Midwives' and obstetricians' experience of place in relation to supporting physiological birth: A hermeneutic phenomenological study

Christine Mellor

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Faculty of Health and Environmental Science
Auckland University of Technology

Primary Supervisor: Professor Liz Smythe

Abstract

National and international evidence shows that ‘place’ influences birth outcomes, but evidence is limited as to ‘how’. In New Zealand, there are significant differences in the rates of spontaneous vaginal births by ‘place’, along with differences when benchmarking low risk primiparae birthing in hospital maternity units throughout the country. This hermeneutic phenomenological study seeks to develop further insight into ‘place’ in relation to physiological birth. The research question asked: how do midwives and obstetricians experience place in relation to supporting physiological birth? Participants consisted of nine midwives (employed and self-employed) and three obstetricians, all practising in the greater Auckland region in primary or hospital maternity facilities, or both. The findings show that ‘place’ is not neutral; it influences what practitioners are directed towards and attuned to, how they feel, their ‘position’ within ‘place’, what is easier to achieve, and this shapes their practise. ‘Place’ affects how the key tensions of protection, time, efficiency, and resources are perceived and negotiated. Findings show that ‘place’ influences how the relationship between normality and risk is ‘seen’, and how being appropriately-patient in relation to labour progress is safeguarded, particularly between primary and secondary maternity care. The findings of this research contribute to a deeper understanding of the barriers and enablers to supporting physiological birth within ‘place’. The recommendations include safeguarding greater openness to possibilities between primary and secondary maternity care; experienced midwives acting as consultants of ‘normal’; providing a separate midwifery-led birthing space for low-risk healthy women who have chosen to birth in the hospital setting; and the importance of student midwives and doctors having an understanding of physiological birthing playing out in primary birthing units and the woman’s home.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 19/07/21

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Chapter One: Introduction to the Study

Background

This hermeneutic phenomenological research study seeks to peel back the layers and uncover meaning within midwives' and obstetricians' experiences of 'place' in relation to supporting physiological birth. The study was conducted in New Zealand and involved midwives and obstetricians who work in primary or secondary/tertiary maternity facilities in the greater Auckland region.

Research Question

How do midwives' and obstetricians' experience place in relation to supporting physiological birth?

Aims of the Study

- Develop understanding about how the facility in which midwives and obstetricians work can influence their experience and practise in relation to supporting physiological birth.
- Capture ideas about what elements of place engender a space that is optimal in enabling midwives and obstetricians to facilitate physiological birth, and what is known to work well in practise.
- Develop meaningful insights for practitioner reflection in relation to the judicious use of labour and birth interventions.

Place and Space

Place and space are tightly interwoven, existing in relation to each other, although fundamentally different. In everyday discourse, the terms are often used interchangeably. Heidegger referred to Dasein which means 'being-there'; being in the world. Place is central to this 'being-in', influencing our 'self' and the way in which we experience the world; and results in our comprehension of a 'sense of place'. Heidegger believed that 'being-in' place shapes our horizon, influences our mode of thinking which is 'situated' reflecting the character of place, and influences how we relate to the world. According to Heidegger, relations are also directly connected to place and its boundaries—they are located (Malpas, 2012).

Heidegger wrote that "space is something that has been made room for" (Crowther, 2007, p. 154); spaces being created from locations. He believed that space and time are conjoined, referring to this unity as 'timespace' which is closely bound to place (Malpas, 2012, p. 32). Heidegger believed that when we utilise and experience a space, we are directed by the possible use of the space itself (Janz, 2017); further, Heidegger contended that space influences the teleological ordering (reflecting the purpose served) of equipment and phenomena within it (Malpas, 2012).

Heidegger referred to 'lived space' as being space where "experience is construed as something distinct" (Schatzki, 2017, p. 35); the space of lived experience. He believed that it is the human activity of relating to and being involved in the space that generates a disclosure and an understanding of the space itself (Wollan, 2010). Van Manen wrote about spatiality, or 'felt space', suggesting that the space that we are in is fundamental to the way that we feel. "In general, we may say that we become the space we are in" (van Manen, 2016, p. 102).

