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*Health (London)* 2009 13: 589  
DOI: 10.1177/1363459308341439

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# **A metasynthesis of midwives' experience of hospital practice in publicly funded settings: compliance, resistance and authenticity**

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**ABSTRACT** Worldwide, increasing percentages of women are giving birth in centralized hospitals in the belief that this maximizes safety for themselves and their babies. In parallel, there is international recognition that the number of birth interventions used in the routine care of labouring women is rising. This is fuelling concern about iatrogenesis, and, particularly, maternal and infant morbidity and mortality. It also has an adverse impact on the economics of health care. National and international policy characterizes midwives as the guardians of normal childbirth. This guardianship appears to be failing. The objective of this metasynthesis is to explore midwives' perceptions of hospital midwifery with a focus on labour ward practice to examine professional discourses around midwifery work in the current modernist, risk averse and consumerist childbirth context. Based on an iterative search strategy, 14 studies were selected for the metasynthesis. Three overarching themes were identified: 'power and control'; 'compliance with cultural norms'; and 'attempting to normalize birth'. Most midwives aimed to provide what they characterized as 'real midwifery' but this intention was often overwhelmed with heavy workloads and the normative pressure to provide equitable care to all women. This raises questions of authenticity, both in terms of midwives living out their beliefs, and in terms of acknowledgement of the power to resist. The theoretical insights generated by the metasynthesis could have resonance for other professional and occupational groups who wish to offer autonomous individualized services in an increasingly risk-averse target driven global society.

**KEYWORDS** *authenticity; bad faith; hospital birth; metasynthesis; midwives; real midwifery; resistance*

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The use of technology and increased levels of intervention has made 'normal birth' a rare event in hospital settings across the world. The impact this has for women and their babies has caused widespread concern (MCWP, 2007; Tracy et al., 2007). While midwives claim to have expertise in normal birth, the literature suggests that they generally acquiesce to what Davis-Floyd (2001a) describes as the technocratic approach to childbirth. In this interpretation both doctors and midwives accept high levels of intervention and readily adopt prevailing technology in the belief that it leads to the best outcomes for women and their babies. This situation illustrates many of the features of Giddens (1999), risk society and of consumerist requirements for certainty and control (Beck, 1992). These modernist cultural norms pose significant challenges for professional and occupational groups whose core identity rests on assumptions of autonomous decision making, and of individualization of practice. Midwifery provides an archetypal case study for such groups. In most countries, trained midwives occupy a potentially paradoxical position of a semi-professional group that is seen by some as subordinate to medical power, but that has autonomy of decision making enshrined in its legislative structures (NMC, 2004; ICM, 2005). International midwifery bodies make strong claims that the core expertise of midwifery is to support women in achieving normal childbirth (ICM, 2005). However, a range of studies from across the world have illustrated that most trained midwives practise labour and childbirth care in hierarchical, rule-governed hospital settings, where intervention is the norm (Downe et al., 2001; Sinclair and Gardner, 2001; Mead and Kornbrot, 2004). This article explores the issues in this area from the perspective of midwives themselves, through their accounts of their experiences of enacting their profession in publicly funded hospital labour ward settings.

## **Methodology**

Metasynthesis involves an exploration, analysis and synthesis of qualitative research by different investigators in a related field (Sandelowski et al., 1997; Thorne et al., 2004). As a relatively new methodological area, researchers have adopted a range of approaches to synthesizing qualitative studies, as illustrated by Thorne and colleagues (2004). Most authors have used a variation of the approach taken by Noblit and Hare (1988) who developed a method of creating a synthesis from the findings of similar ethnographic studies. The process involves the comparison and integration of findings from individual studies in order to generate consensus on a new construction or description of the phenomenon of interest (Jensen and Allen, 1996). A wide search for similar qualitative studies is undertaken in order to establish if there are links between them. Results are collated and summarized providing a descriptive analysis of common themes. From this a deeper integration and further analysis of the studies is undertaken through

a process of reciprocal translation (Noblit and Hare, 1988). This comprises of a compare and contrast exercise which seeks to identify refutation, divergence, difference and dissonance between the individual studies and then to synthesize these translations. From this, fresh insights are gained, which may generate new knowledge through a process of synthesis (Popay et al., 1998; Walsh and Downe, 2005; Downe, 2008). Thorne and colleagues (2004) note that the actual approach taken by experts in this area in terms of rigour currently varies from precision that approximates meta-analytic techniques, to a more open approach that allows for iteration and the inclusion of studies that may not be of high methodological quality. There is as yet no definitive methodological template. For example, while Jensen and Allen (1996) advise against combining studies which use different qualitative approaches, Sandelowski et al. (1997) accept that different methodologies can be used if the approach used is made explicit.

