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## Exploring midwives' interactions with mothers when labour begins: a study using participatory action research

### Abstract:

**Objective:** To explore the interactions between mothers and midwives when labour begins with a focus on midwives and unexpected birth out of hospital.

**Design:** Participatory action research (PAR) that sought to understand and improve interactions between mothers and midwives through interviews, focus groups and a joint workshop.

**Setting:** Maternity services in the north of England, in a district general hospital with one obstetric unit and two birth centres, across two sites and where there was a birth rate of 6000.

**Participants:** A total of 72 participants took part in the study. Thirteen mothers and five midwives were interviewed. Seven mothers were interviewed who had contacted a midwife in labour and subsequently given birth unexpectedly out of hospital. Thirty-one mothers and twenty-three midwives took part in a series of ten focus groups.

**Key Findings:** Three major themes were identified from the midwives' data: 'Formulaic discourse as self-protection', 'One to one or one to everyone' and 'Interactions and time'. The latter theme is discussed in this paper showing that when midwifery activity was high and they did not have enough time, midwives experienced a high degree of conflicting emotions such as fear, helplessness and frustration, which stretched their personal and professional integrity and triggered changes in their thinking and behaviour.

Conclusions and implications for practice: Current maternity services appear constrained by a reduced midwifery workforce that is expected to meet excessive organisational demands whilst coping with reduced bed capacity. These pressures can promote changes in midwives' behaviour and thinking which disconnects them from mothers rather than focussing on their needs. Safety depends on a high degree of midwife to mother continuity. However, a business model approach, prioritising throughput and process promotes fragmented care and can potentially threaten the safety of mothers and babies. In this study, there appears to be a link between disconnected interactions when labour begins and mothers giving birth unexpectedly out of hospital.

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#### Key Words

Gatekeeping

Interactions

Participatory action research

False labour

Latent phase and labour

Unexpected birth out of hospital

#### Introduction

The purpose of this paper is to report some of the findings from a participatory action research (PAR) study, which explored the interactions between mothers and midwives when labour begins. These interactions have significant consequences for women (Carlsson, Hallberg and Pettersson, 2009; Eri et al., 2010; Green et al., 2011; Nyman, Downe and Berg, 2011; Spiby et al., 2014) not least because active listening and effective communication are

central to promoting safe, high quality maternity care nationally and internationally (Scottish Government 2017, Department of Health 2010). This paper addresses midwives' experiences of interacting with mothers around the onset of labour. Such findings from midwives are under-reported in the research literature. This paper highlights the need for more effective communication with all mothers when labour begins and especially with mothers who experience unexpected birth out of hospital.

## Background

During clinical practice, one of the researchers (XX) had met mothers, who described unsatisfactory interactions with midwives around the onset and status of their labour. Some of the key issues mothers raised during consultations were:

- 'They didn't believe me'
- 'They didn't listen to me'
- 'They said I wasn't in labour - when I knew I was'
- 'They sent me home, again'

Deciding when labour has started is one of the most difficult decisions to be made in pregnancy and there is robust evidence to show that maternity services often fail to meet the needs of the mother at this important time (Hodnett, Downe and Walsh, 2012; Janssen et al., 2009; Janssen and Demarais, 2013). Most pregnant women will start their labour at home and then go into a maternity unit for the birth. Remaining at home until labour is established (NICE, 2014) is a recommendation in pathways for maternity care in the UK. As will be seen later in the paper, delaying admissions was based on the assumption that this would improve outcomes for mothers and babies but this was not borne out by the evidence. As a result, some mothers may not have given birth in the place of their choosing because of advice to

stay at home longer. These women often go on to give birth unexpectedly out of hospital with no midwife in attendance. Therefore, gatekeeping admission has implications for mothers who seek support from a midwife because when that support is denied safety can be jeopardised (Jones et al., 2011; Loughney, Collis & Dastgir, 2006; Moscovitz et al., 2000; Rodie, Thomson & Norman, 2002; Unterscheider, Ma'ayeh & Geary, 2011).

