Birthing outside the guidelines; a qualitative research study of student midwives' experiences

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Abstract

Background: Choice in childbirth is not a new concept, yet it is said very few service-users get a genuine choice about birth. Research explores the midwives experience of caring for service-users birthing outside the guidelines, but nothing was known about the student-midwives experience.

Aim: To explore how student-midwives experience birth outside the guidelines.

Method: A generic qualitative approach was employed, and a purposive sampling technique recruited five student-midwives from a university in the East-of-England. Data was collected using semi-structured interviews.

Findings: Three themes arose; 'Contradictions' that focuses upon the incongruity identified in the narratives, 'The actions of clinicians' illustrated the behaviours of clinicians witnessed by participants and 'Punishment and judgement' illustrates the treatment of service-users who birth outside the guidelines.

Conclusions: Students can be exposed to clinicians' behaviours that are inapt, with the failure to protect and advocate for these service-users leaving them feeling anxious and potentially burnout. Midwives therefore should be acting as role models, so the future midwives are aware this behaviour is not conducive to person-led care.

Key words

Student midwife; Guidelines; Birth; Choice; Autonomy; Midwifery.

Reflective questions

1. As a midwife what is my viewpoint on service-users who choose to birth outside the guidelines?
2. Do I feel comfortable providing care outside the guidelines? If I do/do not feel comfortable what has made me feel this way?
3. What additional training would assist me to feel confident in delivering care outside the guidelines?

4. Do I ever use language to discuss service-users that could be considered inappropriate or punishing?
5. Do I consistently act as a role model for student midwives?

Key Points

Choice in childbirth is not a new concept, however, it is suggested that very few service-users get a genuine choice about how they give birth. In practice when service-users choose to birth outside the guidelines, there can be tension between her and her caregivers due to the medical-legal and medical-ethical issues associated with these choices. For student midwives, the experience of caring for these women educates them to the potential challenges that they may face when service-users exert their right to bodily autonomy; yet prior to this research, nothing was known about what it was like for student midwives to care for these service-users, this research aims to bridge that gap.

Introduction

During their training, student-midwives work alongside midwives, who should share with them their knowledge and train them to become person-centred practitioners (Nursing and Midwifery Council (NMC) 2019). A key aspect of person-centred care is choice (Royal College of Midwives (RCM), 2022), with the right to choose care long being part of the maternity agenda (Department of Health, 1993). Yet, despite being part of the agenda for more than a quarter of a century it is suggested that very few service-users get a genuine choice about birth (Newnham, Kirkham, 2019).

Maternity services produce systematic guidance to support clinicians to suggest care to their service-users (RCM, 2022). These suggestions should be based upon the persons own perceived risk factors (Healy, Humphreys, Kennedy, 2016). However, the recommendations provided in these guidelines are not always based on what is consider the best quality evidence (Prusova, et al, 2014; RCM, 2022); but despite this rather than being treated as recommendations, guidelines are often treated as rules of which pregnant people must obey (Feely, 2019). In situations when service-users do exercise their right to make choices outside the guidelines, tension can arise because of the perceived risks associated with these choices (Brione, 2015). This tension Page and Mander (2014) attributes to the hospital's risk management processes, which were put in place to reduce harm (National Health Service (NHS) Resolution, 2020). Yet in addition have inadvertently, Berhan and Haileamlak (2016) suggested impacted upon service-users being supported to make autonomous decisions about their care.

Researchers (Wickham, 2010; Thompson, 2013; Cobell, 2015; Feeley, Thomson, Downe, 2019) have investigated midwives' experiences of birth outside the guidelines. Which Holten and Miranda (2016) describe as making choices that go against medical advice. Whereas Feeley, Thomson and Downe (2019), characterise this as when the service-users' choices "fall outside of national clinical guidelines". A literature search prior to data collection, revealed that nothing was known about the student experience of this phenomenon. This research provides an insight into these experiences.

