talk which directed forceful pushing during contractions and talk which was more supportive of spontaneous woman-led pushing.

A study undertaking secondary analysis of the same data explored reasons why care givers might become more directive as labour progressed (Roberts et al., 2007). The analysis found that caregivers became more directive if women became fearful, fatigued, felt a diminished urge to push or if there was some deterioration in the condition of the baby which required delivery to be expedited. Having reviewed literature around the topic area though, this rationale is refuted because directing women's pushing efforts has not been found to significantly reduce the length of the second stage (Sampselle et al., 2005; Yildirim & Beji, 2008; Cook, 2010).

Roberts et al. (2007) highlighted further communication approaches which they described as 'supportive direction' or 'supportive praise'. During 'supported direction', alternative strategies were recommended by the caregiver but presented in a supportive way which sought to confirm the woman's own ability to push effectively. Supportive praise involved the caregiver providing unequivocal praise purely in response to the woman's spontaneous bearing down efforts.

Roberts et al. (2007) described a further situation when caregivers tended to become more directive and this was when women became reluctant to push through fear and appeared to be holding back from pushing. This reflects earlier research by McKay and Barrows (1991) who filmed twenty women giving birth in the US and then interviewed them to discuss their experiences during the second stage. Women in this study expressed their individual concerns about losing control, opening their bowels while pushing, tearing, experiencing excruciating perineal pain and not feeling ready emotionally to give birth. McKay and Barrows (1991) recommended allowing women to express their fear at the time and that preparation during the antenatal period should include a discussion about the intense emotions and sensations women may experience during the second stage. Roberts et al. (2007) however, noted that caregivers in their study usually increased their directive attempts when women exhibited this kind of fear rather than trying to help them address their anxieties. They summarised their findings by recommending that further study is required on the outcomes of caregivers changing

their approach from supportive to directive in response to a woman's need and whether this is beneficial or if alternative strategies such as suggesting a period of rest or a change of position might be more effective in assisting women.

Data produced from the Second Stage Labour Project (Roberts et al., 1989) is arguably limited in that it involves secondary analyses of video and audio tapes generated from a study with related but different aims, conducted over 30 years ago and including a small group of women in the US. The sample is not culturally diverse and researchers did highlight the need for further research to analyse birth talk and interactions amongst different groups of women (Bergstrom et al., 2010).

The maternity care provided to women in the US is different to that provided in the UK with certified nurse midwives and obstetric nurses supporting physicians to provide care which is medically-led. A survey undertaken in the US in 2012 confirmed this and found that 82% of women received care while giving birth from doctors (Declercq et al., 2013). Whereas in the UK the midwife is the lead carer for all healthy women with normal, uncomplicated pregnancies (DH, 2010). Although findings are an interesting starting point for exploring midwives' practices during the second stage of labour, they cannot be generalised to UK based midwives.

Another more recent US study (Osbourne & Hanson, 2012) used a survey methodology to collect data from 375 certified midwives and certified nurse midwives about their approaches to second stage labour pushing. The respondents in this study reported using mainly supportive approaches to maternal pushing during the second stage. However, as the researchers point out, this is in direct contrast to the US Listening to Mothers III Survey (Declercq et al., 2013) that found that the majority of women in the US push under the direction of a caregiver. As only 10% of births in the US are attended by a midwife then results of this particular survey might reflect those of the care practices of other birth attendants who may be more directive in their approaches (Osbourne & Hanson, 2012).

Results from the Osbourne and Hanson (2012) survey reflected those of Roberts et al., (2007) as midwives confirmed that they may become more directive in their approach if there were changes in either the fetal or maternal condition which necessitated a rapid

delivery, or if women requested more direction. Again this rationale is refuted as there is currently no evidence to suggest that directed pushing **does** significantly shorten the second stage (Sampsel et al., 2005, Yildirim & Beji, 2008). The researchers acknowledge that their study is limited by the potential biases common to survey methodology, including the fact that respondents are essentially self-selected. Although they were randomly selected as active members of the American College of Nurse Midwives (ACNM) they may choose to respond in a particular way because they are active members of the College and their views and practices may not necessarily represent the views of all midwives.

Another recent qualitative descriptive study by Borders et al. (2013) found similar results. In this study, a single researcher observed and audiotaped 14 births in the US (including women who had received epidural analgesia) and concentrated on analysing the way that nurse-midwives supported women verbally during the second stage. Subsequent analysis of the data showed four main categories of verbal support; information sharing, positive affirmation, direction, and baby talk (i.e. talk about the baby as a separate entity). Women pushed spontaneously for most of the time regardless of whether they had epidural analgesia and the use of specific direction by the midwives was commonly observed with midwives only tending to give instructions for a particular clinical reason as highlighted in other studies. The researchers again recognised the limitations of this small study which cannot be transferred to a larger population. The fact that the researcher is a certified nurse-midwife and a member of the group she was observing is a limitation. Although the research team did try to minimize the influence that this might have on results. For example, two independent qualitative experts were involved in data analysis. There were also advantages to her being a member of the group she was studying as this allowed her easy access to the field and the opportunity to blend into her surroundings as a familiar member of the team. Despite the recognised limitations, it is acknowledged that this study does add to the body of knowledge relating to how nurse-midwives verbally support women during the second stage in the US. In particular it is a natural observational study the only intervention being the presence of the researcher in the birthing room.

## Limitations of the studies

This literature review shows that although a number of RCTs have been conducted investigating directed versus spontaneous pushing, the methodological quality of some of these is dubious. Two systematic reviews into the use of spontaneous versus Valsalva pushing during the second stage of labour (Prins et al., 2011; Lemos et al., 2015) highlight the lack of good quality RCTs and their limited generalizability, as findings often appear to be conflicting and ambiguous. In addition, particularly the earlier studies tend to include small numbers. For example, a key study by Thomson (1993) is reported as being a pilot study that was never replicated on a larger scale. Lemos et al (2015) also raised concerns about the randomisation process itself. They considered that randomisation was adequate in only three of the seven trials they reviewed. For example, the trials of Co-Lam (2010) and Yildirim (2008) were thought to be of high risk of bias in that only envelopes were reported as being used during the randomisation process as opposed to computerised sequence generation.

The studies using the extent of perineal trauma as an outcome often lack a clear definition of how perineal trauma was defined (for example Yeates & Roberts, 1984; Thomson, 1993; Sampelle & Hines, 1999). Indeed, it is argued that the potential for inter-observer error is high when measuring outcomes in care which are considered subjective, such as perineal trauma, rates of suturing and amount of postpartum blood lost (Gomm et al., 2000).

A major limitation of any RCT in the area of intrapartum care is the fact that there can be no blinding of either birth attendants or participants with regards to the group the participant is allocated, which could lead to bias. Similarly, Lemos et al (2015) highlighted that in most studies they reviewed, the blinding of outcome assessors was not mentioned either meaning that the risk of potential detection bias is unclear.

In addition, high attrition and crossover rates between groups as women use a combination of different pushing techniques are major limitations to several studies. Thomson (1993) suggested that she overcame this limitation by being present during all births to ensure that the correct group allocation was adhered to. However, as previously highlighted her sample size was small and it was classified as a pilot study. Indeed, the

author herself recommended that a much larger study was required to produce more reliable results (Thomson, 1993). Ethical issues around undertaking any research on women in labour means that a more concrete and less flexible approach cannot be instigated at the expense of giving women the choice to opt out or change as they wish.

There was considerable diversity in the approach adopted by individual researchers. For example some studies included nulliparous women only, some included multigravida only and others included both nulliparous and multiparous women. As Bosomworth and Bettany-Saltikov (2006) argue, the timing of the onset of the second stage is also debatable and may differ between various studies. Roberts et al., (2002) suggest that the start of the second stage is defined as when the cervix reaches full dilatation. Conversely, the NICE intrapartum care guidelines (2014) give two definitions. One is for the passive second stage of labour; that is a finding of full cervical dilatation on vaginal examination before or in the absence of expulsive contractions and the second is for active second stage of labour which is defined as when the presenting part of the fetus is visible, when expulsive contractions are felt along with a finding of full cervical dilatation and/or active maternal pushing following confirmation of full cervical dilatation. However, unless a woman is subjected to numerous vaginal examinations at frequent intervals it is impossible to accurately diagnose when the cervix is fully dilated, regardless of which definition is used (Holvey, 2014). Indeed authors have highlighted that some midwives postpone undertaking a vaginal examination in order to delay a formal confirmation of the second stage (Peterson & Besuner, 1997; Roberts, 2002). This suggests that using the length of the second stage as an outcome is not always reliable or comparable between studies. Bosomworth and Bettany-Saltikov (2006) recommend using length of time that a woman is pushing during second stage as a more reliable measurement. .

There is variation in relation to the posture adopted by different groups of labouring women. For example, some women were left to choose the position they wished to adopt for pushing. In other trials women were placed in lithotomy position, the birthing chair or were in a sitting position. Some studies did not mention the position adopted at all. The study by Jahi (2011) used different postures for each arm of the trial in that the directed pushing group assumed a supine position while the spontaneous pushing group were upright.

There are variations in the country of origin of these studies and although similar standards of maternity care may exist in European countries and the US, the structure of the maternity services is not the same in the UK so transferability from one country to another cannot be assumed.

There are also confounding factors as well as the planned intervention which may affect the progress and outcome of labour including different approaches of caregivers and different physiological and psychological responses of individual women which can never be controlled. McNabb (1987) warned about the dangers of taking a reductionist approach to research around intrapartum care. She argued that labour should be considered as a process rather than an event which has a set start and end point; it cannot be studied in isolation from other factors such as the woman's physical, emotional and psychological state. Clarke (2000) concurs with this view and argues that although RCTs are held up as the gold standard for quantitative research, some aspects of holistic midwifery practice are not conducive to being measured in these terms.

A number of observational studies around caregivers and women's behaviour during the second stage of labour arose out of the secondary analysis of data obtained during one US project (Roberts et al., 1989) which involved just 23 women who were filmed while giving birth (for example, Roberts et al., 2007; Bergstrom et al., 1997; Bergstrom et al., 2010) which again limits transferability. Maternity care has undeniably changed in the three decades since the project was commissioned. Although in defending their ongoing use of the data, some of the project authors argue that the events depicted are still typical of modern day practices and they used expert caregivers to view the original recordings to confirm this (Bergstrom et al., 2010).

A major limitation to the literature reviewed in this field is that there is currently a lack of qualitative research around midwives' perceptions of their role during the second stage and the practices that they undertake in the light of the current evidence base.

Anecdotally, it would appear that midwives in the UK are still directing women to push (RCM, 2007, Perez-Botella & Downe, 2006; Cook, 2010; Hamilton, 2016) but there is no clear research evidence supporting this. Women's views of what they want and expect from their midwife during second stage and their experience of being directed to push or left undisturbed to push instinctively is also lacking. This gap in the literature provides a

rationale for the current study which aims to address this by exploring women's and midwives' views of second stage practices in relating to pushing.

## Summary

This literature review exploring practices relating to directing pushing during the second stage has highlighted a number of studies, some being of poor methodological quality providing ambiguous and conflicting results. This has resulted in some discrepancy around which practices are most effective in providing optimal outcomes for women and their babies. Further good quality research is consistently identified as being required before changes to practice can be recommended (Prins et al., 2011, NICE, 2014). As a result, the current evidence base clearly supports the fact that women should not be directed to push but should instead be encouraged to push instinctively.

Directing women to push does not significantly reduce the duration of the second stage. Other retrospective studies demonstrate that while a prolonged second stage (defined as lasting longer than 3 hours) does appear to lead to an increase in maternal complications (usually as a result of medical intervention such as episiotomy and the use of forceps or vacuum instruments to expedite delivery) a corresponding, increase in neonatal mortality and morbidity is not apparent.

It would seem that anecdotally at least, directed pushing has become widespread in modern midwifery practice (Perez-Botella and Downe, 2006, RCM, 2007, Hanson, 2009, Cook, 2010) despite a lack of evidence to support its use. There is however, little published research into the practices undertaken by UK based midwives when caring for women during the second stage so research evidence relating to whether directed pushing is instigated is lacking (Hamilton, 2016).

This review indicates that there is no robust evidence to support the practice of directing women to push during the second stage of labour using the Valsalva technique (Hamilton, 2016). Until further evidence based on good quality research is forthcoming, the recommendation is that women should be supported by midwives to push spontaneously (RCM, 2012, NICE, 2014; Prins et al., 2011; Lemos et al., 2015) without forceful direction or any intervention from health care practitioners. NICE (2014) also recommends that if pushing is considered ineffective or if the woman requests help,

additional support can be offered and strategies such as emptying the bladder, a change of position and extra encouragement should be considered ahead of directed pushing.

It is recommended that further research into various aspects of intrapartum care is required. This includes the way in which care during labour is provided by midwives practising in the UK, how the quality of care may be improved, and how different approaches to midwifery care may impact on outcomes for women and their babies (RCM, 2012).

This review has confirmed the need for a qualitative UK-based study to find out what midwives are doing in relation to directing pushing and what factors they are using to construct their practice.

The next chapter will review literature relating to physiological birth when the birth process is left undisturbed by any form of medical intervention

### 3. An overview of physiological birth

#### Introduction

The previous chapter reviewed the evidence base around the practices of midwives and other healthcare professionals relating to directing a woman's pushing efforts during the second stage of labour. Most studies in this area have yielded results that are ambiguous and inconclusive. Therefore the overall recommendation from the RCM (2012) and NICE (2014) is that women considered at low risk for complications should be left to push spontaneously led by their own instincts.

This chapter will focus on the complex physiological processes that occur when birth is undisturbed. It will look beyond midwifery practices during the second stage by including a consideration of how the birth environment itself impacts on the ability of women to birth their babies without intervention. The longterm health benefits associated with physiological birth will be considered with reference to the relatively new fields of epigenetics and the study of the human microbiome. The role the midwife plays in supporting physiological birth will be highlighted and finally Birth Territory theory will be introduced as a strategy that midwives can use to protect the birth environment and maximize the chances of women achieving a physiological birth.

#### Normal birth: searching for a definition.

There is currently no universally acceptable definition of a 'normal birth'; the term has different meanings for midwives, obstetricians and child-bearing women (Jay & Hamilton, 2014; Davis 2015). Within the midwifery profession, individuals may cite differing definitions ranging from anything short of a caesarean section, at one end of the scale, to a physiological, intervention-free birth at the other (Jay & Hamilton, 2014). It is argued that most people consider normal birth to lie somewhere between these two extremes (Mead, 2008).

Midwifery writers have highlighted the challenges associated with researching 'normal birth', indeed even calculating the numbers of normal births occurring in the UK is challenging when the definition of what constitutes normal birth is unclear (Downe, et al., 2001; Beech & Phipps, 2008). This issue was referred to in Chapter 1 with the debate around 'normal' referring to common practice versus 'normal' meaning natural (Kitzinger

et al., 1990). There is also an argument that abnormality in birth is usually defined as a deviation from the norm rather than as a pathological issue in its own right (Downe, et al., 2001; Walsh & Newburn, 2002).

Later definitions of normal childbirth (WHO, 1996; ICM, 2008; RCM, 2004) define birth as normal when a woman begins, continues, and completes labour physiologically between 37 and 42 completed weeks of pregnancy and when mother and baby remain in good health after the birth. The Maternity Care Working Party (2007) recommend using the definition of 'normal delivery' as birth "without induction, without the use of instruments and without general, spinal or epidural anaesthesia"(p.1).

However there are inherent challenges associated with using 'normal' in any definition. The term 'normal' implies a phenomenon that is common or most usual (Walsh & Newburn, 2002; Beech & Phipps, 2008; Mead, 2008). In modern maternity units many women have their labours augmented, receive epidural analgesia and have interventions such as regular vaginal examinations and continuous fetal monitoring, all of which have come to be viewed as 'normal'. Midwives interviewed in a German study defined normal birth as the medicalised approach that was their standard practice (Stone, 2012). A definition of 'physiological birth' could be a preferred option for healthcare professionals (Stone, 2012; Maternity Care Working Party, 2007) but this term may not be universally recognised by lay people who may be unfamiliar with what constitutes normal physiology (Beech & Phipps, 2008).

Downe and McCourt (2008), call for a definition of physiological birth to encompass the concept of 'unique normality', where the individuality of each woman is recognized along with the acknowledgement that labour itself is non-linear and besieged with both complexity and uncertainty.

For the purposes of this study and associated discussions, normal birth is defined as physiological labour and a vaginal birth with minimal or no external intervention (Lee, 1999). This definition acknowledges that some women may experience certain interventions but still consider their birth to be normal. For example, a woman might receive epidural analgesia but still be able to push her baby out resulting in a spontaneous vaginal birth. In using this definition however, it must be acknowledged that

whenever an intervention is used in what has been defined as a 'normal birth', a medicalised model has still been utilized and subsequently the birth itself cannot be truly physiological. (Gould, 2000). The focus of this chapter remains a consideration of the definition of physiological birth when the labour and birth process is left undisturbed with no intervention of any kind in the birth process.

### Normal birth: evolutionary influences

Rosenberg and Trevathan (2002) argue that because humans walk upright on two feet (bipedalism), have large complex brains, and give birth to infants who are initially helpless, labouring women need to seek assistance in order to ensure the survival of themselves and their offspring. It is suggested that this is an example of natural selection (Rosenberg & Trevathan, 2002; Odent, 2015), where the potential disadvantages of having another individual with the labouring woman (including increased susceptibility to infection and the stress associated with being distracted by another person) is outweighed by the benefits which this support can bring. Unlike non-human primates, a human female is unable to fully assist in the birth of her own baby as the human infant is born facing the opposite direction from its mother. This means that it is difficult for a woman to reach down and clear her baby's airways or untangle the umbilical cord at the moment of birth (Trevathan, 1987). If a woman attempts to assist by guiding her baby from the birth canal, she pulls against the infant's natural angle of flexion, thus risking damage to the spinal cord, brachial nerves and muscles (Rosenberg & Trevathan, 2002).

Human birth is uniquely different from that observed in non-human primates. Due to the very close proximity of the head and shoulder to the maternal pelvis, the human fetus undertakes a series of co-ordinated rotations as it negotiates the birth canal during labour. The fetus tends to leave the birth canal in the occipital-anterior position (i.e. facing away from its mother) and birth tends to occur in a social rather than a solitary context with other individuals supporting the woman. (Rosenberg & Trevathan, 2002; Trevathan, 1987). Indeed, the human female's desire to seek supportive familiar people to assist her during birth is deeply rooted in evolutionary history (Trevathan, 1987).

## The physiology of birth

Physiology is the science that examines how the body functions in relation to the environment, and it tends to assume a whole systems approach. Schmid and Downe (2010) argue that while birth physiology is the same for all women, human females are also governed by unconscious functions of the brain and by the interplay between cultural and cognitive aspects. These factors can lead to an increase or reduction in physiological responses. Birth should be viewed as a dynamic process that moves between the woman, her environment, and her consciousness with the involvement of numerous elements including her baby and her birth companions. (Schmid & Downe, 2010). This concept is at odds with the dualism of the biomedical model and an either/or approach where the body operates independently from the mind (Foureur, 2008). It also highlights the unique normality of birth as previously suggested. The biomedical model will be explored further in Chapter 4.

Hormones work together to stimulate various changes in the body of the woman and baby during pregnancy, labour and birth (Schmid & Downe, 2010) and simultaneously trigger and are triggered by emotional states that are transformed into physical responses (Young, 2009). Schmid and Downe (2010) suggest that rather than concentrating on the effect of one specific hormone during labour, the interplay between other hormones needs to be taken into account. This is why the use of a synthetic hormone (Syntocinon) to stimulate labour contractions can be problematic; it is used in isolation and yet it will have a significant effect on other aspects of birth physiology (Schmid & Downe, 2010).

This chapter will include a basic overview of birth physiology, in as far as it is relevant to the research question. However, the complexity of the subject of birth physiology must be acknowledged, even though it is beyond the scope of this study to look at it in more depth.

On a basic level, the physiology of birth focuses on the interplay between the two hormones oxytocin and adrenaline. (Odent, 2008). Oxytocin is the key hormone associated with labour and has both physical effects on the body - for example stimulating uterine contractions - and behavioural effects; it is often described as the

'love hormone' (Odent, 1999; Foureur, 2008). In contrast, adrenaline is released in stressful situations, for example when a mammal feels afraid, cold and under scrutiny. Adrenaline is antagonistic to oxytocin, therefore high levels of adrenaline will lead to reduced levels of oxytocin (Odent, 2008, 2015). From this premise, Odent (2008) argues that in order to ensure that optimum levels of oxytocin are released during labour, women should have certain basic needs met; to feel safe within the birth environment, to feel that they are not under scrutiny and to be in a warm, comfortable setting.

Adrenaline and noradrenaline are the main hormones produced in response to stress in order to instigate the 'fight or flight' response. Both are under the control of the sympathetic nervous system (Buckley, 2010). Bodily responses to the activation of the sympathetic nervous system include an increase in blood pressure and heart rate, a shunting of blood from the skin and other non-essential internal organs (including the uterus) to major muscles, a decrease in gut activity and dilatation of the airways to enhance respiration (Nestler, et al, 2009). All of these physical responses, activated when danger is perceived to be present, prepare the individual to either run or fight.

When high levels of adrenaline are detected in a woman's blood in early labour there is an associated increase in the overall length of her labour and more fetal heart rate abnormalities (Lederman et al., 1985). This makes sense as adrenaline diverts blood away from the uterus and other non-essential organs in order to instigate the fight or flight reflex. A minor reduction in the amount of blood supplied to the uterus and placenta will soon manifest itself as fetal distress (Suresh, et al. 2013; Mead, 1996).

The ability to instigate a fight or flight response is relevant to the female of any species as they will be particularly susceptible to attack by a predator when labouring in the wild. Release of adrenaline is initiated when danger is sensed as a short-term strategy to halt labour and provide energy to either fight or, as is more likely, flee from a prospective attacker.

Experiments using mice were undertaken by Newton et al. (1966a; 1966b,) to ascertain the effects of an unsafe environment on mammals giving birth. The researchers found that cortisol stimulation was important even amongst non-human mammals. For example, pregnant mice who were handled frequently during labour or who were put in

containers contaminated with cat urine took significantly longer to deliver their pups than those left undisturbed in safe environments. Pups born in hostile environments were also more likely to be still born or to die soon afterwards.

Women labouring in modern maternity units are also in unfamiliar environments, being observed by strangers as a form of medical surveillance. This may lead to feelings of unease, anxiety and stress which will stimulate the surge in adrenaline and nor-adrenaline (Buckley, 2010). It is no surprise that contractions often slow down, become irregular or cease altogether when labouring women are initially admitted to hospital (Hutton, 1986; Simkin & Ancheta, 2000). As Buckley (2010) points out, the medical response to a slowing of labour is usually to increase surveillance and to include more intrusive forms of monitoring which exacerbates the situation. In contrast Odent (2008), believes that a slowing down of labour is a signal that a woman needs to be left in private which he argues is more likely to lead to a reduction in adrenaline and a subsequent normalization of labour.

Foureur (2008), uses the Fear Cascade theory to explain how maternal stress and the associated release of adrenaline and activation of the sympathetic nervous system impacts on the condition of the fetus and progress of labour. This is initiated when women are expected to give birth in the physiologically hostile environment of the modern maternity unit.

Odent (2008) also highlights the 'human handicap' in relation to birth. The human handicap in this context refers to the increased development of the thinking, rational aspect of the human brain known as the neocortex. The inhibitions which a woman might exhibit during labour and birth originate in the neocortex. Nature attempts to override the influence of the neocortex during labour by allowing this part of the brain to become dormant so that the hypothalamus and the pituitary gland can release the necessary hormones to complete the birth process. When women are left undisturbed they tend to go into a trance-like state during labour (T. Anderson, 2000; Odent, 2008; Odent, 2015) and may exhibit uninhibited behaviour such as screaming, shouting and swearing, which is uncharacteristic of women in civilised society. This behaviour often then leads to an authentic 'fetal ejection reflex' when the baby is born very quickly after a number of involuntary contractions and no voluntary pushing (Odent, 2009).

Odent (2008; 2009; 2015) suggests that when women behave in this way it is a sign that the activity of the neocortex is reduced. This allows the instinctive primitive aspects of brain function to take over. He argues that another basic need of the woman in labour is to be protected against further stimulation of the neocortex by external factors such as bright lights, feeling that she is being observed, or a birth attendant talking to her and giving instructions (such as those provided during directed pushing). Giving birth under the bright lights of modern delivery suites may also inhibit the production of melatonin, a hormone which works alongside oxytocin to stimulate uterine contractions but has been found to be suppressed by light (Olcese & Beesley, 2014; Sharkey, Puttaramu, Word & Olcese, 2009)

Any situation which leads to an increase in adrenaline also leads to stimulation of the neocortex. This is because the flight or fight reflex is dependent on an individual being alert and responsive enough so that they can escape from danger. Odent (2015) argues that the main reason for the 'human handicap' is the inhibitory effect of the dominant neocortex on normal, physiological processes including giving birth.

Fahy (2008) argues that labouring women need to let go of the rational thinking higher brain in order to respond to the primitive instincts originating in the lower level, mammalian brain. A midwife can assist in promoting physiological birth by protecting the birth environment to prevent disturbance and to empower women to let go of the rational brain and succumb to their instincts (T. Anderson, 2000; Parratt & Fahy, 2004; Fahy, 2008).

### Physiological second stage and spontaneous pushing

The second stage of labour has traditionally been defined as being from the time of full dilatation of the cervix to delivery of the baby (Downe, 2011; Downe & Marshall, 2014). However, the linear nature of labour with its inherent phases and stages is being challenged (Walsh 2010; Zhang et al., 2010). A transitional phase between first and second stages of labour has long been recognized by midwives and women (Downe, 2011; Downe & Marshall, 2014; Walsh, 2010), although largely ignored by obstetricians (Woods, 2006). Transition can be characterised by the labouring woman becoming restless, agitated and disheartened, feeling nauseous, shaky and disorientated.

Sometimes she is seen to enter a trance-like state as previously described (Woods, 2006), a condition signalling that activity in the rational neocortex is diminishing. However, the manifestation of a transitional phase is unique to each woman and may not always be apparent. This is a particularly challenging part of the birth process for women, their partners, and midwives as women will frequently implore the midwife to help them and 'do' something. In modern maternity units this may culminate in the offer of an epidural to relieve the intense pain. Leap and Anderson (2008) refer to this as the 'pain relief paradigm' of modern childbirth and acknowledge that the offer pain relief at this point may prove irresistible to a labouring woman.

Once the cervix reaches full dilatation, some women feel an overwhelming urge to push, whereas others may experience a lull in contractions as they reach what has been called 'rest and be thankful' or the passive phase of the second stage. (Flint, 1986; Downe & Marshall, 2014). This enables the body to conserve vital energy in preparation for the impending birth (Woods, 2006).

Contractions become increasingly expulsive as the fetus moves further down the birth canal. The fetal head stimulates nerve endings contained within the pelvic floor, Ferguson's Reflex is instigated and this usually leads to the woman experiencing an overwhelming urge to push. Initially the pushing urge can be controlled, but it becomes increasingly more pronounced and under involuntary control. Women then tend to use other muscles in the diaphragm and abdomen to aid the birth of the baby (Downe & Marshall, 2014).

Rossi and Lindell (1986) found that when left undisturbed, women tended to undertake spontaneous open-glottis pushing. Roberts et al. (1987) and Thomson (1993, 1995) demonstrated similar results. Spontaneous, physiological pushing differs from directed, Valsalva style pushing techniques in that women do not take a deep breath in at the start of a push, and they do not start to push as soon as they feel a contraction, rather they use an individual combination of open and closed-glottis pushing (Thomson, 1995). They do not hold their breath for the duration of a contraction but make several short, strong pushes during the contraction characterised by a deep breath before each pushing effort (Roberts et al, 1987).

## The impact on the woman of a positive childbearing experience

A positive birth experience is considered to enhance a woman's self-confidence and self-esteem (Callister et al., 2003; Beech & Phipps, 2008). Research has demonstrated that following an interventionist medicalized birth, a woman's confidence may decrease resulting in a diminished sense of self and maternal dissatisfaction, as direct result of the birth experience (Fisher et al., 1997; Waledenstrom, 1999; Creedy et al., 2000). Lobel and DeLuca (2007) found that women giving birth by caesarean had a tendency to develop low self-esteem which impacted on their early parenting experiences. This is supported by Fenwick et al., (2009) who found that women who had had caesarean sections were frequently disappointed and had to work to retain their sense of normality.

However, a more recent study (Thompson, 2010) found that a positive birth experience can transcend the mode of birth as women reported positive experiences associated with both instrumental and operative births. The research suggested that a positive birth experience was characterised by a calm and relaxed feeling of normality within the birth environment, whether it be in a home setting, birth centre, operating theatre or delivery suite. This highlights the positive impact that midwives can have on a woman's birth experience when they create the optimum conditions for birth. This aspect will be explored further in the next section.

Walsh (2008) highlighted the challenge of trying to understand why women feel empowered by an experience of physiological birth. As he points out, medical intervention into a complicated birth is warranted for some women and it would be judgemental to assume that their sense of self and experience of motherhood is diminished as a result of it.

Walsh (2008) uses the 'flow' theory of Csikszentmihalyi (2002, 2014) to explain why physiological birth can result in such psychological benefits for individual women. Csikszentmihalyi (2002) suggests that a 'flow state' occurs when the level of challenge of an activity and the skill possessed to complete the activity are in balance. If the challenge is high but skill set is perceived as being inadequate, the situation can lead to anxiety. However, if the skillset is high and the challenge is low this can result in boredom. The optimum state of flow is reached if the level of challenge is perceived to be high and the

skills possessed are thought sufficient to complete to the challenge. (Csikszentmihalyi, 2014) The flow state, once attained, leads to a sense of fulfilment, happiness and achievement. When in a state of flow, an individual is fully immersed in the activity they are undertaking and there is a merging of action and awareness (Csikszentmihalyi, 2014). The theory can be translated into woman's experience of birth by acknowledging that giving birth is a physically demanding and challenging process, but if a woman receives appropriate preparation for labour to instil in her the confidence that she can succeed (as tentative as this may be initially) she has the potential to achieve the flow state and be fully engaged in physiological birth and the sense of achievement associated with it.

Walsh (2008) argues that some conditions of the flow state will never be met if professionals take control of the birth process, as by doing so they disempower women. It is suggested that preparing women antenatally for the conditions needed for physiological birth will enhance their skill level, instil a sense of confidence in themselves and assist them in achieving the flow state (Walsh, 2008). If interventions into the birth process are required then these need to be undertaken in a sensitive and supportive way so that the negative effects on a woman's sense of self are mitigated, as outlined by Lobel and De Luca (2007) and Fenwick, Holloway and Alexander (2009).

### Further benefits of physiological birth and the implications of intervention

Recent research around the relatively new science of epigenetics and the study of the human microbiome has opened up other areas which favours a physiological as opposed to an interventionist approach to birth, although results are still currently in the speculative phase (Cho & Newman, 2013; Odent, 2015).

Epigenetics refers to the study of biological mechanisms that can activate or deactivate genes. Any change in this gene expression will not involve change to the underlying structure of the deoxyribonucleic acid (DNA). Although it is a silent modification, it will affect how cells read genes and will eventually influence the production of proteins in the body (Cho & Newman, 2013; Odent, 2015).

Epigenetic change can manifest itself in relatively simple ways such as how cells develop and, for example, end up as skin, liver or brain cells. It can also have more wide-ranging effects, such as how cells develop to cause diseases such as cancer or Alzheimer's.

Studies have demonstrated that the period around birth is a one of intense epigenetic activity that may cause changes, dependent on the mode of birth (Almgren et al., 2014; Godfrey et al., 2011). Almgren et al. (2014) compared the methylation of DNA in the stem cells of babies born following either an elective caesarean section or a normal vaginal birth. DNA was found to be more globally methylated in the caesarean group. The degree of methylation in the vaginal delivery group was related to the length of time the mother was in labour. These modifications in DNA may have implications for an individual's immune response, regulation of glucose and ketones in the body and the regulation of an individual's response to food intake. Another study (Godfrey et al., 2011) identified the potential for perinatal epigenetic analysis to be useful in identifying susceptibility to obesity and other metabolic disorders in later life. Research suggest that these findings may have implications for future health; babies born by elective caesarean section (before labour) face a greater risk of developing various immune diseases such as asthma, allergies, type-1 diabetes and coeliac disease (Cho & Norman, 2013).

The study of the human microbiome involves the study of the genes associated with all the microbes present in the human body as opposed to the human genome which relates to all an individual's genes. Odent (2015) highlights that the 'microbiome revolution' is a significant breakthrough in understanding how the human immune system works and how it can be susceptible to disease. During a normal vaginal birth, a baby's gut is colonized with bacteria originating from its mothers vaginal and perineal area. Research suggests that during a modern caesarean section carried out in sterile conditions, the baby is deprived of bacteria at a critical period of development, when the immune system needs specific stimulation in order to be activated and to function effectively (Neu & Rushling, 2011). The so-called 'hygiene hypothesis' suggests that lack of bacterial exposure in early life leads to an increased risk of developing immune diseases in later life (Strachan, 1989; Neu & Rushling, 2011).

Another proposed mechanism which may explain the differences in immune response exhibited by babies born by caesarean section and vaginal delivery relates to the different levels of stress hormones present at the time of birth (Cho & Norman, 2013). Uterine contractions during the second stage of labour and the inevitable fetal hypoxia which ensues, stimulates a significant stress response in babies born vaginally. The degree of stress increases gradually as labour progresses physiologically and culminates in delivery.

Babies born by elective caesarean section do not experience this degree of stress and when it occurs it happens immediately at the moment the baby is taken surgically from the uterus (Cho & Norman, 2013). Research suggests that a lack of stress hormone surge and the associated poor activation of the hypothalamic-pituitary-axial pathway may result in an under developed immune system after caesarean section (Hyde et al., 2012). It is beyond the scope of this chapter to explore these potential mechanisms in greater detail. However, the physiological process of birth is so finely tuned that any intervention has the potential to have a wide-ranging influence on the baby's future health. When considering midwives' practices during the second stage, the extent to which an attempt is made to facilitate a physiological birth is of interest when considering the implications of any kind of intervention including directing a woman's pushing efforts.

### The role of the midwife in promoting physiological birth

The focus of this study is midwifery practice during the second stage of labour in relation to directed pushing. Having reviewed the physiology behind birth it makes sense to frame the most effective intrapartum midwifery practices in terms of the midwife becoming a guardian of the birth environment. This favours physiology rather than a controlling dominant figure working within the medical model. This type of approach should also empower women and assist them in the achievement of the flow state, as previously described.

Birth territory theory (Fahy & Parratt, 2006; Fahy, et al., 2008) fits well within this model as it encourages the midwife and woman to combine power in order to facilitate and empower the woman to achieve a positive birth experience. This involves the midwife protecting the birth territory and actively promoting the sense of it being a sanctum where women can retreat to give birth in private (Fahy & Parratt, 2006; Fahy et al., 2008). Odent (2015) describes his vision of Utopian midwifery as follows: "Let us imagine a labouring woman in a small, dark and warm room. There is nobody around, apart from one experienced and silent midwife sitting in a corner knitting."(p.107).

A repetitive activity such as knitting is suggested by Odent (2015, 2004) as a strategy to avoid anxiety on the part of the midwife and enhance a sense of calmness and peace in the birth room.

This idea also reflects those of other authors who argue that midwifery should be about 'being with' and not 'doing things' to labouring women (Fahy, 1998) in order to promote a physiological birth. For example, Kennedy (2000) argues that midwifery is the art of 'doing nothing well' while Leap (2000) suggests that the 'less we do, the more we give'. This contrasts sharply with the medical model of care that is characterised by a compulsion to do something and seize control of any given situation (Grol & Grimshaw, 2003). The use of directed pushing during the second stage clearly fits into this category, when midwives are intervening in a physiological process with their desire to hasten things along. Birth Territory theory will be described in more detail in Chapter 5 when exploring the relevance of power and control to maternity care.

### Summary

This chapter has reviewed the basic physiology of birth to explain the importance of women being left undisturbed to relinquish control over the aspects of their thought processes that may inhibit labour progress. The stress-evoking sympathetic nervous system needs to be kept at bay so that labour-enhancing oxytocin, rather than labour-inhibiting adrenaline is released. However, the paradox is that evolutionary factors have led to human females actively seeking assistance during birth. This means that a balance needs to be achieved between midwives providing a supportive presence and disturbing a natural process.

The potential benefits of physiological birth on both a psychological and physical level have been explored in order to support the argument that it is beneficial for women and midwives to continue to pursue this aim in the face of ever increasing medical domination and the resulting rise in caesarean sections. Recent research, although still speculative, implies that the mode of birth has far reaching implications for future health and well-being of the population.

Birth Territory theory has been introduced and will be explored further in Chapter 5. For a birth to be truly physiological, midwives should not be giving direction to women during the second stage, as this will interfere with natural processes and undermine the woman's confidence in the ability of her body. It is suggested that women and midwives should work in partnership, to combine their power and facilitate a positive outcome for

birth whether that be a spontaneous vaginal birth or an instrumental or operative delivery.

Having described elements of physiological birth in this chapter, the next will explore the interventionist approach of the biomedical model that currently dominates maternity care in the Western world.

## 4. Medicalisation of childbirth

### Introduction

In the previous chapter I presented an overview of the intricate physiological processes and complex endocrinology underpinning childbirth when left undisturbed. The benefits of promoting a physiological approach birth, in terms of epigenetics, human microbiome and the positive influence that this may have on the future health of the population were also highlighted.

In this chapter I will present the argument that midwives intervening into the second stage by directing pushing confirms that they are operating within a biomedical framework (Downe et al., 2001; Hyde & Roche-Reid, 2004; Crabtree, 2008; Downe, 2012). The biomedical model being particularly risk averse (Smith et al, 2014) promotes the idea that childbirth requires interventionist strategies, like directed pushing in order to ensure a safe outcome for the woman and baby (Romano & Lothian, 2008; Walsh, 2012). This is despite the fact that there is no evidence showing that directed pushing is superior to spontaneous pushing in terms of safety. The fact that the practice persists contravenes the basic principles recommended when the Cochrane Database was established; that there should be no intervention into any physiological process unless that intervention is known to be more effective than nature and that associated risks or side effects should not outweigh the benefits (Enkin et al., 2000.) As I have shown, in terms of directed pushing this is not the case as there are no proven benefits and some morbidity associated with its continued use.

This chapter will begin from an historical perspective by exploring how birth in the Western world evolved from being seen as a natural life event where women were supported by other women, into a biomedical process where intervention is perceived as being paramount in ensuring a safe outcome. Medicalisation describes the domination of science over phenomena that had traditionally been situated in the social domain (Hillier, 1991). Exploring the medicalisation of birth, how it happened and why it persists is pertinent to the research question 'What are midwives' practices during the second stage of labour?' in order to gain further insight into the reasons why midwives choose to direct pushing during the second stage of labour.

## Background

Throughout history, childbirth has been perceived as a major transition for women who have traditionally come together to support each other through the process (Donnison, 1988; Kitzinger, 2006). However, during the 20<sup>th</sup> century the birth altered from being a private, hidden process occurring in the domestic arena into a hospital- based public and medicalised event. This change mirrored the political, economic and social transformation occurring concurrently in the industrialised world. Birth changed from being a female dominated process where the presence of men was forbidden, into a technical event ruled over by men and requiring close medical surveillance to ensure the best outcome (Oakley, 1984; Franklin, 1991; Annandale & Clarke, 1996; Kitzinger, 2006; Walsh, 2012).

As highlighted in Chapter 1, the rapid intervention of medicine into childbirth is illustrated by the rising CS rate seen in the UK over the past thirty years. The World Health Organisation (2015), indicate that 10% is the minimum rate of CS to aspire to and that a rate higher than this suggests that the operation is not being carried out for health reasons because the benefits to maternal mortality levels off at this percentage point. Obstetricians argue that their view that birth is only 'normal in retrospect' leads to improved safety for women and babies, yet the increasing CS rate has not been accompanied by any measurable improvement in the health of either and has been associated with increased maternal mortality and morbidity when compared with spontaneous vaginal birth. (NHS, 2006; Walsh, 2012).

## How did birth become medicalised?

During the 18<sup>th</sup> Century a struggle for power between female midwives and the male dominated medical profession began in the Western World (Arney, 1982). The invention of the obstetric forceps meant that it became possible to deliver a live baby in complicated births where previously mother, baby or both would have perished. Forceps were only permitted for use by male doctors and male midwives so if birth became obstructed, female midwives had to call for a man to deliver the baby (Wilson, 1985). The male midwife became a recognised childbirth practitioner in the 18<sup>th</sup> Century when midwifery textbooks aimed at men were first published (Wilson, 1985). These publications discredited female midwives as midwifery became associated with

witchcraft. Male practitioners blamed 'dangerous' midwifery practices for the high rates of mortality associated with childbirth (Oakley, 1987). The rationale for the use of scientific intervention into birth was that it would improve the safety by reducing mortality rates (Lupton, 2012). Foucault's theory (1980) that knowledge is synonymous with power explains how doctors by highlighting their medical knowledge were able to gain power over birth. Issues around power relationships in maternity care will be explored in Chapter 5.

The 'Enlightenment' period was accompanied by a rapid growth in scientific knowledge about the human body in addition to increasing industrialisation and the need for a healthy workforce (Donnison, 1988). This, plus the rise in state provision for healthcare, saw childbirth being redefined as a process belonging in the public arena with the requirement that it should be overseen by qualified professionals rather than by lay midwives (Walsh, 2012). There is a paradox here whereby the biomedical model of childbirth implies that the technical knowledge of the doctors is superior to the embodied knowledge of the women who are actually giving birth (Rothman, 1982; Davis-Floyd 1992; Bergstrom, et al., 1997; Pitt 1997; Downe, 2010).

During the 20<sup>th</sup> Century, the midwife once the central figure in a woman's labour become secondary to the obstetrician. Coppin (2005) argues that the dominance of medicine led to an erosion in the confidence of midwives in their ability to provide intervention-free care which had previously been the norm. This is confirmed by recent studies (Mead, 2004; Keating & Fleming, 2009; Scamell & Alaszewski, 2012; Bedwell et al; 2015) demonstrating that modern midwives have an increased perception of risk and a diminished confidence in the physiology of birth.

Scamell and Alaszewski (2012) found that rather than promoting physiological birth, the midwives in their study introduced pathology into the process whereby birth was not classified as normal until it was over. The authors described midwives creating an 'ever-narrowing window of normality' in which birth was categorised as a dangerous process fraught with risk. This is despite the fact that childbirth in the 21<sup>st</sup> Century is safer than it has ever been and statistics demonstrate that the probability of actual harm befalling either woman or baby is small (MacKenzie Bryers & van Teijlingen, 2010). Midwives

therefore, should feel confident to treat most women as capable of giving birth spontaneously (Scamell & Alaszewski, 2012).

This issue will be revisited in Chapter 5 as I consider the dynamics of power operating within maternity units to try and understand why midwives continue to practice subordinately within the biomedical model.

### Why did birth move from the home to the hospital?

The increasing medicalisation of childbirth was accompanied by an increase in the hospital birth rate. This began in the 1930's and was influenced by the government's concern about high mortality rates (Doyal & Pennell, 1979). In addition, impoverished women were lured by the prospect of having the space to give birth in the perceived safety of the hospital leading them to increasingly demand hospital care (Doyal & Pennell 1979).

However, a government publication (Ministry of Health, 1937) reported that there was increased maternal mortality in women from the higher social classes. This was attributed to the fact that they were more likely to have paid for private care in a maternity home with a higher risk of exposure to infection (Hunt & Symonds, 1995). This contradicted the widely held view that hospital under the care of a doctor was actually the safest place for birth to occur.

Doctors continued to argue that the higher mortality rate was due to a decreasing birth rate amongst the middle classes and the fact that they were usually primigravida and so more likely to experience complications than women undergoing subsequent pregnancies. (Hunt & Symonds, 1995). Another explanation was that women who sought the advice of a doctor were already experiencing complications. This report did not show that giving birth in hospital was any safer than giving birth at home; indeed statistics showed the opposite. However, the medical discourse is a powerful one and doctors were able to retain their dominance over childbirth with ever increasing numbers of hospital births.

Women also turned to obstetricians for the relief of the pain of childbirth. Another government report (Ministry of Health, 1949) showed that only 20% of women at home received any form of analgesia compared with 52% of women in hospital. This

encouraged the medicalisation of childbirth by promoting the superiority of hospital birth. It is argued that this was a professional strategy used by one professional group (the obstetricians) to further their own interests over another (the midwives). (Hunt & Symonds, 1995).

The implementation of the NHS in 1948 led to a rapid growth in the number of hospitals so that admission to hospital became a common event. As the population began to accept hospital care as the norm so hospital values of hygiene and professional expertise were carried into the private world of the home. (Hunt & Symonds, 1995).

In 1970 recommendations from the Peel Report (Department of Health & Social Security (DHSS), 1970) led to a policy advocating that all births should take place in hospital. The rationale for this came from the perceived safety of hospital birth which justified providing hospital beds for all women. However, this report failed to acknowledge that the decrease in maternal and infant mortality could be due to the improved general health of women rather than where they gave birth. (Tew, 1998). The link between the safety of childbirth and place of birth was as likely to be due to coincidence as it is to any causal relationship (Pratten, 1990) and there was no evidence to prove otherwise. Tew (1998) argued that the central issue regarding place of birth was not safety but the promotion of professional self-interest on the part of obstetricians. Her arguments so antagonised these professional interests that she was subject to personal ridicule leading her to having to self-fund her work in later years (Pratten, 1990).

The Short Committee (United Kingdom Social Services, 1980) investigated the perinatal mortality rate in the UK that had not decreased as rapidly as it had in other countries despite the implementation of recommendations from the Peel Report (DHSS, 1970.) The recommendation from this committee was again that all women should be delivered in hospital and home births should no longer be available. The reduction in prenatal and neonatal mortality since the 1960s is still cited as evidence that medicalised births are central to the increased safety for women and babies in the 21<sup>st</sup> Century (DH, 2007a), despite the fact that evidence for any causal link is still not forthcoming.

A more recent study however (Birthplace in England Collaborative Group, 2011) found that for healthy women giving birth in a midwifery-led birth centre or at home were safe

options. This comprehensive study found that healthy women planning to give birth in an obstetric- led, hospital unit were more likely to have an emergency CS than those who planned to give birth in a birth centre or at home. The study also found that the rate of normal vaginal birth was 56% for women choosing an obstetric unit rising to 88% for those choosing a home birth. A cost-effectiveness analysis demonstrated that the cost of care for women in obstetric- led units was significantly higher than the cost in a birth centre or at home.

However, this study also showed that for nulliparous women, a planned home birth did significantly increase the risk to the baby of a poor outcome. There was also a high possibility that nulliparous women would require transfer to an obstetric unit for delivery due to intrapartum complications; the transfer rate being 45% for homebirths. No potential reasons were suggested for these findings or discussion around what could be done to reduce the risk for this group of women (Rogers et al., 2012).

Interestingly, although the popular media reported on the increased risk to the baby when nulliparous women planned a homebirth it failed to highlight that giving birth in an obstetric unit led to increased intervention and associated morbidity for all women (Rogers et al., 2012). The RCM also concentrated on this aspect of the study by recommending that midwives should offer nulliparous women planning a homebirth the opportunity to change their option for place of birth (RCM, 2011). The opposing argument that women planning a hospital birth should be warned about the high risk of them receiving medical intervention was not recommended (Rogers et al., 2012). The Royal College of Obstetricians and Gynaecologists (RCOG) focused on the logistics of managing the high transfer rate of women from home into hospital and also recommended increasing the numbers of consultant obstetricians to ensure a continuous consultant presence in maternity units. (RCOG, 2011)

### [Policy attempts to make birth more woman-centred](#)

From the 1970's onwards, women themselves began to challenge the dominance of the medical model of birth and pressure groups such as the National Childbirth Trust and the Maternity Alliance lobbied policy makers for a change towards a more woman centred model of care (Oakley, 1993; Langan, 1998). This culminated in the publication of the

Changing Childbirth Report (DH, 1993) that identified the importance of continuity of care, choice of care, place of birth, involvement of women in decision making processes and recognition that care for women during normal childbirth should be led by a midwife. The themes from Changing Childbirth recur in all later policies published since then. The National Service Framework (NSF) for Children, Young People and Maternity services (DH, 2004) recommended flexible, individualised services designed to fit in with the needs of the woman and that normal childbirth should be facilitated by a midwife with medical intervention being implemented only if it is was of benefit to the woman and her baby. The overall message of Maternity Matters (DH, 2007a) was that if a woman received high quality care throughout pregnancy and birth, she was most likely to provide the best start in life for her baby. Again the safety issue was emphasised with women being warned that if they needed expert specialist care, it should be close at hand. Similarly, Midwifery 2020 (DH, 2012) provides a vision for the future of midwifery and suggests that while midwives should continue to act as the lead professional for all healthy, low risk women they will also need to work in collaboration with doctors to support women with more complex needs. This means that the requirement for specialist doctors to ensure a safe outcome is still at the forefront of the maternity care debate. Consequently, women and midwives are already programmed to mistrust the innate ability of the body to give birth. The latest Maternity Care Review (NHS England, 2016) raises the same themes including the importance of choice, safety, individualised care and continuity of care for childbearing women. The emphasis in this report however is on effective communication and the importance of multi-professional collaboration. Indeed since Changing Childbirth (DH, 1993) all subsequent policy recommendations have called for a return to a more physiological, less interventionist model of birth and yet in most areas of the UK it is not seen to be happening and latest statistics show no decline in operative delivery rates.

