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A qualitative exploration of how midwives' and obstetricians' perception of risk affects care practices for low-risk women and normal birth.

Abstract

Background: Maternity care is facing increasing intervention and iatrogenic morbidity rates. This can be attributed, in part, to higher-risk maternity populations, but also to a risk culture in which birth is increasingly seen as abnormal. Technology and intervention are used to prevent perceived implication in adverse outcomes and litigation.

Question: Does midwives' and obstetricians' perception of risk affect care practices for normal birth and low-risk women in labour, taking into account different settings?

Methods: The research methods are developed within a qualitative framework. Data were collected using semi-structured interviews and analysed thematically. A purposive sample of 25 midwives and obstetricians were recruited from three maternity settings in Ireland. This included obstetric-led hospitals, an alongside midwifery-led unit and the community.

Findings: Midwifery is assuming a peripheral position with regard to normal birth as a progressive culture of risk and medicalisation affects the provision of maternity care. This is revealed in four themes; (1) Professional autonomy and hierarchy in maternity care; (2) Midwifery-led care as an undervalued and unsupported aspiration; (3) A shift in focus from striving for normality to risk management; and (4) Viewing pregnancy through a 'risk-lens'.

Discussion: Factors connected to the increased medicalisation of birth contribute to the lack of midwifery responsibility for low-risk women and normal birth. Midwives are resigned to the current situation and as a profession are reluctant to take action.

Conclusion: Improved models of care, distinct from medical jurisdiction, are required. Midwives must take responsibility for leading change as their professional identity is in jeopardy.

Keywords

Midwives, obstetricians, autonomy, risk, medicalisation, childbirth

Definition of risk: 'Uncertainty denotes a future that cannot be predicted, an unknown. By contrast, thinking in terms of risk is a process of mitigating those unknowns, minimising the unpredictability of the future in an attempt to improve outcome'[1].

Statement of Significance

Problem or Issue	**What is already known**	**What this paper adds**
Unwarranted intervention in birth, particularly for low-risk women, is leading to unnecessary morbidity. The majority of women in both Ireland and the United Kingdom give birth in obstetric-led hospitals despite policy change to reflect the appropriateness of midwifery-led care for many.	Midwives and obstetricians are using intervention and detailed surveillance to protect themselves from perceived implication in adverse outcomes and litigation. Midwifery-led care results in lower rates of intervention and increased satisfaction for women.	Midwives are resigned to the current medicalised, interventionist model of care and as a profession are reluctant to take action. Midwifery professional identity is in jeopardy if the current technocratic model of care continues to dominate.

Introduction

Risk theory suggests that we live in a 'risk society' where the notion of risk has become more pervasive in modern times [2]. This is particularly noticeable in pregnancy and childbirth. While birth has become safer in many developed countries the risk discourse has intensified as emphasised by Chadwick and Foster [3]. As birth becomes reconceptualised in terms such as 'blame', 'harm', 'hazard' and 'safety' [4] there is little tolerance for mistakes and accountability for adverse events can fall on individuals including healthcare professionals and pregnant women [5]. Contributing to the intensification of the risk discourse is the rise in organisational risk regulation that is concerned with mitigating risk through clinical governance as a form of shared self-regulation [6]. Scamell [5] suggests that clinical governance undermines midwives' commitment to normal birth by escalating the 'scare factor of risk'.

Infant perinatal mortality rates currently stand at 4.7/1,000 births in Ireland (when corrected for congenital abnormalities), representing a decrease of 13.9% since 2005 Corcoran et al. 2016). Direct maternal mortality rates in Ireland and the United Kingdom (UK) are as low as 3.25/100,000 maternities [7]. While this is reassuring, maternity care in Ireland is facing increasing intervention and iatrogenic morbidity rates [8]. This may be partly attributed to, for example, increasing maternal age and obesity but these changes in the maternity population do not fully explain the rise in interventions related to pregnancy and birth. Although technology and interventions have contributed to the decline of both infant and maternal mortality these are 'double-edged swords' when used without clinical indication [9]. An Australian study suggests that interventions can be performed to prevent perceived adverse outcomes and litigation, despite a lack of research to indicate their effectiveness [10]. Dahlen [11] warns that unmanaged fear and deeply held beliefs, without scientific evidence, can cause untold damage and lead to increased levels of intervention and surveillance for all women.

A recent review of Irish maternity services, which included review of international experiences from other developed countries, identifies how consultant-led services work well for complex pregnancies and emergency management but are over-medicalised for low-risk women [12]. This review partly stemmed from a lack of care options available to pregnant women in Ireland. In total, there are 19 hospital units offering maternity services with over 99% of women birthing in one of these units under the care of a lead obstetrician [12]. Approximately one third of these women have booked privately

with a consultant obstetrician [13]. Two co-located midwifery-led birth-centres are in operation and some hospital units offer limited midwifery-led antenatal care and limited homebirth services [12]. Approximately 20 self-employed community midwives offer a homebirth service throughout Ireland so consequently only 0.2% of women birth at home with 0.6% birthing in midwifery-led centres [12]. Two Irish studies [14,15] suggest that women want more choice, particularly midwifery-led birth-centres, but are constrained by the services on offer in their areas.

