The following study was undertaken as the dissertation module as an MSc in Midwifery. An Iolanthe Midwifery Trust Award facilitated the development of this study.

‘An exploration of midwives’ views on normal birth and how the professional and organisational culture of a maternity unit impacts on their ability to support and practice normality.’

The health benefits of normal birth are well documented: women who have normal births compared to caesarean births have lower risk of hysterectomy, death, and haemorrhage, post-birth recovery is quicker with fewer adverse incidents and a more positive birth experience is achievable. For babies, the risk of respiratory problems is decreased, as are admissions to neonatal units, and the chance of being successfully breastfed is increased. Promoting normal birth is an integral part of the role of the midwife. However, despite a campaign for improvements in normal birth rates led by government policy, normal birth rates continue to fall. The role of the midwife in seeking to promote normal birth and influence this low rate is considered to be part of the solution; the role of the midwife in the decline in the normal birth rate has to be considered.

With this in mind this study aimed to obtain midwives’ views on normal birth by exploring their beliefs and understanding of normality, and how they promote and support normality. The study also sought to discover which aspects of the professional and organisational culture of maternity units prevent or enable midwives to promote normality, and to identify what influences midwives to intervene in normal labours.

A literature review revealed that the concept ‘normal birth’ is indeed contentious for midwives, obstetricians, and women. Disparate use of terms such as ‘normal,’ ‘natural,’ ‘physiological’ and ‘managed’ birth can lead to further confusion. Medically defined notions of normality that place emphasis on risk, as opposed to midwife-
based perceptions that centre on the physiological process, are now more or less accepted as the norm.

Historically, normal birth was defined using midwifery definitions, though in recent years medical knowledge has been normalised to a point where technology and medical expertise are highly valued. Whereas midwives may proverbially be considered the guardians of normal birth recent trends in normal birth rates suggest that this guardianship may be in fact be compromised. The literature review highlighted the following areas,

**Promoting and supporting normality** - the difficulties that midwives face in promoting normality in obstetric units are well documented. In order to promote normal birth and regain control over the process, midwives have developed a range of strategies and tactics to promote and support normality. Including being economical with the truth, which enabled them to avoid face-to-face confrontation. Staying in the birthing room with the door closed was one example of a strategy commonly employed. Other midwives preferred to opt for night duty – a time with minimal interference from senior midwives and obstetricians, some midwives felt to be at risk of ridicule for not conforming to a medical model of birth.

**Why do midwives intervene in normal labour** - Obstetricians’ influence and midwifery management are not the only recognised barriers to the promotion of normality; midwives themselves have been implicated in its obstruction. The cultural norms of a unit where an interventionist approach is routine, and where technology is embraced and medical expertise on hand, can lead midwives to conform to the medical model of care. In this instance, midwives who do not conform may find it very difficult to facilitate a non-interventionist approach. Many studies of midwives’ attitudes have found a lack of support for normal birth, as midwives felt they were required to meet the needs of the hospital rather than the needs of individual women. Similarly, some midwives have reported that many of their midwifery colleagues conforming to the medical model of birth – where medical expertise and technology are perceived as superior and standard – create difficulty in facilitating a
The non-interventionist approach in such environments this attitude of acting counter-intuitively due to external pressures has been widely reported. Some midwives are also aware that many of the interventions used in normal birth are not evidence-based, but feel constrained by the philosophy of the obstetric model of normality, where their skills in supporting normal birth were not valued.

**The working environment** - Barriers to facilitating and supporting normal birth are commonplace, and recurrent themes throughout the literature include ‘the working culture,’ ‘lack of autonomy,’ ‘working within a hierarchy’ and ‘lack of power’, acknowledging that the medical model of birth is dominant, and that low-risk birth has a much lower status than high-risk birth. A fear of litigation and other consequences causes midwives to defer responsibility to senior colleagues.

**Guidelines and Interventions** - A significant body of research has shown that midwives find it increasingly difficult to promote normality in an environment where they are obliged to work within obstetric guidelines and protocols. Midwives feel disempowered and unable to utilise their more traditional skills, aware that many common interventions are not evidence-based. Midwives are expected to follow the protocol-driven culture and orders issued by senior staff, but must at the same time follow social policy documents and NMC midwives’ rules.

**The Study**

Six practising midwives working in an obstetric led maternity unit were interviewed by semi-structured interview. 3 definitions of normal birth, the World Health Organisation definition, the Maternity Care Working Party (MCWP)(2007) joint definition and a definition from Mumsnet website were utilised to obtain midwives views on normal birth. Three vignettes of common situations from the clinical area, ketonuria, GBS in pregnancy and the use of lithotomy were used to obtain information regarding the decisions that midwives make while practicing and also
what influences their decisions. The data was transcribed and a thematic analysis uncovered seven themes.

Findings from the study revealed that there is no consensus of opinion on definitions of normal birth. Overall the MCWP definition of normal birth, which plays a key role in normalising interventions, was found to be contentious. Data further demonstrated that certain barriers continue to prevent midwives from promoting normality.

The seven themes that emerged from this study are:

**Definition of normality**

Interestingly, only one participant was familiar with Definition 2 and it’s standing in current midwifery practice. Conversely, this definition was entirely unknown to all other participants. Many interviewees expressed disbelief that this definition of normality was in fact in use within the NHS, believing that its focus on acceptable interventions normalised potentially harmful interventions and precluded normal birth. Three midwives felt that Definition 1 (WHO, 1997) was most closely related to their own practice. Definition 3 (mumsnet.com), however, appeared to hold the greatest appeal, and was described by one midwife as “the ideal,” if it were practicable in her working environment. All of the midwives felt that Definitions 1 and 3 were their preferred options, reinforcing the idea that midwives tend to define normal birth by more historical and physiological standards. It is clear from the evidence outlined in the literature review, as well as statements from participants in this study, that many modern midwives train and work in an environment where interventions are not only acceptable, but the norm.

