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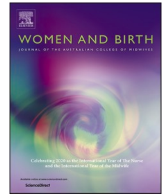

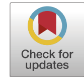

How does place impact intrapartum practice for midwives and obstetricians?

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A R T I C L E I N F O

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A B S T R A C T

Background: Rising rates of labour and birth interventions are causing concern, having the potential to cause harm if used inappropriately. International evidence demonstrates that place itself influences birth outcomes, but evidence is limited as to how. In New Zealand there are differences in the rates of spontaneous vaginal births by place, along with differences when benchmarking uncomplicated primiparae birthing in hospital maternity facilities throughout the country.
Aim: To develop understanding of how place influenced midwives' and obstetricians' practice in relation to supporting physiological birth.
Method: For this Hermeneutic Phenomenological study participants were purposively selected and consisted of nine midwives (employed and self-employed) and three obstetricians, all practising in midwifery led units or hospital maternity facilities. Data was collected using semi-structured interviews. The method of analysis involved writing and rewriting to surface interpretive insights, drawing on philosophical notions from Heidegger and Gadamer.
Findings: The findings revealed that place influences what practitioners are attuned to, what is easier for them to achieve, and their ability to provide woman-centred care. Competing tensions and pressures within place can blur the perceived relationship between normality and risk, influencing what is considered to be safe.
Summary: Place is not neutral; it influences how midwives and obstetricians practise and shapes how they support physiological labour and birth. The findings of this research contribute to a deeper understanding of the barriers and enablers to supporting physiological birth within place.

Statement of significance

Problem or issue

Interventions in labour and birth are rising in many developed countries without measurable improvements in maternal or neonatal mortality or morbidity.

What is already known

Place is a significant variable influencing labour and birth outcomes.

What this paper adds

Midwives and obstetricians experience barriers and enablers to supporting physiological birth within place. These shape their perceptions and practice, and influence how 'ready-to-hand' supporting a physiological approach to labour and birth is.

Introduction

Risk and harm to the mother and baby is associated with both extremes of the continuum of maternity care: 'too little too late' and 'too much too soon' [24]. For some women, labour and birth intervention is needed for reducing risk and can be lifesaving. Non-clinically indicated intervention however may constitute risk for the [1]woman and baby and can cause harm, negatively impacting the woman's experience [24,46]. It is intervention that occurs before it is clinically needed that is a concern in relation to supporting physiological birth. Interventions

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[1] The term 'woman' incorporates woman/birthing person/whānau.

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however are routinely used for healthy women and babies in many hospital maternity facilities [30] and rising rates of labour interventions including caesarean births, are causing concern internationally [2,46]. The upward trend in caesarean births seen in many developed countries, including New Zealand, has not resulted in measurable improvements in maternal or neonatal mortality or morbidity [47].

There is a strong body of evidence that 'place' is a significant variable influencing labour and birth outcomes. Studies have reported substantially fewer interventions for healthy women who start labour in a Midwifery-Led Unit (MLU) or at home [1,10,3,35,7]. Evidence also suggests that place influences how midwives practise [38,8]. International guidelines recommend a physiological approach to care during labour and birth, such as the WHO [46] guide: 'Intrapartum Care for a Positive Birth Experience' and the National Institute for Clinical Excellence [28] guidelines for intrapartum care for healthy women and their babies. However, there are barriers to implementing a physiological approach in some hospital facilities.

In New Zealand women/birthing people can choose a Lead Maternity Carer (LMC) who provides continuity of care throughout the antenatal, intrapartum, and postnatal periods. Data from the Ministry of Health [25] show that 93.6 % of women in New Zealand in 2017 chose to have an LMC midwife. Women can also choose to have a general practitioner or a private obstetrician as their LMC who provide continuity of care, with the support of midwifery services during intrapartum and postnatal periods. Maternity care in New Zealand is publicly funded (unless a woman chooses a private obstetrician) and services are categorised by the level of care in terms of risk and complexity that is required: primary, secondary, or tertiary [26].

It is understood that model of care can influence practise and birth outcomes, and the model of maternity care in New Zealand is reasonably consistent. Yet throughout New Zealand the rates of spontaneous vaginal birth for uncomplicated primiparae at term[2] when this cohort are benchmarked vary considerably according to the hospital maternity facility. This data illuminates the significance of place as an important variable in birth outcomes (Fig. 1).