A metasynthesis can lead to more substantive interpretations than are available from single studies (Arman and Rehnsfeldt, 2003), increases the understanding of a particular phenomenon of interest and enhances the transferability of similar qualitative studies (Paterson et al., 2001; Sandelowski, 2006). Rigour is essential throughout each stage so that the results are perceived as credible (Jensen and Allen, 1996).

We have adopted an approach that we have developed over a number of studies (Walsh and Downe, 2005, 2006; Downe et al., 2007; Downe, 2008). In an attempt to maximize rigour, our approach is based on an iterative approach to the topic definition, and then, once this is determined, a fairly tight control over inclusion and exclusion, included study quality and analysis. Our processes are closely aligned to those of Noblit and Hare (1988) with two key differences. First, our search strategy allows for all qualitative methodologies. Second, we assess the included studies for quality, and do not include any that do not meet Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability.

## **Researcher reflexivity**

To enhance the trustworthiness of the review we recorded our initial position on this topic. Both authors have extensive experience of working in large hospital labour wards. At the beginning of this review, SD believed that many midwives who were based in the labour ward felt themselves to be caught in oppressive institutional and inter-professional hierarchies, which they could not resist. Some of the oppressive aspects identified seemed to be in the control of, and even enacted by midwifery staff but, as this did not fit with midwifery myths about themselves, it appeared to be invisible to them. When RO'C worked in the labour ward active management of labour (O'Driscoll and Meagher, 1986) was prevalent and while she accepted the norms of the hospital she preferred to support women who sought a non-interventionist approach to birth. This led her to question the increasingly

technocratic approach to childbirth and whether individual midwives' apparent readiness to use interventions impacted on birth outcomes as well as women's experience of childbirth.

## Search strategy

The first stage in this metasynthesis was a rigorous literature search to identify accessible qualitative research relating to midwives' accounts of hospital midwifery with a particular focus on labour ward practice. This involved an electronic search of databases, selected journals, conference proceedings and edited books for studies that gathered data from midwives practising in hospital settings (see Table 1). Date restrictions were not imposed.

Databases, individual social and health science journals were searched using the terms 'midwife', 'midwifery', 'nurse midwives', 'nurses', 'childbirth', 'consultant unit', 'labour' and 'labor'. Relevant professional journals, books and chapters within books were reviewed for papers that related to midwives' views or experiences of midwifery and labour ward care or practices. A fruitful source of information was back chaining of reference lists. In all 216 abstracts were reviewed and many of these articles were read in full (Table 2). Journals and books not available using electronic sources were accessed through two university library catalogues.

**Table 1** Search strategy

Databases (17)	BNI; CSA Sociological Abstracts; CINAHL; EBSCO; EMBASE; Emerald; ISI Web of Knowledge; Index of Theses; Informaworld; Medline; MIDIRS; Proquest; PsycINFO; SocINDEX; Sociological Collection; SpringerLink; Swetswise
Midwifery journals (8)	<i>Birth</i> ; <i>BMC Pregnancy and Childbirth</i> ; <i>British Journal of Midwifery</i> ; <i>Journal of Midwifery and Women's Health</i> ; <i>Journal of Obstetrics</i> ; <i>Gynaecology and Neonatal Nursing</i> ; <i>MIDIRS Digest</i> ; <i>Midwifery</i>
Other journals (14)	<i>European Sociological Review</i> ; <i>health</i> ; <i>International Journal of Nursing Studies</i> ; <i>International Nursing Review</i> ; <i>Journal of Advanced Nursing</i> ; <i>Journal of the American Academy of Nurse Practitioners</i> ; <i>Journal of Clinical Nursing</i> ; <i>Journal of Reproductive and Infant Psychology</i> ; <i>Nurse Practitioner</i> ; <i>Nursing and Health Sciences</i> ; <i>Nursing Philosophy</i> ; <i>Social Science and Medicine</i> ; <i>Sociology of Health and Illness</i> ; <i>Health and Social Policy</i>
Conference Proceedings	Normal Birth Conference (x 2) ICM Triennial Conference (x 3)
Edited texts (18)	Robinson and Thompson (1989, 1991, 1994); Kroll (1996); Byrne and Leonard (1997); Kargar and Hunt (1997); Kirkham and Perkins (1997); Marland and Rafferty (1997); Kirkham (2000, 2003); Page (2000); van Teijlingen et al. (2000); DeVries et al. (2001); Mander and Flemming (2002); Downe (2004); Firth and Draper (2004); Page and McCandlish (2006); Reid (2007)