There is a growing body of evidence that supports continuity of care models where safety and efficacy are enhanced through mothers and midwives working and being in relationship (Fahy, Foureur and Hastie, 2011; Hodnett, Downe and Walsh, 2012; Hodnett et al., 2011; Sandall, 2015). In the context of rapidly changing UK NHS maternity services, mothers' expectations around choice, continuity of care and staying in control of decision-making may not be being met despite these factors being important to women (Cumberlege, 2016; Renfrew et al., 2014; Scottish Government, 2017). The decision to delay admission to hospital is made either on the basis of behavioural cues, as assessed by a midwife via telephone conversations, or by assessment of cervical dilatation when mothers self-refer to the hospital (Burvill, 2002; Cheyne, Dowding and Hundley, 2006). If the cervix has not dilated more than 4cm (NICE, 2014) the mother is informed she is not yet in labour and advised to go home to await events. This was best summed up by one mother in this study who reported:

“You’re looked after throughout your pregnancy, you’re made to feel really special, you know you get a headache “you must phone up in case it’s pre-eclampsia”, anything when you’re pregnant, you know it’s so precious, the baby’s so precious. Why when you are in labour does no one give a shit? No one cares about you, you’re just an inconvenience until you get to 4cm and then you’re fine but if you’re 0 to 4 you’re a massive pain in the bum to everybody. Why is it like that? It’s atrocious really’.

(Interview with participating mother, 2014)

As a result of delaying admissions until labour is 'established', XX observed that some mothers were repeatedly sent home, and told they were 'not in labour' even when they were experiencing significant pain, distress and fear. Some mothers, deterred from admission, arrived in advanced labour and some gave birth unexpectedly out of hospital, sometimes at home, or on the way to the maternity unit. This paper will consider those mothers who gave birth unexpectedly out of hospital with a focus on the midwives' accounts.

#### Literature review

Five randomised controlled trials from 1998 (McNiven et al., 1998) to 2008 (Hodnett et al., 2008; Janssen, Iker & Carty, 2003; Janssen et al., 2006; Spiby et al., 2007) were identified. Each tested an intervention to support mothers to stay at home in the early stage of labour. Interventions ranged from early assessment or direct admission to labour ward; to telephone or home assessment; to a more formalised intervention targeting mothers' psychological well-being. A sixth study, a cluster randomised controlled trial (Cheyne et al., 2007), tested an algorithm to improve diagnosis of labour. In each of the trials, the main aim was to determine if support interventions, or a more accurate diagnosis of labour, would reduce caesarean sections, instrumental deliveries and oxytocic drugs, by encouraging mothers to remain at home longer. None of the trials showed a reduction in medical interventions, however, what was significant in Spiby et al's study (2008), was mothers' increased level of satisfaction related to support and there is a growing body of evidence to support continuity of care models (Fahy, Foureur & Hastie, 2011; Hodnett, Downe & Walsh, 2012; Hodnett et al., 2011; Homer, Brodie & Leap, 2008; Sandall, 2015). The mothers who took part in these studies reported experiencing improved satisfaction through more support which was a significant finding and one of the aims that this PAR study set out to explore in more detail.

## Ethical considerations

University and NHS ethics approval was granted in October 2013 (Ref:13/NW/072513352).

Careful consideration was given to recruitment and consent and how not to exert pressure on midwives and mothers. Consideration was also given to support for participants should this be required because of taking part in the study.

## Methodology

PAR was chosen for its collaborative and participatory potential (Brydon-Miller et al., 2011).

This methodology helps to create new approaches to, and understanding of, changes over time and across physical, social and emotional boundaries (Glassman & Erdem, 2014 p.206).

True to the PAR process the focus was to explore interactions between mothers and midwives when support is sought after the onset of labour. An ambition for the study was for participants to be actively involved, and to experience each other's worlds, as well as raise awareness around mother and midwife interactions at the onset of labour.

Based on Freirean concepts, PAR takes account of adult learning theory, in that collaboration can lead to empowerment and social change (Kirkwood and Kirkwood, 2011). Therefore, PAR enables participants to be involved in knowledge production more than just as a resource for data collection. It is a group activity where people with different power, status and influence can come together to work on a problem. PAR brings together action reflection, theory and practice to raise consciousness in participation with others (Glassman and Erdem, 2014), in order to reach practical solutions to issues that concern people. As such, this methodology has the potential to improve the lives of those participating.