Note: Solid line represents the median rate of secondary/tertiary facilities; dashed lines represent the 25th and 75th percentiles. Error bars represent 95 % confidence intervals.

This research reveals new insights into *how* place is experienced by midwives and obstetricians, and how it shapes practise in relation to supporting a physiological approach to labour and birth, bringing the phenomenon of place/space closer into view.

Terminology

Place/space

Place and space are tightly interwoven entities. Nørgård and Bengtsen [29] draw an analogy between place and space and the human body, suggesting that place is akin to the biological body itself, whilst space reflects the subjective experience of how the body is feeling.

Being-in-the-world

Heidegger searched for the meaning of Being and referred to the notion of Dasein which means being-in-the-world, or in other words how we are situated in the world. Heidegger believed that our horizon, or outlook, and how we relate to and experience the world is always situated and is shaped, reflecting the character of the place in which we are in [21].

[2] In New Zealand healthy low-risk women are benchmarked and referred to as 'standard primipare'. A standard primiparae is a woman/birthing person having their first baby, singleton and cephalic, at 37–41 weeks of gestation, is aged 20–34 years, and has no obstetric complications.

Methods

The lived experiences of supporting normality and being-in a birthing facility are complex, dynamic, and multifaceted; the methods used in this study accommodate this complexity. Hermeneutic phenomenology allows the researcher to uncover meanings within lived experiences which may have been hidden, not recognised, or suppressed by dominant discourses [40].

This study is phenomenological, exploring the phenomenon of place in relation to supporting physiological birth through rich practise stories, and is also hermeneutic in the interpretation of what lies unseen within the participants' experiences. Hermeneutic inquiry goes *behind* what is said and asks questions *beyond* what is said [12] striving to uncover a new, or a different understanding [42]. Hermeneutics does not represent a linear, step by step methodological process towards understanding the phenomenon, but rather is a philosophy which supports the conditions for further understanding to take place [44]. The lack of prescribed methods invites the researcher to be more open and attuned to see aspects of the phenomena emerge that are not overt in the data [5].

Approval for this research study was gained from Auckland University of Technology Ethics Committee (AUTEC). Participants were purposively selected in a successive manner, and in total 12 participants who practised in the greater Auckland region were recruited. These were midwives (hospital, community, and clinical charge midwives) who worked in a MLU, a secondary/tertiary hospital facility (hospital with access to caesareans and neonatal facilities) or both, and regularly worked in labour and birthing areas. The Lead Maternity Carer (LMC) midwives often have access agreements with more than one facility. The sole registrar in this study and consultant obstetricians (one employed, and one private) worked in hospital maternity facilities.

Data were collected using in-depth semi-structured, individual face to face interviews which were audio-recorded and transcribed verbatim. Interview questions were open-ended and aimed to capture the essence of the participants' experience of place. Data analysis was a divergent and non-linear process, guided by hermeneutic phenomenological methodology using the key principles outlined by Moules et al. [27]. This dynamic process consisted of immersion in the data; reading and re-reading, writing, and re-writing, reflecting, questioning, and noting significant interpretations, whilst remaining reflexive. The analysis uncovered hidden meaning about participants' experiences, bringing the phenomenon place more clearly into view. Notions were considered both on their own and as a whole, building an evolving picture of the phenomenon. During this process, philosophical notions, mostly from Heidegger and Gadamer, were used to provoke thinking and deepen understanding of what was happening within participants' experiences.

Reflexivity

Pre-understandings, or prejudices, are the understandings and beliefs about the phenomenon that already exist, and the researcher brings these to the study. These inform the research question and are present throughout the research process [43]. According to Gadamer [12] it is impossible for the researcher to be completely objective, but they must make explicit what has shaped their understanding. Prior to the commencement of the research, the prejudices and positionality of the main researcher were discussed with the supervisors in pre-understandings interview to bring these to the forefront and aid self-reflection and reflexiveness throughout the research process.

