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# EVIDENCE BASED MIDWIFERY



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EVIDENCE BASED  
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## The 'z generation': digital mothers and their infants

The author would like to thank Maria Herron for inspiring her to theorise about the future of social media technologies in health care.

**Key words:** Birth technology, social media, mobile technology, evidence-based midwifery

My granddaughter is 20 months old and I am amazed at her ability to press the precise buttons on the iPhone to answer it. Of course, her language skills are crude, but the garbled words are definitely aimed at the picture of her father or mother that appears with the ringtone. Why am I writing about this in an editorial to my midwifery colleagues? We need to gear ourselves up and be ready to support the digital natives coming into our maternity services today and, more importantly, tomorrow. The new mothers preparing for birth are from a unique generation of technologically savvy citizens – 'generation z', born after 1995 and referred to as 'digital natives' (Howe and Strauss, 2000).

Technology permeates every aspect of modern life for the z generation and as soon as the pregnancy is confirmed, tweets herald the announcement to the global e-community. Pictures of the 3D scan posted on Facebook follow.

During pregnancy, mothers-to-be download apps for exercise monitoring and preparation for labour and birth. When labour begins, or if a caesarean birth is planned, the date and time are posted on the network(s) and, during labour, tweets, emails and texts keep everyone informed. When the midwife or doctor pronounces a statement of progress on the labour, this becomes a social media communication for global access.

Midwives and doctors need to be conscious of this as not only is there an opportunity for these conversations to be recorded on smartphones, they can be tweeted, texted or emailed immediately to the eagerly-awaiting family and followers. As midwives, it is vital for us to be conscious of the layers of technology now surrounding every aspect of our work and the social media technology that is there, but almost invisible. I would predict it is only a matter of time before the legal eagles call for the data generated through the social media communication network to be available for medico-legal cases.

Almost 30 years ago, I can remember the very first birthing video request by a doctor when I was assisting his wife, who was in labour with their first child. This event was indeed novel and it was the talk of the tea room for many days. Professional opinion was polarised into two camps: those who felt it was perfectly acceptable, and those who thought it was totally unacceptable; an intrusion into the private world of the birthing space. I was not asked to consent to being part of their everlasting memory of the event and was never privy to viewing the footage.

Today, I have the rights, and we have ethical and governance procedures, to ensure that consent is taken for every person caught on camera. However, less obvious technologies are a natural part of everyday life and we see how much mobile phone footage is used when disasters occur and people instantly switch on the camera that now comes as standard on nearly all mobile phones. Speed cameras,

surveillance cameras and now birthing room cameras.

Mobile phones are being increasingly used to access the internet, and recent data from Fox and Duggan (2012) reports 85% of adults in the US own a mobile phone, more than half of which are smartphones. Furthermore, 52% have searched for health-related information online and one in five smartphone owners have downloaded health apps. Our previous research (Lagan et al, 2011) provided important evidence to support perceptions of increased use of the internet for seeking health information by pregnant women. Data from the UK Office for National Statistics (2011) show that 46% of female internet users and 38% of males had used the internet in the three months prior to the survey in search of online health information. While global data indicate that almost a quarter of all females who have been online have searched for health information (Fox, 2011).

The acceptability of social media has had an enormous impact on our behaviour and you can switch on the television to observe this in action as you watch mothers and midwives showcase birth to the global audience. The modern woman does not seem to have any inhibitions about cameras recording her birth, as evidenced by the increasing number of programmes following birthing journeys.

The mobile is switched on in our birthing worlds, regardless of whether the birth is taking place in the home, midwife-led unit, obstetric labour ward or theatre. We need to be ready for this becoming the 'social norm and the professional status quo' and we need to train our new midwives and doctors to expect 'big brother to be watching'.

I believe that there is mounting evidence to support the global acceptance of social media platforms and online support systems. As such, maybe we need to look into strategic planning and the formation of guidelines to address the effective use of information communication technologies in practice, so that we can be ready for generation z?

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# Recognising stressors and using restorative supervision to support a healthier maternity workforce: a retrospective, cross-sectional, questionnaire survey

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## Abstract

**Background.** Midwifery is frequently written about as a stressful occupation. The RCM refers to stress as the most commonly cited reason for sickness absence (RCM, 2012). The reasons behind the high levels of stress experienced and, more importantly, what can be done to improve the experience for the midwife are not fully recognised or researched. This paper will look at the impact on the midwife of caring for families experiencing miscarriage and neonatal death. Following a randomised and controlled pilot study, which looked at the effectiveness of offering restorative supervision to midwives, the paper will explore the latest evidence of the restorative programme designed to reduce stress, burnout and improve compassion satisfaction and how this can be used to support midwives.

**Objectives.** To explore the nature of midwifery staff stress around loss and its predictive factors and suggest a potential solution to enabling midwives to manage the emotional demands of the job.

**Methods.** A retrospective, cross-sectional, questionnaire survey was undertaken, inviting a total of 350 maternity staff to participate. Pre- and post-measure using a professional quality of life scale were used to evaluate the restorative supervision.

**Results.** Over half of participants reported stress levels indicating a 'high' level of clinical concern. Multiple regression revealed that organisational factors, such as working environment, lack of supervisor support and not feeling that enough had been done to support families, significantly predicted stress and lack of positive coping strategies. Restorative supervision improved coping strategies, significantly reducing stress, burnout and compassion satisfaction.

**Conclusion.** Maternity staff experience significant levels of subjective stress as a result of caring for loss. Formal training does not appear to be protective. Restorative supervision which offers an opportunity to restore the capacity to think about the work and process the emotional demands of the role is significant as a positive coping factor for staff.

**Key words:** Staff stress, neonatal death, professional grief, staff burnout, restorative supervision, evidence-based midwifery

## Introduction

Midwifery is frequently written about as a stressful occupation. The RCM refers to stress as the most commonly cited reason among employees for sickness absence (RCM, 2012). The reasons behind the high levels of stress experienced and, more importantly, what can be done to improve the experience for the midwife are not fully recognised or researched. In a recent RCM study, 82% of staff were cited as considering leaving the profession with morale and motivation among staff being low and vacancy rates high (RCM, 2010).

Midwives manage miscarriage, stillbirth and neonatal loss as an integral and 'normal' part of their work. Dependent on their role and workplace context, however, as many as five losses per shift are reported in large hospital wards (McCraith, 2005). The intimate details of the care provided during this time can be both intense and distressing (Wallbank and Robertson, 2008). Evidence from the literature (Wallbank and Robertson, 2008) suggests that opportunities for midwives to understand and discuss the impact of the work are unlikely to be offered. 'NHS midwifery has a culture of coping' with midwives who are not seen to cope treated very harshly by colleagues (Curtis et al, 2006).

The attention given to the impact of caring and the potential for secondary trauma on the midwife has become more significant as the understanding of birth trauma for

parents has become more understood (Leinweber and Rowe, 2010).

The experience of patient death, particularly that of a child, has been shown as a greater risk factor for staff experiencing psychological difficulties from their work (Maunder, 2006; Healy and McKay, 2000). Unlike settings where the work is recognised as emotionally stressful, maternity services struggle to be identified as needing staff support, perhaps because the negative content of the work is still too difficult to discuss and maternity services are most often associated with good outcomes and positive events. The reality of the employment context means a professional reaction to the situation is needed, but the emotional impact on the individual is not always considered. Previous research focusing on parental experiences of child and infant death comment on how staff appear to withdraw from them following the death (Mander, 2006). It would seem that avoidance of the family, although a useful coping strategy for the staff member, compromises the needs of that family. Supporting midwives to enable them to remain with the family during difficult times, and to ensure that the emotional toll of the work is understood and mitigated, appears critical.

This paper will use the recent results of a pilot questionnaire study reviewing the impact on maternity staff, including midwives, doctors and nurses, of caring for a family experiencing miscarriage, stillbirth and neonatal

death to consider that the nature of the work midwives are involved in can be a significant stressor. Following a randomised and controlled pilot study that looked at the effectiveness of offering restorative supervision to midwives (Wallbank, 2010), the paper will explore the latest evidence of the restorative programme designed to reduce stress, burnout and improve compassion satisfaction and how this can be used to support midwives.

### **Method**

A cross-sectional survey, informed by the transactional model of stress (Lazarus and Folkman, 2004), was used to investigate the impact of staff response to loss. Considered to be one of the most robust frameworks, the transactional model of stress developed by Lazarus and Folkman (1984) focuses on the cognitive-phenomenological activity of the individual confronted by a stressful event. It seems particularly appropriate to explore responses to experience of pregnancy loss.

The model identifies two processes, cognitive appraisal (the thought process that is not necessarily conscious, which leads to an interpretation of events and attribution of their causes) and coping (efforts to manage internal and external demands), as critical mediators between the events experienced by an individual (such as supporting parents through pregnancy loss) and their perception as to whether they are experienced as stressful or not (Lazarus and Folkman, 1984). An individual's knowledge, past experience, beliefs and values all contribute to the process of appraisal and influences efficacy beliefs.

### **Participants**

A priori calculation of participant numbers, predicated on regression analysis assuming medium effect size ( $f^2=.15$ ),  $\alpha=.05$ , power of .80 and up to 16 predictor variables if required, indicated a minimum requirement of 143 participants (Faul et al, 2007). Thus a convenience sample of all midwifery and other staff (350) employed in obstetric and gynaecology settings across five hospital sites over two trusts in the Midlands, UK, were approached. Participants were written to directly by the researchers. A total of 54% of staff returned questionnaires, however, five of these were substantially incomplete and were excluded leaving a final sample of 184. Of the participants, 104 were midwives, were 42 nurses and 38 doctors.

The results reported here form part of a wider thesis of work. The questionnaire pack consisted of a number of validated measures and other questions considered important to the researchers to identify the responses to stress and possible explanations.

### **Instruments and measures**

#### *Impact of Event Scale (IES) (Horowitz et al, 1979)*

The IES, in its original form, was developed as a psychometrically robust clinical tool to measure subjective distress in patients following a specific stressful event.

The IES comprises 15 items; seven assessing intrusion symptoms and eight assessing avoidance, using a five-point

Likert scale: zero (not at all) to four (extremely) regarding feelings at time of exposure to the stressor and which combine to provide a total subjective stress score. Higher scores reflect increased frequency of symptomatology, and the measure can be used to identify levels of clinical concern with low, medium and high symptom levels based on the IES total score: low, <8.5; medium, 7.6 to 19.0; and high, >19 (Horowitz et al, 1979).

The current study included three further questions, informed by how obstetric and gynaecology staff stress have previously described stressors (Nallen, 2006): assessing whether respondents felt they had done a good job; that 'other things could have been done within their workplace for the family'; and how involved they believed they were with patients' care.

#### *Work Environment Scale (WES) (Moos, 1986)*

The WES is a self-rating scale in which participants answer true or false to questions assessing their perception of the workplace social climate. Three domains were utilised relating to working relationships: involvement (assessing extent of staff's commitment to work); peer cohesion; and supervisor support. Dimensions were selected to reduce participant burden and with reference to factors previously shown to mediate the impact of a stressful loss at work.

#### *Brief COPE (Carver, 1997)*

This abbreviated version of the original COPE assesses 14 different coping strategies, and is regularly used to examine clinically relevant outcomes relating to stressors in health psychology (Lowe et al, 2000), ( $\alpha=.76$  (24)). Coping is assessed via two items relating to a specific behavioural or cognitive strategy. Respondents rate the extent to which they have engaged in the defined activity on a four-point Likert scale, from zero (the participant did not use the activity at all) to four (the participant used this activity frequently). Subscales were divided dichotomously to define adaptive (active coping, planning, positive reframing, acceptance, humour, religion, use of emotional/instrumental support) and maladaptive (self-distraction, denial, venting, disengagement, substance use and self-blame). This measure was introduced in order to measure the effectiveness of the restorative supervision.

#### *Professional Quality of Life Scale (ProQOL) (Stamm, 2008)*

The ProQOL is composed of three discrete scales which measure compassion satisfaction – the pleasure one derives from being an effective caregiver; burnout – feelings of hopelessness, difficulties in dealing with work or carrying out the work effectively; compassion fatigue – psychopathological symptoms associated with secondary exposure to stressful events. The ProQOL is a psychometrically sound tool which has been used in numerous studies on the impact of stressful care-giving on staff (Stamm, 2008). Items within ProQOL are scored by asking the participant to reflect on the past 30 days and note to what extent they agree with the statements presented on a 0-5 scale. A score is available for each of the scales; the measure does not provide a composite score.

## Results

A total of 55% of participants recorded subjective distress levels exceeding a score of 19 on the IES, indicating a 'high' level of clinical concern, with a further 24% exceeding a score of eight indicating a 'moderate' level of clinical concern.

Overall scores on the IES revealed a significantly higher degree of stress than other studies investigating the impact of work events (Joseph, 2000).

### *Inter-correlations of variables*

Informed by the Lazarus and Folkman (2004) model, parametric bivariate analysis was undertaken to examine correlations between subjective stress and the independent variables (see Table 1). A regression equation using a block entry method was then undertaken to determine which variables were more significant in predicting stress (see Table 2). The regression equation explained 42% of the variance in predicting distress in staff to a high level of significance. Maladaptive coping was the strongest predictor within the model ( $t=4.878$ ,  $p=.000$ ), followed by total Positive and Negative Affect Schedule (PANAS) score ( $t=3.224$ ,  $p=.002$ ).

The more upsetting the member of staff found the incident the more stress was experienced.

Further predictors included staff perception that an episode of care was lacking ( $t=3.050$ ,  $p=.003$ ), number of losses the staff member dealt with ( $t=2.891$ ,  $p=.004$ ) (less experience of caring for bereaved parents predicted higher distress), and the staff member's perception of deficient personal support

( $t=2.287$ ,  $p=.023$ ).

The inexperience of dealing with loss is also worth noting with the mean IES total score for staff who had cared for more than 50 families being 19.50 (SD 12.93), compared to those who had cared for fewer than 50 families being 26.93 (SD 19.50).

The questionnaire results found that maternity staff are impacted by the work they undertake, especially in regards to supporting families experiencing loss. Positive staff coping styles needed to be supported because strategies such as self-blame, disengagement, and denial appear to exacerbate the negative effect of a stressor and increase psychological morbidity (McPherson et al, 2003). The family's experience of care where the professional only feels able to cope by withdrawing emotional engagement will also be negatively impacted and this fits with negative family views of staff in studies focusing on family experience of loss.

What also seems of paramount importance is that staff can regard their quality of care as effective, with negative staff perceptions of care correlating significantly with higher levels of stress. Staff who blame themselves, or believe they should have done things differently, appear to be more adversely affected than those who attribute failings to organisational systems (McCormick et al, 1989; Joseph et al, 1991).