**Table 2 Selection of studies**

- 
1. Selection and reading abstracts from 216 studies which loosely met the inclusion criteria
  2. Exclusion of 185 studies as the focus of the metasynthesis became clearer
  3. Remaining 31 studies read repeatedly and tabulated to compare and contrast and identify any common themes
  4. Excluded 17 studies for a variety of reasons such as insufficient data, or the inclusion of both quantitative and qualitative data
  5. Remaining 14 studies reviewed using Walsh and Downe (2005) framework to assess the quality of the studies and assist in the construction of the metasynthesis
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The process of searching and reviewing the literature led to a refinement of the search question for the metasynthesis. Studies were considered if they contained midwives' accounts of their own practice in a hospital setting but it soon became clear that many papers focused on specific aspects of practice such as: nutrition in labour, midwives' attitudes to specific interventions; or defined systems of care, such as team midwifery. These were eventually eliminated as were studies on home birth or birth centres to ensure that the included studies involved the same essential phenomena. In addition, the North American studies were excluded as it became difficult to compare the experiences of these midwives with studies that involved midwives where maternity care is publicly funded. The question that gradually emerged from this process was 'what do midwives, who practise in publicly funded maternity hospitals in high resource countries, say about hospital midwifery, with particular reference to labour ward practice?' This iterative process of topic definition is consistent with metasynthesis as during the searching and exploring of the literature the metasynthesis question becomes more defined (Sandelowski et al., 1997; Walsh and Downe, 2005; Downe, 2008).

Searching continued from February 2006 to January 2009 for newly published studies and to ensure that studies were not overlooked or needlessly excluded. When two articles (Blaaka and Schauer Eri, 2008; Keating and Flemming, in press) identified late in the search process did not add anything new to the emerging synthesis, it appeared that theoretical saturation had been reached.

### **Final selection of studies**

Initially everything that was potentially relevant was reviewed; this involved reading abstracts and many papers in full. These studies provided a variety of accounts of midwives' experiences, perceptions and attitudes to intrapartum care or aspects of intrapartum care in a hospital setting. Studies were explored using criteria developed by Walsh and Downe (2005) to assess their comparability. Following extensive scrutiny 14 studies were selected

for the metasynthesis. Details of the excluded studies are available. Eight of the selected studies were undertaken in the UK, three in New Zealand, two in Ireland and one in Norway. All but one were sourced in professional literature with the remaining one in a social science journal.

## **Appraisal of studies**

The metasynthesis was constructed using the Walsh and Downe (2005) framework. The studies were read repeatedly to extract the concepts, categories, metaphors and themes used to describe or interpret the accounts provided by the midwives interviewed. These were compared and contrasted through reviewing phrases, ideas and themes in the published accounts, disconfirming data was particularly sought. Quality was assessed using the criteria developed by Walsh and Downe (2006), which is a summary of a wide range of previously suggested quality assessment tools. Results presented in Table 3 are a synopsis of these findings. The emergent themes were discussed extensively and the studies were reread to consider any evidence that could be considered refutational (Noblit and Hare, 1988). After some debate, a consensus on the themes and the synthesis was reached (Table 4). Of particular interest here was the study by Porter et al. (2007); this, along with the oldest of the studies (Hunt and Symonds, 1995) contained observational data. These were particularly explored to disprove the emerging analysis or any prior reflexive assumptions. This process will be further discussed below.

The quality of the studies was summarized using a tool derived from the detailed quality check (Downe et al., 2007) based on a broad assessment of credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985). While the quality was generally good, some common flaws were apparent. These included the lack of a theoretical framework and somewhat limited evidence of reflexivity, possibly due to word limitations of journal publications. Despite this, the quality of the included studies was generally good.

## **Themes identified**

Though the midwives were from different areas of practice and different countries, the issues that impacted on their practice in a hospital setting were surprisingly similar. The following issues dominated their discourse: power and control; compliance with cultural norms; and attempts to normalize birth in a medicalized environment. The participants presented a version of midwifery that some termed 'real midwifery'. This appears to be an idealized approach to childbirth whereby the woman progresses through labour and birth without any intervention; the midwife facilitates this process actively; and the woman has a positive birth experience. This term was

