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EVIDENCE  
BASED  
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# EVIDENCE BASED MIDWIFERY

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## Observations from the field of PhD research

*Key words:* Observation, clinical research, midwifery, doctoral studies, PhD, evidence-based midwifery

Many of you reading this editorial will be familiar with the statement: “*I want to do a PhD.*” You may have personal experience of being in this position or you may have been listening to a colleague considering this journey. To date, I have had the privilege of facilitating 11 women to safely walk in and out of the field of research and obtain a PhD in midwifery research. The journeys have taken us along many different paths, but I believe all of them have shared the same revelatory experience in which the moment of understanding of what it is all about occurred, and it was only then that they were able to say “*Now... I see!*”. The journey to this point in a researcher’s life can be very challenging as the student needs to be able to transcend the familiarity of everyday practice in order to see the world through the lens of a researcher. This takes exposure in the field of research, time, persistence, confidence and supportive feedback. Coming to know and understand the lived experience of doing doctoral level research is ‘very challenging’, and this is particularly pertinent in clinical midwifery where the field of research is the midwives’ daily practice. I deliberately chose the words ‘field of research’, because I think this helps separate ourselves from the familiar sight of clinical practice and explore an imaginary landscape to ‘see’ and ‘feel’ the field of clinical practice through the eyes of a novice researcher.

Imagine yourself standing in an ordinary green field. Your aim is to experience the phenomenon of being in the field. Your working objectives are to describe what you see, hear, feel and think. Your tools are yourself, a pen and notepad. At first you may see nothing, but an expanse of grass and probably some weeds and stones, but as you focus your attention on achieving your goal you begin to see more and more. You may find yourself scanning the parameters of the field and quickly noting landmarks. You might even recognise familiar church spires or faraway landmarks. After some time when you begin to focus less on the need to find data, but allow your senses to take over, you begin to see small animals, butterflies, wasps and flies. You begin to hear the familiar and the unfamiliar, like the sounds of the crickets, birds, cows, dogs, aeroplanes, trains. Your skin begins to monitor the warmth of the sun or the frost of the morning and you try to protect yourself. As you begin to familiarise yourself with your new surroundings, you remember your primary aim and start writing furiously to try and record the event.

Questions begin to tug at your mind and heart. What do I write? How can I find the right words to describe what I see and feel? How do I organise my thoughts, what do I write about first and what is the order? How do I make sense of what I have written? Can anyone else see and hear what I have heard? When do I stop writing? These are the familiar questions that bring challenge and excitement to researchers and can only be answered from being in the field and living through the experience. Research text-books and supervisors will help, but the personal journey of learning and knowing cannot take place without self-exposure, supportive feedback and self-determination. This is real experiential learning and the process requires personal commitment, trust and old-fashioned ‘learning by doing’.

In my previous editorial (Sinclair, 2009), I made reference to my own doctoral research in which I spent hundreds of hours in labour wards observing women, machines and midwives. The observation was focused on understanding the role of high-technology in the labour ward. The focus was broad and the field was immense in terms of structure, organisation and practice (like walking into the earlier imaginary green field and seeing everything, but not knowing what was important). However, as time passed, my observation skills became more acutely tuned and I developed a systematised approach to data collection. It was only after many hours of literally observing everything that ‘was’ or ‘happened’ in the labour room – from replacing entonox cylinders to watching domestic attendants cleaning the room that distractions became less obvious and my senses were activated so that the real research focus became clear. Only then was it possible to frame the observation in a manner that made the data selection more meaningful and manageable. The half-hourly observation pattern underpinning routine management of labour became the natural categorical record for writing about the actions, interactions and decisions in a more structured framework. This structure had always been there, but I had not recognised the obvious and the “*Now... I see!*” experience occurred only after ‘being’ in the research field for a long time. Every researcher needs time to become familiar with people, routines, procedures and patterns so that they can gain the confidence to look critically at the field with eyes that are trained to pierce the clouds of muddle and focus on what is important. Field research training is valuable regardless of whether or not the design is exploratory, descriptive or experimental. Every clinical researcher needs to develop skill in critically examining the field of practice with the lens of a practitioner, a professional and a researcher. The benefit of doing so can enable the researcher to ask more relevant and meaningful questions that are clinically and academically relevant to professional practice.

So, if a PhD is in your thoughts or on your horizon take the time now to consider your area of practice. Start by physically observing the phenomenon of interest and immersing yourself in the field of experience before designing the research route or unpacking the vast literary treasure of academia. Try to put on the lens of a researcher and stand with your pen and paper and begin to write down what you see, hear, feel and believe before you collect vast files of published papers. Taking time in the field to observe is never wasted, it is an investment for the future as it will enable you to make more informed decisions about the research design, method and analysis.

### Reference

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# Down's syndrome screening in Northern Ireland: women's reasons for accepting or declining serum testing

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## Abstract

**Background.** The use of maternal serum screening to assess individual risk for Down's syndrome is now standard in many countries. The increased uptake of screening and diagnostic tests has provoked concerns about their potential impact on individuals and societal attitudes. Under the current law in Northern Ireland, women are not given the option to terminate their pregnancy if they have a positive diagnostic test, unless it is in the interests of the mother's mental or physical wellbeing. There is limited evidence regarding the extent to which women's decisions are influenced by the cultural and societal context in which screening is offered.

**Objective.** To compare women's reasons for having or declining Down's syndrome serum screening in two hospitals with different screening policies in Northern Ireland.

**Methods.** A prospective cohort study of pregnant women (n=317) offered screening for Down's syndrome in hospital and community settings were interviewed twice using semi-structured interviews. Data collection was from 1 September 2003 to 5 May 2004.

**Results.** The majority of women declined screening irrespective of hospital screening policy as they felt it would not make any difference to pregnancy outcome. Women who declined also voiced concerns about the emotional impact of testing and about the characteristics of the test on offer. Women chose to have screening because of their family history or age, because they wanted to find out more information and for reassurance. The influence of health professionals was reported by women who chose to have screening and also by those who declined.

**Conclusion.** The reasons given for declining screening were emotional rather than knowledge based, which may reflect deep-rooted cultural and religious values. Professional awareness of the impact of societal and cultural attitudes on women's decisions about antenatal screening tests is important when introducing screening policy.

**Key words:** Down's syndrome, pregnancy, midwifery, serum screening, survey, evidence-based midwifery

## Introduction

Antenatal screening is an important aspect of maternity care, which enables parents and health professionals to make choices and decisions regarding the management of pregnancy. Down's syndrome screening has been offered to women in the UK since the early 1980s (Cuckle et al, 1984), but the offer of screening has varied geographically. The most recent guidelines from the National Institute for Health and Clinical Excellence (NICE, 2008) recommends that all women should be offered screening for Down's syndrome, either the combined test or the triple test depending on the gestation at which women book for care. Universal screening has been recommended in the UK since 2003 (NICE, 2003).

However, uptake of screening is variable, the National Screen-

ing Committee (NSC) in 2006 reported an overall uptake of 67% in the UK (NSC, 2006). Redshaw et al (2007) conducted a national survey of women's experience of maternity care in the UK and found that 62% of women had screening for Down's syndrome, with 37% having serum screening only. Shantha et al (2009) reported an overall uptake of 28% across three hospitals in the UK, with individual hospital uptake ranging from 20% to 33%. A downward trend has been suspected in the uptake of screening and a recent UK study that evaluated the uptake of serum screening over a 14-year period in one hospital confirmed a decrease of approximately 2% per year (Gidiri et al, 2007). However, further work is necessary to consolidate these findings across all areas of the UK.

The uptake of antenatal screening for Down's syndrome is

usually high where it is considered part of routine care (van den Berg et al, 2005). Other countries with universal screening policies, such as the US, France and the Netherlands have also identified variation in the uptake of Down's syndrome. A similar uptake to the UK is reported in France (Khoshnood et al, 2004), while in the Netherlands it varies from 38% to 86% (van den Berg et al, 2005; Muller et al, 2006), although these studies were carried out prior to the introduction of universal screening. Knight et al (2005) reported an uptake of 61% in a study involving 11,159 women in the US. In Northern Ireland, uptake is difficult to assess accurately as the information is not routinely collected leading to limited availability of published data. A survey of screening services across Northern Ireland by Lynn and Alderdice (2006) indicated that only one unit was able to report a known uptake, which was estimated to be around 14%.

Variation in uptake has been attributed to social and/or ethnic differences between women, however, the evidence is not conclusive. Some evidence indicates that women from Asian backgrounds have a lower offer and uptake rate (Rowe et al, 2008) and those from disadvantaged backgrounds (Dormandy et al, 2005). Conversely, Rowe et al, (2008) and Michie (1999) reported that offer and uptake for the most disadvantaged groups of women were not decreased.

Women's reasons for having or declining screening tests for Down's syndrome have been reported consistently across studies nationally and internationally. A systematic review of 106 studies (Green et al, 2004) reported a range of reasons as to why women choose to accept or decline antenatal screening. Preparations for the future, finding out more information about their baby, reassurance and the recommendation of a health professional were all cited as reasons to accept screening. Factors reported to influence women who declined screening were anxiety, not wanting to know, test characteristics and individual perception of low-risk status. Additional factors reported by women included religious beliefs and opposition to termination of pregnancy (Press and Browner, 1997; 1998; Sandall et al, 2001; Markens et al, 1999), although the majority of these findings were from studies conducted prior to the introduction of universal screening policy. Other research suggests that women may decline screening based on how society views disability (Bryant et al, 2006) and Gottfredsdottir et al (2009: 4) concludes that the decision to decline is based on a '*complex interplay between personal views, values and social context*'.

The precise relationship between screening policy and the influence on women's decisions has not been extensively researched, however, there is a rising concern that with increasing routinisation of antenatal screening tests, women may not realise tests are optional and remain unaware of the potential consequences of test result knowledge (Suter, 2002). Skirton and Barr (2009) reported similar concerns regarding the lack of clarity reported from both parents and professionals about the purpose and potential of screening tests. Previous research by Santalahti et al (1998) found that in a group of women who had accepted screening, almost half (48%) felt participation was considered to be routine and there was also a lack of recognition that serum screening was different from other routine tests.

This paper has been structured to give a broad overview of screening policy, screening uptake and a summary of re-

ported reasons from women about their decisions to accept or decline serum screening tests. Databases searched included OVID (1966-present), MEDLINE (1966-present), PubMed (1950-present), CINAHL (1982-present), MIDIRS, and the Cochrane Database of Systematic Reviews. The computer-based search was supplemented by a manual search of the references listed. The key words used for the search strategy were 'antenatal and/or prenatal screening', 'Down's syndrome screening', 'Down's syndrome screening uptake' and 'screening policy'. The search resulted in a large volume of literature, which has been detailed in McNeill (2008).

The aims of this study were to describe women's reasons for having or not having screening and to explore whether different screening policies influenced women's decision-making. Data were collected as part of a larger study exploring social inequalities in the offer and uptake of antenatal screening in two hospitals in Northern Ireland (Alderdice et al, 2008).

## Method

A prospective cohort study using survey methodology was carried out in two maternity hospitals in Northern Ireland, which involved women being interviewed face-to-face on two occasions in their pregnancy. The first interview took place when women attended for their booking appointment and the second occurred after all screening, including anomaly ultrasound had been performed. The data collection tool was refined as a result of consultation with researchers who had previous experience in this field (J Sandall, personal communication) and pilot work. The final version was approved by the study team, comprised individuals from various disciplines including midwifery, obstetrics and psychology. Ethical approval was sought and granted from the regional research ethics committee, Northern Ireland (application number 378/02) prior to the start of the study.

## Setting

In hospital one, the policy was to offer all women serum screening for Down's syndrome when offering other routine screening tests between ten and 14 weeks' gestation. In hospital two, only women aged over 35 or those who had a family history of Down's syndrome were offered serum screening for Down's syndrome at the time of the study. Despite these differences in offer policy, the reported uptake of serum screening following offering of tests for Down's syndrome was similar in both hospitals. In hospital one, 83% (n=285) of women reported being offered Down's syndrome screening, of whom 26% (n=74) chose to have screening. In hospital two, 10% (n=32) of women reported being offered screening of whom 28% (n=9) took up the offer.

## Sample

Women were recruited consecutively when they attended the hospital or community antenatal clinic for their booking appointment or dating scan at each of the hospitals from September 2003 until May 2004. Participants were given the option of withdrawing from the study at any stage. A total of 834 women were invited to participate in the larger study, of whom 711 women consented to participate and 45 dropped out, leaving 666 women. The reasons why 45 women dropped out are

reported in full detail in Alderdice et al (2008). Of the women who participated in the main study, 317 reported being offered screening for Down's syndrome. These women form the sample for the study reported here.

#### Data collection

All women attending an antenatal clinic in the chosen sites for their first appointment were approached by a research midwife, given a leaflet about the study and asked if they would like to participate. Women who gave consent to take part were then interviewed by the research midwife face-to-face. Complete data collection processes for the main study can be found in Alderdice et al (2008). The semi-structured interviews were conducted and completed by one of three members of the project team (JM, PG, FC). Women were interviewed initially at 12 and 16 weeks and secondly between 23 and 26 weeks' gestation. The interviews lasted approximately 15 to 20 minutes and were conducted in a private area of the antenatal clinic. Women's responses to open-ended questions were transcribed verbatim at the time of interview by the interviewers.

#### Analysis

The reasons women gave for choosing to have or declining Down's syndrome screening were transcribed into MS Word and coded by topic. Question analysis was conducted where all the responses pertaining to individual questions were read and then analysed by content (Morse and Field, 1996). Members of the project team (FA, DM, RR, and JM) conducted coding independently and then met to reach consensus on emerging categories. Consensus of the resultant categories was agreed by all members of the project team. Direct quotations from women are provided, which are representative of each category. Proportions of women giving responses relating to each theme are presented and key sociodemographic variables, such as education and maternal age are attached to quotations. Pseudonyms have been used throughout.

#### Results

The sociodemographic characteristics of the total sample of women interviewed (n=666) have been published previously (Alderdice et al, 2008). The sociodemographic characteristics of the sample referred in this paper are similar to the overall sample. The age range of women who accepted screening was from 18 to 41 plus years. Overall, the women in hospital one (universal screening policy) who were over 35 and those who had degree-level qualifications were significantly more likely to accept screening. There was also a strong association with level of deprivation: women from more affluent areas were more likely to accept screening. More multiparous women in both hospitals accepted screening compared with primiparous women (hospital one, 58% versus 42%; hospital two, 67% versus 33%); however, the numbers were small in hospital two and this was not statistically significant. Religious denomination was not a significant indicator for screening uptake.

Figure 1 illustrates women's reasons for declining or choosing to have screening. The results section has been divided primarily into women who declined screening and women who chose to have screening, followed by further subdivision by hospital.

#### Women who declined screening

Women from both hospitals (hospital one: 74%, n=211; hospital two: 72%, n=23) who were offered screening for Down's syndrome but declined were asked about their reasons for declining. All women who reported an offer of screening but declined (n=234) responded to this question. The predominant themes emerging from women's comments were similar in both hospitals despite different screening policies. Reasons reported included concerns about the test, they felt it would not make any difference to pregnancy outcome, concerns about the emotional impact of the test, influence of health professionals and perception of individual risk. A small number of women in hospital one also reported their beliefs as a reason to decline screening.