Aims

This research aims to explore the experiences of student midwives who care for service-users choosing to birth outside the guidelines. Focusing specifically on service-users opting to have less care than what is recommended by their local or national guidance.

Design

A generic-qualitative approach was adopted as it is a method that allows the researcher to investigate people's opinions, beliefs, or reflections on their experiences (Percy, Kostere, Kostere, 2015). It is an approach that Caelli, Ray and Mill (2003) state seeks "to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved". It is defined as a standalone approach, which some refer to as basic qualitative

research (Kahlke, 2014). Generic qualitative research is appropriate to use McLeod (2022) suggests when the researcher has no expertise in a specific theoretical approach. This is because it does not have the same explicit philosophical assumptions as other established methodologies (Caelli, Ray, Mill, 2003). It therefore allows the researcher to claim no formal framework at all. This meaning the researcher cannot be penalised for deviating from the strict theoretical rules observed in other qualitative methodologies. Nevertheless, the absence of a methodological viewpoint can be problematic, as rigour cannot be guaranteed if there is a lack of criteria to adhere to (Kahlke, 2014). Therefore the strengths of established methodologies, were considered in the design of the research. To circumvent poorly completing this research the researcher considered their theoretical position. This ensured congruence between the methods and methodology and allowed consideration of how to establish strategies for rigor (Caelli, Ray, Mill, 2003).

Sample

A purposeful sampling technique was used to recruit five-participants (Four in year-2 and one in year-3) from a university in the East-of-England. The university offers placements at three different hospital sites, there were students from each hospital in the study. All eligible students (approximately-140) were emailed an information sheet, outlining the study, and explaining that participation was voluntary. This ensured that the participant made an autonomous decision to contribute (Green, Thorogood, 2018). The plan was to recruit ten participants, unfortunately, the data collection period coincided with COVID-19, therefore a sample of ten was unachievable due to academic deadlines.

Data collection

Written consent was gained prior to data collection. Data was gathered using audio recorded face-to-face semi-structured interviews. Interviews commenced with an invitation for the participant to describe their experience providing context to their interview.

Ethics

All procedures were performed in compliance with relevant laws and institutional guidelines (ethics approval reference NM-SREP-19-013).

Data Analysis

The interviews were transcribed verbatim. These transcripts were read and listened to repeatedly to allow immersion in the data (Brawn, Clarke, 2013). Seventy-five pages of transcripts were uploaded to NVIVO-12 Pro, where thematic analysis was utilized to identify relationships or divergence between the narratives (Polit, Beck, 2018). Common patterns, concepts, variations, and relationships that existed were explored. These were then organized into Nodes, which represented the themes that were found in the data. These were categorised and placed into clusters, if

patterns existed (Vaismoradi, Turunen, Bondas, 2013). This process continued until no further clustering was plausible. These were defined as the final-themes. Entries into the researcher's self-reflexive diary assisted the development of exploratory comments in the transcript, aiding the development of the findings. To conclude the analysis, themes were cross checked against the interviews. This validated that they captured the meaning of the participants' experiences (Braun, Clarke, 2013).

Researcher reflexivity

To ensure personal biases did not obscure the research outcome, the process was diarised. This allowed self-analysis while analysing the data to highlight any biases or assumptions made. It allowed reflection on the researcher's influence on the process, thus ensuring that the findings were solely constructed by the participants (Moule, Goodman, 2016). This was imperative as the researcher had experience of the phenomenon and this Berger (2013) states can lead to researcher bias.