Interestingly provision of formal training was not significantly correlated with reported stress and seemed to provide no mitigation for its experience. Training may be

Table 1. Predictive variable correlations

Variables	1	2	3	4	5	6	7	8	9	10	11	12
1 Total stress	--											
2 Parental status	-.132	--										
3 Psychological health	-.101	.058	--									
4 Home support	-.187*	.119	.399**	--								
5 Formal training	.094	.119	.021	-.023	--							
6 Number of losses dealt with	.273**	.095	-.022	.029	.233**	--						
7 Personal experience of loss	-.079	.277**	.133	.109	.132	.090	--					
8 Self-rated ability to deal with loss	-.145*	-.146*	.376**	.259**	-.153*	.306**	-.023	--				
9 Self-rated perception of best job done	-.183*	.069	.180*	.161*	.012	.022	.035	.101	--			
10 Self-rated perception that other things should have been done	.376**	-.083	.026	-.028	.078	.022	.043	.078	-.247**	--		
11 Total PANAS score	.485**	.014	-.048	-.131	.108	.241**	.115	-.157	.289**	.318**	--	
12 Working Environment Scale (WES)	.242**	-.053	.291**	.173*	-.022	-.127	.019	.126	-.180*	-.199*	-.102	--
13 Negative coping style	.523**	-.095	.061	-.078	.097	.150*	.125	.013	-.085	.337**	.457**	-.145

Table 2. Hierarchical multiple regression predicting stress among respondents (n=184)

	Betas				
	Step 1	Step 2	Step 3	Step 4	Step 5
Parental status	-1.598	-1.612	-1.633	-1.527	-1.648
Psychological health	-.317	-----	-----	-----	-----
Personal support	-1.394	-1.422	-1.444	-1.973	-2.046
Number of losses dealt with	1.925**	1.914**	1.892**	2.101**	2.236**
Self-rated ability to deal with loss	-.978	-1.038	-1.063	-----	-----
Self-rated perception that the best job has been done for the family	-.296	-.312	-----	-----	-----
Self-rated perception that other things should have been done	1.992***	1.980***	2.011***	1.982**	1.932**
Total PANAS score	.363 **	.362**	.372***	.389***	.446***
Total WES	-.399	-.406	-.412	-.445	-.377
Negative coping style	.759 ***	.758***	.753***	.730***	.754***
Total R2	.410	.414	.417	.420	.420
Total F	11.498***	12.613***	13.942***	19.409***	25.455***

\* $p < .05$ ; \*\*  $p < .01$ ; \*\*\* $p < .001$

necessary but not sufficient to support staff and help them respond adaptively to unpleasant and distressing emotions. The question of formal training was repeated during the author's early discussions around what was needed to support staff. The idea that being trained more would enable staff to deal with the emotional difficulties of caring for families is not borne out within this study and may suggest that despite being highly experienced, staff still feel they are not sufficiently trained to cope with these experiences.

The impact on staff experiencing these levels of stress has been the subject of numerous recent studies (Cross-Sudworth et al, 2010; Trzcieniecka-Green et al, 2012; Mackin and Sinclair, 2003). As noted earlier, maternity services are experiencing high rates of sickness, absence and high staff turnover as a direct result of the stress staff experienced.

The initial study demonstrated that staff are impacted by the loss that they are exposed to. Despite support structures, such as supervision by a supervisor of midwives, this did not appear to offer the degree of psychological protection to mitigate the impact of this difficult work. The author worked closely with maternity staff in this time and, following a process of feedback from the initial study and consultation of potential solutions, developed a model of restorative supervision to support the work of the maternity staff.

#### *Restorative supervision*

Following the initial questionnaire study, a pilot study was undertaken to evaluate the effectiveness of a model of restorative supervision with maternity staff (Wallbank, 2010). Supervision in this context is not a method of

managing the content of staff work but one to support them with the emotional demands of the role.

#### *Reminder of pilot study results*

The pilot study (Wallbank, 2010) randomly assigned 30 participants to a control or treatment group. Participants within the control group received no intervention. Those within the treatment group received restorative supervision for an average of six sessions with a clinical psychologist. Using the professional quality of life scale both before and after the sessions, results for the treatment group showed significant differences in subjective stress ( $t(15)=6.59, p=.000$ ) with average scores decreasing from 29 to 7; compassion satisfaction (the pleasure derived from being able to do your work well) scores ( $t(15)=2.66, p=.001$ ) average scores increased from 37 to 41; burnout (associated with feelings of hopelessness and difficulties in dealing with work) ( $t(15)=6.70, p=.000$ ) average scores decreased from 27 to 14; compassion fatigue (related to secondary exposure to stressful events) ( $t(15)=2.18, p=.004$ ) average scores decreased from 16 to 12 and participants appeared to have a reduction of stress.

#### *Next steps for the model*

Following the initial pilot study, significant investment from NHS West Midlands was awarded in order to develop a sustainable model within services. This has led to a training programme being developed. The initial training day covers a range of topics including the theoretical basis for supervision, an outline of the model and how the participant can use the model in order to support them in their work.

The programme is supported by a comprehensive manual to support learning beyond the training.

The model uses motivational interviewing (Rollnick and Miller, 1995) and leadership concepts, among others, to support professionals working within an emotionally demanding role. The emphasis of the model is on the resilience of the professional, improving their own health and wellbeing and supporting their capacity to think and make complex clinical decisions.

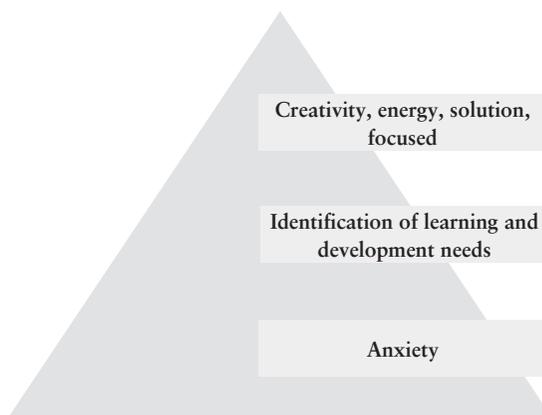
The second aspect of the training programme is for each professional to receive six sessions of supervision from a member of the supervisory team. The team consists of a range of professional staff who have clinically-relevant backgrounds but are no longer delivered just by a psychologist, which was important for sustainability. Participants are then supported to cascade the model to no more than four of their colleagues using a supervisor readiness scale (Wallbank, 2011). This ensures that participants have gained the skills they need to deliver the model of supervision and that they are ready to do so. They are also not overwhelmed by the demand of taking on too many supervisees. This way of training also ensures that organisations commissioning the training are left with a sustainable model.

A model of professional development which occurs within the supervisory session has been created (see Figure 1). This has been widely accepted (Wallbank, 2011) to provide a coherent understanding of why restorative supervision is needed when working with complex families and emotionally demanding roles. It shows how the professional moves between the anxiety of managing the risk, supporting the clinical work, being able to think about themselves and their own learning needs and then becoming creative and energetic enough to think about developing their service. Once participants have been through the programme of supervision they are much more likely to spend a consistent amount of time in the creative zone than the anxiety one. There is no definitive explanation as to how an individual moves through the pyramid, as this differs for each person. But we know that if anxiety is not contained or given a platform to be processed through an activity such as restorative supervision, it can serve to undermine all other activities. We are also confident from the studies carried out that the cumulative effect of dealing with significant emotional stressors without emotional support is detrimental to staff wellbeing.

#### *Study results from other workforce groups*

The programme has now been delivered to over 1800 staff in trusts across the UK with a range of clinical backgrounds (see Table 3). Results from the programme continue to show positive change reducing stress, burnout and ensuring compassion satisfaction is protected (see Table 4). The amount of data collected provides a robust evidence-based method for using within clinical services to support staff in managing their stress on a consistent basis. The programme has been recommended in the Department of Health service level agreement to strategic health authorities and the health visiting early implementer site leads are all receiving training in the model from the programme director.

**Figure 1. Model of development of supervisees (Wallbank, 2011)**



#### *How the model can continue to support midwives?*

The study reported within this paper shows the impact on staff of continuing to support families experiencing loss. A total of 80% of the sample indicated moderate or high levels of clinical concern on the IES, suggesting this is a common experience. The reported difficulties within maternity services would also suggest that staff are spending significant time within the anxious or difficult parts of their role (see Figure 1).

It is also important to note that this study has only looked at one aspect of the experience of the midwife. ‘Normal’ births can also provoke a similar anxious response in parents. The Birth Trauma Association report noted that 80% of births described as traumatic by parents were categorised as ‘normal’ by the professionals involved (Gamble and Creedy, 2005). The fear and trauma that parents experience needs to be managed and contained by staff and this will also have an impact on staff. Symptoms of avoidance and intrusion in our sample both exceed IES norms (Horowitz et al, 1979), and this quantitative data supports earlier qualitative reports of intense distress (Walpole, 2002). However, in contrast to staff working in other clinical areas, notably in oncology and palliative care, there is little systematic acknowledgement of distress integral to work and little provision to address it (Gold et al, 2007).

**Table 3. Participants who have undertaken the restorative programme**

Job role	No. of participants
Acute nurse	48
Community children’s nurse	42
Designated child protection staff	152
Doctor	78
Health visitor	1218
School nurse	185
Manager	28
Midwife	114
<b>Total</b>	<b>1865</b>

Restorative supervision gives staff an opportunity to reflect on their care, the experiences that have impacted on them and improve their organisational relationships. Improving the midwife's capacity to influence the care they provide and the decisions made in their working environment are all positive indicators of stress reduction (Mackin and Sinclair, 2003). The questionnaire study showed that negative coping styles appear to make staff more vulnerable to the impact of loss, as does the perception that care offered was not optimal and personal support lacking. The restorative supervisory sessions can be used to support the way in which the professional engages and is impacted by their work addressing the significant stressors and increase the resilience of the professional ensuring they can offer optimum care experiences.

**Table 4. Latest programme results (n=1805)**

Scale measure	Regional baseline (standard deviation)	Regional post supervisor (standard deviation)
Compassion Satisfaction	44.20 (4.18)	44.72 (4.17)
Burnout	42.81 (4.23)	24.71 (5.13)
Stress	43.35 (4.12)	16.86 (4.02)
Key: 22 or less: low 22-32: average 31+: high		

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# A survey of midwives' attitudes towards illicit drug use in pregnancy

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## Abstract

**Background.** Illicit drug use in pregnancy has significant implications for maternal and neonatal wellbeing. A lack of contact with maternity services is one of the main reasons for poor pregnancy outcomes for substance misusing women. The most frequently reported reason for avoidance of antenatal care is pregnant drug users fear of negative attitudes from healthcare professionals.

**Aim.** To explore midwives' attitudes towards caring for pregnant drug users. Objectives were to examine the relationships between midwives' attitudes, experience and formal education in caring for women who abused drugs in substance misuse.

**Method.** A quantitative research design was used in the form of a survey. Convenience sampling was utilised to recruit 180 midwives from one NHS trust. The data were collected using a previously validated questionnaire. Ethical approval was granted by the local research ethics committee.

**Results.** There was a response rate of 73% (133 midwives). Overall, midwives demonstrated positive, non-punitive attitudes towards caring for pregnant drug users. More recently qualified midwives were significantly more likely to agree with one positive statement: 'Life's circumstances are responsible for pregnant women's drug use.' Midwives who had received formal education regarding drug use in pregnancy were significantly less likely to agree with three negative statements: 'I feel angry in reaction to women who use drugs in pregnancy'; 'women who use drugs when pregnant should be prosecuted'; 'women who use drugs in pregnancy care little about themselves or their babies'. Therefore, the less experienced but better educated midwives were more positive in their attitudes towards illicit drug use in pregnancy.

**Implications.** There is a need for midwives to develop their knowledge and skills in working with substance misuse in pregnancy. The introduction of a specific teaching programme related to substance misuse in pregnancy should be implemented to continue to promote positive attitudes.

**Key words:** Midwives' attitudes, pregnancy, substance misuse, illicit drug use, evidence-based midwifery

## Introduction

Substance misuse remains a global health problem despite the efforts in legislative control, prevention, treatment and rehabilitation strategies. A definition of 'substance misuse' or 'drug use' is the use of substances that are socially, medically or legally unacceptable, or that have the potential to harm (DrugScope, 2005). It is estimated that 200 million people, equivalent to about 5% of the global population age 15 to 64 are misusing substances (United Nations Office of Drugs and Crime, 2006).

Current estimates suggest that there are 72,712 female drug users across England, 65,408 (90%) of which are of childbearing age (Singleton et al, 2006). Epidemiological studies suggest that approximately 5% of the pregnant population are using illicit substances (Crome and Kumar, 2007; Sherwood et al, 1999). The term 'illicit substance' includes central nervous system depressants (heroin and methadone), stimulants (cocaine, crack, ecstasy and amphetamines) and cannabis (DrugScope, 2005).

Drug use in pregnancy does have significant implications for maternal and neonatal wellbeing. For the mother, the problems of drug use usually antedate the pregnancy. Thus, female drug users will generally be in poor health prior to conception. Drug use can cause pregnancy complications, just as the pregnancy itself can exacerbate existing illicit drug related conditions. Problem drug use is associated with malnutrition, anaemia, skin abscesses, blood-borne viruses and dental problems (Walton-Moss et al, 2009). In addition,

associated social issues, such as unemployment, poverty, criminal activity and domestic violence, will also impact on maternal and neonatal outcome (Prentice and Watts, 2004).

The latest Centre for Maternal and Child Enquiries (CMACE) report highlighted that some complex social factors, including substance misuse, were associated with an increased risk of maternal death in the perinatal period (Lewis, 2011). The majority of the pregnant drug users who died were 'late bookers' and poor attendees for antenatal care. One of the key issues leading to a poor pregnancy outcome was that women misusing substances did not access or maintain contact with maternity services (Lewis, 2011).

There has been much discussion on why pregnant drug users do not access antenatal care; one of the most frequently reported reasons being a fear of negative or judgemental attitudes from health professionals (NICE, 2010). Thus, all maternity services need to ensure that the services they are providing are supportive and accessible. Pregnant drug users require early and sustained access to maternity care, therefore, any staff attitude that might affect the provision of care should be explored.

## Literature review

### Literature search strategy

A literature search was conducted on the CINAHL, Medline and Intermed databases using the key words: 'pregnancy'; 'antenatal'; 'drug use'; 'substance misuse'; 'midwives' attitudes' and 'healthcare professionals' attitudes'.