## Recruitment

The approach to sampling was borne out of a strong desire to undertake a locally based study, working with mothers and midwives who had been caught up in the dilemmas that this study sought to understand. The research setting straddled two towns serving multi-ethnic populations. At all times, the researchers endeavoured to reach mothers who were representative of regional ethnicity and social class. In order not to exert pressure on mothers a letter was sent via a third party from the maternity unit, inviting mothers to take part without obligation. Midwives who were purposefully chosen either for their forthright views of, or their involvement in conversations with mothers about whether they were in labour or not, were initially approached personally to ensure they too would not feel obliged or compromised.

Recruitment to the mothers' focus groups was achieved through social media networks. As the research was undertaken in a culturally diverse area the assistance of a maternity support worker was required to recruit some mothers. Recruitment to the midwives' focus groups was through posters, meeting announcements via email and word of mouth. Information sheets were available to all the midwives with tear-off slips to be returned to the researcher.

#### Methods and stages of data collection

Data collection occurred in three stages. Stage one comprised open-ended interviews with mothers. Interviews were followed by a series of six focus groups with different mothers not known to the researcher. Stage two comprised interviews with five midwives, and mirroring the first stage, four focus groups with midwives were carried out. All the participants received a copy of their transcript and were asked to verify it as representative of their words and interview/focus group experience. They were also invited to edit although only



one correction from a mother was requested and several mothers expressed appreciation at having a memoir of their birth.

Stage three occurred after a period of preliminary data analysis, using the NVivo® software programme for managing qualitative data. Numerous codes were generated, and after a period of critical reflection and analysis, a composite story of mothers' and midwives' experiences was compiled. 'Jane's story' became the medium through which mothers and midwives came together in a facilitated one-day workshop to consider and discuss the preliminary research findings, to seek a way forward and make recommendations. After reading the story mothers and midwives worked together to identify the issues that were important to them and discuss and make recommendations for future practice. The workshop enabled the mothers and midwives to consider each other's' experiences in a safe environment, mirroring the potential of collaboration and partnership working.

#### Data Analysis

Analysis moved from coding, to a voice-centred relational approach known as 'The Listening Guide' (Brown and Gilligan, 1992; Gilligan, 2015; Mauthner and Doucet, 1998). This is an emerging method in social research offering a systematic approach to processing and analysing data in a deeply reflexive way (Mauthner & Doucet, 1998, 2003). The guide involves four readings of the text: firstly, and reflexively, there is a focus on the assumptions and biases and the researcher's immediate reactions to the data. The second reading concentrates on how the participants speak about themselves and the parameters of their social world. The third reading focuses on relationships, interactions and their consequences, in this case, early labour interactions. The fourth reading considers power relations and dominant ideologies. The way in which the participants explained and described their interactions were analysed, as well as their approaches to work and the

differences between themselves and the midwives. Following these readings, the data were coded.

## Findings

One of the main findings from this research was the importance of the interaction between the mother and midwife at the onset of labour. Other findings, not discussed in this paper, related to the current context of UK maternity services and challenges to the mothers' and midwives' emotional integrity. In a Norwegian study of mothers' experience of 'birth before arrival', the authors noted that the views of the midwives were unknown to them. Even though mothers reported that they were satisfied with midwives' clinical skills, there were not enough midwives available to them (Vik, Haukeland & Dahl, 2016 p.14). All the mothers who birthed unexpectedly at home in this study, described the psychological impact of not being believed, and not being listened to, when they contacted maternity services at the onset of labour. During interactions with midwives, four out of the seven mothers were advised to stay at home even though they had expressed a need to come to the maternity unit. Like Vik et al's study, the mothers said giving birth unexpectedly at home was a story to tell their children and something they would always remember. However, unlike the Norwegian findings, mothers in this study described some distressing anxiety symptoms. After telling the story, which took up to half an hour, mothers reflected further, and except for one mother, who described feeling empowered by the experience, six mothers described varying anxiety symptoms which had overwhelmed their internal resources. Elly's words described feelings of fear:

'Erm, I'm terrified... I can't move, I'm just rigid with fear and all of your deepest, darkest fears just go through your head so you know whether you lose your house or your home or whatever, and it was that. Everything that could go wrong in my head was so you know I was thinking "what if [husband] goes to get a drink and falls down the stairs and can't help me, I can't help him?" What if something happens to the baby and nobody can help?'