Findings

Five interviews, lasting up to one hour, were conducted between January and February 2020. Participants were able to self-define what 'birthing outside the guidelines' meant to them. All participants provided an example that could be defined as going against medical advice or involved care that fell outside of guidelines (based upon what was at the time the national guidance) (National Institute for Health and Clinical Excellence (NICE), 2017). The examples given included declining fetal monitoring, birthing in a place that was not recommended or declining certain aspects of care e.g. cannulation and blood products. Three themes emerged that described the experiences of these participants; *'Contradictions'*, *'The actions of clinicians' and* '*Punishment and judgement'.*

Contradictions

Theme-one *'Contradictions'* gave an insight in to the incongruity identified in what the participants stated in the narratives. The subtheme *'Supporting without responsibility'* explores how students vocalise supporting choices but assert the opposite closer to completing their training and becoming a registered midwife. The subtheme '*The service users are different to what we expected*' illustrates what causes students to have preconceived ideas that these people will be difficult to care for, as well as the realisation that these beliefs are in fact incorrect.

Supporting without responsibility

The sample all voiced that at the time of the experience they supported these service-users' informed choices; ***"They need to know why we want to do it. If they still don't want to do it, just let them do what they want to do"*** (Participant-5). However, it was evident throughout four narratives that at the time they had not understood the potential implications; ***"We hadn't done emergencies yet at uni, so I guess I didn't think it through like I would think it through now"*** (Participant-1). Now having more knowledge and getting closer to completing their training three participants

stated that their concern around these choices had increased. As a result they felt more concern for their registration if something went wrong. This transformation saw their views becoming more aligned to the midwives they described as not in support of these choices; ***"I would now feel like how my mentor felt, like, oh, it's my pin. I need to make sure that baby is okay"*** (Participant-5).

The service users are different to what we expected

All participants had preconceived ideas that the service-users would be difficult to care for or reckless prior to meeting them. When asked what had led to this opinion, they explained the way they had heard service-users spoken about by other clinicians; ***"The senior midwife who handed over the care, in handover, was a bit, this woman's obviously happy to die"*** (Participant-3). Yet all participants stated that there was a contradiction between the service-user they expected to be caring for and the one they met; ***"I've been told she's this really difficult woman, and actually she was just a bit scared"*** (Participant-4). After spending time with the service-users four participants realised they were not difficult, but were instead driven by a personal belief, a previous experience or fear; ***"she'd had an awful caesarean last time, and she felt she wasn't cared for"*** (Participant-4).

The actions of clinicians

Theme-two *'The actions of clinicians'* discuss how participants experienced clinicians behaving when faced with this phenomenon. The subtheme 'How we s*upport choice'* focuses upon how participants witnessed midwives' behaving defensively, even when appearing to support care outside the guidelines. The subtheme *'Without autonomy'* demonstrated actions witnessed by participants that did not respect bodily autonomy.

How we support choice

When participants were asked about if they felt midwives supported these choices, responses were varied. Some felt midwives were supportive of these choices where others were unhappy to facilitate this care. Other midwives could be influenced by the doctors' opinion; ***"The response wasn't that great by some of the midwives because obviously we want to keep an eye on baby"*** (Participant-5); ***"I feel like sometimes it depends on the midwife, if they're going to just go with what the doctors want, or if they're going to say, I'd be happy to look after her"*** (Participant-1). However, congruence was noted in all interviews, that acceptance of choice by midwives, depended on the perceived risk; ***"It's just like a whole spectrum, isn't there? A woman who wants to free birth on her own and something goes wrong. Then you've got women who want to birth in hospital"*** (Participant-3).

In all narratives regardless of the level of support the midwife exhibited, examples of defensive practice were noted. This included excessive documentation or repeatedly asking the service-user to reconsider. This a participant explained resulted in her also acting this way; ***"I was really meticulous, and I felt that that I might have gone on to her***

a little bit, because I was stressed" (Participant-4). When asked why the midwives behaved this way Participant-4 explained; *"because they believed that's what's best for the woman".*

In four participants experiences non-supportiveness of choice was also exhibited by senior midwives; *"At the time we just, kind of, went to the superior one and she said, "no, you've got to do it" basically"* (Participant-5). This Participant-4 felt was because these choices increased the senior staff's workload; *"It was just the higher band people that were a bit aggressive towards the situation, because they were managing so many people".* Nevertheless, even after the service-user had given birth and the perceived workload had eased, the senior midwifes attitude did not improve; *"she was like, oh, well, it worked out well for her, but it was almost a bit of bitterness towards it" (*participant-4).