UK government policy and international guidelines identify midwives as the most appropriate profession to care for women with healthy pregnancies and have been promoting the benefits of midwifery-led care for over 20 years [16-19]. Research demonstrates that intervention rates decrease and satisfaction rates increase when women are cared for by a named lead midwife or team of midwives in a continuity model of care [20]. It is suggested that despite the high level of policy support for alternative birth settings there continues to be limited opportunity for women to avail of them and this may be a result of contemporary discourse that emphasises risk, blame and responsibility, ultimately constraining women's decisions and choice [3].

Although policy supports midwives to lead care for low-risk women, findings from a systematic review indicate that midwives increasingly view birth as abnormal with normality now defined by the absence of abnormality [21]. Australian and UK studies found that midwives may be increasingly risk averse, relying on technology and surveillance to rule out abnormalities [22,23]. Several qualitative studies from Ireland, Australia and Sweden reveal that a focus on clinical risk management, and an underlying risk discourse, is affecting the role of midwifery advocacy and autonomy. One study suggests that the threat of litigation has resulted in difficulties for midwives supporting low-intervention birth and over-reliance on technology to prevent perceived adverse outcomes [10]. Midwives working in the hospital setting in Australia believe they have become institutionalised and increasingly risk adverse such that they perform interventions when requested by obstetricians despite disagreeing with them [24]. Irish midwives believe that the ability to manage birth in a medical manner is prioritised as a skill in obstetric-led settings [25]. Similarly, a Swedish study proposes that midwifery skills are often looked upon with disdain or as competing directly with safety [26].

The perception of birth as risky and requiring medical surveillance is contributing to a service that relies on technology, intervention and surveillance to achieve 'safe' outcomes. Risk management is no longer fulfilling its role of protecting women and babies from harm but is linked to intense surveillance of birth. While professionals and organisations see this as protecting themselves it does not always serve the women in their care [21,27].

Aim of study

The aim of this study was to understand midwives' and obstetricians' perceptions of risk regarding low-intervention birth and investigate how this affects decision-making. This study adds to the limited literature directly concerned with the effect of risk perception on decision-making in labour. To our knowledge this topic has not been researched in the Irish maternity setting and, as such, the findings will add to the evidence currently available. This is timely in the Irish context, linked to the publication of the new Irish maternity strategy[12] which addresses issues including midwifery-led care, choice and woman-centred care as key principles. This paper sets out findings related to how risk perceptions affect the role of midwifery in the current maternity services. A further paper will explore other aspects of risk.

Study Methodology

Design

The underlying epistemology for this study is based on the theory of social constructivism and is reflected in the research design. This theory argues that situations are not inevitable but are based on jointly constructed understandings, created through social interaction and influenced by factors including culture and social context[28]. A qualitative research design was chosen for this study as emphasis on meaning, context and experience were considered essential to the research question. This study incorporated a pluralistic approach that considered elements from different methodologies to address the research question. There is consensus that combining methodologies rather than resolutely subscribing to one absolute approach can enhance knowledge development providing that the researcher can justify decisions made when selecting methods from different methodologies [29,30]. Thorne [31] supports a pluralistic approach to knowledge development in qualitative inquiry, particularly for the

nursing profession who often focus on complex experiential problems, not always best served by traditional approaches. The following section describes and justifies the methods used to carry out the study.

Sampling and Recruitment

A purposive sampling technique was applied as this technique enables the researcher's knowledge of the population and its characteristics to be used to recruit cases for inclusion in the sample [32]. As such, the researcher's knowledge of the maternity services was used in the selection of participants considered typical of the desired population. The primary researcher in this study is a registered midwife who works part-time in an obstetric-led unit. Recruitment did not take place in this unit to avoid a conflict of interest but the primary researcher did her midwifery training in one of the obstetric units used to collect data. She has a personal interest in homebirth and has recently become involved in community midwifery on a part-time basis.

Participants were recruited from a variety of professional grades, settings and models of care. This was to provide a comprehensive picture of the topic under investigation as context was considered an important influence on healthcare professionals' perceptions of risk. A variety of strategies were used in actual recruitment. This included meetings with senior personnel (directors of midwifery, clinical obstetric leads) to gain access to the settings (see types of setting in *Table 1*) and posters to make potential participants aware of the study. This was followed up with group meetings where the study was explained to interested participants. Midwifery managers, community midwives and obstetricians did not attend any of these meetings so a selection of these groups were targeted directly by email. An email was sent to all for whom an email address could be obtained. From these approaches, 25 participants were recruited for interviews (see *Table 2* for inclusion/exclusion criteria and *Table 1* for participant details). Recruitment and interviewing continued until the researchers were satisfied that data saturation was achieved i.e. when judged that further interviews would not yield new insights to the subject under investigation.