Having the time to listen and focus

The findings showed midwives knew which factors would enhance a positive interaction with a mother when she contacted the birth centre or obstetric unit in labour (see Figure 1).

Place Figure 1 here

Time to talk, and being in the moment with time to listen, in contrast to lack of time, was a recurring thread running through the midwives' stories. The opening question made for a positive interaction with mothers. The first midwife (MW1) responded:

'I think the basis for a good encounter is actually having the time to speak to the mothers to explore the whole, you know spend ten minutes talking to them [so that] we can assess.'

MW3 stated that, 'It's worth spending a long time listening to mothers and a long time talking to mothers' although MW5 responded differently talking about the pressure to adapt to labour ward behaviours:

'Okay, well, when you work on labour ward which is kind of where I did my basic training, if you like, post registration training, it's very difficult not to get into that sort of, "midwife labour ward" ... I think that you automatically, because you want to fit in with the rest.'

Hunt and Symonds (1995) have undertaken research that addresses the socialisation processes where midwives may find themselves pressured and thus conform to certain ways of working and interacting with women. The midwife's words below suggest how such pressures can impact and even determine the way she interacts with women.

'even if you're looking at people and thinking "I don't want to sound like that on the phone, I don't want to be that midwife" you know you almost do assume that role because you're surrounded by that.'

MW5 went on to describe a typical phone call where the mother's knowledge is dismissed by the midwife's response:

[the mother says] "I'm ringing because what it is, I think I'm in labour" and it's very easy just to go, "hmm she thinks she's in labour, what does she know?" and that is quite often the kind of take that you know in handover you know "she thinks she's in labour".'

The mothers who telephoned and were deterred from admission all said they subsequently suppressed their lived experience of the onset of labour in deference to the midwife as the professional who 'knew best'. Spiby et al (2014) explored midwives' beliefs and concerns about telephone conversations with women in early labour finding that midwives exhibited dismissive behaviours resulting in them referring to mothers as 'frequent flyers' (p.1039) and doing 'bugger all' (p.1039) when mothers repeatedly called the maternity unit for help and support.

Midwives working in the obstetric unit and birth centres reported feeling pressure to conform to organisational demands and delayed hospital admission. They experienced conflicting paradigms of midwifery practice; that is, the techno-medical model, most familiar to labour wards (Davis Floyd & Dumit, 1998, Mander & Murphy-Lawless, 2013, Murphy-Lawless, 1998) and the social model of midwifery, more aligned to birth centre principles of normal physiological birth (Kirkham, 2003, Shallow, 2003, Walsh, 2006). Workload pressures intensified the differing paradigms. For example, an experienced obstetric unit midwife (MW2) suggested that a meaningful interaction was 'to listen not to talk particularly.' She distinguished between a telephone and face-to-face interaction, adding that:

'I think it's different on a phone conversation because on the phone conversation you've got to very much lead it with the information you want to get out'.

'Getting information out' of mothers suggested that midwives prioritised information gathering, rather than listening for the information the mother wished to impart.

However, MW4 who worked mostly in the birth centres, responded to the question, 'what made for positive interactions', with words that expressed an intention of engagement and relationship. The verb 'to feel' was repeatedly used:

'I find out what they know. I find out what they're feeling. It's quite a long phone call sometimes and this makes them feel better sometimes that they've had a long chat and they haven't been fobbed off so we'll have a long chat about what they're feeling, what's going on, what they're feeling in terms of contractions but what they're feeling in terms of, how scared they are or nervous.'

MW4 not only wanted to find out what the mother was feeling in relation to physiological sensations but she also wanted to connect emotionally. However, for some midwives relational, including emotional connection seemed more difficult when under pressure to conform to labour ward priorities and demands. This has now been explored and is evidenced in a growing body of midwifery research (Deery, 2005, Kirkham, 1989, O'Connell and Downe, 2009, Pilley Edwards, 2005, Walsh, 1999).