**Table 3** Characteristics of included studies

Criteria	Hunt and Symonds (1995) Wales	Kirkham (1999) England	Shallow (2001a-d) England	M. Hunter (2003) NZ	Hyde and Roche-Reid (2004) Ireland	Lavender and Chapple (2004) England	B. Hunter (2004, 2005) Wales
Scope and purpose	Activities and social processes at work in Labour Ward (LW) setting	Culture of midwifery, context of practice	Midwives' experiences of becoming working in a team	Midwives' differences in intrapartum care in small and large hospitals	Midwives' perception of their role and their views on active management of labour	Midwives' views about birth settings, models and philosophy of care	Midwives experience and management of emotion in their work
Design	Ethnography Observation Interviews	Ethnographic approach Interviews	Mishler's feminist approach Interviews	Qualitative descriptive Interviews	Habermas' theory of communicative action Interviews	Social constructionist Appreciative Inquiry Focus group Interviews	Ethnography Focus group, individual interviews Observation
Sample	2 maternity units	168 midwives 5 sites	6 team midwives	10 independent midwives	12 LW midwives 3 hospitals	Focus groups (15) Midwives (120) Students (6) 14 sites	Students (27) midwives (28) Focus groups, observation and interviews (12)
Analysis	Progressive focusing to identify themes	Grounded theory	Modified grounded theory with feminist ideology	Van Manen's hermeneutic analysis.	Grounded theory style, constant comparison	Themes identified, consensus agreed	Themes analysed, mind mapping
Interpretation	Quotations, field notes, drawings	Parallel process, oppression, gendered institution	Largely descriptive	Largely descriptive	Relates to 'tensions of modernity'	Summaries returned to members of groups	Contrasts practice in home and hospital
Reflexivity	Apparent	Not apparent	Some reflection	Not apparent	Not apparent	Not apparent	Search for trustworthiness of the data. Peer validation
Ethical issues	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Relevance /transferability	LW midwives	Yes	Contrasts hospital and community	Contrasts care in small and large units	LW midwives	Yes	Emotional labour Mostly junior midwives

(Continued)



Table 3 (Continued)

Criteria	Crabtree (2004) NZ	Earl and Hunter (2006) NZ	Davies and Iredale (2006) Wales	Porter et al. (2007) England	Russell (2007) England	Blaaka and Schauer (2008) Norway	Keating and Fleming (in press) Ireland
Scope and purpose	Midwives' construction of 'normal birth' and influences on this	Experience of midwives in tertiary hospitals in 'keeping birth normal'	Midwives' perception of their role and influences on their practice	Midwives' decision-making strategies relating to the use of technology	Midwives' experiences of supporting normal birth	Midwives' experience of biomedical and a phenomenological belief system	Midwives' experiences of supporting normal birth in an obstetric-led unit
Design	Qualitative descriptive with feminist underpinning Interviews	Qualitative interpretative Interviews	Focus group methodology Interviews (7)	Qualitative descriptive Observation	Grounded theory Interviews	Phenomenological approach Interviews	Feminist approach Interviews
Sample	9 independent midwives	8 core midwives 2 tertiary hospitals	48 midwives	2 hospitals, (n = 16), Focus group (n = 8)	6 LW midwives, from 2 obstetric-led units, who attended a 'normal birth workshop'	7 experienced midwives high technology LW	Purposive sample 10 LW midwives, 3 maternity units
Analysis	Thematic analysis	Van Manen used	Thematic analysis	Constant comparison Data saturation achieved	Strauss and Corbin used	Giorgi used	Words, phrases and meanings identified, themes developed
Interpretation	Interpretive	Largely descriptive	Descriptive analysis.	New professionalism Largely descriptive Explanation of modes	Interpretive	Interpretive	Warren's concept of patriarchy used to interpret themes
Reflexivity	Apparent	Not apparent	Not apparent	Not apparent	Not apparent	Not apparent	Apparent
Ethical issues	Not addressed	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Relevance	Independent midwives	Yes	Yes	Yes	Yes	Yes	Yes
/transferability	who attend hospital births				midwives interested in normal birth	midwives	midwives interested in normal birth

**Table 4 Iteration of themes and synthesis**

<i>Themes</i>	<i>2nd iteration</i>	<i>Synthesis</i>	<i>Relevant papers</i>
<i>1st iteration</i>			
Interchangeable midwifery staff			Hunt and Symonds (1995)
Relationships with colleagues and institution	Power and control	<i>Arc one:</i> 'Getting through the work' and providing an equitable service for all women	Kirkham (1999)
Authoritative expertise and experience			Shallow (2001 a, b, c, d)
Senior midwives exerting power over junior midwives and women – midwifery hierarchy			M. Hunter (2003)
Disconnection			Crabtree (2004)
Oppression, guilt and blame			B. Hunter (2004, 2005)
Considering the bigger picture			Hyde and Roche-Reid (2004)
Valuing efficiency and task completion			Lavender and Chapple (2004)
Acceptance and expectation of intervention as normal			Davies and Iredale (2006)
Acceptance of status quo			Porter et al. (2007)
Get through the work			Russell (2007)
Midwifery skills not valued			Blaaka and Schauer Eri, (2008)
Fear of the birthing process, powerlessness			Keating and Flemming (in press)
Unwritten rules and sanctions			Hunt and Symonds (1995)
Junior staff 'sussing out' unwritten rules	Compliance with cultural norms	<i>Arc two:</i> Enforcing compliance to technocratic norms in order to 'get through the work'	Kirkham (1999)
Adaptation to environment, 'fitting in'			Shallow (2001 a, b, c, d)
Engineering agreement/acquiesce to institutional norms			M. Hunter (2003)
Acceptance of medicalized environment			Crabtree (2004)
Intervention and technology as normal			B. Hunter (2004, 2005)
Organizational culture/conformity			Hyde and Roche-Reid (2004)
Ethic of service, self-sacrifice			Lavender and Chapple (2004)
Avoidance of conflict			Davies and Iredale (2006) Earl and Hunter (2006)
			Porter et al. (2007)
			Russell (2007)
			Keating and Flemming (in press)