### [The biomedical model](#)

Most midwives employed in hospitals in the UK work within an institutional, hierarchical model of care dominated by technology and medicine (Pollard, 2003; Keating & Fleming, 2009; O'Connell & Downe, 2009). It is argued however that, midwives employed in birth centres do work within a more woman- centred, less hierarchical culture (Pollard, 2003; Keating & Fleming, 2009; O'Connell & Downe, 2009). Walsh (2012) however argues that

the picture may not be as clear cut as it appears. Edwards (2000) for example found that some women described giving birth at home as experiencing a hospital birth in a home setting. This suggested that midwives caring for them at home still retain the values of hospital- led policies and practices. Similarly birth centre midwives were shown to undertake interventions such as artificially rupturing membranes when women were in advanced labour in order to avoid a prolonged labour which would necessitate a transfer into the obstetric- led area (Annadale, 1988). Here, interventions were used by midwives to avoid what they perceived as being, more major interventions.

Research has demonstrated the challenges faced by midwives when trying to facilitate normal birth in large obstetric units with easy access to obstetricians and technology. (Shallow, 2001; Hunter, 2003; Mead, 2004). Midwives in Hunter's study (2003) reported how much easier it was to use their midwifery skills to facilitate normal birth in smaller birth centres with minimal technology and limited access to obstetricians. Participants in Keating and Fleming's study (2009) felt more autonomous when working at night when there were fewer obstetricians and midwifery managers.

Walsh (2012) presents the respective characteristics of the two maternity care models, namely the social (midwifery) model and the biomedical model in tabular form. This was drawn from the earlier work of Bradshaw (1994) that focused on a social versus medical model of health care generally. It is presented here from a childbirth perspective.

**Table 1 Social model versus biomedical model of care during childbirth**

Adapted from Walsh (2012).

Social Model	Biomedical Model
Holistic- physical, psychosocial, spiritual	<b>Reductionalist: power, passages , passenger</b>
Empowerment & Respect	<b>Control &amp; manage</b>
Technology viewed as servant	<b>Technology viewed as partner</b>
Difference celebrated	<b>Homogeneity preferred</b>
Intuition important	<b>Objective facts preferred</b>
Relational /subjective approach	<b>Importance of expertise/ objective</b>
Anticipate normality	<b>Anticipate pathology (normal in retrospect)</b>
Environment of birth central	<b>Environment of birth peripheral</b>
Self-actualisation	<b>Safety</b>

This highlights how the biomedical approach reduces the childbearing woman into a series of parts, her baby ('the passenger'), her reproductive tract ('the passages') and her uterine contractions and expulsive efforts (collectively known as 'the powers'). This reflects Plato's theory of dualism and the assertion that the mind holds a superior position over the body. (Gerson, 2003). There is an either/ or, black/white aspect of dualism that is also characteristic of a patriarchal framework (Warren, 1994). In this context, reality is arranged into opposing (rather than complementary) and exclusive (rather than inclusive) parts (Keating & Fleming, 2009). The role patriarchy plays in maternity care will be revisited in Chapter 5.

Medicine draws on the philosophical argument of dualism with the assumption that bodily processes are subject to damage requiring repair by knowledgeable specialists (Walsh, 2010). Within this paradigm, the physical processes of labour need to be subjected to careful management and continuous surveillance in order to achieve a successful outcome (Walsh, 2010). Perkins (2004), in a critique of maternity care in the United States (US) suggested that the Ford car assembly line provides the template upon

which modern maternity care is based. Childbearing women are viewed as machines that need regular servicing and repair by obstetricians in order to run smoothly. Another analogy likens childbearing women to factory workers with the obstetrician as supervisor (Martin, 1992). The overarching feature of the biomedical model is that the childbirth experts, whether they be doctors or midwives, keep themselves busy by 'doing' things to women who are the passive recipients of care. It may explain why midwives practising within a biomedical framework feel the need to direct women during the second stage of labour whether it is by instructing them when and how to push or deciding the position they should adopt to give birth. Midwifery theorists have argued for a dismantling of the assembly line model of modern maternity care and a return to a belief in the 'unique normality' of labour for each individual woman (Mead, 2004; Davis-Floyd, 2008; Walsh, 2010; Downe, 2012; Kitzinger 2012).

However, as Walsh and Newburn (2002) highlight, the presentation of the two models in tabular form while allowing them to be compared, does not imply that every midwife or obstetrician will primarily adopt one model at the expense of the other. For example, a CS can be performed in a woman centred way and there is the potential for any birth to need medical intervention (Walsh, 2010, Sandall, 2012). It is argued that most practitioners situate themselves somewhere between the continuum with the medical model at one end and the social model at the other (Walsh, 2010). It is also recognised that all women need access to effective, safe medical care and there is no doubt that intervention into childbirth when used appropriately has reduced mortality associated with birth (Symonds & Hunt, 1996, Sandall, 2012). Stewart (2010) summarises her main concern as being that biomedical knowledge has achieved dominance in maternity care at the expense of the intuitive, female-centred knowledge which epitomises the social model and is the prerogative of childbearing women and midwives. As a midwife in Keating and Fleming's (2009) study stated, "intuition is not valued" (p.525).

The ideal as suggested by Davis -Floyd et al., (2001) is for a midwife to be able to move seamlessly between a social and biomedical model as the need arises. Mackenzie Bryers and Teijlingen (2010) similarly argue against a 'one size fits all approach' stating that

elements of both a social and biomedical model are needed in order to ensure the establishment of a modern maternity service that is fit for purpose.

Downe and McCourt (2008) have developed these ideas further by proposing that maternity care adopts a salutogenic approach by drawing on the principles of Antonovsky (1979). Salutogenesis implies that rather than being rooted in pathology and the risk of things going wrong, health care systems are framed within the concept of health and wellbeing. In this context, a woman who has laboured for many hours with little signs of progress but who is otherwise well and whose unborn baby remains healthy may not be entering the realms of 'failure to progress', particularly if she has a personal or family history of long labours. Midwives adopting this type of approach to intrapartum care would be able to facilitate a normal and physiological birth rather than feeling the need to intervene at the earliest opportunity because the labour trajectory appears to be becoming pathological.

### Summary

This chapter has shown how maternity care has been subjected to extensive technological innovation over the past two hundred years. Traditional relationships and sources of information previously rooted in the social support of other women have been curtailed in favour of a new medical science (Shapiro et al., 1983). Midwifery knowledge and practice is submerged within a culture of birth where medical expertise and the use of intervention and technology is highly valued at the expense of intuition and embodied knowledge (Gould, 2000). Midwifery theorists have continually recommended a move towards a social model of care in order to maximize physiological birth with its accompanying benefits but progress in instigating this within UK Maternity services is slow despite the recommendations of numerous government reports.

The next chapter builds on these ideas by exploring power relationships and how they operate within healthcare systems. The work of philosophers Foucault and Lukes will be drawn on to explain how biomedicine persists in retaining its' dominance over childbirth.

## 5. Power and control: relationships in maternity care

### Introduction

In the previous chapter it was established that in the Western world at least, the biomedical model of childbirth retains its dominance in maternity care. Midwives are required to practice within hierarchical organisations where policy, working practices, and technology frequently override the natural physiological process of giving birth. (O'Connell & Downe, 2009). In this paradigm the emotional needs of women and their desire to have a positive and satisfying birth experience are of secondary importance as birth tends to be framed in a risk averse context, and only viewed as 'normal' in retrospect. In the current hierarchy doctors are situated at the top end of the scale, with midwives below them, and women at the very bottom (Keating & Fleming, 2009).

This chapter will begin by exploring the literature around power relationships in maternity care and the potential influence these have on the midwives' practice of directing pushing during the second stage. The aim is to establish why midwives and women continue to allow the medical model to dominate childbirth, despite it not always operating in the best interests of the mother.

The power-related theories of Foucault and Lukes will be discussed and issues around choice and control for women whilst they are in labour will be considered, as well as the impact of midwives who must work within the patriarchal framework characteristic of a biomedical approach. Finally the Birth Territory theory (Fahy & Parratt, 2006; Fahy et al. 2008) will be revisited. This was outlined in Chapter 4 and will be explored in greater depth here as a potential framework on which midwives could base their practice in order to promote a more holistic woman-led approach to birth.

### Theories of power and how they operate in maternity care

According to Weber, power involves the capacity of an individual to get what they want even when there is resistance from others (Gerth & Mills, 2009). There are many theoretical discussions around the concept of power in the healthcare literature and numerous definitions exist (Shapiro et al., 1983). Fahy (2002) argues that as these definitions may take on different meanings depending on the context in which they appear, therefore there cannot be a single overarching definition of power. Fahy's (2002)

research explored how power operates in the interaction between obstetricians and childbearing women. The study aimed to find ways in which this knowledge might help midwives to empower women to gain control over what happens to them during childbirth. Fahy (2002) drew on Foucauldian principles during her data analysis.

Foucault (1980) distinguishes between 'legal power' and 'disciplinary power'. Legal power operates in public and can be effective even if an individual tries to resist it. Disciplinary power operates in most large hierarchical organisations and, in contrast to legal power, remains hidden, only becoming visible if resistance is met. Disciplinary power also requires the co-operation of the individual (Foucault, 1980).

Foucault (1979) argues that 'surveillance' is central to the effectiveness of disciplinary power. He uses the analogy of the panopticon (the prison observational tower) as a model to show this. The arrangement of the panopticon allowed the prison guards to view the inmates at all times; a form of surveillance which Foucault calls 'the gaze' causing prisoners to become 'docile'. Foucault (1979) suggested that without this gazing, disciplinary power could not exist. Increased surveillance leads to increased disciplinary power and vice versa as more disciplinary power allows for more surveillance.

According to Fahy (2002), this concept can be applied to maternity care to further an understanding of how medical power retains its dominant position. Women are subjected to the medical 'gaze' throughout pregnancy and labour. In the hospital setting, doctors and midwives can enter rooms without knocking and doctors undertake regular ward rounds to assess the progress of labouring women. During the second stage of labour, women are continually watched and monitored. The length of the second stage is timed and the condition of the woman and baby are monitored throughout by recording maternal vital signs, listening to the fetal heart and undertaking abdominal and vaginal examinations at increasingly frequent intervals (for example, NICE (2014) recommend that the fetal heart is listened to after each contraction and at least every five minutes during the second stage).

Fahy (2002) argues that medical power operates subtly, with women being offered the rewards of a safe delivery and a healthy baby if they comply with medical requests, whether these be consenting to an uncomfortable vaginal examination, agreeing to give

birth in a particular position or pushing/not pushing in a set way at a set time. Women who do not comply with medical recommendations (for example, by not consenting to a particular course of action and preferring to await events) receive threats that they are putting their baby's life at risk, which could be seen as a 'punishment' for non-compliance. (Fahy, 2002; Klein, 2006; Sakala, 2006). T. Anderson (2000) found that women complied with instructions from their midwives, as they believed to not do so would put their baby's life at risk.

Poignant examples of how labouring women behave in order to get the information they need from their midwives are included in the seminal study by Kirkham (1989). She describes how women showed respect for the expertise of the staff and were noted to be eager to please and do the 'right' thing. The most successful strategy employed by women in order to gain information from their midwives was to adopt the role of a compliant and passive patient (Kirkham, 1989).

There is an argument that midwives also change into 'docile' subjects under surveillance and become subordinate in the face of the medical power of obstetricians. This may be manifested in the way that they collude with doctors against a woman's choice (Fahy, 2002). The 'punishments' for a midwife who does not conform to hospital protocols in order to advocate for a woman include being criticised and scapegoated by her own colleagues as well as facing the threat of formal disciplinary sanctions (Sundin-Huard & Fahy, 1999).

Hollins Martin and Bull (2006) also found that providing choice for women is a particular challenge for junior midwives who face reprisals from more senior midwives when they attempt to advocate for women against medical advice and/or hospital policy. This led Hollins Martin (2007) to argue that the ideal of true woman-centred care is difficult to achieve when individual midwives work alongside influential others. Milgram (1974) demonstrated people tend to bow to pressure from authority figures in his seminal obedience study on hierarchical relationships.

Hollins Martin and Bull (2006) found various obstacles blocked midwives' ability to support women in their choices. These included feeling obligated to follow hospital policy, being situated in a relatively low position in the hospital hierarchy, being afraid to

challenge senior staff, being fearful of an adverse obstetric outcome and the resulting litigation, wishing to avoid conflict, and fear of intimidation from colleagues. These findings were supported by Kirkham (1989), Keating and Fleming (2009), and Bedwell et al. (2015).

Foucault (1980) theorises that handing over decision-making and control to a more powerful individual leads to the subordinate individual feeling absolved of personal responsibility. Fahy (2002) argues that this explains why some midwives covertly support the medical model of care as an avoidance strategy to relieve themselves of getting involved in challenging situations and the associated stress this brings. It may also explain why women are often more than ready to hand over decision making to midwives and doctors at a time when they feel at their most vulnerable (Bluff & Holloway 1994; Machin & Scamell, 1997, Rooks, 2006). Stewart (2010) argues that this aspect is crucial in understanding the seductive nature and continuing success of the biomedical model. Individuals with less power are relieved to hand over control to others with more power during periods of vulnerability. This strategy may be effective as long as the individual holding the power acts in the best interests of the subordinate individual. In the case of promoting physiological birth in a culture where the biomedical model is dominant, this may not always be the case. The implications of this will be examined later in this chapter.

Another theoretical concept which has relevance to this research relates to the assertion that power is synonymous with knowledge (Foucault, 1980). According to Foucault, the individual who holds the intellectual capital also holds the power. He argues that the success of the biomedical model within maternity care persists because doctors, midwives and women themselves have embraced these values and find the use of technology reassuring (Kent, 2000). For example, Davis-Floyd (2006) points out how initially some feminist writers welcomed the introduction of interventionist, technological birth because they perceived it as a way of achieving equality between the sexes. A birth under epidural where the woman was relieved of pain and had no feeling was seen as a way of women retaining control and autonomy over their bodies (Davis-Floyd, 2006). It would seem that it is accepted in modern society that medicine prevails in the childbirth

discourse, overriding both the woman's embodied knowledge and intuitive midwifery knowledge.

From a feminist perspective, a Foucauldian view of medical power is also consistent with the four concepts contained within the patriarchal framework, as defined by Warren (1994). Patriarchy consists of those behaviours which give privilege and power to men or to practices/professions which have been historically associated with the male gender (such as medicine). Warren's conceptual framework consists of four themes; the valuing of hierarchical thinking i.e. putting the highest value on the beliefs of those in the highest positions, the valuing of dualism, the maintenance of power relations in terms of subordination and domination, and a belief in the logic that superiority justifies subordination (Warren, 1994). Viewing medical power in this way also explains how it continues to achieve domination over the midwifery model of care. Findings from Keating and Fleming's study (2009) are consistent with these themes.

In contrast with Foucault's view that power is not necessarily a repressive force but a positive one that is required in order to maintain social function (Levy, 1999c), Lukes developed a theory about the three dimensions of power (Lukes, 2005). Foucault (1980) would argue that compliance with the recommendations of those holding the power is essential for the effective functioning of a maternity unit.

On the other hand, Lukes' (2005) first dimension of power relates to the decision-making of dominant individuals at the top at the hierarchy, as the decisions tend to reflect their values rather than those of individuals further down in the hierarchy. It is the dominant groups who set the rules which others are required to follow (Levy 1999a). An example of this, within the context of the research question, is when a consultant obstetrician orders midwives to direct women to push using the Valsalva technique as soon as the cervix is found to be fully dilated with the strict time limits imposed on the second stage. Midwives may be aware that the current evidence base does not support this form of management but, as previously discussed, feel powerless to challenge the obstetricians for fear of conflict and reprisal.

Lukes' (2005) second dimension of power relates to the fact that the dominant group also sets the agenda and controls the information provided to others lower down the hierarchy. In her study which explored informed choice, Levy (1999b) gives several examples where midwives withheld information from women. While this may have been done for benevolent reasons to protect women from the need to make challenging decisions at their most vulnerable time, it still tends to favour the needs of the dominant group and the institution. There are examples of midwives not giving women information about water birth or homebirth as they did not feel confident themselves in providing these birth options. This illustrates midwives as the dominant group being gatekeepers to information provided to women (Levy, 1999b).

Stewart (2010) gives the example of midwives undertaking vaginal examinations on labouring women and, on finding full dilatation of the cervix, recording it as not fully dilated. This is to delay the official start time of the second stage of labour in order to 'buy' more time for the woman to give birth spontaneously. Stewart (2010) argues that the altering of results of vaginal examinations in this way shows a midwifery knowledge base at odds with the biomedical one. It also shows that that a second stage may be physiologically normal despite taking longer than hospital policy 'allows'. By withholding this information from women, the midwives are failing to treat them as equal partners. It also means that this midwifery knowledge remains hidden and the biomedical discourse remains dominant and is never publically challenged.

Stewart (2010) also warns about a matriarchal approach adopted by some midwives. Despite being protective and supportive of a woman's needs, the decision to withhold information still represents an unequal power dynamic that is not truly woman-centred. Georges (2003) asserts that it is not part of any health professional's role to withhold information or to assume a position of power by unilaterally deciding what is best for any individual. Midwives should aspire to a feminist model of care where women are equal partners and in control, and where each individual in an interaction communicates honestly with the other (Stewart, 2010; Guilliland, 2016).

The third dimension of power within Lukes' (2005) framework relates to the fact that subordinate groups are subtly coerced by dominant groups into accepting policies and interventions which may be harmful to them (Lukes, 2005; Levy, 1999a, 1999b; Shapiro et al., 1983). This is seen in the medicalisation of childbirth over the past two centuries when obstetricians claimed control over childbirth by persuading society that this was in the best interests of women and their babies (Klein, 2006). Interventions in labour such as the routine use of continuous cardiotography to monitor the fetal heart, the artificial rupturing of membranes, the lithotomy position for birth and directed Valsalva style pushing are examples of the operation of Lukes' third dimension of power when intrapartum care is managed according to medical values rather than based on evidence. Similarly, as demonstrated in a previous chapter, the move from home birth to hospital was not based on reliable evidence and has never been shown to directly improve safety for women (Tew, 1998).

Levy (1999c) argues that Lukes' (2005) third dimension of power operates in a particularly covert and insidious way which avoids conflict, as the subordinate group remains unaware of systems underlying the policies imposed upon them. Shapiro et al. (1983) state that the most interesting aspect of their study was that women left an encounter with a doctor usually satisfied with the interaction and unaware that their own interests had not being taken into account.

### Birth Territory theory

Fahy and Parratt (2006) drew on the ideas of Foucault and Lukes to develop Birth Territory theory that describes and predicts the relationship between the environment of the birthing room, power, and the way in which women experience birth. The theory is divided into two major concepts; the first being 'terrain' with subsets of 'sanctum' and 'surveillance room', and the second being 'jurisdiction' with subsets of 'integrative power', 'disintegrative power', 'midwifery guardianship', and 'midwifery domination'.

#### Terrain

This relates to the physical features of the birth room including the furniture provided and how it is laid out within the room. Within terrain, the minor sub-concepts are arranged along a continuum from 'sanctum' to 'surveillance room'. Sanctum is described

as a comfortable homely environment with privacy for the woman, opportunity for her to close the door, with easy access to bathing and toilet facilities and the outdoors. At the other end of the continuum is the surveillance room, a clinical environment that is arranged in a way which permits easy monitoring of the labouring woman. For example, clinical equipment is on display and accessible to staff, there is no closed door, no easy access to a bath or toilet facilities, and there is often a viewing window. As Fahy and Parratt (2006) highlight, the more the environment of the birth room moves away from being a sanctum the more likely it is that the woman will become anxious and fearful.

### Jurisdiction

Jurisdiction is the other major sub-concept of Birth Territory Theory. This can be defined as the power to do as one wants within the birth room. Four minor sub-concepts are arranged within jurisdiction and are described below.

### Integrative power versus disintegrative power

‘Integrative power’ refers to power used by the woman, the midwife, and any other individual in the birth room as a way of supporting the woman so that her mind and body is able to surrender to her bodily sensations in order to give birth spontaneously. The most important effect of integrative power is that the woman feels positive, even if her labour outcome is not what she had anticipated.

T. Anderson (2000) suggests it is very important to women that midwives know when to stand back to avoid distracting her from focusing on the intense process of pushing her baby out. An earlier study (Berg et al., 1996) confirmed this and described the woman’s need to be supported and guided by a midwife but on her own terms. Another study showed that women wanted to have the midwife’s support as required, with the option of handing over control to the midwife as appropriate (Walker et al., 1995). Labouring women welcomed a midwife taking control at what was perceived to be an appropriate time, and found it highly supportive., T. Anderson (2000) argues that encouraging women to surrender to their own instinctive pushing urges is very different from imposing a pre-learned series of arbitrary instructions on them. The women in these studies appreciated the expertise of their midwives but wanted to retain their own control over the process of giving birth. The discussion around what women mean by retaining control over birth will be developed later in this chapter.

'Midwifery guardianship' is a form of integrative power that involves the midwife controlling who enters the birth room and aims to prevent any person within the room using 'disintegrative power'. Midwifery guardianship respects the woman's own integrative power to enable her to give birth instinctively and undisturbed. Being undisturbed during labour allows the woman to feel safe enough to surrender the need to be on guard, and to respond fully to her own bodily instincts. T. Anderson, (2000) refers to the woman as feeling 'safe enough to let go' (p.92).

'Disintegrative power' imposes individual's self-centred needs on the birth room. This type of power undermines the woman's confidence in her own body and the ability to give birth instinctively. It also undermines the woman as a decision-maker in her own care choices. The women in Anderson's study describe being treated like 'naughty' schoolgirls, with the midwife assuming a position of authority as a strict schoolmistress figure (T. Anderson, 2000). This reflects the disempowering patriarchal approach discussed earlier (Stewart, 2010). Fahy and Parratt (2006) also suggest that a woman can employ disintegrative power herself when she becomes determined to achieve a particular experience or outcome at any cost.

'Midwifery domination' is at the opposite end of the spectrum to midwifery guardianship and is based on the concept of disciplinary power as previously discussed (Foucault, 1980). Midwifery domination uses power in a subtle and manipulative way by encouraging women to become docile and follow instructions by giving up their instinctive knowledge and the innate belief in their power to give birth unassisted. When midwives give instructions to either push in a certain way or not to push, despite a woman feeling the need to do so, they are disturbing the natural rhythms of labour. This is a clear example of midwifery domination.

The overriding theme of Birth Territory theory is that when midwives create a safe birth space in a comfortable environment (which favours physiological birth) there is the increased likelihood that women will give birth spontaneously and will be more satisfied with the overall birth experience. They may also attain the optimal state of 'flow' (Walsh, 2008; Csikszentmihalyi, 2014) as outlined in a previous chapter. Within this framework, the midwife's role in ensuring that midwifery guardianship is maintained and integrative

power has superiority over disintegrative power is of prime importance in the promotion of normal childbirth.

However, as Fahy and Parratt, (2006) highlight there are limitations to the theory, not least that it focuses on what happens in the individual birth room. In order for the theory to benefit the most women, it must be taken into account in the organisation of maternity services on a wider scale (Fahy & Parratt, 2006). Further investigations need to be made on the link between how a woman feels and how her body responds physiologically. This theory formed a framework on which this study of midwives' practices during the second stage of labour can be positioned. During data analysis, attention was given to examples where a midwifery domination or midwifery guardianship approach was evident, and the type of birth environment was supported by the midwifery practices, as described by participants.

### Control in labour: what do women want?

The previous sections have discussed how power relationships operate in maternity care and how they encourage modern midwives to continue to work within the biomedical framework. This is despite the fact that in doing so, they often find themselves unable to fulfil their primary function, i.e. to support women in their choices and to facilitate physiological childbirth (O'Connell & Downe, 2009). When considering the practices that midwives adhere to during the second stage, the role that women themselves play in shaping what midwives do needs to be considered. The questions need to be asked; what is important to women in order to have a satisfying and positive experience of birth, and what can midwives do to facilitate this?

Many studies have shown that a sense of being in control during childbirth is an important factor in determining whether a woman has a positive birth experience (Lavender et al., 1999; Gibbins & Thompson, 2001; Green & Boston, 2003). Bandura (1997) defines control as 'self-efficacy', meaning a belief in oneself and one's ability to perform effectively in any given situation. For childbearing women this may be related to the belief in the innate ability of their bodies to give birth spontaneously and without direction.

However, it is acknowledged that not all studies define 'control' in the same way (Green & Baston, 2003). Control is a subjective concept and may mean different things to different

women. Feeling 'in control' is not a static sensation as women may feel an increased or diminished sense of control at different times during childbirth (Green, 1999; T. Anderson, 2000; O'Hare & Fallon, 2011). For example, there is a differentiation between 'external control' and 'internal control'. External control implies a feeling of having control over the environment, controlling what is done to you and being involved in decision-making (O'Hare & Fallon, 2011). Internal control refers to control over one's behaviour and body (Green & Baston, 2003). Waldenstrom (1999) conceptualizes external control as a woman being a subject in her own right rather than a passive recipient of care and found that involving women in the birth process as active participants was the best predictor of a satisfying birth experience.

Green and Baston (2003) warn about taking an uncritical view of external control which assumes that involving women in decision-making inevitably leads to them feeling in control. Women may feel a greater sense of control in handing over decision making to their midwives (Green, 1999). This is supported by Bluff and Holloway (1994), who found that women perceived midwives as being experts in birth and trusted them implicitly to do the job. Paradoxically women felt more in control by relinquishing control to the midwives. O'Hare and Fallon (2011) found that the participants in their study were happy to 'go with the flow' and be guided by their midwives. A participant in T. Anderson's study (2000) reported losing all sense of both internal and external control as she entered the second stage of labour until her midwife 'saved her' by taking control of the situation. Weaver (1998) suggests that being asked to make too many decisions during labour may lead to additional stress for women, rather than helping them to feel in control. To counteract this, Davis (2003) argues that rather than offering a wide range of choices to childbearing women, the midwife should assume a partnership role by helping woman to make choices that are right for her on an individual basis. This reflects the feminist, equal partnership of care model also suggested by Stewart, (2010) and earlier by Guilliland and Pairman (1995).

The paradox of labour is that in order to succumb to their bodily instincts and give birth spontaneously, women need to let go of their inhibitions and surrender control, and yet they also report the greatest satisfaction in retaining control. In T. Anderson's study (2000), some women reported entering a trance-like state at the start of the second stage. Odent (2001) explains this physiologically as the body's response to the start of the second stage

is to release copious amounts of endorphin, the natural opiate-like substance that will assist the woman in coping with the extreme pain she will experience whilst giving birth. This altered state of consciousness also indicates a separation of mind and body and a diminishing of the neocortex in order for women to 'let go' and surrender to the intense bodily sensations characteristic of the second stage. The vulnerability of women at this time is evident and the fact that they are irresistibly susceptible to suggestion from other individuals highlights both the critical contribution which midwives make to a woman's birth experience and the power they exercise in this setting (Machin & Scamell, 1997; T. Anderson, 2000; Green & Baston, 2003).

Machin and Scamell (1997) found that even women who had previously expressed preference for non-intervention during labour succumbed to the powerful influence of the biomedical model when midwives suggested specific actions. As T. Anderson (2002) also points out, this power on the part of the midwife can be exercised sensitively to support the woman in surrendering to her instinctive urges or abused in such a way that she is directed to behave in ways dictated by the midwife rather than her own bodily sensations.

### Summary

The literature around power relationships in maternity care suggests that the manner in which midwives practice while providing intrapartum care is driven, at least in part, by the way in which maternity care is currently organised in the UK. Medical power, with its focus on intervention and technology, remains the dominant culture with both childbearing women and midwives being lured by its promise of controlling childbirth to make it safe and pain free.

The medicalisation of childbirth, theories of power and patriarchy formed the conceptual framework of the second stage study and these were used to develop themes identified from the data. The next chapter will introduce CST and aspects of feminism which form the theoretical basis underpinning the study.

## 6. Theoretical Perspectives

### Introduction.

This chapter will introduce the theoretical perspective of CST (Paley, 1998) and aspects of socialist feminist theory (Pohl & Biyd, 1993) as frameworks underpinning this exploration of the practice of directed pushing during the second stage of labour. This will include a discussion around the related concepts of emancipation and empowerment. In the context of midwifery practice, it is suggested that midwives and women are oppressed by a biomedical model that continues to dominate the way that women experience childbirth. The work of the critical theorist Habermas (1984, 1987) will be drawn upon to explore how the midwife's role in facilitating women to trust their embodied knowledge of birth and instinctive urge to push is impeded by the colonization of the lifeworld of childbirth by the technocratic system of obstetrics.

### The relevance of modernity

Modernity can broadly be defined as a social perspective characterized by the departure from traditional ideas, doctrines, and cultural values in favour of contemporary or radical values and beliefs chiefly those of scientific rationalism and liberalism (Lyon, 1999; Delanty, 1999). Modernity is grounded in a vision, that humankind would eventually break free from the constraining forces of society (such as the Church) and that social order would be maintained by a political force grounded in democratic principles (Delanty, 1999). Modernity was also seen as a driver to free people from the brutal force of nature by gaining scientific control over it (Delanty, 1999). This would be achieved through cognitive rationality grounded in advances in scientific knowledge.

Feminist researchers and theorists (Oakley, 1993; Murphy-Lawless, 1998) have argued that in the realm of childbirth the conceptualisation of science within modernity as mastery over nature can be interpreted as male-dominated obstetrics gaining mastery over childbearing women as well as over the midwifery model of care. As described in Chapter 4, historically the profession of obstetrics developed its' control over childbirth by arguing that it was safer for women to give birth in hospital supervised by obstetricians. As obstetrics aligned itself with science this added further credibility to these claims. (Murphy-Lawless, 1998). Murphy-Lawless (1998) highlights the paradox of obstetrics as a dominant scientific discourse which seeks to reveal 'natural facts' about

the female body during childbirth. This in itself highlights tension existing between the ideas of modernity as an emancipatory force bringing the potential to release humankind from the constraints of tradition versus the application of reason to control nature through science (Hyde & Roche-Reid, 2004).

### Critical Social theory (CST)

CST developed in Germany in the 1920's and was originally known as the Frankfurt theory (Paley, 1998). Drawing on the philosophies of Marx and Hegel, CST provided a critical opposition to the oppression inherent in the developing capitalism of the Western world in order to promote positive change (Paley, 1998). Social institutions-maintained oppression in order to control economic and social resources (Kuokkanen & Leino-Kilpi, 2000). The aim of CST is to expose oppressive forces that may limit individual or social freedom. Holmes (2002) argues that emancipation must free individuals and remove oppressive social structures replacing them with a more humanistic philosophy based on the basic right to individual freedom beginning with the right to free choice. Critical social theorists argue that research should involve an exploration of existing power structures contained within a culture and should then seek to transform the lives of oppressed individuals through emancipation. (Savin-Baden & Howell Major, 2013).

The German philosopher Jurg Habermas applied CST to interaction and dialogue and further defined it as a reflective communicative practice highlighting a cognitive awareness of oppressive forces. He coined the phrase 'communicative action' to describe dialogue in this context (Habermas, 1984). CST emphasised the importance of dialogue between individuals that was free of a central dominating influence (Habermas, 1984). In capitalist Western society, Habermas (1984, 1987) identified the rise of a goal, success and outcome- focused culture to be to the detriment of a humanistic, equality-orientated discourse. He described society in relation to two opposing perspectives; the 'system' and the 'lifeworld'.

According to Habermas, (1987), the 'system' was associated with scientific rationality and mediated by power and economic resources. In order to operate effectively, the 'system' required efficiency and process- driven rationality. In this view of society, communication, communicative reflection and mutual understanding are minimal, while

the pursuit of economic profit takes priority. Conversely, the 'lifeworld' refers to a symbolic space where meaning, personal identity and solidarity combine. It is defined by reflexive discourse, the importance of human rights and relationships and has the overall goal of achieving consensus through reasoned verbal discourse (H. Anderson, 2000). H. Anderson, (2000), describes the 'lifeworld' as being viewed from an individual perspective, structured through meaningful symbols and communicated verbally with a focus on the achievement of mutual understanding. In other words, the 'lifeworld' constitutes everyday life in the form of a natural rather than a scientific attitude (Mishler, 1984). This includes understanding and assumptions that are shared within a culture in order to influence everyday interactions (Habermas, 1987).

Habermas (1987) describes the potential colonization of the 'lifeworld' where the 'system' continually strives to extend its purposive rationality to the detriment of the communicative rationality of the 'lifeworld'. However, this colonization could be impeded by the introduction of an alternative rationality based on values, ethics and verbal reasoning rather than science.

In reviewing encounters between obstetricians and childbearing women, Scambler (1987) applied elements of CST to assist his analysis. He argued that obstetricians exercised power in their dialogue with pregnant women in order to influence a particular course of action. In this context, he highlighted the obstetrician's perspective as the voice of medicine (based on the 'system') as opposed to the woman's perspective as the voice of the 'lifeworld'. Scambler (1987) concluded that the 'lifeworld' of childbirth in his study was colonized by the technocratic system of obstetrics.

Habermas (1984) argued that with the presentation of valid arguments, communicative action could potentially rescue humanity from Weber's concept of the 'iron cage' of capitalism and associated technocratic rationality (Weber 2002). Habermas (1984) identified three domains that he argued, influenced social reality and knowledge. These were the technical – cognitive domain, grounded in science and positivist methods; the practical -cognitive domain based on subjective and interpretative principles and finally the emancipatory -cognitive or critical social domain based on the concept of an individual developing self-awareness of their individual history leading to an emancipatory understanding of the various dominant forces (for example institutional or

environmental) that may exert control over their personal life choices. (Habermas, 1984; Carr & Kremmis, 1983). It is argued that praxis through reflection is a key component of emancipation (Duchscher, 2000; Kuokkanen & Leino-Kilpi, 2000).

CST further highlights that human behaviour cannot be separated from cultural and environmental influences and that historically society has imposed disadvantage on some groups, for example, women. (Wittmann- Price, 2004). It is argued that where there are underprivileged groups, injustice needs to be challenged on both an individual and a societal level (Wittmann- Price, 2004). Romyn (2000) argues that social structure can only be changed by political action whilst also suggesting that group autonomy is one of the main values of CST. Other authors argue that CST influences individual and group choice whilst acknowledging that most choice is influenced by social attitudes (Owen-Mills, 1995).

The midwifery model of care can be associated with Habermas's (1987) view of the 'lifeworld'. It has several characteristics supporting this; for example, a focus on normality and the uniqueness of childbirth, the development of the individual through reflecting on the experience of birth, and the sharing of information between individuals (Bryar & Sinclar 2011).

The midwifery model of care is also concerned with reframing birth as a normal social event as opposed to a medicalised process with a focus on promoting birth either at home or in the 'home from home' setting of a birth centre. (Hyde & Roche- Reid, 2004). This aligns with the idea of the 'lifeworld' being associated with a natural approach where actions are situated in verbal reasoning and balanced communication as opposed to a scientific approach where actions are technocratically driven (Habermas, 1984). Indeed, Hyde & Roche-Reid (2004) argue that the midwifery model of care could be tasked with rescuing birth from an obstetric dominated technocratic system, (apart from the small percentage of complex cases where obstetric intervention is wholly justified) and relocating it as a normative component of the 'lifeworld'.

In the context of midwifery practice during the second stage of labour, 'communicative action' could be used by midwives to promote a non- interventionist approach to the second stage. This would be through reasoned dialogue based on reflexion and individual

human rights and would need to include debate not only within professional groups and childbearing women but also at societal and institutional level. The overall goal of this linguistic dialogue being to promote a cultural change at a deep societal level in order to increase women's confidence in their body's ability to give birth without direction or assistance. The influence of the modernity project is reflected here in the fact that midwives construct their view of birth as one operating within the technocratically driven medical model. They may seek to gain mastery over the harsh uncontrollable reality of nature by giving women explicit instructions to push during the second stage. The rationale behind this being that safety for woman and baby is improved, despite the fact that this is not grounded in scientific rationality. Here lies the paradox inherent within this practice as modernity provides an overarching discourse upon which midwives structure their practice they attempt to control nature by undertaking directed pushing when this has not been empirically shown to be superior to spontaneous instinctive pushing. In light of this, I would argue that a post-modernist approach to midwifery practice that reclaims the territory of birth for women should form the basis of future maternity care.

Another key principle associated with CST is empowerment including the emancipation of individuals from oppression. These concepts of empowerment and emancipation will be explored in detail later. However, the concept of the 'lifeworld' and its focus on the needs of the individual rather than the system (Habermas, 1987) would seem to fit well with the 'unique normality' notion of childbirth (Downe, 2012).

### Feminist theory

Feminist theory is closely aligned to CST (Wittman-Price, 2004). Pohl and Biyd, (1993) describe three schools of feminism; liberal feminism arguing that equal opportunities for women should be based on the same standards as men; radical feminism that claims that the oppression of women underlies all systems at micro and macro level and finally, socialist feminist theory suggesting that environmental, social and physiological factors all play a role in women's oppression. This also supports the view that feminist theory can be applied to individuals as well as groups and communities. (Pohl & Biyd 1993). During this study, I will draw on various feminist perspectives in order to understand aspects of midwifery practice associated with the second stage of labour

All theoretical feminist approaches focus on the oppression of women, regardless of where this originated from and they advocate for change whether that be at an individual or collective level. (Wittmann- Price, 2004). Arslanian- Engoren, (2001) argues that power over women leads to oppression and a loss of 'voice'. Indeed, giving women an 'authentic voice' is seen as a metaphor for their empowerment, whereas silence has come to epitomise oppression. (Johns, 1999). Feminism claims that in order for women to have a 'voice' they must first be situated in a safe space. (Johns, 1999). Wittman- Price (2004) suggests that this safe space should be a flexible environment in order to enable emancipated decision making. In the context of childbirth this would be aligned to women being free to make their own choices in relation to how they want the experience to be rather than being told how to behave and constrained by hospital policies and procedures.

### Empowerment and emancipation in the context of CST

Emancipation includes the ideals of individual distinctiveness, creativity and autonomy (Fay, 1987). It contrasts directly with oppression which implies a lack of freedom and its' associated negative connotations (Wittmann –Price, 2004). In his seminal work, Freire (1970) describes oppression as an insidious and overt force which can lead to the dehumanization of individuals and groups. A 'culture of silence' and 'fear of freedom' can prevail which is exploited by oppressors as it leads to a sense of perceived security for the oppressed (Freire, 1970, p36.). It can be seen from this, that oppression must be a precursor for emancipation (Wittmann- Price , 2004; Astor et al.1998), emancipation therefore seeks to equalize power between the oppressors and the oppressed in order to promote equality and a humanistic philosophy . Freire (1970) further argues that for emancipation to occur the oppressed group must be aware of the negative influence the existence of oppression has over free choice.

Empowerment on the other hand, is a positive process promoting individual autonomy and independence. In the context of maternity care, this implies that through the sharing of knowledge, power can be shared between health care professionals and childbearing women (Kuokkanen & Leino-Kilpi, 2000). However, as highlighted in Chapter 5, knowledge as power can be used to either liberate or oppress. Lukes (2005) highlighted

how it is the dominant group that sets the agenda in terms of what knowledge to impart and this may lead to more oppression instead of emancipation.

A factor that further complicates the consideration of emancipation within maternity care is the feminised nature of midwifery and the gender of the midwife; as most midwives are also women this means that they already belong to an oppressed group (Wittmann-Price, 2004). Romyn (2000) identified characteristics of nurses (that are applicable to midwives) that are aligned to those of an oppressed group. These being a close allegiance with the oppressor ( in this context, the obstetrician) , horizontal violence ( the incidence of bullying between midwives has been demonstrated by Farrell & Shafari, 2012 ; Gillen et al., 2004) , fear of freedom, emotional dependence , lack of self- esteem and disdain for other women. This phenomenon is explained as a result of the exploitation of nurses and midwives since the movement of healthcare into the institutional hospital domain. Harden (1996) argues that because hospital managers and doctors need nurses and midwives and because these professions are comprised mainly of women, oppression was introduced as a way of controlling their working lives and facilitating maximum production.

### Summary

The fundamental philosophy underpinning aspects of feminism and CST has been described in order to demonstrate how within these frameworks , midwives and childbearing women are perceived as oppressed situated below the auspices of biomedicine in a hierarchical arrangement with obstetricians occupying the higher, powerful positions. This provides the theoretical framework through which findings from the Second Stage Study will be analysed. The practice of midwives undertaking directive pushing during the second stage of labour will be viewed primarily through a CST lens in order to explain why they persist in this behaviour despite the current evidence base.

The next chapter will explain how the Second Stage Study was undertaken by providing a rationale for the methodological approaches employed.

## 7. Methodology

### Introduction

This chapter will outline the methodological approach that underpins the study in relation to the aims and objectives of the research question and the study's overarching philosophical stance. The rationale for the method of data collection is explained, with a specific focus on the ethical issues involved in conducting research with participants who are considered vulnerable, having just given birth and the professional staff who are caring for them. The process of undertaking the study is described alongside an exploration of the challenges involved when the researcher also holds multiple roles within the organisation and therefore has the perspective of an 'insider/outsider'. Finally the process of data management and analysis is detailed to demonstrate how academic rigour was maintained.

### Design and methods

As Savin-Baden and Howell-Major (2013) highlight, the myriad of literature explaining how to undertake qualitative research can lead to confusion for both novice and experienced researchers. It is a challenge to make sense of the definitions of terms such as design, approach, methods, methodology, and paradigm that are frequently used interchangeably. Henn, et al., (2006) define research design as being an umbrella term for the strategic plan which shapes the study. This is interpreted including the paradigm, conceptual framework, approach and methods. Mason (2002) argues that these are linked and that planning at the design phase of a study involves developing a methodological approach that addresses the research question but also acknowledges that other approaches could have been used, as well as providing justification as to why they were rejected.

Savin-Baden and Howell-Major (2013) recommend using the term 'research approach' rather than methodology. They define this as being the specific type of qualitative study undertaken (for example, ethnography or phenomenology). They define 'methods' as being the processes used to collect data (for example interviews or observation). For clarity, these are the definitions which I will adopt as I discuss the study design.

## Design

Identifying the researcher's own philosophical stance is required during the early stages of planning a study. It should be compatible with the researcher's own ideas about the nature of knowledge (Henn et al., 2006; Silverman, 2010). Savin-Boden and Howell-Major (2013) explain that if researchers have considered their philosophical stance in the context of their work, they present as knowledgeable and believable, which provides added assurance of credibility. They warn however that a failure to consider underlying belief systems can lead to faulty research strategies, unbelievable results or a researcher claiming a particular stance and then not applying this in practical terms to the research design.

My personal philosophical stance takes the ontological view that there is no independent reality, but that reality is shaped by our own individual experiences (Ritchie et al., 2014). My epistemological view takes an interpretivist/constructivist slant which supports the view that reality is socially constructed, and only individual meanings and actions can be understood (Ritchie et al., 2014). This epistemological view requires research to be completely and necessarily value laden. Having realised this, it is a logical step to the realisation that the most appropriate way of discovering how individuals understand their world, is through an exploration of their unique, personal experiences rather than through statistical analysis (Henn et al., 2006; Silverman, 2010).

Having reviewed the literature, I was aware that while there were a number of quantitative studies investigating aspects of the second stage of labour, there were very few qualitative studies exploring what midwives were doing to support women or what they felt about the various changes (based on evidence) in the way that the second stage should be facilitated. This, along with the fact that the overall aim of my research question was to gain insight into midwives' practices during the second stage, led me to conclude that a qualitative design would be most appropriate.

## Rationale for qualitative research and a hybrid approach

It is a further challenge to produce a single definition of qualitative research which incorporates the many disciplines and associated professional fields which use it (Barbour, 2014; Savin-Baden & Howell Major, 2013). It has been described as research involving the collection, analysis and interpretation of data which does not fit into

numerical form (Murphy, et al., 1998). Denzin and Lincoln's definition (2011) emphasises that qualitative researchers are concerned with the socially constructed nature of reality, the complex relationship between the researcher and the topic being examined, and the situational constraints governing the study. Marshall and Rothman (2016) describe qualitative research as a 'broad approach to the study of social phenomenon' (p.2). The categories used tend to be naturalistic, interpretive and critical, drawing on several methods of inquiry. Another, albeit simplistic, definition (Langford, 2001) suggests that qualitative research is an objective process using non-statistical methods to explore subjective human experiences. Creswell (2012), argues that the final written report of a qualitative study should include the voices of the participants, the reflexivity of the researcher, and a complex interpretation of the research question adding to the body of knowledge. These themes do resonate with the Second Stage Study as it aimed to explore the practices that midwives undertake as they care for labouring women during the second stage. These definitions combine to support my rationale for undertaking qualitative research as well as the fact that there is a paucity of qualitative studies exploring midwives' views about the use of directed pushing in the second stage.

It has been implied that producing a definition of qualitative research is highly dependent on who you ask (Pope & Campbell, 2001). Qualitative research has a separate history within a number of social science disciplines including anthropology, sociology, and ethnography (Kingdon, 2004). Indeed Seale et al. (2004) argue that rather than using a single version of what constitutes qualitative research, it is preferable for researchers to consider engaging with multiple approaches. They recommend a pragmatic approach which places research practice at the centre of the process rather than methodological philosophy and theory. Barbour (2014) concurs with this view and recommends that researchers draw on two or more qualitative approaches to develop their own unique hybrid which fits the objectives of their research question. These debates were highlighted for me as I came to consider the specific approach within a qualitative paradigm that was most appropriate for my research.

My original study design involved participant observation and the use of ethnography. This is particularly suitable for studies exploring clinical practice and the interactions between professionals and their clients (Mason, 2002; Silverman, 2012). Ethnography is

defined as the direct description of a group, culture or community and is grounded in the social anthropological tradition (Holloway & Wheeler, 2010). This appeared to fit well with the Second Stage Study, which was exploring midwifery practice in the cultural context of maternity services in the UK. I had intended to observe births so that I could see first-hand what was happening. According to Agar (1986) “you need to learn about a world you understand by encountering it first hand and making some sense of it” (p.12). This would have enabled me to contrast what people say they do, with what people actually do (Atkinson & Coffey, 2003). However, for various practical and ethical reasons my original plan to undertake an observational study was not possible. I considered other qualitative research approaches, namely grounded theory and phenomenology. Grounded theory also fits within a constructivist stance as it seeks to generate theory directly from the data by adopting a ‘from the ground upwards’ approach. It focuses on the firsthand experiences of participants and supports the development of new ideas as analysis progresses. However, it does this usually without reference to a conceptual framework or prior knowledge of the subject area (Glaser & Strauss, 1967; Savin-Baden & Howell-Major, 2013). In view of my background as an experienced midwife and lecturer, I already had extensive knowledge on both a practical and theoretical level of the subject and had a conceptual framework in mind following the reading I had undertaken prior to starting data collection. My interview schedule had emerged from this prior knowledge. I wanted to use a conceptual framework as a way of maintaining specific focus whilst exploring a topic area that could potentially generate many avenues of interest and become unwieldy as a result. For this reason I decided to reject grounded theory. Phenomenology is another approach used within health and social care research in order to explore human experiences without generating a theory (Savin-Badin & Howell-Major, 2013). Phenomenology is concerned with the ‘lived experiences’ of participants and seeks to gain a deep insight into the lifeworld as experienced from their perspective rather than that of the researcher (Creswell, 2012). Again this approach tends not to support the use of a conceptual framework (Savin-Badin & Howell-Major, 2013). It also focuses on how participants experience a particular life event or way of life and did not appear wholly appropriate for a study that is exploring midwifery practice. Returning to Barbour’s (2014) recommendation that researchers consider adopting a pragmatic, hybrid approach to their work (a view supported by Savin-Badin & Howell-Major, 2013) my own approach

appeared to be contained within qualitative description (Sandelowski, 2000 & 2010), or pragmatic qualitative research (Savin-Badin & Howell- Major, 2013). I adopted a pragmatic approach which is defined as a mixture of sampling, data collection and analytical strategies that combine to generate a clear interpretation of the topic being studied. This approach has the advantage of allowing researchers to mix and match different strategies within the design, which enables them to address the research question (Caellil et al., 2003) utilising a hybrid approach. Morgan ( 2014) argues that pragmatism in research represents a coherent philosophy that goes well beyond simply 'what works' p.1051. It draws on the work of Dewey (2008) who highlighted the importance of joining beliefs and actions in the process of inquiry that underpins any search for knowledge.