#### Throughput and process

The industrial metaphor of the conveyor belt has been used to describe process-driven care for decades (see for example Curran, 1986, Flint, 1982). As one of the midwives stated, 'you don't get that luxury (the lavender bath) on labour ward. It's like a conveyor belt of mothers'. More recently, Bryson and Deery (2009) linked the conveyor belt to the business model, where the appropriation of time as a commodity linked to productivity, neither values nor takes account of the time needed for engaged and connected continuity of care for mothers.

Hunter (2010) found that conveyor belt processes constrained midwives' emotion work because:

'The prevailing 'production-line' approach requires conformity, task orientation and suppression of emotions in order to ensure that institutional goals are reached. Care becomes reductive and fragmented, and the work of the midwife becomes goal orientated rather than client focused.

(Hunter, 2010 p.257).

The data suggests that organisational demands in the NHS exerted pressure on midwives to make organisational decisions to keep mothers out of hospital. This caused conflict between different philosophies of birth as the midwife from FG4 described, when she reflected on her practice and not being able to make midwifery decisions:

'I think as well going back, it's going back but it's kind of erm, the conversation as well. Have you VE'd her? when we're talking about latent phase women "well no I don't need to VE her just yet", we're talking, we're chatting and then you know we might have another phone call and "what's that woman doing, have you VE'd her yet?", "no we're talking about what's happening to her body".'

Demands were often different on the obstetric unit where midwives experienced pressures to 'clear the board' and 'free up beds'. MW1 described conflicting responsibilities, as her decisions had to take account of work activity, the number of midwives and beds, and more worryingly, not what was necessarily best or safest for the mother. Her words suggest that as a midwife manager she found herself in an impossible position:

'It's frustrating... it's frustrating and at times it's frightening...there's been times when you are down to the last bed on labour ward and I mean this is absolutely horrendous, down to the last bed on labour ward and going and waking mothers up at 3.00 in the morning asking if they'd like to go home because that's what you've been told to do by the managers further up.'

Midwives reported not being able to fulfil their duty of care if they were already looking after mothers in labour and how this might jeopardise their Nursing & Midwifery Council (NMC) registration. MW2 explained that as soon as she knew a mother was pending admission, she assumed responsibility and believed that workload did not influence her decision-making. However, this midwife also believed that workload practices did influence the decision-making processes of less experienced midwives. Her words suggest that:

‘I think it’s easier for them to sort of think “I’ll put mothers off” because then you’re not in a system. Because then “if you’re, if you’re not in a system I don’t have to worry about you”.’

That is, midwives did not need to be responsible. Using the example of frequency to listen in to the fetal heart, MW4 noted that if a midwife admits a mother and then does not have time to care for her because she is already providing one-to-one care for another mother in labour, this presented a dilemma. This is highlighted in the following dialogue:

XX: ‘Right, [let’s] pull that out a bit, this is interesting. If she’s at home we’re obviously not listening in. If she’s in, once she crosses into our territory...’

MW4: ‘And our registration’ (laughter)

XX: ‘Right, into our registration, that’s a good statement. No but it is an interesting question isn’t it? ...If she’s at home she’s responsible for herself?’

MW4: ‘Looking at her movements, yes.’

XX: ‘And if she’s with us there’s a sense of responsibility, that’s really interesting isn’t it?’

These findings add to a growing body of evidence that delaying hospital admission is not in the mother’s best interests, but is more about self-protection for midwives when organisational demands meant they had to work in the way that NHS services are currently configured (Spiby et al., 2014, Vik, Haukeland and Dahl, 2016).

## Triage

Midwives talked at length about the area known as triage, which is the gateway to labour ward and where midwives receive telephone calls from mothers, assessing them for admission to the labour ward. Midwives reported avoiding eye contact with mothers waiting in the corridor outside triage because to acknowledge their presence meant having to connect with them. For example, a midwife in FG1 commented:

‘I don’t like how it changes how you are sometimes. You know sometimes if you’ve got a lot of people on the corridor waiting, you’ve got all your beds full, you don’t want to make eye contact with anybody.’