(Continued)

**Table 4 (Continued)**

<i>Themes</i>	<i>1st iteration</i>	<i>2nd iteration</i>	<i>Synthesis</i>	<i>Relevant papers</i>
Discursive resistance, deviance				Hunt and Symonds (1995)
Fibbing and avoidance, manipulation of information, subversion, doing good by stealth		Attempting to normalize birth in a medicalized environment	<i>Arc three</i> : Discursive, subversive and occasional resistance, in an attempt to provide 'real midwifery' for individual women	Shallow (2001 a, b, c, d) M. Hunter (2003) Crabtree (2004) B. Hunter (2004, 2005) Hyde and Roche-Reid (2004) Lavender and Chapple (2004) Davies and Iredale (2006) Earl and Hunter (2006) Porter et al. (2007) Russell (2007)
Dissonance, frustration, anger				Blaaka and Schauer Eri (2008)
Maintaining appearance of compliance				Keating and Flemming (in press)
Valuing midwifery skills				
Individualized care, relationships with clients				
Having/giving time (to women)				
Tolerating noise, carrying the can				
Letting birth be, keeping definitions fluid				
Supporting women through appeal to the 'choice' agenda				
Having the confidence/foresight to avert/manage problems, stepping back/stepping in				
Keeping/returning birth to 'normal'/Normalizing birth, normal birth is possible				
Protecting women, 'shutting the door', 'keeping women away from medicalization'				

used by a midwife to describe the kind of midwifery that was possible when practice was perceived to be autonomous – in this case, in a small maternity unit (M. Hunter, 2003). The key features of this approach appeared to be fundamental to midwives' professional identity in other settings, but it appeared that 'real midwifery' was difficult to achieve in a hospital setting.

## **Power and control**

The so-called medical model of care, obstetric control and the hegemony of the medicalized system were referred to in all the studies. These were seen as constraints that influenced the midwives' practice and their use of interventions (Crabtree, 2004; Hyde and Roche-Reid, 2004; B. Hunter, 2004, 2005): 'I am very much aware of the power basis and the politics and I have to work within that ... Obstetricians have a huge influence because of their power' (Hyde and Roche-Reid, 2004: 2619).

Midwives experienced a hierarchical work environment and lacked autonomy in their work, but often it was 'other' midwives rather than doctors who determined how they practised (Hunt and Symonds, 1995; B. Hunter, 2004, 2005): 'You have got somebody up there saying, oh no, you can't do that ... and that to me is very frustrating' (B. Hunter, 2004: 269)

In hospitals, birth was seen as a clinical event. Apparently of necessity, skills that were prioritized by the hospital culture were the ability to manage birth actively in an often busy environment, to be able to use technology and intervention in the care of labouring women and to be able to identify and deal with emergencies. These competencies were more valued than providing a woman-centred approach to care or keeping birth interventions at a minimum (Hunt and Symonds, 1995; Shallow, 2001d; M. Hunter, 2003): 'We are all expected to be able to cannulate, to scrub and to suture perineums' (Shallow, 2001d: 239).

The potential for litigation was also a concern: 'I think if it wasn't for litigation then they would probably not practice in that way' (Porter et al., 2007: 529).

In hospital labour wards midwives were often required to care for a number of women at a time and the heavy workload led them to provide a task-based approach to care (Kirkham, 1999; Shallow, 2001c, 2001d; B. Hunter, 2004; Porter et al., 2007): 'it is important to have the woman come in, have her delivered and have her out again ... getting the job done as quickly as possible' (M. Hunter, 2003: 243). Whether this approach is the influence of nursing on midwifery as suggested by Shallow (2001c), the powerlessness of women and midwives under the medical authority of the hospital system combined with gender politics, as suggested by Kirkham (1999) among others, the exercise of street-level bureaucracy as hypothesized in other resource-short public sector settings by Lipsky (1980), the exercise of the Panopticon as proposed by Foucault and his followers (see Arney, 1982 for example) or something else is unclear. Nonetheless, many midwives

expressed dissatisfaction and frustration with the level of care that they could provide in this environment.