Rigour in hermeneutic research does not reflect a strict methodical process but, instead, is a comprehensive attention to developing understanding about the phenomenon [27]. Methodological and philosophical congruence was, therefore, a central consideration throughout this research study. Reflexive conversations between the main researcher and supervisors remained core to the interpretive journey. The main researcher kept notes of reflections, thoughts, questions,

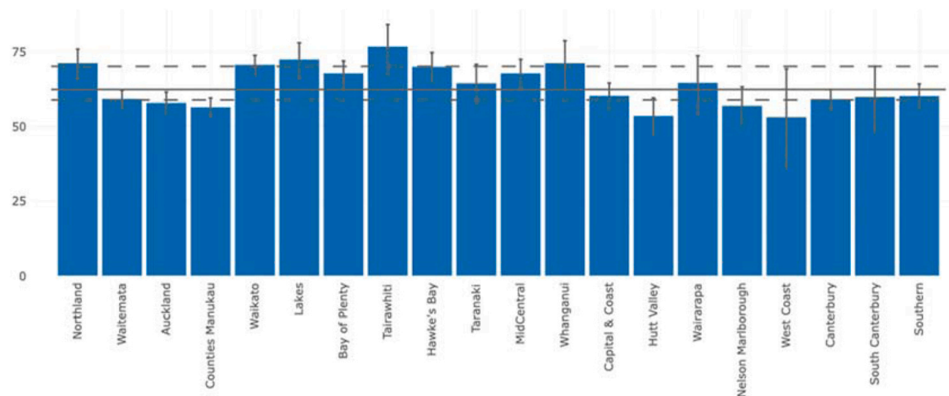

Fig. 1. Percentage of spontaneous vaginal births among standard (low-risk) primiparae, by facility of birth (secondary and tertiary facilities) [26].

creative tensions, and interpretive conjectures, making visible the process towards understanding. The stories identified as key to answering the research question were sent to participants for review.

Findings

The findings of this research suggest 'layers' of influence within place in relation to supporting normality, ultimately shaping what it is easier to achieve; the path of least resistance. Midwives and obstetricians experienced the degree to which supporting normality, and the position of midwifery, is at the essence of place; *practically* in what was easier to achieve, *emotionally* in how they felt professionally and in their response to the 'feel' of the place, and *strategically* in their juggle of resources in the pursuit of safety.

Findings constitute four main threads: 'Messages from the space influencing normality', 'attunement towards normality', 'place is a field of play', and 'safeguarding the art of being appropriately patient'. These represent barriers and enablers to supporting a physiological approach to labour. Sitting at the core of the findings is what is understood to constitute safety within place, and how time and risk are understood and played out.

Messages from the space influencing normality

"Space is in essence that for which room has been made, that which is let into its bounds. That for which room is made is always granted and hence is joined, that is, gathered, by virtue of a location" [19] (p. 72).

Place/space is not neutral. The birthing environment has unwritten directions that can have both a practical and an emotional effect on practitioners as they interact with it, shaping their sense of possibilities, and their practise. Messages regarding normality and pathology are central to how easily practitioners can support normality.

Natalie (obstetrician) shares how environment shapes possibilities:

> It is a hospital, but it would be nice if you could hide the bed away in the wall and only bring it down if you needed it. Because the bed is there, women get on it. I'm forever encouraging women to be off the bed and walk, use the Swiss ball, go in the pool or shower. Sometimes it's hard to get the birthing mats and we haven't got any birthing stools. When a woman is mobile the stool can help with a difficult second stage and probably make the difference between someone having a ventouse and a normal birth.

The lack of equipment to support a physiological approach is an obstacle to normality and instrumental in creating a feeling about what is expected. Supporting normality is more challenging when the practitioner is fighting against an environment that is not working with them to do the 'right thing' in relation to physiological birth.

Aroha (LMC midwife) describes feeling differently in two birthing spaces:

> My usual workplace (and most normal) is facility 'A' [midwifery-led unit]. It's quiet, small, and has a relaxed feel. The midwives there know me well and just leave me to it unless I ask for help, then they are there immediately. I love that everybody is together in trying to support each woman to have a normal birth. The energy of the local hospital unit is a lot busier, just even the level of noise there. It's such a different vibe. I tend to be asking for permission more there, whereas in a primary birthing unit it's a collegial approach. The hospital birthing unit looks like a surgical ward. The physical environment for me is so important; physiological birth unfolds better when you're comfortable and in surroundings that feel good to you. When I'm relaxed, the woman is relaxed.