Morgan ( 2014) further argues that by advocating pragmatism as a paradigm one seeks to disrupt the historical reliance on a metaphysical vision of the philosophy of knowledge. Pragmatism approaches inquiry through research as a human experience grounded in the beliefs and actions of individual researchers. This is in marked contrast to the classification of social research in terms of ontology, epistemology and methodology. However, Morgan ( 2014) is quick to point out that he is not implying that the previous approach was wrong. Instead, using pragmatism to explain this metaphysical paradigm one would say that this was a set of beliefs and actions that were significant within a unique set of circumstances. Since then , these circumstances have altered to the extent that an alternative methodological agenda ( pragmatism) is now called for.

Despite this, I was mindful throughout of Sandelowski's (2010) warning that it is inappropriate for researchers to state that they are using pragmatism as a research design in order to avoid the inclusion of a detailed exploration of the complex theoretical principles underlining other approaches. Indeed, pragmatic qualitative research or qualitative descriptive research has been criticised by some scholars for doing just this. For example, Thorne et al. (1997) referred to it as the 'crudest form of inquiry' p. 170. The approach requires rigorous analysis of the data as well as a detailed exploration of chosen strategies with appropriate references to support their use. It must be informed and influenced by an in-depth understanding of the theoretical perspectives underpinning it (Sandelowski, 2010; Savin- Badin & Howell- Major, 2013).

### Use of a conceptual framework

A conceptual framework refers to a group of related concepts highlighted from the literature underpinning the study (Maxwell, 2005; Savin-Baden & Howell-Major, 2013). Some researchers highlight the conceptual framework as being a key component of research design. For example, Savin-Baden and Howell-Major (2013) suggest that providing a conceptual framework increases academic rigour by identifying a lens through which the data may be then analysed.

My conceptual framework on how medical power has continued to dominate childbirth with the idea that most midwives, although purporting to be autonomous practitioners, actually practice within the boundaries defined by the medical model of care. The literature relating to how childbirth practices have evolved during the 20<sup>th</sup> century demonstrate that they have become technocratically driven rather than woman-centred with an emphasis on risk avoidance rather than on the promotion of women's embodied experiences of giving birth. Specific concepts within this framework include the influence of control and power hierarchies on childbirth practices, the medicalisation of childbirth and the perception of what constitutes 'normality' within childbirth. This conceptual framework with its focus on the consequences of medicalisation of birth opens up a wider discourse on issues relating to why midwives practice in a way that is not grounded in the latest evidence or normal physiology.

### The research methods

I undertook semi-structured interviews with a group of midwives to find out what practices they were undertaking during the second stage of labour to support a woman's pushing efforts. This method fitted well with both my epistemological stance and the qualitative paradigm. Mindful of the fact that I was unable to undertake an observational approach as originally planned, I was reassured by Atkinson and Coffey (2003) who argue that interviews should not necessarily be dismissed as poor surrogates for certain events which cannot be observed. Instead they should be examined for their own narrative structures and functions. Data from participant observation is also second-hand as it is produced from notes made by the observer retrospectively. People being observed may do things differently because they know they are being observed in the same way that participants being interviewed may give information that they think the researcher wants

to hear. Atkinson and Coffey (2003) suggest that there is no real distinction between talk and action if one considers an interview to be action. Interviews were therefore considered to be an appropriate data collection tool to explore the research question.

I also decided to undertake interviews with women who had recently given birth. By interviewing two participant groups I could explore their differing perspectives on the same issue of midwifery practices during the second stage could be explored. A triangulation of data collection methods would enable me to compare what midwives say they do against women's perception of what actually happens.

During the initial interviews with midwives, they highlighted the impact that their medical colleagues had on their practices during the second stage of labour. As a result I also decided to interview a small group of obstetricians in order to gain another perspective on midwifery practices during the second stage.

### Ethical issues

Ethical issues raised by undertaking a study involving vulnerable women in labour are extensive and this is reflected in the number of challenges that I had to overcome before obtaining the required ethical approval. The length of time which it took me to prepare the various ethics applications, submit via the required NHS and University processes and finally achieve ethical approval was considerable and involved me amending my methods several times. Over the period of two years my study evolved from being a 'visual methods' project into a qualitative study that involved interviewing women midwives and obstetricians. This change in direction was due to various ethical constraints that I was unable to overcome within the time limits of a doctoral study.

I initially planned to film births however, there were concerns around ownership of the films (do they belong to the researcher or the participant?) and what might happen if something went wrong during filming. For example there might have been birth complications that could lead to my films being recalled as evidence of the event. Questions were raised in relation to how I would gain consent to film, from all possible people who might be present in the delivery room and the intrusive nature of having a stranger present while a woman was giving birth. As a result the original idea was not pursued.

The next section will consider these ethical issues further and will include a rationale behind my decision to amend the original protocol.

### First application to a research ethics committee

Mindful of the fact that using interviews alone may yield only one perspective on an issue and only that which the interviewee wants to share (Becker, 1970), my study originally included an observational element alongside face to face interviews with midwives.

I developed my participant information sheets after consultation with a reference group comprising midwives and a group of new parents. This approach is recommended as best practice, with user involvement in research being defined as an active partnership between the public and researchers rather than simply using the public as objects to undertake research on (INVOLVE, 2004). Many organisations that fund research now require user involvement to be demonstrated in funding applications (O'Donnell & Entwistle, 2004).

I asked the reference group how they would feel about having a researcher present during their birth. The feeling was that on the proviso that they had been introduced to the researcher and knew that she was also midwife this would not have caused concern. They also provided feedback on my participant information sheets and consent forms to confirm that these had been written in a style that would readily be understood by a layperson.

I had a similar reference group of midwives as I was interested to ascertain how midwives would feel about me being present in the delivery room. I wondered if my substantive role as a midwifery lecturer and supervisor of midwives might lead to some concern that I would be judging practice in a negative way. In an ideal situation I would have chosen to undertake the study in an area where I was not known as a lecturer. Practically however this was not possible as I was undertaking the research on a part time basis working around my primary role. Having worked as a lecturer with collaborative links to several NHS Trusts for a number of years, I would have had to travel some distance to locate a Trust where I was unknown. However, the midwives raised no such concerns. They suggested that they would prefer a familiar researcher rather than a stranger whose motives were completely uncertain.

The initial ethics application was rejected on several grounds including concern about a potential conflict of interest between my substantive role as a midwifery lecturer and supervisor of midwives and the researcher role. The Committee were of the opinion that midwives would not want to participate as this could be seen as a performance management issue rather than a research study. There were also some concerns around the consent process that women would not have long enough to decide whether they wanted to take part.

### Second ethical application to a research ethics committee

In light of these suggestions I reviewed and amended the application form and resubmitted to the REC. Following this application there was still concern that I was only gaining verbal consent from the women. It was recommended that I recruit all women due to give birth during the period of data collection by asking community midwives to distribute information sheets and gain written consent from their clients during the antenatal period. The study was given a provisional favourable opinion with the proviso that these amendments be put in place before it could be finally approved.

On reflection, I decided that making this amendment would not be feasible on either a practical or ethical level. It was estimated that 600 women gave birth in the NHS Trust each month. Asking community midwives to gain consent from so many women would add considerably to their workload. I had planned to observe only 5 births so asking 600 women to give consent to participate in a study which they were unlikely to ever hear about again seemed unethical. The financial impact of producing a further 600 forms was also considerable for a small scale unfunded study. On discussion with my research supervisors I decided to omit the observational aspect of my study. Instead for pragmatic and practical reasons, I would interview 10-15 women who had recently given birth.

A substantive amendment was submitted to the same REC in January 2014. A favourable opinion was finally obtained in February 2014. This was followed by research and development approval from the NHS Trust in April 2014. I began interviewing women and midwives in May 2014. Another substantive amendment was submitted to the REC in September 2014 to request that interviews with obstetricians be included and to extend the duration of the study. Both amendments were approved.

## Recruitment strategy

### Women participants

The original strategy to recruit women was to display flyers publicising the study around the Maternity Unit. Women were asked to contact me for further information. Inclusion criteria were those women who could understand English enough to provide informed consent, were over the age of 18 and had given birth vaginally. I planned to visit the Maternity Unit to distribute the information sheets and expression of interest forms to postnatal women. I would collect expression of interest forms back and contact any interested women by their preferred method a few weeks later. In this way I could ensure that women had time to fully consider aspects of the study before giving consent to participate.

The initial recruitment strategy proved unsuccessful. The flyers attracted no interest from women who had recently given birth and presumably had other more pressing matters to consider. My visits to the ward were also unproductive. Indeed, approaching women who had just given birth felt intrusive. I was conscious that I was approaching them as a stranger at a sensitive time when they were tired and vulnerable. I decided to stop this strategy when a woman on the Birth Centre glanced briefly at the information sheet and asked if she had to take part.

There is an argument that as instigator of a study, the researcher holds a degree of power over the participant (Hoffman, 2007). However, the feelings I had whilst trying to recruit women were akin to those described by Kleinman and Copp (1993) in that I felt grateful to any women who agreed to participate and in that sense more humble than superior. At this stage the women held the power as they also held the knowledge that I, as researcher sought to discover (Becker, 1970). They could also choose which aspects of this knowledge to share with me during the interview process.

A revised recruitment strategy proved more successful. A National Childbirth Trust (NCT) teacher agreed to email the information sheets to women who had attended her groups and had delivered at the Maternity Unit. This meant that an individual who knew the women introduced the study at a time when they felt less vulnerable as they were already home. The onus was on them to complete the expression of interest form and

return to me by email or post. I managed to recruit six women in this way. A midwife who facilitated drop-in parent education sessions also sent information to a woman who had sent her a birth story. I asked several community midwives to distribute forms to women they were visiting postnatally. A further three women were recruited in this way.

An acknowledged downside to this strategy however, was that despite the diversity reflected in the local community a limited range of women responded. The majority were Caucasian, professional women in the higher social bracket who had attended NCT classes and were well informed about pregnancy and birth. Participants lacked diversity in terms of age, ethnic origin and socioeconomic class. Interestingly when I visited the Maternity Unit, I spoke to two women who would willingly have been interviewed but did not want to bother with completing the form. One was from an ethnic minority and the other was a woman in her late teens. Ethical approval had been granted on the basis that I would give women prior information of the study and time to consider whether they wanted to participate. As a result ad hoc interviews were not permissible. This meant that two women from more diverse backgrounds were not recruited and their 'voices' remained unheard.

See Appendix 7a for demographic details of the women participants.

My experiences during the recruitment phase reflected those of Sutton et al. (2003). Whilst the midwives were willing to assist me in recruiting women, there is a potential that they inadvertently selected those women who they thought might be willing to participate and would be 'good' subjects rather than giving all eligible women the chance to make their own minds up.

Sutton et al. (2003) suggest that healthcare workers act as 'gatekeepers' for clients perceived to be vulnerable by choosing whether or not to give them information about a study. Gatekeepers may not give details of the study to potential participants if they cannot see the value in research or if they perceive that introducing it might interfere with their own relationship with the client (Furimsky et al., 2008). Long (2007) suggests that certain groups (usually those considered vulnerable) may be excluded from studies by researchers as gatekeepers are unwilling to inconvenience them. Ethical concerns are then raised around taking away an individual's right to participate in a study that they

might find rewarding. Long (2007) argues that individuals have a 'right to be researched'. Seymour, et al. (2005) highlight similar ethical concerns in that participants who are less vocal may not be recruited to studies because gatekeepers do not promote the study to them due to their own competing priorities. As a result participants with the most dominant voices are more likely to be recruited than quieter individuals. This means that the overall aim of research to achieve multiple perspectives is not always achieved (Sutton et al., 2003).

It is unclear to what extent these factors played a significant part in recruitment to the Second Stage Study but it is certainly biased towards Caucasian professional women in a higher social bracket while the voices of younger, socially disadvantaged women from diverse ethnic backgrounds are absent.

#### Midwife participants

I found that displaying posters in the Maternity Unit informing midwives of the study did not attract any attention. Emailing them directly with the information sheet was more successful.

As part of the ethical application I had stipulated that I would not interview midwives who had been my personal students or who had formed part of my SOM caseload in case this represented a conflict of interest. Midwives might have felt obligated to take part if they knew me in another capacity which could be perceived as being authoritarian.

Ten midwives were recruited. All were female. Four worked only in community, one worked part time in community and part time in delivery suite, two worked mainly in the birth centre, one worked mainly in delivery suite and two worked in both the birth centre and delivery suite. Five were direct entry midwives and five had undertaken a nursing qualification prior to their midwifery training. The time since training had been completed ranged from eighteen months to twenty-nine years. Seven of the midwives had undertaken their training within the NHS Trust and had remained in the same Trust, three had trained elsewhere and had come to work in the Trust. See Appendix 7b for a summary of the midwife participant demographics.

### Obstetrician participants

Initially recruiting obstetricians proved to be challenging as I did not have direct access to their contact details. Eventually I made contact with a consultant at a meeting and asked her if she would participate. I emailed another consultant who eventually responded and agreed to be interviewed. The registrar on his team was a third recruit. Whilst I was waiting to interview one of the consultants in the staff room on delivery suite, another approached me and volunteered to be interviewed.

I interviewed two female obstetric consultants and one male obstetric consultant. Two had worked at the NHS Trust for over ten years and had permanent positions, the third was a locum consultant who had recently joined the Trust on a fixed term contract. The registrar had worked in the Trust on two occasions in the last eight years, each time for a period of three years. See Appendix 7c for demographic details of the obstetricians.

### Data collection: Interviewing women, midwives and obstetricians

Qualitative face to face interviews were carried out with all the participants. The women had received care in the same NHS Trust and had given birth between six weeks and four months prior to the interview. It was considered that talking to women at this point would mean that they would still have a relatively clear memory of their birth experience. This is supported by research which demonstrated how accurately women tend to remember their experience of giving birth (Simkin, 1992). The midwives had all been present at a birth and involved in caring for women during labour within the two years prior to the study to ensure that their knowledge and practice base was relatively current

Interviews provide a way of gathering data by asking participants to talk about their lives (Holstein & Gubrium, 2016). As Marshall and Rossman (2016) suggest, qualitative, in-depth interviews are conversational in nature, the interviewer may ask a few general questions to discover a participant's viewpoint but otherwise allows the participant to structure their own responses. The idea being that the participant's perspective on the topic should be uncovered rather than the researcher's. It is suggested that an interview is fundamentally a conversation between two people or conversational partners (Rubin & Rubin, 2012; Kvale, 2007).

Conversation as interaction ultimately facilitates the construction of knowledge. An interview is also a complex activity where the researcher is required to manage several different activities at the same time (Hoffman, 2007). A qualitative interview involves the researcher listening closely to the potential meaning of what the participant is telling those (Rubin & Rubin, 2012). If the meaning cannot be deciphered, then follow up questions are required to elicit further clarity.

Semi-structured interviews include the use of a pre-prepared interview schedule to ensure that key points are covered during the interview. This guide may include headings or questions that will be raised, but not necessarily in the same way or in the same order with each of the participants (Kane & O'Reilly-De Brun (2001). Using this approach means that data is collected around the topic area defined by the researcher but also gives the participant the flexibility to raise what is important to them. In this way it the participant's true perspective which is ascertained rather than the researcher's. See Appendix 5 for the interview schedules.

All participants were given a choice of where they would like the interview to be carried out. All women participants asked me to come to their homes on a mutually agreed date and time. Midwives were interviewed in a staff room in the Maternity Unit, or in a private room at the University and two were interviewed in their own homes. On two occasions I arrived to interview midwives while they were working to find they were too busy to talk to me. It was also a challenge to find a private place to record the interview. We used empty rooms in the Birth Centre and in the antenatal clinic. It was preferable to interview midwives when they were not on duty but the inconvenience of them giving up their own time to talk to me about their working practices is acknowledged.

On several occasions women participants asked me to change the day or time of the interview to accommodate their family needs, usually because of their babies sleep pattern. On all occasions they stated that if it was inconvenient to me to change then they would stick to the original date. However, I was always flexible in relation to this so that the women did not feel that they had to do anything for my benefit. I was aware that women would be more relaxed if an interview took place at a time of their own choosing.

The obstetricians all chose to be interviewed in a staff room adjacent to delivery suite that was not private and used by other members of staff. During the course of interviews we experienced numerous interruptions and it was a noisy, busy environment. However the obstetricians appeared unperturbed by this and when asked if they wanted to find a more private location stated that they were happy to be interviewed in that setting and did not seem to be distracted. They were all working and on call when I arrived and there was a sense that they needed to be available in case they were required on delivery suite.

Two of the women had their male partners with them when I arrived. One had her sister who came in and out of the room to assist with the baby. One of the men left the room as the interview started but his partner called him back later to clarify a few points that she had forgotten. Another man sat in an adjoining room and listened while I interviewed his partner. At the end of the interview, she asked him if she had got all the details correct and he confirmed this and added some detail of his own which I noted. All of the women had their babies with them.

I used the responsive approach to interviewing (Rubin & Rubin, 2012). This model focuses on the fact that both researcher and participant are individuals with personal feelings, interests, personalities and experiences, all of which are brought to the interaction. Using this approach, researchers are not expected to stay neutral, rather it is acknowledged that how they present themselves will influence the interview to an extent. It is acknowledged that individual researchers will develop their own styles. For example, some may favour a direct approach, introduce themselves, conduct the interview and then leave, others will take a lengthier, gradual build up to the interview, others will make copious notes at the time of interview while some will rely on a digital recorder and will make minimal notes. None of these individual variations in style are considered particularly important. What is most effective is for the researcher to adopt a style that makes the participant feel comfortable, elicits the required data and is compatible with the researcher's own personality.

In conducting interviews for this study I was able to develop a good rapport with the women and midwife participants, as evidenced by the amount and depth of information that was shared with me. I tended to adopt the style of gradually building up to asking questions on my schedule. While I was prepared to make notes at the time of interview I

tended to listen to the participants and then make some written notes on leaving the room. I found it distracting to try and listen and take notes at the same time. Women participants were keen to share their experiences of being new parents with me and a couple were particularly interested in my role as a lecturer as they were considering a career in midwifery.

The responsive interviewing model is adaptable and flexible. The interviewer may be required to change course and ask different questions depending on what is learnt during the interview (Rubin & Rubin, 2012). This approach allows any potential interviewer biases to be continually examined through a process of self-reflection and ongoing self-awareness. This model suggests that the researcher's personal involvement in the interview is a strength in that it encourages participants to open up about their own experiences. However, it can also be problematic in that how a researcher asks a particular question may influence how the participant responds (Rubin & Rubin, 2012). As a midwife and a mother myself, it is inevitable that my own personal experiences of the second stage of labour are going to have an influence on the interview.

However, Rubin and Rubin (2012) emphasise that in order to be a successful qualitative interviewer, the researcher must become sensitive to any potential biases and learn how to compensate for them so that there is minimal influence on the interview itself. For example, as a midwife who trained at a time when directed pushing was the norm and who is very familiar with the evidence base associated with the second stage, there might be a potential for me to question midwives in a certain way because I have a sense that I already know why they are practicing in the way that they do. Rubin and Rubin (2012) recommend a period of time between each interview to give the researcher chance to reflect on any issues that may need to be addressed for future interviews.

On only one occasion did I conduct two interviews back to back. This was when a midwife volunteered to participate at the same time as her colleague. On all the other occasions there was a considerable gap between interviews. This meant that I had time to reflect on the interview and to review my notes and the recordings. I was also able to review my questions to ensure that I was not inappropriately leading participants to answer in a particular way. I also kept a reflective diary and it was useful to record my own observations at the time of each interview.

Using this reflexive approach, I noticed that in the initial interviews with midwives I became uncomfortable when asking them what they knew about research findings associated with the second stage. I was concerned that midwives would feel anxious about sharing a possible lack of evidence-based knowledge with me as I am a midwifery lecturer, and they might feel that I was judging them unfavourably. This led to me asking the question very quickly and not waiting to hear what the midwives had to say before telling them myself what the latest evidence suggested. I could hear myself doing this when I replayed the recordings. I had also made a note in my reflective diary commenting on the level of discomfort I had experienced. In later interviews I consciously set out to put my own concerns aside and asked the question slowly and then waited for the midwife to answer. I found by doing this that when given time, most midwives were aware of evidence around the second stage, although it took them a while to recall the information.

I was also able to reflect on my interviewing style to ensure that I was giving participants the opportunity to provide their own perspective rather than focusing on mine. In the first two interviews with midwives I did most of the talking and filled in for the participants as I felt uncomfortable when there were silences and concerned that I would not get sufficient information. I was able to rectify this for later interviews by ensuring that I did more listening, seeking clarification as needed and using 'elaboration probes' (Maykut & Morehouse, 1994) to encourage participants to expand on their story.

It is acknowledged that any qualitative interview has the potential to cause distress to a participant which may not have been anticipated (Eisner, 1991; Hoffman, 2007). Smith (1992) argues that researchers have an ethical duty not to continue to probe into sensitive issues, even if potentially interesting data is lost. Reinharz (1992) further identifies that there is a power relationship between researcher and participant in that, albeit unintentionally, the researcher is usually perceived to be the expert holding the power during the interview (Hoffman, 2007). As a result, participants may feel obligated to continue with an interview despite the emotional cost. By using a reflexive approach throughout individual dynamics can be ascertained and decisions made about how to proceed if a participant becomes upset during an interview (Rogers 2008). This approach also fits with the responsive interview model.

Asking women to recall their recent experience of giving birth might arouse emotionally charged, traumatic feelings of regret or guilt if their actual experiences were not as they had hoped. The same could be said for midwife participants who may find memories evoked of caring for women in challenging circumstances with poor outcomes or might find themselves revisiting traumatic moments from their own personal experience of birth. I tried to prepare myself for these kinds of 'ethically important moments' (Guillenin & Gillam, 2004; 262) and was aware that I might need to make a decision to stop an interview prematurely if a participant became distressed. Other options included changing to a different topic area once composure had been regained and/or asking the participant how they felt about continuing or if they wanted to stop. However, it has been acknowledged that it may be cathartic for some participants to revisit a sensitive topic (Guillenin & Gillam, 2004).

Commentators recommend a phase in the interview where talk moves to a less emotional level, usually as the interview is drawing to a close (Rubin & Rubin, 2005, Corbin & Morse, 2003). I attempted to do this by engaging participants in general conversation. Interestingly, as highlighted by Corbin and Morse (2003) this was the time when participants shared some relevant information often at the time when the digital recorder was switched off.

None of the participants became overly distressed during the interview, despite the fact that several women recounted experiences of birth that they perceived to be traumatic. I got feedback afterwards from several women that they had enjoyed talking about their birth experiences with an 'outside' person and there was no suggestion of any ongoing emotional trauma experienced as a result of participating. Indeed one of the women recommended to her friend that she speak to me as she had found the opportunity to recount her fairly traumatic birth experience to someone not directly involved with events as particularly useful in allowing her to move on.

### Informed consent

Obtaining informed consent from participants is central to the undertaking of ethical research (Ledward, 2011). Ethical principles require that participants in any study should never be coerced and have the right to be informed of the full nature of the study and

their required involvement in it before giving consent. (Polit & Hungler, 1999, Ryen, 2007). The promotion of participant autonomy is an important aspect of the process along with making them aware that they can withdraw from the study at any time (Ledward, 2011; G. Anderson, 2011).

As recommended by Manning (2004) the participant information leaflets focused on three main components of informed consent; information giving, ensuring the participant's understanding of the study, and the assurance that participation is voluntary with no impact on subsequent care if a participant decides to withdraw. It is recommended that the language used is neutral and mainly descriptive to avoid participants feeling coerced by reading information which focuses on how important it is for them to participate (Manning, 2004).

Prior to starting the interview, I confirmed verbally that participants were still willing to be involved. I also asked if they were willing for the interview to be recorded using a digital recorder. I was prepared to take written notes if anyone preferred not to be recorded but all participants gave consent. They were asked to sign a consent form which indicated that they had received full information about the study and were willing to take part. I reiterated that I would stop the interview at any point if the participant requested this and that no reason would need to be given reason for withdrawing.

Long (2007) challenges the use of consent forms by arguing that although they may provide evidence of the researcher acting 'properly' they do not offer any guarantee to the participant. For example, what happens if something goes wrong? However, the completion of a consent form is usually a requirement of RECs (Long, 2007). In my experience none of the participants were particularly concerned about the consent form and two of the midwives said that they did not plan to keep their copy.

### Confidentiality

Researchers are required to protect the participant's identity and the location of the study (Ryen, 2004). As qualitative studies usually include smaller numbers of participants, ensuring confidentiality can be challenging (Manning, 2004), particularly when studies are being undertaken in an academic researcher's own sphere of work

As Long (2007) highlights, when participants allow researchers access to their personal information and feelings that may be embarrassing or damaging if made public, a contract is implied that the researcher will respect the nature of the shared information and ensure its ongoing confidentiality. On the other hand, if a researcher uncovers information that an individual could be at risk of serious harm then there would be a moral and legal obligation to breach confidentiality (Manning, 2004).

As a qualified midwife I am bound by the Nursing and Midwifery Council (NMC) Code of conduct (NMC, 2015) and I have a professional responsibility to disclose issues if I consider that an individual is at risk of serious harm. This would include me uncovering aspects of midwifery practice which are unsafe or visiting a woman in her own home to find either herself or her baby at risk. As Rogers (2008) argues, despite being aware of these professional responsibilities a conflict will exist when a researcher is required to breach confidentiality where this has been promised as part of the research process. My participant information forms did make this obligation clear and my plan if this situation arose during my fieldwork was to raise the issue with the participant on an individual basis and encourage them to disclose to another appropriate individual and seek help as required (Rogers, 2008). This pragmatic approach can be positive as taking part in research can highlight a situation which can then be changed for the better (Rogers, 2008).

In order to protect the identity of participants, pseudonyms are used throughout the study and the location where the study was undertaken has not been named. I omitted aspects of a participant's story when reporting the data if its unique nature might lead to an individual or organisation being recognised (Rubin & Rubin, 2005).

Confidentiality was extended to data kept electronically as well as written information. Digital recordings were encrypted and anonymised. All data was stored on a laptop computer which was used only by me and was password protected and a Universal Serial Bus (USB) memory stick which was also password encrypted. All hard copies of data including consent forms, transcripts and handwritten notes were kept in a locked filing cabinet within a locked office. Data will be retained for another seven years after completion of the study and will then be destroyed.

## Insider perspective

As a midwife I am already deeply immersed in the midwifery culture and as described in Chapter 1. I was trained at a time when birth was highly managed and directed by professionals. There is a potential therefore that I may be so deeply entrenched in the culture that I may take certain things for granted and not see the significance of behaviours and practices as described by participants (Wagner, 2001). As Patton (1990) summarises, the challenge for the qualitative researcher is to develop an understanding of the culture being studied as an insider while at the same time describing the culture to an outsider. There is a risk of presenting one's own perspective on a topic area which could bias a participant's responses and could lead to a participant being unable to articulate their own ideas (Field & Morse, 1989).

Conversely, being an insider did have an advantage. The women knowing that I was a midwife, appeared very willing to share details of their birth with someone who they perceived had professional knowledge of birth. Midwife participants did not have to explain aspects of their practice because they knew that I would already be familiar with certain terms and phraseology. Indeed, feminist studies of women interviewing other women (Hunt, 2004; Oakley, 1993) suggest that women's perceptions of an interviewer having insider status may actually inspire trust and a culture of openness. It is likely that women and midwives trusted me because they knew I was also a midwife, and in that sense, I was 'on their side'.

## The process of data analysis

### Development of the written transcripts

The interviews were transcribed *verbatim* and a written record of the spoken transaction produced. I transcribed all of the midwives and obstetrician's interviews personally soon after the interviews had taken place. This enabled me to develop a deep familiarity with the data. I transcribed two of the women's interviews but as they were considerably longer than those of the other participant groups, I found this challenging in terms of the time commitment. This is an aspect of qualitative research which is widely acknowledged (Bryman, 2012; Kvale & Brinkman, 2009). The remaining eight transcripts were produced by a reputable transcription service that had extensive experience in the transcription of

health research data. I followed the guidance of Burke (2011) to ensure that using an external agency would maintain the confidentiality of the data and not compromise the overall quality of the transcripts produced.

The agency produced a signed confidentiality agreement and there was a secure transfer method in place for the audio recordings and the completed transcripts to be shared. To check for accuracy I read each transcript a minimum of four times while listening to the audio recording of the interviews (Burke, 2011; Savin-Boden & Howell- Major, 2013). In addition I compared the field notes I had made immediately after each interview with the transcripts and annotated them with some additional comments, usually relating to participant's body language and non- verbal responses as they told their stories. These steps enabled me to develop a deeper understanding of the message the participants were trying to convey (Barbour, 2014) and triggered the process of immersing myself in the data in the data which is a key phase of data analysis (Green et al., 2007; Braun & Clarke, 2006) .

#### Data analysis

Data analysis in qualitative research can be defined as the process of examining the information collected and then transforming it into a coherent summary of the findings (Ezzy, 2002). Green et al. (2007) argue that a detailed presentation of the process of data analysis is necessary in order to judge the contribution of the study to the existing evidence base. They also highlight that despite the importance of data analysis in assessing the quality of a study, details about how it was undertaken are often omitted from the reporting of studies in the medical and public health literature. In their view, the fact that some qualitative papers only describe data analysis in terms of themes emerging from the data, leads to the risk that qualitative research may only be judged in terms of what distinguishes it from quantitative research, namely selective, often emotional quotations from respondent's accounts (Green et al., 2007). Being mindful of this, I aimed to produce my own narrative demonstrating that a careful, rigorous analytical process had been undertaken.

Data was analysed thematically. Thematic analysis is an inductive process which enables small units of data to be reviewed, interpreted and then grouped together into common themes (Braun & Clarke, 2006; Savin- Baden & Howell, 2013). This method allows the

researcher to develop a general sense of the information provided by repeatedly reviewing the data. Savin-Boden & Howell, (2013) suggest that the idea is for the researcher to get an overall flavour of the text by immersing themselves in the data before doing any specific coding or grouping.

The fact that thematic analysis relies on intuition and sensing rather than being rigidly bound by specific rules (Savin-Boden & Howell, 2013) appealed to me as it seemed to fit well with the unique nature of natural childbirth when it is unconstrained by the confines of a biomedical model. It is not a linear process where the researcher moves systematically from one stage to the next but rather a recursive process where one moves backwards and forwards through the phases as needed (Green et al., 2007; Braun & Clarke, 2006). Green et al. (2007) highlight that this is a process which develops over time and should not be rushed. The process must continually ‘test the fit’ as new data emerges and needs to be integrated into the ongoing analysis. This was certainly my experience as the process of analysis for this study evolved slowly over a period of approximately three years with constant movement between various stages of immersion, coding, categorising and the creation of overarching themes.

I used the six-phase framework recommended by Braun and Clarke (2006) in order to demonstrate a systematic approach and to overcome the potential criticism also highlighted by Green et al. (2007) that ‘anything goes’ in qualitative research. See Table 2.

**Table 2 Process of thematic analysis**

(Adapted from Braun & Clark, 2006)

Phase	Activity undertaken
1. Becoming familiar with the data	Listening to audio recordings. Reading and re-reading of written transcripts. Making notes of possible codes. Reviewing the annotation on the transcripts
2. Generating initial codes	Systematically coding interesting elements in the data. Collating data relevant to each code. (An inclusive process which involves reviewing the whole data set.)

3. Looking for themes	Collecting codes into possible themes, gathering together all data considered relevant to each theme.
4. Review of themes and developing a thematic map	Reviewing themes to make sure that they are meaningful and coherent with clear distinctions identified between each theme.
5. Defining and naming themes	Analysing and refining each theme and producing clear definitions and names for each. (Revision of the analysis maybe required.)
6. Production of the report	Writing of the final report with more opportunity for analysis as the themes are brought together.

Immersion permitted a detailed examination of what had been said during the interviews and initiated the process where ideas about analysis begin to grow (Hunter et al., 2002). I immersed myself in the data by reading and re-reading the transcripts and listening to the audio recordings in the manner previously described. I then moved on to the next phase of analysis which is coding. Codes are descriptive labels (categories) applied to segments of the transcript. Coding the transcripts involved me asking questions such as ‘what is this participant saying here?’ and then applying a label to a specific phrase, word or whole paragraph of text where information relating to a specific point was included. I initially organised the data using ‘a priori’ codes which I had developed from questions on the interview schedule relating to directed or physiological pushing (Barbour, 2014). The questions had been developed from my own review of the literature of other research studies undertaken prior to my own data collection. Barbour (2014), refers to this as ‘pseudo data’ and suggests that it allows for consideration of parallels between the study’s findings and those of other studies and so enhances the transferability of the study.

Making sense of any qualitative dataset begins with the development of a provisional coding frame (Barbour, 2014). This involves dividing the data into manageable concepts and themes. Seale (1999) warns that the creation of a fixed coding frame at an early stage of analysis can lead to the blocking of creative ideas. Instead he recommends the use of an indexing system which signposts the researcher to other interesting sections of

data instead of assigning a final argument about meaning at an early stage of analysis. In order to facilitate this process, where data did not fit with my 'a priori' categories, I created new categories and paid attention to themes generated by the participants themselves (*in-vivo* codes). As Barbour (2014) highlights these can help to summarize complex ideas and can guide the researcher to unanticipated and interesting areas which warrant further exploration. Gibson and Brown (2009) use the term 'empirical codes', to describe those that emerged during data analysis as opposed to 'a priori codes'.

Coding data was an iterative process; categories and sub-categories were assigned to sections of the data and were revised and amended numerous times as the data extracts were examined until I was unable to identify any further categories (Barbour, 2014; Mason, 2002). Green et al., (2007) suggest that analytic categories are considered to be saturated when there is enough information for the experience to be viewed as coherent and explicable. For example in the Second Stage Study, it became clear that instigating directed pushing was an integral part of care midwives provided during the second stage when it was mentioned in some form by most participants. I was then able to make sense of the experience of all participants in terms of directed pushing including the two women who did not experience directed pushing and were in this context, exceptions to the rule.

Figures 1 to 3 (on pages 134 to 136) demonstrate how data obtained from the three participant groups was broken down into categories and then divided further into sub-categories.

Figure 1: Women's experience of pushing in the second stage divided into categories and sub-categories

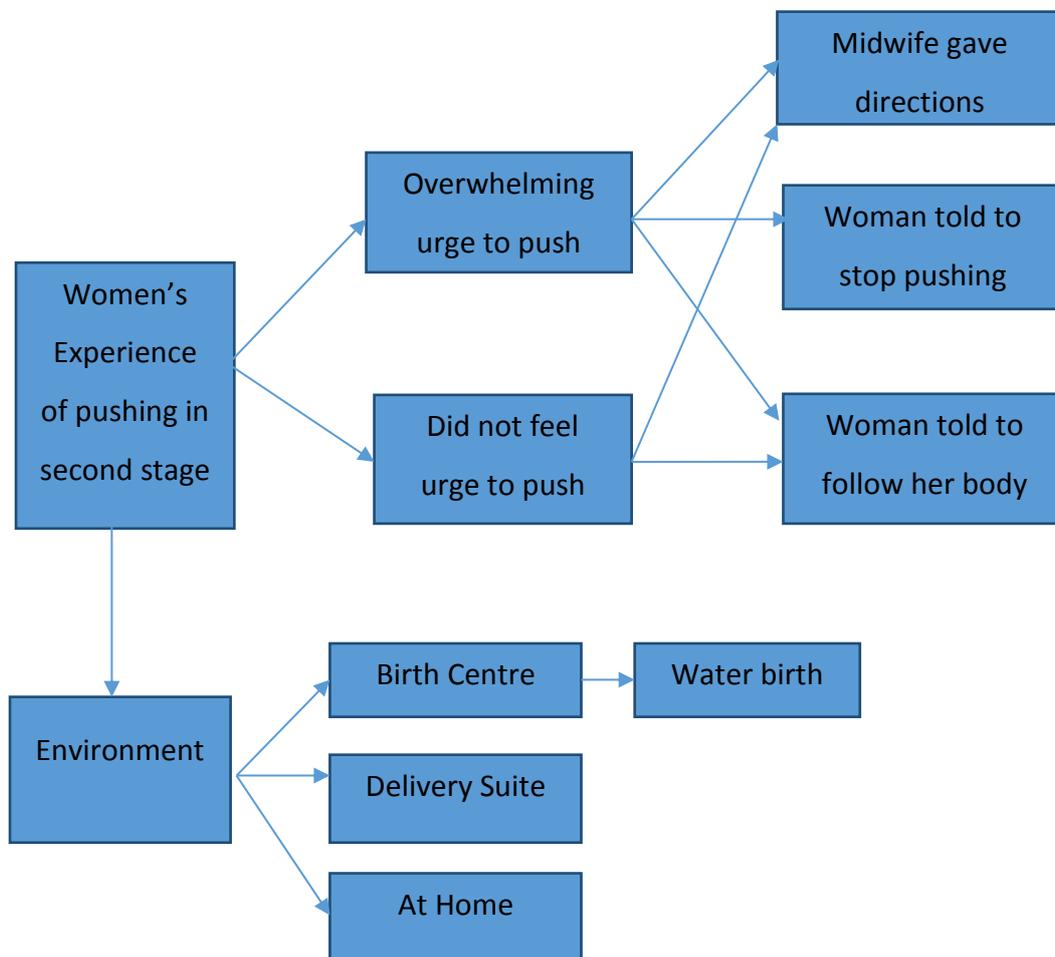
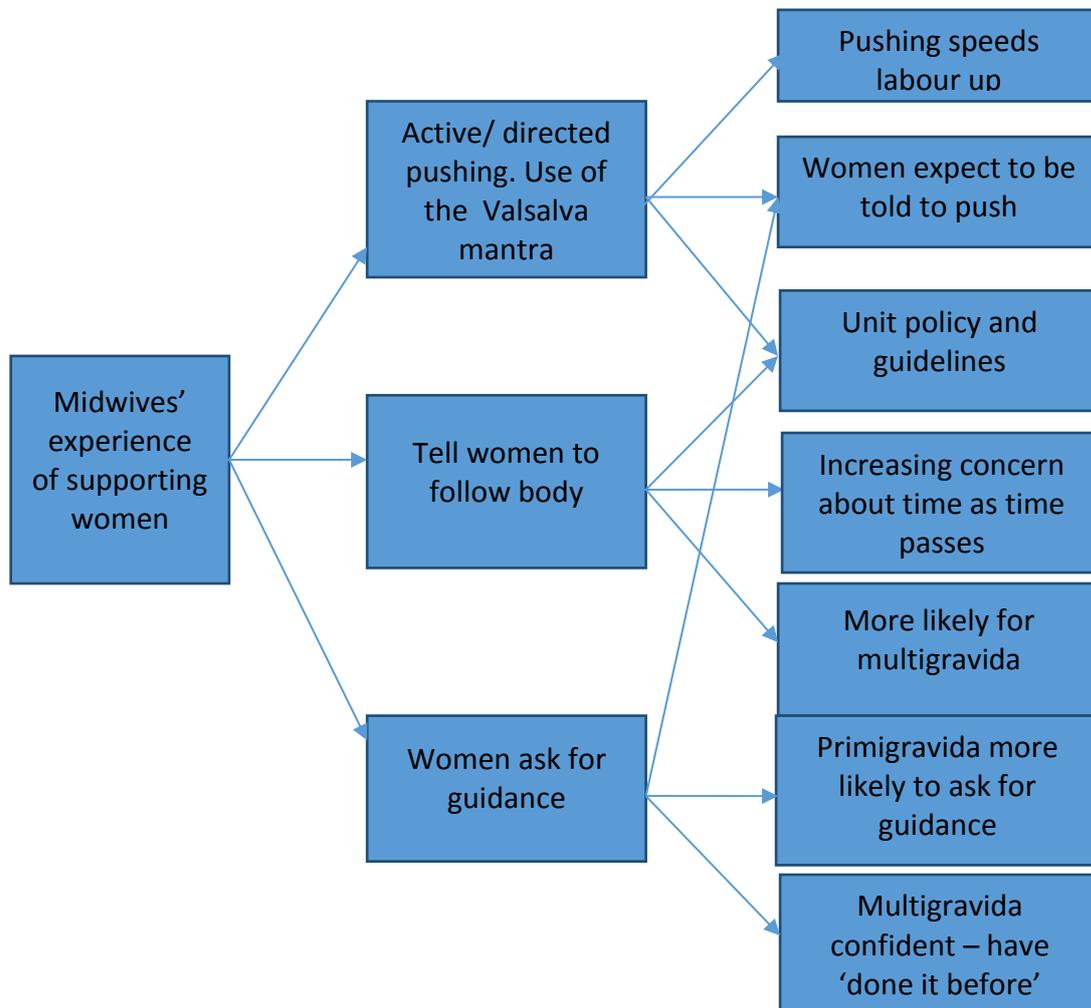
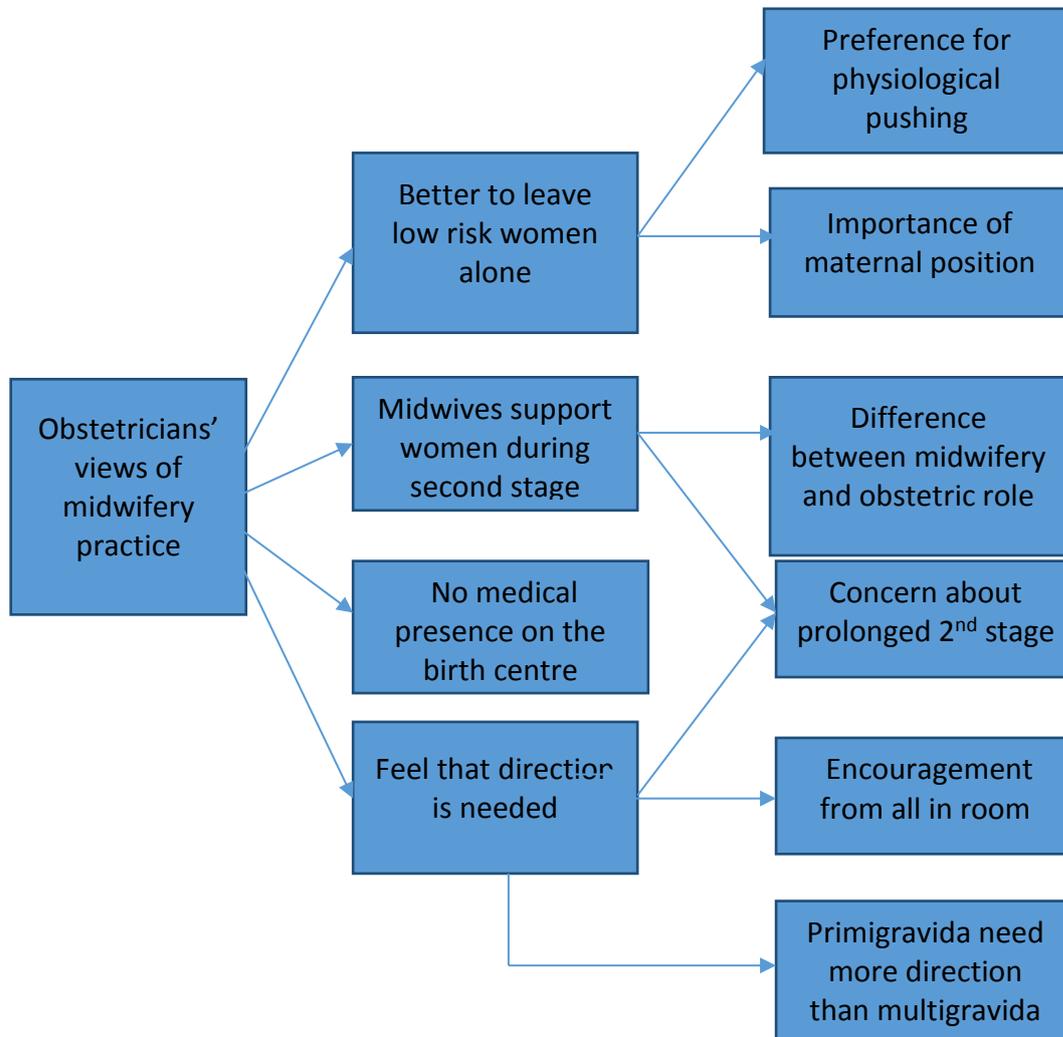


Figure 2: Midwives' experience of supporting women during second stage divided into categories and sub categories



**Figure 3: Obstetricians' views of midwifery practice during second stage divided into categories and sub categories**



The next phase of data analysis involved re-examining the various categories and subcategories and grouping them together into overarching descriptive themes. Green et al. (2007) suggest that the creation of themes progresses beyond the description of a number of categories but involves moving to an explanation or an interpretation of the research topic. Having immersed myself in the data by reading the transcripts and listening to the recordings, I had already developed an idea of the more obvious themes (Savin-Baden & Howell-Major, 2013; Barbour, 2014). By referring to my conceptual

framework and the themes I had previously identified I was then able to search for less obvious themes.

I re-read sections of the data and compared them to each other within and across the three participant groups. By doing this I was able to identify a number of common themes running through the dataset. This process was enhanced by using the software programme NVivo™. The use of this is described later in this chapter.

Barbour (2014) argues that the constant comparative method is the basis of all qualitative data analysis and involves a systematic examination of what each participant says within the context that they say it. As patterns in the dataset need to be identified, there is an element of counting involved, although this does not include making a statistical inference. Barbour (2014) warns that this does not involve simply counting the number of comments from a single participant who highlighted a specific issue but rather ensuring that evidence exists that it is indeed a shared perspective raised by the majority of the participant group.