Following this search, 17 papers were identified as relevant, however, no papers were identified that specifically focused on midwives' attitudes to illicit drug use in pregnancy.

#### *Attitude formation*

An attitude is a hypothetical construct that represents an individual's degree of like or dislike for something (Baron et al, 2008). Attitudes are generally positive or negative views of a person, place or event. An attitude is learned over a period of time and is relatively stable, despite changes in mood or emotional state. Understanding attitude is important because it guides our thoughts, influences our feelings and affects our behaviour (Crano and Prislin, 2008).

The attitude of an individual consists of three components: cognitive, affective and behavioural. The cognitive component includes beliefs, facts and information about the object. The affective component describes the emotional reactions toward an object, and the behavioural component includes the behaviour associated with the object. Individuals' behaviours are influenced by their feelings (affective) and beliefs (cognitive), which are influenced by external factors, such as education and experience (Crano and Prislin, 2008).

#### *Negative attitudes*

Three studies explored neonatal staff attitudes towards substance misuse in pregnancy (Raeside, 2003; Selleck and Redding, 1997; Ludwig et al, 1996). Two multi-centre surveys were conducted in the US with moderate sample sizes of 392 and 215 neonatal nurses, respectively (Selleck and Redding, 1997; Ludwig et al, 1996). Both reported nurse attitudes were negative and judgemental towards pregnant substance misusers. Furthermore, Ludwig et al (1996) reported that 76% of respondents stated that they felt angry towards women who use drugs during pregnancy. These findings were reflected in a smaller Scottish survey of 50 neonatal nurses (Raeside, 2003) where 76% of respondents also reported feelings of anger towards pregnant drug users. It should be noted that these three studies were all conducted with neonatal nurses, not midwives.

Negative attitudes towards pregnant drug users can also become punitive. Abel and Kruger (2002) focused on doctors' attitudes towards the legal coercion of pregnant women using alcohol or illicit drugs. This postal survey was conducted in the US with 847 obstetricians, paediatricians and family practice physicians. The results demonstrated that 52% of doctors were in favour of the compulsory removal of babies of substance misusers and 83% were in favour of compulsory treatment for pregnant drug users already in the criminal justice system. This was despite acknowledgment that enforced treatment of pregnant drug users would likely dissuade them from seeking antenatal care. However, the participants were not asked for their views about women who were not in the criminal justice system, which may have elicited less punitive responses.

None of the above studies addressed the reasons why healthcare professionals held negative attitudes towards substance using mothers. Fraser et al (2007) explored the experiences of neonatal nurses working with families of

babies with Neonatal abstinence syndrome in Australia. The purposive sample group comprised of 32 neonatal nurses. The findings showed that the management of the babies and their parents were compromised by a range of attitudinal factors. One of the themes to emerge was that participants felt that substance misusers were a demanding client group. Fraser et al (2007) used group interviews for data collection, which can lead to pressure for the interviewees to conform to the group norm.

The notion of substance misusers being difficult to care for is also reported in the general patient population (Siegfried et al, 1999; McGillion et al, 2000; McKeown et al, 2003; Skinner et al, 2007). Skinner et al (2007) conducted a study in Australia to examine the role of values, affect and deservingness judgements in 277 nurses. In this postal survey, participants were asked to respond to hypothetical situations related to drug and alcohol use. The findings demonstrated that nurses perceived drug users to hold high levels of responsibility for their alcohol or drug use. However, to what extent nurses' responses to a hypothetical scenario reflect the quality of care they are likely to provide is difficult to assess.

Some staff have reported a sense of being at risk and vulnerable while engaged in clinical activities with substance misusers. Siegfried et al (1999) conducted a survey to explore 338 mental health nurses' experience, knowledge and attitudes towards clients' problematic drug and alcohol use in Australia. The findings showed that 82% of respondents found dealing with these clients moderately or very difficult. Similarly, McGillion et al (2000) surveyed 112 GPs' attitudes towards the treatment of drug users in the UK. It was reported that 66% of participants felt that working with substance misusers was more stressful than any other client group. McKeown et al (2003) explored this issue further by conducting semi-structured telephone interviews with 48 GPs in the UK. The findings suggested that negative attitudes were formed almost uniformly by client behaviour; the most common terms were 'difficult' and 'manipulative'. The respondents also reported a perceived threat to their safety due to the drug user's chaotic behaviour.

Risk, prejudice and stigma were recurring themes in a study by Peckover and Chidlaw (2007), who explored the attitudes of 18 district nurses working with clients who misuse substances. This observational study used semi-structured interviews to assess views in relation to substance misusers. All respondents drew upon a discourse of 'risk' rather than 'need' when describing working with clients who misuse substances. This was illustrated by the participants reporting the aggressive behaviour of clients.

#### *Experience and attitudes*

Attitudes towards substance users can also be influenced by some external factors, such as experience and formal education. The link between experience and attitudes has been identified by Gilchrist et al (2011), who conducted a multi-centre, cross-sectional comparative study with 866 healthcare professionals in eight European countries. The aim of the study was to compare regard for working with different patient groups, including substance misusers. The results

showed that staff with fewer than ten years' professional experience reported significantly higher regard for drug users.

Similarly, Raistrick et al (2008) reported comparable findings from a single phase, cross-sectional survey of 1116 healthcare professionals across six UK health authorities. One of the aims was to assess therapeutic attitudes towards people with substance misuse problems. The findings suggested that it was the staff with the least experience of substance misuse who demonstrated the most positive attitudes. This study reported a poor response rate of 42%, which is problematic in that the non-responders may differ from responders, creating non-responder bias.

One study was able to observe the influence of experience on attitude. Ramirez-Cacho et al (2007) conducted a prospective cohort trial with 104 medical students. The sample group attended a specialist clinic during their placement in an obstetric unit. The findings demonstrated that the medical students became more comfortable and better informed about pregnant women with drug use disorders after attending a specialist substance misuse clinic. Students reported feeling less judgemental towards pregnant substance misusers. This sample group had limited experience of working with pregnant drug users; as such their pre-education attitudes may have been less judgemental.

#### *Formal education and attitudes*

Bland et al (2001) used a comparative questionnaire survey to focus on the effects of a teaching programme related to drug use in pregnancy. The attitudes of 84 Canadian medical students were measured before and after a five-week teaching module on drug use in pregnancy. Following the intervention, the students showed significant improvement in their level of comfort in dealing with pregnant drug users. Similarly, Silins et al (2007) conducted an observational study to assess the influence of structured education on the attitudes of 374 medical students in Australia. First-year medical students were surveyed before and after three weeks of drug and alcohol education. At the same time, fourth-year medical students were surveyed before and after a nine-week teaching programme on substance misuse. Attitudes improved significantly after exposure to the interactive learning modules.

Thuy Tran et al (2009) conducted a survey with 120 general nurses in Australia. This aimed to assess the impact of an educational programme on the nurses' knowledge and competence in identifying and managing patients with alcohol and substance misuse. Knowledge was assessed before and after the educational programme, with knowledge levels improving after intervention. None of these studies were conducted with a control group, making it difficult to assess the exact impact of the interventions.

Strang et al (2007) conducted a randomised controlled trial to assess the impact of a training course on the attitudes of 112 GPs towards substance misusers. The intervention consisted of a six-month, part-time training course related to substance misuse. Participants were randomised to either the training group or the waiting list group.

The GPs that received training demonstrated significant

positive improvements in their attitudinal responses. The participants had volunteered to undertake the training and, as such, this self-selected group had a prior interest in the treatment of substance misusers. By reviewing the relevant literature the following aims and objectives were identified:

- Explore midwives' attitudes towards illicit drug use in pregnancy
- Describe midwives' attitudes towards caring for mothers affected by substance misuse
- Examine the relationship between midwives' attitudes, formal education and experience.

#### **Method**

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To address the aim and objectives, the attitudes of a large group of midwives were required, therefore a quantitative approach, in the form of a survey, was designed. As the attitudes of midwives were being explored, the identified sample group included all registered midwives working in one NHS hospital. Convenience sampling was used to allow quick and easy access to every midwife during the data collection period. The inclusion criteria were: registered midwives who were available during the data collection period and who consented to take part in the study. The exclusion criteria included agency midwives and student midwives. There was a total of 180 midwives employed within the maternity unit during the time of data collection.

To collect data from a large sample group in a short period of time it was decided that a questionnaire would be the most appropriate data collection method. The questionnaire used was chosen because it had been previously used to assess neonatal nurses' attitudes towards illicit drug use in pregnancy (Raeside, 2003; Ludwig et al, 1996). This improved the validity of the data collection tool. The questionnaire included six demographic questions and 20 five-point Likert rated statements. Ten of the statements were positive and ten were negative.

The data collection period started on 15 April 2011, when posters inviting midwives to participate were displayed around the maternity unit. Participant information sheets (PIS) and questionnaires were placed in all the clinical and staff areas and data collection lasted four weeks. Local research ethics committee approval was granted to undertake this study. The primary ethical issue identified in this study was the vulnerability of the participants. Asking midwives to examine their attitudes could have been unsettling. Participants were given the opportunity to discuss any issues arising from the study with either the researcher or staff counselling services. To enable volunteers to gain informed consent, a PIS was available for all potential respondents. Implied consent was obtained from returned, completed questionnaires.

#### **Results**

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There was a total sample of 180 midwives working and eligible to complete the questionnaire during the data collection period. A total of 133 questionnaires were returned with a response rate of 73%. Six of the questionnaires had missing data and were excluded from the data analysis; the total number of usable questionnaires was 127 (70%).

Of the respondents, the most prevalent age range was 26 to 35 (39%). A total of 42% of respondents had been qualified as a midwife for less than five years and 56% were educated to degree level or above. Some 60% had received no formal education regarding drug use in pregnancy and 90% of midwives had cared for less than five pregnant substance misusers in the last year.

Attitudinal statements were assessed on a five-point Likert scale and for data analysis purposes, the following codes were used: strongly agree = 1, agree = 2, no opinion = 3, disagree = 4, strongly disagree = 5. See Table 1 for a sample of the responses to the attitudinal statements. Negative values were not re-coded in the questionnaire, following statistical advice based on the mean values (see Table 2).

The Spearman correlation test identified no statistical difference between midwives' attitudes and their experience of working with substance misusers.

The Spearman correlation test identified a statistical difference between midwives' attitudes and their length of time qualified. A positive correlation was identified between the variables and one positive statement: 'Life's circumstances are responsible for pregnant women's drug use' ( $r=.332$ ;  $p=.000$ ). Therefore, these midwives were more positive in their attitudes towards illicit drug use in pregnancy.

The Mann-Whitney U test identified a statistical significance between midwives' attitudes, formal education in substance misuse and three attitudinal statements. Three negative statements showed a relationship between the variables; 'I feel angry in reaction to women who use drugs in pregnancy' ( $p=.010$ ); 'women who use drugs when pregnant should be prosecuted' ( $p=.027$ ) and 'women who use drugs in pregnancy care little about themselves or their babies' ( $p=.040$ ). Therefore, midwives who had received formal education in substance misuse were more positive in their attitudes towards illicit drug use in pregnancy.

## Discussion

### *Negative and positive attitudes*

Negative attitudes were prevalent in the literature, with 76% of neonatal nurses reporting that they felt angry in reaction to women who use drugs in pregnancy (Raeside, 2003; Ludwig et al, 1996). Only 23% of midwives agreed with this statement in the study. Moreover, only 12% of midwives reported a lack of empathy towards pregnant substance misusers and just 5% of participants reported that their attitude had become more negative.

These findings have demonstrated that the midwives sampled reported positive and non-judgemental attitudes towards illicit drug use in pregnancy. The contrasting findings reported in the literature and the current study might be related to occupational differences in the sample groups. None of the studies in the literature review were conducted with midwives, but four were conducted with neonatal nurses. The neonatal nurses' primary responsibility is to the baby, not the mother, and neonatal nurses will witness the effects of maternal drug use on the baby. This may explain why midwives reported more positive attitudes towards pregnant drug users than the neonatal nurses.

Punitive attitudes were also noted in the literature with US doctors supporting legal coercion of pregnant drug users. Just 10% of midwives reported that they were judgemental or punitive towards pregnant drug users and only 5% agreed with the prosecution of pregnant drug users.

The findings have shown that the midwives sampled demonstrated non-punitive attitudes towards pregnant substance misusers. The differences between the attitudes reported in the literature and the attitudes reported in this study might be explained by geographical, cultural and social issues. Abel and Kruger (2002) conducted their study with doctors in the US. Punitive attitudes exhibited towards pregnant drug users may be more prevalent in areas

**Table 1. Sample of responses to attitudinal statements (n=127)**

Strongly agree	Agree	No opinion	Disagree	Strongly disagree	Mean	Median	Mode	Standard deviation
<i>I feel angry in reaction to women who use drugs in pregnancy</i>								
2 (2%)	27 (21%)	16 (12%)	62 (49%)	20 (16%)	3.56	3.56	4.0	1.04
<i>Individuals are responsible for their problematic drug use</i>								
3 (2%)	43 (34%)	32 (25%)	38 (30%)	11 (9%)	3.09	4.0	4.0	.68
<i>Women who use drugs in pregnancy deserve the same quality care as those who don't</i>								
64 (51%)	61 (48%)	0 (0%)	2 (1%)	0 (0%)	1.53	1.0	1.0	.59
<i>I feel sympathetic towards women who use drugs in pregnancy</i>								
14 (11%)	48 (38%)	34 (27%)	29 (23%)	2 (1%)	2.66	3.0	2.0	1.00
<i>Women who use drugs when pregnant should be prosecuted</i>								
0 (0%)	7 (5%)	35 (28%)	57 (45%)	28 (22%)	3.83	4.0	4.0	.83
<i>I believe working with drug using women is rewarding</i>								
13 (10%)	44 (35%)	46 (36%)	23 (18%)	1 (1%)	2.64	3.0	3.0	.92

**Table 2. Mean values of non-decided negative items**

Statement	Formal education	No formal education
<i>I feel angry in reaction to women who use drugs in pregnancy</i>	3.84	3.37
<i>Women who use drugs when pregnant should be prosecuted</i>	4.04	3.70
<i>Women who use drugs in pregnancy care little about themselves or their babies</i>	3.55	3.12

of the US where legislation exists for forcible treatment. Therefore, the attitudes observed in the US study may not be representative of those from the UK, where there are no legal sanctions for drug use in pregnancy. Moreover, it may also be due to professional differences between the sample groups. The concept of the midwife, particularly of being an advocate for women, might negate punitive attitudes.