Practitioners are orientated towards the essence of place by the environment, how this makes them feel, and how they understand they are positioned professionally. Midwives' ability to feel at home and instrumental in creating the essence of the birthing facility could be fundamental to how safe they feel to practise midwifery authentically.

Attunement towards normality/risk

According to Heidegger [18], attunement makes things 'matter' to people, making it possible to "direct oneself towards something" (p. 176). It sets the tone for being-in-the-world and determines the manner of being.

The findings show that participants experienced a tone or attitude within place relating to a continuum of safety/risk. They were predisposed to an alertness to normality/risk influencing the degree to which normality is seen and matters within place, and how safe they felt to work with the woman's physiology and sit with the non-linear.

Clara (LMC midwife) shares how place affects how risk is seen:

> Those of us who have been privileged to work with women committed to non-interventional births know how beautiful birth can be, but an obstetrician who is called in to deal with disasters has only seen this side. There is an element of fear, the elephant in the room, which we feed because we're afraid that something could be missed with a consequence for us. We are aware that we need to keep ourselves safe; some believe that the ultimate safety is to perform a caesarean. If you're always swimming in shark infested water, you forget that there are waters with no sharks. It's as though a good outcome just dodged the sharks.

The discourse in this hospital space is that normality only exists retrospectively if the 'sharks' (risks) have been avoided. The resulting understanding becomes a lens through which the practitioner sees, influencing their approach to potential risk, and limiting their attunement to features of normality. Fear of risk dominates, bringing

anticipation of risk to the foreground, and blurring the relationship between normality and risk. A heightened attunement to risk and increased risk surveillance could result in avoidable intervention.

Natalie (obstetrician) talks about a maternity facility where normal birth was the focus; it was expected, and normality was central to the culture. However, there was a change in the culture when this became part of the main hospital block:

> The maternity unit [now a hospital facility]… was more of a birthing unit. You just had a couple of rooms where you could go if you had to have oxytocin or forceps, but other than that there were normal birthing rooms and the whole culture was around normal birthing. There was definitely that feeling that if the woman and her baby were well you weren't expecting a lot of intervention. You expected to have baby naturally and only be transferred if there was a problem. They then moved to the main hospital block and the feeling about the birthing facility changed your perspectives. They had anaesthetists and an epidural service was readily available, whereas previously there wasn't the expectation of having it. Access to the theatre came along quite quickly. I felt that for a lot of women who didn't need intervention, it started creeping in and became the norm. So women's expectations and their choice of place of birth are very important, and psychologically they affect how you approach the birth.

Natalie suggests that in this birthing unit rather than anticipating risk, and sometimes intervening prophylactically, labour was left to take its course whenever that was without problems; normal labour and birth was not pathologized. There was a different feeling in the birthing facility when it moved to the main hospital block; the focus and discourse had shifted away from physiological labour and birth being the expectation and the core business.

Intervention in women's labour and birth became ready-to-hand, the new normal, even though for many women it may have been safely avoided.

Place is a field of play

Gadamer [12] described the human ontological condition in terms of play and proposed that the truth can be revealed within play, or in this case, practise. There is an understanding about the game which is already there in place, creating expectations and influencing practise.

Findings point towards drivers that shape play/practise within the birthing facility. Participants' experience of supporting normality was directly linked to negotiating key tensions within place. Participants in different roles perceived and experienced these tensions from a different vantage point, but safety was always at the core. Safety was not limited to the safety of the woman and baby, but safety of the facility, and of the self, also played out in practise. The tensions were navigated by practitioners in pursuit of perceived safety, resulting in the 'play of protection', 'play of time', 'play of efficiency', and 'play of resources'.

Findings uncover a lack of patience and a tension in relation to time and labour progress in the hospital field. I called this notion *the rush*. It is a mood that is felt reflecting the dominant discourse, a catalyst to avoidable interventions, and steers focus away from the best interests of the woman and baby. Participants discussed their efforts to mitigate this rush and support normality.