The midwives reported a lack of midwifery leadership and support for normal birth (Hyde and Roche-Reid, 2004; Lavender and Chapple, 2004) and tended to blame doctors, other midwives and even the women themselves for what is described in all of these studies as the medical model of care. An interesting finding is that even in New Zealand where midwives practise as lead maternity caregivers with explicit professional and financial autonomy (M. Hunter, 2003; Crabtree, 2004), the experiences of these midwives were similar to those of Irish midwives who, arguably, experience less actual autonomy as they work in consultant-led maternity hospitals (Hyde and Roche-Reid, 2004; Keating and Flemming, in press).

### **Compliance with cultural norms**

Midwives adapted to the practices of the unit even where this differed from their preferred approach to care (Hunt and Symonds, 1995; M. Hunter, 2003; Crabtree, 2004). The studies indicate that there was a perceived lack of support for normal birth and midwives were constantly required to meet the needs of the hospital rather than the needs of individual women (Hunt and Symonds, 1995; Kirkham, 1999; B. Hunter, 2004, 2005; Hyde and Roche-Reid, 2004): 'Some of the older midwives trained in the times of technological advancements and have forgotten that childbirth is normal' (Lavender and Chapple, 2004: 328).

With more echoes of Lipsky (1980), midwives complied in order to manage often heavy workloads and provide an equitable service for all women: 'To find enough time for each woman when other women are waiting for you, it is a battle on many days' (Blaaka and Schauer Eri, 2008: 348).

Though midwives complained in principle about the so-called medicalized approach to care it seemed that, in actual practice, other midwives rather than doctors were the main influence on their practice (Kirkham, 1999; Crabtree, 2004; Lavender and Chapple, 2004; B. Hunter, 2005):

I am not going to stand here and argue with this woman (midwife) who has been qualified for God knows long – I'm not gonna win. (B. Hunter, 2005: 258–9)

there is an expectation (by other midwives) that the woman will come in and lie down and be monitored ... (Crabtree, 2004: 88)

Also of importance was the choice or expectation of intervention by women themselves (M. Hunter, 2003; Crabtree, 2004); this was sometimes described as an unquestioning passivity and acceptance of the medicalized approach to care (Hyde and Roche-Reid, 2004; Porter et al., 2007): 'A lot of women will come in and they don't have a clue and that's you know, quite the way that they want it' (Hyde and Roche-Reid, 2004: 2617). Midwives acquiesced to this approach as it appeared to be easier for them to conform

than to work against this system (Crabtree, 2004; Lavender and Chapple, 2004): 'So you go along with this thinking' (Crabtree, 2004: 89).

According to Shallow (2001c) the medicalized approach to care and the growth in technology has met with little resistance from midwives themselves. Even self-employed midwives in New Zealand accept medical intervention as a 'normal' part of birth when it occurs in hospital (M. Hunter, 2003; Crabtree, 2004; Earl and Hunter, 2006). As one midwife states: 'Midwifery [at the large obstetric hospital] is almost easier, because it is all black and white, and the woman's lying there with her epidural and you are watching the machines' (M. Hunter, 2003: 241). Indeed, in an insightful analysis, Sandelowski (2000) hypothesizes that the introduction of technocratic maternity care (and, specifically, foetal monitoring) could not have taken place without the 'retrofitting' activity of nurses (in this case, obstetric nurses in the USA) who, she claims, were pivotal in persuading women to accept such monitoring as a norm.

### **Attempts to normalize birth in a hospital environment**

A number of midwives experienced divided loyalties between their support for normal birth and a loyalty to their colleagues who had different philosophies of care. These midwives were in a difficult position; their options were to acquiesce to the system, live with the conflict or to rebel against the norms of practice (M. Hunter, 2003; Crabtree, 2004; B. Hunter, 2004, 2005; Lavender and Chapple, 2004). For some this led to subterfuge or occasional resistance to avoid aspects of medicalized care even where this may be seen as rebellious by their midwifery colleagues (M. Hunter, 2003; B. Hunter, 2005; Russell, 2007). This can lead to emotional stress for midwives who experience dissonance by practising in an environment where normal birth is not valued (Shallow, 2001c, 2001d; B. Hunter, 2004, 2005; Blaaka and Schauer Eri, 2008): 'If I as a midwife don't follow the procedure book, I can get into big trouble. You stretch the limits where you see there's a possibility of doing so' (Blaaka and Schauer Eri, 2008: 349).