#### Common themes in hospitals one and two

##### Concerns about the test

This was the most common reason why women declined screening in both hospitals (67%). Concerns were related to the type of test on offer, that the test could only indicate the woman's 'risk' of having an affected baby and perceived fear of miscarriage. Some women (33%) also commented that the nature of the test – a non-diagnostic test with a potential false-positive result influenced their decision not to undertake screening. Fiona, a 23 year old in her first pregnancy said:

*"One of the midwives recommended that it was not necessary because it only gave risks and there was no definite result. The test was explained clearly, but I didn't know what would happen if the result was high risk. I wouldn't have an amniocentesis because of the risk of miscarriage but if I had a baby with Down's or spina bifida I would have done something about it. The test only gave me a likelihood."*

A small number of women in hospital one (10%) reported confusion about the type of screening test they had been offered. These women thought they had been offered an amniocentesis instead of a serum-screening test and subsequently declined due to the risk of miscarriage with amniocentesis. There was no confusion reported by women in hospital two between serum testing and amniocentesis, although the overall number of women offered the test in hospital two was small. Frances, a 27 year old educated to degree level in her first pregnancy from hospital one said:

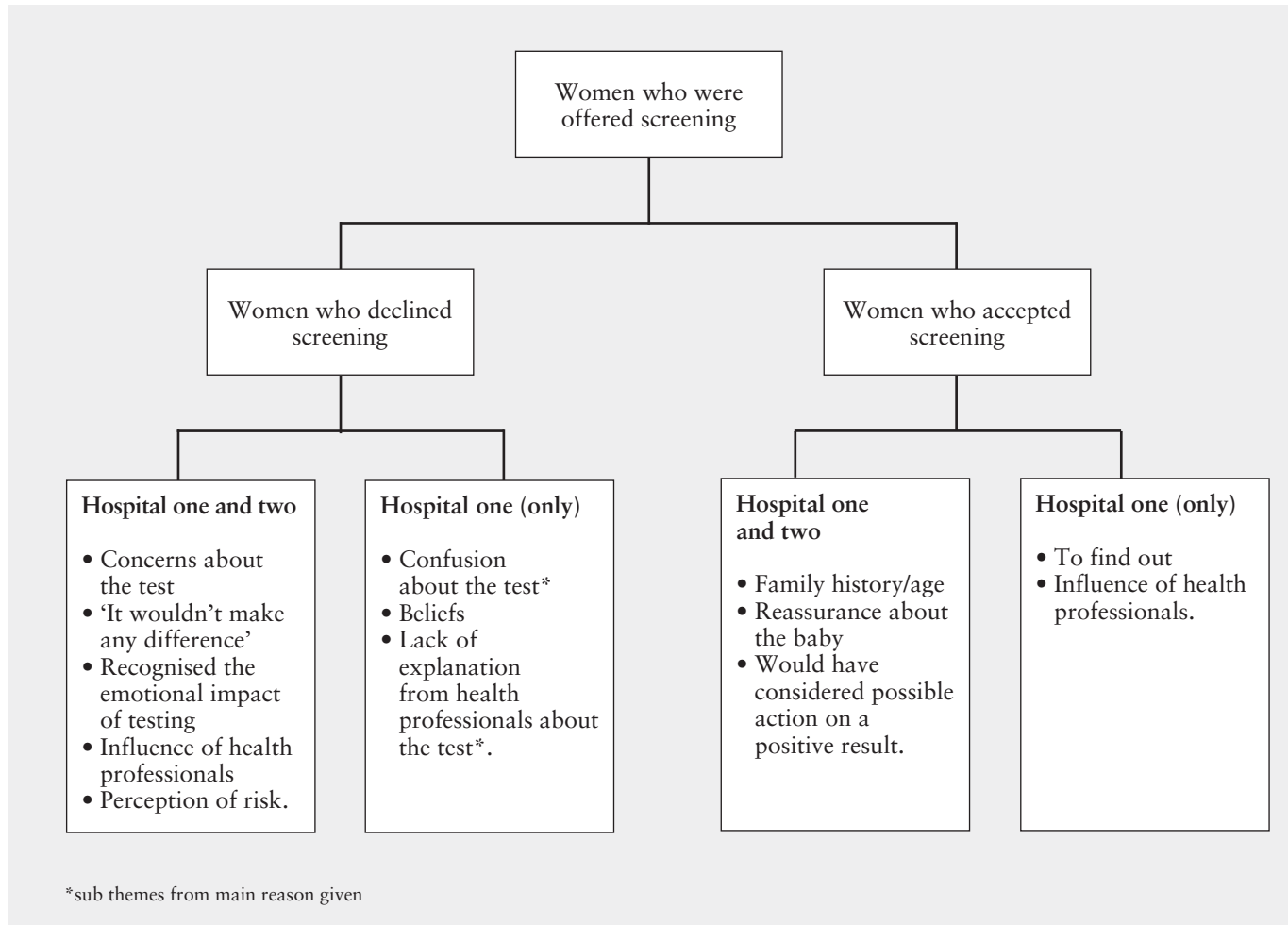
*"I didn't realise there was a single blood test for risks. I thought it was an amniocentesis. The risk of miscarriage would have worried me. I wouldn't want to know because I wouldn't do anything about it. I would maybe have accepted the triple test if I had realised it was a blood test."*

##### 'It wouldn't make any difference'

This was a common reason given by almost half of the women (48%) in the total sample. Women who said 'it wouldn't make any difference' fell into two categories: those who said they would accept the baby regardless of any abnormality and women who said they would not act on a high-risk serum result or a potential positive amniocentesis result. Mary, a 43 year old in her second pregnancy:

*"[I] was happy to accept the baby regardless of any problems [and] therefore I didn't feel screening was necessary."*

Figure 1. Women's reasons for their screening decisions



### Emotional impact of the test

Recognition of the emotional impact of accepting screening was reported by 30% of women across both hospitals. A number of women said they felt that accepting screening would increase their anxiety levels during pregnancy and that they did not want to know if there was any abnormality in pregnancy. Katie, a 25 year old with two children said:

*"I thought it better not to know. Maybe I should think about it more, but I don't really want to.... it's tempting fate. I think pregnancy is stressful enough without that."*

Women reported they felt reassured by their structural scan and if there was an abnormality present, it would be identified when they had their scan. Maria, a 35 year old educated to degree level said:

*"I felt reassured by my scans and therefore was not overly worried about having the Down's syndrome/spina bifida blood test."*

### The influence of health professionals

A number of women in both hospitals reported the impact of the discussion with health professionals about screening as a reason to decline (26%). This was generally in two ways: either by directly influencing women in their decision-making or by not giving enough information about the screening tests on offer.

Some women reported that health professionals had directed them away from testing (29%) by saying 'well you wouldn't really want it anyway' and that discussion about the tests available were vague. Amanda, a 28 year old educated to degree level in her first pregnancy felt:

*"The doctor seemed to suggest that the blood test [for Down's syndrome screening] had no real benefit and that put me off going for it. The doctor in [hospital one] only talked about it because we asked, I felt patronised. If it [the result] had come back high risk, I'm not sure I would liked to have known either way."*

Several women also suggested that the level of information was not sufficient from health professionals about the test on offer. In hospital one, where there was a universal offer of screening, a definite lack of explanation from health professionals about the triple test on offer was identified. In some cases women initiated discussion about screening themselves. The comment below is from Karen, a 37 year old woman who had two previous pregnancies and was educated to GCSE level:

*"Although I brought up Down's syndrome and spina bifida screening with the consultant [obstetrician], there was no big discussion given regarding these genetic tests. He simply said 'go away for a few days and think about it', if I felt I wanted these tests to let him know. In the end I decided myself not to have*

*these tests as I wouldn't act on any result positive for Down's syndrome. If women wouldn't act on a positive result, information should still be given about the tests."*

### Perception of risk

A small number of women in both hospitals perceived their individual risk as low and subsequently declined serum screening (16%). Women's perception of individual risk was related to having no family history of abnormality, their own age and eligibility for low-risk care. The majority of women in the study were defined as low-risk in terms of organisation of care and therefore eligible for shared care between their GP and midwife or midwife only. Some women felt being defined as 'low risk' in terms of organisation of care carried over into risk status in relation to screening. Kathy, a 31 year old with one previous child said:

*"I didn't want to know the result and I felt I wasn't in a high-risk group. I have no family history and one previous successful pregnancy."*

### Hospital one: themes for women who declined screening Beliefs

Beliefs, either moral or religious, were reported by a small number of women (7%) as a reason why they did not accept screening for Down's syndrome. Brenda, a 27 year old with two children said:

*"I suppose I would be affected by the way I was brought up and what I believe. I didn't have it done with the other two and they were fine. My religion would also prevent me from having them and wouldn't have done anything about it"*

### Women who chose to have screening

Women who chose to have some form of screening for Down's syndrome (n=83) were asked why they had made this decision. Despite the different policies in the two hospitals, the uptake in both hospitals was similar (hospital one: 26%, n=74; hospital two: 28%, n=9). Women's reasons for having screening showed similarities and differences between the two hospitals. Overlapping themes were age/family history, reassurance and women who would have considered acting on a positive test result. Two themes emerged specifically from hospital one (universal policy offer), which indicated that women who had accepted screening did so because they wanted to prepare for the future and were influenced by health professionals.

### Themes common to hospital one and hospital two

#### Family history/age

A proportion of women in both hospitals (31%) accepted screening mainly due to their increased risk associated with age or family history. Women perceived they were in a higher-risk group and therefore should avail of serum screening on offer. More women in hospital two accepted screening for this reason compared to hospital one. These results are not surprising particularly in hospital two given the high-risk screening policy at that time and the small number of women who chose to have screening.

Gillian (39) who was educated to A-level standard with one daughter said:

*"[My] age, and I have a three year old. My husband and I, we are older parents and I would like to know and plan for the future. It would have affected my decision regarding the outcome of the pregnancy.... I probably would have terminated depending [on the result]."*

### Reassurance

A number of women (20%) indicated they had accepted Down's syndrome screening tests for the purpose of reassurance. Women included in this category felt the test gave them 'a peace of mind' and in several cases acknowledged they were a low-risk group with no family history, but still wanted to have screening. Eva, a 29 year old with a degree-level education was having her first baby and said:

*"[There is] no family history, just to allay fears. If you have a choice, you want to check the baby is normal."*

### Women who considered acting on a positive screen test result

A small number of women who accepted screening in both hospitals indicated they had accepted a serum-screening test, with a view to termination of pregnancy if the results were positive.

Joanne a 35 year old in her first pregnancy educated to A-level standard:

*"In the initial stages of my pregnancy, this baby was unwanted. I wanted to make sure my risk factor for Down's [syndrome] was low and also to eliminate any other concerns about the baby. If the result was high risk, I would have had an amniocentesis and would have terminated [the pregnancy] if the result of the amniocentesis was positive for Down's syndrome."*

### Themes specific to hospital one

#### To find out

In hospital one, 34% of women suggested they had accepted screening because they had concerns about the future, a desire to 'prepare for the future' or 'to find out or know what was ahead'. Within this group there were three subgroups of women: those who felt they might consider termination of pregnancy, women who wanted to know so that they could consider all of their options during pregnancy and women who wanted to know, but definitely were not going to act on the results. Deidre, a 17 year old in her first pregnancy who had just undertaken her GCSEs felt:

*"I wanted to know if anything was wrong so that I could make choices. It's good to have an option on whether to do something about the pregnancy and it also prepares you."*

### Influence of health professionals

The influence of health professionals was evident in the responses of a small number of women who accepted the offer of screening in hospital one only. Health professionals were influential either directly or more covertly in that a test offer was perceived by women as a recommendation to take the test. Catherine, a 23 year old with one previous child and A-level education said:

*"...because the midwife recommended it and I wanted to know."*

For the majority of women the health professional concerned was a midwife, although women who had private antenatal care also mentioned the influence of their consultant obstetrician.



Many women felt that if the tests were offered to them by health professionals, it was in a routine context and they therefore accepted them. The majority of women stated that it was part of their care, that they 'just had it' and did not question exactly why they were having tests.

Some women reported more detailed explanations from specialist health professionals such as midwives, obstetric consultants or genetic consultants who work exclusively in this area. Lynn, a 37 year old who had three children and was educated to A-level standard said:

"[A] genetic doctor took our family history at the antenatal diagnosis clinic and explained in great detail about the blood tests."

### Discussion

The two main reasons why women declined screening in this study were because of concerns they had about the test and that knowing the tests results would not make any difference to the outcome of their pregnancy. These reasons have been cited previously in the literature (Green et al, 2004) as to why women decline serum screening.

Women who accepted screening gave reasons such as family history, age and the possibility of taking further action depending on the test result. The reasons reported by women who accepted or declined screening were similar in both hospitals despite different policies. However, the study included only a small number of women in hospital two who were offered screening. In addition, the interview included questions about why women decided on screening rather than how the decision was made. Although this study did not examine the decision-making process specifically of women in relation to serum screening for Down's syndrome, the reasons given by women for their choices give some insight into the process. It was interesting to note the similar uptake rate in both hospitals, despite the offer to a higher-risk group of women in hospital two.

This is one of the few studies to investigate the universal offer of screening in a country where termination of pregnancy is available in very limited circumstances and, until recently in Northern Ireland, there were no published guidelines available to assist professionals when discussing this issue with women (Department of Health, Social Services and Public Safety, 2009). Termination of pregnancy and provision of antenatal screening tests raise ethical dilemmas for parents and significant personal or professional conflict for practitioners (Garel et al, 2002). As a result, difficulties may emerge when implementing a universal screening policy in a country where termination of pregnancy is not legal. It remains to be seen how the new guidance will affect or influence professionals when counselling women about screening. Many countries have adopted universal serum screening policies; however, the individual benefit for women is debatable if the cultural context in which screening is offered is not taken into account.

### Women's decision-making

Attitude to termination of pregnancy has been cited previously as an indicator of how women will decide about testing (van den Berg et al, 2008) and a positive attitude to termination is more likely to predict uptake of screening (Green et al, 2004). Although women were not specifically asked about

their view on termination of pregnancy, it was rarely reported as a factor in their decision. These findings may reflect superficial consideration by women of information about the test and also wider implications of accepting or declining screening tests. However, there is also the possibility that religious and moral beliefs are so deeply embedded in Northern Irish society that they do not surface as explicit reasons for decisions about testing.

Etchegary et al (2008) proposed that experiential knowledge of women plays an important role in decision-making about antenatal screening. Their study indicated that although women had technical knowledge about the tests, it was interpreted by women in relation to their experiential knowledge – that is previous experience of pregnancy and screening, experiences of friends and relatives. Similar themes were identified for women who accepted a screening test in this study, demonstrating consistency with this theory (Etchegary et al, 2008). These results highlight the importance of an individualised approach for women as they are counselled, advocated by van den Berg et al (2008) and Boyd et al (2008), resulting in a greater consideration of the values and social context of pregnant women during counselling.

### Communication about screening

The offer of screening tests for Down's syndrome took place in both hospitals at booking or the first hospital visit. Women need to be informed at the first visit about various aspects of their care and pregnancy, but there may be little opportunity for the assessment of individual needs within a busy clinic of scheduled appointments. Women's responses indicated that many were not clear what test, that is serum screening or amniocentesis, was being offered or about the associated results. Evidence from previous research suggests women's understanding of screening tests is questionable (Pilnick et al, 2004; Smith et al, 1994). Seror and Ville (2009) have indicated that women are often unaware of the full implications of screening – this resonated with findings from Santalahti et al (1998).

The uptake of serum screening for Down's syndrome was significantly lower in this study than has been reported in other countries, despite the test being offered in a routine way alongside tests for HIV and syphilis. Press and Browner (1997) specifically noted that the test was often incorporated into the routine offer of other screening tests and that portrayal of the test as routine did not connect it with termination of pregnancy. The low uptake of serum screening in this study may suggest some insight by women about the test they were offered or more likely that the test was offered from a negative perspective by professionals reluctant to enter into discussion, as suggested by additional research (McNeill and Alderdice, 2008; McNeill, 2008).

McNeill and Alderdice (2008) and McNeill (2008) reported that midwives felt conflict between the time they had to explain serum screening and the actual time necessary to discuss the test fully. Subsequently, the test was offered in a routine way, which did not highlight the full implications of accepting screening possibly directing women to decline screening. Midwives also reported the lack of discussion around termination of pregnancy and observed that it rarely entered into the discussion with

women when offering serum-screening tests. Despite this, some women mentioned that they would actively seek termination of pregnancy. The Office of National Statistics (ONS, 2009) reported approximately 17% (n=1173) of non-resident abortions were to women from Northern Ireland who had travelled to England and Wales for a termination.