For Gadamer, place, space, and 'play' are closely connected. Gadamer's notion of 'Spiel', meaning game or play, is important for understanding place and space in relation to experience. From a hermeneutic perspective, place and space are experiential; and play (or experience) is shaped by the 'mode of being' determined by place and space (Janz, 2017). Gadamer also believed that games take place within a certain 'mood' or atmosphere, and Heidegger argued that this 'mood' is always spatial (Janz, 2017).

The notion of 'situation' is core to hermeneutics and refers to both place and space. All human experience is essentially tied to place—the context in which meaning happens. This is understood in connection with the 'space of experience'. Place/space, experience, and understanding are, therefore, interlinked; the subjective experience of place is essentially what constructs its meaning (Janz, 2017). According to Malpas (2017), in his writing about Heidegger, experience, thinking, and being are all intimately connected with place, as are space and time.

> From a hermeneutic point of view places are experienced whilst the subject is both in the place and part of the place. There is a dialectical relationship between the individual and a space that is always already at work for that individual. Similar to what happens in play, the experience of the place overcomes

> subjectivity, which means that an 'experienced place' has its own essence independent of the consciousness of the one who is in the place. (Janz, 2017, p. 97)

In this thesis, the way practitioners experience place is referred to as 'space'. In other words, when a participant tells a story of working in a specific place on a given day with a particular woman, their account is of their sense of 'space' that somehow shaped the experience. The experience of 'space' differs within each maternity setting and is influenced by time, busyness, and the practitioners. Each of these notions is explored in depth within the findings chapters.

Introducing the Methodology

Hermeneutic phenomenology was chosen to aid the development of a deeper understanding of midwives' and obstetricians' lived experience of 'place', and how this influences their practise in relation to supporting physiological birth. Whilst phenomenology requires the researcher to "return to the things themselves" (Smythe, 2012, p. 7), which are present within the participants' stories, hermeneutics refers to the interpretive analysis of the text. According to van Manen (1990), the aim of phenomenological research is to unpack the layers around the phenomenon and allow the essence of it be 'seen' and better understood. Van Manen wrote that the phenomenon is uncovered and revealed through the participants' lived experience of it, and the researchers' interpretation of the hidden meaning that lies within participants' experiences in the rich stories. The resulting revealing and understanding of the phenomenon, however, is not considered to be final; rather, the process of interpretation and understanding is ongoing (Gadamer, 2013). This research will draw from both Heideggerian and Gadamerian philosophical notions to aid questioning, thinking, interpretation, and the generation of understanding throughout the research study.

Of note is an initial commitment to bring an appreciative lens to this study, encouraging participants to focus on stories where because of the 'space' the labour and birth went well. While some such stories emerged, participants seemed to need to talk more about how hard it was to support physiological birth. Thus, the appreciative lens was over-taken time and again. The quest became to reveal the meaning important to the participants.

Rationale for the Study

Rising rates of intervention in labour and birth (e.g., induction of labour, artificial rupture of membranes, epidural analgesia, routine cardiotocography, routine episiotomy, caesarean section) are causing international concern and warrant inquiry (World Health Organization [WHO], 2018). Despite international concern, many interventions are routinely used for healthy women and babies in many hospital maternity facilities (Nyman, Roshani, Berg, Bondas, Downe, & Dencker, 2017). Some of these interventions and practises are known to cause harm when used inappropriately and may increase the need for additional labour and birth interventions and result in a decreased rate of physiological birth (Miller, Abalos, Chamillard, Ciapponi, Colaci et al., 2016; Nyman et al., 2017; Rossignol, Boughrassa, Moutquin, & Chaillet, 2014). According to the WHO (2018), this interventionist approach to labour and birth care "is not adequately sensitive to the woman's (and her family's) personal needs, values and preferences, and can weaken her own capability during childbirth and negatively impact her childbirth experience" (p. 8).

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' (Miller et al., 2016). Clinical interventions such as induction of labour, augmentation of labour, and caesarean section, when medically indicated, can be instrumental in decreasing the risk of maternal and neonatal morbidity and mortality. However, labour and birth interventions can also result in negative short- and long-term consequences for mothers and infants, and, therefore, should be limited to medical necessity (Miller et al., 2016; Sandall, Tribe, Avery, Mola, Visser, Homer et al., 2018; WHO, 2018). Caesarean section results in a higher risk of maternal mortality and morbidity than a vaginal birth; for example, it is associated with increased risk of abnormal placentation, uterine rupture, preterm birth, and stillbirth in subsequent pregnancies. Babies born by caesarean have an increased risk of having altered immune development, asthma, and obesity (Sandall et al., 2018).