Without autonomy

The behaviours and language witnessed by all participants did not always respect autonomy. The use of words like 'allowed', and 'can't', participants stated recalling hearing regularly, but not just exclusively to these scenarios; *"I've heard it a few times, can't"* (Participant-2). Four participants experienced care plans being made without the consultation of the service-user; *"The doctors had almost made a plan for her, before they'd even seen her"* (Participant-4). When the service-users went against the plan, Participant-4 witnessed the midwife's annoyance and questioning of the service-user; *"This is ridiculous. Why can't we cannulate? Ridiculous. You've done that…why can't you do the rest?"*.

Punishment and judgement

Theme-three '*punishment and judgement'* explores the treatment of service-users who go against the guidelines. The subtheme *'midwives' reluctance to provide care outside the guidelines'* explores midwives' unwillingness to provide care to these service-users. The subtheme '*Unprofessional behaviour'* illustrates the language and behaviours that were witnessed being used by clinicians in these experiences.

'Midwives' reluctance to provide care outside the guidelines'

One participant witnessed midwives refusing to provide care; *"In handover it was, oh, it's one of those women and everyone was like, oh, I don't want her. I don't want that one"* (Participant-4). Another participant described how the service-user was treated when a midwife realised that she would be birthing outside the guidelines; *"I felt uncomfortable by the midwife's attitude, because you saw an instant change in the care given"* (Participant-2). When asked why they felt midwives acted in this way, two participants stated that they felt midwives did not know how to provide care in these scenarios; *"she didn't know what to do"* (Participant-2). Further adding they also did not know what to do as they did not recall birthing outside the guidelines ever being discussed; *"I can't pinpoint a specific conversation we've had where we've talked about…birthing outside the guidelines"* (Participant-1); *"I feel like there's not that much preparation for when you're off a guideline, because if that's what guides our practice, what do you do when you haven't got anything?"* (Participant-4).

Unprofessional behaviour

The participants spoke of service-users being discussed by midwives in a derogatory way, including implying they lacked awareness of the risk of their decisions. Some midwives even cast judgement over choices, including those relating to religious beliefs. Participant-3 discussed the care of a Jehovah witness who declined blood products; ***"When you get handed over and the senior midwife's like, "She's obviously happy to die," and you're like, "Yes, but that's her belief".*** However, this participant recognised, that the chance of the service-user dying because of their decision was minimal; ***"the chances of that happening are slim"*** (Participant-3).

Despite witnessing negativity towards these choices all participants described what they felt were positive outcomes; ***"She went home a few hours after… she was happy with the way everything went"*** (Participant-1). This good outcome Participant-1 did not expect because of what she had been taught would happen if guidelines weren't followed; ***"I was like, that was completely different to what we've been taught and what we've been told we should do, but we still got a completely healthy baby, a completely healthy mum".***

Two participants also witnessed members of the wider multi-disciplinary team demonstrating poor attitudes towards service-users; ***"a member of the theatre team was openly annoyed at her, that she was not wanting to have blood products"*** (Participant-3). When participants were asked how they addressed these behaviours, they all stated university taught them there was a professional obligation to safeguard service-users from undignified treatment and that they must be their advocates; ***"Our lecturers are really good, like, "It's your woman, advocate for her, if that's what she wants, advocate for her"*** (Participant-5). Yet, they felt powerless to do so. Three of the participants stated that this left them feeling guilty. When asked to elaborate on why they did not feel they could challenge these behaviours four participants stated that they feared it could damage the student-supervisor relationship. Two participants further adding that they feared it would affect their grades; ***"You don't want to ruffle anyone's feathers either way… she's got to do my paperwork later"*** (Participant-2).