#### *Role of health professionals*

The influence of the health professional was the only theme that featured in the responses of both women who declined and accepted screening. Existing research has suggested that the personal attitude or opinions of the health professional can affect the decision-making process of women (Bernhardt et al, 1998; Bishop et al, 2004; Lewis et al, 2006). Poor knowledge has also been demonstrated by health professionals (obstetricians and midwives) who were involved in offering screening tests to women (Smith et al, 1994; Skirton and Barr, 2009). This has the potential to impact on women's knowledge and capacity to make an informed choice. Other factors such as the time available to discuss the test and the organisation of care may also affect the discussion with women. Many comments from women indicated that directional counselling by health professionals had influenced their decision-making, which is supported by other research (Marteau et al, 1992; Levy, 1999; Simpson et al, 1998). It has also been suggested in the literature (Press and Browner, 1993; Pilnick et al, 2004; Smith et al, 1994) that the decision to have screening is not always a premeditated conscious decision by women, therefore increasing women's susceptibility to influence.

Genetic counselling aims to be value neutral and non-directive; however, there is debate about the reality of this in practice. A recent study in Hungary (Tóth et al, 2008) demonstrated that approximately 68% of patients undergoing genetic counselling wanted the decision-making process to be shared by their counsellor. If decision-making is to be shared between parents and professionals, it is vital that health professionals are appropriately trained and prepared for this role. Existing evidence indicates training is not a priority for professionals working in

this area (Sandall and Grellier, 2001; Harcombe and Fairgrieve, 2004; Cleary-Goodman et al, 2006). Lynn and Alderdice (2006) conducted a regional survey across Northern Ireland and found that training needs of antenatal staff were met predominately on an ad hoc basis indicating a clear need for more comprehensive training. This highlights the importance of appropriate and relevant training for staff as new tests, screening programme and counselling approaches are introduced.

#### **Conclusion**

This study adds evidence to the existing literature on women's reasons for their decisions about screening for Down's syndrome and considers their reasons in the context of different screening policies and against a societal background where termination of pregnancy is not available. Women's reasons for having or declining screening differed little from previous studies and did not seem to vary with different screening policies, however, it is difficult to draw firm conclusions from the data given the small number of women who accepted screening in hospital two. These findings are important in the absence of regional screening policy and where NICE guidelines are implemented on a good practice basis only (NICE, 2008).

The aim for future practice should be individualised counselling with consideration given to women's values from health professionals who are supported by clear policies and guidelines on antenatal screening and termination of pregnancy. Further research focusing on educational interventions for midwives in relation to discussing screening tests with women and also investigation into the most effective mode of delivering screening information to women are essential in order to ensure informed choice for women and their partners.

The study highlights the need to take into consideration the constraints of the current law and the general context of care. Introducing universal antenatal screening in a context where termination of pregnancy is not available is fraught with difficulty for women and health professionals. In this study this was reflected in low uptake, confusion about the test and lack of discussion with women about the implications of antenatal screening.

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# Applying critical medical anthropology to midwifery research

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## Abstract

*Aim.* To illuminate the way in which the theoretical underpinnings of another discipline, that is critical medical anthropology, may be applied to midwifery research.

*Method.* The theoretical perspectives underpinning the discipline of critical medical anthropology are discussed. An associated methodology – critical ethnography – is described and how it has been applied to research in maternal and infant health by referring to the author's research on 'breastfeeding as labour', which constitutes an extension of earlier 'labouring body' research. The metaphors 'supply' and 'demand', used by both health practitioners and breastfeeding women, with regard to breastfeeding are explored from a sociopolitical and economic perspective. The embodied, emotional and social nature of breastfeeding and the ways in which women negotiate their experience are then linked to provide a macro-micro perspective.

*Findings and conclusion.* The linkage between a macro and micro perspective is highly relevant to midwifery research and practice to ensure that both the wider political agendas and individual perspectives are addressed.

*Key words:* Critical medical anthropology, political economy, ethnography, breastfeeding, evidence-based midwifery

## Critical medical anthropology

Critical medical anthropology originated in the early 1980s as a critique of traditional medical anthropology, which itself was a subfield of social and cultural anthropology. It added a perspective to medical anthropology that focused upon differential distributions of power, wealth and status and how they shape social processes and healthcare practices, seeking to be transformative by merging theory with social action (Baer, 1997).

Critical medical anthropology as a discipline is informed by a range of theoretical perspectives, which may broadly be referred to as critical inquiry (Crotty, 1998). One branch of critical inquiry – the political economy of health perspective – is particularly embraced within critical medical anthropology. The political economy of health perspective focuses upon relationships between capitalism, health and illness and associated medical practice. These relationships have been described in various ways by leading authors in this field (Gough, 1979; Frankenburg, 1980; Doyal and Pennell, 1981; Navarro, 1992; Illich, 1995).

The seminal work of Doyal and Pennell (1981) highlights the overwhelming contradictions between the goals of health promotion and the imperatives of capitalism. Doyal and Pennell (1981) also highlight the ways in which medical practices and associated technologies have developed within societies that embrace capitalism. This includes a focus upon power relationships stemming from, and contributing towards, the development of multinational corporations. Health and healthcare practices therefore, need to be understood in relation to the activities of powerful groups within society and power relationships that stem from them. The medical equipment, pharmaceutical and food industries are among the most powerful.

Thus the political economy of health perspective, when set alongside a biomedical perspective, creates a shift in thinking towards issues related to unequal access to health care, the social organisation of health care and socioeconomic divisions. It allows us to explore the social, political and economic roots of

ill health within society and the need for socioeconomic reform. This perspective enables us to consider the ways in which, despite growing knowledge of health indicators, we have not alleviated the overwhelming levels of poverty and associated morbidity and mortality occurring across the world and in particular in developing nations. The United Nations (UN) millennium development goals report (UN, 2009: 3) powerfully illustrates this: 'Today, we face a global economic crisis whose full repercussions have yet to be felt. At the very least, it will throw us off course in a number of key areas, particularly in the developing countries. At worst, it could prevent us from keeping our promises, plunging millions more into poverty and posing a risk of social and political unrest.'

Doyal and Pennell (1981) argue that many forms of medicine may be potentially or actually harmful, a point reiterated by Illich (1995) in his examination of the iatrogenic nature of Western technomedicine. Doyal and Pennell (1981) therefore challenge the continuing demands within society for more medicine as misguided in that more of the same will not tackle the social, political and economic roots of ill health within society. They also challenge the direction being taken by the public health movement in that focusing too heavily upon the individual as responsible for her/his health maintenance and placing the person centre-stage for blame, should they become ill, shifts the focus away from the need for socioeconomic reform. Thus, despite rhetoric about equal access to health care through national services, the social organisation of medicine still tends to reinforce socioeconomic, sexual and racial divisions.

Although the analysis of Doyal and Pennell (1981) took place over two decades ago, it remains alarmingly pertinent and relevant today. As Levin and Browner (2005: 749) argue: 'Social inequalities continue to produce stark inequalities in health and health care for wide ranging groups and populations'. Thus political economy of health supports us in making sense of political issues related to health and healthcare practices.

Central to critical medical anthropology is recognition of power structures, ideology and hegemony (Gramsci, 1971; Kapferer, 1988; Baer et al, 2004; Bellamy, 1995). Hegemony as a concept was a major political contribution developed by Gramsci (1971). Gramsci emphasised the rise of groups or classes above others in society and the transmission of economic power through ideology and culture. Ideology refers to a shared set of fundamental beliefs about the world that justify 'what is' (Thomas, 1993: 8) and these ideas serve as 'weapons for social interests' (Berger and Luckmann, 1966: 18).

Critical medical anthropology has, as its starting point, a 'macro perspective' (societal level focus), which it balances with a 'micro perspective' that focuses upon local situations. It relates the: 'Traditional anthropological close-up view of local populations and their lifeways, systems of meaning, motivations for action, points of view, and daily experiences and emotions [micro-perspective], to the encompassing holism of the political economy of health approach [macro-perspective]' (Singer, 1990: 297).

The micro focus could relate to a specific community, group of people or organisation, such as a hospital. The culture of this group or organisation may then be studied in detail using a critical ethnographic methodology. Increasingly, critical medical anthropologists extend the micro perspective to probe further into the lived and embodied experiences of individuals within that situation or context (Frankenberg, 1980; Csordas, 1988, 1994; Singer, 1990; Lyon and Barbalet, 1994). Kapferer (1988) highlights that it is within the body that life is experienced and organised and the body cannot be considered to be simply an expressive vehicle of a world, inscribed by culture with mind being separated from body, and mental from material. There has been a shift in focus from seeing the body as simply representational to understanding experiences stemming from the body and the associated lived experiences of being in the world (Kapferer, 1988; Csordas, 1994; Lyon and Barbalet, 1994). Thus, critical medical anthropologists tend to see a person's body as active in its own construction (Lyon and Barbalet, 1994) viewing people as active agents, while acknowledging that there are many socio-cultural constraints upon them. In this way, a balance is achieved between recognition of structural constraints upon people and their health and individual agency.

While the main theoretical perspectives underpinning critical medical anthropology come from within critical inquiry, other perspectives may be incorporated with caution, for example, cultural constructivism, poststructuralism and postmodernism (Baer et al, 2004).

### Critical ethnography

Critical ethnography is a methodology that is closely aligned to the theoretical perspective of critical inquiry and to critical medical anthropology as a discipline. Ethnography involves eliciting cultural knowledge, which may be explicit or tacit with the latter referring to hidden (taken for granted) forms of knowledge (Polanyi, 1967; Spradley, 1980). As Spradley (1980: 6) argues, what we see represents 'only the thin surface of a deep lake [and] beneath the surface, hidden from view, lies a vast reservoir of cultural knowledge'.

Critical ethnography is a specific approach to ethnography that is underpinned by notions of ideology, power and control

and these are seen as central to the research process, analysis and theoretical conceptualisations. As Thomas (1993) argues, the ethnographer actively seeks out and opens up to scrutiny power relationships and assumptions that lead to oppression, inhibition, repression and constraint upon individuals and communities. This approach demands of its proponents a call to action ranging from challenging existing assumptions to political activism. Critical ethnographers are concerned with emancipation: 'The process of separation from constraining modes of thinking or acting that limit perception of the action toward realizing alternative possibilities' (Thomas, 1993: 4). Their goal is also to negate repression and social domination of specific groups.

Critical ethnography involves immersing oneself in the community or setting to be studied using the methods of participant observation and interviewing (Thomas, 1993; Hammersley and Atkinson, 1995). Critical reflection is central to this methodology and, as Freire (1972: 41) states, 'reflection – true reflection – leads to action'. Critical reflexivity involves a rejection of the bracketed ethnography and acknowledgement that the researcher is inevitably influenced by her/his sociocultural background and personal, political and intellectual values and beliefs (Freire, 1972; Hammersley and Atkinson, 1995). Crucial to critical ethnography is a constant reflection on power issues related to the conduct of the research and the ways in which the findings are gained and the results presented.

A critical ethnographic approach was adopted in two maternity units in the north of England, (Dykes, 2005a; 2005b; 2006; 2009) with 61 postnatal women and 39 midwives participating. Participant observations of 97 encounters between midwives and breastfeeding women, 106 interviews with breastfeeding women and 37 interviews with midwives were conducted. The ethnographic study involved long periods of observation of activities on the postnatal wards and interactions between midwives and breastfeeding women. The observations were supplemented by interviews with both midwives and breastfeeding women. As Hammersley and Atkinson (1995) state, the two methods are mutually enhancing in that what is seen informs what is asked about, and what is heard at interview informs what is looked for. Full details of the conduct of, and dilemmas around, a critical ethnography may be accessed in Dykes (2006).

### Breastfeeding as labour

Emily Martin (1987) was one of the first anthropologists to research women's experiences of birthing within a Western, medicalised, institutionalised setting. Martin (1987) interviewed women in North America about their experiences of labour and birth and, based on women's accounts, argued that with the institutionalisation and hospitalisation of birth, women in labour were increasingly seen within obstetrics as part of an industrial factory and that was how they experienced labour and birth. For the institutionalised system, and indeed the women, labour had become a production process with the woman as labourer, her uterus as machine, her baby as the product and the obstetrician, a factory supervisor or even owner. Martin (1987) applied Marxist notions of human alienation and separation from the product of one's labour to provide a conceptual lens on her findings. The labouring woman, Martin argues, is metaphorically and experientially disconnected from her birth as it is managed

and controlled by and within an institution.

The critical ethnographic research the author conducted in postnatal wards, like Martin's (1987) research with birthing women, illuminated the ways in which women tended to experience breastfeeding in a disembodied, mechanical way (Dykes, 2005a; 2005b; 2006; 2009), a brief summary is presented here.

Physical separation of mothers from their babies in hospitals around the world is being systematically reversed, in part due to the WHO/UNICEF Baby Friendly Hospital Initiative (Bilson and Dykes, 2009). However, in Dykes (2005a, 2005b; 2006), notions of separation were evident in the ways women conceptualised and experienced breastfeeding. They tended to see the act of nutrition as separate from and indeed, more important than nurture of and relationship building with the baby. To this end, they conceptualised their breasts as functioning primarily to produce milk that they would then deliver to the baby. However, they often mistrusted their body's ability to produce 'good enough' milk in terms of quality and quantity using words such as 'produce', and 'deliver' when referring to their breastmilk. These words are metaphorically aligned with industry and the production line and are used in a wide range of medical and midwifery texts to elaborate upon the physiology and practice of breastfeeding.

The tendency to mistrust a woman's ability to supply and deliver breastmilk is unsurprising given that the defining discourses of femininity, over the last two centuries in the West, have assisted in constructing the female body as weak, defective and untrustworthy (Martin, 1987; Davis-Floyd, 1994; Duden, 1993; Shildrick, 1997; Dykes, 2005a; 2006). The wide reporting of 'insufficient milk' in industrialised countries around the world appears to stem, in part, from this lack of trust and confidence in breastfeeding (van Esterik, 1988; Dykes, 2006).

The concept of 'supplying' encompasses notions of production of breastmilk and delivery to the baby. In Dykes (2005a; 2005b; 2006), women tended to conceptualise their breasts as machines and this conceptual separation from one's body, breasts and products was particularly powerful when breastfeeding became challenging or problematic, as reported by others (Balsamo et al, 1992; Mahon-Daly and Andrews, 2002). Women often expressed anxiety related to the 'delivery' of their milk to the baby, related to actual flow of breastmilk from their bodies, becoming concerned that they were unable to monitor, measure and visualise how much milk the baby was receiving. The desire to visualise and measure bodily activities is not surprising since women, as Duden (1993) argues, are increasingly exposed during their pregnancy through ultrasound scanning to the notion of dependency upon visual verification and validation of embodied experiences. They are then subjected to every other imaginable form of surveillance and measurement during pregnancy, labour and birth (Downe and Dykes, 2009).

Breastfeeding women appeared to conceptualise their bodies as vessels that were conceptually separate from them as a person with a sense of alienation and separation from the product breastmilk, a finding also reported by Balsamo et al (1992). The notion of 'supplying' appears to relate to the discursive reduction of breastmilk to a substance that is valued for its components (van Esterik, 1988; Blum, 1993; Dettwyler, 1995; Nadesan and Sotirin, 1998; Dykes, 2005a; 2006). These dualistic understandings of bodies tended to be reinforced within the hospital setting

through mechanistic language used by midwives. When conceptualising bodies in this disconnected way, as machines, the task was inevitably seen as demanding.

The concept of demand feeding appeared in the Western literature in the 1950s (Illingworth and Stone, 1952), but did not become firmly established until the 1980s. Advocacy of demand feeding came about with the recognition that if babies were given unlimited and un-timed access to their mother's breast, then they would be able to regulate their own calorific and nutritional requirements and the mother's supply of milk would be optimised in the long term through a calibration process (Woolridge, 1995). The term 'demand', however, constitutes an industrial metaphor that links with the notion of the production line. The concept of the baby demanding a feed and indeed her/his demands being 'pandered to' is, however, antithetical to many of the beliefs around child care in Western countries.