Despite reporting more positive and non-punitive attitudes, less than half of the midwives (49%) reported that they felt sympathetic towards pregnant drug users. Without further exploration, it is difficult to speculate as to why some midwives lacked sympathy, but it may be linked to a sense that pregnant women are responsible for their drug use and associated poor outcomes.

One study reported that nurses perceived drug users to hold high levels of responsibility for their drug use (Skinner et al, 2007). In contrast, this study demonstrated that midwives were ambiguous about who was responsible. Nearly equal numbers of midwives agreed (36%) or disagreed (39%) that pregnant substance misusers were responsible for their own drug use. Conversely, 79% of midwives agreed that life's circumstances were responsible for pregnant women's drug use. The ambiguity in these findings may be because less than half (40%) of the midwives had received formal education in substance misuse. Despite indecision surrounding responsibility for drug use, midwives' attitudes were clear in regards to the provision of care. The vast majority agreed that pregnant drug users deserve equal care (99%), while only 45% found caring for pregnant drug users rewarding.

This finding is supported by the literature where five studies reported that healthcare practitioners felt a sense of being at risk and feelings of vulnerability were experienced when working with drug users (Fraser et al, 2007; Peckover and Chidlaw, 2007; McKeown et al, 2003; McGillion et al, 2000; Siegfried et al, 1999). However, in this study, 38% of midwives had not cared for any pregnant substance misusers in the last year. Consequently, their attitudes towards working with pregnant drug users might have been based on hypothetical situations.

*Experience and attitudes*

Two variables were used to assess experience: length of time qualified as a midwife, and experience of working with pregnant substance misusers. No relationship was identified between experience of working with substance misusers and attitudes. This was in contrast to the literature, where

two studies identified a relationship between experience of working with substance misusers and attitudes towards them (Raistrick et al, 2008; Ramirez-Cacho et al, 2007). It may be that no relationship was noted because the sample group was inexperienced, with only 10% of midwives caring for five or more pregnant substance misusers in the last year.

Midwives with less experience were more likely to agree that 'life's circumstances are responsible for pregnant women's drug use'. Although only one statement showed any statistical significance, this finding is supported in the literature (Gilchrist et al, 2011).

There may be several reasons why inexperienced midwives working with substance misusers demonstrated more positive attitudes towards personal responsibility for drug use. Firstly, those who have qualified recently may have benefitted from teaching modules related to drug use in their training. Secondly, less experienced midwives would be expected to be younger and drug use may be more socially acceptable among younger generations. Thirdly, midwives who have not been practising for long may be less exhausted by the complex nature of working with substance misusers.

*Formal education and attitudes*

Midwives were less likely to agree with three negative statements if they had received formal education in substance misuse. These related to feelings of anger in response to drug use in pregnancy, the prosecution of pregnant drug users and pregnant drug users caring little about themselves or their babies. Therefore, formal education in substance misuse has been shown to result in more positive attitudes; a finding supported by the literature. Four studies showed formal education was positively associated with improved comfort and confidence levels when working with substance misusers. This positively impacted on practitioners' attitudes towards drug users (Thuy Tran et al, 2009; Silins et al, 2007; Strang et al, 2007; Bland et al, 2001).

Education regarding substance misuse can enhance positive attitudes from midwives for a variety of reasons. Firstly, education increases knowledge, which increases comfort and confidence levels. This can reduce stress and feelings of vulnerability, thus increasing the midwives' motivation. Secondly, the provision of current, accurate data and the development of relevant skills can positively influence midwives' attitudes. Thirdly, by teaching midwives about the complex and challenging issues that substance misusers may experience, empathetic attitudes will be encouraged.

*Limitations*

This study was conducted in one NHS trust, therefore the results are only representative of that trust, and possibly others that are similar. The host site maternity unit had a low prevalence of pregnant drug users. It is, therefore, difficult to generalise the results to maternity units that have higher rates of substance misuse in pregnancy. Midwives' knowledge of substance misuse in pregnancy was not explored and this might have influenced their attitudes. It is possible that the midwives who completed the questionnaire had good knowledge levels surrounding substance misuse

in pregnancy. Convenience sampling may have reduced the representativeness of the population being studied. It may be that the midwives who chose to respond had more positive attitudes towards pregnant substance misusers or a particular interest. The higher rates of positive and supportive attitudes, in contrast to the literature, might also suggest the possibility of social desirability response bias.

## Conclusion

The aim of this study was to explore midwives' attitudes towards illicit drug use in pregnancy. The main findings of

the research demonstrated that midwives reported positive, non-punitive attitudes towards pregnant substance misusers. This was in contrast to the findings that were reported in the reviewed studies. Midwives with less experience were significantly more positive in their attitudes towards illicit drug use in pregnancy. Furthermore, midwives who had received formal education regarding drug use in pregnancy demonstrated significantly more positive attitudes. These findings were supported by the studies reviewed. The findings of this research provide evidence for the benefits of an educational programme for drug use in pregnancy.

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# Normal birth and its meaning: a discussion paper

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## Abstract

**Background.** The importance of working in partnership with women to engender true 'choice' may be challenging for many midwives, but there is a need to confront those who promote authoritative knowledge within their own organisations if the profession is going to reclaim the fragile construct of normal birth as a physiological and social process in the future.

**Aim.** Using Foucault's (1976) concept of power and knowledge, this paper aims to explore how growth of authoritative knowledge and dominant discourse associated with medicine – in particular obstetrics – in the 20th century has transformed society's view concerning 'normal birth'. Discussion is placed within the context of recent NICE guidelines published in 2011, which afford women the choice of CS birth in the absence of clinical need.

**Key objectives.** To understand how the use of authoritative knowledge and dominant discourse in obstetrics has influenced society's view concerning the concept of 'normal birth'.

**Findings.** It is recognised as that which Foucault (1976) identified as the singular concept of power and knowledge has influenced society's vision of 'normal birth' in the present day. Increasing medicalisation and pathologising of childbirth has led to the current practice of birth by CS in the absence of clinical need, as a genuine alternative birth choice available to all women in the UK.

**Implications.** Midwives need to be mindful of how within the domain of present day maternity services in society, authoritative knowledge and dominant discourse surrounding 'normal birth', can influence women in their decision-making.

**Key words:** Women, normal birth, medicalisation, dominant discourse, caesarean section, evidence-based midwifery

## Introduction

This paper will focus its discussion on the key issues of birth, knowledge and women's choice. The structure of the paper is embedded within a discourse framework to maximise attention on the multiplicity of factors that influence perceptions about childbirth. Recognising at the outset that the author is a midwife, it is acknowledged that there is the potential for a conflict of interests, as a practitioner rooted in the perspective that childbirth is inherently a physiological process. However, the intention is to stimulate discussion and debate and by focusing on the evidence from the literature, it is hoped that the reader will be able to gain a deeper insight into the key issues that dominate modern thinking in this area.

The early 20th century witnessed an emerging dichotomy, which altered society's view of 'normal birth'. This changed the concept of 'normal birth' from that of a physiological and social process taking place within the home, to the dominant policy of the present day, which sees birth as a largely medicalised process within the UK. This century witnessed the prominence of a persuasive campaign of 'safety' by the medical establishment, which contributed to figures that by 1980 showed that less than 1% of births occurred in the home (Tew, 1995). Supported by the political milieu of post-war Britain, and with the establishment of the NHS, this singular policy was embraced by society, leading to maternity care that became more and more fragmented (Henley-Einion, 2003). It was a policy that pathologised childbirth (Flint, 1986) as a process that required technological management within a hospital setting (Towler and Bramall, 1986). Such medicalisation can be contextualised within feminist and social theory by considering the societal influences surrounding knowledge

and power, which, historically, have afforded privilege to the increasingly dominant discourse of obstetrics. In turn this led to the marginalisation of discourse surrounding normal birth, midwifery knowledge and women's intuitive knowledge (Hewer et al, 2009). Later in the 20th century, there was largely unquestioning and wide placed subscription to the findings of publications, such as *The Peel report* (DH, 1970), which recommended all births take place in a hospital setting, aligning it to one which equated to safety, overtly implying that midwifery care in the community was inherent with risk (Cahill, 2001). This message of 'safety', as a component of patriarchal control, coerced women to accept medical control over their bodies for the greater good; that of a healthy newborn. It was not until over two decades later that the report of the expert maternity committee in 1992 afforded women a voice and recognised that the overwhelming majority would welcome an alternative to medical birth in hospital (DH, 1993). Although the publication of the *Changing childbirth* (DH, 1993) report did not see the reversal of medicalised birth, it did identify the need for women to be offered choice in relation to maternity services and reaffirmed that midwives should be at the fore of normal pregnancy and birth. However, this report has been instrumental in reinforcing the power base of obstetricians by continuing to place them as the lead for 'complicated' childbirth, itself a concept which has long been poorly defined (Cahill, 2001).

Half a century of doctrine and medicalisation coincided with a time of improvement in maternal and neonatal mortality rates in the UK, once again strengthening dominance of medicine over birth. The unsubstantiated links subsequently drawn between association and causation assumed that biomedical knowledge and technocratic births

were the reason for improvement in this area, these have since been discredited (Tew, 1995). Cahill (2001) identified other factors working to underpin and sustain the status quo. The theory that dominant professions may be selective in the evidence they pay credence to, as mainly that which supports their position of power within any institution and society, is likely to have a significant role in this. With the publication of *Midwifery 2020* (Midwifery 2020, 2010), there is once more a vision that seeks to place midwives as the lead professional for women with straightforward pregnancies, but also as coordinators of care for those women who have more complex pregnancies. The report acknowledges that the coming decade will present challenges as well as opportunities for midwives to develop their role as leaders in the delivering and shaping of maternity services in a changing environment (Midwifery 2020, 2010: 1).

### **Authoritative knowledge in childbirth**

It was initially the French philosopher, Foucault (1972) who supported the theory that the ontological 'truth' is that which is socially constructed, recognising that dominant discourses were accepted as 'true'. Hagell (1989) argued that every occupational profession will seek to create their own individual epistemology. This epistemology will lead to the creation of social norms which are embedded within dominant discourse, subsequently working together to encourage conformity (Fahy, 2008). Jordan proposed this theory of 'authoritative knowledge', whereby one form of knowledge gains ascendance and legitimacy over another, as early as 1988, and Oakley (1992) applied this to the scientific paradigm of medicine and obstetrics, proposing that both had long worked to suppress competing forms of knowledge within the hierarchy of healthcare practice. Non-authoritative knowledge systems, such as that of the midwifery profession, are frequently devalued through this dominance of hierarchical knowledge (Jordan, 1997). The medical view of childbirth presents a process that is inherently full of danger, for which only hospital can offer the safety required for all childbearing women. This 'pathologising' of childbirth marginalises the philosophy of midwifery as one which seeks to maintain pregnancy and birth as a normal, non-pathological process (Thachuck, 2007).

Benner (1984) and Jarvis (1986) identified different ways of knowing; propositional knowledge (knowing that) and practical knowledge (knowing how) used within the profession of midwifery. It was Belenky et al (1986) who explored women's ways of knowing and quantified these as forms of knowledge that could be seen as subjective, procedural and constructive. In reality, multiple discourses and knowledge systems surrounding childbirth will exist, creating multiple ways of knowing (Jordan, 1997). Propositional knowledge resides comfortably within the dominant, reductionist, bio-medical model of childbirth in support of medical knowledge; that which is male and scientific and thus viewed as superior in nature to female intuitiveness (Cahill, 2001). The midwifery profession, which values scientific knowing, but also incorporates

subjective knowing as 'legitimate' knowledge, may experience conflict in supporting women's choices within the institutions they work and Hunter (2008) argued that the often polarised professions of obstetrics and midwifery present competing forms of knowledge, both of which are rivalling one another for authority.

Church and Raynor (2000: 25) refer to this tacit concept of 'knowing how' as that which cannot be quantified, therefore, it is often undermined and undervalued by those supporting the dominant discourse. Parratt and Fahy (2008) advanced this concept with their discussion of the 'rational base' of western medicine, seen in the structure and function of maternity services. Non-rational ways of knowing that may be employed readily by women and midwives can be difficult to express and quantified in standard, 'rational' ways.

Medicine does not provide credence to this, due to such knowledge residing outside the established concept of evidence-based practice. This concept is largely driven by the positivist paradigm of research; that which can be objectively quantified and tested, which cyclically authenticates the dominance of obstetric discourse. Stewart (2001) referred to this hierarchy of evidence, whereby studies that employ methodologies and methods, such as randomised controlled trials and meta-analyses, are seen as 'gold standard' and viewed by many as the pinnacle of medical science. It is clear that quantitative studies, which provide statistical evidence of outcomes, are still favoured for publication in historically 'prestigious' journals with an 'obstetric' focus. This consensual co-construction of authoritative knowledge (Jordan, 1997) is further preserved through publications produced by the Cochrane database and NICE guidelines which adopt this 'ranking' of evidence with these publications then commonly being incorporated into clinical guidelines adopted in everyday practice.

### **Normal birth?**

Jordan (1993) suggested that women's decision-making power regarding birth is intertwined with the concept of birth territory and ownership. Anderson (2003) defined normal birth as one without intervention in an environment that enables choice and empowerment for the woman. Midwives have previously been referred to as the guardians of birth 'normality' (RCM, 2004). It is clear that an ideology can guide that which is viewed as 'normal' and childbirth is no exception – historically it has been targeted and used effectively as a means for social regulation (Price and Johnson, 2006). A collaborative working party (RCOG, 2008: 32) highlighted that the promotion of normal birth is the philosophy of maternity care, but qualifies this with the statement '...with intervention only if necessary for the benefit of mother and child'. How can women deem which interventions are necessary and which ones are not? Definitions of normal birth vary from author to author with no universal agreement (ICM, 2008; RCM, 2004) with such complexity it is difficult to perceive how women can exercise true choice in such circumstances.

Henley-Einion (2003) discussed how women are only

offered the illusion of choice. Often the very information received by women is such that is controlled and restricted by the institution itself as the language used by the dominant domains in such descriptions may only be understood by the initiated (Foucault, 1976). Savage (2006) acknowledged this issue of 'knowledge control', whereby healthcare professionals may actually withhold information from women, directing them towards socially accepted choices, thus reflecting Foucault's (1980) theory, which acknowledged that people will behave as they are expected to behave following the norms constructed through pervading belief systems (Snowden et al, 2011). Authors such as Henley-Einion (2003: 178) suggest that in this context the only real options related to childbearing are of 'normal medical labour' or 'complicated medical labour'.