Francesca (LMC midwife) shares her play of protection:

> I don't like institutional pressure put on the woman. I find this difficult, and I'll sometimes dig my toes in when the institution's needs are put first and this could negatively impact the woman. I don't feel this pressure in midwifery-led units, there you can guard physiological birth with ease. I keep the charge midwife informed about what's happening, but it doesn't mean I invite people in quickly if all is well. I've got to protect the woman from the institution's expectations around time. I know that intervention could be easy; intervention is really easy. If you're in a hospital you have to be a greater guardian. You have to be 1000 angels, not just one.

The play of protection is an interplay between practitioners with inherent tensions around time and labour progress. Francesca describes this play as protecting the woman from the ease of and pressure for intervention: *the rush*. There is a sense of time as a construct, *the time of the place*. Facility expectations regarding time and progress are already there.

Harriet (registrar) shared her experience of the play of time and efficiency:

> Handovers in the morning can be stressful and decisions can be challenged. When it comes to two hours before the handover you start to question your every decision, which can influence your decision-making to reflect what you know will be expected of you at the handover. They'll sometimes question your management of a woman's labour, questioning why you have waited, 'you've now delayed things for a good hour or two', and you are anticipating this happening. It's not supposed to be like this, but often is.

The focus on delay suggests that what is considered to equate to efficiency is valued by the obstetric team and delay is automatically considered to be a risk. The focus on time, progress, and efficiency could indicate a perception that labour progress is always linear, in spite of a body of evidence to suggest that it is not. Perhaps delay is also considered to be a risk to the facility and to the practitioner.

Safety of the woman and baby, facility, and self were also described as being core to the play of resources; Lara (clinical charge midwife, hospital facility) shares how this creates tensions around time:

> The staffing issue and the stress directly impacts our ability to give labouring women the time that they need. There are many occasions where it's been so busy, I haven't been able to spend enough time supporting staff to support women. When a woman has been pushing for a while new energy and support can make a difference to the outcome. Sometimes though I've had to just send the doctor in when progress was slow; I know that I should have gone in, assessed the situation and helped, but due to lack of staff and busyness of the unit I wasn't able to. There are also times, it's terrible to say, when I've done a vaginal examination in the hope that the woman has progressed so we could call in her LMC, there was no other indication for it.

Optimally, a key component of 'the game' would be safely supporting normality whenever possible, giving labour time. However, when resources are compromised, they may be reluctantly 'played' to keep progress moving in the field. Fear of risk underpins the pursuit of safety whilst juggling tensions within place; intervention may be used as an instrument to aid what is considered to be efficiency. Play, or practise, may change to cope with capacity.

Safeguarding the art of being appropriately patient

According to Heidegger [19], the act of safeguarding is to set something free into its own essence.

Midwifery and medicine are both an art and a science. The findings highlight the significance of the art of being appropriately patient in relation to supporting normality. Practitioners bring qualities for this art, but there are many things already there in place that are instrumental in safeguarding patience, enabling these qualities to play out in practise. Findings suggest the benefits of an approach to care that embodies *first doing no harm* where the aim of intervention, when needed, is to re-establish the equilibrium then allow physiology to continue to lead. 'Too much' in relation to intervention may cause harm; important in the vital balance of 'too much too soon' and 'too little too late' [24]. A culture of medicalising the normal is a barrier to the art of being appropriately patient playing out well.

Holly (LMC midwife) describes a culture of 'doing to' women:

> Hospital facilities all operate differently, impacting practise and birth outcomes. Facility X is the extreme regarding intervention; it makes facility Y look and feel like a midwifery-led unit with their approach to labour and birth and has strong midwifery leadership. The culture of facility X is all about doing to women. It does not have a culture of understanding normal birth or supporting it. Many women are medicalised just because they are in there, dependent on place rather than clinical need. Labour is managed, epidurals and syntocinon are the normal package of care. Birth pools are empty with little encouragement to use them. Much of the focus is on standardised care that doesn't consider the individual.

Holly suggests that managing labour and doing to women in facility X is normalised and at the heart of the culture. Risk reduction may be at the essence of the technocratic model, but it appears that at this place it has, to use Heidegger's words, become a 'single ordered totality'; magnified beyond its essence. The art of being appropriately patient is best safeguarded by facilities where physiological birth is the focus, and the midwifery voice is strong. Amid this culture, the potential harm of the technocratic imperative is understood, and intervention used judiciously.