While biomedical literature on demand feeding is extensive, there is little emphasis upon the ways in which women in a Western culture conceptualise, experience and negotiate demand feeding their babies. In this study, demand feeding created a sense of discord for women due to the removal of culturally ingrained, linear temporal markers from a lived and embodied experience. The irregularity and indeterminacy of demand feeding led to profound feelings of uncertainty; women seemed to feel dislocated in time. Balsamo et al (1992: 74) refers to this '*social conditioning to order*' in Western communities with unscheduled breastfeeding representing '*disorderliness*' and being perceived as '*never-ending and exhausting*'. There was a striking preoccupation with the frequency and duration of feeds and indeed the time-consuming nature of breastfeeding, with women often documenting for themselves the time between feeds and the time their babies slept. This relates to what Helman (1992: 37) refers to as the Western linear assumption that '*every event or phenomenon will have both a beginning and an end*'.

Thus, it appears, demand feeding tends to be seen as a transient or liminal phase that, in time, will resolve to conformity to external and indeed internal clock time. The emphasis upon babies behaving and conforming to clock time is in stark contrast to the notion of babies taking time referred to by Kahn (1989). Kahn highlights that babies are fundamentally sociable from birth; she refers to babies' innate abilities and tendencies that are particularly evident following an unimpeded birth. An example of this is provided by the baby who actively, indeed interactively, displays sociable gestures and makes his/her way to the mother's breast and suckles. The baby, therefore, initiates his/her realignment to the mother.

In a society in which productivity, in the industrial sense, is so highly valued and with daily lives structured around routines, breastfeeding women experience multiple contradictions. Their bodily rhythms and 'demands' of their babies contrast with the socially dominant pressures of clock time. Kahn (1989) argues that this creates major dilemmas for women, because they are trying to mother in a culture dominated by deadlines, routines and clocks. Indeed, women are now increasingly engaged in two forms of production, reproductive and industrial, and this dual activity brings complexities and temporal pressures to their lives (Galtry, 2000; 2003).

In the UK, women tend to see breastfeeding as a relatively

short-term project and returning to work may be given as the reason for discontinuing (Mahon-Daly and Andrews, 2002; Dykes, 2005a). Inevitably, transferring the baby to a bottle facilitates this early cessation of breastfeeding, independence for the mother and 'progress' for the baby. In this study, the preoccupation with return to 'normal activity', control and predictability, combined with women's lack of confidence, contributed to a desire to shift accountability, so that women were not solely responsible for nourishing their baby. Thus the future was marked by the temporal notion of time moving on towards the re-establishment of 'normality' with a major part of that being related to returning to paid 'production'. Women's ways of negotiating breastfeeding therefore related to varying degrees of desire to be 'in control' of their life, both in their immediate situations and in the projected longer term.

### Linking micro- and macro-perspectives

The discussion above illustrates the ways in which an embodied experience may be understood from a critical perspective. In the case of breastfeeding, 'supply' relates to commodity production and delivery, with the producer of the product experiencing alienation from that product, which is seen as separate and outside of her. 'Demand' relates to consumption, that is, to the requirements of the consumer(s), which, in turn, dictates 'supply' (Dykes, 2005a; 2009). While breastfeeding women continue to conceptualise their bodies as mechanical vessels that deliver the product of their breasts to their baby, breastfeeding will continue to be perceived as unidirectional and demanding.

The experience of breastfeeding as labour represents an extension of Martin's (1987) industrial model applied to labouring women. Breastfeeding becomes the next stage in the production process, the woman remains as the labourer and her breasts, like the uterus, are machines. Breastmilk is the product and the baby the consumer. If the breasts are working properly, they 'produce' a good quality and plentiful 'product', breastmilk. If they are used effectively, by the labourer, they deliver the 'product' efficiently and effectively and in the correct amount to the 'consumer'. A range of health practitioners are assigned to supervise the labourer, her activities and outputs (Dykes, 2005a; 2006).

It is crucial to explore the macro-sociopolitical issues that relate to women experiencing breastfeeding as a form of labour. Transformative action and active resistance may then be planned and be undertaken to challenge underpinning ideologies, public knowledge and discourses (Street, 1992). One of the pressures upon women in industrialised communities relates to time constraints; women's experiences of breastfeeding appear to be heavily influenced by a sense of pressure upon their time and this relates to the imperative for some to return to paid employment (Dykes, 2005a; 2006; 2009). Breastfeeding may then be experienced as time-consuming, impeding, or potentially impeding more pressing calls upon women's time. This sense of temporal pressure relates to the predominant form of time experienced in Western industrialised communities, referred to as linear or clock time. As Kahn (1989) asserts, linear time is so deeply embedded within Western culture that any other notion of time is rarely considered. It is a time that is pitched relentlessly towards the future and is centred upon the notion of efficient production.

If some of the limits or constraints upon women's time were

lifted, for a time, then their perceptions of their breastfeeding bodies would, perhaps, also change. Breastfeeding might not then be seen and experienced as simply using time up and taking time from other activities. A re-conceptualisation of women's time would therefore be an essential part of any transformative action. There would need to be recognition that women need time in order to give time to others. This, in turn, requires recognition that caring time is indeed cyclical and rhythmical allowing for relationship building, sociability, mutuality and reciprocity.

There are several levels in which midwives may engage politically with the issues raised in this piece of research. First, political activity is needed to restore the possibilities for women to take 'time-out' for mothering and breastfeeding, should they wish to do this, while carefully avoiding a return to essentialist notions around maternal role and duty. It seems likely that increasing numbers of women will return to paid employment at various stages during early motherhood. This global pattern, nevertheless, creates many dilemmas for women as they juggle the demands upon their time and bodies.

Improving maternity rights, pay and workplace flexibility through statutory processes has had a marked impact upon the duration for which women breastfeed within Scandinavian countries (Austveg and Sundby, 1995; Galtry, 2003). In the UK, the extension of maternity pay and leave, in line with European Commission guidelines is a positive move that reduces penalties upon vulnerable low-paid part-time workers, whose rights were often very limited. Clearly such statutory recognition sends powerful messages related to valuing parenting. Legislation like this tackles an aspect of the cycle of nutritional deprivation by supporting women from socially-excluded communities to be able to provide the nutritional and nurturing benefits of breastfeeding (Dykes and Hall Moran, 2006).

Midwives can also participate in changing language used and concepts explained to pregnant, birthing and postnatal women by shifting their emphasis to incorporate understandings of breastfeeding as both nutritional and relational. Midwives are likely to have been socialised through the same culture as the women they support and, in addition, have received education that commonly reinforces the biomedical perspective on birth and breastfeeding. Raising awareness of the paradigms underpinning the discipline of midwifery, how they have evolved and ways in which they may be challenged would constitute an important start. This is a key role for those working in various aspects of midwifery education.

### Conclusion

Critical medical anthropology makes an important contribution to understanding the connections between embodied experience, specific cultural contexts and wider sociopolitical issues. Critical ethnography, as an associated methodology, may be adopted by anthropologists and midwives to facilitate in-depth study of specific local cultural settings, such as a maternity unit or birth centre, through participant observation and interviews. The findings may then be linked to the broader sociopolitical context, in order to make recommendations for policy, practice and research. In this way, midwives may make a difference at a strategic level, in addition to challenging and changing specific local practices.

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# Pain and epidural use in normal childbirth

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## Abstract

With epidural rates doubling in the UK over the past 20 years, the impact on normal labour and birth is profound. Changes have also occurred in wider birthing milieu, such as the rise of a risk discourse, the diminishing of a 'rites of passage' meaning to birth, the growth of obstetric anaesthetic services and the advent of informed choice in maternity care policy. This paper discusses these issues and argues that inadequate service provision and an impoverished approach to labour pain rather than women's preferences are contributing to the rise in epidurals. An elective epidural service in relation to low-risk women is challenged and a call made for an urgent debate on how maternity services and ultimately society should respond to these profound changes.

*Key words:* Epidural, Zepherina Veitch memorial lecture, normal birth, risk, pain, evidence-based midwifery

## Introduction

This paper discusses rising epidural rates in low-risk labour in the UK, proffering some reasons for this trend. The side-effects of epidurals are detailed and, from this, the suggestion is made that epidural use is incompatible with normal labour. It then argues that inadequate service provision is the main contributor to the rise. Contrasting pain paradigms are then outlined, based on Leap's (2000) and later Leap and Anderson's (2008) seminal research and writing. Their approach of 'working is pain' is critically examined to see if it offers a way forward for the current debate around labour pain.

## An epidural epidemic?

Epidural rates have doubled in the UK from 17% in 1989 to 33% in 2007/08 (BirthChoiceUK, 2009). Though the reasons for this have never been investigated, it is likely that some of the following play a part in this change:

- Elective epidural provision is now almost universally available in consultant maternity hospitals in the UK. A survey in 2006 found only four out of 196 consultant maternity units did not provide this option (Jones et al, 2008). Obstetric anaesthetists now have their own association and their numbers have grown substantially over the past 20 years (Wee et al, 2002)
- Epidural provision has been available in some UK maternity units for nearly 30 years and hence, crosses two generations of childbearing women. Anecdotally, midwives say the mothers of the childbearing women now more commonly recommend epidurals to their daughters than they did a generation ago
- Celebrity birth stories and media portrayals of childbirth often include epidurals (*Daily Mail*, 2004)
- Over recent decades, there has been a loss of 'rites of passage' meaning to childbirth, so that pain and stress are viewed negatively (Leap and Anderson, 2008)
- A technorationalist society considers pain as either preventable or treatable (Lauritzen and Sachs, 2001)
- The pain relief paradigm is dominant in maternity services (Leap and Anderson, 2008)
- The movement to institutional birth (93% hospital verses 7% home and birth centres) reinforces medical solutions to clinical symptoms, such as pain (Walsh, 2007)

- Fragmented models of care and loss of continuity contributes to greater use of pharmacological agents in labour (Hodnett et al, 2007)
- Informed choice as an ethical imperative influences practitioners' responses to maternal requests for pain relief in labour (Walsh, 2007)
- The risk discourse predisposes to childbirth intervention including the use of pain-relieving agents (Walsh, 2007).

Several of these factors work in tandem. 'Technorationalist society' (Lauritzen and Sachs, 2001) is shorthand for a society that equates all scientific advances with progress. In relation to pain, technology and drugs have either prevented pain from emerging or treated it effectively when it does. It is counter-cultural in such a society to see a purpose to pain, especially physical pain related to biological function, which is how traditional and indigenous societies have probably viewed childbirth over thousands of years (Kitzinger, 2000). Childbirth within indigenous societies studied by Jordan (1993) was viewed as a 'rite of passage', an anthropological phrase referring to growth milestones. Rites of passage are associated with movement from one level of maturity and responsibility to another (van Gennep, 1966) – in the context of childbirth from woman to mother. It commonly involves passing through an experience of challenge and uncertainty known as a luminal phase before re-integrating into the new role.

Allied to an antipathy to childbirth pain, is a risk discourse that carries within it several paradoxes. In the West, it has never been safer to have a baby if judged by maternal and perinatal mortality rates (Department of Health, 2007), yet it appears that many women have never been more frightened of the process. The relatively new diagnostic category of 'tokophobia' (morbid fear of labour) is testament to that (Hofberg and Brockington, 2000). Another paradox is a high degree of risk aversion, yet a willingness to embrace medical interventions like drugs and surgery that carry risks themselves. Risk aversion appears to operate quite selectively. Mixed messages co-exist like a public health message to avoid any form of drug pre-conceptually and prenatally, but accept an array of drugs during intrapartum care.

Discussion about epidurals is often linked to the broader discussion of medicalisation of childbirth, because epidural typifies the 'cascade of intervention dynamic' that contributes to

medicalisation (Johanson et al, 2002). Public health concern has prompted the Department of Health in the UK to measure normal labour processes as well as normal birth outcomes (NHS Information Centre, 2008). A working definition has now been agreed as to what constitutes a normal labour and birth and it excludes epidural or spinal anaesthetic, induction of labour, forceps or ventouse, caesarean section (CS) and episiotomy. The difficulty of reaching agreement across a multi-disciplinary group is reflected in the fact that it can include augmentation of labour, artificial rupture of membranes, the use of entonox, opioids, electronic fetal monitoring and an actively managed third stage of labour (Werkmeister et al, 2008). The fact that the Consensus Group had to compromise to accommodate the various positions of the stakeholders indicates how certain procedures and drugs are now considered normal in labour. The ubiquity of oxytocin augmentation and epidural is demonstrated in Mead and Kornbrot's (2004) survey of low-risk women, when they found that rates varied between 48% and 76% (augmentation) and 29% and 62% (epidurals). Furthermore, Symon et al (2007) demonstrated the stark contrast in low-risk women's self-reported intervention rates between midwifery-led units and consultant units: pain agents were 25% in the former and 77% in the latter.

#### Side-effects of epidurals

When it comes to specific risks associated with a medical procedure, epidurals have many. These include:

- Increased length of first and second stage of labour (Anim-Somuah et al, 2009)
- Need for more oxytocin (Anim-Somuah et al, 2009)
- Increased incidence of malposition (Anim-Somuah et al, 2009)
- Increase in instrumental delivery (Anim-Somuah et al, 2009)
- Increase in third- and fourth-degree tears (Rortveit et al, 2003).

Maternal side-effects are:

- Reduction in mobility (MIDIRS, 2006)
- Can lead to an inability to pass urine (MIDIRS, 2006)
- Hypotension, headache (MIDIRS, 2006)
- Pyrexia (Yancey et al, 2001)
- Up to 30% of women get partial, but not complete relief (Simkin, 1989)
- Reduces breastfeeding rate on discharge from hospital (Wiklund et al, 2009).

Neonatal side-effects include tachycardia due to temperature rise, and they are more likely to be hypoglycaemic (Lieberman and O'Donoghue, 2002). It also diminishes breast-seeking and breastfeeding behaviours (Ransjo-Arvidson et al, 2001). All of these negatives have to be balanced with the fact that an epidural offers the following advantages:

- It is more effective than non-epidural analgesic methods (Anim-Somuah et al, 2009)

#### Box 1. A story from a midwife typifying the current conflict around pain and labour

The midwife had taken over from her colleague who was looking after a woman having her second baby. The woman had been in the latent phase of labour, but had recently shown signs of her labour accelerating. In the short time it took to hand over, the woman had become very distressed. The midwife rapidly tried to develop a rapport with her and gave some advice about focusing on breathing during the contractions. This was not enough and she began using entonox within a short period. The contractions were long and intense and beginning to get expulsive. As the midwife auscultated the fetal heart on the woman's abdomen, she noted that the auscultation point was tracking down the abdomen to rest over the symphysis pubis. She recognised the familiar manifestation of transition, but by then the woman was shouting loudly 'to go home', 'caesarean now' and 'get me an epidural'. Her distress was greater on the bed so the midwife encouraged her to get up, though she was continuously monitored because of meconium-stained liquor. She coped a little better upright or on the floor but still vocalised her distress in no uncertain terms. The midwife was faced with a dilemma. She was sure the second stage of labour was imminent, but the recourse to an epidural would have calmed the woman and made monitoring the fetal heart easier as she would have been semi-recumbent on the bed. After another 15 minutes, the woman was bearing down strongly and birthed a healthy baby boy. Later, both an anaesthetist and another midwife suggested an epidural was wholly appropriate in this situation and a lively discussion ensued.

- It makes CS safer (May, 1994)
- It enables pain-free assisted vaginal birth
- It is valuable for protracted, induced or augmented labours (MIDIRS, 2006)
- It is useful for some women with tokophobia or post-traumatic stress disorder (Heinze and Sleight, 2003).

Few childbirth professionals would argue against epidural availability and use in these or similar situations. Because of the side-effects outlined above, the position of this paper is that epidurals render labour non-physiological and therefore a pivotal point for discussion is its role in normal labour. A related question is to what extent 'informed choice' has become an ethical imperative, regardless of context and prior preferences (for example, as expressed in a birth plan). In the story above (see Box 1), the scenario of a multiparous woman requesting an epidural in late first stage of labour has been used as an exemplar for the application of informed choice. Many UK midwives would express the tension between responding to a woman's request in this situation and knowing that this is a transient and challenging part of the labour that will soon pass. Midwives from other countries have expressed surprise when this scenario has been presented in workshops, concluding quite unequivocally that 'an epidural is not appropriate'.