Table 3 below, demonstrates how categories of data were grouped together into overarching descriptive themes:

**Table 3 Data categories grouped into themes.**

Theme	Data Categories
Time passing and watching the clock	Pressure of time 'Is she delivered yet?' Time limits to pushing Following the guidelines Time to change shift The clock is on A lovely quick delivery Timing contractions Time of birth Time allowed for multip and primip Taking too long Speeding things up

<p>Midwives take charge</p>	<p>Active pushing</p> <p>Getting more directive as labour progresses.</p> <p>'She said, you're tired'.</p> <p>Midwives shouting at women to push</p> <p>The pushing mantra</p> <p>Using Valsalva</p> <p>'Take a deep breath and push'</p> <p>'Don't push, you are not ready yet'</p> <p>Best way to push to avoid wasting energy.</p>
<p>Different Women</p>	<p>Multigravida: know what to do, just get on with it.</p> <p>Primigravida need to be told what to do.</p> <p>'It's my first baby, I don't know what to do'</p> <p>Primigravida need direction.</p> <p>Physiology of birth differs between multigravida and primigravida.</p> <p>Women ask for direction.</p>
<p>Different Worlds</p>	<p>A different vibe</p> <p>Different atmospheres: home from home on the birth centre.</p> <p>Women more receptive to 'going with their body' on the birth centre.</p> <p>Expect to be told what to do on delivery suite.</p> <p>Medically managed births</p> <p>Ready for intervention on delivery suite</p> <p>Quicker to intervene on delivery suite</p> <p>Home is woman's territory</p> <p>Midwife as guest in her home</p>

	No medical presence on the birth centre
Increasing confidence and changing practice	<p>Influence of other midwives: learning from each other and role models</p> <p>Learning from women</p> <p>Trusting women more as time goes on</p> <p>Changing from being directive over time</p> <p>Importance of confidence and experience of physiological birth</p> <p>Feel the need 'to do something' when newly qualified</p>
Conflict	<p>Not getting on with the midwife</p> <p>Midwife had a different philosophy</p> <p>Anger</p> <p>Difference of opinion</p> <p>Tension in the room</p> <p>Shouting and noise</p> <p>Doctor and midwife disagreed</p> <p>Woman and midwife disagreed.</p> <p>Woman not being listened to.</p>

#### Using NVivo™ to assist analysis

A computer-assisted qualitative data analysis software package (CAQDAS) was used at a basic level to support the sorting and retrieval of data. I chose NVivo™ (*version 11@QSR International*) initially for pragmatic reasons because the University held a licence for the use of NVivo™. I was aware that there were a number of other computer packages which I could have used, however having attended a basic taster session at the University followed by an intensive two-day course elsewhere, I felt confident that it would meet my needs in terms of assisting with the storage and retrieval of my data and in the production of a systematic 'tree' of categories. The tools within the package I used most frequently were the coding memo production and modelling tools. These enabled me to link codes and identify the emergence of particular themes. I was also able to search the

data for recurrences of particular words or phrases. For example, if I typed a phrase such as 'take a deep breath and push' I was able to identify every time a participant referred to the use of the pushing mantra. This method led to an enhancement of analytical rigour by showing that the whole body of data had been explored, highlighting all occurrences of a phrase rather than just those which supported my own interpretation (Barbour, 2014; Seale, 2013).

I realised the advantages of using CAQDAS over a paper-based approach to analysis. It led to the systematic and efficient sorting and retrieval of the large volumes of data which is characteristic of the qualitative paradigm. It also allowed for a more objective view putting some distance between myself as researcher and the potential impact of the data. As Mason (2002) points out, this has the potential of enabling previously unexpected ideas to emerge. Despite this, I was also aware of the disadvantages of using CAQDAS, namely that it cannot ascribe meaning to codes or themes and will not 'do' the analysis on behalf of the researcher. In essence it is a useful tool but is only as good as the researcher herself (Barbour, 2014; Mason, 2002). In order to counteract this potential limitation, I followed the advice of Seale (2004) who recommends that researchers continually conduct an 'inner dialogue' with themselves. This led to me questioning my own interpretation of the data and continually considering how it might stand up to external scrutiny.

## Summary

In this chapter I have described how this study was undertaken using a pragmatic approach with thematic analysis. I have discussed and justified my chosen study design and related this to the overall aim of the study which was to explore midwifery practice in relation to directing a woman's pushing efforts during the second stage. I have described and discussed the method of data collection with a focus on the ethical challenges raised and how these led to an amendment to the original method of data collection method. I have demonstrated how a systematic and rigorous approach was adopted for data management and analysis.

The next two chapters will present the findings of the study. Chapter 8 presents findings associated with practices which midwives undertake during the second stage in relation to directing pushing. Chapter 9 will develop this further by presenting themes relating to why midwives practice in the way that they do, and what factors were found to influence their practice.

## 8. Findings 1 : Midwifery practice during second stage

### Introduction

The following two chapters present the findings from a thematic analysis of the interview data supported by written notes from my own reflective diary. This chapter will present findings relating to the participant's perspectives of midwifery practice, with a focus on directed pushing, undertaken during the second stage. Chapter 9 will consider themes gleaned from the data that were found to impact on the construction of midwifery practice during the second stage.

In order to provide structure, themes are grouped under the overall heading of the specific participant group they belong to. Each theme is supported by illustrative quotations with a focus on the context in which they were provided to demonstrate that the original meaning is not distorted. Some have been edited to enhance clarity and brevity and where participant's words have been omitted this is indicated with the use of square brackets: [...]. However, where this has been done, care has been taken not to alter the overall meaning of the quote. A biographical overview of each participant is included in Appendix 6. In order to preserve anonymity, all names are pseudonyms and bear no relation to any characteristics of the participants.

## Midwives knowledge of the evidence base

The midwives were asked what they knew about research associated with pushing and the evidence base underpinning recommended practice. There was a general awareness that spontaneous, physiological pushing rather than directed pushing was currently recommended by NICE (2014). However, precise details of the research were vague and non-specific. Most of them had not read or heard of any recent research on the topic of second stage pushing. This was unrelated to the time since qualification:

*'Well, I know NICE guidelines and things do say just encourage women to listen to their body, you know. It's just..., I don't know specifically.'*

Bonnie, birth centre midwife, 18 months qualified.

This comment was representative of most of the participants, suggesting that engagement with the latest research around the second stage was not seen as a priority for this group of midwives. The preference was to rely on their own tacit knowledge and experience of caring for women during the second stage. The midwife identified as 'Mandy' was the exception in this regard. She demonstrated an in-depth knowledge around the evidence base underpinning second stage pushing that was inherently analytical in nature:

*'I would say the majority of the time we would begin active pushing because of fetal distress. And I know all logic says that if we get her actively pushing that is probably going to make things worse but it is striking that balance between a potentially prolonged second stage or I think it [directed pushing] increases the risk of fetal distress but doesn't reduce necessarily the length of the second stage.'*

Mandy, birth centre/ delivery suite midwife.

However, Mandy confirmed that she would direct maternal pushing in cases of fetal distress to expedite the delivery. The implication here being that doing something is better than doing nothing, even when the action is unlikely to have a positive effect on the outcome. Mandy was aware that this is not a logical way of managing this scenario, nor is it evidence-based and yet she continues to do so. The midwives' desire to be seen

to be proactively 'doing' something appears to override the underlying knowledge that the proposed intervention is unhelpful. Mandy's observation highlights a dilemma for midwives in that working within a medical framework means that they have a tendency to undertake interventions into birth which have no demonstrable benefit (Peter et al., 2004). This aspect of the findings will be considered further in Chapter 9.

### Directed versus physiological pushing

Directed pushing was a key feature of the midwives' practice. The participants all confirmed that at some time, they had directed a woman's pushing efforts by providing guidance about when and how to push. Some stated that they had heard colleagues directing pushing and had assisted midwives in birthing rooms where directed pushing was being undertaken:

*'I think most midwives will probably tell them, directed pushing I think.'*

Nadia, birth centre/ delivery suite midwife.

Directing pushing featured extensively in the way that these midwives described their support of women during the second stage. It is a widely accepted intervention that seems to be embedded into routine midwifery practice despite the latest NICE (2014) recommending that pushing efforts should be woman-led. Most midwives reported becoming more directive in their guidance after a woman had been pushing for an hour with few observable signs of progress, such as the baby's head being visible externally. For example:

*'I'd say I'd hold back unless... things were not progressing, so I would then obviously go to directed pushing if..., you know.... If she had been pushing for some time and there was not much descent.'*

Josie, birth centre midwife.

Josie used the word 'obviously' frequently during her interview, suggesting that this was the normal approach she would use if labour had not progressed within the designated time limits. She mentioned the Maternity Unit guidelines as the benchmark on which she based her practice:

*'The policy? Well, they are allowed to push for two hours, umm primips. And then I think..., multips you would intervene after an hour? Yeah.'*

Josie, birth centre midwife

NICE (2014) guidelines however, do not recommend that directed pushing is instigated if these time limits are approaching. The suggestion being that women should be offered encouragement, a change of position and encouragement to empty her bladder. There is no mention of directed pushing being recommended as a way to hasten birth.

### Style of communication including the pushing mantra

When instructing women to push, several participants described giving very precise directions to promote effective pushing:

*'The instructions would be to push down into their bottom, like they are going to the toilet and can they feel anything, umm and umm, to keep going. Keep pushing until I say, and then take a deep breath and we'll push again and try to get three pushes in with each contraction.'*

Julie, delivery suite midwife.

There was a slight variation in directions provided by the midwife identified as 'Marjorie':

*'I don't let them take a deep breath after each push. I say, "take a deep breath and then you blow it out for all you can do, and you are blowing like you are going to fart" sort of thing, so they know the direction they are going to push.'*

Marjorie, community midwife

This was a common style of communication mentioned independently by most of the midwives and reminiscent almost word for word of the 'pushing mantra' described by Cook (2010). The instructions implied that women should aim to push three times with each contraction and that pushing should be directed downwards into their rectums

rather than into their throats which was perceived as being ineffective and a waste of energy.

*'Take a nice deep breath in hold that pressure and let it down into your bottom.*

*Don't let it out of the top because then the energy is coming out up the top rather than going down below.'*

Bonnie, birth centre midwife.

This method of directed pushing, Valsalva-style, is in direct contrast to the physiological pushing Thomson (1995) observed in her study exploring how women pushed spontaneously. This was recognised by Fiona:

*'I honestly think that if you really leave somebody and you haven't examined them at all actually, if you look at somebody in the second stage they only really give a push at the very height of a contraction and it's almost just a grunt, isn't it? Right at the peak of a contraction.'*

Fiona, community midwife.

Bonnie described a paradoxical situation when supporting women during the second stage; as the baby's head was emerging, if women listened to their bodies, they were tempted to hold back and not push because it was so painful. Instead, Bonnie encouraged them to push through the pain and to look upon this as a way of defeating pain by getting the experience over with.

*'I often try to say to women that it is a bit of a fight or flight kind of situation. It's a bit like, you know you have to go through it you have to override what your body is telling you because if you hold on to the baby you are just going to keep having contractions and you are going to keep going through this same thing. I said, "you have got to push past that pain you have got to, you have got to over that feeling of wanting to hold back".'* Bonnie, birth centre, midwife.

Midwives were keen to emphasise that when they did direct pushing, their approach was not aggressively forceful but encouraging and supportive.

*'Some midwives will... you know, be more.... forceful.... Not forceful..., more umm, more.... assertive with women saying "come on, (you know), push..."'*

Penny, community/ delivery suite midwife.

However, these observations are in direct contrast to Mandy's experiences as she reported hearing midwives shouting aggressively at women to stop making a noise while pushing:

*'I think there is a certain school of midwives who can be quite directive in their pushing. I think that is not very nice, it seems to undermine the women quite a lot. It instils fear and they are less likely to achieve a normal delivery.'*

Mandy birth centre/ delivery suite midwife

The vocalisations women make whilst pushing seems to be an issue here. The midwife identified as 'Fiona' implies that women-centred pushing is associated with a grunt at the peak of a contraction, in directed pushing women are required to make no noise.

A physiological style of pushing is seen as the best way to encourage women to take heed of their embodied sensations and do what felt right, whether that be to push, hold back, make a noise or be quiet. Midwives reported an encouraging approach that implied reassuring women that their innate sensations could be trusted. Similar words, terms and phrases were used when midwives described supporting spontaneous, woman-led pushing;

*'So I encourage them and say if you need to push, go with your body. So I try to encourage them to do.... what they feel. If you don't feel that you need to push then you know you can breathe it through and things like that until you get the urge to do it. So I try to encourage them obviously listen to their own bodies.'*

Josie, birth centre midwife.

Reassuring women that the intense, physical sensations they were experiencing were normal was also mentioned, as was encouragement to keep going because it would 'all be over soon'.

*'To just say, "do what you need to do", is fine and "you are doing it right". Because they always ask, don't they? "Am I doing it right?"*

Fiona, community midwife

The perception amongst midwives was that the pushing phase was an unpleasant, painful experience that women had to be helped to endure and this was a key role of the midwife during the second stage. None of them suggested that their practice involved watching a woman give birth without any words in the mode of the birth model advocated by Odent, (2015) (see Chapter 3). Midwifery practice always involved some kind of intervention whether that was specific direction on how to push or instructions to 'listen to your body and go with it'.

Fiona suggested that women expected her to be proactively supporting the birth process. Her perception was that she would be challenged by the woman or her partner if she just sat back and observed the events unfold:

*'I think if I sat there doing my knitting they'd be saying, "aren't you going to do something?" I could say, "Well I've got nothing to do," but I think they like to see me there with my gloves on.'*

Fiona, community midwife

The styles of directive communication described by these participants align closely with the findings of other studies exploring similar themes (McKay & Barrow, 1990; Roberts et al., 2007; Osbourne & Hanson, 2012). These studies also found that midwives tended to become more directive if there were changes in either the fetal or maternal condition which necessitated an expedited delivery or if a woman specifically requested more direction, a finding reflected in the Second Stage Study as illustrated by this quote:

*'So I think yes, there is a lot of "Oh gosh I think I'm hearing decels [sic]," but then that can be normal that is not necessarily you know, ummm... so I think they worry, and they just think, "right I'll just get the baby out because at least once the baby's out you can sort the baby out on their own or get the paed[sic] or something".'*

Nadia, birth centre and delivery suite midwife.

A notable finding was that midwives reported directing pushing despite suggesting that they favoured a woman-led approach. Bonnie illustrates this contradiction inherent in a midwife purporting to support a woman-led approach to second stage pushing while still feeling that guidance and direction is needed:

*'I was just saying to her, "you just do, just do what your body is telling you to do, listen to your body". I think I did say at one point because she was involuntarily pushing but it was all coming out of her throat, and I think I did say to her, "if you feel like you need to push then push. As in you know take a nice deep breath in hold that pressure and let it down into your bottom".'*

Bonnie, birth centre midwife.

This woman was involuntarily pushing and 'following her body' yet Bonnie felt compelled to offer guidance. This contradictory approach suggests that the midwife perceived herself to be the expert in this woman's birth experience with more authority to know the best way to push than the woman. So the woman is told to 'do what comes naturally' but still given specific guidance on how to do this.

Marjorie too, although very scathing of 'controlled pushing', guided women in the best way to push so her approach was not truly women-led:

*'I don't let them take a deep breath after each push. I say, "take a deep breath and then you blow it out for all you can do".'*

Marjorie, community midwife.

Marjorie justified this by saying that directing a woman's pushing in this way meant that she was being helped to avoid medical intervention. While Marjorie confirmed that she would only take this approach in an 'emergency', she later clarified that this was when the baby's heart rate was showing decelerations. This contradicts the evidence which demonstrates that directing pushing can have an adverse effect on the fetal heart rate and does not significantly reduce the length of the second stage (Bloom et al., 2006; Prins et al., 2011; Lemos et al., 2015).

### Other midwifery practices associated with the second stage

#### Vaginal examinations

Several midwives admitted avoiding undertaking vaginal examinations to assess progress during the second stage, despite NICE (2014) providing recommendations for frequency of examinations. The implication being that that once full dilatation of the cervix was confirmed by vaginal examination, the clock was started with an expectation that delivery would follow within a set period of time:

*'But I consciously avoid diagnosing fully [sic] because I know once you've done that, everybody fibs about an anterior lip, or you know, you say 8cms when really it is 9cms because it buys you more time which doesn't really do us any favours as midwives. But I do think that once you've diagnosed fully [sic] there is this expectation that the baby will be born.'*

Fiona, community midwife.

The strategy of delaying formal diagnosis of the onset of the second stage by either not performing a vaginal examination or underestimating the findings of a vaginal examination was used by some midwives as a way of buying more time for the woman. According to participants, it was an unspoken rule of midwifery that most used when considered appropriate. There was no mention that it was discussed with women and 'true' findings shared with them, or a rationale provided for not performing a vaginal

examination. Women participants did not mention knowing about this strategy at all. The feeling from them was that the vaginal examinations were used to confirm that they were fully dilated and able to start pushing, regardless of whether they felt a need to or not:

*'So I remember her saying, "Right, let me just check and make sure you're fully dilated", and that was after I'd been pushing a bit I think and she said, "yes, you definitely are".'*

Hilary, primigravida, transferred from birth Centre to delivery suite for a forceps delivery.

#### Helping women to know where to push

Some of the midwives mentioned a practice that they had undertaken in the past or seen others doing which involved the midwife putting her fingers into the vagina while the woman was pushing to demonstrate where pushing efforts should be directed:

*'You see some... some midwives directing by actually using... actually putting their fingers into the vagina... you know to... direct pushing.'*

Penny, community and Delivery Suite midwife.

The midwives did not view the practice favourably as it was considered to be a painful and unnecessary intervention. Only Marjorie mentioned it in positive terms:

*'I must admit if it is an emergency situation I will still do a perineal stretch... ummm for them. Especially with the primips for them to get an idea of where they are going to be pushing.'*

*Marjorie, community midwife.*

The fact that she feels the need to 'admit' to still using it at times implies that this is a midwifery practice that has fallen into disrepute. None of the women mentioned this practice in relation to their care.

### Maternal positioning during the second stage

Most of the second stage practices described by the midwives related to guidance provided for pushing. However most also mentioned the importance of encouraging women to adopt an upright position for pushing. This strategy is confirmed by research (Roberts, 2002; Sutton & Scott, 1995; Kopas, 2014) as being particularly effective in using gravity to enhance second stage pushing. Midwives reported that sometimes women were too tired to move but it was considered a key role of the midwife to encourage them to keep active.

*'Maybe if I say to them, "Would you like to change position?" If they say no then I've offered it... Or if they say they are adamant to stay in one position or sometimes if they say they are not sure, I'll say, "Well why don't we try?" And if they don't want to move too much they can go from left lateral and try to go on hands and knees.'*

Josie, birth centre midwife.

Both Mandy and Penny reported how much they learnt from their colleague's practice in terms of what positions they might try during the second stage to aid delivery:

*'Someone has told me recently, [about] a woman, I think she was a multip who had been pushing for a while with no obvious signs of descent, [it was suggested] to try left lateral on her. And that wouldn't have been a position I'd normally adopt because it seems quite uncomfortable, and that's worked a couple of times. I don't know if there is any evidence to support that.'*

Mandy, birth Centre and delivery suite midwife.

The latter part of this quote, when Mandy states that she is unaware of any evidence to support women adopting a lateral position, is interesting in that it seems to imply that

more women-centred practices such as the adoption of a particular position during labour require evidence to support their use, whereas the midwife-led intervention of directed pushing does not require evidence. In fact, it is implemented despite evidence demonstrating that it is not beneficial. It is also interesting in that this is the only time in the midwives' interviews that evidence to support a particular practice is mentioned. Usually midwifery practice seems to be based on tacit knowledge gleaned from what they had found to work or what they had seen others do. Another example is Marjorie's modified version of the Valsalva technique that she adopted when women needed extra direction. Again this was not reported as being based on any kind of evidence but more on her experience after a long career.

The general consensus was that frequent position changes rather than adopting any one favoured position that was a key factor in facilitating the second stage. Nadia also suggested that the main issue for women labouring on the delivery suite with epidurals in situ and strapped to the CTG monitor was that they tended to stay in one position which led to poor progress during pushing.

*'But it just seems, and I don't know whether it is because they have the epidural or maybe it is because we don't change their position..., maybe if we moved the bed especially with the epidurals, if we kind of put them in a more upright position for that passive hour? Because they just seem to sort of stay in the same position, so I just think well it doesn't really do anything.'*

Nadia, birth Centre and delivery suite midwife.

This was confirmed by the women participants who laboured in the delivery suite:

*'And then when I was on my back, because it was the worst position for me, on my back with my legs in stirrups having the tests done. That was very painful, and she [the midwife] was just talking about how good it was.'*

Lucy, normal delivery on delivery suite

On the other hand, women participants who had laboured in the birth centre described being encouraged to move around during the second stage and that this felt instinctive:

*'I was trying in all sorts of different positions. So I was on my back for a bit, I was sitting on one of those seat things, I was on all fours I think at some point. The whole way through it I just kept wanting to change positions, so I didn't feel like I could stay in any position for too long.'*

Hilary, primigravida.

### The passive hour

Midwives mentioned a period they called 'the passive hour'. This was described as being a period of time after a woman's cervix was found to be fully dilated when she was encouraged to 'wait and rest' rather than start pushing. The rationale behind this was to allow time for the baby's head to descend the birth canal aided by uterine contractions rather than maternal pushing efforts.

The implication for the midwives was that the passive hour was another opportunity to buy time and give women the best chance of achieving a normal birth. There was no suggestion that it was a 'lull before the storm' or used to give women a rest before the full drama of active pushing commenced.

Fiona suggested that allowing an hour for 'passive descent' was only of relevance to woman with epidurals who were unable to feel pushing sensations:

*'I find it really difficult because they talk about the passive hour, don't they? There's not really such a thing for somebody in spontaneous labour without an epidural in reality.'*

Fiona, community midwife

She believes that leaving women to push whenever they felt ready was preferable to advising them not to push for the passive hour or directing their pushing. As she pointed out, a woman without an epidural and ready to push would not be able to stop herself because her body pushes instinctively. This means that it is impossible for her to have a

'passive hour' of not pushing. Fiona believes that this is an intervention that has the potential to interrupt the flow of normal, physiological labour:

*'And babies do usually come, I know labour is hard work but if they are left alone, everybody leaves them alone, they usually come pretty easily I think... In my experience then.'*

Fiona, community midwife

Nadia also had doubts about the passive hour and whether it was beneficial, even for women with epidurals. She suggested that the passive hour was of little use unless the woman was also encouraged to adopt an upright position when gravity could assist the descent of the baby.

*'Maybe if we moved the bed especially, with the epidurals, if we kind of put them in a more upright position for that passive hour [it would help the descent].'*

Nadia, birth centre/ delivery suite midwife.

### Obstetrician's perspective of second stage practices.

All four obstetricians agreed that, by the time they became involved, women needed encouragement and guidance from midwives. This might take the form of directed pushing:

*'Most, if not all women, when they get to second stage they... a lot of them are quite exhausted.... And it is a big challenge for them. I think there is certainly a psychological component which might be overlooked at times. And I do feel that kind of active encouragement from everybody in the room is crucial to them achieving the goal.'*

Lionel, registrar

As with the midwives, there was uncertainty amongst the obstetricians about what the current evidence base suggested in relation to second stage. Indeed, three of them asked

me to tell them what the latest research recommended. NICE (2014) guidelines also evoked mixed reactions amongst the obstetricians:

*[CH: You know the latest research, the NICE guidelines that say that women should not be directed to push but should be left to their own devices. I mean ... what are your thoughts about that?]*

*'Maybe that is OK if everything is progressing normally but sometimes. Do you think it works then? Just letting them?'*

*Stella, consultant*

Thomas felt strongly that intrapartum care should be individualised and was disparaging about arbitrary time limits imposed upon the second stage of labour:

*'No, I think it is wrong... I strongly believe that in labour..., or generally in obstetrics and maternity, care should be individualised and not giving finite points like one hour or two hours obviously.'*

*Thomas, consultant*

Interestingly this was a point which was not highlighted as an area of particular concern by the midwives. They were aware of time constraints imposed upon the second stage by NICE (2014) but did not overtly challenge them in the way that Thomas did.

Thomas was the only obstetrician who stated that he favoured a non-directed approach to the second stage and suggested that if the baby was positioned in the optimal occipital anterior (OA) position, then the woman would feel the urge to push when the time was right, and would not need direction:

*'If they don't have an epidural then the body will tell them the head is in, unless it is an OP position. In the normal OA position by the time they have urges to push it is because the head is low enough down, and that is the right time for them to start pushing.'* Thomas, consultant

Instead, Thomas implied that he preferred an approach tailored to meet the needs of each individual woman, dependant on a multitude of factors which could impact on the progress of her labour and subsequent birth:

*'Care should be individualised to... the size of the baby, to the position of the head, to the shape and size of the mother, to the medical condition apparent to the mother's ..., how tired she is..., or not tired she is. There are so many factors and all that should guide the care giver, be that a midwife or doctor. As to when to start pushing, how to push, how they support the woman. Some women don't need any support at all. They will get in and push it through. Others need directed pushing and supporting because they don't know what to do, so these should be individualised.'*

Thomas, consultant

In this context, Thomas did possess a woman-centric view of childbirth which in some way was more overt than that of some of the midwives. He demonstrated his belief that the woman herself would know what she needed to do in terms of how to push, or whether she needed guidance to achieve this. This is not in keeping with what is usually recognised as the medical model of childbirth that imbues the professional with expert status.

However, some of his views echoed those of his consultant colleague Madeleine as well as the midwife participants, who suggested that multigravida and nulliparous women had different needs and required different care. Madeleine based this view on the physiological differences inherent in a nulliparous woman as opposed to a multigravida:

*'A second time mum, they can go with their body because the tendency is that the cervix is probably fully dilated by the time the woman is feeling rectal pressure. And if she wasn't fully dilated the pushing will probably dilate the cervix and get*

*the baby out. However, with the first time mums, they tend to feel rectal pressure long before they are fully dilated especially with babies in the posterior position... So I think with the first times mums we should actually be guarded as to, you know, prescribing non-directed pushing.'*

Madeleine, consultant.

Lionel agreed that primigravida women often required more direction and could not always be left to follow their own devices:

*'Particularly in primips, when it is their first ever time in labour, you know? It is one thing to leave people to their own devices but if they are not following the urges in a way that is going to optimise the outcome for themselves then a bit of direction and a bit of encouragement I think is not a problem.'*

Lionel, registrar.

Again, these perceptions aligned closely with those of the midwives who suggested that nulliparous and multigravida women had differing needs in relation to the guidance each required during the second stage. It was noted however that obstetricians tended to focus on physiological reasons for this difference while the midwives, suggested that it had more to do with the inexperience of nulliparous women and unfamiliarity with the intense physical sensations of the second stage.

When asked why they might become involved in the second stage, all the obstetricians gave the same answers. Notably, if labour became prolonged, or if fetal distress was noted and the possibility that operative or instrumental intervention into the birth process might be required.

Lionel describes the women whose care he became involved in as usually being at their limit, both emotionally and physically. Usually labour had deviated dramatically from the physiological event they had prepared for. This idea correlates with the experiences of some of the woman who described how the doctor came in at the end of the second

stage when they were physically exhausted, emotionally drained, and desperate for an end to labour. Indeed five out of the ten women participants had undergone labour and birth which deviated significantly from what they had planned during pregnancy.

Obstetricians had then become involved in their care which support's Lionel's view:

*'They've had nine months, most of which they have spent with a birth plan and how it is all going to go, and then it changes. And what does that do to their confidence? How does that confidence affect their performance in the second stage? And .. I know things have changed a lot; they are no longer downstairs, they are up on Delivery Suite, they've got drips and so forth. But giving them that little bit of ownership of the situation... I think giving them that does help. And lots and lots of encouragement I can't reiterate that enough.'*

Lionel, registrar.

Lionel gives this as his rationale for directing women to push during the second stage. He also suggested that by doing this, he had sometimes seen normal births that occurred spontaneously as he was preparing to undertake an instrumental delivery.

Stella shares this view:

*'And then I've missed so many forceps deliveries because I think... the woman needed that extra, not threat... just encouragement. And just empowerment to say you know she can do it.'*

Stella, consultant

The length of time of the second stage was mentioned by all of the obstetricians. For example, a prolonged second stage was noted to be a common reason for the obstetrician to intervene in the birth process, by offering to do an instrumental delivery:

*'We've tried to deliver. We haven't achieved delivery within this time frame and therefore they might have exceeded the kind of criteria for a midwifery-led delivery and now need to involve the obstetrician. 'Lionel, registrar.*

However, when I mentioned to Thomas that midwives sometimes tried to expedite labour because they were concerned that doctors were going to intervene if things were not progressing at the required rate, he felt he had a rationale for the differing approach of obstetricians to this issue. He suggested that this was as a direct result of the way that maternity services were organised, namely that obstetricians were usually responsible for the care of a number of labouring women at any one time:

*'The thing about length of time... I am biased because as a doctor you don't have the luxury of being with one patient and seeing them through. At the time you are in to deliver someone you have two or three other things waiting. So because of that there is pressure on to deliver a woman quickly so that you can get on to go and do something else. So I guess the attitude or the approach of a medic or a doctor would be very different from that of a midwife.'*

*Thomas, consultant.*

However, Madeleine felt that the time limits for pushing in the second stage (one hour for a multigravida and two hours for a primigravida) were reasonable, although she too recognised that this was an arbitrary measurement. None of the obstetricians knew where these time limits had originated or if they were evidence based:

*'The time limits I think are reasonable although arbitrary. And... I would not want to prolong them because when you prolong them the risk of bladder problems increases for the mother and then you have a... neuropraxia of the bladder nerve because the baby has been sitting there. No I would not want to change them.'*

*Madeleine, consultant.*

Three of the four obstetricians mentioned urinary complications as a side effect of a prolonged second stage; an issue that is supported by research, although it was actually the directed pushing group that suffered significantly more complications in the RCT that investigated this (Shaffer et al., 2005).

The obstetricians felt professional collaboration was key in the second stage, and clearly described the teamwork in the delivery room. They noted that midwives, obstetricians, and women worked together to achieve the goal of a successful delivery and healthy baby

There was a feeling from both Stella and Madeleine that sometimes they were called into the delivery room when the midwife was unsure about possible fetal distress. They were not necessarily needed to expedite the birth at that point but were on hand to encourage the midwife to continue to support a normal vaginal delivery. They saw themselves empowering the midwife to trust in the woman's body and its ability to give birth without intervention; they were there on the sidelines ready to step in just in case they were needed:

*'We generally won't be called in unless the midwife is concerned. And it is not necessarily every time that the midwife calls you that, as an obstetrician, you need to intervene. What the midwife might just need is support, the encouragement to achieve the normal birth.'*

*Madeleine, consultant.*

Lionel talked about care being transferred from midwife-led to obstetrician-led as a result of labour taking longer than is allowed for in the guidelines. However, he still saw an active role for the midwife in an instrumental delivery as an individual who has developed a close relationship with the woman over the duration of the labour:

*'And there is always some collaboration. It may be that she is now chaperoning the delivery of the baby but the midwife will still be playing an active role... She*

*knows the woman, so again giving that encouragement, palpating for contractions, so it is all team orientated really.'*

Lionel, registrar.

Stella suggested that she personally preferred a more experienced midwife to assist her during the second stage because she favoured a 'cheerleading' approach which she felt was lacking in the more recently trained midwives. The suggestion was that because of the latest NICE guidelines (2014), midwives are no longer taught to give women instructions:

*'When you are doing an instrumental delivery it is really nice to have an experienced midwife who will then help the woman to draw her legs up and be actively pushing. So she can instruct her properly because it is nice to have her as a cheerleader.'* Stella, consultant.

Despite favouring a directed approach, Stella still spoke negatively about the number of people in the room shouting instructions at the woman as she was trying to push. She suggested that a calmer more controlled approach with just one person giving directions was preferable:

*'What I've noticed in the room is that everyone shouts at the woman and I think... "Whoa! No, no, no!" We only want one person directing the pushing, and the midwife who is in charge with the lady who has been with her all the time and has that relationship.'*

Stella, consultant.

This reflected the experience of Lorraine, one of the women participants who found the number of people shouting at her while she underwent an instrumental delivery very disconcerting:

*'I think I screamed at all of them. No I think... No I did. And I said "Listen, I cannot listen to all of you so, please just one person talk to me. Because I cannot talk to all of you, and I don't understand what's going on." But I didn't understand what was happening.'*

Lorraine, primigravida, forceps delivery on delivery suite.

It is acknowledged that obstetricians are based on the Delivery Suite where high-risk women are admitted and epidurals, continuous CTG monitoring, and Syntocinon™ infusions are the norm. The participants admitted that they rarely if ever visited the Birth Centre and this was not seen as their domain:

*'I haven't observed the practice [of directed pushing] on the Birth Centre because you know we don't go down there often... I haven't been there for years... for about 5 years.'*

Madeleine, consultant.

The women that obstetricians care for during the second stage no longer have straightforward labours, which potentially impacts on the obstetrician's experiences of directing pushing and may lead them to have a biased view. This was confirmed by Stella:

*'The women we don't see are the ones on the Birth Centres who do really well ... we just get the really exhausted ones who get brought up here and maybe have had a long labour.'*

Stella, consultant.

When discussing the second stage of labour with this small group of obstetricians, their goal-based vision of childbirth was evident. On numerous occasions they mentioned outcomes and goals, and their practices during the second stage were focused very clearly on achieving the ultimate goal of the birth of a healthy baby. This is very much in keeping with the reductionist view of the biomedical paradigm of childbirth that was discussed in Chapter 4. It was interesting to see it represented so explicitly in this group.

## Women's perspective of second stage practices.

Of the ten women who had given birth vaginally, six of them (all nulliparous) reported receiving direction around how to push from their midwife during the second stage. Of the other four, two were multigravida, one had given birth at home with no midwife in attendance and one had had a water birth in the Birth Centre. The two multigravida women both recalled being told not to push during the second stage. The guidance the six women remembered receiving was the Valsalva technique:

*'I said, "Right, I've got a contraction now", so then she'd say, "Right, come on then, push, push, push, really hard, really hard."'*

Caron, primigravida, labouring on the birth centre.

*'And I start to push, so they told me, "chin down". She said, "chin down" and she put my legs up.'*

Lorraine, primigravida labouring on the delivery suite.

*'So it was three pushes for each contraction and I remember by the time it got to the third one I was thinking "there's no way I can do another one".'*

Hilary, primigravida labouring on the birth centre prior to transfer to delivery suite.

It is of note that four of the women; Elizabeth, Lucy, Hilary and Lorraine had epidural anaesthesia, although Lucy said that she still felt an urge to push. Anita, having her second baby arrived in the Birth Centre in advanced labour. And while she did not receive specific guidance around how to push, she had a clear recollection of the midwife telling her not to push. She recalled the same thing during the birth of her first baby:

*'I say the thing ironically on both of them. Somebody, the midwife both times said "Don't push".'*

Anita, multigravida labouring on the birth centre.

Anita's perception was that this instruction was given in order to provide the midwife and student midwife with more time to get their equipment ready for the imminent birth.

However, Anita felt unable to comply with their instructions:

*'And literally as they said it, straightaway I was pushing.'*

Anita, multigravida labouring on the birth centre.

The other multigravida, Rosie also remembers being told not to push as her baby's head delivered:

*'And they told me to slow down obviously when she was crowning so at that point they were telling me what to do.'*

Rosie, multigravida labouring on the birth centre.

Despite being told not to push, neither Anita nor Rosie were given guidance on how to push and both had very quick second stages. Anita was told that hers took only six minutes while Rosie's lasted 12:

*'It was so hard and fast, it was quite daunting really.'*

Rosie, multigravida labouring on the birth centre.

Lucy also remembers being told not to push before it was confirmed that her cervix was fully dilated:

*'And then I started having this bearing down sensation.'*

*[CH; Oh, okay, you could feel it, even though... you had the epidural?]*

*Very much so. And yes, definitely could feel it, and the midwife told me not to push, because I was going to tear in two.'*

Lucy, primigravida labouring on the delivery suite.

Lucy found these words very distressing, despite knowing that she would not 'tear in two'. Her knowledge came from her own research and her attendance at antenatal classes:

*'I didn't believe her, which I think is fortunate because it would have been quite frightening.'*

Lucy, primigravida labouring on the delivery suite.

Of the other two women who reported receiving no guidance in relation to pushing, Glenda gave birth in her hallway at home with her husband and three paramedics in attendance. Two of the paramedics had previously attended births. The other paramedic had never attended a birth. She reported that they gave her no guidance at all in relation to pushing:

*'They didn't really know about instructions to push or not. So they just checked to kind of see I think what was going on down there.'*

Glenda, primigravida, unplanned birth at home.

Glenda had a completely physiological labour and birth with no intervention from any healthcare practitioner. She described trying to stay calm in order to follow her body's instinctive urge to push:

*'When I felt the urge to push I was trying to do little breaths to try and help it along.'* Glenda, primigravida unplanned birth at home.

Emily laboured in the birthing pool in the Birth Centre. She did not recall receiving any guidance from her midwife in relation to pushing and remembered a very woman centred approach to the second stage:

*'It was just kind of like, "If you need to, just do what you need to do, go with it".'*

Emily, primigravida gave birth on the birth centre in the water.

With the exception of Emily, these findings from the women's interviews correlate with the findings from the midwife and obstetrician interviews, in that pushing during the second stage was usually directed by a midwife or obstetrician. Indeed, eight of the ten women in this study received directions to push from midwives and of the two that did not, one had no midwife in attendance. Her birth attendants were individuals who had limited experience of supporting women during labour and left the woman to her own devices almost by default. This means that only Emily who had a water birth on the birth centre received no guidance while pushing and was left to follow her own instinctive pushing urges.

In terms of how valuable, the women found the directive approach, some described it in positive terms:

*'I'm quite a competitive, quietly competitive person, so when she said to me, "That wasn't a good enough push", I was like, "Right!" You know..., so that really helped me, I felt anyway, so I thought she was really good.'*

Caron, primigravida, laboured on the birth centre, transferred to the delivery suite.

These participants were middle-class professional women, and it is interesting that their frames of reference for birth appear to be grounded in the world of work. Reading these descriptions one gets a sense that women felt that they had a job to do and wanted to do it well, so approached it in a business-like, manner and they appreciated the same in their midwives. Others were not so satisfied with their midwives' approach and felt that it did not suit their individual needs:

*'The midwife that I'd had throughout, I'd found less helpful. Because she didn't, unfortunately, she didn't listen to me, throughout, and was telling me that my body wasn't doing anything and I was going to need all the intervention and all that kind of stuff.'*

Lucy primigravida, normal delivery on the delivery suite.

Lucy's description of her birth experience resonates with some of the views expressed by the midwives who stated that a woman would require intervention if her body were working inefficiently, or if she was not pushing in the 'right way'. Lucy had a normal delivery but had an obstetrician assisting as there had been concern about fetal distress and a suggestion that she might need a Ventouse delivery. When the doctor took over direction, Lucy found his approach to be undermining:

*'The consultant had a word with me and told me to take it all, said, "Now you've got to take this seriously", which kind of implied that I hadn't already been... He told me off more than encouraged, I thought, before the process had even begun. He kind of*

*gave me a bit of a talking to, which I was surprised at because I felt like I was fully on board with putting some effort in anyway.'*

Lucy, primigravida, normal delivery on the delivery suite.

Again the obstetrician's remark to Lucy to take giving birth 'seriously' implies a professional work-based approach to childbirth ('let's get the job done'). This contradicts women's views that birth is a unique and complex life affirming event (Larkin et al., 2009).

Hilary was given detailed guidance to push all the way through a contraction and to try to achieve at least three big pushes per contraction. She was instructed to do this when in the birth centre and thus this guidance was an intervention in what was, up until then, a completely physiological birth. Hilary stated that, left to her own devices, she would not have pushed in this way. She said that giving short pushes helped her to cope with the pain of the contractions:

*'I wouldn't have done that. I would have been pushing because, like I said, it kind of helped with the pain. But towards the end of the contraction the pain's obviously easing anyway and to try and do another one after you've just pushed really hard - twice - was really difficult.'*

Hilary, laboured on the birth centre prior to transfer to the delivery suite.

However, despite feeling that her midwife was directing her pushing in a way that was against her innate urge, Hilary concluded that she would not have liked to have been left to push instinctively:

*[CH: 'Do you think you would have preferred to have been left then or...?]*

*'No, probably not. I don't think so.'*

Hilary, primigravida, laboured on the birth centre prior to transfer to the delivery suite.

Like Hilary, Lucy also felt that she needed direction in pushing. It was her first baby and she felt that she lacked both experience and confidence:

*'I was more than happy to be told what to do, because obviously I don't know what I'm doing.'*

Lucy, primigravida laboured on delivery suite.

Lucy's lack of confidence in her ability to push without guidance due to her being a primigravida was in keeping with the views of the midwives who suggest primigravida women require directed pushing, and could not be left 'go with their bodies' due to inexperience.

Emily, who had a very positive experience of giving birth in the water without direction, was less clear on what her expectations of the midwife had been prior to giving birth. However, she did suggest that she had anticipated more guidance:

*[CH: 'Did you expect them to give you more guidance? 'Cos it sounds like they were just in the background and did not do very much?']*

*'Possibly. But I guess I had when I was thinking about it. If I was out of the water and... I don't think I needed any more guidance.'*

*Emily, primigravida laboured on the birth centre.*

However, despite expecting guidance, Emily was satisfied with the approach of her midwife and probably had the most positive birth experience of all the women interviewed.

Rosie received guidance from a midwife during the second stage of the birth of her second baby and had mixed feelings about it. On one hand she felt she needed someone to guide her as she struggled to stay in control. She found the overpowering force of relentless contractions very disconcerting during late first and early second stage:

*'There's a sense of feeling someone's in control if they're telling me what to do and that's quite helpful. But at the same time you don't have the opportunity to sort of go, do your own thing.'* Rosie, multigravida laboured on the birth centre.

In terms of the women's expectations for birth, Glenda had not expected to give birth without the support of a midwife. She had gone into hospital when she started having contractions but was discharged home and told that she was not yet in labour. On reflection she was pleased with the outcome;

*'And to be honest I think you want as little as possible distracting you when you're in labour and bringing you back to thinking, because when you think about things you tend to freeze up.'*

Glenda, primigravida, unplanned birth at home.

Glenda had a clear sense that she needed to let go of her higher functioning brain to enable her to surrender to her instinctive bodily sensations:

*'And like I remember xxxx was saying in the class that you're trying to switch off a part of your brain and just go with it. So it definitely makes sense.'*

Glenda, primigravida, unplanned birth at home.

### Women's antenatal preparation for the second stage

Most of the women participants mentioned watching the television programme 'One Born Every Minute' (Channel 4, 2010-2017) as a way of preparing themselves for what to expect during labour. When I asked how birth was depicted on this programme, women described midwives directing pushing with extensive use of the Valsalva technique. It seemed that for these participants 'One Born Every Minute' did influence their expectations of birth. For example, Hilary's midwife had directed pushing and Hilary had expected this:

*'Um, yeah, I think it is probably what I expected. Most of that probably comes from watching 'One Born Every Minute' and what they're like on there.'*

Hilary, primigravida.

This might also explain why Emily expected more guidance around pushing, having watched the programme regularly throughout pregnancy. Glenda, on the other hand, had not watched programmes about birth during pregnancy and had gone out of her way to avoid seeing any:

*'I was afraid it would be very, um, dramatic and stuff and I didn't want it to make me feel worried about the birth.'*

Glenda, primigravida.

She was the exception to the rule, as all the other participants alluded to watching. For these women it was a prime source of information about what giving birth in a modern maternity hospital would be like.

All but two of the women (Lorraine and Harriet) had attended National Childbirth Trust (NCT) antenatal classes. Of the two multigravida women, both had attended NCT classes during their first pregnancies and Anita had attended a couple of hospital sessions during her second pregnancy. Lorraine and Harriet had attended hospital antenatal classes with their partners. Women reported that information given the classes had not focused particularly on how they might feel or what they might be asked to do during the second stage. Emily was representative of the others as she was vague about what she had been told about the second stage:

*[CH: And did they talk to you about the second stage then about what to expect and what the midwife might do?]*

*'Umm, did we? I know they were kind of talking about, for my husband, signs that you know second stage was coming, like me going quiet and stuff, and he said he definitely recognised the things so yes we definitely talked about that... and I think we talked about slowing down stuff, yeah, yeah.'*

Emily, primigravida.

Hypnobirthing was mentioned by seven out of the ten women as a technique they had used while preparing for birth. This is based on hypnosis which seeks to remove anxiety,

fear and stress, and the inhibitory effect which these may have on the production of oxytocin and endorphins. These hormones are required for a normal physiological experience of birth. Hypnobirthing techniques enable a woman to work with her body during childbirth (Graves, 2014). Lucy described her understanding of hypnobirthing as follows:

*'Hypnobirthing is kind of based on the idea that when you're in pain, the anxiety and stress about the pain makes your body tense, which makes the pain worse, which makes you more frightened, so it's a way of managing your feelings about being in labour, and trusting that your body will do what it needs to do, and using different, kind of, breathing and grounding techniques to just help you remain calm.'*

Lucy, primigravida.

Several of the women found that using the hypnobirthing techniques they had learnt in the antenatal period were of some benefit to them during labour. For example, Glenda asked her husband to put the hypnobirthing CD on in the background as she was giving birth at home and found this to be effective in helping her stay calm and focused. Lucy wondered if her midwife had misread her progress in labour as she remained calm by using hypnobirthing techniques:

*'I wonder whether, because I did hypnobirthing before, so it was quite calm, and I think the midwife was gauging my labour based on being quite calm and not distressed enough.'*

Lucy, primigravida.

In contrast, none of the midwives mentioned hypnobirthing without prompting. Once I had undertaken several interviews with women I realised that this was a technique which women were using to help them prepare for labour. This led to me asking some of the midwives what they knew about it. Jenny was supportive of women using anything which might help them during labour:

*'Anything that they want to do as long as it's safe, that's the thing I've got to be supportive of.'*

Jenny, community midwife

However she was dubious about the effectiveness of hypnobirthing:

*'I know a lot of them practice it but, you know, it all tends to go to pot at the end it really... with hypnobirthing. They can be very focused in the early stages, but I think once the pain... you know?'*

Jenny, community midwife

Midwife Fiona described how women used hypnobirthing techniques:

*'It is to avoid using negative words like 'pain' or 'difficult' and things like that. And to keep it very quiet and very calm and it is very specific about avoiding guided pushing.'*

Fiona, community midwife

Harriet had practised something she called 'natal hypnotherapy' and felt that her midwife did not have a clear understanding about the technique:

*'I think she thought I was asleep, but I wasn't asleep, I wasn't even tired or anything, but I felt very focussed and she kept going, "Come on, wake up, wake up", and very sort of, yes, snapping me out of my zone of kind of focus.'*

Harriet, primigravida, instrumental birth transferred to delivery suite from the birth centre.

Harriet was disappointed that her midwife had shown such limited awareness of hypnobirthing and reported that she had become defensive when Harriet's husband had

asked her to avoid mentioning the passage of time:

*'And she kept mentioning the time and so he was saying, "Oh, is it necessary to sort of mention it so much, because I think it's sort of maybe get, [sic] you know, interfering". And she sort of shouted at him a little bit as well, she was quite sort of, "I have to mention the time, she has to be aware of what's going on and how long she can be here for". And, again, I was upset that she was sort of talking to him like that as well.'*

Harriet, primigravida, instrumental birth transferred to delivery suite from the birth centre.

## Summary

This chapter has presented findings relating to specific practices undertaken by midwives during the second stage of labour and the associated language and communication strategies used to support women during the pushing phase. Findings from the perspectives of the three participant groups the midwives, obstetricians and women have been outlined.

Despite the evidence base recommending that women should be encouraged to follow their own embodied experience, directed pushing was seen to be one of the key midwifery practices undertaken during the second stage. This is reflected by the finding that, although some of the midwives claimed to favour a physiological approach to labour and birth, most resorted to directing pushing whether it was to provide specific advice on pushing technique or a suggestion that women don't push and take a 'passive hour'. All the midwives admitted to being directive on occasions and were aware that their colleagues were also directive.

This finding was confirmed by the women. Eight of the ten women had received some kind of guidance during the second stage. The two multigravid women had received instructions not to push despite feeling they wanted to. The other women had all been instructed to push using the Valsalva technique and descriptions of this were universally

similar. One nulliparous woman had given birth with only her husband and inexperienced paramedics in attendance and another gave birth in the birthing pool the Birth Centre with a midwife. These were the only two who experienced physiological birth. Women's experiences tended to be framed within a work-based, professional model with a matter of fact approach adopted by the midwives and mirrored by the women in terms of getting the job of birth done efficiently and quickly.

Knowledge around research relating to directed pushing was generally hazy for both midwives and obstetricians. Midwives on the whole, were aware that physiological pushing is considered the best approach based on research evidence, but directed pushing continues to be seen as normal practice. They know it is not recommended but still instigate it regardless.

Women expected to be directed in their pushing and most welcomed this direction from their midwives. This expectation seems to have arisen in part from watching television programmes specifically 'One Born Every Minute (Channel 4, 2010-2017) where midwives are depicted as being highly directive during second stage. Formal antenatal preparation did not seem to include information about how the second stage might feel or what women might be expected to do. The use of hypnobirthing techniques was favoured by most of the women in this study but the midwives did not have a clear understanding of what this involved and it was not mentioned by any of them unless prompted.

The next chapter will focus on presenting findings from the data which seek to explore the reasons why midwives practice in the way that they do during the second stage of labour.

## 9. Findings 2: Factors affecting midwifery practice

### Introduction

The previous chapter presented findings in relation to midwives' practices associated with the second stage of labour. This chapter will highlight themes identified from data analysis as well as those relating to midwives' rationale for their practice of directed pushing.