The findings show how being on the cusp, or on the edge of needing obstetric care could be a pressure point for labour and birth intervention but could also be an opportunity to continue to support normality with some alongside support, depending on how the team work together at this interface between midwife-led and obstetric-led care (the in-between space).

Holly (LMC midwife) talks about alongside support at this interface:

> I had an experience with a primip having a bradycardia at 8 cm, involuntarily pushing as the baby rotated to OA. The consultant stood in the background and watched. After some time, he assessed the woman and an anterior lip was present; he was confident to get her back on her hands and knees and encouraged her to 'just go with it'. Shortly after the woman birthed her baby in good condition.

The obstetrician situated his art within the physiological process focusing on safely restoring equilibrium in the best interests of the woman and baby. Anecdotally obstetricians tend to step in and suggest labour and birth interventions when midwives consult with them during the intrapartum period; this may be understood by obstetricians to be the expectation. However, this obstetrician held off, bringing practical wisdom and alongside support into the subtle balance between 'too much' and 'too little' where a woman is on the cusp of requiring intervention.

Discussion

Consulting the work of Heidegger and Gadamer we can come to understand the many ways that place/space invites us into certain practices. Midwives and obstetricians do experience place, and this is a shaper of their practice. They are in-place and layers of influence in relation to supporting physiological birth stand behind them, in front of them, and wrap around them. These represent barriers and enablers to their own professional ideologies and philosophies being played out with ease within place.

Messages from within the space influencing practice

Birth place/space is experienced and 'felt' by midwives and obstetricians. Practitioners are orientated towards the essence of place by the design and aesthetics, the messages communicated by the environment and culture in relation to birth and risk, and how the space makes them feel emotionally. Ultimately how well the essence of place aligns with their professional ideologies influences how readily they are played out in practise. These findings echo research by Setola et al. [36] who also found that the aesthetics and resulting feel of the birthing space communicates a particular message and influences the mood of the place which impacts upon midwives' practise. Hammond et al. [13] suggest that the birth environment has the capacity to influence midwives neurobiologically and impact how they feel in the space, and how they provide care.

Hammond et al. [14] explored midwives' perceptions of birth rooms and concluded that characteristics of friendliness, functionality, and freedom support midwifery practise, wellbeing, and may enhance the quality of care provided. The authors suggest, as did our research findings, that the birth space influences midwives experience of it in several ways. Birth space has a practical influence in what is easier to achieve in the space, messages are communicated by the space about what is expected in relation to labour and birth, and that space elicits an emotional response for midwives in relation to how safe and relaxed they feel to practise midwifery. Small et al. [39] also illuminated the impact that the birth environment and the messages that this communicates can have on practise, in this case from the introduction of a central CTG fetal monitoring system. The authors found that this directly influenced the provision of care, the process of risk assessment and decision-making, birth outcomes, and the dynamics within the maternity team.

Place influences how risk and normality in relation to labour and birth are seen and understood by midwives and obstetricians. This understanding is *felt* within place and subsequently plays out in practice. Midwives are the keepers of normal labour and birth, yet this can become lost when midwives are practising amidst a technocratic model of care with an overriding attunement to risk and pathology. A systematic review in relation to supporting a physiological approach to labour care in obstetric settings also identified the significance of practitioner's perceptions of risk in relation to birth [6]. The authors identified two overarching themes: perceptions of birth as inherently physiological, and perceptions of birth as inherently risky. Further, Gabriel et al. [11] found that the hospital environment, biomedical culture, and the inter-professional relationships between midwives and obstetricians influenced midwives' perceptions of intrapartum risk; working in the hospital environment is a shaper of midwifery practice and represents a catalyst for the cascade of intervention.

This research highlighted that place influenced what midwives and obstetricians understood to equate to safety which influenced their practise in relation to supporting normality, and findings suggest that this safety is multifactorial. This is not limited to just what is understood within place to be consistent with safety for the woman and baby during the intrapartum period, but decision-making is influenced by competing needs and pressures in relation to perceived safety of the facility, and safety of the self (practitioner safety). Midwives and obstetricians continually navigate competing tensions within place in pursuit of safety.