#### Epidural rise and the inadequacies of service provision

While recent media coverage reported the epidural debate as professionals urging women to accept labour pain (*The Observer*, 2009), the original intent of the Zepherina Veitch memorial lecture (RCM, 2009) was to highlight the failure of the maternity services to provide forms of care that are known to lower epidural rates. High-level evidence exists in three areas: one-to-one care in labour (Hodnett et al, 2009), the provision of a home-like birthing environment (Hodnett et al, 2009) and access to water immersion (Cluett et al, 2009). All three forms of care lower epidural rates in low-risk groups, especially in nulliparous women. Yet, surveys reveal these forms of care are not universally available to women in the UK (Healthcare Commission, 2008; Redshaw et al, 2007; Alderice et al, 1995). This is despite the fact that the effectiveness of the first two (one-to-one care and home-like birthing environments) has been known about for over ten years. Given the slowness of service provision to implement these forms of care, it is not surprising that women opt for epidurals. Fragmented care systems

and clinical, austere labour rooms would appear to be risk factors in themselves for greater reliance on pain medication.

Research also points out that the best predictor of labour pain is maternal confidence (Leeman et al, 2003) and this opens up two further dimensions to an understanding of labour pain: the significance of relationally-mediated care as a conduit for building confidence and the importance of pre-existing expectations. In addition to the studies of one-to-one care in labour, randomised and non-randomised controlled studies of a specific organisational model called caseload, which guarantees a known carer for labour, consistently shows lower rates of epidural and other birth interventions (Benjamin et al, 2001; North Stafford, 2000). Hodnett (2002) discovered the overlap between pain perception, confidence and how women rate their childbirth experience when she undertook a systematic review of the role of pain in childbirth satisfaction. Her conclusion was that *'the influences of pain and pain relief... on subsequent satisfaction are neither as obvious, as direct, nor as powerful as the influences of the attitudes and behaviours of the caregivers'* (Hodnett, 2002: 160).

Women reported positive birth experiences when they felt in control, when communication was effective and when power was shared in relation to decision-making (Carlton et al, 2005). Carlton et al (2005) showed that pain relief did not necessarily improve women's childbirth experience and that such a request may indicate a need for emotional support. These findings are backed up by Kannan et al's (2001) research, where most women requesting an epidural for pain reported being less satisfied with their childbirth experience, despite lower pain intensity.

The importance of prior expectations and beliefs was shown in Heinze and Sleigh's (2003) study, exploring the differences between women who labour with or without an epidural. The epidural group had a higher fear of childbirth, were less aware of the side-effects, had an external locus of control for childbirth and a desire for passive compliance in the process. The non-epidural group had an internal locus of control and had less fear, believed that control came from within and wished to actively participate in the process.

### Attitude to labour pain

Leap (2000) and Leap and Anderson (2008) have made a seminal contribution to the area of attitudes and beliefs about labour pain and have developed an explanatory theory called 'working with pain'. Their theory is based on research into home-birth experiences of women and the midwives who attended them and, for this reason, may have less applicability to institutional birth settings. Nevertheless, their approach is at the very least theoretically generalisable to women in normal labour in other birth environments. They contrast 'working with pain' with 'pain relief' (Leap and Anderson, 2008). Table 1 summarises the main differences between these two approaches.

The 'working with pain' paradigm is predicated on labour physiology that requires pain to be present for the release of beta-endorphins, a naturally occurring opiate-like compound (Buckley, 2009). These hormones have analgesic and euphoric effects, similar to exogenous opiates and probably contribute to the dynamic behind oxytocin release so that it is neither understimulated nor overstimulated. Endorphin effects are also associated with altered states of consciousness, ecstatic experiences and

excitation (Ribeiro et al, 2005). An altered state of consciousness may be important for a labouring woman in helping her behave instinctively, for example, to use bodily movements to assist in the descent of her baby (Buckley, 2009).

It is probable that it is these effects that are captured so beautifully in *Hannah's birth*, a short DVD produced by Sheena Byrom (Byrom, 2006). What the DVD also captures are the empathic responses from Hannah's birth companions. Moberg (2004) in her captivating book, *The oxytocin factor* suggests that this hormone is secreted in both men and women, especially during therapeutic touch. She highlights the necessity to bathe a birth setting in love, not fear. When this occurs, the synergy created is more than the sum of individual parts. Hence the centrality of empathic relationships to the birth process, the importance of an optimum environment and of minimising disturbance. All of this takes on an urgency in an institutional birth setting where some of these factors are already compromised.

### The transforming power of labour

One of the key questions for maternity care stakeholders is what will happen to the narratives of transformation and growth in childbirth if normal labour pain is effectively removed by rising epidural rates. These are the countless number of personal testimonies that women share about an experience of growth and empowerment through childbirth. The vast majority of these are characterised by drug-free or low intervention labours, though not all (Thompson, 2007). Lundgren and Dahlberg (1998) found that women placed a meaning onto pain that assisted

**Table 1. The different approaches of pain relief and the 'working with pain' paradigms**

Pain relief approach	'Working with pain' approach
Language suggestive of pain as a problem	Language suggestive of pain as normative
Paternalistic – 'we can protect you from unnecessary stress'	Egalitarian empowerment – 'we are alongside you'
Technorationalism age – pain is preventable, treatable	Labour pain – timeless component of 'rites of passage' transitions
Neutral impact of environment	Seminal impact of environment
Clinical expertise of professional carers	Supportive role of birth companions
Special session/focus on antenatal education	Woven throughout labour preparation sessions
'Menu approach' to options for coping with pain	Supportive strategies for journey of labour
Pain as a management issue for assembly-line birth	Pain as one dimension of labour care in one-to-one, small-scale birth settings
Contributes to trend of rising epidural rates	Contributes to trend to less pharmacological analgesia
Risks of pharmacological agents outweighed by benefits	Cascade of intervention dynamic
First birth special case for 'menu approach'	First birth optimal opportunity for working with pain
Informed choice means all options must be presented	Informed choice within context of birthing plan and philosophy

them in the transition to motherhood. Women in Callister et al's (2003) cross-cultural study of pain perception viewed mastering pain as an integral part of a self-actualising experience and, for some, this increased their sense of self-efficacy. The most moving testimonies come from vulnerable women whose lives prior to birth had been blighted by abuse or disempowerment. Phrases like 'my greatest achievement' (Esposito, 1999), 'I can do anything now' (Spitzer, 1995) and 'I feel so strong' (Walsh, 2006) characterise these stories. In addition to these qualitative papers, randomised controlled trials of midwife-led care, where epidural provision is not available, show higher levels of satisfaction with the birth experience (Hattem et al, 2008). All these studies pose a profound challenge to the 'pain relief' paradigm.

There is a difficulty in debating the topic because it could imply criticism of women who choose or need intervention. Emerging evidence that normal birth primes the bonding areas of a mother's brain better than CS birth adds to this perception (Swain et al, 2008). In recognition that CS birth may undermine birth physiology, obstetricians have been researching the so-called 'natural caesarean' (immediate skin to skin at birth, delayed cord-cutting) to see if normal physiology can be harnessed in this situation (Smith et al, 2008). The advent of the 'mobile epidural' illustrates how obstetric anaesthetists are trying to engage with labour physiology around movement and upright posture to accrue those benefits for women with epidurals.

These attempts to engage with childbirth physiology in the context of medical procedures that undermine it highlights how science struggles to mimic precisely what is natural. The complexities behind oxytocin secretion remind biomedicine that altering one variable (skin to skin in caesarean or bodily movement in epidural), laudable though those initiatives are, will struggle to reproduce the exact conditions for maximising birth physiology (Odent, 2001) – that probably requires a whole system approach (Downe and McCourt, 2008), examining environment, attitudes, beliefs, practices, and relationships, for example.

### Elective epidural service

In the light of this discussion so far, a rationale certainly exists for questioning the appropriateness of an elective, 'on-demand' epidural service for women at low obstetric risk, especially if there is public health commitment to increasing the rate of normal labour and birth in the UK. However, given its embeddedness

in maternity service provision, it would be a brave person who would take up such a position. This paper's intent is to simply encourage debate about these issues.

An anecdote is told of a maternity care professional who used to refer to epidurals as 'happidurals'. In the context of a fragmented model of care, with little continuity and patchy provision of one-to-one support in labour, in a clinical environment with little resemblance to home, it is understandable that epidurals are a welcome relief. But it is important not to confuse system failure with women's preference. In fact throughout the UK in different birth settings, women are birthing entirely drug free, even with their first baby. This group can be found in midwifery-led units, birth centres and at home. Although this only represents a small minority of women, surveys suggest many more women would like these options to be available (Redshaw et al, 2007). First birth mothers' stories of drug-free labours tend to remain hidden in small-scale birth settings because they are seldom told beyond these settings. Their testimonies are important for labour ward midwives, obstetricians and anaesthetists to hear, because they are routinely exposed to the opposite. Case reviews in maternity hospitals tend to be of complications and emergencies only.

### Conclusion

The evidence is indisputable that epidurals undermine childbirth physiology. That rates are double what they were 20 years ago says more about the context of childbirth and childbirth professionals' attitudes, than it does about the current generation of women's ability to adjust to labour pain. In fact, there is considerable anecdotal evidence that women adapt their expectations to the service provision, so the rare consultant unit that does not have an elective epidural service has not seen a fall in bookings (A Musgrave, 2005: personal communication) and, birth centres remain popular with women where available. However, the vast majority of women anticipating a normal labour and birth enter a large maternity hospital where epidural provision is electively available. In this context, the impact on childbirth intervention rates is profound. Addressing this context requires a rethinking of pain paradigms, attention to birth environment, and a move to more relational models of care. Finally, there needs to be a robust debate about whether epidurals really serve the maternity services best by being an elective choice, especially in relation to normal labour and birth.

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# Experiences of lesbian parents in the UK: interactions with midwives

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## Abstract

*Aim.* To discuss findings from a study of lesbian parents' experiences of health care in the UK, focusing on interactions with midwives.

*Objectives.* To identify issues that have affected lesbians' experiences of midwifery care, and ways in which care could be enhanced in the future for child-bearing lesbians.

*Method.* A qualitative approach was employed, using Heideggerian phenomenology. Ten lesbian women: four couples, one representing a couple, and one now single, were recruited via snowball (chain-referral sampling). They consented to participate in unstructured interviews recorded on digital mini-disc. Interviews focused on respondents' interactions with healthcare professionals. Following transcription, narratives were analysed using McCormack's Interpretive Lenses.

*Findings/results.* Stories were told which indicated both positive and negative attitudes towards lesbians by midwives. Findings suggest that some midwives were supportive and inclusive, while others struggled to care for lesbians appropriately, and that homophobia and heterosexism exist within midwifery practice.

*Implications.* Further education and information for midwives is necessary to enhance the quality of care given to lesbian child-bearing women.

*Key words:* Coming out, heterosexism, homophobia, homosexuality, lesbian parents, midwife, evidence-based midwifery

## Background

Homosexuality's long uncomfortable social, political and medical history has influenced the experiences of lesbian, gay and bisexual (LGB) people within health care for decades. From 1533 to 1861, male homosexuality was punishable in the UK by death and only declassified as a mental illness by the American Psychiatric Association in 1973. Yet, homosexuality remained listed as a diagnosis on the International Classification of Diseases until 1992 (King and Bartlett, 1999). Male homosexuality was finally decriminalised throughout the UK in 1982. Female homosexuality (lesbianism) has never been a criminal offence.

Recently, historic legal changes have secured a more positive political and social climate for all homosexuals. The repeal of Section 28 in 2003 (which had banned the promotion of homosexuality as an alternative or better lifestyle) and the introduction of the Civil Partnership Bill in 2004, illustrate the sea-change in sociopolitical opinion and a more inclusive attitude towards this previously marginalised group. The Equality Act (Sexual Orientation) Regulations 2007 now makes it illegal to withhold services, such as booking hotel rooms, reserving tables at restaurants and provision of health care, on the grounds of sexual orientation. However, it remains difficult for LGB people to overcome the legacy of centuries of oppression and they still fear homophobic reactions from society and healthcare professionals (Albarran and Salmon, 2000; Rönndhal, 2009).

Around 5% to 7% of the population is believed to be LGB (Stonewall UK, 2009), but sexuality has never been recorded by national census. International and UK midwifery research and commentary has explored experiences and needs of lesbian parents (Zeidenstein, 1990; Stewart, 1999; RCM, 2000; Spidsberg, 2007). There is one mixed-methods study on gay and lesbian-parented families in child health care from Australia (Mikhailovich et al, 2001), but no previous, purely qualitative research into the experiences of lesbian parents seeking health care for their children.

## Study design

Between 2001 and 2007, I undertook a study seeking to understand the experiences of lesbian couples when their children required health care. The study adopted a Heideggerian phenomenological approach (Koch, 1995; Maggs-Rapport, 2001) embracing my position within the research study as a children's nurse and as a lesbian parent. Phenomenological enquiry is a recognised methodology in social and health sciences where the aim is to understand an experience as described by the experiencing person. Phenomenology can, broadly, be Husserlian or Heideggerian. Husserlian phenomenology insists that the researcher brackets themselves from any connections they may have with the field of study to avoid any negative bias exerted by existing knowledge and assumptions (Giorgi, 1997). In contrast, Heidegger considered that it was impossible to suspend one's knowledge of what is known, that knowledge becomes part of the knower and cannot be separated from who that person is, and it influences the decision of what to research (Koch, 1995). In developing Heidegger's theory, Gadamer (1975) reasoned that connectedness with the subject should be embraced as being the key to enabling the truth about a phenomenon to be established. The positive bias that is introduced by the researcher's connectedness with the field creates a relationship between truth and prejudice, where prejudice, or pre-existing knowledge is recognised as a positive method of drawing meaning out of other's experiences (Maggs-Rapport, 2001). Positive bias can enhance qualitative inquiry, but researchers should make their influences explicit so that they can be considered in the overall assessment of the study (Finlay and Gough, 2003).

## Insider status

Researchers who are inside their research topic can enable exploration of issues that might otherwise not be investigated (Chesney, 2000). I had both a professional and personal insider role in this study. The professional 'me' enabled a level of

understanding about illnesses, medical terminology and systems within the UK NHS, while the personal 'me' empathised about lesbian lifestyles, lesbian parenting, and being the parent of a sick child. These positions probably enhanced dialogue (Bonner and Tolhurst, 2002); for example, one couple needed only to mention 'the placental abruption and the crash section' for me to understand the consequences of this obstetric emergency that had up-ended their plans for a home birth. Another, describing the discovery that her newborn son had 'a TOF' – a trache-oesophageal fistula – needed only a verbal 'yes, yes' from me to know that I fully understood the significant immediate and future implications of this diagnosis. Personal connections with lesbian culture and lesbian parenting seemed to create an easy rapport and a comfortable openness in sharing experiences with me. Being 'inside' also gave me connections to start points to locate my sample that I may not have otherwise been able to access.

Being an insider does not mean the researcher can assume that they 'know' of the respondent's experiences, and it is a role which has to be managed carefully (Platzer and James, 1997). Being close to the subject can blur one's vision, making it difficult to 'see' clearly what is taking place (Pugh et al, 2000; Pellatt, 2003; Simmons, 2007). I managed this through the outside position of my supervisor whose critical questioning helped me recognise inadvertent bias and maintain my focus. I kept field-notes, and adopted a reflexive stance to contain my influence during interviewing. While my position as a nurse, a lesbian and a mother was known to respondents, I withheld all information about my own experiences as the parent of a sick neonate that may have prevented respondents from speaking freely about theirs. Such information was only shared at the culmination of the interview if respondents asked directly for it.

### Participants

Participants were recruited using snowball (chain-referral) sampling with multiple start points, as recommended for locating hard-to-find groups (Biernacki and Waldorf, 1981; Lee, 1993). Start points were three professional contacts located around the UK who had connections to lesbian networks, and a posting on a gay parents' online forum at Yahoo®. The study took place while Section 28 was still in force, and lesbians and gay men were very reluctant to reveal their sexual orientation to healthcare staff for fear that their care would be compromised (Walpin, 1997; Platzer and James, 2000). In total, ten women (four couples, one representing a couple, and one now single) received study information sheets and all subsequently consented to participate. Each group was interviewed within their own homes. As befits phenomenological enquiry, there was no interview schedule other than the women being asked to tell the story of their interactions as parents with any healthcare professional when seeking care for their children. I did not introduce subjects for discussion, but followed with active listening, whatever themes were introduced by participants. Women therefore told of the experiences important to them, and of the ten women involved, six spontaneously related experiences of interactions with midwives.