The power that dominant obstetrical discourse conveys can often be seen by some as that which is perpetuated by many within the midwifery profession (Hunt and Symonds, 1995). As a profession, which consists of a largely female workforce, they can be viewed by some as 'handmaidens' to those holders of power – obstetricians – who themselves provide an invisible authority and are frequently male (Savage, 2006). Midwives can be submissive to the dominant medical discourse and may themselves unintentionally contribute to the marginalisation of women. In an increasingly litigious society, the desire to avoid responsibility and not to be held accountable, may lead to them handing over decision-making power to that 'powerful other' (Foucault, 1980). Within a patriarchal society 'gendered power' is prevalent in identifying knowledge as that which supports the authority of the masculine profession of medicine (Lee and Kirkman, 2008). Midwives will frequently identify themselves as advocates for women but may be hampered by the institutionalisation of their profession, which remains largely hierarchical in nature. In western societies this sees obstetricians placed at the pinnacle of that hierarchy, with women at the bottom and midwives situated somewhere in between (Stapleton et al, 2002).

Kitzinger (2005) discusses the importance of midwives being able to understand and critically analyse all forms of research evidence, in order to challenge dogma and rigid institutional practises in the light of such evidence. She suggested that midwives needed to place themselves 'at the edge', an uncomfortable place to be involving confrontation and conflict with the existing hierarchy. Straddling this divide, with the ethos of midwifery as the guardians of normality but while working within an obstetric framework, is inherently problematic.

Odent (2008) goes further and proposes that the dogma of evidence-based medicine has the potential to lead to the erosion of 'normal childbirth', and the promotion of birth by CS, as the norm for all women. Three years later, with the recent publication of NICE guidelines (2011) for CS in childbirth, some may feel this view sanctioned. Women are now able to request a CS in the absence of medical need under the guise of 'choice', constructing CS birth as an alternative to vaginal birth (Douché and

Carryer, 2011). This could reconstruct the way in which women experience birth and may be seen as a new form of obstetric and 'consumerist discourse' (Douché and Carryer, 2011: 143). Hewer et al (2009) suggested that we need to view the current debate on elective CS within its social context, whereby birth is viewed as inherent within the discourse of risk, with technology seen as progressive, and recognising the medical profession as dominant. Dominant groups will find their interests served by outlining CS as the woman's choice and marginalising any voices of dissent (Hewer et al, 2009). The portrayal of CS delivery, as an alternative to vaginal birth again exposes a pathologising paradox in which 'normal bodily performance emerges as the abnormal and the abnormal as normal' (Douché and Carryer, 2011: 144).

Rates of CS have been increasing over the years with levels in the UK, at some maternity units, now at 25% or above, with the normal delivery rate remaining consistent at around 62% (The Information Centre, 2012). This may partly be attributable to the endorsement of the benefits of CS within discourse clearly portrayed in citing the avoidance of pain and reduction of anxiety and fear (Handelzalts et al, 2012). The unequally balanced discourse surrounding CS covertly minimises its proven risks, including higher maternal morbidity and mortality rates, as well as the potential for negative compromise in future pregnancies (Hewer et al, 2009).

#### **Influencing choice**

Porter, in 1998, acknowledged that as scientific discourse remains largely inaccessible to those whom it is written about, women will continue to have little opportunity to affect it in striving to create their own childbirth identities.

It is recognised that this authoritative knowledge of medicine will invariably supersede women's intuitive personal knowledge which, in turn, may lead them to distrust their own body's ability to birth without intervention (Savage, 2006). Lee and Kirkham (2008: 459) suggest that it is medicine which has appropriated birth for which childbearing women themselves are the experts and should be acknowledged as such.

Kitzinger (2006) discusses how the admissions procedure on entry to hospital marks the handing over of power and control for many women, which is often then compounded by the 'active management' of labour. With the policy of only one birthing partner being allowed in many maternity units, women are separated from friends and family, expected to conform to the image of a 'good patient' agreeing to that care, treatment or intervention, which is recommended by those in authority. Kitzinger (2006) acknowledges that in most countries birth is seen as 'men's business' with the dominant discourse of obstetrics expressing suggestions of female incompetence and male superiority. Terms such as 'failure to progress' and 'incompetent cervix' in relation to a woman in labour are often still used in many maternity units today. This demonstrates the woman's 'failure' to adhere to clinical guidelines, which then has to be rectified by the expert obstetrician at the pinnacle of that medical

hierarchy (Kitzinger, 2006).

Childbirth is individual to each woman and, as such, is multifaceted in its meaning and identity. Governments have now long recognised that choice during childbirth should be acknowledged as an integral right for every woman with influential publications such as *Maternity matters* (DH, 2007), *National service frameworks* (DH, 2004) and NICE guidelines (2007) all paying reference to this. While the publication of the NICE (2011) guidelines for CS will be seen by many women, midwives and obstetricians as a positive step forward in affording true choice during childbirth, it should be recognised that this is still a choice that has been legitimised within current dominant discourse in society. The guideline (NICE, 2011), which offers the possibility of choosing CS in the absence of medical need, may be empowering for some women, but it further supports the premise that birth requires technological support in order to occur. The guidelines place the 'positive' aspects of CS birth at the outset with the risks placed secondary to these (NICE, 2011).

It is interesting that CS birth appears to warrant its own individual guidelines while discussion surrounding women's options for midwifery-led care and home birth remain within the generic NICE guidelines related to intrapartum care (NICE, 2007), thus ascribing less importance. It is not ignored that it is the women who give birth and their individual choice should be respected, but Henley-Einion (2003) suggests that women should still be challenged as to the reasons why they are choosing to medicalise their birth.

In many western patriarchal societies, the rights of the fetus are clearly set against the woman's right to autonomy, self-determination and choice. Lee and Kirkman (2008: 460) identify how discourse has previously been used to overtly portray women who requested an 'unnecessary' CS as those women who were 'foolish, irresponsible, and with unreasonable expectations'. At the heart of this, is the concept of the 'good mother', which requires women to be selfless in their choices, ultimately putting aside personal desires in order to succumb to medical reasoning, thus ensuring the health of their newborn. Almost 20 years ago Schwarz (1990) identified this as 'engineering childbirth', suggesting that the choices made by women will only ever be individual to them within the context of the dominant obstetric discourse prevalent at that time. This perception has since been supported in studies by Shaw (2007) and Snowden et al (2011) exploring women's experiences of

researching choices related to childbirth. Both identified that these choices often failed to translate into the levels of confidence required to discourage the dominant medical view. Women may want to exercise choice surrounding their birth, but this is set against what Foucault (1991) previously described as 'led by rewards for compliance'. More recent research by Fahy (2008) drew attention to to the dilemma facing women who fear 'punishment for non-compliance', which included fear of pain, disability or death. The echoes of fear persist across the time barriers, and the comments by Machin and Scamell in 1997 remain as poignant today as they were 15 years ago: a brave woman may be prepared to accept such 'punishments' for herself but the added complexity of being 'with child' will often lead to the most informed losing faith in her convictions as childbirth advances ever closer.

### Conclusion

The aim of this paper was to explore the concepts of dominant discourse and authoritative knowledge in relation to the concept of 'normal birth'. It is a salient point that, while some progress has been made, there remains a continuing polarisation of views regarding the concept of 'normal birth' between professional groups that practice within the maternity services and who directly care for women. It is recognised that Foucault wrote of the single concept of power and knowledge, such a concept is intertwined with dominant discourse which will seek to promote power through attaining authoritative knowledge (Lee and Kirkman, 2008). At present, it appears that women are offered, or only able to exercise, choice in relation to childbirth within the context of the dominant medical discourse of obstetrics. Continuing and active engagement is required by midwives, firstly in the critique of dominant discourse surrounding obstetrics, coupled with an appreciation of how authoritative power functions to control birthing practices, in order to affect change. The issue of CS in the absence of clinical need offers a challenge to the midwifery profession. The need to strengthen our own professional epistemological stance is required at a pivotal moment in the creation of our own legacy and history surrounding childbirth. The profession needs to reclaim the fragile construct of normal birth as a physiological and social process in order to truly empower women in affording genuine choice in relation to childbirth in the future.

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# Issues for consideration by researchers conducting sensitive research with women who have endured domestic violence during pregnancy

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## Abstract

**Background.** Pregnancy has been identified as a specific time in which domestic abuse can start or escalate. However, understanding this complex phenomenon requires further research and the challenge faced by midwifery researchers is the conduct of 'sensitive research'.

**Aim.** The aim of this paper is to provide a description of the process of conducting sensitive research using a framework for good practice applied to an actual research study.

**Approach.** The WHO's ethical and safety recommendations for the conduct of domestic violence research were used as a framework for guiding this research. Full NHS Ethical approval was obtained from the local research committee to undertake a feminist phenomenological research study using unstructured, in-depth interviews.

Data were collected from a qualitative sample of 11 women who had been pregnant in the previous two years and the data were subject to thematic content analysis.

**Findings.** Gaining access to this vulnerable group of women was a challenge and required sensitivity and thorough consideration at each stage of the recruitment process. Conducting such interviews has the capability to emotionally re-traumatise survivors, especially when women are being asked to recall physical, emotional and sexual abuse. Establishing a reciprocal relationship challenges the traditional researcher and participant hierarchy and dynamic.

**Implications.** Conducting sensitive research requires ethical guidance and this paper illustrates how the WHO ethical guidelines for conducting domestic violence interviews were utilised at every stage of this research and their value to midwifery researchers'.

**Conclusion.** Researching 'violence' is a high risk activity for both researcher and participant and requires particular attention to planning every aspect of the study and paying specific attention to details regarding safety and ethical behaviour.

**Key words:** Conducting sensitive interviews, women's experiences, domestic violence and abuse, women's voices, evidence-based midwifery

## Introduction

Domestic violence during pregnancy has emerged as a national and global health issue that has the capability to fatally harm a woman and her unborn fetus (Reilly et al, 2010). It is known that pregnancy may be an especially vulnerable time for a woman and her unborn child, as the violence has been shown to begin or escalate during or shortly after pregnancy (Helton et al, 1987; Walby and Allen, 2004; Lewis, 2007). It is difficult to estimate the exact prevalence of domestic violence during pregnancy, as it is thought that many women may be reluctant to disclose their experiences. However, reported prevalence rates of violence in pregnancy range from 0.9% to 20.1% (Gazmararian et al, 1996). The WHO, in 2005, reported on 48 worldwide studies indicating that the incidence of physically abused pregnant women was greater than 5% in 11 of the 15 countries studied (WHO, 2005). More recently, Taillieu and Brownridge (2010) suggest that the majority of international studies have found prevalence rates of between 3.9% and 8.3%. Three UK prevalence studies have reported rates of domestic violence during pregnancy of between 2.5% and 5.8% (Bacchus et al, 2004a; Bacchus et al,

2004b; Johnson et al, 2003). However, Bacchus et al (2007) suggest that the reliance on anecdotal reports from pregnant women or hospital-based samples within the UK currently makes it impossible to confirm whether or not pregnancy per se increases the risk of violence. However, international studies have suggested that pregnancy can act as a trigger for domestic violence or exacerbate an existing problem (Campbell et al, 1992; Webster et al, 1996; Valladares et al, 2002). Although prevalence rates vary between studies, it is evident from the figures available that a significant minority of pregnant women will experience violence during pregnancy and in the immediate postnatal period.

For almost 30% of women who suffer from domestic violence in their lifetime, the first incidence of violence is thought to occur during pregnancy (Helton et al, 1987). The risk of domestic violence during pregnancy increases the risk of miscarriage, preterm labour and maternal and fetal injury. There are also a number of high-risk harmful behaviours to both the mother and unborn child such as smoking, alcohol abuse, drug taking (prescribed and illegal) as a means of coping with the violence and abuse, (McFarlane et al, 1995, 1996; Valladares et al, 2002; EL Kady et al,

2005). There is also some indication that violence during pregnancy is not a one-off event, for example, Martin and colleagues (2004) revealed that abused pregnant women on average experienced one violent attack resulting in one injury per month, perhaps suggesting that pregnancy is not a protector against violence and abuse. The conduct of research in a sensitive area like domestic abuse requires specific training and guidance so that the research or the researcher does not add to the pain or trauma already experienced by the interviewee. Sensitive research has been defined as 'Research that intrudes into the private sphere or delves into some deeply personal realm' (Elam and Fenton, 2003). Research on the conduct of 'doing' sensitive research is still developing within the midwifery profession and, seven years ago, Sinclair (2006) wrote about the risks involved in sensitive research being 'real for the midwife as researcher and the woman as participant'.

### Method

A feminist phenomenological paradigm was utilised for the research. Feminist phenomenology suited the purpose of the research because it is naturalistic, with an ontological principle that maintains that the world is not objective and discovered but is socially constructed (Fisher, 2000; Sarantakos, 2005). Such a philosophical framework believes that to understand this world of meaning one must interpret it (Denzin and Lincoln, 1998). As an approach, phenomenology seeks to reveal how human awareness is implicated in the production of social action, social situations and social worlds (Sarantakos, 2005). It was anticipated that by combining the philosophies of feminism and phenomenology together a deeper understanding of women's lived experiences of domestic violence would be achieved.

It was imperative to fully describe and define the women's experiences as communicated by them, rather than prescribed by the dominant masculine structures of phenomenology (Nelson, 1989). Investigating and understanding the everyday world of women's experiences has always been paramount to feminism and feminist research (Stanley and Wise, 1983; Reinhartz, 1992). However, it was also important that the study was reflective of women's experiences of domestic abuse against the background of patriarchy, hierarchy, disembodiment, power and control; all inherent when living in a world of violence.

### Data collection

Data were collected from 17 interviews undertaken using unstructured interviews with 11 women who had been pregnant in the previous two years. The number of interviews with each participant varied, ranging from a single interview with some participants, two interviews with others and three interviews with one participant. The number of interviews with each participant depended upon individual personal circumstances and their availability at the time of data collection.

During the data collection phase, eight of the participants were residing in a women's refuge and three were participating in a support programme. Informed consent

was obtained from every participant prior to starting any interview. Having agreed to take part in the study, interviews were conducted a week later, allowing participants seven days to reconsider their agreement to participate. The principle of ongoing negotiation was always respected. All the interviews lasted between 30 minutes and two hours. With consent, all the interviews were digitally recorded and transcribed verbatim. The interviews were analysed using Reinhartz's (1992) content analysis framework. Full NHS ethical approval was sought and gained for the study.

### *Ethical and practical considerations of conducting sensitive interviews*

According to the Watts et al (2001: 2), researching domestic violence can be a significant risk to the wellbeing of the participants: '*Researching abuse is not like other areas of investigation – the nature of the topic means that issues of safety, confidentiality and interviewer skills and training are even more important than in other forms of research. It is no exaggeration to say that the physical safety and mental wellbeing of both the respondents and the research team can be put in jeopardy if adequate precautions are not taken.*' In response to the concerns, the WHO published guidelines in an endeavour to raise awareness of some of the ethical issues in conducting research on violence (see Table 1). The guidelines were used as a framework to ensure safe and ethical practice when planning and conducting the interviews.