Despite the perception of an oppressive medicalized environment, many participants remained committed to normal birth (M. Hunter, 2003; Crabtree, 2004; Lavender and Chapple, 2004) or at least to normalize birth as much as possible (Hyde and Roche-Reid, 2004; Earl and Hunter, 2006). This was seen as doing 'real midwifery' and may involve keeping women 'safe' from the excesses of intervention: '[I] protected her to have a normal birth, even though it was induced. It could have been a lot worse for her. They would have had monitors and scalp clips and God knows what else' (Crabtree, 2004: 95).

Midwives reported that normal birth was difficult to achieve in a hospital setting but was more likely to occur at night when doctors and senior midwifery staff are not around (Hunt and Symonds, 1995; Hyde and Roche-Reid, 2004):

The best time I enjoy is night duty ... when you have a one to one with minimum intervention. There's no one popping in to see what's happening and why she isn't making more progress and putting subtle pressure on you. (Hyde and Roche-Reid, 2004: 2619)

Many midwives tried to provide a positive birth experience for women with the minimum of intervention and while there is considerable debate as to what constitutes 'normal birth', some were convinced that it was possible to achieve in a hospital setting (M. Hunter, 2003). Others maintained that they provided the best care possible under the constraints of the medical system (Hyde and Roche-Reid, 2004). It was interesting that midwives had many different views of what constitutes normality. For some it was 'normal birth but some assistance during the labour' (Crabtree, 2004), and the moderate use of technology was also supported (Hyde and Roche-Reid, 2004). Intervention was also used somewhat paradoxically by some to avoid what they perceived to be more interventionist approaches to care: 'I suppose that's a judgement call of when you can sit back and do nothing versus when you get in and do something less minor to prevent the major intervention' (Earl and Hunter, 2006: 22).

Annandale (1988) explored this phenomenon of midwives using interventions that fall within their role to reduce medical referral and interventions. In her study of a freestanding midwifery unit, it is not always clear if these interventions were undertaken with the explicit consent of the women concerned. Such practices raise interesting questions of motivation, ethics and the possibility that the pursuit of normal birth in opposition of medical input may on occasions be undertaken as part of a midwifery professional project, rather than for the explicit good of the individual woman and/or baby.

## **Synthesis**

Based on the included studies, midwives' experience of practice on publicly funded hospital labour wards appears to fall into three broad arcs of activity. These are not mutually exclusive:

1. 'Getting through the work' and providing an equitable service for all women.
2. Enforcing compliance to technocratic norms in order to 'get through the work'.
3. Discursive, subversive and occasional resistance, in an attempt to provide 'real midwifery' for individual women.

These arcs form the following line of argument (Noblit and Hare, 1988): midwives who work in a publicly funded hospital labour ward setting strive to provide best care, to get through the work and to provide equitable treatment for the population of women in their care through ensuring or delivering compliance to technocratic norms, and accommodating women's

choice where this did not deviate too far from these norms. Some midwives engage in discursive or subversive practices, and occasionally overt resistance to technocratic norms, in an attempt to provide 'real midwifery' for individual women.

## **Discussion**

Eliciting accounts from professionals about their practice might be expected to produce idealized narratives. In contrast, however, many of the midwives' own accounts presented in the papers included in this metasynthesis subvert their stated professional identity as guardians of normal childbirth. The two studies that contained observational data tend to support these findings. Hunt and Symond's (1995) work is largely confirmatory of compliance with cultural norms. The more recent study by Porter et al. (2007) observed that the decisions made by midwives were generally 'bureaucratic' in nature with an adherence to policies and protocols rather than negotiated with women. Porter et al. (2007) argue that midwives experience a tension within the requirements of 'new professionalism' which requires that decisions are made in collaboration with clients. While many midwives appeared to support this facilitative approach in principle, their accounts of their work indicated that this was not always enacted in practice. Where reasons for this variation were given, they tended to focus on the environment where they worked, the influence of powerful others and their perception of women's exceptions of care. This is similar to findings by Crozier et al. (2007) who found a bureaucratic approach was prevalent in how the midwives used technology in the labour ward.

Blaaka and Schauer Eri (2008) take a different approach and describe how experienced midwives are required to mediate their practice between two different belief systems; a biomedical tradition which is reliant on scientific knowledge and technology and a phenomenological tradition which values the physical, emotional and social well-being of women. Midwives move between the biomedical aspects of care while trying to be sensitive to women's needs but there can be a struggle between the two ideological traditions as the midwives learn to accommodate opposing belief systems. This is similar to what Davis-Floyd (2001b) describes as 'hybrid' or 'postmodern' midwives who move between traditional and biomedical approaches to childbirth, in trying to provide the best outcomes for women and their babies. Similarly Lane (2002) maintains that few midwives fall completely into either the medical model or the midwifery model of care but could be considered as 'hybrid' midwives, changing their practice with experience and adapting to their work setting whether that is private or public hospital, birth centre or home. Even where midwives provide care of women who are at high obstetric risk, experienced midwives seek to normalize the birth as much as possible for the women in their care (Berg and Dahlberg, 2001).