### Data collection and analysis

Interviews were recorded on digital mini-disc and transcribed by hand. Narratives lasted between 49 and 129 minutes, and

were analysed using McCormack's Interpretative Lenses, which enables data to be viewed through four different 'lenses': language, narrative processes, context and moments (McCormack, 2000a; 2000b). This approach enables a multifaceted interpretation of data to create a contextual understanding of each story. Recurring themes shared between stories were also identified, and those relating specifically to interactions with midwives are discussed here.

### Ethical issues

Ethical approval was granted by the research ethics committee of the University of East Anglia. Informed consent was secured prior to interviewing. All data were handled and stored by the researcher. In all representations of the data, names have been changed to protect identity and preserve confidentiality.

### Findings

Among the data describing interactions with a wide range of healthcare professionals, were stories of experiences with midwifery services. These experiences appeared to be either neutral, openly hostile, or positive and addressed subjects of 'coming out' in a healthcare setting, heterosexism and homophobia, and supportive staff.

#### 'Coming out'

'Coming out' occurs when the homosexual person, having progressed through a series of emotional and psychological stages, accepts and embraces their new sexual identity and chooses to share it with others (Taylor, 1999). This rite of passage among homosexuals is a means of publicly stating their orientation, so that others may understand them for who they really are. Within health services, coming out is intended to enable the practitioner to recognise that the homosexual person may have different healthcare needs. This was the aim behind Sally's comment in interview 2 about revealing her sexual orientation to the community midwife providing antenatal care for her:

*"I did make an overt statement about my sexuality at some point... I think it was because I wanted to make it clear, because I wanted... to let this woman know, that I wanted a home birth and this was my situation."*

Coming out is not straightforward and carries enormous personal risk, so that individuals choose to come out only if they consider it necessary, usually when they feel it is relevant to the care they hope to receive. As Sally explains, the process has to be managed thoughtfully: *"I kind of think if you're militant about it – about everything – it can get people's backs up. If I talk about it, I don't think I talk about it in a militant... you know, like when I mentioned it to the midwife, it wasn't like 'I'm a dyke, alright?!' It was like, 'By the way, my partner's a woman.'"*

The ability and opportunity to come out are influenced by heterosexist attitudes that lead to 'passing and silencing' (Platzer 2006). Passing occurs when the homosexual person declines the opportunity to come out, either because they feel it is unsafe, unnecessary or advantageous to them to keep quiet. In this study, passing occurred in reported interactions with other healthcare professionals, but none of the women passed up the opportunity to come out in midwifery encounters. Instead, as in Sally's

example, they appeared to make careful efforts to secure the support they needed without offending or upsetting anyone.

Silencing involves the majority group placing barriers to prevent people from sharing identity information about themselves. A common example of silencing is manifested through the standard admissions paperwork in the health service:

“No... like me booking in at antenatal... was I single, married, widowed or divorced?” Katrin (interview 4).

and: “‘Are you married, divorced, single or widowed?’ and I said, ‘None... of those’... so she went, ‘Er... well that’s all the boxes I’ve got!’ So I said, ‘well, tick ‘other’ then’... she went, ‘oh, I can’t put ‘other’ in here... you have to be married, divorced, single...’” Tessa (interview 5).

These narrow categories limit the capacity of healthcare staff to accurately gather and record these demographic data, indicating an institutional inflexibility and lack of awareness of the richness, depth, and variety of relationships within society. Health services tend to assume that everyone is heterosexual (Röndhal et al, 2006) and is either single, married, widowed or divorced, categories that do not allow for common-law heterosexual partnerships, long-term stable but unmarried heterosexual relationships, and same-sex partnerships to reveal their relationship status. With no open questions to allow for alternatives, the problem is as Kate (interview 5) suggests that: “The systems aren’t there, I think, for people to ask the right questions in order for you to feel comfortable in saying what you’ve got to say...”

#### Homophobia

Homophobia is a fear or hatred of homosexuality (Herek, 1991), which can influence practice in subtle and in overt ways and can lead to staff denying treatment, avoiding contact or being overtly homophobic (Sinding et al, 2004). This study revealed instances of perceived or actual homophobic reactions relating to midwifery care.

#### Denying treatment

Kate and Tessa had planned to have their second baby at home, but the community midwife, with whom they had a good relationship, was going to be on holiday when the baby was due, so a replacement midwife was to be arranged:

Tessa: “... And she said: ‘Oh look, when the baby’s due I’m gonna actually be on leave... but there’s a team of us, and you know, I’ll try and introduce you to as many of those as I can over the preceding weeks... Um... so that it’s easy for you... and next time she came back, she’d said that there was one of them that refused to... come out to us”

Kate: “That’s a bloody cheek, isn’t it?”

Tessa: “It is a bloody cheek!”

Kate: “How can you have a midwife refusing to deliver a child?”

Tessa: “But we were happy with that, because we’d actually asked her to check it on the basis that we didn’t want anyone in our home that was homophobic” (interview 5).

This excerpt appears to suggest that one midwifery team member declined to provide care because the women were lesbians. Midwives are professionally expected to provide safe and appropriate care within the guidance of the code of conduct for midwives and nurses (NMC, 2008). Can a midwife, even con-

sidering her personal, moral and religious viewpoint, refuse to provide care to a pregnant woman when the code specifically states that ‘You must not discriminate in any way against those in your care?’ (NMC, 2008: 2).

In another example, Sophie and Katrin were banned by their community midwife from attending antenatal classes:

“... but she (midwife) wouldn’t let us go to antenatal classes in case we put the other parents off!” Katrin (interview 4)

Banning the couple from antenatal classes denied them access to information that has been demonstrated to enhance maternal and fetal health and which contributes to preparation for delivery (National Collaborating Centre for Women’s and Children’s Health, 2008; NICE, 2008). In both cases, the midwives’ actions had moral and professional implications and were discriminatory, but at the time, not illegal. In the current political climate, both couples would be able to claim discrimination against the midwife, who under the Equality Act (Sexual Orientation) Regulations 2007 – which includes access to and provision of health care – is no longer able to withhold care on the grounds of the client’s sexuality (Fish, 2007).

#### Avoiding contact

Healthcare staff may avoid contact with lesbian parents if they feel uncomfortable or are unsure of how to ‘be’ in their company. Even if it is not intended as such, clients may perceive this avoidance as homophobic in origin. In interview 2, Mel and Sally say:

Mel: “... But also having said that she would definitely be at the birth... she booked her holiday... so that she’d miss the birth... very strange, a very strange thing to do.”

Sally: “And she didn’t tell me that until, you know, a couple of weeks before I was due to have the baby... I don’t know what it was about me, or us... I don’t want to go maligning her, but she’d actually made a decision that she didn’t want to be at my birth.”

Sally and Mel appear confused by the actions of their midwife, who until this point had seemed willing to support them through delivery. Sophie and Katrin in interview 4 also suggested that they perceived that some members of the midwifery team had avoided caring for them:

Sophie: “Yeah, but it was... you could tell... it was something that one of the midwives said that made us believe that they’d allocated people who wanted to be, you know, our midwife... you know – and the sister? – never saw her, the midwifery sister, never... and she didn’t know how to even look me in the eye, actually. She obviously found it (difficult). It was quite interesting – there was (sic) various people who just didn’t have a clue.”

Allocation of midwives to labouring women may mean that women routinely only see a handful of staff, but Sophie and Katrin’s interpretation was that staff actively chose not to care for them because of their sexuality.

#### Overt homophobia

Homophobia seems to be expressed most often in subtle ways, but occasionally, this irrational fear can be exposed. Sophie and Katrin had devised a birth plan for their home delivery. Katrin wanted Sophie to be the first person to have physical contact with the baby, touching his head as it crowned. This would



involve Sophie touching Katrin intimately, an action which the midwife clearly understood to be sexual:

Katrin: “*And this woman went ‘Oh, I’m sorry, but I really don’t think that’s appropriate – if you want to do that sort of thing I suggest you go into the toilet!’.* And I said, ‘*we don’t want to have sex! Presumably it won’t be a sexual act when you do it to me?!*”

Sophie: “*And until she said that, I hadn’t clicked in terms of the potential distaste*” (interview 4).

The midwife would also have to touch Katrin intimately to assess how dilated she was and therefore how the labour was progressing, but obviously understood this to be entirely different. Earlier research has identified that female nurses believe the focus of lesbianism to be sexual activity, and that the lesbian client will try and ‘hit on them’ or seduce them in some way (Eliason, 1996), and it may be this that prompted the midwife’s response. Sophie and Katrin’s sexuality is such a normal part of their lives, embedded into their relationship in the same way that it is for heterosexual couples that it never occurred to them that their proposal could be misinterpreted.

#### Positive experiences

All of the women who described interactions with midwives had planned for home births. None, due to unexpected alterations in maternal or fetal status, achieved this and all accepted that the change to their plans had been appropriate and necessary to ensure safe delivery of their infant.

Sally, who’s son Flynn was born with an undiagnosed TOF and a heart defect, valued the fact that no one criticised her decision to decline any form of screening during pregnancy, although this would probably have identified the defects and ensured the delivery was planned carefully:

“*I felt they were really good about accepting the choices that I had made, because not only had I chosen to become pregnant and I’d chosen to have an anonymous donor, but also I chose not to have any scans and various other tests through pregnancy... and it is possible that some of the stuff might have been spotted had I had scans, and nobody ever criticised, (not) even indirectly or anything.*” Sally (interview 2).

Sophie and Katrin described the events surrounding the delivery of their first child; even though they have commented previously on what they perceive as avoidance strategies among staff, the supportive efforts of one midwife who met their needs in exactly the right way overshadowed everything else:

Katrin: “*And that was a wonderfully positive experience of health care – you know, we’d planned the home birth, we’d got the tarpaulin from B&Q – the lot – and then we had the placental abruption and crash section... and got put in this single room, and I said, ‘I don’t want Sophie to go home’, so this midwife got a second bed and pushed it up next to mine and the three of us slept together in a row, in the hospital the first night after he was born. With the loveliest – the loveliest midwife... It was so nice that there was that enlightened (midwife) ‘cos it was such a frightening, horrible day, we both have memories of that day ... but such magical memories of just waking up in the night – and there was this baby in the bed in between us and it was just perfect, wasn’t it?*”

Sophie: “*Yep, we just kept waking up and there was this*

*baby there.*”

Katrin: “*Thank goodness that somebody did that, just saw what we needed*” Sophie and Katrin (interview 4).

Kate and Tessa’s first child had been born at home, and in seeking the same care for their second, they drew on their experiences during the first pregnancy to guide them. Having struggled to get ‘permission’ for the first home delivery from the GP and the nurse manager, they wanted to build on the positive relationship they had developed with the midwife:

“*We spent a bit of time talking to her and she was lovely, a really nice woman, and we got on really well with her, didn’t we? So when Polly was due, we asked for her again on the basis that she knew us – we didn’t have to go through all that crap again*” Tessa (interview 5).

Tessa’s final sentence here refers to not having to deal with organisational red tape, as well as not having to go through the coming out process again, because the midwife already knew them and was not homophobic. Their wish to manage this aspect is fulfilled when they later learn that another midwife has refused to care for them, and they are able to view this positively:

Kate: “*She did a good job actually... she sorted it out.*”

Tessa: “*She did a good job – she came back and said: ‘Look, actually there is one midwife that doesn’t want to come here.’ And we said: ‘Okay, I’d rather she didn’t come near our house, thank you very much!’*” Kate and Tessa (interview 5).

Both couples are able to counterbalance the impact of negative experiences because of the inclusive, supportive and individual care provided by a midwife who was not homophobic.

#### Neutral experiences

Some experiences were reported as being neither good nor bad, but the women had a sense of anticlimax or discomfort that they couldn’t pinpoint exactly. Kate and Tessa, diverted from their planned home delivery to a hospital delivery, felt unable to be themselves in that environment:

Tessa: “*I don’t think we could be as comfortable with each other as we would have wanted to be – I think, I do think that... we couldn’t sit on the bed, cuddling*” Tessa (interview 5).

Tessa describes the atmosphere after their child was born:

Tessa: “*I just didn’t feel that they were quite as, I dunno, what’s the word, they just all went out, didn’t they? There wasn’t any: ‘Congratulations to the couple with the new baby!’, d’you know what I mean? It was a very different scenario to what I might have expected.*”

Their sense is that they were treated differently at this point, because they did not receive emotional support in circumstances where they perceived heterosexual parents would – and they felt inhibited from providing physical support to each other by a perception of institutional disapproval.

Sally also describes care which, while not neglectful, was probably fuelled by anxiety, but whether this was related to homophobia or simply a nervous practitioner cannot be determined:

“*I can’t say that what it was about the midwife was anything to do with the sexuality thing. I think it was just her and she’s like that, but she just didn’t appreciate the kind of ambience we were trying to create. She was really fussy and anxious and jabbery and she kept wanting to do an internal rather more frequently than I could bear*” Sally (interview 2).

## Discussion

Homophobia and heterosexism in health care can make the midwifery environment a difficult place for lesbians to be. Understanding why these issues remain important is fundamental in enabling practitioners to understand and meet the needs of this client group. Issues facing lesbians during childbirth that were originally addressed in the 1980s are still being addressed (McManus et al, 2006), while new legislative changes take affect.

### *Coming out*

All the women in this study reveal their lesbian orientation because they considered this necessary if they were to receive appropriate care, but not all lesbian women using midwifery services may feel confident to do so. The choice of whether to reveal sexual identity or not is described as 'personal risking', and lesbians use numerous strategies to make that decision (Hitchcock and Wilson, 1992). 'Telling', in order to be understood leaves one at risk of homophobic reprisal, rejection, and reduced quality of care (Neville and Hendrickson, 2006). Even without evidence that any of these negative issues will occur if identity is revealed, the fear or expectation of them based on prior experiences within a powerful heteronormative society and as a member of a minority group, ensures that the risk is perceived as real. Coming out is a continuous process of choice and decision (Neville and Hendrickson, 2006) – and it is a unique requirement for lesbian parents and parents-to-be. Since the default assumption is of heterosexuality, non-lesbian parents do not have to grapple with the coming out process when they may be dealing with a very stressful situation and already be feeling emotionally vulnerable. Unless the lesbian receives any indicators from the midwife that the environment is inclusive and accepting, she has no idea how her information is likely to be received. If she perceives the risk to be very high, the lesbian woman may not disclose, and is then unlikely to receive care specific to her needs. Even if she does disclose, there is no guarantee that personalised appropriate care will be given, particularly if the midwife does not know about the issues affecting lesbians within the healthcare environment (Meads et al, 2007).

### *Heterosexism and homophobia*

The assumption that everyone is heterosexual also implies that it is superior. Heterosexism is 'to regard heterosexuality as being better, more normal, more natural or morally right than homosexuality' (Wilton, 2000). Institutional heterosexism refers to an attitude of heterosexual superiority throughout an organisation, which may not reflect individual staff beliefs, but is evident through organisational structures and systems that perpetuate the socially prevalent ideal of heterosexuality as superior. Homosexuality is considered abnormal and therefore inferior, leading to attitudes that marginalise and make invisible everyone who does not meet the 'norm' (Wilton, 2000; Kitinger, 2005; Platzer, 2006). Institutional heterosexism pervades the health service and affects a wider group of people than may be appreciated. The assumption that everyone is either single, married, widowed or divorced and therefore 'fits' into the conventionally expected (heterosexist) social struc-

tures marginalises anyone, either hetero- or homosexual, who does not fit those categories. Because there is no opportunity to record these data accurately, these groups become invisible within health care and may not feature in care commissioning or professional education programmes if their existence is not recognised. The discrimination is levied not only against lesbians, but against any person whose orientation and/or relationship status does not conform to society's expectations of what is normal.