Discussion

In this paper we highlight the conflicts student midwives experience when caring for service-users making birth choices outside the guidelines. This conflict exists in what they are taught and what they see, the judgements they hear and the service-users they meet. This conflict is also internally, as they address feeling powerless to advocate for service-users, despite knowing they have a duty to (RCM, 2022). Furthermore the participants narratives revealed that birth outside the guidelines was not discussed during their education. This lack of awareness is what potentially makes these situations challenging for midwives and could theoretically, be why the midwives discussed by participants did not know how to provide kind and dignified care in these circumstances (NMC, 2018).

It was evident that a variety of attitudes towards service-users who make choices outside the guidelines existed among those providing care. This concurring with Feeley, Thomson and Downe's (2019) findings, which suggested a spectrum of attitudes exists among midwives, from "willingly facilitative' to 'reluctantly accepting" when faced with this phenomenon. All participants experienced at least one person who behaved negatively towards the situation. This manifesting in reluctance to provide care, clinicians making care plans without the service-users consultation or speaking about them disrespectfully. These behaviours created preconceived ideas for the student midwives, as to what the service-user would be like. These behaviours witnessed by the participants could be considered contradictory to the work that has been done to humanise birth, by moving away from paternalistic healthcare (Dahlen, Kumar-Hazard, Schmied, 2020). Furthermore these actions fail to meet the expectations outlined by the NMC (2018) in regards to preserving service-user dignity and providing care that respects individual autonomy (RCM, 2022).

Autonomy, at its most basic level is being able to control one's own life without regulatory and limiting interference from others (Beauchamp, Childress, 2019). The reluctance to provide care, witnessed by the participants, could be said to fail to acknowledge this basic human right and the individuals' right "to timely healthcare" (World Health Organisation, 2015; The White Ribbon Alliance, 2021). Although midwives have a right to conscientiously object to providing certain care (NMC, 2018), the attempt to abandon them in these participants experience could be considered a form of punishment (Jenkinson, Kruske, Kildea, 2017). It may also be a way the midwives exhibited their moral opposition to these decisions (Feely, Thompson, Downe, 2019). These behaviours made the participants feel uncomfortable as they realised, service-users had specific motivations for their choices, which the midwives they were working alongside had a duty to be sensitive to (NMC, 2018; 2019).

Language that surrounds childbirth and the impression it creates, has been extensively discussed (Simkin, et al., 2012; Hill, 2015). In these participants narratives language could be described as directive with words such as 'allowed' and 'can't' being used as the norm. Participants felt exaggerated language was also used by midwives when describing the risk associated with choices, yet participants recognised that the articulated risk was not a definite diagnosis (Odent, 2014; Birthrights, 2017). This language is used Odent (2017) suggests because clinicians believe individuals cannot give birth without assistance. It could be considered that in these experiences that when a choice challenged this belief, it caused tension between the service-user and the clinicians, thus aligning to the experiences and tension felt by midwives in other research studies (Cobell, 2015; Jenkinson, et al., 2016; Thompson, 2013). This tension is suggested by the NMC (2018a) to be a result of a misinterpretation by midwives of where the accountability lies if something goes wrong. This has been apportioned to the historic blame culture that has existed in midwifery practice.

Fear of blame is what participants felt impacted their supervisors' actions, with evidence of defensive practice articulated in all scenarios (even when the participant stated the midwife was comfortable facilitating choice). This fear is what Healy, Humphreys, and Kennedy (2016) suggests prevents clinicians from trusting individuals to make decisions about their care. This can result in midwives practicing defensively (Weir, 2017). Defensive practice among

midwives when providing care outside the guidelines, is not exclusive to this research (Thompson, 2013). This is concerning as this type of practice prevents midwives providing personalised care, which is unacceptable as personalised care is cited as being safer (NHS England, 2016; Brigante, 2022). Fear was less evident initially in the participants, and although they stated they believed that following guidelines was in service-users' best interests they also stated that they respected individuals right to choose their care. However, the participants narrative changed when considering themselves qualified. This was as their professional responsibilities began to be realised. This manifested in participants seeming more fearful of the perceived risks that were associated with these choices.