MW1 said of triage, ‘at best it is tolerable at worst it is deplorable’ and a midwife from FG1 described taking calls from mothers whilst at the same time abandoning a mother ‘awaiting a speculum under the sheet’. She then stood up and demonstrated what she named ‘the midwife’s walk’ - head bowed and shoulders hunched, she scurried across the room, in double quick time.

MW3 referred to the pressure of paperwork and clinical governance for midwives. She concluded that ‘an enormous amount of midwifery now is about self-protection and not about being a good midwife.’ This dismal conclusion was most recently supported in the Healey, Humphreys and Kennedy (2015) study of midwives and obstetricians, and the risk-averse culture that currently dominates maternity care in the UK. Inappropriate paper work, administration and bureaucracy were also factors highlighted as inhibiting midwives from providing personalised care, in the recent maternity review (2016) chaired by Baroness Cumberlege.



MW3 acknowledged that:

‘I think we do get it wrong, I think we do get it wrong and I think we get it wrong, for very difficult to analyse reasons. I think it’s because you can’t predict how much is going to be going on at any one time, you can’t predict what is going to happen.’

Ironically, as midwives could not predict what was going to happen in relation to labour activity, they then managed labour activity by predicting how mothers’ labours would play out. This phenomenon was identified in the mothers’ findings as midwives ‘foretelling the future’. To prevent what they perceived as early, unnecessary admissions that might increase their already unmanageable workload, midwives sometimes advised mothers that their labours would not begin for hours, when for some the birth was imminent. When talking about mothers birthing unexpectedly at home, MW3 concluded that ‘ever thus will it be so’.

There appears to be a covert acceptance that some mothers will fall through the net, and that collateral damage is the price to be paid for a universal approach. Fragmented service provision de-personalises care and denies the uniqueness of each mother, leading to some mothers falling through the net. The problem therefore is the universal approach and not the mothers seeking support.

#### Discussion

There will always be mothers who arrive at the maternity unit in advanced labour and there will always be mothers who labour too quickly to reach their chosen place of birth. However, the interaction they have with midwives beforehand is crucial to their birth experience. There is evidence from mothers’ accounts in this study that interactions were not personalised and joint decision-making was absent. For some of the mothers this resulted in

dissatisfaction, and experiences which challenged their internal resources even though their births were documented as normal. Mothers lamented the lack of care after their babies were born unexpectedly out of hospital with little or no midwifery support. The midwives in this study were no longer required to attend a call for impending unexpected birth at home as was the case in Vik et al's study (Vik, Haukeland & Dahl, 2016). Instead the ambulance crew are summoned, and what is locally called the 'scoop and run' policy is instigated. That is, the mother and baby are transferred to the hospital unless the mother chooses otherwise. The data from mothers who gave birth unexpectedly out of hospital showed that any midwifery input was highly appreciated and very much missed when absent. One mother, who urgently needed to birth her baby, referred to the ambulance crew as the 'three gormless men', when, unsure what to do, they told her to cross her legs and wait for the midwife. Neither were mothers given an opportunity to talk about their experience apart from cursory light-hearted jokes about the excitement the out of hospital birth had stirred.

The thought of another pregnancy was anathema for one mother's partner. She had helped her partner birth their baby and was shocked by the baby's colour, which she described as 'Dulux white'. The risks to the baby of unexpected birth out of hospital are well documented (Unterscheider, Ma'ayeh & Geary, 2011a; Vik et al. 2016). However, the psychological impact on mothers and their partners is less well understood.

Midwives described constraints on their time and the limitations of their practice as they are required to work to organisational demands - to work leaner, work keener, and 'do more with less' (Bagenal, Moberley & Goodlee, 2015 p.7). However, being overworked was not the only factor, as midwives described being pressured to conform to organisational culture (Kirkham, 1999). Midwives in this study described how they developed ways of connecting

and interacting with mothers that in effect were more self-assuring and justified their actions, in order to protect themselves from overload or an overbearing work colleague.

When midwives are fully occupied, or when the maternity unit is full, midwives gate-keep admissions in order to ease their workload and decision-making responsibilities. At the same time, midwives are beset with ever more checklists, clinical pathways, guidelines and increased paperwork, driven by risk averse clinical governance, that limits their capacity to work in relationship with mothers (Bryson & Deery, 2010, Cumberlege, 2016, Kirkham, 2010). Importantly, relationship-centred practice and effective communication are central to promoting safe, high quality effective maternity services (Scottish Government 2017, Department of Health 2010) which then leads to better outcomes for women and babies where mothers feel safe.