In terms of safety of the self, the practitioner is influenced by how safe or otherwise they feel it is to be patient in relation to labour progress; how safe they feel they are professionally to support a physiological approach. Practitioner fear regarding the safety of the self was also suggested by Spendlove [41] who found that fear of risk in relation to potential practitioner blame triggered midwives and obstetricians to manage labour and birth. Peterwerth et al. [32] found that obstetricians may experience a tension when assessing risk between providing the best care for the woman, and risk of legal repercussions. Scamell [34] writes that midwives are caught between a commitment to woman-centred care and evidence-based practice, and a responsibility for risk management within organisations. Whilst risk management can represent a barrier to keeping the woman central to midwifery decision-making, a failure to align with these practises could represent a professional threat, undermining midwives' commitment to normality.

Perception of risk and safety in relation to the facility is tightly interwoven with time, resulting in *the rush* in hospital maternity facilities; a catalyst for a *practitioner driven cascade of intervention.* The practitioner is influenced in terms of *the rush* by how safe or otherwise

they feel the facility is in terms of capacity, and this tension sits alongside the perception of risk to the woman and baby, and to the self. Meyer et al. [22] also suggest that a lack of support for physiological labour and birth in busy maternity units reflects a 'with institution' approach to providing care rather than 'with woman'. This tension in relation to time in the hospital space was identified by Miller [23] as a barrier to supporting a physiological approach to birth. Miller referred to the pressure to hurry labour progress as a 'relentless-moving-forward-momentum' (p. 195) which reflects the facility culture, and highlights that the conditions which facilitate safe care for women with complexities represent a barrier to working with a woman's physiology. Shallow et al. [37] propose that the dominant technocratic model legitimises time pressures, perhaps representing a convenience for the facility to deal with its heavy workloads. This takes the focus away from the needs of the woman, enabling a facility-centric approach to decision-making.

Midwives practising within *the rush* have less time to be with the woman, and senior midwives less time to support the team, both represent barriers to supporting physiological birth. Our findings align with research by Davis and Homer [8] who claim that the expectation of 'busy work' in hospital birthing facilities, along with surveillance of their practise in relation to labour progress, equates to a barrier to midwives being with the woman and supporting normality.

A vicious cycle may emerge in the hospital space with fear of risk and a desire for efficiency at the core. Yet supporting a physiological approach to labour and birth equates to efficiency. Paradoxically, the fear of risk and time pressures driving intervention equate to risk in themselves. Non-clinically indicated interventions may bring significant risks to the woman and baby, both physiological and psychological in nature, and also to the facility in terms of higher acuity and strain on resources.

If allocation of resources were appropriate (including place) and intervention used judiciously, intervention and acuity would be lower, resulting in more time and space available for supporting normality, and less pressure to rush labour and birth. A study by Plough et al. [33] identified three main birthing facility design trends that influence the provision of intrapartum care and were associated with a lower low-risk caesarean rate, one of these being flexibility and adaptability. Flexible and adaptable designs have an overflow space that could accommodate additional birth beds when needed, potentially reducing pressure for practitioners to intervene in labour to increase the flow of women through the facility.

This research study suggests that the effects of *the rush* can be mitigated, and findings illuminate the importance of supporting a physiological approach to labour and birth being visible. Yet in hospital maternity facilities this ideology is not always core to what is widely seen and heard. Findings show that keeping the supporting of physiological birth within the confines of the birthing room is sometimes used as a strategy to hold space for normality amidst an overriding attunement to, and surveillance of, risk. This may help in the short-term but is a barrier regarding the bigger picture of supporting physiological labour and birth, keeping this less visible amidst a more dominant technocratic discourse.

A study by Hansson et al. [15] echoed the findings of this research in relation to the importance of physiological birth being visible and central within place, and how supporting normality remaining behind closed doors can lead to this becoming invisible. de Jonge et al. [9] also write that what is often visible and accounted for in organisations is monitoring and 'doing to' care such as interventions, pain relief, examinations rather than being with the woman. The authors propose that being with the woman and all that this represents in terms of presence, support, holistic assessment and individualised care, should be referred to as *watchful waiting* to make it visible and accounted for.

This research highlights the importance of midwives leading, normalising, legitimising, and inspiring a *play of normality*. This is central to supporting a physiological approach to labour and birth. Leading and keeping this philosophy and practice visible requires midwives to feel confident and well supported; midwives must feel that midwifery is respected and valued within place to feel confident to practise authentically. This notion was also identified by Catling and Rossiter [4]. The authors write in relation to midwives' perceptions of workplace culture in Australia that 'an overall technocratic paradigm impinged on their ability to be a midwife' (p. 470).