The upward trend in caesarean section rates in many developed countries, including New Zealand, is giving rise to both health and economic concerns. Within this increased trend, Miller et al. (2016) argued that caesarean sections that are not medically indicated are prevalent. This upward trend has not been accompanied by measurable improvements in either maternal or neonatal mortality or morbidity (Ye, Betrán,

Guerrero Vela, Souza, & Zhang, 2014). The effects of this trend are not linear, and diversities are evident both within and between countries (Boerma, Ronsmans, Melesse, Barros, Juan, Moller et al., 2018; Nyman et al., 2017).

Throughout New Zealand, the rates of physiological birth for low-risk primiparae (women having their first baby) at term vary considerably according to the hospital maternity facility. In 2018, the percentage of spontaneous vaginal births among low-risk primiparae ranged from 46.2% to 80.8% in secondary/ tertiary hospital maternity facilities (Ministry of Health, 2020b), as seen in Figure 1. The Ministry of Health use the criteria for a 'standard primaparae' to benchmark nationally the outcomes for women who are considered to be low-risk. A standard primiparae is a woman who is having her first baby (singleton and cephalic) at term (37-41 weeks of gestation), is aged 20-34 years, and has no obstetric complications.

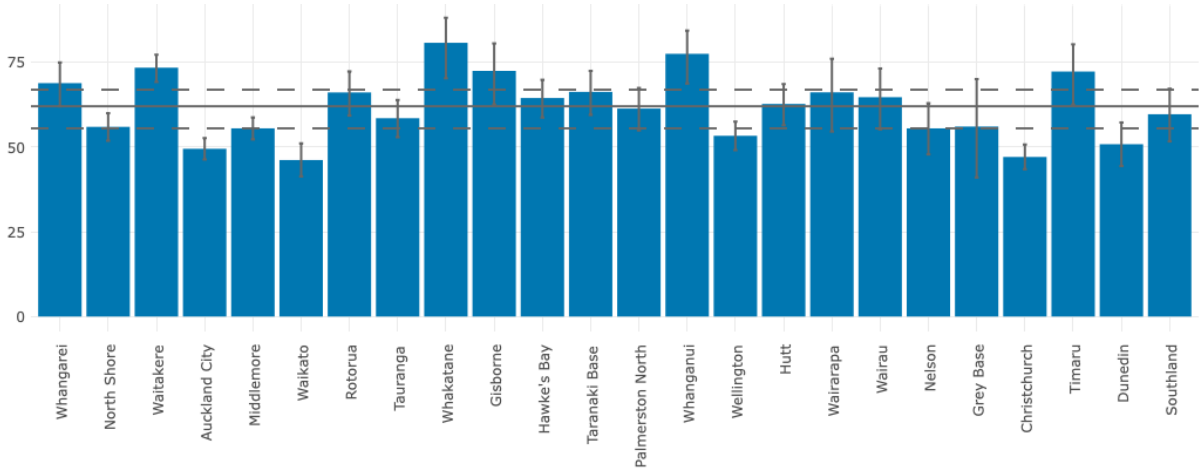

Figure 1. Percentage of spontaneous vaginal births among standard (low-risk) primiparae, by facility of birth (secondary and tertiary facilities). (Ministry of Health, 2020b)

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.

Although physiological birth rates will be influenced by a myriad of epidemiological factors, it is reasonable to suggest that this differential represents variation in practise by place whilst caring for a clinically comparable cohort. In Figure 1, data from the two secondary maternity units of Waitemata District Health Board (DHB) can be seen side by side. These maternity facilities share the same practise guidelines and policies, as well as similar systems and processes. However, the percentage of low-risk primiparae having a spontaneous vaginal birth at North Shore Hospital in 2018 is on the 25th percentile, while

at Waitakere Hospital it is above the 75th percentile. Although North Shore Hospital maternity unit accommodates more women with complexities than Waitakere maternity unit, the difference in complexity may not account for the difference in rates of spontaneous vaginal birth.