### *Negotiating access and ensuring safety for participants*

The WHO guidelines state that the safety of women and the research team is paramount and such safety decisions should

**Table 1. WHO ethical consideration for conducting research**

1. The safety of respondents and the research team is paramount and should infuse all project decisions.
2. Prevalence studies need to build upon current research experience and how to minimise the under-reporting of abuse.
3. Protecting confidentiality is essential to ensure both women's safety and data quality.
4. All research team members should be carefully selected and receive specialised training and ongoing support.
5. The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.
6. Field workers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
7. Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.

permeate all project decisions. Indeed, one of the most difficult challenges when conducting interviews for this type of research, or indeed any other research involving sensitive interviews, is gaining access to the participants. Although this proved to be a lengthy process, such negotiations with both the agencies and the women were essential in building up a trusting, respectful relationship. Emergency housing, advocacy, helplines and women's support groups continue to be established by women's organisations, with many of these services supported and administered by survivors of domestic violence. The result has been that such services are responsive and extremely protective and sensitive to abused women's needs (Mullender et al, 2003). Such sensitivity has included being cautious about being 'used' or exploited by outsiders, including academics (Abrahams, 2007). Therefore, negotiating access to the participants was expected to be exigent. A priority of the various support groups was to ensure that the research would not be exploitative, or detrimental to the participants. It is crucial that women's organisations are able to trust and have confidence in both the researcher's capability and their overall motive and commitment to the research they are undertaking (Abrahams, 2007).

Following various meetings with directors of the service, refuge managers, team leaders and support workers, it was agreed that they would support the research. This support included placing a poster in the refuge, seeking the women's thoughts about the impending research at weekly house meetings, handing out the information sheets and acting as a conduit between the participants and researcher. Discussing and obtaining the views and opinions about the research from the refuge residents at their weekly house meetings seemed to add credibility to the work, in that they felt it was important to conduct research in this particular area. Having successfully negotiated access, it was then extremely important that an open, genuine approach was maintained with the refuge staff, support workers and the participants themselves. It was realised that receiving support to enter the refuge to conduct the research is a rare privilege, as refuges are persistently underfunded, with a transient population cared for by staff who work under extreme pressure and often in difficult circumstances (Abrahams, 2007). Recruitment to the study always occurred through a third party, usually the refuge manager or the women's support programme facilitator. This ensured that no undue pressure was placed on the women by the researcher to participate in the study. It was therefore important having gained the trust and confidence of the organisations, that a continued relationship of reciprocity and trust was maintained throughout the research.

#### *Respect for participants*

The participants were aged between 19 and 40. The inclusion criteria were pregnant currently, or in the previous 24 months, and over 18 years of age. All the women had children residing in the refuge with them, the children's ages ranged from 13 years being the eldest, to eight weeks being the youngest. Eight of the women who took part in

the study were white British, one was black British, and two were Indonesian by birth but were residing in the UK.

All the women interviewed had experienced several types of violence and abuse in the previous 12-month period. The number of interviews conducted with each participant was very much dependent upon their availability, willingness to be interviewed and the accessibility of a private and safe space. The interviews with the women residing in the refuge were, in most instances, a single interview; the decision for only one interview was made out of respect for the women, the refuge staff and the availability of a private interview room. The staff in the refuge, regardless of the limited space, always endeavoured to make a private space available to conduct the interview. This sometimes involved giving up precious office space. The refuge also provided play workers for the children, thereby allowing the women to participate in complete privacy. The interviews with the women in the refuge lasted between 60 to 120 minutes and on the day, or the day before their interview, the women had access to a counsellor who visited the refuge. For the women who were recruited via a woman's support programme, all their interviews were conducted prior to their attendance at their weekly support meeting in a children's centre. During the interviews, the participants' children were cared for in the crèche by play workers. The length of the women's interviews was determined by the availability of a private room. Each interview usually lasted 30 to 45 minutes and two to three interviews were conducted with each woman.

All the women were asked to describe their experiences of the violence and abuse during their pregnancy or pregnancies. No difference was noticed on the quality of the interviews, regardless of whether they were conducted in the refuge or in the children's centre. The first statement was 'Tell me a little bit about yourself'. This was used as a preamble to the interview by allowing the participant's time to talk about themselves. This was a really important phase of the data collection stage as it was vital to allow enough time to be able to develop a rapport with them. Miller and Tewksbury (2001: 55) suggest: '*Becoming trusted and seen as someone with whom research participants are comfortable spending time, talking and sharing their lives is called "establishing rapport". In order for a researcher to truly understand the world from the perspectives of those being studied and to see how persons being studied think about their world it is critically important for rapport to be established.*'

It was important to avoid what is referred to as a 'smash and grab' interview, meaning getting in, doing the interview, and getting out without any real interest in the participants in the study (Liamputtong, 2007). Conducting such interviews is sometimes referred to as the 'rape' model of research (Reinharz, 1983). According to Dickson-Swift (2005) for some vulnerable participants who share their experiences with a researcher, it may be the first time they have shared these experiences with anyone else. It was therefore important to build up a rapport and relationship with all the participants before conducting the first interview.

Before conducting any of the interviews, the researcher met all participants at least once, this offered an opportunity

to verbally explain the study in more depth and arrange a suitable date and time to meet again. This first meeting was extremely important as it offered the women an informal opportunity to meet the researcher for the first time, in a non-threatening way, while allowing them to ask any questions or voice any concerns they may have about participating in the research. In accordance with feminist principles, every effort was made to develop an ongoing rapport with the women, this included spending extra time at the refuge, sitting in the kitchen and lounge chatting about things in general, drinking tea and playing with the children. At every visit fruit, biscuits and treats for the children were brought to share with everyone, including the staff. This was not viewed as an incentive to bribe the women to participate in the study, nor was it taken as such; it was taken in the spirit that it was offered, purely as a way of saying thank you for their time and generosity of spirit.

In accordance with the ethical principles from the WHO, it was important that KB (first author) had the skills to encourage a reciprocal relationship, thus challenging the traditional researcher and participant hierarchy (Oakley, 1981; Reinhartz, 1983, 1992; Watts, 2001). When conducting sensitive research, possessing excellent communication skills and researcher attributes are essential; such skills include being an empathic listener, and making the effort to be non-judgemental. The ability to establish a relationship, a sense of trust with a participant can be challenging. Taylor and Bogdan (1998: 48) suggest that to enter people lives for the purpose of research, researchers need to communicate and have 'a feeling of empathy for informants', 'penetrate people's defences', and have 'people open up about their feelings'. Clearly, conducting research and undertaking sensitive interviews exploring women's experiences of violence and abuse, calls for the highest integrity with a deep capacity for reflexivity. It is very important to take a reflexive approach in all aspects of the study including the topic, recruitment of participants, data collection, analysis and writing up. It is also the researcher's responsibility to represent a true interpretation of participants' stories. However, reflexivity is not easily achievable, nor is it possible to stand back and examine the effects of one's pre-conceptions, especially if one is not aware of what they are. Finlay (2003) claim that reflexivity is very challenging as it requires huge efforts on the part of the researcher to identify and interrogate personal and professional practice. In fact, Holland (1999) suggests that the word 'reflexivity' is used in so many different senses that it often sustains confusion rather than clarifying any underlying issues.

It is now widely accepted that the researcher is the principal figure who actively constructs the collection, selection and finally the interpretation of data, and according to Finlay (2002), qualitative research no longer seeks to abolish the researcher's presence – instead 'subjectivity in research is transformed from a problem to an opportunity' (Finlay, 2002: 531). Conducting sensitive interviews around the topic of domestic violence will always have the potential to raise anxiety and distress for participants. Indeed, King and Horrocks (2010) emphasise that any qualitative research

interview has the potential to raise questions and bring back thoughts that an interviewee may find distressing. Nevertheless, asking women to recount episodes of violence and abuse could inevitably induce strong feelings and emotions. It has been suggested that there may be trepidation from a researcher that they would not be able to respond appropriately or effectively to the participant or indeed their own emotions. Prior to the interviews, concerns about processing the necessary skills, which would be able to adequately deal with participant disclosures did raise some anxieties, however, such anxieties were mostly unfounded as the majority of the women were very open and willing to talk about their experiences. In accordance with ethical guidelines (Watts et al, 2001; Ellsberg et al, 2001), the questions were expressed in such a manner as to avoid terminology such as 'rape', 'violence' or 'abuse'. Instead the participants were asked whether or not they had experienced certain specific acts, such as being hit, slapped, or beaten by their partners during their pregnancy (Watts et al, 2001).

Due to the sensitivity of the topic, it was also important the environment where the interviews were conducted felt private and safe for all the participants. How and where the interviews were to be conducted initiated a lot of thought and consideration. An undisturbed venue was of a highest priority, as it was important that participants felt comfortable, safe and secure and the interviews could be conducted without any interruptions. In the refuge, the interviews were always conducted in a private secure office, away from the other residents in the refuge. Preludes always ensured that the participants were relaxed and every attempt was made to ensure that the relationship of interviewer and interviewee was one of openness, compassion and gentleness.

The principles of non-beneficence were followed; written and verbal consent was always obtained prior to the start of the interview. All the women were aware that they could stop the interview at any time and the interview transcripts were made available to the women. The women were all also advised that they could have their support worker present during the interview; however, none of them took up this offer. Another major consideration was the avoidance of potential exploitation of the participants. As alluded to previously, there was a genuine concern that some research participants may be unreasonably distressed or even traumatised by being asked to disclose events which they find emotionally disturbing (Dickinson-Swift et al, 2007). However, this claim was contradicted by participants who claimed that the interview was helpful, cathartic, and in some cases empowering. Indeed, past research with vulnerable groups has highlighted that many participants consider participation in research a positive experience (Watts et al, 2001; Richards and Schwartz, 2002). Having someone listen to their stories, while validating their experiences, is very important (Kelly, 1988; Renzetti and Lee, 1993; Morse and Field, 1995; Baker, 2008). Following the interviews, some of the participants expressed feelings of recompense at having contributed to research where their own views and feelings had been heard and acknowledged. Nonetheless, there must be an awareness and recognition by

researchers that some participants may experience distress when talking about their past experiences. This is especially relevant when conducting research in domestic abuse, when women are often being asked to recall and discuss extreme physical, sexual and psychological violence.

*Valuing individual women's feelings and experiences and building upon current research*

One of the main issues in planning and considering the study was assessing the risk of participation with the overall benefits of the study. A major aim of the study was to give a voice to the women; allowing them to speak about their experiences. Adhering to feminist principles it was very important to pay attention to what the women had to say and how they felt about their unique individual experiences (Stanley and Wise, 1983). To be able to develop an adequate understanding of the nature and extent of the issue requires that some of the myths and misunderstandings about domestic violence and especially domestic violence in pregnancy are replaced with accounts of the women's actual experiences, as only these constitute the most appropriate evidence on which to base any intervention. Mullender (1996: 1) claims that this is only likely to occur when women's stories are voiced and heard, placing them in the role of the expert: 'To understand the complexities of women's attempts to escape; the use by male partners of all forms of abuse to prevent this; the interaction between emotional impact of the abuse and the difficulty of negotiating the maze of legal and welfare services; above all, the crucial need for advocacy, self help and support services to empower women through this process on their own terms.'

It was important to adhere to the feminist principle where women and their concerns were the main focus of the investigation (Stanley and Wise, 1983; Liamputtong, 2007), and in agreement with Campbell and Wasco's (2000: 783) philosophy the aim of any feminist research 'is to capture women's lived experiences in a respectful manner that legitimates women's voices as sources of knowledge'. With any research, there should always be a duty of care towards participants, requiring a strong awareness and sensitivity both during and following the interview. Participating in emotive research always has the potential to result in an unexpected emotional impact either during the interview or indeed at a later date. In view of such possibilities, it was imperative that all the women had access to support following the interviews. Even though the women were already within the safety net of local domestic violence support groups, contact details of local and national support systems were also taken along to each interview and made available to each participant. The next day, following each interview, contact was made with either the women or their named support worker to enquire about their wellbeing following participation.

It was noticeable that the participants exhibited different ways of coping with disclosure during the interviews. Each woman demonstrated her emotional distress in a different way; some became angry or spoke very quietly when

recalling the horrific abuse they had endured. Others became visibly upset and tearful. This was especially significant when some talked about the sexual violence they suffered in the relationship. Whenever the women became upset, the offer to suspend or stop the interview was offered, yet none of the women wanted to discontinue the interview, some took a few minutes to compose themselves, on two occasions, women took time out from the interviews to have a cigarette, while others refused to stop the interview and wanted to continue. All the women's stories were powerful and never failed to touch and leave a lasting impression. It was impossible not to become personally affected when they were visibly distressed. Sometimes a reassuring touch or an embrace seemed to be the appropriate response. Acknowledging the women's experiences and pain seemed to be important to all the women. They wanted to be able to tell their story, recalling every intimate detail, with one respondent Sarah (pseudonym) emphasising the importance and relief of finally 'being allowed to talk about the violence after years of silence'.

*The impact of conducting sensitive research on the researcher*

Listening to the women's stories was extremely powerful. Their strength and spirit was remarkable and listening to them recounting their experiences left a lasting, profound effect. The risk of personal emotional turmoil was never underestimated and initiating support mechanisms for not only the women, but the researcher, were integral to the success of the study. It was also important to take into account the emotional wellbeing of the researcher, especially as they were solely responsible for undertaking all the interviews. Researcher support is not only vital throughout the data collection phase but also during the data analysis and writing up phase of the research, where the women's stories were often retold and relived (Liamputtong, 2007).

For this particular study, support mechanisms included regular PhD supervisory team meetings and monthly one-to-one counselling sessions with an independent professional counsellor. Additional support was also available by accessing PhD student workshops, which included informal lunch-time drop-in sessions with experienced researchers, some of whom had previous experience of conducting sensitive interviews. Due to the sensitivity of the data being collected and analysed, the researcher was also aware that an impromptu telephone call or unplanned meeting could be arranged at short notice with their director of studies and the counsellor.