Participants ➡

Units	Obstetricians*: consultant level (n=6), registrar level (n=3)	Midwifery management*: working directly with women in a clinical setting (n=3), working indirectly with women in a clinical setting (n=2), practice development midwife (n=1)	Midwives working in obstetric-led models of care	Midwives working in midwifery-led models of care
Unit A – Obstetric-led unit with alongside midwifery-led unit	2	1	1	2
Unit B - Obstetric-led unit	2	3	3	0
Unit C – Obstetric-led unit with DOMINO service	5	2	1.5**	0.5**
Community homebirth service				2***

***Grades of professions/type of management are not distinguished within units to protect participant identity**
****The .5 figures reflect one midwife who works between an obstetric-led and midwifery-led model of care**
***** Both community based midwives previously worked in obstetric-led units within 2 years of data collection**

Table 1: Setting and participant details

Inclusion Criteria for Participants
Must be currently working in a birthing environment i.e. labour ward, homebirth setting, birthing room of a midwifery-led unit Have at least six months' experience working in their current birth environment Have at least six months of experience in their current role Must be either a: Midwife in a clinical or managerial role Registrar obstetrician Or Consultant obstetrician

Exclusion Criteria for Participants
Midwifery or medical students Obstetric SHOs (Senior House Officers)

Table 2: Inclusion/exclusion criteria for participants

Data collection

Data were collected by the main author, using semi-structured interviews, arranged at the convenience of the participant. This method is in line with the social constructivist theory where participants' attitudes are not considered pre-determined but are revealed through the emergent conversation [33]. All but two of the 25 interviews were carried out in the hospital or midwifery-led unit. Community midwives chose to be interviewed at home. Interviews lasted from 30 to 70 minutes. An interview schedule comprising open questions, based on an extensive review of the literature, guided the discussion (see *Table 3*). The questions implicitly rather than explicitly asked about risk so as not to bias participant answers. Three pilot interviews were conducted with midwives prior to the main study but were not included in the final sample. All interviews were audio recorded with consent and transcription was performed by the main author.

Interview Guide
1. There are concerns that birth is becoming increasingly medicalised. What is your view in relation to this?
2. Can you tell me about issues which might influence your decision-making when working with low risk women in labour?
3. Do you think the issues of safety and risk are a dominant influence on practice? Can you give me any examples?
4. In your opinion what are the views of the healthcare professional team on achieving normal birth?
5. Can you give me examples of what measures exist that promote/prevent normal birth in your unit/practice?

6. Do you feel that you base your practice on the best evidence available in relation to low-risk women in labour? If so can you give an example of this? If not what do you think affects your ability to practice evidence-based care?
7. Do you feel that your unit bases its practice on the best evidence available in relation to low-risk women in labour? If so can you give an example of how this is achieved? If not what do you think affects the ability of the unit to practice evidence-based care?
8. Are there key differences between the attitudes of midwives and obstetricians regarding physiological birth? Can you elaborate on this drawing on specific examples in your experience?
9. In what ways does continued professional development impact on your decision-making and practice when caring for low-risk women in labour?
10. In your experience what are the factors that impact women when choosing a place for birth?

Table 3: Interview guide

Data Analysis

Data were analysed thematically using Yin's five step process for thematic analysis [34]. Analysis commenced after the first interview and emerging preliminary results guided recruitment. Step 1: Compiling - involved the compilation of a database in NVivo 11. Interviews were listened to and transcripts read several times with general notes made on emerging themes. Step 2: Disassembling - NVivo 11 was used to code interview data. The method of data analysis borrowed elements from grounded theory [35] and involved open coding of all text into short segments of code. This was level one coding and assigned descriptive codenames to all codes. Level two involved assigning higher analytical codenames to the descriptive codes. Step 3: Reassembling - connections were made between ideas/concepts coded and higher level analytical categories were developed. Categories were subsequently synthesised to form themes. This was an iterative process with emerging themes refined and verified on a continuous basis with all three authors. Bias was minimised by continuously re-engaging with the data to reveal negative instances. Step 4: Interpreting – this commenced with

interpretation at level 2 open coding and continued through to interpretation regarding theme formation. Step 5: Concluding – this entailed the assignment of further meaning to the data through discussion of the findings within the broader literature (see discussion section).

Ethical considerations

Ethical approval was granted by three relevant ethics committees in the local Health Services Executive. Interested participants were provided with an information sheet on the study prior to interview. At the interview stage, the study was explained again and participants had an opportunity to ask questions before they signed a consent form. All participants were informed they could withdraw from the study at any time but none did. Privacy and confidentiality was ensured by assigning codenames to participants and any identifying data was removed from quotes used. Data were securely stored on a password encrypted computer in a locked office. Consent forms were stored in a locked cupboard in this office.