The themes explored are:

- Time passing and 'watching the clock'
- Different worlds
- Different women
- Midwives take charge
- Growth of confidence and changing practice
- Conflict

### Time passing and midwives 'watching the clock'

The influence of time and a perceived pressure of time on midwifery practices during the second stage was a recurring theme. Participants frequently mentioned time, the passage of time, measuring labour in terms of time, the importance of time, and perceived notions of risk and safety. These have been grouped together here under the general theme of 'time and clock watching'. An awareness of time passing during the birth was marked by incessant clock watching and checking of time by midwives and women.

Midwives referred to the passage of time in terms of the need to get the baby delivered within set time limits 'allowed' for the second stage. Most midwives began their support of second stage pushing by encouraging women to respond to their embodied instincts and push as they wished. After an hour of pushing however, most midwives' practices changed to become more directive and less dependent on instinctive pushing:

*'If they are getting on to sort of the hour, then I might sort of say get a little bit more focused.'*

Josie, birth centre midwife.

This is done in a bid to hasten the labour and get the baby delivered safely and 'in time'. The sense of urgency to get the baby delivered within a set time scale was more pronounced in the delivery suite than in the birth centre:

*'I think we are just a lot quicker to intervene on delivery suite, so we won't, we don't tend to give the women so much time.'*

Mandy, birth centre and delivery suite midwife.

Marjorie confirmed that time constraints were more apparent on the delivery suite and suggested that midwives were more likely to comply because of the dominant medicalised approach:

*'Well yes, because I suppose, if they are considered high risk and they know the doctors are going to come in... they've got the time restraints...'*

Marjorie, community midwife.

This observation was reiterated by the obstetricians. Madeleine stated that she worked to the guidelines and felt that the time limits for second stage were appropriate:

*'The time limits I think are reasonable, although arbitrary. And I would not want to prolong them because when you prolong them [you] risk bladder problems.'*

Madeleine, consultant.

Lionel also mentioned time limits when explaining why an obstetrician would become involved in a birth:

*'They are concerns that the baby's heart rate is down and therefore they might be exceeded the kind of criteria for a midwife. We've tried to deliver we haven't achieved delivery within this time frame and now need to involve the obstetrician.'*

Lionel, registrar.

Gloria, a community midwife, agreed that time pressures on the delivery suite were more apparent than either at home or in the birth centre:

*'Sometimes I get the feeling that time is of the essence and if the delivery suite is busy there is pressure for them to get on and get delivered.'*

Gloria, community midwife.

Gloria was an exception to the other midwife participants, in that she did not believe that time was the most relevant factor in deciding progress during the second stage, regardless of where she was working. Gloria reported that she did not measure labour progress in time but more in relation to how the baby was descending through the birth canal;

*[CH: So you are you worried about the time then?]*

*'Oh no as long as they are progressing then no, no.'*

*[CH: 'So it is about progress? Is that the main thing?]*

*'Yes, definitely. Yes.'*

Gloria, community midwife.

Although the pressure of time for community midwives caring for women at home was not so pronounced, Fiona still felt bound by the guidelines:

*'I know the time limits are only there if you allow them to be there but I do work for a Trust and I do have guidelines to follow.'*

Fiona, community midwife.

Fiona was aware that the Trust guidelines recommended a time limit of three hours in second stage for a primigravida and two hours in second stage for a multigravida. However, she also stated that if caring for a multigravida at home she would be concerned if the baby had not delivered after two hours of pushing:

*'But you know a multip without an epidural? Two hours later I'd be really twitchy at home, I would be, I'd be really twitchy at home because, but that's not based on..., that's just based on what you've see as a midwife.'*

Fiona, community midwife.

Fiona implies here, that her concern about a multigravida woman who is not progressing in labour, is not based on any known evidence but on her own tacit knowledge drawn from what she has observed after several years of practice.

As highlighted in Chapter 8, Fiona and other midwives admitted to a covert strategy they used to 'buy time' which involved delaying undertaking a vaginal examination to avoid diagnosis of second stage. Fiona challenged the time limits imposed on the second stage

by suggesting that in the most part they were not needed and actually could lead to more intervention because of increased diagnosis of prolonged labour for delay in second stage. She mentioned the practice of experienced midwife who she had worked with:

*'She said you should never get them pushing until you can see the head I think. Of course that is so sensible isn't it? The head is up there in the gods and you are asking women to push. The effort it would take? I mean, no one could ever push a baby out in an hour. Yeah, it seems really counter intuitive to me and we've got, you know, we do have loads of instrumental deliveries, for you know, delay in second stage and actually is it really a delay?'*

Fiona, community midwife.

Fiona thought that two hours of pushing for a multiparous woman was 'too long' and might indicate a problem and that on other occasions, only 'allowing' two hours for pushing did not provide enough time for the baby to move down through the pelvis and be born spontaneously. Of interest here is that Fiona still speaks about 'getting a woman' to push or 'not getting' a woman to push. Her practice is based on what the midwife believes is appropriate based on tacit knowledge, and not what the woman feels the need to do based on her embodied sensations. For example, a woman may want to push even if the head is not visible and if her cervix has not reached full dilatation. Care that is truly women-led, would recognise this, rather than 'getting' a woman to do anything else. This supports the finding presented in Chapter 8 that midwives reported views are often contradictory to the way they actually practice

Jenny suggested that directed pushing does speed up the second stage for nulliparous women but did not think that this was the same for multigravida women who were more able to follow push spontaneously without guidance.

*'I think it does speed things up with a primp yeah. But I don't think the multips, I think the multips just go with it'.*

Jenny, community midwife.

Again, Jenny gave no clear rationale for her beliefs that were presumably based on her experiences of caring for women over thirty years. The suggestion is that primigravida need guidance because their embodied feelings cannot be trusted and they are 'novices' at birth. Multigravida however are experts who have 'done it all before' and can be trusted to 'just get on with it' or 'go with it'.

### Women's perceptions of time

Time and the passage of time during labour were key themes for women. Their understanding of 'labour time' was that it followed a linear pathway with certain time limits 'allowed' for each stage. Women were also continually clock watching, and the timing of events was a key element of their birth stories. There was a sense that labour time was measured in clock time:

*'I went into triage about four o'clock, so this was about eight o'clock, shift change.'* Elizabeth, primigravida

*'My waters broke a 4.30pm and she was born at 2.30am.'*  
Emily, primigravida

Some were also aware of the pressure of time and knew that the second stage had to be completed within a set time, otherwise intervention would be needed to ensure a safe birth. They had picked up this sense of urgency from the midwives caring for them. For example, Caron and Harriet were both transferred from the birth centre to the delivery suite during the second stage, having both been informed that the second stage was lasting 'too long'.

Caron reported that she felt fine and that her baby's heart beat was showing no signs of distress. However, her midwife was anxious about the time she had spent pushing and encouraged her to transfer to the delivery suite after an hour of pushing. The midwife persisted in directing her pushing despite the fact that Caron was on the birth centre where any intervention should have been minimal:

*'My [contractions], they literally stopped, and I said to her, "Oh, but I don't know why, I feel fine," and she said, "You're tired..." And I think I was quite dehydrated, not that I felt that I was, but according to my midwife... she said, "You're*

*dehydrated, you've run out of energy, even though you feel you can do this, your body's tired, so we need a bit of intervention."*

Caron, primigravida, labouring on the birth centre.

Caron and her partner were aware that the midwife kept looking at the clock and was concerned about the amount of time the pushing phase was taking. The midwife explained to Caron that intervention was needed in order to prevent future problems, despite the fact that at this time neither Caron and or her baby showed any signs of compromise:

*'I think it probably was about an hour, because she was very anxious, checking her clock. And she explained to me, and I might have this wrong, from what I remember, she said, "Where your baby is, if you leave it any longer, it will cause damage to your urinary tract." I think that's what she explained.'*

Caron primigravida, labouring on the birth centre.

*'And also she said, "The baby can get distressed as well."*

Caron's partner.

The rationale that the midwife gave to support a transfer to the delivery suite was that if they did not do so Caron's baby would be put at risk, although this view is not evidence-based. Caron was moved to the delivery suite where she was given intravenous Syntocinon™. She continued directed pushing with the same midwife and her baby was born spontaneously an hour after arriving in the delivery suite. Caron's memory of birth was positive and she liked the midwives directive approach that she had been expecting and felt comfortable with.

Elizabeth also had intervention an hour after she had started pushing:

*'We were sort of approaching an hour and the obstetrician said to me, she said, we usually only let you push for an hour.'*

Elizabeth, primigravida, instrumental delivery, delivery suite

The obstetrician undertook fetal blood sampling (FBS) and despite the fact that the result showed that the baby's oxygen levels were within normal limits, it was suggested that because time was 'getting on' intervention was required for that reason alone. Elizabeth, like Caron, was satisfied with her care during second stage. She felt fully involved in the decision to intervene despite the fact that this was the opposite of the natural birth with minimum intervention she had planned for:

*'The doctor said, "I know you don't want forceps particularly, and I'm prepared to let you go a little while longer but if still we can't get baby out by then we'll have to use... give you some help". And I really liked that because I felt she was consulting me and I had the option umm and it was like she gave me a little bit of leeway.'*

Elizabeth, primigravida, instrumental delivery, delivery suite.

It is significant that this intervention was planned an hour and a half into the pushing phase when the FBS showed no signs of fetal compromise. There was a sense that it was done 'just in case' to avoid a potential future complication of fetal distress. Despite it not being the birth she had hoped for, Elizabeth felt well supported by the midwives and obstetricians as she felt fully involved in their decision to use forceps. She believed that the intervention was necessary as it was the safest option for her baby

This finding supports the argument of Levy (1999c) that in power dynamics, the subordinate group often remain unaware of underlying systems imposed upon them by those holding the power and so conflict is avoided. As Shapiro et al. (1983) note in their study, Elizabeth left her birth experience satisfied with the obstetrician delivering her baby, despite the fact that the doctor's agenda rather than her own had been at the forefront of any decisions made. Likewise Caron who accepted her midwife's advice to transfer up to the delivery suite for a Syntocinon™ infusion. Both women felt safe with this approach as they perceived that the health care professionals were putting the needs of their unborn babies first.

Lucy had an epidural, although she did not find it very effective as pain relief and was aware of contractions and an intense pushing sensation. Lucy's second stage happened rapidly which took her by surprise. She suggests that the signs that she was close to delivery were missed by the midwife caring for her as she did not listen to Lucy:

*'I think, looking back, all the signs were there, but they hadn't been picked up on. So all of a sudden, it was time to push, and it was done in 15 minutes. But they were getting ready to use the Ventouse. She didn't listen to me, throughout, and was telling me that my body wasn't doing anything and I was going to need all the intervention and all that kind of stuff.'*

Lucy, primigravida, normal delivery, delivery suite.

### Time and midwife shifts

Women appeared acutely aware of the times of the midwife shift changed because it meant that they would be allocated a different midwife with whom they would need to establish a rapport. This was of particular significance at such a vulnerable time. In this context, rapport implies a feeling of mutual understanding between woman and midwife. This was in stark contrast to feelings of discontent from the women when they perceived that their midwife was working in opposition to them.

For Elizabeth the shift change was positive as she formed more of a rapport with the midwife who took over from the day shift:

*'I felt a lot more at ease, a lot calmer... I felt involved in the decision making process whereas I didn't feel comfortable with the midwives on the previous shift.'*

Elizabeth, primigravida, labouring on delivery suite.

Not so for Harriet, who found that the midwife who took over did not seem to be as supportive of her choices for birth as her original midwife had been:

*'I really felt like I'd got to know the one who dealt with me during the day and I just, I guess, because of the timing, I didn't really get to... It was just like, bam, and someone there, and just sort of shouting at you all the time.'*

Harriet, primigravida, transferred to delivery suite from birth centre.

Indeed for Harriet, time became a subject of contention between herself and her midwife. Harriet had practised hypnotherapy techniques during pregnancy and one of the key components of this is that the passage of time is not mentioned during labour. Harriet's midwife kept talking about time and distracted Harriet when she was in a relaxed state fully focused on her labour:

*'She was quite sort of, "I have to mention the time, she has to be aware of what's going on and how long she can be here for.'"*

Harriet, primigravida, transferred to delivery suite from birth centre, instrumental delivery.

Interestingly, Harriet tried to make excuses for the midwife's behaviour by suggesting that this lack of understanding might have been because the midwife took over her care when she was in advanced labour and had had little opportunity to find out about what Harriet wanted in terms of her birth plan.

Lucy described a similar situation:

*'The first midwife [ ]. She was absolutely lovely, and very calm and reassuring, and there was a real sense of, "We're going to do this together". Whereas the second midwife was saying, "This is going to be done to you now". So it was just a very different philosophy, I thought.'*

Lucy, primigravida, labouring on delivery suite.

The fact that shift changes occurred during these women's labours was significant in that a change in midwife could be a positive thing if they had not built up a rapport with the original midwife or negative if they were losing a familiar midwife who they felt they had established a good relationship with. It also highlights how significant the midwife is to a woman in defining a birth experience as positive or negative.

## The pressure of time and 'busyness' in the maternity unit

There was a sense of 'busyness' inherent throughout the Maternity Unit but particularly noticeable on the delivery suite. Some women participants mentioned that the Maternity Unit was busy, implying that there were a number of women in labour. With a high number of women in the Unit came a number of tasks which midwives had to undertake in order to care for them. This took up the midwives' time, which had a knock on effect on aspects of the women's care. Harriet described how her midwife had been too busy to read her leaflet about hypnobirthing:

*I had a leaflet that came with it, and it said to put that in my notes, which I did. But obviously she didn't have time to, because I know they're, it's really busy and everything. But that would be a useful thing, just for midwives to have generally, I think, just that copy of that, so they know what's going on.'*

Harriet, primigravida, labouring on the birth centre.

Harriet's perception was that she would have had a better relationship with her midwife if the midwife had understood some of the basic principles of hypnobirthing. However, Harriet saw her midwife not prioritising reading the leaflet but occupied with other tasks and being 'too busy' to do so.

Emily was labouring in the birth centre but wanted an epidural. However as the delivery suite was 'too busy', she had to stay in the birth centre where she was given pethidine instead:

*'Had delivery suite not been so busy I think I would have... I did ask for an epidural.'*

Emily, primigravida, laboured on the birth centre.

In hindsight, Emily felt that this was a good thing because she had coped well without an epidural and eventually had a positive experience of giving birth in the water.

Caron was also pleased that she and her husband were able to stay in the birth centre with just one midwife who used her husband as an 'honorary' birth assistant because there was no one else available to assist her as it was 'so busy' elsewhere.

Fiona was the only midwife who actually mentioned 'busyness' when she discussed working on a 'busy labour ward'. Although Gloria observed that if a woman had been in second stage for longer than an hour, senior midwifery staff would start knocking on the door to find out how things were progressing; the implication being that the room was needed for other labouring women, as the Unit was 'so busy'.

### Different worlds: impact of context on midwives' approach to second stage pushing: delivery suite versus birth centre

In the maternity unit where this study was undertaken, the birth centre was located just one flight of stairs below the delivery suite, and yet the cultural of each area was worlds apart. When talking to participants about their experiences of working and being cared for in each area it was hard to believe that they were located in the same building:

*'You walk through the doors of delivery suite and it is a totally different atmosphere. The vibe of it there, it is totally different.'*

Julie, delivery suite midwife.

Women whose pregnancies were perceived to be low risk were initially admitted to the birth centre. This was described as a 'home from home' birth setting. Women were transferred 'up' to the delivery suite if complications arose (for example, decelerations in the fetal heart rate, prolonged labour), or if epidural anaesthesia was requested. Usually care was handed over to a delivery suite midwife on transfer. Caron had the same midwife caring for her in both areas, although this was the exception rather than the rule as midwives usually stayed in their own areas. Despite this, two of the midwives (Nadia and Mandy) divided their time between the delivery suite and the birth centre and one (Penny) spent time in the community as well as delivery suite.

Labouring women were admitted to the delivery suite if they had had a complicated pregnancy with an underlying medical condition (diabetes epilepsy, heart condition) or if they had developed a complication such as pre-eclampsia, or had had a complication in a previous birth, or if their labour was being induced. However, not all women on the delivery suite were classified as high risk and sometimes 'low risk' women were admitted:

*'[Low risk women] go there sometimes. The birth centre can be shut because of staffing problems so women will go there sometimes. Women will go there because they think they might want an epidural. It could be various reasons. Or maybe triage is closed and they have reduced fetal movements or something like that and then they end up actually in labour so there could be different reasons.'*  
Julie, delivery suite, midwife.

Nadia describes the perceived cultural differences inherent in each area:

*'On the birth centre again, I hope that they are better prepared for what we expect of them, so I find them more receptive to going with their body on the birth centre. On delivery suite, I think they do just want to be told what to do. Because if things haven't gone quite according to plan or if they are so exhausted by the time they get there ... or ... yeah'*

Nadia, delivery suite/birth centre midwife.

The overall perception amongst midwives being that the birth centre was more women-centred and relaxed which was empowering to women who were then more inclined to follow their bodily instincts.

In contrast, on delivery suite, where interventions such as epidurals and continuous CTG monitoring were commonplace, women handed themselves over to the professionals and became passive recipients of care rather than actively involved. Penny confirmed this:

*'When you are medically managing somebody's labour, it's a little bit more..., you have much more, sort of hands on role.'*

Penny, delivery suite and community midwife

The fact that women in second stage tended to be lying in bed or with their legs in stirrups was highlighted in Chapter 8. Lucy described this type of interventionist culture when she was initially admitted:

*'I think the first thing that happened when I met her was that she came in and I was wearing just a big shirt, the first thing that happened was she came in and said, "Right, we've got to get you out of that and into a hospital gown, because*

*you're going to need an epidural, and you've got to be ready for intervention." And so she came in with her way of seeing things, and I said, "Well I don't think I really want an epidural," and she said, "In my 30 years, every single woman has had an epidural, you'll be having one." So it just felt very much, like, very prescribed, and you know, she ended up being right, I did have one.'*

Lucy, primigravida, normal delivery, delivery suite.

Lucy's midwife was clearly ready for intervention, and this was perceived as being the norm for the delivery suite, even though Lucy was not in a high-risk category. However, as she was two weeks overdue, hospital policy required her to be induced (despite the fact that on arrival in the hospital she was already experiencing mild contractions). Lucy described a goal-orientated approach practiced by the delivery suite midwife that was similar to the approach highlighted by the obstetricians:

*'The second midwife... I came away with a very strong sense of, I was kind of just a vessel, and xxx was the priority, which I agree with, but she made it quite clear that the aim was to get xxx out as quickly as possible.'*

Lucy, primigravida, normal delivery, delivery suite.

In Chapter 8, the finding that women tended to frame their experience of giving birth within the serious and competitive world of the workplace was most pronounced on delivery suite. This was reflected by midwives who spoke about being interrupted when caring for women on delivery suite with the sense that 'we need to hurry things along here' and keep to deadlines (time allowed for second stage). There was also a sense that women were marked (appraised) on how good they were at pushing, the implication being that some were better at birth than others, and that primigravida were novices, unable to push without guidance. Lucy illustrates this in the quote below:

*'A midwife came back after everything had calmed down and everybody had left. She was the midwife who'd been present just for the second stage, came back to say, "I don't think you know how well you did," and she was really kind, and said, "Because you've never had a baby before, you wouldn't know, so I wanted to come back and tell you that you were brilliant, and that you saved your baby from the Ventouse." And I think because she'd kind of picked up on it being quite a*

*difficult atmosphere, it was really kind of her to come back and say, "Don't take that stuff on board because you did really well and your baby's fine, and it's because you've paid attention."* Lucy, primigravida, normal delivery, delivery suite

Rosie had a similar feeling that birth was something that one could be marked as being 'good at', or 'not good at', with midwives being responsible for making this judgement:

*Her approach was to say, "You're doing really well", and I was just like "But I'm not", and it actually was a bit frustrating for her, it almost felt a little patronising for her to be telling me that I was doing great and just keep going and all that sort of thing.*

Rosie, multigravida, birth centre.

As a community midwife, Fiona is used to attending home births. She confirmed that women looked to midwives for affirmation but also emphasised that it was the midwives' role to reassure women that anything they wanted to do was fine, rather than implying that there was a right or wrong way that they might be 'marked down' for:

*'The role is to be reassuring isn't it? Second stage? To just say, "do what you need to do is fine, and you are doing it right." Because they always ask, don't they? "Am I doing it right?" And I say, "Of course you are doing it right, it's fine... just do whatever you need to do."*

Fiona, community midwife.

Fiona referred to a home birth as 'being all in a day's work' but framed within normality and the women's world of home and family, rather than the institutionalised world of the hospital:

*'It was in the middle of the day, we'd done a clinic. Popped over to do a visit. She [the student midwife] said it's all in a day's work isn't it? I can't believe she is just sitting there on the sofa and she's just had a baby. And I was like, "But that's what it is. That's what it's always been. It's just we've had thirty years when it has become this horrible hospital thing, but actually it is just normal part of life and our job really is to make sure that it does not deviate from that."*

Fiona, community midwife.

The medicalised environment of the delivery suite seems to encourage midwives to undertake a directive approach to pushing during the second stage. Mandy suggested that this aspect of practice was instigated sooner than was always necessary:

*'I think we are just a lot quicker to intervene on delivery suite so we won't... we don't tend to give the women so much time sometimes. The trace is just you know... it is... typical variable decelerations. It is not you know, anything we would need to get overly stressed about but I think we jump in quite quickly.'*

Mandy birth centre/delivery suite midwife.

Mandy reported that if she was caring for a woman on the delivery suite without an epidural she would favour physiological over directed pushing, and would still suggest that the woman was led by her own instinctive urge to push:

*'I think the difference on delivery suite if everything is going... to plan, you know there is no complications, the baby is quite happy... and we can just allow the woman to push involuntarily. We know there is descent. Then, you know, I wouldn't treat her any differently if she was up there or down here.'*

Mandy, birth centre/delivery suite midwife

In contrast, Nadia, who also divided her time between birth centre and delivery suite, reported taking the same directive approach regardless of where she was working. These findings are in keeping with those of Hyde and Roche-Reid (2004) and Keating and Fleming (2009), who found that women tended to adopt a passive role when giving birth in obstetric units and that midwives were expected to conform to the medical model of care even though the interventions prescribed were not always evidence-based.

### Pushing with an epidural

Midwife participants reported that supporting women with epidural anaesthesia to push required a different approach. All four midwives who worked on the delivery suite said that if epidural anaesthesia was in place, directed pushing would be required. They would instigate it because women with epidurals are usually unable to feel any pushing urge and so need guidance to tell them when a contraction begins so that they would push at the right time:

*'For the most part... guiding them... depending on when they had their when they had their last epidural top up and whether they can feel any pressure to push.'*

Julie delivery suite, midwife.

As women in these circumstances were often (but not always) devoid of physical sensation, midwives described using technology (watching contractions build up on the monitor by observing her (CTG), and their own knowledge of the birth process to inform women of when the time was right to push:

*'Certainly the births on delivery suite, most of the ones I've been involved in recently would involve an epidural, meaning that the second stage is a little bit more directed. There is more direction in that... there is more looking at palpating the contractions or watching the contractions on the monitor and then saying... "Right you have got to push now." And then saying, "you have got a contraction now". Probably more of the "take a deep breath in. Hold. Push."'*

Penny, delivery suite and community midwife.

Fiona agreed and suggested that there could not be a comparison between the care given to women with epidurals and to those without:

*'And epidurals... you can't really judge midwives looking after people with epidurals by the same standards as not because it is completely different. It totally, you know... sees it off doesn't it? Women who have no sensation... it does make it difficult.'*

Fiona, community midwife.

The general consensus was that most women admitted to delivery suite for whatever reason did eventually request epidural analgesia. This frequently led to other medical interventions such as a Syntocinon intravenous infusion in order to augment contractions and was also accompanied by continuous CTG monitoring.

### Pushing on the delivery suite without an epidural

Whilst the midwives were all clear that they would give directions around pushing to women with an epidural they were less clear about the usual practice when a woman was labouring in delivery suite without an epidural:

*'It is difficult to say really, because a lot of the women will have epidurals... It is difficult. If I say yes, actually there is because... going back to thinking about an example when someone has come in via ambulance pushing, and I was in with another midwife in the room and we were both instructing the woman to push.'*  
*Julie, delivery suite midwife.*

In this example, Julie remembered instructing a woman to push who was admitted in advanced stage of labour, and so would be classified as low risk and should be able to give birth without intervention. However, Julie remembered giving definite directions to her to push in a specific way. She was unable to say why she had done this, it seemed to be a case of custom and practice on the delivery suite.

These comments point to the fact that when women give birth in the delivery suite, for whatever reason, there was a tendency for midwifery practice to become directive in relation to second stage pushing.

### Pushing in the birth centre

Women labouring in the birth centre were classified as low risk and were expected to undergo a physiological labour with no intervention from obstetricians who had no presence on the birth centre. If women requested epidurals or if other labour complications arose, they were transferred to the delivery suite and were reclassified as 'high risk'. However, despite this, the situation around midwives directing pushing or favouring a physiological approach was less defined in the birth centre. Bonnie and Nadia stated that they would direct pushing for all women, even those in the birth centre:

*'I think I can be quite directive. I struggle sometimes to not kind of be, you know, "This is how you need to do it".'*

*Bonnie, birth centre midwife*

*'I do tell them to push with each contraction and to try to get three pushes out of each contraction.'*

*Nadia, birth centre and delivery suite midwife*

Midwives seemed more inclined to describe tailoring their approach to second stage pushing to suit the individual woman and her particular situation in the birth centre. Josie described her intervention in the following way:

*'A bit more supportive, rather than her just doing her own thing. And you know, not intervening, you know, getting involved in it a bit more, you know. I might sort of get her to focus a little bit more on her; how she is pushing, the way she is pushing.'* Josie, birth centre midwife.

### A third setting: home birth and leaving things alone

The five community midwives all reported leaving women to push spontaneously, particularly when caring for them at home:

*'But home births... really the last ones I've seen, certainly from my perspective, just tend to be watch and wait. And be very much led by the woman's instincts.'*  
Penny, delivery suite and community midwife.

A less intrusive approach was described at a homebirth, the suggestion being that midwives were invited guests:

*'Home is so different. When you go there you are in their house and it is really private and you know they could tell you to get out at any minute if they really wanted you to.'*  
Fiona, community midwife.

The midwives suggested that it was the home environment that influenced their practice and encouraged a more woman-led approach. The pace was slower, more relaxed and, as the woman was in her own environment, she was left to decide the best way to give birth with minimal intervention from the midwife. At home, midwives described being 'left to get on with it', being undisturbed by other colleagues and so able to practice within a physiological framework:

*'I think sometimes you get the feeling that time is of the essence and if the delivery suite is busy there is pressure for them to get on and get delivered. I think that's a huge thing and sometimes you do notice that there might be a little knock on the*

*door you know, "just checking...has she delivered?"*

Gloria, community midwife

Marjorie however suggested that even at a homebirth she would become more directive in her approach in certain situations:

*'I only ever do controlled pushing in an emergency situation if I need a woman to stop screaming and to focus on what she is doing.'*

Marjorie, community midwife.

The implication here is that when a woman panics and becomes uncontrollable during the second stage, the midwife's role is to calm her down and bring her back to reality and the task in hand. Marjorie suggested that she achieved this by giving explicit instructions on how to push. It is interesting here that Marjorie classifies a woman losing control and becoming uncontrollable as an 'emergency situation'. She did however quantify this later in the interview:

*'That is only in an emergency... Well, if you know where you have got decelerations which are that little bit slower picking up that sort of thing.'*

Marjorie, community midwife.

Marjorie implies that in taking control of the situation by giving detailed guidance about pushing, she will expedite the delivery and will therefore negate the need for a hospital transfer.

### Different women

Although some midwives did claim to be inherently directive or non-directive in their practice during the second stage, the general consensus was that some women needed more direction than others and that midwives should adapt their approach accordingly:

*[CH: Do you think that women on the whole expect you to tell them what to do during the second stage?]*

*'I think it depends... I think it is quite individual... Some women have said to me that it really helped in that bit, "It really helped when you told me to breathe or when you said to me keep pushing keep pushing that really helped." Whereas, you*

*know, some women, I think they just don't know what to expect.'*

Bonnie, birth centre midwife.

Gloria suggested that the amount of antenatal preparation a woman had received prior to the onset of labour made a difference to her expectations of giving birth and that influenced her practice during the second stage:

*'One or two might... They might just look for reassurance that what they are doing is OK. But I don't think they want to be told. If they have been to classes and they are well-prepared I think they are prepared to a level that they know that what they are doing is OK.'*

Gloria, community midwife.

Gloria's implication here is that there has to have been some kind of preparation for a woman to be able to give birth without instructions and guidance from a midwife. Again this fits in with the work-based view of birth described earlier by implying that preparation is essential to ensure the best outcome. In the same way that a professional needs to prepare for a meeting or work event, a woman needs to prepare herself intellectually for the experience of giving birth.

Josie concurred with the view that women who had been to preparatory classes were less scared and required less guidance than those who had not attended any antenatal classes:

*'It varies I would say. Sometimes the more sort of anxious patients... more like anxious women... Maybe they haven't gone to..., sometimes they haven't gone to antenatal classes, sometimes they just get a bit sort of scared.'*

Josie, birth centre midwife.

Most of the participants made a clear distinction between their care of primigravida women during the second stage and that of multigravida women:

*'Especially with a primip.... Sometimes they will say, "Can I push?"'*

Josie, birth centre midwife.

It was implied that when left to their own devices as recommended by the NICE intrapartum guidelines (2014), nulliparous women tended to push ineffectively which necessitated intervention from the midwife:

*'You have someone who is normally it's a primip because they..., you know... they push and it is all coming out of their mouth and you know... you can't see any, you know, descent. Then I tend to be a bit more directed and then I'll say, "Right, you know what you need to do is... do two to three really big pushes."'*

Bonnie, birth centre midwife.

This is a clear example of Bonnie using the Valsalva technique to direct pushing during the second stage. Bonnie describes herself as being a directive midwife, which is interesting as she was based on the birth centre, so there should have been no need to intervene in a physiological birth process. Despite this, Bonnie suggests that there is a need to be directive, for nulliparous women. Again there is the sense that women can be either 'good' or 'not so good' at pushing and that their pushing technique may need refinement in order to be effective. Similarly, Jenny said that she would give pushing directions to primigravid women but was less directive with multigravid women:

*'Primips..., I think you need to tell them to push. They need directed pushing. I don't think they can..., you know in the early stages, you know, when the vertex is just visible... They can't just breathe the baby out. I think they really need directed pushing.'*

Jenny, community midwife.

The implication here being that nulliparous women cannot be left to follow their instinctive urges because the physical sensations of the second stage are unfamiliar to them. Consequently they need guidance from a midwife or at least attendance at antenatal preparation classes in order to be able to give birth. This observation seemed to be based on the midwives' past experiences of caring for different women of during the second stage. Fiona reiterated this by suggesting that her job supporting, low-risk multigravida women at home was easier and less risky than that of midwives caring for high-risk primigravida women in the delivery suite:

*'I just always think how easy it is... if you leave it alone. How easy it is to be a midwife really, but I am looking after low-risk women and in the main I'm looking after multips... It is easier when the body has done it before isn't it? It is just easier.'*

Fiona, community midwife.

Fiona went on to describe a perception amongst the community midwives that nulliparous women who had opted for homebirth were highly likely to need hospital transfer:

*'I can't remember the last time I was at a... Gosh, that says something doesn't it? At a primip home birth where they actually stayed at home and delivered at home. I don't know what the transfer rate is but it is much higher for primips definitely... I think there is an expectation in community midwives you know a bit like, you know she is going to end up coming in. So I think they go in there thinking they're going to end up coming in.'*

Fiona, community midwife.

Some of the women supported this view that as they had not given birth previously, they needed direction:

*'I was more than happy to be told what to do, because obviously I don't know what I'm doing.'*

Lucy, primigravida, normal delivery on delivery suite.

Of most interest in this context is Glenda's unexpected homebirth. Glenda had a physiological birth with no intervention from any health care practitioner. She was a primigravida and yet was able to follow her own instincts and gave birth spontaneously with no complications. She was seen by a midwife a shortly after the birth but was able to stay in her own home without transfer to the Maternity Unit.

This conflicts with the views of the midwife and other women participants who suggested that nulliparous women needed directed pushing during the second stage due to their lack of prior experience. Glenda's story demonstrated the capability of the female body

to give birth unaided She had an overwhelmingly positive memory of her unique birth experience, as did Norwegian women in a qualitative study exploring their experiences of giving birth before arrival (Vik et al. 2016).

### Midwives are in charge

Another theme arising from the women's interviews was their perception that midwives are in charge of labour, regardless of the birth setting. There are frequent examples of women looking to their midwives for direction when they are at their most vulnerable. This is also illustrated by the importance that women attached to their midwife and how they perceived her contribution to the quality of the birth experience:

*'I felt massively deflated... I said to [xxx husband] at one point, with the midwife that I didn't get on so well with, I felt like she absolutely broke me because I'd had so many ideas about how I wanted things to go. And I understand that's all well and good, the reality is very different, but because I didn't want an epidural, and it was, she frightened me when she talked about the drugs being ramped up, thinking that I wasn't going to be able to cope with the massively stepped up level of pain.'*

Lucy, primigravida, normal delivery on delivery suite.

In contrast, other women credited their positive birth to the support they had received from their midwife:

*'I felt very confident in the midwife, I can't fault that. I've got nothing but good things to say about everyone I came into contact with. I felt I had a really good experience.'*

Emily, primigravida, water birth in the birth centre.

*'I think she was a really good midwife for us because she was quite, she was tough. I remember her saying, "Now come on, that push, that was a strong push but that wasn't long enough," and I remember saying to her, "I am really trying my hardest you know," and she was like, "I know you are, but you need to try harder."'*

Caron, primigravida, normal birth on delivery suite after transfer from the birth centre.

There are further examples of women being told how they felt and what they were to do by the midwife even though it was sometimes at odds with their embodied experiences:

*They [the contractions] literally stopped, and I said to her, "Oh, but I don't know why, I feel fine," and she said, "You're tired..." and I think I was quite dehydrated, not that I felt that I was, but according to my midwife... She said, "You're dehydrated, you've run out of energy, even though you feel you can do this, your body's tired, so we need a bit of intervention."*

Caron, primigravida, normal birth on delivery suite after transfer from the birth centre.

Similarly, Harriet was instructed to push despite not feeling an urge to do so:

*'As she made me aware of it, I did, you know, and I think I got. I, yeah, sort of got into learning what to do and feeling when to do it... I think it took me a long time to get that. It was only because she was saying, you know, to push that I felt.'*

Harriet, primigravida, laboured on the birth centre before transfer to delivery suite.

Hilary was told to push in a way that felt uncomfortable:

*'Sometimes for me it was just because doing something was easier than doing nothing but the midwife was telling me to push on every contraction that I got. So if it had been me there doing it naturally... I wouldn't have done that. I would have been pushing because, like I said, it kind of helped with the pain but towards the end of the contraction the pain's obviously easing anyway and to try and do another one after you've just pushed really hard. Twice was really difficult.'*

Hilary, primigravida, laboured on the birth centre and then transferred to delivery suite.

Lucy, on the other hand was given a stark warning not to push despite having an overwhelming urge to do so:

*'And yes, definitely could feel it, and the midwife told me not to push, because I was going to tear in two.'*

Lucy, primigravida, laboured on delivery suite.

Prior to this she had been informed by her midwife that she was not in labour, despite the fact that she was feeling strong physical sensations and a desperate need to bear down:

*'I had been told that I wasn't in labour and everything, and then I started having this bearing down sensation.'*

Lucy, primigravida, normal delivery on delivery suite

I reflected while listening to Lucy's story that if she had 'followed her body' as recommended (NICE, 2014) she would probably have given birth spontaneously with minimal trauma and intervention. Lucy's birth story is an example of an experience being normal in retrospect. Although she did have a normal vaginal delivery with no particular complications the birth experience was traumatic and this had a lasting, negative effect on her. In Lucy's eyes there was not much about her experience that was 'normal':

*'I came away from the experiences, the only thing I suppose that was good about having the birth there was that when we left [the hospital] it really felt like we were leaving the story behind, and we were taking the best bit home, and sitting and having cuddles in the days after was such a wonderful tonic.'*

Lucy, primigravida, spontaneous vaginal birth on delivery suite.

However, some women's experiences of being told how they felt and what to do was not perceived negatively. Women welcomed such direction as they were unsure themselves how to cope with the intense sensations characteristic of the second stage. They seemed relieved to hand over responsibility to an individual who they believed had their best interests at heart.

Emily was the only woman who reported that her midwife had asked how she felt and suggested that pushing should be guided simply by that:

*'No I don't remember them saying, "Yes now you are ten centimetres, start pushing." It was just kind of like. "If you need to, just do what you need to do, go with it." Quite liked the way she was just, "If you feel you need to push then just push." I know a couple of friends from the antenatal classes although they said that they needed to push and the midwife said no not yet and... it was just I wasn't really and particularly at the beginning I wasn't intentionally pushing, I was just doing what my body told me to do.'*

Emily, primigravida, water birth, birth centre

Emily's experience was the only one where there was a clear sense of events being truly woman-led rather than the directed by the midwife:

*[CH: I get the impression that you were not so aware of the midwives?]*

*'Yes, although I wasn't massively aware of my husband either so.... yes I know they were there on the side.'*

Emily, primigravida, water birth, birth centre.

### Midwives take charge

The three most experienced midwives, Marjorie, Gloria, and Jenny had undertaken their training during the 1970s and 1980s. They described a very directive approach to pushing and routine use of the Valsalva technique during their training and the early years of their practice:

*'I can remember, you know, back in xxxxx when they used to have, you know the midwives used to have the women's feet on their hips. They are lying flat on their backs and they are telling them to push until their eyes have got bloodshot you know?'*

Jenny, community midwife.

All three also reported a change in their practice over the years to one which encouraged physiological pushing and a belief that women should be left to push instinctively during the second stage. This change mirrors the publication of research from the mid-eighties onwards which recommended that a more woman-led approach to second stage was preferable to directing pushing. Despite this, Jenny still supported a directed approach for nulliparous women, Marjorie still gave clear pushing directions in order to get a woman

to focus if she became very panicky, and Gloria highlighted the importance of women being educated antenatally in order to be able to push without guidance.

When asked why they thought their practice had changed all three suggested that it was down to experience and their observation of women in labour and how ineffective directing pushing was. None of them implied that the change was instigated in accordance with recommendations from the aforementioned research studies.

*'I don't like controlled pushing I think it just exhausts them so much quicker.*

*[CH: Yes... and what made you change?]*

*I think just experience.'*

Marjorie, community midwife.

*'I think because you're used to women labouring at home on their own listening to their own bodies, in tune with their own bodies.'*

Jenny, community midwife.

Marjorie also suggested that her years of experience made her more inclined to stand up for herself and challenge other midwives who favoured a more directive approach:

*'And you know, being able to stand up for myself... You had to fight the midwife to do it and once you are qualified you have more opportunity to do that.'*

Marjorie, community midwife.

Marjorie then described how her own experience of childbirth and how she was treated by the midwives caring for her led her to realise that directing pushing was effective:

*'I think afterwards the way I was treated when I was in labour certainly made me look at how I did things when I was a midwife.'*

Marjorie, community midwife.

In fact, Marjorie was one of only two midwife participants who mentioned their own personal experience of giving birth at any point during the interviews, although most of the midwife participants were mothers themselves.

The only other midwife to mention her own experience of birth was Fiona, who described how she felt when she was in labour herself and her midwife suggested she follow her own instinctive urge to push:

*'I can remember being in labour and the midwife, a lovely midwife and me saying, "What do I do?" And she said, "Do what you want to do." But I thought, that's not... just tell me what to do. But that's not just, "Tell me to push". And I can remember thinking even though I was in labour, I was thinking, "So that's what it feels like when somebody tells you to do whatever you want."'*

Fiona, community midwife.

Fiona had been qualified for nine years and also felt that as her experience increased she had become less directive in her support of labouring women. On first qualifying she described herself as being a directive midwife who regularly used the Valsalva technique. In recent years she had worked as a community midwife and had seen the benefits of facilitating a more physiological approach to pushing. During the interview she described a memorable case which highlighted how different physiological pushing is to directed pushing. Her detailed description of how a woman pushed instinctively mirrors the findings of Thomson's (1995) study:

*'I just remember I didn't say anything to her and watching how she pushed. It was really clear, watching her push and it was these really short pushes and this baby was just coming. And I thought that is nothing like anything I've ever seen and being amazed at how the process worked and how she wasn't exhausted by it and the baby wasn't exhausted by it. and it was so easy because every few seconds she gave... it was almost like a primal deep grunt and this baby was appearing and I was like, "Oh!" And I'd been qualified a year or two then and I thought, "So that is how to do it then."'*

Fiona, community midwife.

It is interesting that in this description Fiona is amazed at how a birth progresses when left alone, the implication being that as a delivery suite midwife at the time she was not accustomed to seeing this often. Similarly, in her current practice as a community

midwife caring for low risk women often in their own homes she now appeared to be biased towards the more physiological approach:

*'Yes so my practice has changed a lot. I think I've been a midwife long enough so I don't find the whole thing terrifying. I think in the beginning you are a bit like, "I've got to do something otherwise it's all going to go wrong." Whereas actually you realise that these are generally low risk women. I just don't believe it works, you know... pushing somebody. It just doesn't make any difference, so why do it? You may as well let them have a better experience and just see what happens. Basically... I'm talking myself out of a job here.... [Laughs] You don't really need to be there.'*

Fiona, community midwife.

It appeared that it was midwives' experience of caring for women usually at home that made them realise that a physiological approach to pushing led to a better and more effective birth experience for women. Witnessing this was more influential on their practice than the knowledge of the evidence base around directed pushing, or an awareness of recommendations from the NICE Intrapartum Care guidelines (NICE 2015). A growth in confidence in the midwives' own ability to practice midwifery correlated with a growth in this approach.

## Conflict

There was an underlying sense of conflict running through some of the midwives' and women's interviews, although this was not apparent in the obstetricians' interviews. The conflict took the form of differences in opinion between groups of midwives, midwives and obstetricians, midwives and women, and obstetricians and women.

Harriet, for example noticed tension between her midwife and the obstetrician. She found this quite unsettling:

*'I know there was definitely this sort of conflict. The doctor, she was quite a young doctor, and the midwife was a little bit older, and I just felt like she [the midwife] was really talking down to her. And even afterwards when the midwife came back and reviewed my care, she was saying, "Oh, she's cut the umbilical cord way too long", and things like that. And I just thought, "It's just a bit disrespectful", you*

*know.'*

Harriet, primigravida, transferred from the birth centre to delivery suite.

Elizabeth had a difference of opinion with the midwives and obstetricians, when she asked to wait and see if labour would start naturally after her waters had broken rather than being induced:

*'And they were all sort of standing there at one point saying, "So, you are going to have the syntocinon", and sort of looking at me and waiting for me to answer. And I thought, "Well, you have already made the decision for me."*

Elizabeth, primigravida, laboured on delivery suite.

Lorraine sensed tension between the midwives and obstetricians whilst she was undergoing an instrumental delivery. During the interview she frequently became tearful and emotional as she recalled what for her, had been a traumatic experience:

*'I am very angry with, not with the hospital, I am angry with... the problem in that room was the communication between the doctors and the midwife is a disaster. You can feel that everywhere, in ward, in the hospital or I don't know if it's the whole NHS thing. But my experience was like, "I am a doctor, I am the best" and the midwife says, "I am the midwife, I know what I'm talking about, and I am the best."*

Lorraine, primigravida, laboured on delivery suite.

The conflict in this case appeared to be that the obstetrician wanted to proceed to a caesarean section while the midwives were asking for a Ventouse to be considered. However, it appeared to be so chaotic in the room that Lorraine did not understand what was going on or what decisions were being made on behalf of her and her baby.

Lucy experienced conflict between herself, the obstetrician and the midwife:

*'The consultant had a word with me and told me to take it all, said, "Now you've got to take this seriously," which kind of implied that I hadn't already been. We'd asked on our birth plan for there to be delayed cord clamping, and the midwife initially laughed, and then I explained that we were serious.'*

Lucy, primigravida, normal delivery on delivery suite.

There was a sense that women's carefully prepared birth plans providing strategies that they wanted to employ to try and keep birth as normal as possible were dismissed by some of the midwives as being unrealistic. This was confirmed by Jenny, a community midwife:

*'Yes... [hypnobirthing] I know a lot of them practice it but you know it all tends to go to pot at the end, it really does.'*

*Jenny, community midwife.*

Lucy also described conflict arising within groups of pregnant women themselves. She had initially planned for a homebirth:

*'I think that, I think throughout pregnancy and labour, where I felt the most criticism, was from other women, and typically women who'd had babies. They seem to do it a lot to each other.'*

*Lucy, primigravida, laboured on delivery suite.*

This was reiterated to an extent by Rosie who described her own feelings after watching a television programme showing women making individualised choices about birth:

*'The one who gave birth on her own, I thought was crazy. And there was the other women who gave birth at home, even though she was high risk and I thought that was crazy because it just seems crazy to take that risk with a child.'*

*Rosie, multigravida.*

In terms of tension within groups of midwives, these have been highlighted previously. For example, Marjorie mentioned having to 'fight the midwife', Gloria described being disturbed by colleagues who wanted to find out if her client 'had delivered yet', while Mandy found it disturbing to hear some midwives shouting aggressively at women to push and keep quite during labour. The data suggested that the Maternity Unit, particularly the delivery suite was a stressful area where conflict between the medical and woman-centred approach to birth frequently came to a head. For the women this had had a negative impact on their overall birth experience and for the midwives there

was a feeling that it had influenced the way they practiced during the second stage of labour.

## Summary

The findings chapters have highlighted several recurring themes relating to how midwives care for women during the second stage and women's experience of their care. When conceptualised within the framework for the study focusing on power relationships and how they operate in midwifery practice, care is seen to be constructed upon the biomedical model that conflicts with the woman-centred approach favoured by the midwifery model. Midwives and obstetricians used the strategies described by Foucault (1979, 1980) and Lukes (2005) to retain their power over women accessing maternity services (see Chapter 5). This study demonstrates that midwifery practice in relation to maternal pushing during the second stage of labour was rarely woman-led.

Despite the evidence base recommending that pushing efforts in the second stage should be woman-led, for this group of midwives the practice of directed pushing continues and is an accepted and routine part of intrapartum care. Midwives stated that they favoured a woman-led approach but still directed aspects of the second stage either directing pushing or telling women to stop pushing. They even gave the opinion that some women were better at pushing than others who needed more guidance. Pressure of time was noted to be a key factor in this as was a 'matter of fact, let's get the job done well' approach to childbirth reflected in quotations from women and midwives. Midwives expressed a need to 'do something' and sitting back to observe a labouring woman was not presented as a feasible option by any.

Midwives were concerned about breaching hospital guidelines in terms of length of time 'allowed' for pushing and there was a need to get women delivered to free up beds for others. Conflict was noted between how midwives wanted to practice and what they felt they were required to do to conform to the requirements of the hospital-based service they were providing.

Context was also important and the degree of direction was related to the birth setting with pushing guidance becoming more pronounced as the birthplace moved from home ('we are guests in the woman's house') to the birth centre ('the women are guests in our house') to the delivery suite ('obstetricians are in charge, we all do as we are told').

Findings suggest that women and midwives perceive the midwife as being the birth expert with women expecting to be told how and when to push.

The obstetricians seemed to demonstrate a more woman-centred approach than some of the midwives. The feeling being that when labour was normal then time constraints for second stage were not helpful, but a labour that deviated from the norm would require intervention in order to keep the woman and baby safe. These themes will be explored in the next chapter and linked to the literature in order to explain why midwives persist in the practice of directed pushing. Findings will be framed within critical social theory to explore the extent to which midwives' practices during the second stage are influenced by the organisation of maternity services in the UK.

## 10. Discussion.

### Introduction

*'I think sometimes you get the feeling that time is of the essence and if the delivery suite is busy there is pressure for them to get on and get delivered , I think that's a huge thing and sometimes you do notice that there might be a little knock on the door you know , "just checking, has she delivered?" '*

Gloria, community midwife.