Researchers have come to appreciate the full meaning of reflexivity within the context of their own research. Although, Finlay (2003) cautions researchers that immersing themselves in their own data can prove to be a painful and sensitive experience and that researchers must be careful to not privilege their own voice at the cost of their participants. During the data collection phase, a common risk for researchers undertaking sensitive research in this field is the emotional sorrow of listening to women's repeated stories of physical pain and emotional abuse (Watts et al, 2001). Therefore it was not unanticipated that personal feelings of

sorrow and anguish would be experienced when listening to women recount their experiences. However, it was unexpected that such emotions would become intensified during the data analysis phase, when the women's stories were relived and retold several times, allowing for the powerful words of the participants to come alive again (Dickinson-Swift, 2005). Re-visiting the women's narratives evoked strong emotions, with the women's stories remaining prominent for a long time after the data analysis stage of the research had been completed.

Morse (2000) proposes that when researchers conduct sensitive research, they run the risk of encountering and becoming engulfed with a shared suffering. Morse and Mitcham (1997: 650) refer to this as the 'compathy phenomenon', which they describe as the 'acquisition of the distress of another'. Dunkley and Whelan (2006) support Morse and Mitcham's (1997) conjecture. They identify shared suffering as vicarious traumatisation, which can occur when the researcher starts to develop feelings of anguish and trauma, during the research. Liamputtong (2007) suggests researchers must try to prepare themselves and attempt to block the compathetic responses so that the participant's pain is not shared. A research study can become a personal and emotive journey for a researcher, especially when a researcher may have had some personal experience of violence and abuse. Listening to women's stories of personal abuse may awaken disturbing emotions (Watts et al, 2001). Therefore, prior to conducting this form of research, it is essential that researchers have developed support strategies to help them to deal with such feelings. Such strategies include regular opportunities for emotional debriefing and one to one individual counselling. According to the Watts et al (2001), putting such strategies in place will not only help interviewers endure the demands of conducting this type of research, but will also improve their ability to collect quality data.

## Conclusions

Many of the issues and considerations that have arisen out of this doctoral research will have a resonance for midwifery researchers. The challenge faced by midwifery researchers undertaking sensitive research merits further consideration to ensure that unnecessary harm is not experienced by participants contributing to research or the researcher. The obligation of any researcher is to carefully consider the risks and benefits of the study they are undertaking. They must be constantly aware of the impact that that the interviews and the research may have on the participants involved – this involves being ethically receptive and morally perceptive. The risks involved when interviewing women who have experienced violence and abuse are always going to be inherently large, but those risks must be balanced against the ethical considerations of doing nothing and maintaining the silence and isolation that often accompanies violence against women and children. Embarking on research in this particular discipline is not straightforward and requires a lot of prior contemplation and consideration. However, this experience has shown that it is possible to design and conduct research which allows for the exploration of sensitive topics. Researching violence and abuse will always touch people's lives and by the very nature of the subject will carry with it inherent risks. Therefore it is imperative that ethical and safety considerations of both participant and researcher remain paramount to any study design. Utilising a framework such as the ethical and safety recommendations for domestic violence by Watts et al (2001) will help to protect both researched and researcher.

*'The emotions of researching emotionally difficult topics are often overlooked in academic discourse. Yet, the emotionally engaged researcher bears witness to the pain, suffering, humiliation, and indignity of others over and over again'* (Campbell, 2002: 150).

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# Midwives' experiences of home birth transfer

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## Abstract

**Background.** Transfer rates from home to hospital for mothers in labour range from 7%-45%.

**Aim.** To explore the midwives' experience of home birth transfer from a planned home birth to an obstetric unit (OU).

**Method.** A phenomenological approach was adopted in an attempt to understand what it was like for midwives to transfer a mother birthing at home to obstetric care in the hospital. Unstructured interviews involving ten midwives were undertaken. The interviews were recorded, transcribed and analysed.

**Ethical approval.** Granted by the research governance and ethics committee at the Institute of Postgraduate Medicine and the NHS trust where the research project was carried out.

**Findings.** The study identified issues relating to five themes which include: difficulties surrounding the decision to transfer, the importance of supporting the parents, the significance of collaborative working, the ongoing organisational challenges and the need for a reliable ambulance service.

**Conclusion.** The study highlights the necessity for a home birth protocol, which reinforces appropriate action with regards to transfer. This needs to include a strategy for dealing with parents who oppose transfer, and a procedure for prompt handover of care to an OU. It is apparent that midwives appear confident and well-trained in dealing with transfer, despite the challenges faced. There are concerns about the availability of a second midwife, which need to be addressed.

**Key words:** Midwives, home birth, transfer, low-risk pregnancy, phenomenology, evidence-based midwifery

## Background

Choice regarding place of birth has been at the forefront of many government papers, encouraging low risk-women to seek alternative birth settings to the traditional obstetric units (OUs) (DH, 1993, 2004, 2007; RCOG, 2011). At present, approximately 92% of births in England take place in OUs, regardless of whether the high-technology facilities are needed (Hollowell et al, 2011).

Strong evidence exists about the benefits of midwife-led care for low-risk women outside of an OU, such as midwife-led units and home births. Women choosing these options experience more spontaneous vaginal births, fewer medical interventions and greater satisfaction with the care (Olsen and Jewell, 1998; Walsh, 2008; Mori et al, 2008; Begley et al, 2009; de Jonge et al, 2009; Hodnett et al, 2010; Hollowell et al, 2011). The latter option is also significantly more cost effective (Hollowell et al, 2011).

Birth is a life-changing event and it is important that women and their partners are able to choose a setting that feels safe and comfortable and welcoming; this includes home birth (NICE, 2007; RCM, 2008; NCT, 2009). Nevertheless, complications during labour requiring intervention can occur without warning and may necessitate prompt transfer to the nearest OU (Wax et al, 2010; Evers et al, 2010; Hollowell et al, 2011). Transfer rates, especially for women having their first baby, range from 7.4% to 45%, according to the place and the literature available on this subject (Mori et al, 2008; Evers et al, 2010; Hollowell et al, 2011). Rates have seen a sharp rise over the last decade (Hollowell et al, 2011) and are thought to be influenced by changing risk profiles and an increased analgesia demand (Amelink-Verburg et al, 2009).

The professionals responsible for the safety of mother and baby in UK home births are registered, qualified midwives.

It is the midwives, NHS or independent, who are expected to deal with appropriate and timely home birth transfers and who are in charge of the event (NMC, 2010). A midwife's ability to manage a transfer safely and competently is crucial for the wellbeing of mother and baby (Hollowell et al, 2011). With a potential increase in women choosing the home birth option, midwives need to be prepared to take on this challenge. The focus of this study will be on midwives conducting home births within one NHS facility.

Over the last decade, numerous studies on alternative birth settings have shown positive maternal and perinatal outcomes (Maternity Care Working Party, 2007; Fullerton et al, 2007; Walsh, 2008; Begley et al, 2009; Hodnett et al, 2010) including birth at home (Janssen et al, 2003; Lindgren et al, 2008; de Jonge et al, 2009). However, while previous research demonstrated good outcomes, some recent studies contradict these findings. The Birthplace study reported that the risk of poor outcomes for babies of first-time mothers is found to be significantly higher in planned home birth (Hollowell et al, 2011). This confirms earlier reports of an increase in risk of perinatal mortality in home birth settings, particularly surrounding emergency transfer (Mori et al, 2008; Wax et al, 2010; Evers et al, 2010). It should be noted that concerns regarding the methodological quality of these latter studies have been raised and outcomes should be interpreted with caution (Walsh and Downe, 2008; Reitsma, 2009; de Jonge et al, 2010; de Vries and Buitendijk, 2012).

## Method

A phenomenological approach was chosen as it uncovers the lived experience of individuals or groups (Rees, 2003; Bowling and Ebrahim, 2005; Greenhalgh, 2006; Vivilaki and Johnson, 2008) and attempts to articulate, through

the content and form of text, the structures of meaning embedded in lived experience (van Manen, 1990).

*Sample*

Ten qualified midwives from an NHS trust consisting of two separate OUs consented to participate in the study. Letters containing participant information sheets with consent forms were sent to the midwives' home addresses and individual consent was obtained via the return forms. Sampling in phenomenology is purposive because it selects participants who will have knowledge of the phenomena concerned, and allows an understanding of the lived experience (Mapp, 2008). Six midwives were based in the community setting and four were in the OU at the time of the interviews.

*Inclusion and exclusion criteria*

Research participants were required to be qualified midwives who had been in charge of at least one planned home birth that required transfer during labour to an OU. Planned home births were defined as all births that were planned at home at the start of care in labour, regardless of whether a transfer occurred during labour or immediately after birth (Hollowell et al, 2011). The midwives needed to be employed by the local trust at the time of conducting home birth transfers. This was important as variations in practice between different trusts could have affected the transferability of data.

*Data collection*

Interviews were conducted in the privacy of a previously booked room within the trust, surgeries or children's centres and pseudonyms were provided by the midwives. Interviews were audio recorded and took between 17 and 50 minutes. Field notes were taken.

*Ethical considerations*

This study was approved by the research governance and ethics committee at the Institute of Postgraduate Medicine. It gained further approval from the research and development directorate and the head of midwifery at the local NHS trust where the research project was carried out.

*Trustworthiness and rigour*

In qualitative research, trustworthiness is one of the criteria

used in establishing the authenticity and accuracy of the information presented (Rees, 2003). Revealing the meaning of an experience can be difficult as phenomenology always looks to go beyond the first layer of description (Snow, 2009). By member checking, keeping field notes, arranging an audit trail and incorporating a reflexive account within this study, an attempt has been made to prove credibility and increase trustworthiness. By using the tools according to the specific underpinning philosophy of Heidegger, analyses of data could be carried out in a reflective and epistemological way. In doing so, an attempt has been made to add rigour to this enquiry (Vivilaki and Johnson, 2008). A written report containing topics identified during the interviews was sent to the midwives for verification.

**Analysis**

Interviews were transcribed verbatim into the same format. All transcripts were given a serial number for reference purposes in order to relocate material quickly and return to points in the data of particular interest (Denscombe, 2003). A summary of topics for possible categories from each interview was created by searching for the essence in the midwives' individual stories. A matrix was used, as described by Greenhalgh (2006), and the following five key themes were identified:

- The decision to transfer
- Supporting the parents
- Collaborative working
- Organisational challenges
- Ambulance services.

The themes are made up from 12 categories (see Table 1) and represent the essence of the midwives' lived experiences of home birth transfer.

**Findings**

Analysis of the data revealed five key themes of midwives' experience of home birth transfer (see Table 1). These have been subdivided into categories in which aspects of the findings have been described. Each category presents data excerpts directly taken from the interviews in an attempt to capture the midwives' perceptions of their experience. The findings and the discussion are presented separately in order to consider the significance of data within the context of the overall aims of the research (Denscombe, 2003).

**Table 1. Themes and categories**

Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
The decision to transfer	Supporting the parents	Collaborative working	Organisational challenges	The ambulance
Categories	Categories	Categories	Categories	Categories
Making the decision	Good relationships	Communication and teamwork	Logistics surrounding transfer	Ambulance services
Obstruction to the decision	Dealing with parents' expectations	Collegial support	Protocols and guidelines	Ambulance crew
Midwives' emotions	Debriefing the parents			

### *The decision to transfer*

Decision-making surrounding transfer seemed to be influenced by a midwife's level of confidence and expertise, as well as the parents' willingness to comply. In some cases, there was evidence of strong emotions at play during the transfer process.

### *Making the decision*

Midwives considered themselves well-trained to make decisions and relied on their own professional judgement, as well as a generic protocol and national guidelines for parameters of normality:

*"It is getting the balance right and it's doing what is right for everybody and giving women exactly what they want, bearing in mind that they have an agenda and I have an agenda. And it is my responsibility, at the end of the day, to make sure that they are all safe"* (Alf).

### *Obstructions to the decision*

Problems occurred when a midwife's decision was challenged by a partner, family member, friend or doula. This could subsequently delay the transfer and thus put mother and baby in potential danger. Alice desperately tried to convince the parents that there were serious concerns regarding the wellbeing of their unborn baby, necessitating immediate transfer. In this case, it was the woman's partner who challenged Alice's decision by not agreeing to the transfer:

*"He [the dad] really wanted a home birth: she was in advanced labour and she was already 'fully' by the time we got there. She wasn't bothered, she said: 'yes I will'. But she could barely even get the words out because she was so in labour. He said: 'I don't want to.'"*

Midwives wanted the home birth to be successful, but not by compromising the health of the mother and baby. Although they felt well-equipped to deal with challenging behaviour, it was also a source of serious concern, as they felt that this could affect the birthing process, delay admission to the OU and possibly result in further complications. Situations similar to that of Alice were experienced by a number of midwives who were interviewed.

### *Midwives' emotions*

Midwives admitted to feeling a host of emotions when asked what it was like for them to transfer labouring women. Although most felt confident about dealing with emergencies, there were situations in which they described feeling anxious, scared, panicky, or even terrified. Murriel summed this up with the following statement:

*"Sometimes there is a sense of blind terror, when you get a fetal heart of 60 and you are 12 miles from the hospital and you are transferring in. So, you know, there are many, many different emotions depending on the situation."*

### *Supporting the parents*

Midwives worked to support parents by trying hard to build good relationships, providing evidence-based information and aiming to offer feedback after transfer.

### *Good relationships*

Building a rapport through open discussion with the labouring woman and her birthing partner was considered extremely important. Trust appeared to be achieved through honesty and openness. Midwives made considerable efforts to give explanations that parents could understand, welcomed questions and tried to provide a clear plan of care for transfer, including the parents in the process. Sam explains:

*"They [the parents] know that I have tried my hardest and that I have kept them there as long as I could. And you built up a relationship, hopefully, with those people and they get to know you and they know that you aren't just towing the line and that you are doing it for a reason."*

### *Dealing with parents' expectations*

Parents' expectations of labour and birth appeared to play key roles in accepting advice from health professionals. Midwives felt that this was influenced by the quality of education and evidence-based information offered to women during the antenatal period, as Beatrice illustrates:

*"I think preparation of women antenatally is of utmost importance. And I think the service run by our local midwives, who try to provide information for women who are thinking of having a home birth, is invaluable. To give people real, sort of a chance to ask questions and to be able to give them knowledge about what we would be looking at a transfer for."*

Furthermore, midwives believed that continuity of care enhanced good relationships, as well as encourage realistic expectations. This process could facilitate positive experiences for women, as well as midwives.

### *Debriefing the parents*

Postnatal debriefing after transfer was seen as an important part of accepting the transfer and maintaining good relations with the parents. This usually took place shortly after birth or during a postnatal visit at home. Although not always easy due to different shift patterns, the majority of midwives made debriefing a priority, particularly after a traumatic event. Furthermore, this gave midwives an opportunity to gain feedback about the way they handled the transfer:

*"So we had a chat about what happened and that was quite therapeutic for both of us. Because as it turned out she was relieved and scared and she did not realise that I was relieved and scared. She thought I was just being very professional so it is good getting someone who has been in the same situation. She thought I coped very well, whereas I thought that I had panicked but I hadn't obviously"* (Beth).