Originally the study sought to carry out observations in the settings to further inform the inquiry but ethical approval was denied for this element. The reason given for this was that gaining informed consent from all involved (women and healthcare workers) would prove too difficult.

Findings

These findings suggest midwifery is assuming a peripheral position with regard to normal birth as a progressive culture of risk and medicalisation affects the provision of maternity care. Midwives are professionally recognised as the experts in normal birth but this role is either not apparent or diminishing as obstetrics is increasingly prominent in normal birth. Our findings suggest that midwives themselves contribute to this; they operate at a level of sub-optimal professional accountability and autonomy to avoid implication in adverse outcomes. These points are developed further in four subthemes: (1) Professional autonomy and hierarchy in maternity care; (2) Midwifery-led care as an undervalued and unsupported aspiration; (3) A shift in focus from striving for normality to risk management; and (4) Viewing pregnancy through a 'risk-lens'.

Professional autonomy and hierarchy in maternity care

Midwives in this study believe the obstetric profession has power over decision-making in care organisation and delivery for both high and low-risk women.

> *"If you have somebody who comes here (labour ward) in labour or for assessment, as a midwife you still have to defer to the registrar on-call or the consultant on-call before say you would send a woman back to the ward … Sometimes your hands are tied a little" [OLU (obstetric-led unit) midwife 5]*

As well as reflecting the situation in obstetric-led care, as illustrated in the quote above, midwives working in midwifery-led care models felt that important areas of decision-making were under obstetric control. They experienced similar frustrations to those working in obstetric-led care.

> *"Unfortunately, our mums will have to be released by an obstetrician to come through the DOMINO scheme [midwifery-led programme] at 20 weeks. I think it is totally unnecessary ... I think we are all capable of making our own decisions. So that's just the way it is and we have to get it off the ground." [OLU (and MLU) midwife 4]*

The hierarchy of decision-making was evident in discussions on the value of retaining the admission Cardiotocograph (CTG) for low-risk women admitted in labour. This is a routine intervention that is not evidence-based.

> *"[to keep] the admission CTG. That was an obstetric decision, consultant obstetrician decision. It's not one I believe every midwife believes in and even like the NICE guidelines outlay, that it is not appropriate for low-risk women, but we still do it." [OLU midwife 6]*

The perception is that obstetrics has become more powerful, with decisions unrelated to care also dominated by consultant obstetricians. Acceptance, resignation and reluctance by midwives to challenge such decisions were in evidence, linked to the dominance of obstetric-led care.

> *"It is consultant led, you know, even decisions around offices, or storage, or anything like that … it's becoming more and more and more consultant-led and I do find myself saying fine, you know, if that's the way it is, how can I fight this system?" [OLU midwife 2]*

An obstetrician that had previously worked in another country made the following observation:

"… they [midwives] are much more tolerant than I would expect them to be, or I would be if I was a midwife, of interference in normal births." [Obstetrician 1]

The hierarchy in relation to decision-making may be attributed in part to the organisation of care where most women, irrespective of their risk status, are under the care of a named obstetric-lead. Both midwives and obstetricians agree that obstetrics is increasingly and unnecessarily involved in both the planning and provision of care for low-risk women.

"I think obstetricians should just clear out and have a corner of the hospital where you do have high-risk women that need help." [MLC (midwifery-led care) midwife 4]

"I think 95% of the women I see at the antenatal clinic don't need to see me. They would be just as well-off seeing the midwife from the very beginning, because a lot of what we see is normal antenatal care." [Obstetrician 2]

The majority of obstetricians in this study identified that they have skewed perceptions of risk as a result of only becoming involved in birth when it has become abnormal. For this reason, they agree they may not be the most appropriate profession to be the lead carer for low-risk women.

The perception amongst both midwives and obstetricians is that many midwives do not want autonomy, nor to take on the role of lead carer for low-risk women because they are fearful of being accountable for decisions and implicated in adverse outcomes.

"I don't feel midwives necessarily are empowered enough … to manage completely low-risk women. … Sometimes I feel they just don't take pride in their role as a midwife and the huge kind of responsibility they have as a midwife as well is to promote and advocate to their patient that they are low-risk and sometimes I feel particularly in the labour ward and in the early hours of the morning that I am nearly talking midwives out of having to intervene or section almost because they don't just want to be there in case anything goes wrong and it's not necessarily a risk at that point in time, do you know what I mean?" [Obstetrician 5]

Linked to this, we find that midwives sometimes over-refer to doctors for potential problems, often because midwives want reassurance from a doctor.

"I suppose it's so, it's hard to be confident enough to know what you are doing is right … whereas, it's easier to nearly get someone else to make that decision for you." [OLU midwife 3]

One obstetrician commented on the capability of midwives but noted how they were reluctant to take ownership of decisions.