This study set out to discover what practices midwives working in a Maternity Unit in the UK were undertaking to support women during the second stage of labour, with a specific focus on directed pushing. The study was informed by CST and undertaken against a backdrop of research highlighting weak evidence for the widely accepted orthodoxy in midwifery practice that directing a woman to push is beneficial in terms of a shorter duration of labour and improved mortality and morbidity for the woman and baby (Yildirim & Beji, 2008; Co Lam & McDonald, 2010; Jahdi et al., 2011). Conversely there is evidence suggesting that prolonged use of the Valsalva manoeuvre can have an adverse effect on a woman's urinary system (Shaffer et al., 2005).

With a lack of robust evidence to support the intervention, the physiological approach of leaving women undisturbed to push spontaneously should take precedence (NICE, 2014; Lemos et al., 2015). Anecdotally however the practice of midwives directing women's pushing efforts persists (Hamilton, 2016, Cook, 2010). Whilst much has been written about the management of risk and power relations in maternity care from a feminist stance and the impact of medicalisation on modern childbirth practices, (Kirkham, 1999, Oakley, 1984; Kitzinger, 2005) there has been little qualitative research focusing specifically on directed pushing during the second stage. This study aimed to address this gap by exploring reasons why midwives continue to direct pushing, utilizing a CST approach and incorporating the views of a small group of midwives, obstetricians and women with recent experience of childbirth.

Indeed, as demonstrated in Chapters 8 and 9, for these participants a directed approach to pushing during the second stage of labour remains the expected norm and

appears to be a deeply embedded orthodoxy within the cultural context of what it means to be a midwife: 'doing' rather than 'being' (Leap, 2000).

I would argue that these findings suggest that persistent use of the Valsalva technique represents midwives' attempts to control the natural process of birth by oppressing women's innate pushing urges and providing specific guidance on how to push during the second stage. This reveals a conflict for midwives in that they while they continue to work within the biomedical model they are essentially, undermining a central feature of midwifery that is to promote woman-centred care including 'the liberation of the autonomous subject' (Hyde & Roche-Reid, 2004, p. 2613). From a CST perspective this highlights that in the context of second stage pushing, there are two oppressed groups: the midwives oppressed by the dominant obstetric model of care and labouring women who are seen to be oppressed by their midwives as their instinctive behaviour is suppressed in favour of a directed approach.

Evidence presented in Chapter 3 demonstrated that undisturbed physiological birth has the potential to influence the long-term health and well-being of individuals (Almgren et al, 2014; Godfrey et al, 2011) and can be life-changing for women (Humenick, 2006). Conversely, routine intervention into birth without good cause can result in iatrogenic harm to women and babies (Requejo et al. 2012) as well as adding considerable economic cost to maternity care (McIntyre et al. 2011). The second part of my argument relates to the fact that in continuing to intervene into the second stage in this manner, midwives may inadvertently be disrupting the natural physiological pattern of birth.

This chapter focuses on exploring key themes emerging from the data to gain understanding into why midwives working in this UK Maternity Unit persisted in directed pushing despite the evidence base. Women's perceptions of the midwives' role during the second stage and how media representations of birth reinforce the orthodoxy of directed pushing are also discussed.

Implications for midwifery practice are framed around how midwives can be empowered to provide woman-centred intrapartum care despite working within the constraints of the current UK maternity care system where the organisational needs of the maternity unit are prioritised above the embodied needs of women.

Birth Territory theory (Fahy & Parratt, 2006; Fahy et al., 2008) is recommended as a framework on which midwives could construct their practice in order to empower women into making choices rooted in their unique embodied needs rather than the authoritarian knowledge of health care professionals. Although it is not grounded in CST per se, Birth Territory theory highlights the concept of midwives and women combining power to facilitate the type of birth environment that will optimize the conditions needed for physiological birth. It is argued that awareness of Birth Territory theory could lead to the raising of the critical consciousness of women and midwives by highlighting the importance of the embodied knowledge of women and how this has been superseded by authoritarian knowledge through the medicalisation of birth. The practice of directed pushing is seen as symbolic of this although midwives seem unaware of its significance in this context and do not view it as intervention.

The chapter ends with a consideration of potential limitations of the study.

### The influence of time and ‘watching the clock’ on second stage practices

*I didn't really need to push, but I think at that point when there was so much going on in the room and so much stress, I was kind of relieved to think, "Right, well, let's get this done and go home."*

Lucy, primigravida, normal delivery, delivery suite.

Findings suggested that ‘time’ was a major factor influencing the decisions midwives made around their care of women during the second stage. Lack of time, trying to ‘buy time’ running out of time, wasting time were often mentioned as being the rationale underpinning the practice of directed pushing. There was a general sense, highlighted by the midwives and reflected in the women’s stories that the aim was to get the pushing phase over with as quickly as possible; directed pushing was felt to facilitate this. This was despite the fact that no evidence exists to support this view; some of the midwives were aware of this but instigated Valsalva pushing anyway.

Historical documents reveal that because childbirth is grounded in uncertainty, latter-day midwives were forever mindful that dangerous complications for the woman and baby could arise quickly even when labour appeared to be progressing well (Gelis, 1991.,

Cassidy, 2007., Epstein, 2011). This ever present fear led to them doing all they could to hasten birth; an overwhelming concern being that the woman would be too exhausted to deliver her baby and if she died, the midwife would be blamed and accused of not doing her job properly. Gelis (1991), in his anthropological study of the history of childbirth, described midwives' and women's' perceptions that a successful labour was a rapid one. Midwives in the Second Stage Study spoke in similar terms and their practice was geared towards ensuring a rapid birth which they perceived led to less complications and reduced the need to call for medical assistance.

Another issue related to time was the concept of midwives 'being busy' and how this was understood in terms of midwifery practice. Being busy in their work did not emerge as a central theme in the midwives' interviews but it was mentioned by some of the women in relation to the unit being 'extremely busy'. This seemed to impact on the care they received. For example, Emily was not transferred up to the delivery suite from the birth centre for an epidural because delivery suite was 'too busy'.

This finding reflects the work of Nagington et al. (2013) who in their study of district nurses demonstrated that the desire of the nurses to maximise their efficiency by undertaking specialist tasks that only they could do, such as dressing leg ulcers precluded them from undertaking other tasks which, although highly valued by their patients, were not considered viable in terms of efficient working practices. Examples included forming professional friendships with patients and undertaking tasks like massage and aromatherapy. In this sense 'efficiency' with a need to prioritise innovative ways of producing more for less was seen as the most desirable requirement for working within a capitalist model ( Harvey & Braun, 1996; Cross, 1993). This supports the work of Brooks and Scott, (2006) who argued that in the context of working within a time pressured environment such as the hospital, the construction of work priorities is influenced by the local culture inherent within that environment. In other words work tasks are prioritised in terms of what should be done as defined by the values of the manager and other colleagues rather than by the patient.

In the context of the second stage of labour, it could be argued that a midwife leaving a woman to push undisturbed or leaving a woman whose contractions have subsided, to rest could be perceived as an inefficient, 'slow' way of working; a waste of time and

therefore not a viable proposition in an environment where efficient working is prioritised. Certainly the prevailing culture on the delivery suite was one of 'getting on with the job' and working in a task-orientated fashion and there were examples in the data reflecting this.

Time is usually considered to have a linear progression in terms of the past, the present and the future. However, this does not translate readily to the uncertainty of childbirth. In social science, temporality, is studied in relation to individual perceptions and the social organisation of time. For most people, time is a taken-for-granted concept which remains hidden within individual consciousness to the extent that it is rarely discussed as a separate entity (Adam, 1990). Despite this, there are numerous references to time in everyday living, with terms such as *opening times*, *waste of time*, *overtime*, *time is running out* being commonplace phrases. The Second Stage Study was no exception in this regard.

Indeed giving birth in this study and elsewhere, is seen as an experience frequently defined in relation to time (Maher, 2008; Simonds, 2002). For example, labouring women are asked repeatedly about the duration of their contractions, the time interval between contractions and the time that various labour-defining events occurred (for example time the urge to push was initially felt and time spent pushing). The Valsalva technique includes an element of measuring time in that women are instructed to take a deep breath, hold it and then push at least three times for the duration of each contraction. Additionally, as discussed in Chapter 4, the biomedical model of maternity care requires limits to be placed on the length of time that the stages of labour are 'allowed' to be (NICE, 2014).

Simonds (2002) is critical of the obstetric model arguing that it imposes artificial timescales that ignore the physiological fluidity of labour. Walsh (2003) recommended that labour is viewed more constructively as a rhythm that ebbs and flows according to a range of complex factors arising within the woman and incorporating intricate interplay between hormones, anxiety and stress. This recognises that labour takes as 'long as it takes' and may not always proceed along a pre-defined trajectory. Gaskin (2003) coined the Spanish term '*pasmo*' to explain the phenomenon (also reflected in women's accounts in the Second Stage Study) when labour stops for a while. Gaskin (2003)

suggested that this should lead to the midwife leaving the woman to rest, returning only when contractions resume. Flint (1986) termed this the 'rest and be thankful phase'. In both cases it is seen as a normal part of labour. This implies that there is no need to rush the woman 'upstairs' for Syntocinon™ augmentation, put her legs in stirrups or shout at her to push as seen in the Second Stage Study. Instead this is time for the woman to rest, sleep and conserve her energy in readiness for the onset of intense physical activity, which epitomises the final act of birth.

As discussed in Chapter 4, the biomedical model of birth defines the body as a machine susceptible to error and breakdown (Oakley, 1984; Martin, 1992; Davis- Floyd, 2008). It imposes strict time limits on the duration of birth to try to make it more manageable (Downe & Dykes, 2009; McCourt, 2009; Simonds, 2002)). Helman (1992) describes linear time as '*monochromic*' when the timeline is divided further into sections of seconds, minutes and hours and life becomes dominated by set rules to ensure that time is not wasted. Again there are echoes of the Valsalva technique in this concept when midwives tell women to push for the duration of a contraction and not to waste their time or energy by pushing in between (even if a woman's innate feelings may be prompting her to push in a different way). Women in the Second Stage Study were told not to waste energy by pushing into their throats and making a noise.

Chourcri (2012) suggests that the *monochromic* view of time is used as a way of midwives retaining order over chaos. She uses the metaphor of a conveyor belt moving horizontally through the past, present and future. Failure to fill the boxes moving on the conveyor belt with appropriate activities leads to time being wasted and anxiety felt on the part of the worker/midwife.

It is argued that the development of time limits for the stages of labour has led to increased intervention as the medical evaluation of risk in birth is closely linked to time limits (Reibel, 2004; Maher, 2008). This concern about obstetric intervention into labour was confirmed by midwives some of whom admitted to manipulating vaginal examinations in order to 'buy more time' and delay intervention by suggesting that women were in more advanced labour than they actually were.

Research is starting to emerge challenging the benefit of setting guidelines on labour time limits. For example, a recent albeit underpowered RCT from the US (Gimovsky & Berghella, 2016), found that extending the time limit of the second stage by an hour decreased the incidence of CS by a half in nulliparous women with no corresponding maternal or neonatal morbidity compared to those following the normal care guidelines (2 hours in second stage for women without epidural anaesthesia). The authors concede that larger trials are needed to further address the safety of extending the time limit for the second stage but these preliminary findings further support the benefit of promoting a non-interventionist approach to childbirth.

Dunmire, (2000) describes a second type of time orientation as 'cyclical time' when events and activities are defined by the amount of time taken to complete them. This idea in the context of birth is reflected in the words of a midwife in Crabtree's (2008) study who stated that labour 'will take as long as it takes'.

Cyclical time is alternatively called '*natural time*' (Fox, 1989) or '*process time*' (Walsh, 2009) and is time defined by the woman's body where labour rhythms progress at their own pace and cannot be measured or predicted. It is argued that the evaluation of risk where the clock guides the expectation of progress during labour is '*medical time*' (Maher, 2009) This works in direct opposition to a woman's embodied experience where the physiological changes in her body act as a guide to the progress of labour (Simonds, 2002; Walsh, 2009). Downe and Dykes (2009) argue that the time-dependant perspective of birth works effectively for midwives, operating within the surveillance orientated culture characteristic of modern maternity care. It is easier to transmit information to other professionals if it arises from a standardised set of data such as centimetres of cervical dilatation or number of minutes spent pushing than if it is grounded in embodied sensations uniquely expressed by individual labouring women.

Anthropological studies of cultures away from the Western world demonstrate how birth progresses when not situated within a medically dominated framework. For example, Becker (2009) studied aborigines in Northern Canada and found that temporality in their culture was not linked to the clock but to an innate sense of when the time was right. Rather than clock watching, traditional midwifery relied on family support, intuition and a relaxed, unhurried approach to birth.

In Chapter 3, I referred to Csikszentmihalyi's (1975) theory that individuals can lose all sense of time and presence when they are involved in a particular activity where their skill and ability are in perfect alignment. This is described as being in a state of *'flow'* and it is suggested that women labouring spontaneously need to achieve this state in order to relinquish control of the neonatal cortex (Walsh, 2010; Downe & Dykes, 2009; Odent, 2015). T. Anderson (2000) suggests that losing track of time may be a coping strategy for women as they attempt to manage the intense physical sensations associated with birth. The state of flow contrasts with the perception of time suggested by Flaherty (1991) who argued that time tends to be perceived as going slowly in situations that are emotionally charged with an associated sense of urgency (he described this as *'empty time'*). Downe and Dykes (2009) applied this to childbirth by suggesting that during labour, women may be achieving a state of flow but onlookers including midwives, may be experiencing Flaherty's *'empty time'* and feel compelled to do something. This may be particularly evident in an environment such as delivery suite where time is viewed as a valuable commodity that must not be wasted. The sense of *'doing something'* such as directing a woman's pushing efforts, may be perceived as being intrusive by the labouring woman engrossed in her own embodied sense of timelessness. In the Second Stage Study, this was reflected by Harriet who described how undermining she found the constant interruption of her midwife reminding her to stay focused on time.

It is acknowledged, that some women may want as much of the uncertainty of labour removed as possible. (Downe & Dykes, 2009). Some women may welcome induction of labour, Syntocinon™ augmentation and an epidural in order to achieve a controlled birth experience. Some women may experience *'empty time'* and interventions to *'speed things up'* including Valsalva pushing will be accepted and sometimes demanded (Davis-Floyd, 2006). None of the women participants in the Second Stage Study fitted into this category however as they had all planned for non- interventionist, physiological births.

A limitation of the study is that the women participants were a homogenous sample most of them Caucasian, well educated professionals who had attended NCT classes. They had all professed a desire to achieve a physiological birth experience. It is of note then that most of them did not achieve this goal. A more diverse sample might have included less well – informed participants or those framing their vision of birth within a technocratic -

industrial model and this would be an interesting area of research for future consideration.

For the midwives, data analysis revealed that they were governed by linear time. They worked within the obstetric model of birth and the notion that if labour does not progress consistently forwards in time then it is problematic with interruptions in the ebb and flow of labour being considered pathological (Simonds, 2002). Labouring women were seen as deviant if they failed to keep time with the arbitrary clock originally introduced by Friedman's curve in the 1950's (Rothman, 1991) (See Chapter 3).

The influence of time and use of Friedman's curve seemed to be less pronounced the further from the hospital labouring women were situated. In the home, there was a sense of release from the constraints of time with the implication that here, women took the lead. This seemed to be used as an excuse for midwives not to intervene into birth. The community midwives spoke of having to do what the women wanted because as guests they could be asked to leave the home at any time. Despite this, the transfer rate from home to hospital, particularly for primigravida women was perceived to be high; the main reason being delay during the second stage. This correlates with findings from the Birthplace Study (Brocklehurst, et al., 2011) that found that the peripartum transfer rate for nulliparous women who had planned to have a homebirth was 45%. This suggests that women are being guided by midwives presumably advising them that transfer to hospital is necessary. It needs to be acknowledged however that as I did not interview any women who had planned for a homebirth and were then transferred into hospital during the second stage, these ideas are speculative and did not emerge from the data. The potential impact of risk perception on midwifery practice will be revisited later in this chapter.

Even in the home, linear ('labour must be completed within x amount of time') rather than natural time ('labour takes as long as it takes') had the upper hand with midwives working in accordance with Trust guidelines. These state that intervention of some kind (directed pushing or referral to an obstetrician) is needed once a woman has been pushing in second stage for a defined amount of time. This was seen to put pressure on midwives to conform or risk taking the blame if things went wrong.

Findings here support those of Chourcri (2012) following a literature review that explored the impact of time on midwives' working lives. The literature showed that midwives caring for women within the current hospital-based culture face conflict in how they are required to manage their time (Simonds, 2002, Hunter, 2004; Dykes, 2009). Linear time, which, as the Second Stage Study and others (Dykes, 2009; Downe & Dykes, 2009) have demonstrated dominates the hospital culture, requires women to be processed speedily and efficiently through the system 'conveyor belt' style. Linear time is seen as a way of controlling and dominating others (Chourcri, 2012). This is at odds with a feminist vision of ideal woman's time characterised by the processes of birth, life and the cycles of reproduction. Hochschild (1997) argues that this puts midwives in a 'time bind' in that they are expected to organise their work into tasks which run like 'clockwork' at the same time providing woman-centred, compassionate care requiring emotion work that is uncertain, unpredictable and does not fit any predetermined timeline. The time midwives might use to develop emotional connections with women is used up on monitoring activities and interventions associated with a medically defined model of institutionalized midwifery (such as directed pushing). This is certainly borne out in findings from the Second Stage Study where midwives and women were seen to take a matter of fact, work-based approach to labour, with a sense that the most important thing was getting the job of birth done efficiently and speedily.

This discussion around time and its impact on midwifery practice suggests that midwives continue to implement Valsalva pushing as a result of working within a biomedical and managerial framework where linear time dominates to ensure efficient functioning of the institution. Despite the fact that there is no evidence showing that directing pushing will expedite delivery, midwives continue to do so as they view labour from an 'empty time' perspective (Flaherty, 1991) with a need to 'do' rather than wait. When viewing labour through the lenses of linear time, waiting without action could be perceived as a waste of time. The midwives in this study, did not conform to the philosophy of 'natural time' where labour takes as 'long as it takes'. On the contrary, they were seen to become anxious to do something after women had pushed in second stage for less than an hour.

This 'keeping busy' approach is also described by the psychoanalyst Menzies Lyth (1959) whose classic study depicted hospital systems acting as defences for nurses against the anxiety evoked by caring for people in traumatic situations. From a critical psychoanalytical perspective, Menzies Lyth (1959) argued that hospital-based nurses are confronted with the reality of life and death on a daily basis and this arouses strong emotions of pity, compassion, guilt and anxiety that must be contained if they are to work effectively within the institution. If this theory is applied to midwives caring for labouring women, then one could argue that midwives directing women to push is a strategy used to protect themselves from feelings evoked by watching another woman going through the emotionally intense experience of giving birth. Menzies Lyth's central argument was that all individuals are engaged in a lifelong struggle against primitive anxiety and that this is particularly relevant to health care professionals working in a hospital (Menzies Lyth, 1988).

From this perspective, 'empty time' could be perceived as more time for midwives to feel distressed and anxious. It could also be argued that 'keeping busy', 'working like clockwork' and adhering to strict timelines act as defence mechanisms protecting midwives from evoking memories of their own birth experience or anxiety about what is to come for them if they are yet to have experience birth. Interestingly, only two midwives out of ten made any mention of their own personal experience of birth suggesting that maybe it is not something they chose to dwell on when providing intrapartum care to other women.

#### **'Midwives take charge': how midwives shape the birth experience.**

Another theme that emerged from the woman's data, was the perception that their birth experience was constructed and defined primarily by the midwife. There was an unspoken sense that midwives held the expertise around birth while women's embodied understanding was negated (Bluff & Holloway, 1994). Women listened to their midwives and pushed as they were told even though in some cases this was at odds with how they wanted to push. As discussed in Chapter 4, the way that birth is constructed in the developed world promotes the idea that women are passive recipients of care and are told what to do and how to do it by expert professionals. Given this, it is unsurprising

that the women appeared satisfied with this dynamic; it was what they expected and, in most cases, they did not challenge it. This finding reflects the theory behind Lukes third dimension of power (Lukes, 2005) that the dominant group exerts power by subtly coercing subordinate groups into accepting interventions which may not always be in their best interests (Levy, 1999a, 1999b). For example, Caron readily accepted her midwife's assertion that she was tired, dehydrated and needed to transfer to delivery suite for augmentation despite the fact that she did not feel tired, or thirsty and her baby was showing no sign of distress. If she had been left to rest on the birth centre it is likely that labour would have resumed without intervention. Caron however, was delighted with her experience and as both she and her baby were healthy, she took this as proof that her midwife had done the right thing in transferring her.

Caron placed great trust in her midwife and it is suggested that the modern day image of a midwife is one inspiring trust. (Levy, 2004). In this study, most of the women reported watching 'One Born Every Minute' ( Channel 4, 2017) a TV show in the UK that also depicts midwives in a supportive, encouraging but authoritarian light implying that this is the way to 'do' birth. Midwives are seen giving explicit instructions to women to push and women are seen as passive recipients trying their best to do as the midwife tells them. Images of birth from this programme reinforce the view that midwives are experts in normal birth, their role being to take charge of a woman's pushing efforts. In most cases, watching this programme was the closest women had got to seeing birth before experiencing it themselves (Clement, 1997). The influence of media representations of birth on women's expectations of birth will be revisited later.

If midwives truly framed their practice within a physiological model of birth they would be mindful that in order to encourage optimal physiological function, a labouring woman should be left undisturbed, preferably in a warm, dark environment (Odent 2008). The Valsalva technique is an intervention that has the potential to interrupt the finely tuned rhythms of labour by stimulating the release of adrenaline and also undermine the woman's confidence in her body's innate ability to give birth. (Odent, 2008, 2009, 2015; Fahy, 2008; Walsh, 2000, 2012). In this context, the data confirms that midwives working in this UK Maternity Unit were practising within a biomedical framework as all of them, regardless of their place of work described giving instructions

around pushing at some point. None of them suggested that sitting unobtrusively with a woman in labour was acceptable practice during the second stage. Although there was an attempt to frame care within a woman-orientated model there was still an implicit need to 'do' rather than simply 'be' with a woman.

Gloria summarised this succinctly; '*midwives direct pushing because they want to be seen to be doing 'something' rather than because it makes a difference to women*'.

The practices described by the midwives, aligns closely with the '*birth as a lurking risk*' view expressed by obstetric nurse participants in Regan and Liaschenko's (2007) study. Three views of birth were described. Firstly, nurses who cognitively framed birth as a natural process and used empirical, intuitive and empathetic knowledge to underpin their care. They viewed birth as a normal physiological process that women are capable of achieving carrying no risk for woman or baby. Nurses worked collaboratively with women to optimise normal bodily function and women were recognised as credible knowers who were actively encouraged to choose options of care that supported their birth plans. Those participants who viewed birth as a '*lurking risk*' supported the physiological capacity of the body to an extent but demonstrated limited belief in the woman's ability to rationally understand birth. They were seen to rely on empathetic and empirical knowledge that structured practice aimed at balancing what the woman wanted against the wellbeing of the fetus and organizational policy. These nurses directed women to follow their recommendations with nurses being expert knowers rather than the expert guides represented by the '*birth as natural process*' group. The midwives in the Second Stage Study were representative of the '*birth as lurking risk*' group in that they directed pushing and believed that women needed this guidance. Regan and Liaschenko's (1997) third group framed birth as '*risky business*' their view being that nature is inherently flawed with risk being an inevitable aspect of birth. In the Second Stage Study, this cognitive frame is representative of Lucy's midwife with her suggestion that Lucy should prepare herself for medical intervention from the outset.

It is acknowledged that Regan and Liaschenko's (2007) study is based in the US and involves obstetric nurses rather than midwives so not directly generalizable to UK midwives. However, the cognitive frames of childbirth expressed by the nurse

participants are similar to those demonstrated by the midwives in the Second Stage Study. Of significance is that the authors hypothesize that nurse' beliefs about birth and risk may drive their practices along trajectories that could be associated with CS and other interventions. Whilst this does not prove that nurses or midwives drive CS rates it does generate hypotheses suggesting that there may be a relationship between nurse/midwives cognitive frames of childbirth and the actions which follow.

As demonstrated in Chapter 9, women reported that their birth experience had been positive if they had developed a rapport with their allocated midwife characterised by mutual understanding of a kind described by Emily, Caron and Lorraine. It was a different story for Lucy and Harriet who sensed a discord between their philosophy and that of their midwife. Other studies have demonstrated the significance that a midwife can make to a women's experience of birth. (Waldenstrom, et al, 1996; MacKinnon et al., 2003; Larkin, et al., 2009). Lucy's perception of her midwife was that she had 'broke' her. The vulnerability of labouring women was highlighted by the significance they attached to midwife shift changes when they might lose a valued supportive midwife and gain one that they had less confidence in and vice versa. (Axten, 2003; Blix-Lindstrom & Christensson, 2008).

Women's general compliance and unchallenging attitude towards their midwives has been recognized in previous studies. (Edwards, 2008; Sakala, 2006) There are various explanations for this; one being that with very little else to inform them, women tend to assume that what is suggested to them must be in their best interests (Edwards, 2008; Jomeen, 2007; Sakala, 2006; van Teijlingen, et al., 2003). The seminal study by Machin and Scamell (1997) showed how vulnerable labouring women become when they enter the alien hospital environment experiencing intense physical sensations. In this setting, women were seen to become incapable of making their own choices but were reassured by the 'safe' boundaries of care offered by the dominant biomedical model and enacted by the midwives. This will be considered further within the context of Van Gennep's (1960) theory of 'rites of passage'.

Fahy (2002) argued that health care professions foster compliance amongst women by encouraging them to think that being compliant will lead to the reward of a healthy baby

whilst safety may be compromised if they choose not to accept advice. This was reflected in the Second Stage Study, when women confirmed that they had taken medical advice and changed their original plans for physiological birth in the interests of a safe outcome for their baby:

Rather than exercising true informed choice during birth, it is argued that women are being steered towards 'informed compliance' (Kirkham, 2004). Although, Kirkham (2004) bases her arguments on projects carried out several years ago, the results still resonate today as these findings suggest. These women were articulate and well educated and had all attended classes to prepare for birth. However, during the second stage they all complied with the plan of care suggested by their midwife usually involving directed pushing.

Findings support those from other studies demonstrating the significance that women attach to the midwife caring for them during labour (MacKinnon, et al., 2003, Larkin et al., 2009). From this it can be postulated that if midwives amended their own terms of reference and adopted a woman-led approach to pushing, then it is likely that women would feel better equipped to trust their innate feelings because in their eyes, 'midwives know best'.

### [The influence of context and culture on pushing practices: 'different worlds'.](#)

The cultural differences between the environments on the birth centre and delivery suite were mentioned by all participant groups. The birth centre was described as being midwife-led, promoting 'normality' for low-risk women in a 'home from home' setting whilst delivery suite supported an obstetrician-led, interventionist model of care for women classified as high risk. There was no sense however that either of these areas were 'women-led' which if a physiological model of birth was truly being followed would be expected.

Midwives confirmed that they were aware of different groups of their colleagues who practiced within competing ideologies with some adopting a more woman-led, less directive philosophy of care than others. Whilst context did play a part in relation to directed pushing, most midwives acknowledged that they would be directive on occasion

regardless of where they were working or whether the woman was classified as high or low risk. It was not as clear cut as midwives working in one area being more inclined to be directive than others. Midwives working in the birth centre reported directing pushing despite the fact that the philosophy of birth centres is supposedly to provide a woman led setting devoid of medical intervention (Shallow, 2003). Interestingly at the time of the study, there was a sign on the birth centre door imploring visitors to be patient if they were kept waiting to be admitted as 'midwives might be busy delivering babies' and unable to come to the door. This simple sign conveys a sense of *'hustle and bustle'* with midwives actively doing things, delivering babies rather than facilitating a truly woman centred environment where women are left undisturbed to birth their own babies.

These findings reflect those of Styles et al., (2011) who demonstrated that there was a wide range of referral decisions made by midwives when given identical case vignette information. This variation was not linked to differences in experience, place of work, personality or individual propensity for risk. This led Styles et al. (2011) to suggest that midwives' decision making is more likely to be influenced by previous experience than it is to a perception that certain birth settings are 'riskier' than others. This finding could explain the differences between the midwives in the Second Stage Study although I did not question them specifically as to whether previous experience influenced their approach towards directed pushing. However, the three community midwives told me that their practice had changed over the years to become less directive which they put down to their experience of seeing how much this had improved the birth experience for women.

Community midwives, like Marjorie and Jenny although overtly stating that they favoured a physiological approach to pushing still had a tendency to intervene in the process by recommending specific ways that women should push or not push and implying that a nulliparous woman would be unable to push effectively without specific instructions.

The findings further demonstrate that these midwives, tended to frame their practice within a biomedical, interventionist model. This is supported by other research showing that midwives working in maternity units are institutionalized within the dominant

culture of risk aversion and intervention (Scamell & Alaszeki, 2012; Healey et al, 2015; Scamell, 2011).

Hunter and Segrott (2014) highlighted that the culturally constructed categories of 'normal birth' (the midwife's domain) and 'abnormality' (the obstetrician's domain) are ambiguous and fluid 'with fuzzy demarcation lines and a large grey area at their interface' (p.722). It is argued that both professions engage in boundary work drawing on specific discourses to legitimize their skills and authority and so demonstrate their own distinctive characteristics (Sanders & Harrison, 2008). Whilst the dominant midwifery discourse may emphasise a woman- centred holistic approach contrasting with the biomedical model anticipating danger and over- emphasizing risk, this simplistic dichotomy does not take account of the continuum of practice along which individual midwives and obstetricians situate themselves (Mackenzie Bryers & Teijlingen, 2010). It is too simplistic to suggest that delivery suite midwives' practice in a medically orientated way while birth centre and community midwives adopt a holistic, woman centred approach or that obstetricians demand that all women receive medical interventions.

Jay (2015,unpublished thesis) puts forward another argument; that in the context of 21<sup>st</sup> Century maternity care, the concept of birth as fitting either a midwifery or biomedical model of care is no longer applicable. She suggests that a cultural shift is occurring amongst childbearing women in the Western world in which the ideals of what constituted a good childbirth experience are being reconstructed. Jay, (2015, unpublished thesis) argues that some women will embrace the idea of controlling childbirth by medically framed interventions such as directed pushing. They may want a controlled, pain free experience of birth and if this is their choice, that model of childbirth will result in an empowering experience for them (Leap & Anderson, 2008). It is argued that despite the discourse on promoting a more physiological model of birth women are actually becoming more willing to accept medical interventions by choice (Green & Baston, 2007). Certainly Elizabeth's lasting memory of her forceps assisted delivery under epidural was positive as she had felt fully involved in the decision making process, despite it not being the experience she had anticipated.

Jay (2015,) uses anthropological studies from non- western societies to show how women react when coming to a new understanding of childbirth norms. For example, Van Hollen (2003) in a study of impoverished Tamil women showed how they adapted to increasing medicalisation in their society. Women were seen to actively select aspects of medicalisation such as induction and augmentation of labour as these interventions coincided with their cultural ideas of safety and a need to shorten labour. Van Hollen (2003) argued that in engaging in medicalisation the women were becoming active participants in change rather than passive recipients.

As Jay (2015, unpublished thesis) argues, there is a need for further exploration of how women in the UK conceptualize normal birth and the extent to which they are actively participating in the change. Women's voices need to be heard in debates about the promotion of normality rather than just those of experts. It is important that their preferences are taken into account when considering the development of future maternity care.

### [The influence of risk perception on pushing practices](#)

Findings showed that directed pushing was undertaken to reduce perceived risks and increase safety for women, the overall goal being the delivery of a healthy baby. As discussed, there was a sense, mainly expressed by the midwives but transmitted to the women that the ideal second stage should not last 'too long'. The Trust intrapartum care policy based on NICE guidelines (2014) provided constraints by providing time limits for the second stage that midwives were expected to conform to. This guidance quantified how long was 'too long'.

There are examples of midwives acting in a risk averse manner and undertaking a particular practice 'just in case' rather than because there was a genuine clinical need to do so. Women's stories provided illustrative examples of both obstetricians and midwives practising defensively. Elizabeth had tried to resist having a Syntocinon™ infusion to induce her contractions. She had researched issues around birth carefully was well aware of risk and prepared to take responsibility for what she perceived to be a small risk in waiting to see if labour started naturally. However, she was overwhelmed by the

response of the medical team including midwives and felt coerced into accepting intervention.

These findings combine with those of other studies to demonstrate a risk-averse culture of fear operating within maternity care. Despite the ideal that midwives are seen as guardians of normal birth, many midwives view birth as pathological with normality only attributed retrospectively (Scamell & Alaszeki, 2012; Healey et al, 2015). Scamell, (2011) showed that this assumption results in midwives undertaking detailed surveillance of low risk women in labour to rule out complications rather than to confirm normality. Trusting the physiological process of birth is seen as unrealistic in the litigious, fear based culture inherent in modern maternity units (Hood, et al., 2010). A Canadian study (Hall et al., 2012) reported that health care professionals defend the practice of making decisions in the best interest of the woman and baby as they feel personally responsible for the outcome. However as Munro (2015) argues , this external locus of control has the potential to be destructive leading to an abuse of power where professionals provide information to women in a way which magnifies risks in order to gain compliance :‘ if you don’t do as I say , your baby will die’.

Despite statistics showing that maternal and infant mortality rates remain low in the Western world (Mantelow et al, 2017) and direct maternal mortality rates are as low as 3.25 per 10,000 maternities (Knight et al., 2016), birth continues to be perceived as risky business by women, health care professionals and the wider society (Healy et al., 2016). It is acknowledged within these statistics however, that the infant mortality rate in England is higher than many other European countries (Mantelow et al. 2017) so in that sense this perception could be seen to be legitimate until it is realised that reasons around the increased infant mortality rate centre on issues such as neonatal prematurity, congenital malformations and treatment of neonatal infection rather than specific aspects of intrapartum care. (Tambe et al. 2015).

Overall statistics should be reassuring to women and midwives and yet the current interventionist practices inherent in modern maternity care do not reflect this. The CS rate continues to rise with rates of normal vaginal birth declining (Health and Social Care Information Centre, 2015). Practitioners make decisions erring on the side of caution and

rooted in a fear of litigation rather than on best evidence or the embodied feelings of women ( Crawford, 2004; Hood, et al, 2010). Dowie (1999) argues that risk management has restricted how critical incidents in health care are dealt with. Commentators have argued that the slow implementation of UK Policy advocating normality in maternity care and calling for a return to midwife led care ( DH, 2004; 2010) is a direct result of the rise of a risk management culture (Benoit et al.,2005; MacKenzie Bryers & van Teijlingen, 2010).

As previously highlighted, The Birth Place Study (2011) demonstrated that intervening into birth does not make it necessarily safer for low risk women. While it is acknowledged that there will always be complex cases that do require obstetric intervention consideration needs to be given to how midwives' perceptions of risk and the prevailing culture of risk within hospitals may influence practice (Healy, et al., 2016).

Of note here, the media reported extensively on the fact that the Birthplace study (2011) demonstrated nulliparous women had poorer perinatal outcomes if they had planned a home birth which, which while adding weight to the argument that nulliparous women are 'riskier', fails to highlight that the risks of intervention and subsequent morbidity were higher for all women if they had planned a hospital birth (Rogers et al., 2012). This supports the view that the media contributes to the intensification of risk in homebirth by reporting on it in an emotional manner (Edwards & Murphy-Lawless, 2006). Stories of damaged babies and traumatized mothers make the front pages of the popular press and add to a sense of fear and risk around birth as well as reinforcing the rhetoric of birth as a medical event (Symon, 2002; Coxon et al., 2012).

Women in the Second Stage Study watched 'One Born Every Minute' (Channel 4, 2017) and alluded to the dramatic perspective of birth which the programme adopts in the name of entertainment. In terms of second stage pushing, it is presumably more entertaining to watch a midwife enthusiastically coaching a woman to push while the fetal heart rate is heard dropping dramatically in the background than it is to watch hours of a physiological second stage when a woman labours in a darkened room with minimal intervention. The cultural implications of this on the manner in which birth is constructed in the Western world will be explored later.

Another element of risk relates to the suggestion that women may be afraid to take what could be perceived as unacceptable risks in case they are branded 'unfit mothers' (Cheyney, 2008; Scamell & Alasewski, 2015). Mackenzie Bryers and van Teijlingen (2010) argue that the social construction of birth as a medical event perpetuates a negative cycle of risk leading to a prevailing culture of intervention and surveillance. As Healey et al. (2016) highlight the expectation of a perfect birth outcome has skewed the perception of risk for women and society. Women expect to have a healthy baby and operating within a risk averse culture, midwives and obstetricians are placed under considerable pressure to get it right all the time.

In the context of risk, it is interesting to note that secondary analysis of data generated by the Birthplace study (Li et al., 2015) showed that the babies of women deemed higher risk of complications who planned to give birth at home were less likely to be admitted for neonatal care than were those who chose to give birth in an obstetric unit.

Additionally labour related mortality and morbidity were not significantly different for higher risk women who planned either a home or obstetric unit births. Numbers were small and it is acknowledged that larger studies are needed in order to rule out a clinically important difference between the two groups. This is required before developing an evidence base to inform guidelines around planned place of birth. However, findings like these challenge the widely held perception that it is always safer for high risk women to give birth in a delivery suite. And yet, high risk women who do opt for homebirth are branded as selfish and foolhardy (by other women and sometimes midwives) for daring to gamble with their babies' lives (T. Anderson, 2004; Murphy-Black, 1995). Rosie for example, described a woman with a high risk pregnancy 'crazy' for even contemplating a homebirth. It seems that because the dominant discourse of childbirth in the Western world occupies a biomedical perspective, women are particularly critical of other women who are striving for a more physiological experience as this represents a competing ideology to their own.

When applying perceptions of risk to the practice of directed pushing it can be seen that midwives in the Second Stage Study believed that the longer the second stage lasted the more likely that the woman and baby would be exposed to risk. If birth is only classified as normal in retrospect then it will always be potentially pathological and there will be a

temptation for midwives to ensure that time in second stage is limited (Murphy-Lawless, 1998). Paradoxically, directed pushing may actually place woman at increased risk of intervention that may have a negative impact on perinatal mortality and morbidity because it interferes with the finely tuned physiological processes underpinning birth (Odent, 2015). Harriet spoke of how her midwife's interventionist approach had contributed to her becoming increasingly stressed and 'heightened *her adrenaline*'.

My findings support the views of Healey et al. (2016) who argue that although the midwifery discourse focuses on safety, the reality is that the management of potential risks rather than safety of the woman and baby is given the greatest precedent. Caron's midwife who instigated an early transfer to delivery suite blindly followed rules designed for the needs of the hospital institution (i.e. to move the woman rapidly through the system) rather than the needs of the individual (Murphy-Black, 2008).

Rather than providing safer care for women, it is argued that the focus is on protecting the healthcare professionals who work in the system. The rise of a blame culture means that risk based care takes priority over holistic, individualized and compassionate care (Downe & Bryom, 2015). Midwives perceive that engaging in risk management will protect them from litigation even if it means the care provided for women is not optimal and that their psychosocial safety is compromised (Dahlen & Caplice, 2014).

Studies have shown how challenging it can be for midwives to incorporate a midwifery model of practice within the existing dominant biomedical one. (Blaaka & Schauer, 2008; Priddis et al. 2011). Newham et al. (2017) described a phenomenon they called the *Paradox of the Institution* to show how institutional surveillance introduced new risks in a cycle of intervention despite being implemented to improve safety.

### [Birth as a rite of passage: using ritual theory to explain risk perception](#)

The association of childbirth with fear is historic and while this may have been appropriate hundreds of years ago, with the advances in medical science and technology it is now safer than ever to give birth in the Western world. The reason that fear remains an integral part of maternity care may be analysed further from the perspective of ritual theory as identified by the anthropologist Van Gennep (1960) and based on his

pioneering studies of pre-industrial societies in the early 20<sup>th</sup> Century. He described the social and cultural practices associated with childbirth as '*rites of passage*' associated with the transfer of the woman from one state (being pregnant) to another (becoming a mother) while the fetus transfers from an unborn to an independent being.

During his work, Van Gennep (1960) observed that an individual's transition through various stages of life is often associated with danger. He argued that culturally specific ritualistic ceremonies have been developed to protect all those involved in the journey. In this context the dangerous biological process of birth is seen to be protected by culturally defined rituals and ritual theory is applicable to modern childbirth practices in the Western world (Lomas et al., 1978; Davis – Floyd, 1992; Machin & Scamell (1997). Lomas et al. (1978) argue that many maternity care practices are heavily ritualized although the wider society does not view them as such. Instead, people are so drawn in by the rational and scientific assumption behind such practices that they remain largely unchallenged. Davis-Floyd (1992) suggests that in a hospitalized system, rites of passage associated with birth are used more to protect staff from the unpredictable nature of birth than to protect the woman and baby. Using rituals, imposes a sense of order best serving the interests of the institution than individualized to each woman. An example of this was when Anita was instructed to stop pushing despite having an overwhelming urge to do so to give the midwife time to get her instruments ready. The use of the Valsalva technique with its' accompanying 'pushing mantra' could be described as an example of the use of ritual to maintain mastery over nature.

Machin and Scamell (1997) incorporated the ritual theory into explaining the powerful influence of the medical metaphor during labour. The women in their study on admission to hospital were separated from their familiar, everyday lives and entered into an area of transition. During the period of transition whilst overwhelmed by intense, physical sensations, they became vulnerable and bewildered but during this time of crisis they '*were reassured by the symbolic messages of the medical staff and their equipment*' p. 83 (Machin & Scamell, 1997). It is argued that in our Western culture, science has become the dominant metaphor for keeping things safe. A Foucauldian view reinforces this by arguing that domination is even more likely if it is in best interests of powerful groups who, because they hold the power, are also able to define what legitimate (Foucault,

1976) is. Machin and Scamell (1997) demonstrated that all the women in their study relied upon the medical model of birth because that was the cultural tool offered to them by the midwives. Similarly, Keating and Fleming (2009) found that women were identified as passive recipients of medicalised approaches to birth that permitted the dominant ethos to flourish unchallenged. This phenomenon was also present in the Second Stage Study and seen when women who had planned a physiological birth were readily persuaded to give this up in favour of epidurals and instrumental birth.

When viewed through a CST lenses, this symbolic power represents a strategy used by the dominant group to exercise control over oppressed groups in that both women and midwives are reassured by the messages sent out by the medical staff who are on hand to rescue them from disastrous consequences if birth goes wrong.

#### The influence of the media on women's expectations of the second stage.

Most women watched 'One Born Every Minute' (Channel 4, 2017) and although they had attended antenatal classes, this programme was reported to be a significant, if not the main, source of information about the experience of labour and birth. Glenda however avoided watching the programme as she was concerned that it would make her overly anxious. She had heard from others that it depicted birth as being dramatic, a concern reflected graphically in this quote from a journalist:

*I've never had a baby, and for 92 per cent of a One Born Every Minute episode I vow that I never, ever will. Those screams. Those looks of pure horror. The head emerging. All that pushing. All those tears. That metal equipment.... (Delago, 2015).*

Garrod (2012) questioned how birth, a major life transition come to be seen as entertainment in modern society. Some Second Stage Study participants found reality programmes reassuring, educational and informative. However, birth in a reality programme has been constructed by the programme makers and developed for entertainment not to prepare women for the realities of birth. As birth is now primarily hidden away in hospital institutions, women have little experience from real life to inform them. They are likely to develop expectations of birth and the role of the midwife based

on what they have seen because this is usually the only frame of reference they have. Others like Glenda and Delago (2015) are fearful of the way birth is constructed in these programmes and this may undermine their confidence in their body's innate ability to labour.

After viewing several episodes of the programme myself, I could see that editing is specifically geared to maximize entertainment value. The hours of the first stage of labour when little happens are rarely alluded to. Instead images focus on the dramatic highlights of the second stage. The 'pushing mantra' is used repeatedly by midwives as it is in other reality documentaries (Morris & McInerney, 2010). Women are seen labouring in bed on their backs and every episode provides examples of medical intervention. Women confirmed that they had expected to hear the pushing mantra used by midwives because of how labour is depicted on the programme.

A recent review of the media representation of childbirth identified three themes, namely; the medicalisation of birth, that women are using the media to learn about birth and the perception of birth as an extraordinary event that is absent from normal, everyday life (Luce et al., 2016). In most television programmes, women's bodies are represented as being incapable of giving birth without medical intervention. Midwives shout at women to push and refer to them as 'good girls' while praising them for not making a noise during labour (Morris & McInerney, 2010). These factors are likely to have negative consequences on the way that women approach labour as well as their relationship with and expectations of midwives.

In terms of fictional television, the drama of birth is always heightened. The start of a 'TV' labour is typically signalled by a pregnant character complaining of sudden severe pain and assuming a panicked expression, while birth in the home occurs during historical dramas frequently resulting in the death of the mother, baby or both (Kitzinger & Kitzinger, 2001). On the whole if a woman in a hospital drama expresses the wish for a natural birth, this acts as an implicit warning to viewers to expect a long and perilous childbirth journey (Kitzinger & Kitzinger, 2001). An exception to this is the drama series 'Call the Midwife' (British Broadcasting Company (BBC), 2012-2017) which focuses on midwifery care in London's East End in the latter half of the 20<sup>th</sup> Century. Birth here is set

in the context of everyday life where it is represented as a normal part of a woman's daily routine usually fitted in while her husband is at work. However, as Garrod (2012) reminds us, for most modern women such a scenario will be far removed from their experience of birth in the 21<sup>st</sup> Century. These examples demonstrate how the media has produced a powerful mythology of modern childbirth (Kitzinger & Kitzinger, 2001). Drama feeds into fears already contained within the biomedical model of birth and adds another layer of risk further conditioning women to conform.

However, as Luce et al., (2016) highlight, despite much discussion in the midwifery literature about the media's role in influencing women's perceptions of birth, there have been no published studies exploring the actual impact of the media on labouring women's behaviour. Halloran (2009) argues that media representations of birth are filtered by the individual woman using her own knowledge and experiences including interactions with her friends, family and her midwife. It is suggested therefore, that midwives have a key role to play in changing how birth is represented in the media (Hundley, et al., 2015). In order to achieve change, it is recommended that they need to harness the power of the media to convey positive messages to society. Midwives should engage with media producers to ensure a more balanced media representation of birth with a focus on physiological rather than medicalised birth. In order to achieve this, they need to develop an understanding of media reporting on both women and other health care providers (Hundley et al. 2015). MacLean (2014) argues that midwives need to develop an awareness of the influence that the media has on pregnant women and suggests that this could start by asking women what they have learnt about birth during the antenatal period. This would give the potential for misrepresentations to be corrected and anxieties allayed.

The 21<sup>st</sup> Century has seen the rise of information communication technologies which means that birth is no longer a private affair shared only with health care professionals and close relatives. Women are now sharing personal birth videos with millions of others as part of the online video community of 'YouTube' (Longhurst, 2009). It could therefore be argued that modern women now have access to another construction of birth that is grounded in reality rather than a media maker's interpretation of it.

Using a feminist, poststructuralist approach, Longhurst, (2009) analysed hundreds of online videos of birth on YouTube. She concluded that YouTube does indeed provide an opportunity for women globally to share information about the reality of birth. This further opens up the potential for a reconfiguration of how normal birth is constructed. For example, seeing women give birth without intervention could inspire other women's confidence in their body's ability to birth. However, as Longhurst also highlights, the cyberspace represented on YouTube is dominated by Western women presumably because they are most likely to have video equipment and the skills required to use it. Longhurst found that the hegemony of US birth practices was reflected online in that spontaneous vaginal births were censored as being unsuitable for viewers under the age of 18 whereas operative births showing graphic scenes of surgery were shown uncensored and considered appropriate for anyone. Interestingly this applied to only human vaginal birth whereas animal birth did not result in any kind of censorship. It would appear that birth viewed as a medical event is considered acceptable but when it is presented as a natural loving act involving a woman, her partner and their baby it is viewed in a sexual way and considered obscene.

Longhurst (2009) argued that this demonstrates that power relations in cyberspace reflect and reinforce power relations in real space and that birthing bodies are constructed in a similar way both off and online. Her study concluded that although YouTube has the potential to open up new windows on birth, this is still to be fully realised. Mindful that this study was completed more than 8 years ago, I undertook a superficial review myself and after searching for 'birth' on YouTube concur that the current situation remains similar. Issues surrounding the posting and viewing of birthing videos online warrants further research and discussion.