### *Collaborative working*

The need for excellence in communication, teamwork and support between health professionals was highlighted by most midwives taking part in this study.

### *Communication and teamwork*

Midwives believed that good communication inspired confidence in parents and helped resolve possible conflict.

They felt that evidence of good teamwork and effective communication influenced how parents perceived their competency. Jinny's statement reflects good teamwork:

*"I think it is who is coordinating and how much you have communicated with the midwife [labour ward coordinator] that you are coming in to. I think communication at home is really important, and preparing them [labour ward staff] for what you are going to bring in."*

#### *Collegial support*

The labour ward coordinator was considered to be the main source of advice and support. The possibility of transfer was always discussed with the coordinator by telephone and she or he would be the first person notified of an incoming transfer. The presence of a second midwife at a home birth has always been considered good practice in the trust but seemed hampered by a lack of available midwives. Nevertheless, attendance at the house of a second midwife during the birth was seen as invaluable and midwives expressed serious concerns if this was not organised in time, as Emily describes:

*"Sometimes it has sort of been, 'well we will do our best to get you a second', and sometimes it hasn't happened. Or it is 'we will try to send you a second when more staff come on'. And sometimes it doesn't happen, and there are times when midwives are out there on their own."*

Without exception, all midwives interviewed felt very strongly about the provision of extra midwifery support when a birth was imminent. The presence of a second midwife could become crucially important during a neonatal resuscitation, or when dealing with a postpartum haemorrhage at home, as Alf experienced:

*"That was really, really scary, but she [the woman] was fine and that shows again that we are well trained – the pair of us – we just flew into action, dealt with the situation."*

#### *Organisational challenges*

Attention to logistics in addition to good-quality guidelines and protocols were seen as an essential part of the smooth running of home birth transfer.

#### *Logistics surrounding transfer*

Organising transfer, particularly during an emergency, required a host of different skills from midwives. Not only did they have to manage an unexpected event without immediate assistance, they also had to cope with basic equipment only. The sometimes cramped and cluttered home birth environment was very different from the relatively sterile clinical labour ward. Although this has many benefits for women in labour, it can be a challenge for the health professionals. For example, midwives found it extremely problematic to make phone calls and arrange for urgent transfers without alarming the parents. The challenge surrounding the organisation of an emergency transfer is illustrated by Beth when she was called to a home birth some distance away from the hospital:

*"Trying to organise transfer, explaining to the parents what is going on, getting her [the woman] out of the pool*

*all at the same time. And blue lighting it into the unit. It all went OK, but this is one of those where you do not have the luxury of the time. You've just got to act really quickly and it is afterwards when the baby is born in the unit and you think afterwards: 'Oh my God, what if?'"*

#### *Protocols and guidelines*

At present there is no dedicated home birth protocol, thus midwives are guided by a generic labour ward protocol, NICE guidelines and locally agreed practice for home birth transfer. As a result, confusion with respect to the interpretation of current practice is not uncommon. Sarah gives an example of confusion regarding place of arrival of a very sick baby following emergency transfer from home:

*"I hadn't had a transfer like that, where it was such an emergency that labour ward were asking me 'where have you sent the first ambulance with the baby to? Are they going to A&E or are they coming straight up?' And I didn't really know. I didn't... I was like: 'Oh well they have just gone and I am assuming they are going to A&E'. And she said 'well, where do you want me to send the paed's? Are they coming up here or down there?' So that got a bit confusing."*

There was a preference for written agreements in order to provide clarity. Beatrice sums up what several midwives voiced during their interview:

*"So, for myself, I think, you know, the question of transfer is about having a really robust protocol – robust in that it covers options so that, obviously women still have the choice and they don't have to stick to these – but if we were actually able to come up with a protocol that is going to be safe for them and it is going to give, you know, the reasons why we are saying this, then I think that will go a long way towards making women... keeping women safe."*

All midwives interviewed were extremely happy with their local service provision, in particular when an emergency transfer was requested.

Paramedics were invaluable during obstetric emergencies at home, as they would bring extra equipment as well as being a reassuring presence and assist the midwife where necessary. This is illustrated in the following examples:

*"It was like the cavalry have arrived wasn't it? It was just like they are here"* (Sam).

*"Yes, yes, it was myself and the paramedic who then did the resuscitation, and he had already brought in all the oxygen and had the bag and mask and everything ready. Of course we have our bag and mask out ready at the home birth, but we don't have oxygen and things like that. And he was very familiar with resuscitation on a neonate, so yes, he became part of the team straight away"* (Sarah).

Inevitably, some babies were born in the ambulance.

*"We ended up stopping in a lay-by and delivering the baby, which of course came out screaming and pink"* (Murriel).

#### *Discussion*

##### *Working in partnership with parents*

Working in partnership and including parents in decisions about their care is an essential part of building good relationships (Smith, 2011; Boyle, 2011; Catling-Paull et

al, 2011; Jefford et al, 2011) and influences how parents perceive the midwives' competency (Catling-Paull et al, 2011; Dabrowski, 2012). Midwives in this study made considerable efforts to achieve this. Nonetheless, opposing a midwife's decision to transfer by parents or birth supporters did undermine this process and midwives expressed concerns about the effects this could have on labouring women. Midwives in the UK use their expertise and evidence-based knowledge to support and empower women in exercising autonomy (Jefford et al, 2011). However, difficulties may arise when a fundamental conflict of views about care management occurs between parents and the midwife. This study highlights that quality antenatal preparation and continuity of care could possibly help prevent such a situation, as midwives felt that this not only encouraged realistic expectations of labour and birth, but also appeared to play a key role in informed choice. Available literature emphasises the importance of making parents aware that a normal low-risk pregnancy is no guarantee of an uncomplicated birth, thus education should include the possibility of an unplanned transfer when choosing birth in midwife-led settings (Creasy, 1997; Wiegers and Keirse, 1998; Jevon and Raby, 2002).

Findings in the study indicate that making time to debrief after transfer, particularly during an emergency, is extremely beneficial for parents. This is supported by several studies on the subject, suggesting that debriefing parents cannot only assist in the process of acceptance (Creasy, 1997; Lucas, 2011) but help prevent postnatal depression or post-traumatic stress as well (Boyle, 2011).

#### *Handover from midwifery-led to obstetric-led care*

The quality of leadership demonstrated by the labour ward coordinators was a significant factor in the seamless operation of transfer. Good communication, mutual respect and supportive leadership are vital components when trying to maintain a sense of urgency during transfers (Jevon and Raby, 2002; de Jonge et al, 2009; Dabrowski, 2012). Communication problems, as well as misinterpretation of a transfer situation between healthcare professionals (HCPs), could delay obstetric intervention and thus influence outcomes (Symon et al, 2010). Prompt handover to obstetric care was highlighted as problematic by several midwives during the interviews in this study. This could be an important finding and may go some way towards explaining the higher risk of intrapartum related perinatal mortality among the low-risk planned home birth group that required transfer during the course of labour (Mori et al, 2008; Evers et al, 2010; Wax et al, 2010; Hollowell et al, 2011).

#### *Changes in midwifery practice*

Traditionally, home birth was organised entirely by community midwives, as the community setting provided the midwives with more opportunity to offer continuity of care, thus knowing the women's wishes. However, it appears from the interviews that this is no longer achieved. Benefits of continuity of care are well-documented (Walsh, 2008; Hodnett et al, 2010; Kirkham, 2010). Findings in this study

suggest that frequently, neither hospital nor community midwives met the parents and were required to establish a good rapport quickly. This may have influenced the number of transfers, as evidence suggests an increased risk of transfer if continuity could not be achieved (Lindgren et al, 2008).

Evidence from this study suggests a further change in practice which is causing concern among local midwives. All midwives without exception hugely valued the support of a second midwife when a birth was imminent. Until quite recently, this was accepted by the local trust as common practice in home birth. However, findings from this study suggest a lack of availability of this additional support. It became clear during the interviews that the apparent unreliability of a second midwife is extremely challenging and, consequently, has an effect on practice, as midwives admitted to being less keen to attend a home birth in this situation. This reluctance could have an influence on midwives' attitudes towards home birth. This is another significant finding which needs to be addressed in order to promote local home birth provision. The availability of a second midwife for NHS home births has come under scrutiny following midwife shortages and a rise in birth rate (Healthcare Commission, 2008). As a result, alternative options of less-qualified personnel, such as the use of MSWs, are currently under review (Warwick, 2012).

Midwives experienced several situations at the home that warranted the presence of two skilled HCPs, such as postpartum haemorrhage following birth and resuscitation of the baby. Failed resuscitation after a home birth was found to be the most significant contributory factor to infant death in a study by Wax et al (2010). The above findings suggest the necessity of two skilled HCPs which could pose a dilemma for the planning of future home birth services. The RCM (2008) promotes one-to-one care for all women, whether at home or in hospital. The request for a second midwife at a home birth could potentially deny other women this one-to-one care, given the current climate of staff shortages (Healthcare Commission, 2008). However, additional support at home is extremely important to midwives, and clear policies regarding the use of a second HCP skilled in neonatal resuscitation need to be in place to achieve continued high standards of care.

#### *Home birth outcomes*

Midwives achieved good overall outcomes following transfer, despite a number of emergency situations at home. This suggests high levels of competency in managing these situations. Good results are known to give midwives increased confidence and more faith in their ability to provide safe, competent care (Lucas, 2011; Jefford et al, 2011). It became clear from the findings that making good use of knowledge and being well supported had a positive effect on midwives as well as parents. This is confirmed by several studies on the subject (Creasy, 1997; Walker, 2000; Jevon and Raby, 2002).

Adverse maternal outcomes are rare, but poor perinatal outcomes do occur, regardless of birth setting, and cannot always be avoided, no matter how competent an attending midwife might be (Olsen and Jewell, 1998; de Jonge et al,

2009; Evers et al, 2010; Wax et al, 2010; Hollowell et al, 2011). Although no serious adverse outcomes were discussed during the research interviews, it is possible that midwives did not wish to share this experience. Nevertheless, being given time to debrief after a traumatic event was considered extremely important. The value of debriefing should not be underestimated, as adverse events may significantly influence subsequent referral behaviour (Styles et al, 2011).

#### *The need for protocols*

Good relationships between maternity staff are likely to improve women's experiences of transition from home to OU (Creasy, 1997; Wiegers and Keirse, 1998; Catling-Paull et al, 2011). This study exposed some of the difficulties that midwives experienced when communications break down, or when logistics are not in place, leaving them concerned about the influence this would have on the women in their care. Midwives interviewed in this study believed that high-quality guidelines and protocols would avoid some of these problems, as well as assist them in making an acceptable plan of care. They believed this would send a clear message to parents, avoid confusion with other HCPs and improve communication within the maternity team. These findings not only suggest a need for a home birth protocol, but also one that deals specifically with the issue of transfer. The quality of transfer protocols in England is unsatisfactory and there is an urgent need to improve the system (Rowe, 2010; Hollowell et al, 2011; Dabrowski, 2012). More attention to the transfer process would become especially relevant given the government's drive to create more midwife-led facilities (Warwick, 2012; RCOG, 2011; Dabrowski, 2012).

Despite obstacles and changes to midwifery practice, most midwives thoroughly enjoyed the autonomy required for home birth settings. They also recognised their limitations and relied on the ambulance and OU team if complications became apparent. A focus on birth outside an OU would promote a change in midwifery practice with the potential for benefits for midwives as well as women and their families (Pettersson et al, 2001; Baird, 2007; Warwick, 2012).

#### *Limitations*

Seeking the women's views would have strengthened these findings but, despite this limitation, the study is able to highlight many aspects of transfer, as seen through the eyes of the midwives involved.

#### *Implications*

The most significant outcome from the findings is the clear necessity of a home birth protocol with emphasis on home birth transfer. This should include:

- The provision of a skilled second HCP/midwife when birth is imminent at home
- Strategies for dealing with parents opposed to a midwife's decision to transfer
- Prompt handover to obstetric care to avoid delays
- Allocated time to debrief for both parents and midwives
- Up-to-date information on transfer audit and statistics
- Evidence-based antenatal preparation, specifically aimed at parents planning a home birth.

This study reveals changes in midwifery practice, such as the much reduced continuity of care and a reduction in the availability of a second midwife. These are likely to have an impact on current and future services and need to be taken into consideration when developing a home birth protocol.

#### *Conclusion*

Giving birth at home offers many benefits for low-risk women, as well as midwives, and is significantly more cost-effective (Begley et al, 2009; Hollowell et al, 2011). Action on the key issues revealed by the midwives who took part in this study could make a significant contribution in strengthening the home birth provision in the local community consistent with government recommendations.

Addressing these issues would not only benefit midwives but has the potential to enhance midwife-led services for the local women and their families, ultimately increasing quality of care and choice in place of birth. This small scale 'in depth study' could form the basis for larger scale work in this area in the future.

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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: rob@midwives.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

### More advanced grants for women

More women than ever before are receiving advanced grants from the European Research Council (ERC), it has been revealed. New figures show that there has been a consistent 3% year-on-year increase in the number of females receiving grants, and that women now make up 15% of the total recipients. There has also been a 4.5% rise in the number of women applying for a grant.

### Experts sought for Horizon 2020 panel

Health professionals with an expertise in demographic change and wellbeing are being sought for one of Horizon 2020's new advisory groups. The European Commission (EC) is setting up the groups to help shape the work programmes that the Horizon 2020 research and innovation project will cover. The groups will be given the task of providing high-quality, timely advice to help the EC as it prepares for the upcoming call for project proposals. Applicants have until 6 March to register their interest. Please visit: [ec.europa.eu/research/horizon2020](http://ec.europa.eu/research/horizon2020) for more details.

### Logo helps identify most recent content

A new interactive logo is helping researchers ensure that they are accessing the latest version of a paper. The CrossMark has been developed to help direct readers to the most up-to-date content when searching for documents online. When readers click on the CrossMark logo, a pop-up window appears that will either confirm that a document is the current version or will provide a link to an updated publication. Elsevier is among the publishers who have already introduced the logo on its online publications.

### Deadline looms for ICM Congress submissions

Anyone wishing to have their paper considered for the ICM's 30th Triennial Congress programme must submit an abstract by 29 March 2013. The theme of the congress, which takes place in Prague on 1 to 5 June 2014, is 'improving women's health globally'. For more details, please visit: [midwives2014.org](http://midwives2014.org)

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