"I think they want to be more autonomous, but I don't know whether if it's the whole culture of nursing and midwifery in general in Ireland or whatever, but … I think there is definitely some who would be well capable of managing lots of stuff that we do, but they don't get the chance because they feel they have to run it by somebody." [Obstetrician 4]

Midwives and obstetricians recognise problems in the way care is organised and delivered and that this impacts on midwives' professional autonomy and responsibility for decision-making. While there is frustration with this situation, midwives are accepting of the *status quo* while obstetricians perceive it as a midwifery issue and not within their remit.

Midwifery-led care as an undervalued and unsupported aspiration

Recognition that midwifery-led care is severely lacking in maternity services is attributed to a perception by both obstetricians and midwives that the medical model can reduce risks of litigation. The impression from these data is that development of midwifery-led care is supported by certain individuals but not by hospital organisations as a whole. Certain midwives in favour of midwifery-led schemes perceive that funding for this is never going to be a priority. Where such schemes exist, interviewees, including one obstetrician and several midwives, believe it is undervalued and often unsupported by both the midwifery and obstetric professions.

"it's an unfortunate position that some DMOs [Designated Midwifery Officers – who act as liaison officers between the Health Service Executive and women seeking a homebirth], I don't think, chose to be in that role and that's a real disappointment because it could be a really, should be a really key role in developing an area [homebirth], in developing midwives and supporting them." [MLC midwife 5]

"No one's been pushing the DOMINO service and some consultants actively discourage the home delivery service and are quite vocal about it." [Obstetrician 1]

Lack of support is partly attributed to mistrust of this model of care as well as a belief that birth quite often requires medical involvement. Overall, there is greater trust in midwifery models of care located alongside a hospital and a sense of unacceptable risk regarding birth that is not in close proximity to medical equipment and personnel.

"you have an emergency call bell to get additional people. I think it would take nerves of steel to work in independent birth centres" [MLC midwife 2]

Where midwifery-led care was established, this was connected with the development of a trusting relationship between midwives and obstetricians.

"It took a while for the doctors to realise that there is room for them and us." [MLC midwife 1]

"I think a midwifery-led system works well here. I don't think it's working well in [place name deliberately omitted] as I don't think there is the same degree of trust between midwives and the consultants as here." [Obstetrician 8]

While there are different levels of support for midwifery-led care some obstetricians believe there is too much focus on who is leading care and not enough on woman-centred care. One obstetrician particularly noted that midwives may be more focussed on the measure of their input into care rather than on the woman.

"my biggest issue about this is that there is a little bit too much discussion to do about models and not enough discussion about … patient-centred care. Actually, no, sorry can I change the term, woman-centred care is what we regularly hear about but actually to be honest, when I sit it in at any of these discussions, the woman at the centre of the care commonly, sadly, is the midwife and not the patient." [Obstetrician 3]

While there appears to be good rapport between midwives and obstetricians at an individual level, there was a sense that midwifery as an autonomous profession cannot be trusted completely,

particularly midwives working in the community. Midwives feel that obstetricians do not always completely trust their decision-making and obstetricians perceive that midwives' desire for low intervention or normal birth may at times outweigh concerns for safety.

> *"I just wonder sometimes, is it because they don't trust either the midwives with the intermittency of the monitoring, I'm not sure." [OLU midwife 7]*
>
> *"some of the practices have been dangerous [at homebirths] ... they definitely push things further than we would in a hospital setting." [Obstetrician 6]*

Drawing these findings together, an essential antecedent to supporting and valuing midwifery-led care is trust. Midwifery-led care can thrive and contribute to change when there is a relationship of trust between the professions and safety is assured. However, the findings of this study show there is a perception that the current focus for change is narrowly aimed at promoting midwifery-led care and not sufficiently focused on women-centred care as a key principle. On the other hand, midwives' frustration at the lack of organisational support for midwifery-led care is evident from these findings and should be acknowledged.

A shift in focus from striving for normality to risk management

This theme suggests that the focus in institutional, medicalised settings is not particularly on achieving the best outcome with the least amount of intervention but more on implementing and maintaining approaches, including administration duties, that contribute to risk management. The effects of this on midwifery and normal birth is the emphasis of this theme.

The perception of the negative impact of a predominantly medical culture on achieving normal birth within obstetric-led units is portrayed by a midwife involved in practice development.

> *"I think the midwives have got a focus on normality and are very clear about what they need to do ... but I think the medical culture is really, there is probably a very nice word like clamping down or hindering them from actually progressing that normal culture." [OLU midwife 10]*

This situation is compounded by a lack of appropriate leadership in midwifery. Midwives, including one midwifery manager in particular, perceive that midwifery managers are often unavailable to support midwives in the labour ward as administration tasks increasingly take over, removing their expertise from clinical decision-making.

> *"I think our clinical managers here have a huge role in lots of different areas and they have lots of meetings to go to, they have lots of admin work to do and it means that they are not readily available to the junior midwives." [OLU midwife 4]*

The administration and risk management burden was also seen as problematic for clinical midwives by removing them further from woman-centred care. This is so much the case now that it was suggested that this role be taken on by another profession.