These observations of the manner in which birth is portrayed in the modern media also plays into CST and could be categorised as oppressive. In this context, the dominant group has the benefit of most media exposure perpetuating the idea that the best way for a woman to give birth is via a biomedical, interventionist model. Attempts by oppressed groups to empower other women by sharing examples of natural, physiological childbirth on YouTube are thwarted by censorship, accompanied by a sense

that the images are distasteful and that their underlying sexual connotations make them unsuitable for general consumption.

### Conflict in the room of birth.

There was a prevailing sense of conflict underpinning the accounts of some of the participants. This correlates with the findings of Balaaka and Schauer (2008) who described midwives working in obstetric units as 'being in a room of struggle' (p. 348).

Conflict was most evident when there was dissonance between a woman's desire for physiological birth and what an obstetrician or midwife considered to be safest as found in other studies (Balaaka, & Schauer, 2008; Keating & Fleming, 2009; Copeland, et al., 2014). Balaaka and Schauer (2008) argue that an ideological battle is enacted between interventionist treatment and physiological birth. This battle may influence a midwife's way of 'doing' midwifery as she seeks to balance her thinking on what is safe for the woman compared with what is perceived as being risky. It may also influence her way of thinking about the body and trusting it to do the right thing. (Balaaka & Schauer, 2008).

More than twenty years ago, Kirkham (1999) argued that modern midwifery in the UK is defined by the more powerful profession of obstetrics. When reviewing these findings from a CST perspective, the fact that conflict emerges as a theme supports the view that women and midwives are oppressed groups. It also corresponds with the definition of an oppressed group as being one which is governed by societal forces determining the behaviour of its leadership (Roberts, 1983). Most midwives are women meaning that from a feminist perspective, they are already part of an oppressed group (Wittman-Price, 2004). Freire's (1972) seminal work suggested that while internalizing the values of the dominant group, the characteristics of the oppressed group come to be viewed in a negative way. This idea is supported by Romyn (2000) who identified characteristics of nurses as representative of an oppressed group (this is applicable in this context to midwives as the organisation of work within the NHS is the same for both professions). These are: a close alliance with the oppressor (the obstetrician), horizontal violence, and lack of self-esteem, and disdain for other women. Some of these characteristics were displayed in the data and is evident in the examples of conflict situations described in Chapter 9.

In relation to horizontal violence, studies have demonstrated that this remains an ongoing issue within midwifery. (Farrell & Safari, 2012; Gillen, et al., 2004). Leap (1997) described scapegoating, backstabbing, negative criticism and lack of support as examples of horizontal violence in the profession. Bullying behaviour was not explicitly demonstrated in the Second Stage Study amongst the midwives who tended to focus on the supportive relationships they enjoyed with colleagues. It is acknowledged however, that a limitation of this study is that they may have chosen not to share elements of their practice that they perceived presented them in an unfavourable light.

There was an absence of any perception of conflict in the obstetricians' accounts. They described working alongside midwives and women in a professional, mutually respectful manner with recognition of the importance of promoting physiological birth. This confirms their status at the top of the hierarchy; they did not experience conflict because others working below them conformed to their authority.

These behaviours are explained by feminist commentators as arising from the exploitation of nurses and midwives since the movement of healthcare into the institutional hospital domain. As Harden (1996) argues, doctors need nurses and midwives to work and because the majority of these professions are comprised of women, oppression was introduced as a way of controlling their working lives and maximizing production. In the case of midwifery practice, this ensures compliance to the biomedical model of care.

### [Using CST to challenge the current orthodoxy of directed pushing](#)

Applying a feminist philosophy grounded in CST in this context recognizes that midwives need emancipating from the constraints of the biomedical model before they are able to empower women who are situated below them in the hierarchy (Keating & Fleming 2009; Kirkham, 1999). Wittman-Price (2004) argues that women need to be empowered through education and information sharing to make their own decisions about birth. They also need to be emancipated through an unconditional acceptance of their choices by healthcare professionals. This is a simplistic explanation of why midwives practice in the way that they do and why women conform to midwives' alternative suggestions so

readily. However, it is a starting point from where we can build an understanding of the deeply rooted cultural beliefs that underpin their behaviours.

In the context of the second stage, empowerment of women means that midwives need to refrain from challenging women who chose to undertake strategies aimed at promoting physiological birth, such as hypnobirthing. In the Second Stage Study there was a sense that midwives did not always support women's choices unconditionally. Empowerment would also involve midwives not directing pushing but instead demonstrating a belief in women's innate ability to give birth unaided by leaving her undisturbed.

When these findings are viewed via a CST perspective, aspects of 'communicative action' (Habermas, 1984) could be utilized to modify the dominant medicalised orthodoxy around pushing. This would be through reasoned dialogue between women, midwives and obstetricians based on reflexion and individual human rights. The overall aim of such dialogue being to empower individual women by increasing their confidence in their body's innate ability to birth. This would involve them being left undisturbed whilst pushing so that the environmental conditions required for physiological birth could flourish but with the facility for obstetrical assistance to be available if required. The role of the midwife here would be to situate herself unobtrusively in the birthing room to observe the progress of labour from afar and to intervene only if there was definite lack of progress (Odent, 2015).

Communicative action aimed at changing the orthodoxy of directed pushing would involve midwives, obstetricians and women engaging in respectful and individualised debate in order to mutually agree strategies which could be employed during labour. The aim of this being to achieve a balance between managing the uncertainty of birth, ensuring the safety of the woman and baby whilst still facilitating a woman-led model of birth and acknowledging the uniqueness of each participant involved in the process. Practices (such as directed pushing) would need to change to facilitate a woman-led approach to second stage pushing, such as the revision of the parameters associated with the second stage used to decide when intervention is necessary and when a woman can be safely left to labour undisturbed. Recent evidence from the US (Gimovsky & Berghella, 2016) has shown that extending the length of time 'allowed' for second stage in

nulliparous women, led to a significant reduction in the CS rate. If women, midwives and obstetricians were encouraged to adopt a partnership approach to maternity care, then parameters for length of time 'allowed' in second stage could be different for individual women based on their own informed choices and unique perception of risk.

Long (2006) recommended redefining the second stage of labour by placing the emphasis for progress on the descent of the fetus through the vagina rather than on cervical dilatation. Using Long's definition, the second stage would begin when the fetus had passed through the cervix and was lying below the ischial spines. Others suggest focusing on the overall ebb and flow of labour as a process rather than a number of clearly defined stages that are essentially artificially constructed (Walsh, 2003).

It is acknowledged that for communicative action to be translated into a discernible change and become transformative all those involved in birth need to embark upon a process of critical self- reflection. In keeping with a CST perspective this means that midwives need to start questioning aspects of their own practice which may be so deeply entrenched in the culture of midwifery in the Western world that they have not hitherto recognised that they are operating within a medical model. In other words, midwives need to recognize that they are being oppressed before emancipation can occur (Freire, 1972).

In the Second Stage Study, for example, midwives spoke about the expectation from all players in the birth process that their role involved instructing women how to push during the second stage. There was no suggestion from any that leaving a woman undisturbed to await events was ever a viable option. Midwives seemed unaware that giving instruction to women around pushing was actually an intervention into a physiological process. As T. Anderson (2002) highlighted, many years of instigating the pushing mantra has had the effect of transforming it into an invisible intervention. There was also a general expectation amongst women that midwives were actually supposed to 'do' something; an expectation reinforced by the images of birth depicted in the popular media and received enthusiastically by women. Only Emily's description of her water birth provided any sense that pushing had been truly woman- led; her recollection placing her midwife resolutely in the background. Glenda too described an empowering birth experience without a midwife. Indeed, Glenda's experience challenges the rationale

provided by the midwives for their intervention in the pushing phase ('primigravid women need direction to push') because despite having no previous experience of birth, she managed the whole process guided purely by instinct.

#### Place of birth: birth centres providing an enabling culture.

Kirkham,(2003) and Shallow ( 2003), suggest that midwives working in a birth centre are well placed to provide an enabling culture framed within the social model of care where women feel empowered to birth physiologically. However, in this study even birth centre midwives were influenced by the biomedical culture albeit to a lesser extent than delivery suite midwives. In this Trust the birth centre was located only one floor below delivery suite and this could explain the continued influence of the biomedical mode due to its physical proximity. There was no free standing birth centre although one had closed a few years previously for economic reasons amid concerns that it did not provide a full range of medical services in the event of unexpected complications arising during labour. This in itself provides an example of the risk averse culture presiding over maternity care. Kirkham (2003) argues that the perception that medical services are a necessity for all women is in stark contrast to the positive outlook of the social model where normality is considered the most likely outcome. However, as previously noted, historically public policy around birth is grounded firmly in the biomedical model and is universally accepted as correct because it is supported by authoritative knowledge.

Griew (2003) describes midwifery care provided in birth centres as being individualized and responsive to the unique needs of the woman and her family. A listening culture is promoted which leads to a different type of language being used incorporating less jargon, less instruction and a focus on support rather than use of language which protects the midwife. An example might be not using the word 'allowed' in relation to women making choices about birth, as in; "this woman is high risk, she is not 'allowed' a water birth".

Hunter (2000) devised a list of additional skills required by birth centre midwives. These included being confident enough to care for labouring women without resorting to technology, using the embodied knowledge of women to assess labour progress, being able to let labour 'just be' and being sufficiently confident to trust the physiology of

labour without being constrained by time limits. As Kirkham (2003) argues, trust is significant in this environment where women learn to trust their bodies, the midwife learns to trust her judgement and they both learn to trust each other. In this context, trust is seen to be 'infectious' as the midwife's inherent belief in the body's innate ability to cope is conveyed to the woman. Historically the role of the midwife has always been to be 'with woman', a calm, reassuring presence who is there to convey that the intense feelings experienced by labouring women are normal and can be coped with as previous generations of women have coped. Kirkham (2003) argues that this is the polar opposite of the self-fulfilling prophecy of modern midwives needing to have intervention on standby 'just in case'.

Based on the findings from the Second Stage Study, it is suggested that the birth centre and the woman's own home are optimum environments for midwives to provide care during the second stage which is primarily non-directive. A small but significant way of promoting the culture shift required to move maternity care away from the biomedical model would be for midwives to adopt a non-directed approach to second stage pushing in the birth centre and homebirth settings. On a smaller scale, this is akin to Cheyney (2008) citing homebirth as a 'systems-challenging praxis' when women in the US were seen to circumvent the dominant obstetric paradigm by giving birth at home with independent midwives. In the context of CST, this example refers to Habermas's (1987) view of society where 'the system' represents scientific rationality and those parts of society which are governed by power and economic resources as is characteristic of the biomedical model currently operating in maternity care.

### Implications of findings for midwives and intrapartum care

It has been shown that a woman's experience of birth can have a lasting effect on both her physical and psychological health (Kirkham, 2004; Oakley, 1980) and that the experience can be life-changing (Humenick, 2006). The Second Stage Study captures the significance that birth holds for women through the detail expressed in each of the participant's personal birth stories. The benefits for wider society in maintaining a physiological model of birth (Renfrew et al. 2014) have been acknowledged (See Chapter 3) and yet as this study confirms, birth in the UK continues to be constructed by midwives on a biomedical model that favours technology, surveillance and intervention and is

grounded in risk management (Mackenzie Bryers & Van Teijlingen, 2010; Healey et al. 2017.). Medicalisation removes the ownership of birth from women and places it firmly into the hands of healthcare professionals (Wray, 2006). Consequently, midwives and women become preoccupied with time limits arbitrarily allocated to the second stage and directed pushing is instigated as a matter of routine, the intention being to hasten birth. In the Second Stage Study, directed pushing was seen as ritualist practice that midwives undertook in order to claim mastery over the uncertainty of physiological birth. This was done despite their assertion that they supported women-led care.

I would argue that midwives should be reassured by research that shows that it is acceptable to sit back, watch and wait during the second stage (where watching implies observing unobtrusively to avoid a woman becoming disturbed by the overt gaze of an onlooker) and that midwifery can be 'the art of doing nothing well' Kennedy, (2000). Midwives in the Second Stage Study seemed uncomfortable with doing nothing, they did not demonstrate much confidence in a woman's innate pushing ability. More, they reflected Kirkham's (2003) description of modern midwives "as being active professionals rescuing needy women from pain or risk, combating emergencies and delivering babies" (p.257).

I concur with Downe's (2010) argument for a salutogenic vision of birth in the 21<sup>st</sup> Century. This would see maternity care framed within a model of well-being and health rather than risk and pathology. Salutogenic birth demonstrates an awareness of the need to move away from the over-magnification of risk in the name of safety and towards the positive concepts of birth including transformation, joy, elation, becoming a mother and being in a state of health and well-being (Bryar & Sinclair, 2010). Downe and McCourt (2008) use complexity theory to explain how safety in clinical, physiological and emotional terms in maternity cannot be imposed on an individual or a group but are rather emergent phenomena as long as bodily systems are treated as being salutogenic and grounded in authentically positive relationships. El-nemer et al., (2006) refers to this as being 'skilled help from the heart' reflecting a compassionate, humanistic vision of maternity care rather than one based on a positivist 'one size fits all' philosophy demonstrated here. Downe et al. (2007) argue that it is as ethically unacceptable to undertake routine risk averse intervention into normal birth as it is to blatantly ignore

risk. Instead it is suggested a return to the constructs of wisdom and vocation as practiced by latter day midwives whilst integrating the modernist concepts of evidence based practice and post- modernist concepts of realist research and policy.

The Birth Territory theory (Fahy et al., 2008) is recognized as providing a potentially useful vehicle through which communicative action could be harnessed to drive the cultural shift needed in order to promote a salutogenic vision of birth. The central proposition of this is that, when midwives facilitate optimal environmental and emotional conditions for physiological labour there is an increased chance of spontaneous birth, greater maternal satisfaction and a readiness to adapt to the demands of motherhood. (Fahy et al., 2008).

In order to facilitate such optimal conditions, midwives need to relinquish their power within the birth room, meaning that they should not direct pushing during the second stage. Instead, they need to share their power within the birth territory so that the woman's embodied knowledge is recognized as being as important as their expert knowledge. It is acknowledged that such a cultural shift cannot be expected to occur without midwives engaging in extensive and professional reflection that is transformative in nature and is applied to communicative action.

It is further acknowledged that not all women will want physiological birth and some may embrace medical intervention such as directed pushing. In the context of the Second Stage Study, a collaborative sharing of power would have benefited Hilary who had wanted an epidural but felt unheard by her midwife who persisted in promoting physiological birth. The concern of some women that midwives will 'bully' them into having normal births when this is not their choice (Glaser, 2015) is a further example of midwives working paternalistically rather than collaboratively and was reflected in the findings of the Kirkup Report (DH, 2015). This highlighted the unsafe practice of the self-titled 'musketeer midwives' of Morecombe Bay NHS Trust who strove to keep birth normal at all cost by refusing to call obstetricians and then colluding to hide their negligence.

I would argue, that elements of Birth Territory theory are applicable to all women including those who chose or need to accept intervention. It is acknowledged that birth in

the 21<sup>st</sup> Century is becoming ever more complex incorporating women who previously might have been unable to achieve a pregnancy (for example those with cardiac conditions, diabetes, epilepsy and asthma) while there has been an increase in women with obesity and those giving birth later in life (NHS , 2016). A collaborative approach to care where the midwives' role is of an 'expert guide' rather than an 'expert knower' would lead to a more woman – centred approach for all women regardless of the complexity of their needs. Bryar and Sinclair (2010) recommend a shift in professional gaze so that birth is seen as a complex, dynamic and self-organising process unique to each individual woman rather than a simple, predictable linear one.

It is postulated that in order to move away from the dominant model, midwives, obstetricians and women need to engage in a process of reflexion culminating in communicative action to allow them to discuss (on equal terms) issues relating to risk perception and a more women focused guidance for intrapartum care based on individual choice rather than inflexible policy. It is important to note that routine intervention into birth can cause iatrogenic harm to women and babies (Requejo et al., 2012) and adds substantial economic cost to maternity care (McIntyre et al., 2011). This was not raised as an issue by the midwives in this study or elsewhere (Kennedy & Shaw-Battista, 2010) the general feeling being that non- intervention would be challenged if the outcome ended up being poor but inappropriate intervention could proceed without question despite the risk of iatrogenic harm.

Midwives need education and support to develop the additional skills identified by Hunter (2000), particularly those of being confident enough in their ability to make decisions and manage unexpected complications without access to immediate obstetric assistance. Gutteridge (2013) describes various women centred strategies that midwives can use to assess progress and support women through labour using 'midwifery wisdom'.

In relation to the education of midwives, some years ago T. Anderson (2002) argued that the challenge in instigating this cultural shift lies in how to teach midwifery students that "elusive art of intelligent inactivity" (p.209) if all they see is a midwife sitting by a woman in labour silently knitting! In order to address this, she recommended the categorisation of midwifery practice into three levels of intervention to raise the visibility of practice

such as directed pushing that is not currently viewed by midwives as an intervention. See Table 5.

T. Anderson's (2002) idea was that by categorising midwifery interventions in this way, awareness within the profession would be stimulated enabling midwives to see that much of what they do is an intervention with the potential to disturb the physiology of birth. A midwife needs to use her clinical decision making skills to assess each woman individually and to decide the appropriate level of intervention required. As Table 5 demonstrates a 'no intervention' category is included as a way of legitimizing the option of 'doing nothing'. These ideas were published a number of years ago but do not seem to have been incorporated into pre-registration midwifery curricula. I would argue however that categorising midwifery interventions in this way will assist midwifery educationalists in promoting the cultural change needed for midwives to acknowledge that no or minimal intervention into birth are viable options.

Indeed, T. Anderson's idea of categorising birth interventions has been instigated to an extent in a recent UK study that demonstrated a significant reduction in severe perineal trauma following the introduction of several simple, low cost measures during the second stage. These include midwives providing verbal encouragement to women to slow down their pushing during crowning and simple tactile control with one hand being used to slow down delivery of the fetal head (Basu et al., 2016). Initial positive results have been achieved by midwives using what T. Anderson would describe as level 2 interventions, although the authors acknowledge that it is unclear what element of the care package is having the most effect on outcomes. Indeed, they postulate that an associated factor might be simply the enthusiasm for change generated by staff involved in the project. Further research is therefore required in this area to ensure that these interventions are leading to better outcomes than if birth were left undisturbed. However, at first glance this study does seem to highlight a positive outcome of midwives using their clinical decision-making skills to utilize interventions appropriately.

Recommendations for intrapartum care arising from the Second Stage Study are timely in light of the publication of the National Review of Maternity Care (NHS, 2016). This also recognises that modern maternity care in the UK needs to be personalized and women supported to make their own decisions about birth following a full discussion of the

associated benefits and risks. The importance of developing trust between childbearing women and their midwives is also emphasized in this review with a call for the transformation of modern maternity care to include continuity of carer and a caseload approach culminating in a relationship/ partnership based model of care. A strategy through which communicative action of the kind described here could be facilitated within groups of midwives is via the new strategy for professional support envisioned by the A-EQIP (Advocating for Education and Quality Improvement) model that is currently being developed as a replacement for statutory supervision of midwives (SOM). In the new model, the role of SOM is replaced by that of Professional Midwifery Advocate (PMA) (NHS, 2017b). Providing an opportunity to reflect and a safe space to talk is central to the PMA's 'restorative clinical supervision' function. This aims to address the emotional needs of staff by providing confidential sessions either individually or in groups where midwives can be supported to learn from their experiences (NHS, 2017b; Hopper et al., 2017). It is postulated that this might provide an ideal forum to support midwives in the radical cultural shift needed to improve maternity care.

**Table 4 Midwifery Interventions during the second stage of labour**

(Based on T.Anderson, 2002).

No Intervention	First level intervention	Second Level Intervention	Third level intervention
Woman moves freely and adopts whatever position she wishes.	Midwife asks woman to move to an upright position.	Midwife asks woman to push with contractions	Swabbing of the vulva area.
Woman bears down spontaneously and as she wishes.	Midwife provides encouraging words to reinforce the spontaneous pushing behaviour.	Warm pads are placed on the perineum to relieve discomfort.	Vaginal examination performed to confirm full dilatation of cervix

			and assess progress.
Midwife 'guards' the birth in environment to prevent disturbance from others.		Midwife cleans faeces from the perineal area.	Midwife performs a catheterisation of the urinary bladder.
		Midwife asks woman to stay in a position so that the vulva can be viewed.	Woman is encouraged to undertake the Valsalva technique.
		Midwife places her hands on the fetal head to slow down a rapid delivery.	Woman is placed in the lithotomy position.
		Asking a woman to pant or blow as the fetal head is crowning.	Midwife 'guarding' the perineum and using her hands to deliver the head by controlled flexion and extension.
		Massaging a woman's legs and thighs to aid relaxation.	Performing an episiotomy to expedite birth.

## Limitations of the study

This was a qualitative study and therefore findings, although providing an in-depth description of these participants' experiences of pushing during the second stage of labour, cannot be generalised more widely. It does however provide insight into the way that midwives provide intrapartum care that will have relevance beyond the experiences of this small sample.

All participants were drawn from the same NHS Trust. The women participants were a self-selecting group meaning that the more articulate or those with a story to tell were more likely to volunteer. They were of a similar age and socio-economic background and had all undertaken antenatal preparation for birth. It has been highlighted that these groups are already over represented in research generally (Levine, 2008). These women did not reflect the proportion of ethnic groups in the area of the NHS Trust where the study was undertaken. In order to gain ethical approval, women under the age of 18 and those considered to be vulnerable had to be excluded. As the study was unfunded; financial constraints meant that I could not interview women who had a poor understanding of English as I was unable to employ an interpreter. These factors meant that a significant section of the local childbearing population was not represented in the study. I relied on the subjective judgement of midwives acting as gatekeepers for recruitment and it was possible that they purposely chose not to approach women whom they deemed unsuitable but who may have been willing to participate (Barbour, 2014).

It is acknowledged that different findings may have been produced if participants had been recruited from another NHS Trust or geographical area. Using another strategy for recruitment such as social media or via community based groups, may also have led to increased demographic diversity. It would have been valuable to interview a woman who had experienced a homebirth with an independent midwife working outside the sphere of the NHS. Similarly, it would have been interesting to interview an independent midwife in order to discover if she directed pushing despite working outside the constraints of hospital protocols.

The fact that at the time of the study, I was a midwifery lecturer and a Supervisor of Midwives (SOM) who knew most of the midwives prior to interview might have had an

inhibitory effect on what they chose to share with me, particularly if they perceived that I held a position of power. For pragmatic reasons I had to undertake the study in a particular Trust, however, if I had travelled further afield to include participants who did not know me then findings might have been different. The insider/ outsider debate has associated benefits and limitations. Undertaking a period of participant observation in the maternity unit would have strengthened the validity of the findings and this offers scope for future study.

The fact that I am close to the subject matter as an experienced midwife and a mother may have influenced my subsequent interpretation of the data (Henn et al. 2006; Kingdon, 2005). However, this was acknowledged from the outset and to counteract this I took a reflexive stance throughout and maintained a reflective diary recording instances where my own personal and professional experiences had the potential to impinge on the way I interpreted the data (Lambert et al., 2010). In addition, my two doctoral supervisors were not midwives and were able to assist me with an impartial perspective of the findings. Sharing findings with fellow doctoral (non- midwife) students and midwifery colleagues throughout the period of data analysis was also invaluable in this regard. In addition, the use of NVIVO 11™ helped me to withdraw from the immediate impact of the data supporting a more objective and balanced view (Mason, 2002).

### Final Personal Reflection

I initially approached this study from a critical stance on how the medicalisation of birth and hegemonic dominance around the management of maternal pushing during the second stage of labour may have prevented the implementation of a more woman-led approach to care. However, further reflection on my own position as the study unfurled, led me to acknowledge that as an experienced midwife myself, I am inevitably influenced by the rhetoric that obstetricians and midwives are working at opposing ends of the childbirth continuum with obstetricians favouring intervention and midwives striving to promote physiological birth.

During the process of data analysis I became increasingly aware that a more nuanced approach to this argument is more appropriate and relevant. Indeed, the obstetricians in this study were largely supportive of a woman – led approach to labour contrasting

sharply with the medicalised care provided by some of the midwives. There was no medical presence of any kind in the birth centre and consequently no opportunity for obstetricians to exert any influence over the midwives working there. Despite this, some of the birth centre midwives acknowledged that they were as directive in terms of pushing practice as were those based in the delivery suite (for example Bonnie and Nadia, page 166).

Further data analysis uncovered more examples of midwives failing to provide care in a woman-centred way. For example, Lucy graphically described how her midwife had 'broke her' (page 172) and Lorraine (page 179) suggested that no professional group had had her best interests at heart as she described the overriding sense of conflict within the room of birth. These women longed for their voices to be heard and yet their experience of being cared for by midwives suggested that no one was listening, let alone encouraging them to follow their instinctive, physiological urge to push during the second stage.

The data suggests that different types of communicative action are operating within maternity care, with the positioning of midwives suggesting that they also want to retain control of the birth process and appear reluctant to share their power with the women. This is represented in the descriptions of how midwives support women to push by providing very clear instructions on how to push (despite claiming to favour a physiological approach to second stage pushing) and the positions they describe encouraging women to adopt for birth: none of which are women-led. There was a sense amongst most of the midwives that women's bodies, particularly primigravid bodies, cannot be trusted to know what to do because they have never experienced birth before.

This positioning of the female body as untrustworthy and 'risky' in relation to giving birth physiologically, contrasted with Glenda's experience. Glenda laboured with no midwife in attendance; guided simply by her embodied sensations and an innate contractual urge to give birth. Glenda's account is particularly interesting and led to a marked change of direction in my own thinking as she reported experiencing the most positive and satisfying birth of all the participants with no midwifery or medical presence at all. The account from Glenda demonstrated that despite having no previous birth experience, the

body can be trusted to respond to normal physiological stimuli and a baby can be safely delivered even within the confines of a domestic hallway.

Returning to aspects of the theoretical framework and Habermas's (1987) view of the colonisation of the lifeworld, this data supports the idea that the 'lifeworld' of physiological birth in the Western World in the 21st Century has been colonised by technical rationality to the extent that midwives (myself included) remain unaware of how we contribute to the continued dominance of the biomedical model. Habermas (1987) argues that a greater sense of critical consciousness and a deeper understanding of why we do what we do is needed is required if this situation is ever to change.

I will end this section with an example from my professional practice as a midwifery educationalist. This illustrates in practical terms how whilst undertaking the study, my thinking shifted from occupying a binary position (where midwives aim to be woman centred but are oppressed by powerful obstetricians supporting the interventionalist, biomedical culture) to a more nuanced position and the acknowledgement that multifactorial discourses operate at different levels and things are not always as clear cut as they may first seem. Added into this mix is the observation that some women welcome all the technological intervention into their birth that is currently available and see this as a feminist approach to freeing them from the confines of nature by providing them with choice.

My lecturer colleagues and I have been considering how we can organise a display of midwifery artefacts and memorabilia within the corridors of the University. Our idea is to promote the midwifery profession by providing the public with a sense of what it means to be a midwife. We have a selection of 'tools' of our trade including pinards, sonicaid, baby weighing scales along with photographs of old-fashioned midwifery uniforms and training school badges. Having reflected on my position in the context of the Second Stage Study, I have come to the realisation that even a simple display of this kind promotes the biomedical model of midwifery where smart uniformed professionals use instruments to 'do things' to women during birth. This view of what it means to be a midwife (busy, active, reactive) is so deeply imbedded within our collective consciousness that this was the first idea that came to all of us and was accepted without hesitation. It

may be empowering for midwives, but it is not empowering for women seeking to reclaim control of the process of giving birth.

Decolonising childbirth from the oppression of medicalisation and risk aversion would incorporate an alternative approach to promoting a woman-centred vision of midwifery. Our display would transfer the instruments to the background and would incorporate a video of a labouring woman empowered at the moment of birth, taking centre stage with a midwife supporting her quietly from the sidelines and the 'tools of our trade' situated on the periphery, almost out of sight.

### Summary

This study has drawn on the principles of CST and aspects of feminism to understand why midwives continue to practice within a biomedical framework and in so doing disempower women from physiological childbirth. The key finding was that the main focus of midwifery practice during the second stage of labour is on directing pushing. A risk-averse culture thrives unchallenged, where ways to maximise production are prioritised and the needs of the institution are valued over the psychosocial needs of women and the 'emotion work' aspect of the midwife's role.

I have presented the argument that the practice of midwives undertaking directed pushing is an example of institutionalised oppressive behaviour symbolising the way in which knowledge and rationality is disregarded in favour of a controlling and risk-averse behaviour that is paradoxically the opposite of evidence-based recommendations. When viewing this phenomenon through the lenses of CST, midwives are identified as being an oppressed group working within a hierarchical structure located beneath obstetricians with women occupying the lowest position.

The implications of these findings for midwives and midwifery practice during the second stage are clear. A salutogenic approach to intrapartum care should be considered as a way of recognising the unique normality of individual women and permitting a more flexible ontology of childbirth.

## 11. Conclusion

The Second Stage Study was a qualitative project situated within a growing body of midwifery knowledge that seeks to promote physiological birth (Downe, 2008; Fahy et al., 2008; Walsh, 2012; Gutteridge, 2013; Byrom & Downe, 2015; Odent, 1999, 2007, 2015). It utilized aspects of CST and drew on feminist principles to answer the question ‘what midwifery practices are undertaken while supporting women to push during the second stage of labour?’

Whilst there has been research into how midwives manage birth in modern maternity units (Healey et al., 2017; Fleming & Keating, 2009; Hunt & Symonds, 1995; Dykes, 2009) and women’s experiences of birth (Larkin et al., 2009; Gibbins & Thomson, 2001; Lavender et al., 1999; Waldenström et al. 1996) there has been little qualitative work relating to how midwives support women during the pushing phase of labour. Similarly there have been no known studies seeking to understand why midwives persist in undertaking a practice that is not evidence- based. This study also included the views of obstetricians and women who had recently given birth in order to gain another perspective and further insight into this area.

My thesis concludes, that midwives working in this UK NHS maternity unit undertook directed pushing as a matter of routine even for those women who were labouring in midwifery -led settings and classified as low risk of developing complications. When considering the normal physiology of birth, it is argued that directed pushing is an intervention that has the potential for disrupting the intricate hormonal pathways required for physiological birth (Odent, 1999; 2007; 2015). It is a distraction for women that may inhibit them from reducing the activity in the neocortex, another requirement for physiological birth (Odent, 1999; 2007; 2015) as well as undermine their confidence in their innate ability to give birth (Walsh, 2012).

Midwives in this study, had a basic awareness of research related to directed pushing although their knowledge base was limited. The rationale they provided for why they persisted in facilitating directed pushing, centred on their perception that it would reduce the duration of the second stage and would minimise the risk of complications arising if labour was prolonged. There was a general perception of pressure from midwifery colleagues and obstetricians to intervene if progress was considered ‘too slow’ and there

was no sense of midwives asking women what they wanted to do. Instead, most midwives perceived that women, particularly nulliparous women needed instruction in how to push in order to give birth within the time constraints permitted by Trust policy.

In this context, the idea of women having a physiological labour where they were left undisturbed was far removed from reality. Overall, midwives' perception of their role was to be 'doing' rather than 'being'. Although community midwives caring for women at home did report being more guided by women's wishes there was still a prevailing sense that they were 'in charge'. Of interest here though is that the two women who described giving birth with least intervention had the most positive experiences and were most satisfied with their care.

These findings lead me to the conclusion that midwifery practice in relation to second stage pushing continues to be framed within a biomedical model with its accompanying risk orientation, reliance on technology and understanding of labour as something that needs 'fixing'. Midwives undertake directed pushing because they are conditioned to 'do' rather than watch, wait and trust women's innate ability to birth. This conclusion supports the findings of other recent studies examining the influence of the institutional culture of the hospital on birth practices (Newnham et al, 2017; Healey et al, 2017).

Explaining these finding from a CST perspective, it is postulated that women and midwives display the characteristics of members of an oppressed group. The hierarchical positioning of midwives and obstetricians within the current arrangement of UK maternity services provides a simplistic explanation for why midwives construct their practice on a biomedical model and why the number of physiological births continue to decrease in the UK. It helps to explain why midwives persist in undertaking directed pushing even when they are working in environments far removed from the highly medicalised culture of the delivery suite. If midwives are seen as an oppressed group, then the power of the dominant group will permeate their practice to the extent that they continue to work in a medically orientated fashion in the manner of Foucault's docile subjects (Foucault, 1979) even when they are not under surveillance.

However, of particular interest in this study was the finding that the obstetricians while unsurprisingly aligning themselves with the biomedical model, did not appear to be trying

to dominate the care midwives provided to women in midwifery- led settings. There was a general sense from this small group of obstetricians that they too favoured a physiological approach for low risk women and perceived themselves as having no kind of presence in the birth centre. Women too, were trying to reclaim birth for themselves by preparing as much as possible for an intervention- free birth. On the whole however, these attempts were seen to be thwarted by midwives rather than by obstetricians. These findings suggest that it is midwives themselves who are resistant to change with the practice of directed pushing being so deeply entrenched in their sense of what it means to be a midwife that they seem to be struggling to let it go. As Odent (1999) argues midwives need to learn how **not** to disturb birth in order for it to be reclaimed as the physiological process that it is.

For this transformational shift towards a social model of midwifery to become reality, midwives need to emancipate themselves from the dominant medical model. A precursor for this is for the oppressed group to be aware of the negative influence that the oppression has over their free choice (Freire, 1972). Indeed, a feature of the Second Stage Study was that midwives seemed unaware of the significance that their persistence in carrying out a directed pushing had on the experience of birth for women. They did not view directed pushing as an intervention; it was just routine practice and as such could be classified as an 'invisible' intervention. From the perspective of these midwives, the second stage was all about 'getting women to push' and 'getting the job done'.

A transformational change means that midwives need to reject modernity and work towards the adoption of a post-modernist approach to praxis that reclaims the territory of birth for women and forms the basis of future maternity care. The challenge comes in raising midwives' awareness of the fact that the potential for change must begin with themselves and involves them reframing birth within salutogenesis rather than pathogenesis. In terms of directed pushing, this means that they must learn to hold back and give women the space they need to take heed of their embodied feelings rather than proceed straight away to giving instruction.

## Contribution of findings to the body of knowledge.

This is the only known qualitative study to focus specifically on the practice of UK midwives undertaking directed pushing during the second stage of labour and include the perspective of both obstetricians and postnatal women. Whilst there have been a number of studies, predominantly quantitative, exploring directed versus spontaneous pushing there have been none that have sought to explore midwives' perceptions of the practice, particularly in the light of conflicting evidence that has emerged over the past two decades. Midwives have been informed that directed pushing should not be used routinely but have not have been provided with alternative strategies to support women during second stage without this type of intervention. For a number of years, midwives have been accustomed to 'doing' (directed pushing) rather than just 'being' (with a labouring woman) so this presents a challenge to them.

The idea that midwives may use the distraction of 'doing' to prevent them from the potential discomfort of watching another woman undergoing the physically and emotionally intense experience of birth adds to their dilemma. It seems that they prefer to fill any 'empty' time that may evoke anxiety within themselves with the 'pushing mantra'. However the problem with this is that the intervention of directed pushing if used indiscriminately has the potential to pathologize the normal physiology of birth to the extent that further intervention is necessary leading to increased morbidity and a negative birth experiences for some women.

Since 1993, the political agenda in the UK has focused repeatedly on the promotion of physiological birth and various recommendation that maternity care should be woman – led (DH, 1993; DH, 2004; DH, 2007a; DH, 2007b; DH, 2011; NHS England, 2016). Despite this, my study confirms that this vision for maternity care is not a reality at least in this UK NHS Trust. Instead, it supports the idea that physiological birth is on the 'endangered list' (Dahlen, 2010). There are competing arguments suggesting that an increasing acceptance of intervention into birth may form part of a growing population trend (Green & Baston, 2007) and this was reflected in the study as some women participants seemed very happy to accept medical intervention into labour, including directed pushing and were still satisfied with their overall birth experience.

## Recommendations

### Recommendations for midwifery education and practice

These findings have implications for the education of student midwives and midwives' continuing professional development needs.

1. The concept of probability and risk needs to be appreciated at a much deeper level by both women and midwives. Evidence suggests that health care professionals tend to have a poor understanding of the concepts of risk (Furedi, 2006; Gigerenzer & Muir-Gray, 2011). There needs to be an appreciation of what constitutes 'risky' care decisions and this should be individualised for each woman. This is becoming more important as complexity in childbirth is increasing due to factors such as higher levels of obesity and diabetes in the general population and the fact that women are giving birth later in life (Jackson & Wightman, 2017). A woman with a complex pregnancy will have a different level of risk and it may be that for her, thresholds for intervention need to be lower. Midwives and women need to appreciate this to avoid the overmagnification of risk and the undertaking of routine practice, such as directed pushing for all women regardless of risk or the woman's unique needs.
2. Education for midwives should include more of a focus on how to promote physiological birth if labour progress slows rather than moving straight to directed pushing. Practical examples include, suggesting changes in position and providing a positive attitude with an accompanying belief in the woman's ability to give birth (Davies, 2011; Simkin & Ancheta, 2011). The categorisation of midwifery interventions as suggested by T. Anderson (2002) should be widely discussed in the education of midwives. Admittedly these measures are not scientifically proven and are based on intuition rather than authoritative knowledge. However, as Jackson (2017) highlights a body of evidence is beginning to emerge that demonstrates the positive effects of a more humanistic approach to labour with less reliance medical intervention.
3. Birth Territory theory (Fahy et al., 2008) should be considered as a framework for midwifery education. Although this was initially published almost a decade ago, it has not been widely embraced by the midwifery profession in the UK and is

conspicuous by its absence from recent midwifery texts and articles. I would argue that using Birth Territory theory as a framework for praxis provides a theoretical approach to challenge the current biomedical model. Birth Territory theory favours a partnership approach where, midwives, women and their birth partners work collaboratively to channel energy and power in the room of birth into the promotion of an experience firmly rooted in physiology. Power is shared to assist the woman to give birth and not to force compliance into any course of action. This theory offers practical, spiritual and physiological insights into returning birth back to women and as such could prove to be a valuable resource for midwives in the 21<sup>st</sup> century as they work towards the desired paradigm shift leading to their emancipation.

#### Recommendations for the antenatal preparation of women

1. For women, antenatal education should be more geared towards preparing them and their birth partners for the intense physical sensations associated with the second stage of labour. Women in this study, although they had all attended antenatal education classes were frequently overwhelmed by the intensity of second stage contractions to the extent that confidence in their body's innate ability to birth was diminished leading to a state of fearful dependence
2. Midwives and women should work collaboratively with media makers to promote physiological birth as the significance that media representations of birth held for all the participants in this study was notable.

#### Recommendations for future research

1. This study included a homogenous sample of women participants from a single NHS Trust who were not representative of the population served by the Trust. Future research in this area should seek to include women from lower socio-economic groups, from ethnic minorities and from the younger age group. Future studies need to be undertaken in different geographical areas in order to present a more balanced view of practices relating to directed pushing across the UK.
2. Further research is recommended into hypnobirthing or other strategies designed to encourage women to let go of the conscious neocortex and enter a state of 'flow'. The recent multi-centre randomized controlled trial investigating self-

hypnosis for intrapartum pain management (SHIP) (Downe et al., 2015) did not demonstrate any significant reduction in epidural use in participants who accessed the self-hypnosis intervention. The researchers recommend further investigation into the impact that self-hypnosis might have on women's anxiety and fear levels as they approach labour. A technique such as hypnobirthing if found to have a significant benefit on any aspect of birth would be a cost-effective way of supporting a physiological approach to birth with its accompanying benefits.

## Final Summary

The midwives in this study actively directed women to push during the second stage of labour despite the evidence base stating that pushing should be women-led. Reasons for this dissonance have been discussed and the conclusion is that midwives and women continue to be constrained by the dominant biomedical model framing birth in a proactive, 'doing' paradigm rather than letting it 'just be'. This is compounded by the institutionally focused way that maternity care is currently organised in the UK

Obstetricians in this study demonstrated a willingness to leave midwives to practice in a more physiological way during low risk labours and women were doing all they could to have an intervention free birth. However the midwives although providing what they perceived to be very woman-centred care were reluctant to stop directed pushing; a practice that they did not perceive as being an intervention.

My thesis concludes that instigating communicative action by highlighting this to women and midwives will promote the benefits of a physiological approach through education, discussion, debate and reflexion at a deep level. Midwives need to be encouraged to ask themselves searching questions about all the childbirth practices they facilitate even those that are so deeply entrenched in their culture, such as directed pushing. This accompanied by positive representations of physiological birth in the media will help to facilitate a societal and cultural shift back to a woman-led model where birth is seen as a normal every day event framed in salutogenesis rather than pathogenesis.

Midwives, childbearing women and obstetricians need to work collaboratively to facilitate this change so that women at low risk of birth complications are supported to reclaim the territory of birth and the associated benefits that this brings. Pollard, (2003)

presents the argument that midwives need to educate society about the meanings of woman-centred care and midwifery autonomy or resign themselves to an acceptance of the medical model. This supports the argument that strong midwifery leadership needs to come from within the midwifery profession itself and not be imposed upon it (Kitzinger, 2005). I would argue alongside this that a fundamental change needs to begin within individual midwives themselves with the recognition that most of what they do routinely is actually an intervention with the potential to disturb the physiology of birth and it is only with this recognition that care will ever change to become less interventionist.

I am not arguing however for complete inaction in all labours to the extent that midwives never say anything to women during the second stage. Instead I agree with Anderson's assertion that sometimes midwifery intervention is appropriate and should be instigated without hesitation (T.Anderson, 2002) otherwise the damaging culture at Morecombe Bay NHS Trust highlighted by Kirkup (DH, 2015) might result. As Kitzinger (2005) wrote "a midwife needs to be relaxed but alert and watchful even when she may seem to be doing nothing" (p.147).

The Maternity Transformation Programme (NHS, 2017a) is currently in progress across the UK and this presents an ideal opportunity for midwives to consider innovative and creative strategies and lead the way in redesigning services to align them with a social rather than a medical model. It is postulated that the model of professional support envisioned in clinical restorative supervision (NHS, 2017b) could assist midwives in negotiating a radical shift in their thinking and praxis that is required for there is to be any kind of cultural shift. The results of this study add to the body of knowledge confirming that this is the way forward.

I have drawn many ideas from the work of Michel Odent and it seems fitting therefore to conclude with a quote that summarises the very essence of my thesis:

When you consider birth as an involuntary process involving old, mammalian structures of the brain, you set aside the assumption that a woman must learn to give birth. It is implicit in the mammalian interpretation that one cannot actively

help a woman to give birth. The goal is to avoid disturbing her unnecessarily.

(Odent, 2007, p. 8).

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## Appendix 1. Summary of reviewed studies

Study	Type	Country of Origin
Barnett, M.M and Humenick, S.S. (1982). Infant outcome in relation to second Stage pushing method. <i>Birth</i> , 9(4), 221-8.	RCT	US
Bergstrom, L, Seidel, J., Skillman-Hull, L. and Roberts, J. (1997) "I gotta push. Please let me push." Social interactions during the change from first to second stage labor. <i>Birth</i> , 24(3), 173-180.	Qualitative	US
Bergstrom, L, Richards, L, Morse JM, Roberts, J ( 2010) How Caregivers Manage Pain and Distress in Second Stage Labor <i>Journal of Midwifery and Women's Health</i> 55 (1) 38- 44	Qualitative	US
Beynon, C. (1957). The normal second stage of labour: a plea for reform in its conduct. <i>Journal of Obstetrics and Gynaecology</i> 64(6): 815-20.	Quasi experimental	UK
Borders, N, Wendland, C, Haozous. , E Leeman. , L Rogers, R (2013). Midwives' Verbal Support of Nulliparous Women in Second stage Labor. <i>Journal of Obstetric Gynaecology and Neonatal Nursing</i> 42 (3) 311-20.	Qualitative	US
Borrelli, S.E. Locatelli, A. & Nespoloi, A (2013) Early pushing urge in labour and midwifery practice: a prospective observational study at an Italian maternity hospital. <i>Midwifery</i> , 29(8), 871-875.	Longitudinal	Italy

Bloom, S.L., Casey B.M, Schaffer J.I., McIntire, D., Leveno, K.J. (2006). A randomized trial of coached versus uncoached maternal pushing during the second stage of labour. <i>American Journal of Obstetrics and Gynecology</i> , 194 (1), 10-13.	RCT	US
Cheng, Y.W., Hokins, L.M, and Caughey, A.B (2004).How long is too long: Does a prolonged second stage of labor in nulliparous women affect maternal and neonatal outcomes? <i>American Journal of Obstetrics and Gynecology</i> , 191, 993-8.	Retrospective	US
Chang, S., Chou, M., Lin, K., Lin, Y. & Kuo, S (2011). Effects of a pushing intervention on pain, fatigue and birthing experiences among Taiwanese women during the second stage of labour. <i>Midwifery</i> , 27, 825-831.	RCT	China
Co Lam, C. & McDonald, S. J. (2010). Comparison of pushing techniques used in the second stage of labour for their effect on maternal perception of fatigue in the early postpartum period among Chinese women. <i>Hong Kong Journal of Obstetrics, Gynaecology and Midwifery</i> , 10(1), 13-21.	RCT	China
Downe, S., Trent Midwives Research Group, Young C. & Hall Moran, V. The early pushing urge: practice and discourse. In S. Downe. (Ed.). <i>Normal childbirth: evidence and debate. (2<sup>nd</sup> Ed)</i> . London: Elsevier.	Survey	UK
Jahdi, F., Shahnazari, M., Kashanian, M., Farahani, M.A & Haghani, H. (2011). A randomized controlled trial comparing the physiological and directed pushing on the duration of the second stage of labour, the mode of delivery and Apgar score. <i>International Journal of Nursing and Midwifery</i> , 35 (5), 55-59.	RCT	Iran
Low, L.K., Miller, J.M., Ying, G., Aston-Miller, J., DeLancey, J.O.L & Sampsel, C.M. (2013) Spontaneous pushing to prevent postpartum urinary incontinence: a randomized, controlled trial. <i>International Urogynecology Journal</i> , 4, (3):453-460.	RCT	US

McKay, S., Barrows, T. & Roberts, J. (1990). Women's views of second stage labour as assessed by interview and videotapes. <i>Birth</i> , 17(4), 192– 8.L	Qualitative	US
Myles, T.D.& Santolaya, J. ( 2003) Maternal and Neonatal Outcomes in Patients With a Prolonged Second Stage of labor <i>Obstetrics and Gynecology</i> , 102 (1) , 52-58.	Retrospective.	US
Osborne, K. & Hanson, L. (2012). Directive versus supportive approaches used by midwives when providing care during the second stage of labor. <i>Journal of Midwifery and Women's Health</i> , 57(1), 3-11.	Survey	US
Paine, L. L. and Tinker, D. D. (1992) The effect of maternal bearing- down efforts on arterial, umbilical cord pH and length of the second stage of labour. <i>Journal of Nurse-Midwifery</i> , 37, 61–63.	Quasi experimental	US
Parnell, C., Langhoff-Roos, J., Iverson, R. & Damgaard, P. (1993). Pushing method in the expulsive phase of labour. A randomized trial. <i>Acta Obstétrica et Gynecologica Scandinavia</i> 72(1), 31–5.	RCT	Denmark
Roberts, J.E., Goldstein, S.A., Gruener, J.S., Maggio, M. & Mendez-Baur C. (1987) A descriptive analysis of involuntary bearing down efforts during the expulsive phase of labor. <i>Journal of Obstetric, Gynaecological and Neonatal Nursing</i> , 16(1), 48-55.	Qualitative	US
Roberts, J.M., Pittman Gonzalez, C.B. & Sampsel, C. (2007). Why do supportive Birth Attendants Become Directive of Maternal Bearing Down Efforts in Second Stage Labor? <i>Journal of Midwifery and Women's Health</i> 52(2) 134- 141.	Qualitative	US
Roberts, J.E, McKay, S., Goodlin, R., Norr, K and Seidel, J (1989) A comparison of supportive versus directive care during the second stage of labor. Grant #1 ROI NR01 50003). <i>National Center for Nursing Research</i> , Bethesda, MD. National Institutes of Health, US DH and Human Services	Qualitative	US

Sampselle, C. & Hines, S. (1999). Spontaneous pushing during birth. Relationship to perineal outcomes. <i>Journal of Nurse – Midwifery</i> , 44(1), 36-39	Retrospective	US
Sampselle, C.M., Miller, J.M., Luecha, Y, K.Rosten, L. (2005) Provider support of spontaneous pushing during the second stage of labour. <i>Journal of Obstetric, Gynaecological and Neonatal Nursing</i> , 34 (6) 695-702.	Qualitative	US
Schaffer J.I., Bloom, S.L., Casey B.M., McIntire, D.D., Nihira, MA, Leveno KJ (2005). A randomized trial of the effects of coached versus uncoached maternal pushing during the second stage of labour on postpartum pelvic floor structure and function. <i>American Journal of Obstetrics and Gynaecology</i> , 192 (5), 1692-1696.	RCT	US
Thomson, A.M. (1993). Pushing Techniques in the second stage of labour. <i>Journal of Advanced Nursing</i> , 12, 171-177.	Quasi experimental	UK
Yeates, D.A. and Roberts, J.E. (1984). A comparison of two bearing down techniques during the second stage of labor. <i>Journal of Nurse- Midwifery</i> , 29(1), 3-11.	RCT	US
Yildirim, G and Beji, N.K. (2008). Effects of pushing techniques in birth on mother and Fetus A randomized study. <i>Birth</i> , 35 (1), 25-30.	RCT	Turkey

## Appendix 2 Participant Information Sheets

### Appendix 2a Midwife Participant Information Sheet



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: C.J.Hamilton@herts.ac.uk

#### **Midwifery Practice during the Second Stage of Labour**

This is an invitation for you to take part in a research study which I am undertaking as part of my doctoral work. This leaflet explains why the research is being done and what it would involve for you. Please read the information and if you wish, discuss it with your colleagues. Ask if there is anything that is not clear or if you would like more information. If you have any questions my contact details are at the end of the leaflet.