Healy et al. [16] caution that midwifery is 'assuming a peripheral position in relation to normal birth' secondary to a risk-based culture and technocratic approach to care and an increased prominence and 'higher position of obstetrics' (p. 370). Further, Healy et al. [17] stress the importance of midwives taking responsibility for supporting normality amidst a medicalised model of care which is threatening their professional identity. The significance of the placedness, or situatedness, of midwifery within the facility was also emphasized by Hansson et al. [15] who found, as did this research, the importance of midwives feeling recognised for their responsibility for normal births, supporting a strong sense of autonomy, professional identity, courage, and meaningfulness.

The findings of this research suggest that when midwives and obstetricians have expertise in supporting physiological birth this fosters a feeling of safety in the non-linear and appropriately *sitting with uncertainty*. Weckend et al. [45] found that place can influence how labour plateaus are understood in relation to normality/pathology, and the likelihood that the plateau will result in intervention. An extensive study on labour progress by Oladapo et al. [31] identified that cervical dilatation is not always linear, rather the progression of spontaneous labour is more of a stepped process, having periods of accelerated and slower activity. Yet within hospital facilities this non-linear pattern of progress may be considered to equate to dystocia and result in avoidable labour augmentation.

Being appropriately patient in relation to labour and birth is both an art and a team sport. When there is a degree of uncertainty it feels safer to be appropriately patient when there is alongside support available. Lundborg et al. [20] also identify that alongside support from the midwifery team, maximising their shared expertise, was a key variable for midwives keeping birth normal. Shorey and Ng [38] also emphasize the importance of a collaborative workplace culture and good interprofessional support for supporting physiological birth. Further, a systematic review by Darling et al. [6] identified that support and role modelling of a physiological approach from senior midwives was a key enabler to supporting normality, along with close inter-professional collaboration.

A key enabler for supporting normality sits at the cusp of referral from midwifery-led to obstetrician-led care. This is a space for midwives and obstetricians to stand back, holistically assess, consider possibilities, and collaborate. It is a space to consider features of risk and normality for *this unique woman* at *this time in her labour*; peeling back the influence of place and more clearly seeing normality and risk in relation to the woman's uniqueness. Practitioners in this space are seeing a situation that could represent normality and lead safely to physiological birth, but there may be risk that could necessitate intervention that is not fully disclosed. Black and white is not automatically seen in this space; instead, shades of grey are carefully deliberated.

How this interface is navigated and the degree of fluidity within this space could be pivotal in supporting a more patient approach. Convening and nurturing this space exemplifies a key opportunity to better supporting normality. Healy et al. [17] however claim that midwives may have limited experience of supporting a physiological approach to labour and birth, have become resigned to the obstetric dominance in hospital facilities, and normal birth may not be a priority in obstetric-led facilities. Such barriers to fluidity in the space between midwife-led and obstetric-led care warrant careful consideration.

Strengths and limitations

The strengths of this research lie in the understanding that was generated from incorporating the experiences and perspectives of

midwives and obstetricians working in different roles within labour and birthing services. Hearing the different angles of vision helped to bring to light the phenomena that were at play within place, influencing how practitioners were able to support normality. As it is possible that there are regional differences in maternity facilities, this is a limitation of the study; recruiting participants nationally may have generated deeper understandings.

Conclusion

The research findings bring into view that providing woman-centred care may be facilitated, or compromised, by place. Place ultimately shapes practitioners' ability to accommodate the woman's normal, her time, her best interests, and midwives' ability to be with the woman amidst *the rush*. Competing tensions and pressures, along with the dominant technocratic discourse, can steer practitioners' focus away from the woman's unique labour and blur the perceived relationship between risk and normality, making being appropriately patient more challenging. Ultimately physiological labour and birth, need to matter. This mattering needs to be a strong and consistently visible thread that is legitimised, understood to equate with safety, and collectively embraced.

Ethical statement

Approval for this research study was gained from Auckland University of Technology Ethics Committee (AUTEC number 19/17).

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Conflict of interest

None declared.

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