**Interventions**

All of the midwives interviewed queried the definition of normality, and the inclusion and exclusion criteria of interventions outlined in Definition 2. Some were doubtful that the use of interventions should be included in any definition of normality, especially given that many of the interventions indicated in the inclusion
criteria were considered potentially harmful. All interviewees expressed the view that Definition 2 normalised and legitimised interventions, and this was thought by some to be in line with common midwifery practice. The apparent contradictions associated with Definition 2 were also noted, using the parameters of Definition 2, a woman who had a spontaneous labour, with the aid of an episiotomy, could not be classified as having had a normal birth. On the other hand, a woman who may have been issued a range of interventions accepted in the inclusion criteria throughout the course of her labour would be classified as normal, the definition of the MCWP, therefore, was considered to increase the confusion surrounding definitions of normal birth.

Guidelines

The impediment of guidelines, policies and protocols to the promotion of normality by midwives was also highlighted in the interviews. For the midwives interviewed, the implementation of hospital guidelines had a significant impact on their practice, and in some cases they felt that their ability to provide skilled midwifery care was greatly restricted. Vignette 2 was unanimously recognised as non-evidence-based, and all participants described being aware of practising within non-evidence-based guidelines. Despite this, the interviewees did concede to occasionally working outside of the guidelines. All midwives described feeling uneasy about deviating from procedure in these scenarios, revealing the difficulties of working within inappropriate or non-evidence-based guidelines, which inform clinical decisions, and were felt to restrict autonomous practice. This is heavily echoed within the published literature. The midwives in this study were unanimously critical of the role of CNST in the proliferation of guidelines. One consequence of CNST implementation is the increased surveillance of both women and midwives, which is heavily condemned by many.

Midwives are thus forced into an uncomfortable situation where they fear deviating from the guidelines (whether evidence-based or not) and yet are expected to use professional judgement and work outside of guidelines when clinically indicated. A
decision in either direction may be scrutinised, and can lead to sanctions if deemed inappropriate.

The working environment

All 6 midwives described their ability to practice as being heavily influenced by a number of factors within their working environment, including the organisation, professional dominance, the hierarchy, and the shift leader. The influential role of the shift leader was also underlined by the interview data. Most of the midwives said they would always inform the shift leader before taking any decisions, though some midwives (particularly those that acted as shift leaders themselves) described this routine as simply a means of gaining support.

Fear

The role of fear in contemporary midwifery practice and the promotion of normality were also highlighted in a discussion of why midwives intervene in labour and continue to use non-evidenced-based interventions and technology. The midwives in the study referred to their clinical practice with such terms as ‘scared’, ‘fear’ and ‘watching our backs’.

Pressures of paperwork and time

In addition to fostering fear within the working environment, CNST was also viewed as a source of increasing paperwork and computer time. The latter were implicated by several midwives as having an impact on the promotion of normality and midwifery practice generally. Although the remit of CNST is to improve care and safety for women and babies, all of the midwives interviewed resented the pressures of increased paperwork and the consequent limitation of time spent with women in their care. All midwives expressed the view that their ability to provide care was diminished as a direct result. There is little information in the published literature regarding the effects of CNST introduction on the workload of midwives, though
there is much anecdotal evidence of widespread concerns about the rigidity and restrictiveness of the guidelines aimed at avoiding risk

**The women using the service.**

For some of the midwives, the women themselves were said to influence how they promoted or practiced normality. All participants felt that by the time a woman arrives at the labour ward in labour, she may already have made important decisions about the type of birth she would like. Some midwives were unsure whether expectant mothers were as concerned about normality as midwives are as a profession, pointing out that the internet, as an open forum, gives women access to poor as well as high quality sources of information and that most women will have previously conducted their own research, and made decisions about the type of birth and pain relief they want.

**Conclusion**

It is clear that midwives generally form their views of normal birth at a young age influenced by family or personal experience or during their midwifery training. All of the midwives in the study aligned their views to the physiological view of normal birth associated with historical definitions. However evidence from the literature review and the results of the study suggest that midwifery practice in normality does not necessarily reflect their own personal views but is heavily influenced by other factors that impacts on a midwife’s ability to promote, support and practise normality.

Midwifery practice appears to be heavily influenced by several factors, both evidence and non-evidence based guidelines influence how midwives practice which often leads to interventions being introduced into normal labours. Often the midwives know that these guidelines are not evidence based but feel unable to work outside of the guidelines, as their professional judgement isn’t valued. Midwives are also greatly influenced by the culture of the working environment and often feel powerless to not only practice autonomously but also to influence change. Fear of conflict and sanctions from senior colleagues prevent midwives from promoting
normality. Midwives have lost confidence in practicing normal birth and are often more comfortable in an environment where intervention are the norm, these midwives need to gain both experience and confidence in promoting birth without interventions when appropriate.

These aspects of midwifery practice and the working environment must be tackled if the decline in normal birth rates is to be reversed.

Recommendations for Practice:

Midwives must be involved in defining normal birth at a local and national level.

Shift leaders and midwifery managers must be aware of the influence they have over the decisions that midwives make and must involve midwives in decisions regarding the care of women.

Midwives must be involved in the development of evidence-based guidelines.

The introduction of CNST guidelines and the affect on midwifery practice and the promotion of normal birth require further research.

The practice and promotion of normal birth workshops should be added to mandatory study days to increase midwives confidence in physiological birth.

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