#### **What is the purpose of the study?**

The purpose of the study is to explore the practices which midwives undertake while supporting women during the second stage of labour. My aim is that this information can be disseminated amongst midwives so that we can learn from good practice and at the same time improve our care of women in labour. During this study I will be interviewing midwives and postnatal women to find out their views.

#### **Who I am.**

My name is Cathy Hamilton I have been a midwife for over twenty years. I am also a supervisor of midwives and a midwifery lecturer working at the University of Hertfordshire. As a registered midwife I am bound by my professional code of conduct.

#### **Why have you been invited to participate?**

You have been invited to take part in this study because you are a midwife working in West Herts NHS Trust where I will be undertaking this study. I am intending to recruit midwives who have had relatively recent experience (within the past two years) of caring for women when they are in labour.

### **Do you have to take part?**

It is up to you to decide whether you would like to take part. If, after you have had time to read the information sheet, you decide that you do not want to be involved with the study then there is no requirement for you to do so. You do not have to give me a reason for your decision and you will not be approached again.

### **What will taking part involve?**

- .If you agree to be interviewed as part of this study, then I will contact you and we will arrange a time and place for the interview that is convenient to you .This might be in the Maternity Unit, at my work place the University of Hertfordshire or at any other venue convenient to you.
- The interview should take no more than one hour and may take less time than this.
- I would like to tape-record the interview, but if you prefer, I will write notes I instead.
- You may withdraw from any aspect of the study at any time without having to give a reason for your decision.

### **What are the possible benefits of taking part?**

Finding out more about the practices midwives undertake during the second stage of labour may help to benefit midwifery care in the future as it will show how midwives support women to give birth. It is about working collaboratively to promote the very best midwifery practice and about the dissemination of good practice.

### **Are there any risks?**

There are minimal risks to you in taking part in this study. If you agree to be interviewed then I will be asking you to give up your time, which while not a risk, could be considered a disadvantage of taking part.

### **Will my taking part in the study be kept confidential?**

All information collected from you during the course of the study will be confidential. Your name will only be known by me. Information that could identify you will be kept separately from the audio-taped recordings of your interview. The audiotape will be encrypted and anonymized.

The recording and transcript of your interview will be stored securely in a locked office for 7 years after the study has been completed and will then be destroyed. Anything held on a computer will be password protected, so that only I have access to it.

### **What if there is a problem?**

If you are unhappy about how you feel you have been treated during the course of the study or how any part of it has been carried out, then please contact my Principal Supervisor at the University of Hertfordshire, Professor Sally Kendall , telephone number :01707 286380.

### **What will happen to the results of the research study?**

The study will be completed towards the August 2014. Results from the study will be shared with midwives during workshops and conferences to help them to develop their midwifery practice and learn what other midwives are doing to support women giving birth. Quotes from interviews will be used in my final written work, in educational lectures, presentations, conferences and journal or book publications. When these are included I will use pseudonyms to ensure that no one will be able to identify you or the Trust. You will never be referred to by name and the place that the study has been undertaken will not be disclosed. I will send you a summary of the study findings if you would like me to and also a hard copy of any publications arising from the study.

### **Who is organising and funding the research?**

The study is academically sponsored by the University of Hertfordshire and professionally supported by West Herts NHS Trust. I am receiving no external sponsorship from any other organisation. I am being supported in my work by two experienced academic supervisors who have expertise in this particular area of 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 safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Surrey Borders NRES Committee The study is being carried out and supervised as part of my Doctorate in Health Research at the University of Hertfordshire.

**What if I have some questions about the study?**

If you would like to find out more about this study before deciding whether to take part, or if you think you would like to take part you can contact me, Cathy Hamilton on 01707 285298 or e-mail on [c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk) You may have to leave a message on the answering machine but I will get back to you as soon as possible.



Cathy Hamilton

Lead Researcher

[c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk)

Telephone 01707 285298

Thank you for taking the time to read this information. Please do not hesitate to ask for any more information if you need it.

## Appendix 2b Woman Participant Information Sheet



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: [C.J.Hamilton@herts.ac.uk](mailto:C.J.Hamilton@herts.ac.uk)

### ***Research into Midwifery Practices during the Second Stage of Labour***

*The information below tells you about this research and why you are being invited to take part. If anything is not clear, you can contact the researcher on 01707-285298 or 07866-424653 (mobile) or email [c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk)*

### **Information about the research**

*My name is Cathy Hamilton. I am a qualified midwife and midwife teacher currently working at the University of Hertfordshire. I am doing this research as part of a PhD. I am intending to do a study to find out how midwives care for women while they are giving birth, particularly during the second stage of labour which is the time when the baby is pushed out. One part of the study involves me interviewing midwives and doctors the other part involves me interviewing women who have recently given birth on the delivery suite, birth centre or at home. Ethical approval has been given for me to undertake this study in West Herts NHS Trust.*

### **Why have I been invited to take part?**

*You have recently given birth within West Herts NHS Trust either in the Maternity Unit or at home and had a normal vaginal delivery.*

### **Do I have to take part?**

*No. It is entirely up to you to decide and no-one will hold it against you if decide not to. If you decide to take part, you can opt out at any time, without giving a reason. Your care will not be affected in any way whatever you decide.*

**What will happen if I decide to take part?**

*In about two to three weeks' time, I will contact you by phone, email or text. I will ask your permission to interview you.*

*You can decide where and when you wish to be interviewed. I will come to your home if that is the most convenient place for you. If you change your mind – that is fine.*

*I will ask you to sign a consent form before the interview begins.*

*The interview will last about an hour, depending on how much you want to say.*

*I would like to tape-record the interview, but if you prefer, I will write notes instead.*

**Will taking part in the research affect my care?**

*No. I do not work for the hospital and my research will have no effect on your care.*

**Is there any benefit in taking part?**

*The interview gives you a chance to talk to the researcher about your experience of giving birth. This may not benefit you personally, but may help to improve care for other women in the future.*

**I am interested: what should I do?**

*Simply sign the form on the next page and return to me in person, to the midwife who has given it to you or place it in the box on the desk at the midwives station if you are in the Maternity Unit. This is NOT a consent form – it is just giving permission for me as the researcher to contact you.*

**You do not have to make any decisions now** – you may prefer to discuss it with your partner, your family or a midwife first. *If you want to think about it for a few days, you can post the form using the pre-paid envelope.*

**What if I change my mind?**

*You may change your mind at any time – even during the interview itself. I will understand and will destroy any notes or recordings made. This will not affect the care you receive from any health professionals*

**Will I need to give any personal details?**

*The form overleaf only requires your name, contact details and signature. If you agree to be interviewed, I will ask you for further details, but you can choose how much you wish to tell me.*

**Will any information about me be passed on to anyone else?**

*All information given will be treated in strictest confidence. I will only pass details on to another person if I believe that you or a family member is in danger.*

**Will my name be used in the research? Will people be able to identify me?**

*Your name will not appear in any part of the research. I will use a number or pseudonym (false name) to distinguish you from other people taking part in the research.*

**What will happen to the information I give?**

*The recording and write-up of your interview will be stored securely for 7 years in a locked office and then destroyed. The audiotapes will be both encrypted and anonymised. Anything held on a computer will be password protected, so that only I have access to it. At the end of the study, all audio recordings and computer held records will be deleted.*

*When the study is finished, it will be written up and may be published in midwifery journals. Parts of it may appear in other journals or midwifery textbooks in later years. Quotations from people taking part in this study may be used, but no real names will appear. This means it is highly unlikely that anyone who reads about this research will be able to identify you or your family.*

**What if there is a problem?**

*If for any reason you decide to pull out of the study, simply phone or text me on one of the numbers below. You do not have to give a reason and no-one will be annoyed with you.*

*If you are unhappy about the way you were approached or treated during the study, you can contact any of the following people:*

*My research Supervisor is: Professor Sally Kendall*

*Telephone number: 01707- 286380.*

*Patient advice and liaison services PALS: 01923-281600*

*Independent Complaints Advocacy Services (ICAS)!: 0845-4561082*

***How do I contact you?***

*You can phone, text or email me and my contact details are as shown below:*



*Cathy Hamilton*

*Lead Researcher, Second Stage Study*

*[c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk)*

*01707 285298*

## Appendix 2c Obstetrician Participant Information Sheet



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: C.J.Hamilton@herts.ac.uk

### **Midwifery Practice during the Second Stage of Labour**

This is an invitation for you to take part in a research study which I am undertaking as part of my doctoral work. This leaflet explains why the research is being done and what it would involve for you. Please read the information and if you wish, discuss it with your colleagues. Ask if there is anything that is not clear or if you would like more information. If you have any questions my contact details are at the end of the leaflet.

#### **What is the purpose of the study?**

The purpose of the study is to explore the practices which midwives undertake while supporting women during the second stage of labour. My aim is that this information can be disseminated amongst midwives so that we can learn from good practice and at the same time improve our care of women in labour. During this study I will be interviewing midwives, obstetricians and postnatal women to find out their views.

#### **Who I am.**

My name is Cathy Hamilton. I have been a midwife for over twenty years. I am also a supervisor of midwives and a midwifery lecturer working at the University of Hertfordshire. As a registered midwife I am bound by my professional code of conduct.

#### **Why you have been invited to participate.**

You have been invited to take part in this study because you are an obstetrician working in West Herts NHS Trust where I am undertaking this study. Having interviewed some

midwives, I would now like to interview obstetricians to get your viewpoint of how women are supported during the second stage of labour.

### **Do you have to take part?**

It is up to you to decide whether you would like to take part. If, after you have had time to read the information sheet, you decide that you do not want to be involved with the study then there is no requirement for you to do so. You do not have to give me a reason for your decision and you will not be approached again.

### **What will taking part involve?**

- If you agree to be interviewed as part of this study, then I will contact you and we will arrange a time and place for the interview that is convenient to you. This might be in the Maternity Unit or at any other venue convenient to you.
- The interview should take no more than one hour and may take less time than this. I would like to tape-record the interview, but if you prefer, I will write notes I instead.
- You may withdraw from any aspect of the study at any time without having to give a reason for your decision.

### **What are the possible benefits of taking part?**

Finding out more about the practices midwives undertake during the second stage of labour may help to benefit midwifery care in the future as it will show how midwives support women to give birth. It is about working collaboratively to promote the very best midwifery practice and about the dissemination of good practice.

### **Are there any risks?**

There are minimal risks to you in taking part in this study. If you agree to be interviewed then I will be asking you to give up your time, which while not a risk, could be considered a disadvantage of taking part.

### **Will your taking part in the study be kept confidential?**

All information collected from you during the course of the study will be confidential. Your name will only be known by me. Information that could identify you will be kept separately from the audio-taped recordings of your interview. The audiotape will be encrypted and anonymized.

The recording and transcript of your interview will be stored securely in a locked office for 7 years after the study has been completed and will then be destroyed. Anything held on a computer will be password protected, so that only I have access to it.

### **What if there is a problem?**

If you are unhappy about how you feel you have been treated during the course of the study or how any part of it has been carried out, then please contact my Principal Supervisor at the University of Hertfordshire, Professor Sally Kendall , telephone number 01707 286380.

### **What will happen to the results of the research study?**

The study will be completed towards end of May 2015 .Results from the study will be shared with midwives and obstetricians during workshops and conferences to help them to develop their midwifery practice and learn what other midwives are doing to support women giving birth. Quotes from interviews will be used in my final written work, in educational lectures, presentations, conferences and journal or book publications. When these are included I will use pseudonyms to ensure that no one will be able to identify you or the Trust. You will never be referred to by name and the place that the study has been undertaken will not be disclosed. I will send you a summary of the study findings if you would like me to and also a hard copy of any publications arising from the study.

### **Who is organising and funding the research?**

The study is academically sponsored by the University of Hertfordshire and professionally supported by West Herts NHS Trust. I am receiving no external sponsorship from any other organisation. I am being supported in my work by two experienced academic supervisors who have expertise in this particular area of 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 safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Surrey Borders Research Ethics Committee( Reference 13/LO/1597) . The study is being carried out and supervised as part of my Doctorate in Health Research at the University of Hertfordshire.

### **What if I have some questions about the study?**

If you would like to find out more about this study before deciding whether to take part, or if you think you would like to take part you can contact me, Cathy Hamilton on 01707 285298 or e-mail on [c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk) You may have to leave a message on the answering machine but I will get back to you as soon as possible.



Cathy Hamilton

Lead Researcher

[c.j.hamilton@herts.ac.uk](mailto:c.j.hamilton@herts.ac.uk)

Telephone 01707 285298

Thank you for taking the time to read this information. Please do not hesitate to ask for any more information if you need it.

## Expression of interest form

**Important: Please read the participant information sheet before signing below.**

The purpose of this form is to give the researcher permission to contact you.

You are not committing yourself to taking part in the study.

**Your full name**.....

**Date your baby was born** .....

I am happy for the researcher, Cathy Hamilton, to contact me in 2-3 weeks time.

**I prefer to be contacted by: (please tick box)**

Phone (please give your number).....

Text (please give your number).....

Email (please give your email address).....

I confirm that I am over 18 years old and that I have had a normal vaginal delivery. I have read the attached leaflet and understand its content

Signed.....

Date.....

You can return this form to the researcher in person or leave it in the box on the ward reception desk. If you would prefer to post it, an S.A.E is attached.

Appendix 4: Consent Forms  
Appendix 4a: Consent Form for Women

**INTERVIEW CONSENT FORM**

Title of Study: Midwifery Practices during the Second Stage of Labour.

Name of Lead Researcher: Cathy Hamilton

*Please initial in the box to confirm that you agree with the statement.*

1. I confirm that I have read and understood the information sheet dated 11.12.13 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and that my care will not be affected in any way whether I take part or not.
  
3. I agree to be interviewed by the researcher as part of the above study
  
4. I agree for the interview to be audio-taped by the researcher

Name of Participant                      Date                      Signature

Name of person                      Date                      Signature  
taking consent

When completed, 1 copy for the participant; 1 copy for researcher site file;

## Appendix 4b: Consent form for Midwives

### INTERVIEW CONSENT FORM

Title of Study: Midwifery Practices during the Second Stage of Labour.

Name of Lead Researcher: Cathy Hamilton

*Please initial in the box to confirm that you agree with the statement.*

1. I confirm that I have read and understood the information sheet dated 11/12/13 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree to be interviewed by the researcher as part of the above study

4. I agree for the interview to be audio-taped by the researcher

Name of Participant                      Date                      Signature

Name of person                      Date                      Signature  
taking consent

When completed, 1 copy for the participant; 1 copy for researcher site file;

## Appendix 4c: Consent form for Obstetricians

### INTERVIEW CONSENT FORM

Title of Study: Midwifery Practices during the Second Stage of Labour.

Name of Lead Researcher: Cathy Hamilton

*Please initial in the box to confirm that you agree with the statement.*

1. I confirm that I have read and understood the information sheet dated 11.8.14 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree to be interviewed by the researcher as part of the above study

4. I agree for the interview to be audio-taped by the researcher

Name of Participant

Date

Signature

Name of person

Date

Signature

taking consent

When completed, 1 copy for the participant; 1 copy for researcher site file;

## Appendix 5. Interview Schedules

### Women's Interview Schedule



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: C.J.Hamilton@herts.ac.uk

### **What midwifery practices are undertaken during the second stage of labour?**

Suggested questions and topics to be explored at interview with women exploring their experiences during the second stage of labour.

The interview is expected to take approximately 30 to 45 minutes but should last no longer than an hour. Participants will be given a choice of venue to meet the researcher to undertake the interviews. Open ended questions will be used. The following may be used as prompts as required. The participants will be reminded at the beginning of the interview that it will be audio recorded and that they can ask to stop at any time without giving a reason. I will check that they have read the information sheet about the study and have signed the consent form. I will confirm that they are aware that the interview will be recorded and that they are still happy for this. If they prefer I will take hand written notes instead but tape recording the interview is my preference. I will ask if they have any further questions before we begin. I will then switch on the audio recorder.

*Thank you for agreeing to take part in this study. Just to remind you that I am interested in finding out women's experiences during the second stage of labour (when you were pushing the baby out) particularly in relation to how your midwife supported you and the things she did. I am going to start by asking you a few background questions:*

- *How many children have you had previously?*
- *Could I confirm that you had a normal vaginal birth this time?*

- *Where did you give birth?*
- *Were you familiar with the midwife caring for you during labour?*
- *How many midwives cared for you during your labour? Had you met any of them previously? What type of pain relief if any, did you have? ( E.g. epidural, water, pethidine, Entonox)*
- *Did you attend antenatal classes? If so did you discuss issues around the second stage of labour during these classes? What information were you given?*
- *Tell me about your recent experience of giving birth.*

*Specific questions might include:*

- *How did you know you were in the second stage of labour?*
- *What physical sensations did you experience if any?*
- *What guidance if any did your midwife give you during the second stage of labour?*
- *Did she suggest you get into any particular position?*
- *What approach did your midwife take?( e.g. was she very proactive or was she in the background and you hardly noticed her give examples if you can)*
- *Do you remember the type of language she used?*

- *Do you remember if your birth partner gave you any particular support/ guidance?*
- *Tell me about any expectations you had of what your midwife might do or say during the second stage of labour?*
- *Tell me what you remember about the different stages of labour ?*
- *What information did your midwife give you during labour?*
- *What position were you in as your baby was born?*
- *Is there anything else you would like to tell me about your experience of giving birth?*

*I will then inform participants that I am switching off the voice recorder.*

## Midwives' Interview Schedule



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: C.J.Hamilton@herts.ac.uk

### **What are midwives practices during the second stage of labour?**

#### **Suggested questions and topics to be explored at interview.**

The interview is expected to take approximately 30 to 45 minutes but should last no longer than an hour. It will take place in a venue selected by the participant which might be her own home, place of work or the researcher's place of work. Open ended questions will be used. The following checklist may be used as a prompt to assist the researcher in asking the most relevant questions. This is an indicative rather than a definitive list and questions will be broadly based around the following themes:

- Midwives philosophy of care.
- Midwives knowledge base in relation to the second stage
- Factors which might influence her practice during the second stage.
- Changes in midwifery practice over time

The participants will be reminded at the beginning of the interview that it will be audio recorded and that they can ask to stop at any time without giving a reason. I will confirm again before starting the interview that they have read the information sheet about the study and have signed the consent form. I will also ask if they have any further questions before we begin. Then I will switch on the audio recorder.

*Thank you again for agreeing to take part in this study. Just to remind you about the aims of my study: I am particularly interested in finding out what midwives do (in other words the actual practices they undertake) when they are caring for women during the second stage of labour.*

### **Midwives philosophy of care**

*To begin, tell me about a recent labour you have been involved in? Was it a typical 'routine' labour or would you say there was anything unusual about it? Could you give any other examples to show how you care for women during the second stage? What do you think about a 'hands on' or 'hands off' approach to the second stage of labour?*

### **Midwives knowledge base**

*How do you usually get information about midwifery practice? For example, tell me about something you have read recently or have you attended a study session or discussed any issues with your colleagues? What do you know or what have you read about the second stage of labour? Could you give examples?*

### **Factors influencing practice**

*Tell me about the kind of things which might influence how you care for women during the second stage? Could you give some examples maybe from a recent experience to show me what you mean?*

*What do you think a woman expects a midwife to do during the second stage of labour?*

*Why do you think this?*

### **Changes in practice.**

*What do you remember about your training in relation to the second stage?*

*Have there been changes in your practice over the years? If so could you give me examples to show me what you mean?*

*Is there anything else you would like to add about your practice during the second stage of labour?*

### **Final checklist for demographic information:**

*Could I just finish my checking a few of your details?*

*When did you undertake your midwifery training?*

*How long have you practiced as a midwife?*

*What areas have you worked in during that time?*

*Thank you for taking part and giving up your time to help with this study. If you wish I will send you a summary of the study's main findings when they are available.*

## Obstetrician's Interview Schedule



School of Health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
HERTS  
AL10 9AB  
Tel: 01707 285298  
E-mail: C.J.Hamilton@herts.ac.uk

### **What practices are undertaken during the second stage of labour?**

#### **Suggested questions and topics to be explored at interview with obstetricians**

The interview is expected to take approximately 30 to 45 minutes but will last no longer than an hour. Participants will be given a choice of venue to meet the researcher to undertake the interviews. Open ended questions will be used. The following may be used as prompts as required. The participants will be reminded at the beginning of the interview that it will be tape recorded and that they can ask to stop at any time without giving a reason. I will check that they have read the information sheet about the study and have signed the consent form. I will confirm that they are aware that the interview will be audiotaped and that they are still happy for this. If they prefer I will take hand written notes instead but tape recording the interview is my preference. I will ask if they have any further questions before we begin. I will then switch on the audio recorder.

*Thank you for agreeing to take part in this study. Just to remind you that I am interested in midwifery practices undertaken during the second stage and would welcome your views around what you have observed while working with midwives.*

*Could I ask a few background questions before we begin?*

*How long have you worked for the Trust and what is your role?*

*Have you undertaken any normal deliveries? If so, what has been your experience of this?*

*What is your usual role when caring for women during the second stage of labour?*

*What are your views about care of women and the management of the second stage?*

*Why do midwives usually call you to review a woman during the second stage?*

*How do you work collaboratively with the midwives during the second stage?*

*What do you know about the recent evidence base around the second stage of labour ( for example of hands on or hands poised , directed versus non-directed pushing)?*

*What practices have you observed midwives undertaking while supporting a woman during the second stage?*

*What are your views about these?*

*Is there anything else that you would like to tell me about the management or care of women during the second stage and practices associated with it?*

The audio recorder will now be switched off.

*Thank you for taking part and giving up your time to help with this study. If you wish I will send you a summary of the study's main findings when they are available.*

## Appendix 6 Ethical approval confirmation letters

REC approval

Letter of Approval from NHS Trust

Letter of approval from NHS Trust to extend data collection period and include obstetricians

Any wording which identifies NHS Trusts or NHS personnel have been removed.

**NRES Committee London - Surrey Borders**

HRA  
Research Ethics Committee (REC) London Centre  
Ground Floor  
Skipton House  
80 London Road  
London  
SE1 6LH  
Tel: 02079722580

17 February 2014

Mrs Catherine J Hamilton  
Principal Lecturer ( Midwifery)  
University of Hertfordshire  
Room 2F254, Wright Building,  
College Lane  
Hatfield, Hertfordshire  
AL10 9AB

Dear Mrs Hamilton

**Study title:** An exploration of the practices undertaken by midwives while supporting women during a normal, uncomplicated second stage of labour.  
**REC reference:** 13/LO/1597  
**Protocol number:** HSK/SF/NHS/00008  
**Amendment number:** Amendment 1 26.1.2014  
**Amendment date:** 27 January 2014  
**IRAS project ID:** 139993

The above amendment was reviewed by the Sub-Committee in correspondence.

**Ethical opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form: Client's consent for interview	1	11 December 2013
Participant Information Sheet: Midwives PIS	5 (clean and tracked changes)	11 December 2013

Protocol	4 (clean and tracked changes)	11 December 2013
Interview Schedules/Topic Guides	1	11 December 2013
Participant Information Sheet: Clients PIS	3	11 December 2013
Client's Expression of Interest	1	11 December 2013
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1 26.1.2014	27 January 2014

#### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

#### R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

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/>

13/LO/1597:	Please quote this number on all correspondence
-------------	--

Yours sincerely



**Canon Christopher Vallins**  
Chair

E-mail: [NRESCommittee.London-SurreyBorders@nhs.net](mailto:NRESCommittee.London-SurreyBorders@nhs.net)

Enclosures: *List of names and professions of members who took part in the review*

Copy to: 

**NRES Committee London - Surrey Borders**

**Attendance at Sub-Committee of the REC meeting on 12 February 2014**

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>
Canon Christopher Vallins	Regional Chaplaincy Adviser	Lay Plus
Dr Mark Weeks	Senior Research Associate	Expert

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Amy Spruce	REC Assistant



Research & Development Department



Catherine Hamilton  
University of Hertfordshire  
School of health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
AL10 9AB

Dear Catherine Hamilton

**RE Study Titled: (An exploration of the practices undertaken by midwives while supporting women during a normal, uncomplicated second stage of labour)**

Project Reference Number	RD2013-52
NRES Reference Number	126065
Research Ethics Committee Approval Letter date	22-Jan-2014
Sponsor	University of Hertfordshire
Protocol Reference	Research Protocol version 4
Trust	[Redacted] S Trust
Approved Research Site	[Redacted] NHS Trust

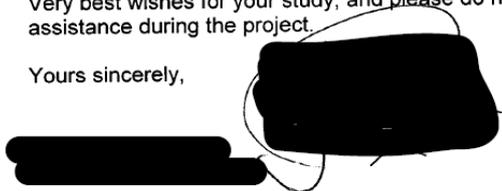
This letter is issued on behalf of the above named NHS Trust, and I am pleased to confirm that the above study (defined by those documents listed overleaf) now has permission to proceed at the above site(s). Please note that this permission only relates to the above named Trust. If your research involves other organisations then you are recommended to contact them to find out if you require their permission.

May we remind you that the Principal Investigator is locally responsible for ensuring that:

- the research is conducted in accordance with the Department for Health Research Governance Framework,
- the research complies with the law, all internal Trust policies and processes and any relevant good practice guidance, including ICH GCP and reporting of Serious Adverse Events / SUSARS
- appropriate indemnity arrangements are in place,
- NHS Permission is sought for all project amendments,
- the research is managed in a way that internal or external monitoring can be carried out with reasonable notice.

Very best wishes for your study, and please do not hesitate to contact the R&D office for any assistance during the project.

Yours sincerely,



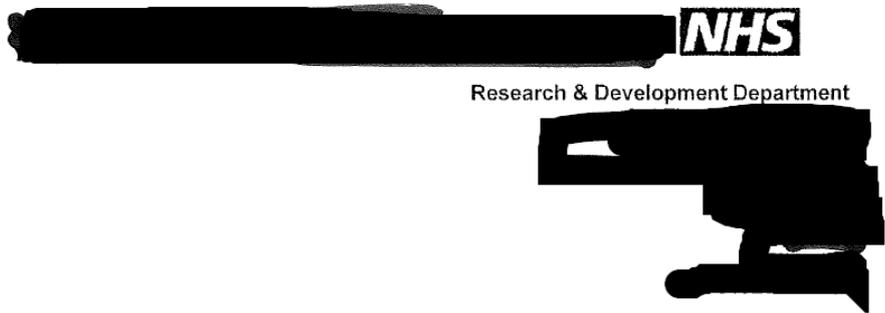
Date... 28. APR. 2014

**Approved documents (dates/versions):**

<b>Document</b>	<b>Version</b>	<b>Date</b>
Research Protocol	version 4	11/12/13
Midwives PIS	Version 6	17 January 2014
Client's IS	Version 4	17 January 2014
Consent form for Women	Version 2	17 January 2014
Consent form for Interview	Version 01	08 January 2013
Consent form Observation	Version	08 January 2013
Expression of interest form	Version 1	11-12-13
Women's Consent form for Interview	Version 1	11-12-13
Women's Interview Schedule	Version 1	11-12-13

Carbon Copy: (CI) Catherine Hamilton

Letter of approval from NHS Trust to extend data collection period and include obstetricians



Catherine Hamilton  
University of Hertfordshire  
School of health and Social Work  
University of Hertfordshire  
College Lane  
Hatfield  
AL10 9AB

Dear Catherine Hamilton

**REVISION OF STUDY DOCUMENTATION**

<b>R&amp;D Ref:</b>	RD2013-52
<b>Full Title:</b>	An exploration of the practices undertaken by midwives while supporting women during a normal, uncomplicated second stage of labour
<b>Short Title:</b>	Midwifery Practices during the Second Stage of labour
<b>Date of original R&amp;D Approval to commence study:</b>	28/04/2014

The following document(s), revised since approval to commence the study, have been approved by [redacted] department, for use in the above study:

Document	Version	Date
Ethics Approval Letter		15 <sup>th</sup> September 2014
Notice of Substantial Amendment (non-CTIMP)	2	11 <sup>th</sup> August 2014
Participant Information Sheet (Doctors)	1	11 <sup>th</sup> August 2014
Protocol	5	11 <sup>th</sup> August 2014

Signed: [redacted] .....

Name: [redacted] Position: R&D Assistant Date: 22/09/2014

Appendix 7: Outline biography of participants by pseudonym  
 Appendix 7a Women

**Elizabeth**

Age Group	30-35
Ethnicity	British Caucasian
Occupation	Environmental Consultant
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	37
Onset of labour	Induction
Type of Birth	Forceps
Place of Birth	Delivery suite
Analgesia	Epidural
Type of pushing in 2 <sup>nd</sup> Stage	Directed

**Notes**

Had attended NCT classes, practiced yoga and hypnobirthing techniques and was well informed about the benefits of physiological birth. However Group B step was found in a urine sample towards the end of pregnancy and there was some doubt about the position of the placenta and concern that it might be low- lying. Waters broke at 37 weeks and she was admitted to delivery suite rather than birth centre. Did try to challenge the doctors but labour was induced via Syntocinon ™ infusion had antibiotics too. Was very sick during labour. Eventually had epidural. Preferred night shift to day shift. Doctors and midwives listened to her. Had urge to push before epidural took effect but did not tell anyone. Fetal heart decelerations so had fetal blood sampling. Baby was fine but after 30 mins of pushing felt exhausted and doctor recommended forceps. Felt this was done in the best interests of the baby and felt included in decisions. On the whole a positive experience at the end although not what she had planned for. A relaxed interview as Elizabeth was very interested in midwifery and was keen to find out more about how she might go about applying.

## Emily

Age Group	30-35
Ethnicity	British Caucasian
Occupation	PH D student
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	40
Onset of labour	spontaneous
Type of Birth	Normal vaginal birth in water
Place of Birth	Birth Centre
Analgesia	Pethidine, Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Physiological
<b>Notes:</b> Had attended NCT but no high expectations about a normal birth. Admitted to birth centre, later requested an epidural but delivery suite was too busy so had pethidine instead. Water birth; midwives told her to listen to her body. She was hardly aware of them. Very positive and empowering birth experience.	

## Caron

Age Group	30-35
Ethnicity	British Caucasian
Occupation	Primary School Teacher
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	40
Onset of labour	Spontaneous
Type of Birth	Normal vaginal birth
Place of Birth	Delivery suite

Analgesia	Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Directed
<p>Notes</p> <p>Admitted to birth centre. Had good rapport with her midwife who was 'tough' but Caron appreciated this? Midwife was very hands on and told her what to do which again Caron liked. Her husband felt part of the team. Transferred up to delivery suite for Syntocinon <sup>TM</sup> in second stage. Pushed up in wheelchair which was very uncomfortable. Her midwife stayed with her, throughout her transfer to delivery suite. Midwife was very directive, described the Valsalva manoeuvre and told Caron how she was feeling. Caron trusted her midwife above her own embodied feelings. Normal delivery on delivery suite eventually. A very positive experience, Caron felt empowered throughout. Her husband was present for the interview and it seemed as though they had both enjoyed the experience as there was a real sense of teamwork between them. Caron liked the coaching approach to pushing and her midwife had taken on a kind of cheer leading role.</p>	

### Lucy

Age Group	30-35
Ethnicity	British Caucasian
Occupation	Clinical Psychologist
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	42
Onset of labour	Induction
Type of Birth	Normal vaginal birth
Place of Birth	Delivery suite
Analgesia	Epidural
Type of pushing in 2 <sup>nd</sup> Stage	Directed
Notes	

Lucy had been to NCT and practiced hypnobirthing techniques. Had originally wanted a home birth and was surprised by other women's responses to this which were negative. Felt that during labour her midwife was not listening to her. On delivery suite for induction as labour was almost two weeks overdue. Told to put on hospital gown and that she would need an epidural. She did have one in the end. Doctor facilitated the delivery which was normal eventually. Told to push but told she was not doing it correctly. One supportive midwife who came back to reassure her. Overall a very negative experience which left Lucy traumatised. Hoped that undertaking the research would help other women. Seemed to find interview cathartic and a chance to ask further questions relating to the birth experience.

### Glenda

Age Group	30-35
Ethnicity	British Caucasian
Occupation	IT Manager
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	41
Onset of labour	Spontaneous
Type of Birth	Normal vaginal birth
Place of Birth	Home
Analgesia	Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Physiological

#### Notes

Went to Maternity Unit as thought she was in labour but examined and sent home to await events. On way home in the car contractions increased and eventually gave birth in the hall way of her own home. Two fairly inexperienced paramedics in attendance. No midwife. Pushed as and when she wished. Husband put hypnobirthing CDs on in

the background. Very empowering experience, glad it had happened that way. A relaxed interview. Glenda showed me photos from the birth.

### Anita

Age Group	35-40
Ethnicity	British Caucasian
Occupation	Employment Law Manager
Marital status	Married
Parity	Multigravida, one previous birth
Gestation ( weeks)	38
Onset of labour	Spontaneous
Type of Birth	Normal Vaginal Birth
Place of Birth	Birth Centre
Analgesia	Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Physiological ( but told to stop pushing)

#### Notes

Main theme here was the speed of the birth which took Anita by surprise. Sustained a third degree tear but had not found this too problematic at all. Midwife told her not to push as they were getting the trolley ready but Anita was unable to comply. Frequent comparisons between this birth and her previous one. Both were very different but overall positive.

### Hilary

Age Group	35-40
Ethnicity	British Caucasian
Occupation	Learning and Development Manager
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	40
Onset of labour	Spontaneous
Type of Birth	Failed Ventouse then Forceps
Place of Birth	Delivery suite

Analgesia	Spinal
Type of pushing in 2 <sup>nd</sup> Stage	Directed
<p><b>Notes</b> Admitted to delivery suite initially as had bleeding and was Group B positive. Had antibiotics and then went down to birth centre. Used water and hypnobirthing techniques. No strong urge to push but told when to do so by the midwife who was very forceful in her direction. Pushing for 4 hours on birth centre before transferring up to delivery suite. Hilary felt she should have gone up sooner but no one listened to her. Eventually had a forceps delivery under spinal anaesthesia. Felt traumatised by the pushing phase, very painful with little progress. Baby was lying against her back. Wished she had been transferred earlier as she had felt stuck but no one listened. Midwife wanted a normal birth and was determined to achieve that.</p>	

### Harriet

Age Group	30-35
Ethnicity	British Caucasian
Occupation	Musician
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	39
Onset of labour	Spontaneous
Type of Birth	Ventouse
Place of Birth	Delivery suite
Analgesia	Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Directed
<p><b>Notes</b> .Had not attended NCT due to working hours so attended hospital classes instead. Had practiced natal hypnotherapy however and found this very effective in helping her stay calm but the midwife was very over bearing and shouted at her to push. . Did not have good rapport with the midwife who kept disturbing her and wanted her to be aware of the time. Husband tried to support her but midwife was sharp with him too. Had wanted an epidural but midwife wanted her to try for</p>	

natural birth. Transferred to delivery suite in second stage because had been pushing for a long time. Found the pushing very long and traumatic although had felt no real pushing urge and was only pushing because the midwife told her to. Would have pushed differently if left to her own devices. Had an episiotomy for Ventouse delivery and baby was distressed at birth and unable to settle, Harriet felt much of her difficulty was related to her traumatic birth experience. A negative experience overall although initial stage of labour with a supportive midwife had been positive. Conflict was described in the birth room. Harriet seemed to find the interview cathartic. Her husband was present and helped her remember parts of the birth experience.

**Lorraine**

Age Group	30-35
Ethnicity	Columbian Caucasian
Occupation	Manager in Leisure Industry
Marital status	Married
Parity	Nulliparous
Gestation ( weeks)	42
Onset of labour	Spontaneous
Type of Birth	Vento use
Place of Birth	Delivery suite
Analgesia	Epidural
Type of pushing in 2 <sup>nd</sup> Stage	Directed

**Notes.** Lorraine had had a traumatic experience of birth She spoke about having too many people in the room and she could not understand what was going on. English was not her first language and she wondered if this might have been a contributory factor. She had an excellent relationship with her midwife though and felt that she was on her side throughout, There was a sense that it was Lorraine and her midwife against the world. The medical team had wanted her to go for a caesarean but her midwife supported her in waiting for a while. Lorraine had a venous eventually. She felt communication between her and the medical team was poor. She pushed with legs in lithotomy, very directive but felt her midwife was excellent. Lorraine felt highly traumatised by the experience itself but also seemed to find the interview cathartic.

She became tearful and emotional throughout but at no time asked to stop the interview. She recommended to her friend that I interview her too which suggests that she did value the experience. Lorraine's sister and baby was present throughout and there were many interruptions but Lorraine clearly had a story that she wanted to tell me. A very medicalised experience of birth although I could not see that Lorraine had been particularly high risk initially.

### Rosie

Age Group	30-35
Ethnicity	British Caucasian
Occupation	Counsellor
Marital status	Married
Parity	Multigravida, one previous birth
Gestation ( weeks)	40
Onset of labour	Spontaneous
Type of Birth	Normal Vaginal Birth
Place of Birth	Birth Centre
Analgesia	Entonox
Type of pushing in 2 <sup>nd</sup> Stage	Physiological but told not to push.

**Notes:** As with Anita, the other multigravida, the speed of the birth was the main theme here. Rosie felt she had lost control completely and had found the pain overwhelming. Felt the midwife was good but patronising in telling her that was doing 'well' when clearly, she wasn't at all (her perception). A different experience to first time round which had been under epidural and her friend who was also an anaesthetist had been there to assist her. Was also told not to push which she had found impossible. Midwife did not tell her what to do but asked her what she wanted to do which Rosie found frustrating but understood why this was the midwives stance. Had had her waters broken by the midwife the reason for this was unclear but contractions came very quickly after this. Second stage of labour was recorded as being only 12 minutes long.

## Appendix 7b Midwives

### Josie

Time since qualification	2 years 6 months
Area of Work	Birth Centre
Direct Entry	Yes
Trained outside Trust	Yes
<b>Notes.</b> Josie had come to work from another Trust and had completed her preceptorship in the Trust. She was primarily based in Birth Centre although had rotated throughout the area. She felt that she would only direct pushing in case of need such as time getting on or fetal distress. She was not very aware of the latest research but knew that it was recommended that women should push spontaneously. She felt she learnt a lot from her colleagues.	

### Mandy

Time since qualification	1 year 6 months
Area of Work	Birth Centre and Delivery Suite
Direct Entry	Yes
Trained outside Trust	No
<b>Notes:</b> Mandy had excellent knowledge of research around pushing. Worked in birth centre and delivery suite and felt that there was a tendency to intervene on delivery suite. Tried to encourage physiological pushing in both areas, Heard midwives shouting at women to push on a regular basis.	

### Bonnie

Time since qualification	1 year 6 months
Area of Work	Birth Centre
Direct Entry	Yes
Trained outside Trust	No

**Notes:** worked in the birth centre but said she was a 'hands-on' midwife who favoured directed pushing. Was not very aware of the research.

### Nadia

Time since qualification	10 years
Area of Work	Birth Centre and Delivery Suite
Direct Entry	Yes
Trained outside Trust	No
<p><b>Notes.</b> Was an experienced birth centre midwife but still used directed pushing. Felt that this was the case for most midwives and she was used to hearing midwives directing pushing. Not very aware of current research. Felt she was gaining in confidence but noted that others might be keen to hurry things along. Had recently tried to encourage women to look down and see their babies deliver.</p>	

### Penny

Time since qualification	16 years
Area of Work	Delivery Suite and Community
Direct Entry	No
Trained outside Trust	No
<p><b>Notes.</b> Spoke about the contrast between home birth and birth on delivery suite. Mentioned that care was different in community because midwives were guests. Was aware of research as had studied the topic when a student and research was first emerging that women should not be told when to push. Interesting as Penny moved between delivery suite and community and did not seem to find this challenging although acknowledged that they were completely different and separate spheres. Had trained as a nurse initially.</p>	

### Julie

Time since qualification	4 years
Area of Work	Delivery Suite

Direct Entry	Yes
Trained outside Trust	No
<p><b>Notes.</b> Hands on and directed pushing even with low risk women in delivery suite. Was aware of the research around directing research but was unable to verbalise why this was the case. Felt it was just the norm and expected practice on delivery suite which all the midwives did. Most women on delivery suite resorted to epidurals and this caused complications and they were unable to feel urge to push so felt that this was a factor.</p>	

**Fiona**

Time since qualification	9 years
Area of Work	Community
Direct Entry	Yes
Trained outside Trust	No
<p><b>Notes:</b> Community midwife who favoured a woman centred approach to care and had a slight knowledge of the evidence base. Preferred no time limits for labour but recognised that she was bound by hospital guidelines and policies to practice in particular way. Mentioned her own birthing experience when she was told to follow her body and was left unsure what to do. Mentioned high transfer rate from home to hospital for nulliparous women.</p>	

**Marjorie**

Time since qualification	40 years
Area of Work	Community
Direct Entry	No
Trained outside Trust	Yes
<p><b>Notes.</b> Had trained in a time when the Valsalva was widespread. Now realised that woman led pushing was preferable but still had set ideas around how to guide women with their pushing. Spoke about her own experience in labour which made her realise that directed pushing was not the way forwards. Valued the students for bringing their</p>	

knowledge of research. Interviewed at home but interview finished early when her friend arrived.

**Gloria**

Time since qualification	31 years
Area of Work	Community
Direct Entry	No
Trained outside Trust	Yes

**Notes.** Had been very directive and had trained that way in the 1980s but practice had changed based on how women responded. Was not concerned about time just the woman's progress in labour. Felt the pressure of other midwives to 'get on with it'. Felt that midwives directed pushing because they wanted to be seen to be doing something. Was aware that directed pushing with legs in stirrups was still going on particularly on delivery suite but some midwives were directive even on birth centre. Had basic awareness of research and had been on a study day around promoting normality. Felt all women could be left to reply instinctive pushing urges and was only midwife who did not make a distinction between primigravida and multigravida women. Was concerned about women pushing before the cervix was fully dilated though and would tell a woman not to push in those circumstances.

**Jenny**

Time since qualification	29 years
Area of Work	Community
Direct Entry	No
Trained outside Trust	No

**Notes.** Was hazy on research but said she favoured a woman led approach although felt primigravida needed more support and she would usually direct pushing for them. Described much directed approach to second stage in the earlier days of her career. Was unsure that hypnobirthing was effective and did not like to raise women's hopes. Recognised that there were two camps of midwives who were either very directive or more woman centred. Interviewed in antenatal clinic with frequent interruptions and interview had to be cut short as she was due to go off on her visits.

## Appendix 7c Obstetricians

### Stella

Grade	Locum Consultant
Time at the Trust	Few months
<b>Notes:</b> Stella was a very experienced locum Consultant who had moved around to a number of NHS Trusts in her career. She had also worked for a while in Bangladesh. She would be working at the Trust for two years. She preferred an older more experienced midwife to support the woman during pushing. Fetal positioning and gravity were important. Valued team working during second stage but suggested only one person should take the lead. An opportunistic interview undertaken while I was waiting for another Consultant to arrive. Stella was extremely interested in the study and volunteered enthusiastically to participate.	

### Madeleine

Grade	Consultant
Time at the Trust	12 years
<b>Notes.</b> Madeleine had worked at the Trust for a long time and was a very experienced Consultant. Loved to facilitate normal birth but did not often go to birth centre. Had seen Midwives directing pushing on delivery suite. Felt that time limits of second stage were acceptable. Primigravida and multigravida women had to be treated differently because they were different physiologically. . Recognised that sometimes doctors are called to support the midwife in achieving a normal delivery. We discussed a case we had been involved in when a midwife had been very quick to intervene in the second stage. Madeleine pointed out that in that case she had been less interventionist than the midwife. However did not feel there was a huge different in roles between midwives and obstetricians as they were both accoucheurs. Quite a short interview. I had to wait for about an hour as Madeleine had been called away as I arrived. Stella was still in the room and listened to the interview. Madeleine did not want to go to a more private area.	

## Thomas

Grade	Consultant
Time at the Trust	14 years
<p><b>Notes.</b> Felt that care should be individualised and that some women needed to be directed. Did not agree with arbitrary time limits for second stage but suggested that too much time with the fetal head pushing on the pelvic floor could lead to bladder problems. Did not always agree with NICE guidelines. Felt that hands off approach to second stage was wrong and had led to an increase in serious perineal tearing. Suggested that doctors did not have the luxury of guiding up a rapport with women, if called they had to get on with the job and move on. Time was important to them in that sense. Midwives had usually one client and could focus on her so passage of time was less important. Asked his Registrar to take part and went to find him after the interview had ended.</p>	

## Lionel

Grade	Registrar ( rotational)
Time at the Trust	1 year but had undertaken two year rotations previously
<p><b>Notes:</b> Saw second stage as a huge psychological challenge for the women he came into contact with. When medical intervention was needed, women were in a difficult place as was often not in accordance with their plans. Support and encouragement was paramount. Understood as that leaving women to follow their instincts gives them autonomy and can be empowering but suggested that some women mainly primigravida would need further guidance. He suggested that normal deliveries had been achieved by encouraging women to push. He discussed the time frames and having to get women delivered within these. He had noticed that more junior midwives were not so encouraging ( his words for directing pushing was my own perception of this) but that senior midwives were still directive and he put this down to the research findings recommending instinctive pushing which newly qualified midwives were trying to follow.</p>	

## Appendix 8: Publications and conference presentations

- Hamilton, C. (2012). *Using an Ethnographic Approach to explore midwives practices during the second stage of labour*. Oral Presentation. East and North Hertfordshire NHS Trust Research conference. University of Hertfordshire, Hatfield, October 2012.
- Hamilton, C. (2013). *What are midwifery practices during the second stage of labour?* Oral presentation. Student Colloquium Conference. Trinity College, Dublin. November 2013.
- Hamilton, C. (2014). *Negotiating NHS Ethics: A personal journey*. Oral presentation. Evening seminar. DHRes programme, University of Hertfordshire, November 2013
- Hamilton, C. (2014). *What are midwifery practices during the second stage of labour?* Poster presentation. RCM conference, Telford. November 2014.
- Hamilton, C. (2016). Using the Valsalva technique during the second stage of labour. *British Journal of Midwifery* 24, (2), 90-94.
- Hamilton, C. (2016). *Midwifery practices during the second stage of labour*. Oral Presentation. Department of Allied Health Professionals and Midwifery Research Conference, University of Hertfordshire, Hatfield, April 2016.
- Hamilton, C. (2016). *Midwifery practices during the second stage of labour*. Oral Presentation. Postgraduate Research Conference, University of Hertfordshire, Hatfield, July 2016.
- Hamilton, C. (2016). *Initial findings from the second stage study*. Poster presentation. RCM conference, Telford. October 2016.