Fear is often based on ignorance and homophobia that can be fuelled by a lack of understanding. Lesbian culture, and lesbian family culture, is a dynamic and sophisticated world, just as straight (heterosexual) culture is (Tasker and Golombok, 1997). Ignorance about different cultures can lead health professionals to make incorrect assumptions, focus on inappropriate issues relating to the client, or overlook pressing health issues (Trettin et al, 2006; Weisz, 2009), while exposure to LGB people can increase cultural tolerance and understanding (Anderssen, 2002). Midwives should be aware of different racial and religious considerations, and the requirement to raise understanding of other diverse cultures is important for enabling the delivery of culturally sensitive care (Renaud, 2007).

Lesbians are no less responsive to the desire to have children than heterosexual women are, and are as influenced by hormones and 'the body clock' as any other woman may be (Bos et al, 2003). Historically, pregnancy has been difficult to achieve, but with increasing access to reproductive technology, increasing numbers of lesbian pregnancies are likely. Lesbian women achieve pregnancy through one of three actions – either an agreed or covert sexual liaison with a gay or straight man, via official or unofficial anonymous donor insemination or via assisted reproduction techniques (Stonewall UK, 2009). The last of these options has historically been difficult to pursue since fertility clinics were legally able to withhold treatment from lesbians. Since the Human Fertilisation and Embryology Act of 2008, fertility services are no longer able to deny access to treatment for lesbians. Whichever route is followed, a great deal of planning will have taken place (Bos et al, 2003; Renaud, 2007) – unplanned lesbian pregnancies, unless arising from rape, are highly unlikely – which illustrates the cultural ignorance when Sophie and Katrin were asked, "Was the pregnancy planned or unplanned?". It also impacts on the appropriateness of giving routine postnatal advice about contraception, and professionals who provide this without regard to individual circumstances are perpetuating heterosexism and heteronormativity by assuming that all women have sex with men. The fine detail between treating everyone the same and treating them as if they were the same can easily be overlooked. Goldberg's (2005) work with perinatal nurses in Canada suggests that nurses believe that they are being inclusive and not discriminatory if they deliver the same care to everyone, irrespective of individual situations. Lesbians want to be treated to the same standard as everyone else while having their individual differences recognised and appreciated. Differences such as relationships and family structure are significant enough to warrant a different type of midwifery care, postnatal support and contraceptive advice.

Lesbian family culture includes many features that exist

**Table 1. Strategies to support midwives in providing inclusive care for lesbian child-bearing women**

Practice reflexively	Challenge assumptions and feelings about homosexuality. Raise understanding of this alternative lifestyle and address personal views on whether homosexuals have any choice about their sexual orientation.
Use inclusive language that avoids assumptions	Preconceptions about the gender of partners automatically preclude women from revealing their circumstances, and there is a world of difference between 'Tell me about your husband' and 'Tell me who's at home with you'.
Provide equal standards of physical and emotional support	Midwives need to consciously consider whether they provide the same level of emotional and physical support to lesbian women and their partners, as they do to heterosexual women.
Be aware of institutional heterosexism and homophobia	Adding 'Civil Partnership' and 'Other' to the usual categories of relationship status on official paperwork offers an opening for lesbian women and any other women who do not fit the standard categories.

in any family – shopping, laundry, bedtime stories, supporting children with homework, paying the bills, and are also as unique as any other family is. Katrin (interview 4) points out that “*we’re not just one homogenous lump, you know*” – stressing the need to recognise this individuality. Midwives get to know and understand the family structure and needs of heterosexual women and should not fear doing the same for lesbian women, but also need to recognise the differences that exist across the lesbian parenting paradigm (Saffron, 1999) and should not make assumptions: ‘*The only thing that pregnant lesbians have in common is pregnancy... to know that a client is lesbian reveals nothing about the type of sexual activity she engages in, whether she is promiscuous or monogamous, whether she identified with a lesbian community or even whether she has sex with men. Pregnant lesbians may be single or coupled or not fit into any such category. Some lesbians intend to share parenting, but others do not.*’ (Saffron, 1999: 19).

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Understanding lesbians’ individual needs means discarding the many stereotypes that influence the behaviour, attitudes and assumptions of healthcare staff.

*Counteracting homophobia*

Midwives have a professional responsibility to enhance their knowledge and know their client group, however broad and varied that might be. There is a wealth of social science literature, and a growing healthcare evidence base to aid understanding of lesbian culture, parenting and health issues (McManus et al, 2006; Roberts, 2006; Renaud, 2007). By informing themselves, midwives will be able to be more inclusive and supportive to lesbian clients.

Midwifery education providers should include gender studies in pre- and post-registration programmes, aimed at reducing negative stereotypes, exploring personal assumptions and prejudices, and teaching an understanding of the emotional, social and psychological influences of what it means to be different.

In the practice setting, being inclusive to lesbian clients does not simply mean ‘not being exclusive’. Midwives need to practice in positive ways that encourage inclusion and send supportive signals to child-bearing lesbians (see Table 1).

**Conclusion**

The findings of this study demonstrate repeated patterns of discrimination to lesbian women entering the UK’s healthcare system (Stewart, 1999; Saffron, 1999; Jackson, 2003; Goldberg, 2005; Spidsberg, 2007). Homophobia and heterosexism is still a local, national and international phenomenon. Recent changes in UK law offer a pathway towards increased inclusion, tolerance and acceptance of homosexuals in all areas of society. Being able to care for lesbian women requires a willingness to examine personal attitudes and prejudices and respond reflexively to these, and to challenge policies and procedures that perpetuate marginalisation of this minority group.

Since this study was completed, there has been no new research published on lesbian issues in UK midwifery and nursing and the impact of recent legislative changes are as yet unknown, although there are discussion papers about the potential impact (Fish, 2007; Cant, 2009). Industries such as banking and insurance have instigated numerous policies that support equal rights for LGB clients, by 2009 the NHS has not made corporate policy changes across all Trusts to protect patients, and changes may not be consistent within each Trust. The potential is that the findings from this research remain relevant today, wherever organisational policies have not been updated to reflect new legislation, and wherever midwives have been able to access education, training and advice to support appropriate care for lesbian mothers.

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# The planning and preparation for a 'homely birthplace' in Hangzhou, China

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## Abstract

**Background.** This paper describes a project planned in the context of China's rapidly rising caesarean section rate and a prevailing view that midwives are unnecessary to normal birth.

**Aim.** To describe the preparations for setting up a midwife-led normal birth unit, in order to promote normal childbirth and improve women's birthing experience.

**Design.** An action research design was used. The process for setting up the unit included five stages: defining, planning and preparation; assessing midwives' opinions; setting up policies and standards of practice; a review of the first three stages; and three site visits. Also included were discussions, four collaborative meetings and a one-week training course. Women were not directly involved.

**Setting.** An obstetric unit in a large teaching hospital in Hangzhou.

**Participants.** Eight midwifery team-leaders and five researchers.

**Findings.** Midwives can play a dynamic part in the introduction of this new pattern of working. The study highlighted changes that could be made to existing policies and routines. The broad issues identified for attention were staff orientation, support in labour, clinical skills and midwives' job allocation. Concern also arose relating to staffing levels, hand hygiene, birth companions, birthing positions and pain-coping strategies.

**Conclusion.** The concept of a midwife-led unit was unknown in China in terms of its philosophy, organisation and midwives' leadership in the care of normal birth. The implementation of this type of unit requires a system of care that is acceptable to women, midwives and the hospital administration.

**Implications for practice.** This unit will act as an exemplar for midwifery and maternity services in China. It will encourage midwives to recognise their responsibilities, and to set up their own framework for clinical support and supervision.

**Key words:** Chinese midwives, midwife-led care, normal birth, homely birthplace, action research, evidence-based midwifery

## Background

This paper describes the planning and preparation of a groundbreaking development of a midwife-led normal birth unit (MNBU) – named a 'homely birthplace' by midwives – in a maternity department of a Hangzhou hospital. To the authors' knowledge, this is the first midwife-led unit (MLU) in China.

The authors' previous studies have found that midwifery services in China have experienced major difficulties, especially since the advent of the 'free market economy'. Chinese midwives' roles have gradually been taken on by nurses, doctors and doulas. After 1996, the total hospitalisation of childbirth was enforced by government regulations. This resulted in 100% caesarean section (CS) births in some hospitals (Cheung et al, 2005a; 2005b; 2006a; 2006b; 2007).

Chinese undergraduate and postgraduate midwifery education was withdrawn after 1949 under the communist government. Midwifery higher education has not yet recovered. However, a two- to three-year midwifery diploma has survived under the umbrella of nursing in the rural and less-developed urban areas (Cheung, 2007).

At present, the Chinese healthcare system favours the affluent (Cheung et al, 2008). This can be seen in the provision of three kinds of hotel services in hospitals, according to clients' ability to pay. This encompasses 'VIP five-star service', en suite

double room services, and the basic multi-bed ward service. A 'homely birthplace' was thus designed to improve the situation and to promote normal birth and Chinese midwifery (Cheung et al, 2008). Chinese midwives responded enthusiastically. They recognised the significance of the project designed to empower their clients, provide privacy, respect women and regain the role and status of midwifery.

This paper presents the second stage of a three-stage study:

- Stage one: a questionnaire was sent to 143 Hangzhou midwives to assess their perception of the need for midwife-led care in China, followed by a small number of qualitative interviews (Cheung et al, 2008)

- Stage two: planning and designing

- Stage three: implementation and evaluation of the MNBU.

The study involved the development of a philosophy, policies, strategies and procedures. These were reviewed at the beginning of 2008. The training of midwives took place from January until March 2008. It was fully operational in late April 2008.

## Aim

The aim of this paper is to describe the preparation for establishing this unit, which was based on a literature and practice review. This formed the basis of the provision of a friendly environment for midwives and for continuous intrapartum support

for women by a midwife. This phase also established the policies for introducing a birth companion of the woman's choice.

### Literature review

A structured literature review was undertaken to identify what was already known in the subject area. The review focused on 'midwife-led units', 'normal childbirth', 'birth centres' and 'Chinese midwifery' (see Table 1). The inclusion criteria were English and Chinese publications within the previous ten years related to normal childbirth.

The electronic databases, the Cochrane Database of Systematic Reviews, MEDLINE, Medline Plus, Science Direct, Sage Journals Online, Taylor and Francis eLibrary service, British nursing index, and Foreign Medical Journal Full-Text Service were accessed. Hand-searching of unindexed Chinese journals was also undertaken. The abstracts of relevant papers were critically reviewed. They were discarded if they did not relate to the policy development of an MNBU.

A critique of the papers demonstrated similar finding to that of the Cochrane review by Hodnett et al (2007) – women value continuous support from known carers while giving birth. Hodnett et al compared 16 trials from 11 countries involving 13,391 women and concluded that intrapartum continuous support is indispensable. To achieve this level of support, they suggested that some institutional changes must be made to policies and routines. The policy-makers and managers must use the evidence available to reform the system, give power to women and midwives to strive for normal births, and to prevent unproven interventions (Hodnett, 2000; Hodnett et al, 2007; National Institute for Health and Clinical Excellence (NICE), 2007).

MLUs are relatively well-developed in the West (Walker, 2000; Mead, 2004). However, women's desire to be cared for continuously by someone they know is often taken for granted in many countries (Jordan, 1993; Oakley and Houd, 1990). This is because the woman's body is often seen as an object of expert scrutiny, which provides the basis for interventions and treatments that increase obstetric power (Howson, 2005). Childbirth in both popular and obstetric discourses is regarded as a risky business prone to pathology, which requires obstetric surveillance and treatment. This social recognition was understood as the basis of medicalisation of childbirth.

The proposed practices of the homely birthplace were developed in reaction to this popular understanding and attempted a radical shift to respect women's innate ability to give birth. In this sense, a homely birthplace had been clearly welcomed by the midwives in the authors' previous study, because they believe that such practices are in their best interests (Cheung et al, 2008). With the help of the new NICE guidelines (2007), a tentative policy was developed over a one-year period to provide intrapartum care for healthy women and their babies.

The existing philosophies, policy and procedures of the labour ward of the participating hospital were critically examined. Comparisons were drawn locally, nationally and internationally. The homely birthplace that the authors' were planning was identified as similar to a 'midwife obstetric unit' in a medicalised South African hospital (Lester and McInerney, 2003). The midwives there were coping well, but they required reorientation and their skills updated, before the opening of that unit.

### Method

Action research was chosen to inform both research and practice in an interactive manner to enhance the midwife's role and to improve women's birthing experience (Avison et al, 1999; McNiff, 2002; Deery, 2005). There are five stages involved in the second phase of this three-phase study:

- Define the planning and preparation to decide what, where, and how change would happen
- Assess Chinese midwives' opinions, their confidence and ability to cope with working in the new birthplace
- Outline the policies, procedures and standards of practices
- Review the above stages and look for contradictions
- Tackle any contradictions by three site visits in November 2007 and March 2008 to understand the working environment and workloads, to plan a way forward and to modify the policies and procedures accordingly.

To implement these first four steps, four meetings were held at different stages to exchange ideas and evaluate what had been achieved and plan further action and clinical management. These stages of action research are presented for clarity, but in reality, the process is not as straightforward as this might suggest. Each cycle of fact-finding, actions and evaluations reflects the complexity of planning and preparation. The authors expected ambivalence and uncertainty to emerge in the process of change.

### Setting

The highly medicalised maternity department in a 1100-bed city hospital. The MLU has been allocated to two birthing rooms. It has 59 midwives, 25 obstetricians, 154 maternity beds, and originally three standard delivery beds, which were reduced to two after the unit was established. The hospital annual birth rate was over 3000 and its CS rate was 40.4% in 2007.

### Data collection

Two formal meetings were held for the researchers and midwifery leaders from all three participating institutions (Nursing College of Hangzhou Normal University, the First People's Hospital of Hangzhou and the University of Edinburgh) in November 2007 and March 2008. Two other meetings for the staff from the two institutions in China were held in September and December 2007. Each researcher visited the site three times. A one-week refresher course was arranged for midwives (see Box 1).

### Box 1. Components of midwifery refresher course

- British midwifery education and practice
- Introduction to the philosophy of midwife-led normal birth
- Introduction to the policy and procedures designed for the MNBU
- Birthing positions
- Non-pharmacological pain management
- Hand-washing
- Interview skills
- Breathing exercises (Lamaze workshops)
- Care in loss and bereavement.