> *"I think everyone should have a doula because midwives now are so pre-occupied with technology and paperwork. Because, you know, sometimes I find that in the hospital you try to be there for the woman and yet you are trying to keep up–to-date with your notes ..." [MLC midwife 4]*
>
> *"Actually, that is one of the things that I find has really affected my practice and I resent it. There is so much writing everything, you know, at the beginning when you admit a woman and you review her history and introduce yourself and do all the things you have to do and then you are supposed to write all that" [OLU midwife 6]*

The findings of this study present a picture that as birth becomes more medicalised and clinical care practices more risk-oriented there is limited exposure to physiological birth and 'waiting and watching' type of care in obstetric-led units. There is awareness amongst midwives that this has a direct effect on midwifery knowledge and on gaining the experience necessary to become experts in normal birth.

> *"A lot of the time here you are only seeing obstetric [medicalised approach to care] ... It's very hard to even imagine a woman could have a baby by herself without needing some intervention" [OLU midwife 3]*

Lack of exposure to normal birth and expectant rather than interventionist care is seen to particularly affect professional development of student midwives.

> *"they are growing up in a medical environment … the students are learning from girls that came through this [medicalised] system as well, so it's snowballing and what we used to have is slowly fading away." [OLU midwife 4]*

There is a perception that experience of working in midwifery-led care can help midwives to trust physiological birth but this requires adjustment to working with a different approach.

> *"you do see some of them [midwives] going upstairs [to midwifery-led unit] for a stint and coming back down here and they are much more like laid back, kind of treating women as more normal ... because they have seen the normality for maybe a few months, that it's kind of more instilled in them. When you are here all the time, you kind of lose it a little bit sometimes along the way I think." [OLU midwife 11]*

A community midwife describes having to relearn midwifery skills on commencing her work with homebirths.

> *"I've been learning just how to sit on my hands and let them be. I haven't been needed in the way that I perceived myself to have been needed before … I don't always have to be in the room. I can be just around the corner listening ... and I have been astonished at how little I've been needed." [MLU midwife 1]*

Along with a lack of exposure to normality in medical settings, our findings indicate that training is lacking to support midwives in facilitating physiological birth. While study days to promote normality were encouraged within the MLU, midwives working in obstetric units noted these are a rarity and focus is on obstetrical emergency training.

> *"you know, there is an awful lot of study days and continual development that we have to do, but they all manage high risk … maybe if there could be days all about the natural (facilitating physiological birth) and you know, telling younger midwives that it's okay for certain things [not have an admission CTG] to happen" [OLU midwife 4]*

When midwives did attend study days on promoting normality they reported the positive effects.

"I was just heartened by it" [OLU midwife 6]

Despite recognition that experience and training in normality and midwifery-led care can make a difference, the findings indicate that midwives are not actively seeking solutions to the problem. This is reflected in their apathy to seeking study days that could support them in facilitating normal birth and in utilising existing facilities that support normality such as the 'homebirth room'. When asked what facilities exist to promote normality midwifery interviewees identified aids such as birthing balls and did not seem to have any deep sense of how they could contribute to change.

This theme highlights that achieving normal birth does not appear to be a priority in obstetric-led units in this study. While midwives recognise the importance of normal birth the lack of specific supports for it, such as education and leadership, was apparent. Midwives appear to have accepted the decline of normal birth as inevitable and as a result are not actively seeking solutions to protect it.

Women view pregnancy through a 'risk lens'

The findings show a perception amongst midwives and obstetricians that many women view pregnancy and birth through a 'risk lens'. They believe women often expect pregnancy to be a medical experience with significant medical input to care.

"The vast majority of normal healthy women who would be suitable for that model of care [midwifery-led model] still want obstetric involvement." [Obstetrician 1]

The organisation of services, including involvement of obstetricians in the care of all women, compounds this.

"I think more and more people are being seen by a doctor and that is very much changing that patient, and generally the public perception, of what is normal and then they almost assume there is something wrong [that pregnancy is an illness]." [Obstetrician 5]

There is a perception that many women may not understand and as a result may not value midwifery input. Several participants, both midwives and obstetricians, believe that women are generally unaware of midwifery services and have little access to midwives to source information early in their

pregnancies. Promotion of midwifery care was perceived by one obstetrician in particular to be vital in improving women's uptake of these services and in fostering normality around birth.

> *"… if we are seen to have poured resources into midwifery-led care I think it might give women the impression that it actually is safe and is a really good idea" [Obstetrician 5]*

However, it is questioned by both professions whether women will tolerate a dominant model of midwifery-led care as women seem to place greater trust in doctors than midwives. The perception is that most women are not concerned about what model of care they receive as long as the outcome is good.