Two participants voiced that they felt the midwives did not know how to manage care outside the guidelines. This, Robotham (2000) suggests, is to be expected, as to practice autonomously clinicians must have the expertise to do so. This proficiency many midwives may struggle with, due to the reliance on technology, guidelines, and the risk management processes they have become accustomed to (Benoit, et al., 2005; Wickham, 2011). Nevertheless, when service-users opt to birth outside the guidelines, midwives are not expected to act alone. Instead they should work alongside a consultant obstetrician or midwife, referring the service-user to them so they can discuss their plans. This ensures individuals are supported to make informed decisions about their care (NICE, 2017).

Participants spoke passionately about autonomy and knew it was their professional obligation to safeguard individuals against undignified treatment (NMC, 2018). Nonetheless, participants felt that this was impossible as a student, as doing so could impact their relationship with supervisors and potentially their grades. This parallels Davies and Coldridge (2018) findings who also found students felt powerless to advocate for service-users. This feeling is not unreasonable when you consider Gillen's, et al. (2009) and Steen (2011) work which suggests students can be bullied in practice. This need for self-preservation distressed participants, who struggled with the guilt associated with failing to advocate. These feelings Hunter and Fenwick (2018) suggest can negatively affect the student's psyche, which can potentially lead to anxiety and burnout (Beaumont, et al., 2016). With so many midwives leaving the register (NMC, 2022) it is important that we look for ways to reduce this burnout so early in a midwife's career, this is essential if we are to preserve the future of midwifery practice (RCM, 2017).

Limitations

Although the small sample can be considered a limitation, as qualitative research is not intended to be generalisable, but instead utilised to construct meaning, the modest sample size could be argued not to be a limitation especially as three themes did emerge, which readers can explore and consider against their own circumstances (Holloway and Galvin, 2017). It was also evident during analysis that the same themes were emerging in the narratives, this suggesting data saturation had been met (Faulkner, Trotter, 2017). This supports the believe that it is possible to achievable a homogeneous qualitative sample with just five to eight participants (Cooper and Endecott's 2007; Holloway, Galvin, 2017).

The researcher acknowledges the Hawthorn effect, which could mean the participants may change their responses to the questions due to the presence of the interviewer, thus impacting the validity of these findings (Sedgwick, Greenwood, 2015). Although qualitative methodologies support researchers undertaking interviews to enhance reflexivity a third-party could have conducted the interviews. This would have ensured the researcher did not impact the findings, especially as the researcher had experience of the phenomenon (Berger, 2013). A further limitation was that as this was an unfunded piece of research there was not the ability to employ a second researcher to also analyze the data, which could have increased this works credibility (Polit, Beck, 2018).

Conclusions

Students are exposed to clinicians' behaviours that are at times inapt, with the failure to protect and advocate for these service-users leaving them feeling distressed and anxious. This feeling of anxiety can Beaumont, et al., (2016) lead to burnout. Therefore all midwives, from a practice supervisor to a practice assessor, should serve as role models (NMC, 2018; 2019), supporting choice and working with consultant obstetricians and midwives to ensure safer personalised care. This will teach the future midwives to provide a standard of care that is person-led, thus aligning with the NMC code (2018). Yet as it is apparent that some midwives may not know how to provide care outside the guidelines, which could be a potential catalysis for poor behaviours, training on how to provide choice should be a part of midwifery education and midwives mandatory training.

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Reflective questions

6. As a midwife what is my viewpoint on service-users who choose to birth outside the guidelines?
7. Do I feel comfortable providing care outside the guidelines? If I do/do not feel comfortable what has made me feel this way?
8. What additional training would assist me to feel confident in delivering care outside the guidelines?
9. Do I ever use language to discuss service-users that could be considered inappropriate or punishing?

10. Do I consistently act as a role model for student midwives?