Table 1. A summary of the search terms used and the papers selected

Search terms	Papers selected
'Midwife-led birth unit'	<ul style="list-style-type: none"> <li>Guiver D. (1999) <i>A midwife-led service evolves</i>. Association of Radical Midwives. See: <a href="http://www.midwifery.org.uk">www.midwifery.org.uk</a> or <a href="http://www.radmid.demon.co.uk/midwife-led.htm">www.radmid.demon.co.uk/midwife-led.htm</a> (accessed 10 April 2009).</li> <li>Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. (2007) Continuous support for women during childbirth. <i>Cochrane Database Syst Reviews</i> 3: CD003766.</li> <li>Hodnett ED. (2000) Continuity of caregivers for care during pregnancy and childbirth. <i>Cochrane Database Syst Reviews</i> 1: CD000062.</li> <li>Lester B, McInerney P. (2003) Midwives' perceptions of a midwife obstetric unit in a hospital setting. <i>Africa Journal of Nursing and Midwifery</i> 5: 28-33.</li> <li>Walker J. (2000) Women's experiences of transfer from a midwife-led unit to a consultant-led maternity unit in the UK during late pregnancy and labor. <i>J Midwifery and Women's Health</i> 45(2): 161-7.</li> </ul>
'Normal childbirth'	<ul style="list-style-type: none"> <li>Annandale E. (2009) <i>Women and reproduction</i>: In: <i>Women's health and social change</i>. Routledge Taylor and Francis Group: London.</li> <li>Beverley A, Beech L, Phipps B. (2008) <i>Normal birth: women's stories</i>: In: Downe S. (Ed.). <i>Normal childbirth: evidence and debate</i>. Churchill Livingstone: Edinburgh: 67-79.</li> <li>Crabtree S. (2008) <i>Midwives constructing 'normal birth'</i>: In: Downe S. (Ed.). <i>Normal childbirth: evidence and debate (second edition)</i>. Churchill Livingstone, Edinburgh: 97-113.</li> <li>Downe S. (2007) The uniqueness of normality. <i>Midwives</i> 10: 132-3.</li> <li>Downe S. (Ed.). (2008) <i>Normal childbirth: evidence and debate (second edition)</i>. Churchill Livingstone: Edinburgh.</li> </ul>
'Birth centre'	<ul style="list-style-type: none"> <li>Eposito NW. (1999) Marginalised women's comparisons of their hospital and free-standing birth centre experience: a contract of inner city birthing centres. <i>Health Care for Women International</i> 20(2): 111-26.</li> <li>Fahy KM, Tracy S. (2006) Birth centre trials are unreliable. <i>The Medical Journal of Australia</i> 185(7): 407.</li> <li>Hodnett ED, Downe S, Edwards N, Walsh D. (2005) Home-like versus conventional institutional settings for birth. <i>Cochrane Database Syst Reviews</i> 1: CD000012.</li> <li>Kirkham M. (2003) <i>Birth centres: a social model for maternity care</i>. Books for Midwives: Hale, Cheshire.</li> <li>Penwell V. (2009) <i>Mercy in action: bringing mother- and baby-friendly birth centers to the Philippines</i>: In: Davis-Floyd RE, Barclay L, Daviss BA, Tritten J. (Eds.). <i>Birth models that work</i>. University of California Press: Berkeley: 337-62.</li> <li>Walsh D, Downe S. (2004) Outcomes of free-standing, midwifery-led birth centres: a structured review of the evidence. <i>Birth</i> 31(3): 222-9.</li> <li>Walsh D. (2006) A birth centre's encounters with discourses of childbirth: how resistance led to innovation. <i>Sociology of Health and Illness</i> 29(2): 216-32.</li> <li>Walsh D. (2006) Subverting assembly-line birth: childbirth in a free-standing birth centre. <i>Social Science and Medicine</i> 62(6): 1330-40.</li> <li>Walsh D. (2007) <i>Improving maternity services: small is beautiful. Lessons from a birth centre</i>. Radcliffe Publishing: Oxford.</li> <li>Walsh D. (2009) <i>Small really is beautiful: tales from a freestanding birth centre</i>: In: Davis-Floyd RE, Barclay L, Daviss BA, Tritten J. (Eds.). <i>Birth models that work</i>. University of California Press: Berkeley: 159-86.</li> </ul>
'Chinese midwifery'	<ul style="list-style-type: none"> <li>Cheung NF, Mander R, Wang X, Fu W, Zhu J. (2008) Chinese midwives' views on a proposed midwife-led normal birth unit. Article in press: <i>Midwifery</i> doi: 10.1016/j.midw.2008.01.009 (accessed 26 April 2008).</li> <li>Chinese Ministry of Health. (1985) <i>The standards and requirements of maternity health care in the urban and rural China</i>. See: <a href="http://www.law-lib.com/law/law_view.asp?id=3207">www.law-lib.com/law/law_view.asp?id=3207</a> (accessed 16 December 2007).</li> <li>Chinese Ministry of Health. (2004) <i>The standards and requirements of maternity health care in the urban and rural China</i>. See: <a href="http://www.medage.net/News/policies/index~ArticleId~2712.htm">www.medage.net/News/policies/index~ArticleId~2712.htm</a> (accessed 16 December 2007).</li> </ul>
'Midwifery policy'	<ul style="list-style-type: none"> <li>Jordan B. (1993) <i>Birth in four cultures: a cross-cultural investigation of childbirth in Yucatan, Holland, Sweden and the United States</i>. Waveland Press: Prospect Heights.</li> <li>Mead M. (2004) <i>Midwives' practice in 11 UK maternity units</i>: In: Downe S. (Ed.). <i>Normal childbirth: evidence and debate</i>. Churchill Livingstone: Edinburgh: 71-83.</li> <li>National Institute for Health and Clinical Excellence. (2007) <i>Intrapartum care: care of healthy women and their babies during childbirth</i>. NICE clinical guideline 55. Developed by the National Collaborating Centre for Women's and Children's Health. See: <a href="http://www.nice.org.uk/CG055publicinfo">www.nice.org.uk/CG055publicinfo</a> (accessed 12 November 2007).</li> </ul>

### *Participants*

The highest attendance at the midwives' refresher course was over 100. Some midwives attended from the other hospitals. The average class size was 20. Two UK researchers and five collaborators from the Nursing College of Hangzhou Normal University visited the site. The programme was designed by eight midwifery team-leaders from the hospital, four researchers from the local nursing college and one from the University of Edinburgh.

### *Ethical considerations*

Ethical approval was obtained from the ethics committees of Hangzhou Normal University and Hangzhou First People's Hospital. Access to the wards was approved by the hospital management. The purposes of the study were explained to the midwife participants verbally and in writing.

### *Data analysis*

The researchers analysed data from meetings and field notes for emergent themes, such as the meaning and philosophy of a homely birthplace, the roles, social status and practices of midwives. The audiotapes and handwritten notes were transcribed into an electronic file within days. As with any qualitative research, the data analysis began at the same time as the data were collected. The data were analysed using the techniques of constant comparison (Joffe and Yardley, 2003).

### **Findings**

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The findings are divided into seven sections: definition, negotiations, accommodation, specific practices, the philosophy of the homely birthplace, policy development, and developing Hangzhou solutions for Hangzhou aspirations.

#### *Definition*

The unit was named 'homely birthplace' by the clinical midwives. It was defined by the researchers after analysis of the literature, as a place that offers care to women in labour from 37 to 41 completed weeks' gestation, with an uncomplicated pregnancy and birth and where midwives are the lead professionals.

#### *Negotiations*

During the unit's development, discussions focused on policies, the responsibilities of collaborators and how to carry forward this study. The unit and its design were welcomed and supported by the obstetric consultant and the head of the hospital.

#### *Accommodation*

The hospital was classified as level 3A. This category is given to the best provincial hospitals with greater numbers of highly-qualified practitioners and modern equipment, which provide care mainly for middle and upper-middle class clients (Cheung et al, 2008).

The hospital had three standard delivery beds, which were in two labour rooms. The double-bedded room could be used as a 'family room', allowing the woman's partner to be present. This conversion, however, was not considered feasible by the midwifery staff, because they planned to continue to use it for an obstetric standard care room. Therefore, it was agreed that the treatment room and the single delivery room would be converted into the new unit.

### *Specific practices*

It was noted that midwives wore white 'dresses' over their clothes, despite the environment being warm. The dresses had long sleeves with elastic cuffs. The UK researchers considered such sleeves might impede effective hand-washing. There were no hand-washing facilities in the labour rooms. However, there was a wash-hand basin in each of the two clients' toilets in the postnatal rooms, which would obviously not be available to staff when occupied. A soap dispenser was found in a side room.

A face mask was expected to be worn by staff caring for a labouring woman, because the hospital believed it to protect against infection. People did not appear to be aware that a mask could constitute a communication barrier between the midwife and woman. This practice was out of date. However, wearing a mask was perceived as a symbol of professional status.

The issues of hand hygiene, and policies and practices around birthing positions, pain-coping strategies and a birth companion of the woman's choice were identified to be in need of updating by the researchers.

### *The philosophy of the homely birthplace*

The authors' previous study illustrated that Chinese midwives viewed their role as supporting the woman while 'letting nature take its course' (Cheung et al, 2008). They expressed their desire to focus on the psychological aspects of how the woman felt about her pregnancy and her birth experience (Cheung et al, 2008). These empathetic and altruistic ideals were transferred into policies by the midwives' leaders and the researchers, in direct contrast to the existing paternalistic management and medically-imposed interventive practice (Cheung et al, 2008).

### *Development of policy*

The new policies were developed over one year by a multi-professional group of researchers and clinical staff from the host hospital. The development was based on formal evidence, and discussion among two senior midwives as policy-leaders, seven midwives and two medical and two midwife academics. The academic midwives provided full support for the policy development process, undertook literature searches, retrieval and appraisal of the evidence published in the developed countries. Together with the leaders from the hospital, they revised successive drafts of the policy.

The policies cover the procedures and the care of healthy women at term. It encourages the woman to be accompanied by her husband/partner or other family member of choice during labour. The policy document also encourages midwives to make decisions about appropriate responses to certain specific situations or conditions. These include the midwife's role to encourage normal birth and not to use routine interventions such as episiotomy and pubic shaving. The other areas within the remit of policy included:

- Antenatal education for the woman and her partner or birth companion
- The establishment of a rapport with the labouring woman
- The assessment of the woman's knowledge and coping ability
- Care throughout the three stages of labour



- Referral protocol.

Information leaflets for women were designed by the researchers to be displayed on the walls of the hospital maternity unit. In the policy and information leaflets, the emphasis was on the birth plan, a birth companion and providing a women-friendly and intervention-free environment.

The development of the policies highlighted a number of concerns. Firstly, there was a lack of midwifery input at senior organisational levels within the health board to solve the perceived shortage of midwives. Second, the routine induction and augmentation of labour for the convenience of the staff caused concern. Third, the practice of routinely using intravenous infusions and intravenous antibiotics needed to be justified.

#### *Developing Hangzhou solutions for Hangzhou aspirations*

The ethical approval and permission to access the research site indicated that Hangzhou midwives and hospital authority have recognised the marginalisation of the profession. So midwives have created this unit to encourage normal birth and to solve the problem of their professional status. They have assumed more responsibility for how services are delivered to their hospital. This is reflected in the policy, which attempted to cultivate a shared positive attitude towards birth as a physiological process.

#### **Staffing and routine practice**

As the preparatory work progressed, it became clear that one-to-one care had a different meaning for Chinese midwives – a doula midwife or a doula nurse hired by them (Cheung et al, 2005b). The idea of having a midwife and a woman's birth companion of her choice was a new concept.

Because of the staff shortages, midwives would need to move between the unit and standard care. While this may benefit women receiving standard care, the midwives' experience of the unit's care would be diluted.

These arrangements were considered necessary and satisfactory for low-risk women by the hospital management because of the serious shortages (Tan, 2006). It was also the formula offered to allow this project to proceed, because the hospital, like others in China, is financially independent. The reluctance of the hospital administration to employ more midwives was due to plans for allocation of resources and attempts to balance running costs with staff pay levels.

The potential for more normal births poses another financial challenge to the hospital – normal births, unlike instrumental or surgical births attract less income. Therefore, the tension between these two modes increases the likelihood that midwives will be stretched to take on more responsibility in the care of low-risk women in the unit; though the incentive of better pay and less responsibility may tempt midwives in the other direction.

#### **The roles of midwives and women**

It was evident from the site visits that the routine use of intravenous infusion, pubic shaving, episiotomy, administration of oxygen and pharmacological augmentation of labour were standard procedures. As the concept of an MNBU is new in China, some skills were identified as needing updating, especially the applica-

tion of different birthing positions, the emotional support, non-pharmacological pain control and hand hygiene. In response to the problems observed, appropriate education was designed to prepare the midwives and ensure the quality of their services in the proposed unit. The one-week refresher course was designed by the researchers and the manager of the unit to be offered prior to the unit's opening.

The women were recruited at 36 weeks' gestation from the antenatal clinic. They would be given a telephone number to contact a midwife if any concerns arose. During the birth, the woman would be accompanied by her husband or a relative of her choice. Her birth companion would have attended a companion course to learn how to be supportive.

It was agreed that an infrastructure of peer support, through a monthly meeting of researchers and midwives during the study period would be a conduit for sharing best practice. The policies were finalised by discussion between the labour ward sisters and the researchers, to encourage utilisation, recognition and scope of midwifery skills and their practice.

#### **Identification of outcomes of interest**

A list of indicators to measure the differences in clinical outcomes between those who received MNBU care and standard care was drawn up. The indicators act as a checklist to see whether midwife-led care was provided and to demonstrate the extent to which genuine midwifery care has been implemented:

- Mode of birth
- Induction/augmentation of labour
- Mobility of the mother
- Maternal analgesia in labour
- Continuous electronic fetal monitoring (EFM)
- Number of routine vaginal and/or rectal examinations
- Use of episiotomy
- Use of enema
- Pubic/perineal shaving.

These indicators are used for every woman.

#### **Discussion**

There were a number of issues that emerged from the planning and preparation of the MNBU, such as hand-washing, and routine application of pubic shaving. A policy was designed to tackle the problem; however, putting it into practice was a challenge.

The unit aims to promote normal birth, encourage midwifery care and women to trust their own bodies, and to seek the information they need to make decisions about pregnancy, birth, and parenthood. This development strives for high levels of supportive care, such as a trained midwife and birth companion of the woman's choice, hydrotherapy, massage, warm and cold compresses, and visualisation and relaxation techniques.

As a result, it discourages unnecessary interventions, such as the routine use of ultrasound and episiotomy, continuous EFM and pharmacological pain control.

There are some limitations to the first stage of the study's action cycle. Importantly, there was no involvement from women in the unit's planning and preparation. This is partly due to Chinese customs that discourage women from articulating their needs. It is partly due to limited research funding as a result of

the low status of Chinese midwifery – midwives are perceived as lacking research experience.

## Conclusion

This paper described the application of the first phase of an action research project to establish an MNBU in Hangzhou. Its implementation required a system of care that was acceptable to

women, midwives, obstetricians and the hospital administration. Such a system depended, to some extent, on mutual adjustment of each party's role.

The authors' project placed great emphasis on service issues, new policies and procedures to challenge some of the deeply routinised practices and to explore the ways in which midwifery support can be better facilitated.

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## Information for authors

*Evidence Based Midwifery* is published quarterly and aims to promote the dissemination, implementation and evaluation of midwifery evidence at local, national and international levels. Papers on qualitative research, quantitative research, philosophical research, action research, systematic reviews and meta-analyses of qualitative or quantitative data are welcome. Papers of no longer than 5000 words in length, including references, should be sent to: maura@redactive.co.uk in MS Word, and receipt will be acknowledged. Suitable papers are subject to double-blinded peer review of academic rigour, quality and relevance. Subject area and/or methodology experts provide structured critical reviews that are forwarded to authors with editorial comments. Expert opinion on matters such as statistical accuracy, professional relevance or legal ramifications may also be sought. Major changes are agreed with authors, but editors reserve the right to make modifications in accordance with house style and demands for space and layout. Authors should refer to further guidance (RCM, 2007; Sinclair and Ratnaik, 2007). Authorship must be attributed fully and fairly, along with funding sources, commercial affiliations and due acknowledgements. Papers that are not original or that have been submitted elsewhere cannot be considered. Authors transfer copyright of their paper to the RCM, effective on acceptance for publication and covering exclusive and unlimited rights to reproduce and distribute it in any form. Papers should be preceded by a structured abstract and key words. Figures and tables must be cited in the text, and authors must obtain approval for and credit reproduction or modification of others' material. Artwork on paper is submitted at the owner's risk and the publisher accepts no liability for loss or damage while in possession of the material. All work referred to in the manuscript should be fully cited using the Harvard system of referencing. All sources must be published or publicly accessible.

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## News and resources

### Pain management of CS

Giving a local anaesthetic during a caesarean section (CS) helps manage pain after the operation and reduces the consumption of painkillers, according to a new review.

The researchers recommend local anaesthetics as part of integrated pain management strategies for CS operations.

They reviewed data from 20 studies that together involved 1150 women who gave birth by CS in both developing and developed countries. They found that women treated with local anaesthetic, as well as local or regional anaesthesia did not require as much morphine or other opioid drugs for pain relief. When non-steroidal anti-inflammatory drugs were also given, pain was reduced further.

However, none of the trials addressed the cost implications of increasing the use of local anaesthetics.

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### Midwifery 2020: have your say

Midwives are being asked to describe their vision for the profession by the year 2020. Midwifery 2020 is a programme of work aimed at shaping the profession's future direction and identifying the changes that need to be made. More information can be found at: [www.midwifery2020.org](http://www.midwifery2020.org). Any comments should be directed to Carol Curran via email at: [carol.curran@nes.scot.nhs.uk](mailto:carol.curran@nes.scot.nhs.uk)

### Next DMRS meeting

The next Doctoral Midwifery Research Society meeting is on 2 October at University of Ulster, Northern Ireland. Professor Tina Lavender from the University of Manchester is presenting a lecture on mixed methods research as part of the meeting's professors of midwifery research series.

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