#### Study limitations

Mothers' partners did not take part in this study apart from one in a same sex relationship. Further research in the area of unexpected birth out of hospital needs to include the experience of partners as they have a significant role to play and can be deeply affected by feeling responsible for an unprepared situation (Nolan, Catling & Smith, 2011). Although the study endeavoured to reflect the local population, all participants spoke English despite not being everyone's first language. The researchers were aware of non-English speaking mothers who declined to take part, even though they had important stories to tell, which may have shed light on different matters.

#### Implications for practice

UK maternity services are centralised and fragmented, despite decades of political rhetoric encouraging woman-centred, individualised care (DoH, 1993, DoH., 2004, DoH., 2012). New

strategies such as promoting distinct career pathways in midwifery, would make explicit the on-going education and training needs of post registration midwives. Instead of trying to train the midwife to be a 'jill of all trades' (Shallow, 2001), pre registration midwifery training could focus more on the unique role of the midwife as the expert in physiological pregnancy and birth. Relationship and midwifery, interactions and communication with interdisciplinary teams, as well as the essential skills required for emergency situations are also important. Post registration midwives could decide in which area they wanted to practice; obstetric or social midwifery. This would facilitate midwives to develop distinct skills in either acute or community settings without being pulled in all directions. This would also enable midwives to support mothers and families more appropriately and to help mothers realise their own agency working in partnership with known midwives, thus supporting them to build confidence in their own embodied knowledge. Only then can mothers trust that midwives are real partners in decision-making.

Feedback from mothers showed how the process of PAR gave closure to what had been difficult births, and for midwives, the study raised awareness and understanding, not only of the impact of their interactions on mothers, but also the impact of NHS service constraints on themselves. There needs to be a listening service offered to mothers who need to reflect and talk about birth experiences. Listening clinics are available in some maternity services but not all. Likewise, support for midwives is crucial (Deery, 2005, Kirkham and Stapleton, 2000). Despite international differences in maternity services and practices (Page, 2008), the problems that undermine midwifery practice in the NHS have wider relevance. Midwives become deterred from drawing on a wide range of professional and experiential knowledge when organisational demands are given priority (Deery, 2011). Unfortunately, midwifery is now predominantly based on performance monitoring and audit. However, connected, compassionate midwifery practice depends on the development of positive relationships

with mothers and is essential for effective communication which is jeopardised by pressure of throughput, lack of capacity and resources and not enough midwives.

## Conclusion

The data presented in this paper show the complexity behind a 'simple' phone call or face-to-face interaction and cast light on why, according to mothers, midwives sometimes get it wrong. Organisational demands driven by operational management decisions are affecting mothers' and midwives' emotional wellbeing and may worryingly be compromising mothers' and babies' physical safety. Midwives alter their natural caring behaviours by detaching from their emotions in order to cope, otherwise they become either ill or despondent and leave (Curtis, Ball and Kirkham, 2006; Deery, 2005). The dominant techno-medical environment of UK labour wards provides a breeding ground for behaviours that are sometimes inappropriate and masked by real issues of work overload in a service configuration no longer fit for purpose.

Shildrick (1997) argued that the overriding medical ethic has resulted 'in the dominant ethical discourse' that 'inevitably denies full moral agency to mothers' (Shildrick, 1997 p.6) and we suggest, midwives too. Conforming to excessive organisational demands reinforces institutionally defined aims and goals with relationship centred practice and the art of midwifery succumbing to an increasingly 'risk focused rhetoric' (Brown and Calnan, 2010 p.10). Coupled with the economic down turn in NHS fortunes and a radical re-think of priorities via the 'Health and Social Care' Bill (DoH., 2012), early labour rhetoric about labour onset, and 'best to be at home' until labour is 'established' (NICE, 2014), take on new meanings and this has resulted in a dilemma for mothers, their families and midwives.

## Declaration of interest

There was no personal, financial or any other conflict of interest

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