From this metasynthesis, it appears that the way midwives work in hospital appears to be mediated by a 'street-level bureaucracy' (Lipsky, 1980) in which the actual determinants of midwifery practice are senior midwives and not obstetricians. Street-level bureaucrats are those who provide a public service, which involves caring and responsibility. While the nature of this work is allegedly to provide individualized care, the nature of the work setting and institutional imperatives makes this difficult to achieve. Clients have no option but to accept the service available. They are encouraged to confide in and trust professionals who are strangers and to permit themselves to be manipulated in the expectation of fair treatment. Street-level bureaucrats use their discretionary authority defensively to manage an otherwise overwhelming workload. The public service is therefore delivered through a system that values detachment and an attempt at equal (not individualized) treatment under conditions of limited resources and constraints. There is a *myth of altruism* (Lipsky, 1980: 71).

It seems that midwives may have certain myths about themselves. While maintaining that they wish to provide women-centred care while supporting normal birth, they practise as if bound by the power dynamics in maternity units which work against them achieving this. There is an acceptance that hospital-based maternity care is inevitably based on medical protocols and emerging technology and as a consequence midwives accept intervention as a 'normal' part of birth. It is unclear from these studies what the underlying factors for this are. When questioned, midwives tend to blame doctors, other midwives and even the women themselves. This suggests that midwives perceive that they cannot take personal responsibility for the care that they provide. This disempowerment influences their practice, even when the factors that are seen to be oppressive are not actually operating. While this suggests a classic Foucauldian operation of the panopticon (Arney, 1982), a more subtle analysis is suggested by a recent article that has examined the nature of authenticity in occupational groups undertaking 'emotional work' as part of their activities (Ashman, 2008). The author contrasts a Heideggerian notion of authenticity, which recognizes that individuals are 'responsible for choosing their identity, given their particular situation' (Ashman, 2008: 294) with existential notions of authenticity and bad faith as offered by Sartre. In the latter case, Ashman (2008: 295) quotes Sartre (1990) as saying that 'authenticity ... consists in having a true and lucid consciousness of the situation, in assuming the responsibilities and risks that it involves, in accepting it in pride or humiliation, sometimes in horror and hate'.

In this analysis, 'bad faith' results when those doing emotion work perform their culturally determined role automatically and inauthentically, without taking responsibility for the choices they make in performing this role. The exercise of bad faith serves to avoid the uncomfortable sense of dissonance, and a potential impetus to make change happen that might arise if these individuals were, instead, to inhabit their role authentically. One of

the signs of bad faith is an assertion that the individual has 'no choice' than to behave the way they are doing.

This theoretical framework offers a potential underpinning for the synthesis given above, which could now be reframed theoretically as:

Seeking to perform 'real midwifery' is perceived by most midwives to be the authentic position of the midwifery profession. Cultural and environmental constraints can restrict the practice of real midwifery in hospital-based labour wards. In this circumstance, the authentic position is to recognize that there is a range of responses possible, including compliance, and discursive, subversive or overt resistance, and that each of these choices engenders personal responsibility. Bad faith is only evident when midwives assert that only one course of action is possible, and that this is dictated by powerful others and specific cultural and environmental conditions.

This synthesis both incorporates and moves beyond the data in the individual papers in the review. It offers an initial application of the theoretical position that has recently been proposed by Ashman (2008) for a range of occupational groups involved in emotional work. Future empirical work in midwifery and other such professions might illustrate how far this analysis can be sustained in prospective studies.

## **Limitations**

In terms of limitations, while the focus of this metasynthesis was on midwifery practice in labour ward settings, just three of the studies focused specifically on labour ward midwives. The remaining studies included midwives from a variety of settings, including the labour ward and the discourse tended to focus on labour ward settings though this was sometimes implicit. In addition we only included studies published in books or journals and while a few additional abstracts were identified from conference proceedings, if they were not published elsewhere, we did not contact the authors. We also recognize that the process of conducting a metasynthesis is an interpretive process and findings are therefore subject to different interpretations.

## **Conclusion**

The question this topic sought to explore is how midwives experience midwifery practice in a hospital environment. The complexity of midwifery practice, and concepts with wider application such as authenticity and bad faith have been incorporated into the synthesis. These might have implications for the kind of maternity care currently being delivered in publicly funded labour wards. Further studies are required to explore these notions future in this specific context, and identify potential solutions, which will enable midwives to provide 'real midwifery' for individual women and support normality in childbirth in a hospital setting. Work in other contexts

where professional and occupational groups undertake emotional work as a component of their practice might also illustrate the potential for this framework of analysis.

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