> *"I feel that the view out there is that the doctor knows everything and the doctor is best and that they [women] believe the obstetrician." [OLU midwife 2]*

> *"Is that enough for the majority of our patients or will they want to get scanned as well and meet the doctor and so on. And again it comes down to - women will do anything to have a very safe outcome" [Obstetrician 7]*

Community-based midwives and those working in an MLU noted, however, that when women experience midwifery-led care they understand and appreciate it.

> *"So, there are women out there that understand about midwives, midwifery-led. And the moment they experience it, you know ... they use that language. They like it, they buy into it and they start mirroring what they're seeing and what they're receiving." [MLC midwife 5]*

In summary, women preparing for, and giving birth may not be aware of the benefits of midwifery and midwifery-led care. Compounding this is the perception that women favour obstetric care in general but may only realise the benefits of midwifery-led care when they experience it.

Discussion

The findings from this qualitative study suggest that birth is strongly embedded in the medical model of care in the Irish setting. This is apparent in the continued hierarchy of obstetrics within maternity services where doctors are the lead carer for most pregnant women, despite objections from the obstetric profession about the appropriateness of this arrangement. Midwifery-led care can be undervalued and unsupported leading to limited opportunities for midwives to practice skills to facilitate

normal birth and limited choice for women. Based on views articulated by professionals, women themselves are buying into the medical discourse, restricting their experience of midwifery-led care in labour and this is also a contributing factor. A key finding from this study is that midwives, while acknowledging the value of normal birth, may be resigned to the medical model of care despite perceiving it as restricting normal birth.

The recent publication of the first maternity strategy in Ireland[12] provides a useful framework in which to view these results. The new maternity strategy proposes three care pathways for women depending on their risk status. The first pathway, named 'supported care' recommends that low-risk women be cared for by midwives with the input of other professions if necessary. The second pathway, named 'assisted care' is for medium-risk women who will be under the care of a named obstetrician and have midwifery input in a hospital setting. This pathway will also be available for low-risk women who choose to have an obstetrician as their lead carer. While this gives the appearance of increased choice, in reality it is perpetuating the medical model by suggesting that this pathway is as suitable for low-risk women as the 'supported care' pathway. It may also reflect the difficulty in changing from the current situation, resulting in obstetric-led care remaining the dominant option or choice for women. Complicating this is the two-tier level of care in Ireland whereby private obstetric practice ensures that a large proportion of women may not have contact with a midwife in their pregnancies. Research[14] suggests that women want choice but the data from this study illustrate that the professions believe women may not tolerate a dominant model of midwifery-led care. This perception may stem from not having developed relationships with women that could aid understanding of what they really want. It appears lip-service is paid to 'choice' but no one is pushing this agenda. The strategy promotes giving impartial advice to women on maternity care options but does not suggest strategies for increased education to help women make an informed choice and hence have an opportunity to experience midwifery-led care. Our study confirms that many women may subscribe to the medical model of childbirth until they experience midwifery-led care. If midwifery-led care is to make any strides within maternity services, consumers of this care – women - must be more aware of its advantages but midwives must also be interested in leading the changes to bring it about.

Pollard [36] suggests we must educate society about midwifery autonomy or else 'let it go' and accept the medical model. While educating society may be important, the findings of our study suggest that it is crucial that midwives practice midwifery autonomy so that women actually experience it and thus realise the benefits. In our study, midwives, including midwifery management, sometimes accept the practice of unnecessary interventions at the direction of the obstetric profession. This raises questions about the identity of a professional midwife, specifically, whether they are capable of working autonomously or are content to let other professions take over their role. Our study suggests that midwifery loss of autonomy may be a self-fulfilling prophecy – i.e., midwives are resigned to it – and other professions will fill the gaps if the profession does not step up to the challenges it faces. Previous research suggests that midwives often require validation of their clinical judgements from the medical profession [37]. Our findings verify this as midwives tend to over-refer to obstetricians to protect themselves from implication in adverse outcomes. This suggests midwives don't actually see themselves as experts in normal birth. Recent research by Scamell [5] highlights the difficulties for midwives who are committed to normal birth. This study proposes that midwives are too easily diverted from this commitment by organisational risk operations and that concerns about risk outweigh concerns for normality.

While the new Irish maternity strategy calls for an increase in midwives and midwifery-led care it does not stress the specific role of the midwife. The UK policy report, Midwifery 2020: Delivering Expectations[18], acknowledges the importance of midwifery input into maternity care by promoting the midwife as the first point of contact for all women accessing maternity services. The Irish strategy continues to promote the General Practitioner as the first point of contact with midwives having no visibility in the community for early pregnancy. Our study highlights how obstetricians as well as midwives are frustrated by obstetrics being involved with all women ante-natally as well as obstetric over-involvement in normal birth. Previous research indicates that the dominant medical model can drive risk management in maternity care, creating obstacles in implementing strategies to increase midwifery-led care and normal birth [38].[39] In spite of the growing body of evidence on safety of midwifery-led care it may be difficult to implement unless there is strong support from medical

practitioners [39]. There were suggestions that it should be removed from medicalised settings as midwives facilitating intrapartum care in hospital settings, whether it be obstetric-led or midwifery-led, cannot extricate themselves from the dominance of the medical model [40]. This may be difficult in Ireland as the new strategy does not recommend free-standing birth centres but advocates for alongside midwifery-led units that remain under the governance of the 'Mastership' or similar system. The 'Master' is both CEO and Lead Consultant Obstetrician of the hospital and retains overall corporate and clinical responsibility. The strategy has deemed the 'Mastership' a suitable governance model resulting in midwifery-led services being ultimately governed by a medical model.

Our study implies that while many midwives may be frustrated by medical dominance they have accepted the *status quo* by failing to actively engage in seeking alternatives to supporting normality. The increase in midwifery-led care, proposed by the strategy, would be a significant change for the profession of midwifery in Ireland and expecting midwives to take stronger lead roles without increased exposure to this model may be naive. Failure to address this issue will ensure that midwifery-led services will not thrive. Fortunately, the new strategy has identified that undergraduate programmes will need to respond to the changing nature of midwifery practice. This is welcome as student midwives in Ireland only very recently are required to have experience of midwifery-led continuity care models as part of their training [41].

Our study highlights a lack of focus on woman-centred care. Woman-centred care has become a widely recognised concept in midwifery discourse that encompasses empowerment for women and individualised care that places the woman's needs ahead of those of the institution or the professionals [42]. This prevailing discourse, which was originally welcomed as an antidote to the medicalisation of birth [43], is at odds with our findings i.e. midwives appear to be more aware of how the medical model has affected their position rather than how it affects women. Previous research suggests that woman-centred care may be difficult to achieve when midwives make bureaucratic decisions based on adherence to written policies and procedures as opposed to collaborative decision-making with women [44]. A recent UK study on partnership revealed that women perceive midwives to be just 'ticking the box' and are unable to meet their psycho-social needs as time constraints only allow for physical checks

[45.] Our findings similarly show that midwives are overwhelmed by administration duties, with the burden of documentation compromising capacity to facilitate woman-centred care. Townsend, Langille [46] suggest that institutional dominance may prevent healthcare professionals from truly participating in client-centred by a dominant managerial culture of efficiency and a dominant professional culture. They question whether healthcare professionals can fully understand client-centred care when working within an institution as it prevents them from working in the context of people's lives. Despite acknowledgement that working as a midwife can be a complex process where one is required to act as an advocate for the woman and promote midwifery philosophy while also conforming to a medical approach [47] our study highlights that midwives may be resigned to the current situation and are slow to take action to change it. It was felt they perceived it to be outside of their control or as someone else's responsibility to make changes. This view may be compounded by the rise in organisational risk management that is shifting away from individual decision-making towards models of clinical governance to manage risk. Within this model, midwives may increasingly feel that they have little impact on how decisions on care are made.

The findings from this study imply that midwives are sometimes relieved to not have to make certain difficult decisions while facilitating care for labouring women. The rhetoric of midwifery-led care, including autonomy and woman-centred care, does not appear to be aligned with reality. It appears that this cannot become a reality until midwives make a stand and become comfortable providing true woman-centred care whether this be in an institutional setting or in the community.

Conclusion

Our interpretation of the findings of this study is that the hierarchy between the professions of obstetrics and midwifery is a simplistic explanation of why midwifery-led care and normal birth are diminishing in maternity services. The hierarchy is in the way birth is framed. Currently within our maternity services, birth viewed through the lens of medicalisation is firmly at the top of the hierarchy and midwives are often resigned to this. The medicalisation of birth is not only endemic within the maternity services but also in wider society. This has an enormous impact on maternity care including routine and often unnecessary use of intervention and technology.

For midwifery professional identity there are far-reaching consequences. Autonomy, a cornerstone of midwifery philosophy, has been almost completely relinquished within obstetric-led care. Many midwives have never experienced facilitation of birth outside of the hospital environment and hence do not truly understand autonomy. This has completely altered how midwives think and operate, leaving very few in the position of defending normality and trust in birth. To change this situation, the planning of maternity care must provide care options that are distinct from medical jurisdiction and opportunities and education for midwives to take a lead role. Midwives must be the profession to take on this role because their distinct identity, as it now stands, is in jeopardy. If the midwifery profession has the courage to take on this responsibility, there is some chance of creating services that are true to the woman-centred care philosophy.

Study Limitations

While this study attempts to understand perceptions across a variety of maternity units and settings, the findings cannot be generalised. The findings relating to women's perceptions are not the views of women but of professionals working with women. In keeping with qualitative research the interpretation of data will be subjective. However, the process of analysis involved on-going review by all three authors to arrive at our conclusions and to achieve consistency in interpretation of these data.

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