Place of birth and its direct relationship with labour and birth outcomes has been researched for many years, both nationally and internationally. There is now a substantial body of evidence providing a strong argument that the place itself is a significant variable influencing labour and birth outcomes (along with maternal and perinatal morbidity). Studies have reported substantially fewer obstetric labour and birth interventions for low-risk women when planning to birth in primary birthing units or at home (c.f., Bailey, 2017; Brocklehurst, Hardy, & Hollowell et al., 2011; Davis, Baddock, Pairman, Hunter, Benn, Wilson et al., 2011; Farry, 2015; Scarf, Rossiter, Vedam, Foureur, Sibbritt, Homer et al., 2018).

This issue of rising labour and birth interventions is highly complex and multifaceted. Increasing clinical risk (frequently suggested to be the key determinant for rising rates of intervention in labour and birth) does not, in itself, represent the entire explanation. Literature suggests various other reasons for this upward trend, many of which are grounded in perception of risk; an increasingly risk-averse society, women's right to choose and a change in women's preferences, the increased acceptance of technology use, and fear of litigation amongst health professionals (Healy, Humphreys, & Kennedy, 2016). Current societal shaping of the perspectives of women and health professionals challenges the notion that a normal birth without interventions is optimal (McAra-Couper, Jones, & Smythe, 2010). According to McAra-Couper, Jones, and Smythe (2012) women's choice in labour and birth "is always situated"; they write that women's choice "is powerfully influenced-and even pre-determined-by the context and the milieu in which women give birth" (p. 94).

Maternity facility culture could represent an important variable in labour and birth outcomes. Facility culture is increasingly understood to be a key determinant in how healthcare systems operate, for professional practise, and for outcomes of care (Catling, Reid, & Hunter, 2017a; Davis & Walker, 2010; Freemantle, 2013). According to Frith, Sinclair, Vehviläinen-Julkunen, Beeckman, Loytved, and Luyben (2014), midwives acknowledged organisational culture to be a core determinant of midwifery practise and identified that culture could represent a significant barrier to good maternity care. A

quantitative study by Zinsser, Stoll, and Gross (2016) identified workplace to be the most significant variable in the midwives' (n=181) attitudes towards supporting normal birth.

Research conducted by myself and a colleague (Farry & Mellor, 2018) explored midwives' decision-making around artificial rupture of membranes (ARM) in low-risk labour. Artificial rupture of membranes is not supported by evidence in normally progressing labour and can increase the likelihood of fetal distress and caesarean section (Smyth, Markham, & Dowswell, 2013). Findings of our research highlighted that the shared norms and values representing underlying ideologies within maternity facilities shaped midwives' decision-making around ARM. Furthermore, our study highlighted that midwives' who practised in a primary birthing unit did not experience the same pressures to ARM as midwives who were providing primary care in a hospital maternity facility.

This illuminated the centrality of the notion of time (and progress) in labour and birth by 'place'. Although all health professionals ideally base practise on evidence, it is widely understood that there are challenges to putting evidence into practise in the clinical setting (Fairbrother, Cashin, Conway, Symes, & Graham, 2016). According to Fairbrother et al. (2016), organisational culture can represent a key enabler or barrier for the application of evidence to practise.

Given the strong body of evidence suggesting that place is directly related to birth outcomes along with evidence that midwives may practise differently in different settings (discussed in Chapter Two) it is essential to better understand how 'place' influences practise. A research study examining 'place' in relation to supporting physiological birth could identify barriers and enablers within 'place' to supporting a physiological approach to labour and birth.

Physiological Birth and 'Normality'

There is a lack of consensus and universality regarding what constitutes a 'normal birth' (WHO, 2018). The WHO (1997) defined normal birth as having a

> spontaneous onset, low- risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition. (p. 121)

In response to a call for a standard definition of normal birth, Werkmeister, Jokinen, Mahmood, and Newborne (2008) developed a multi-disciplinary consensus on what a normal birth consisted of, categorising normal birth in relation to the process as well as the outcomes. They wrote that normal birth is a birth without induction, epidural or spinal anaesthesia, general anaesthetic, forceps, ventouse, caesarean, or episiotomy.

Downe (2006) challenged the definitions of normality, writing that many women who have a 'normal birth' in hospital maternity facilities experience a range of interventions. Downe and McCourt (cited in Downe & Byrom, 2019) described normal birth as a "dynamic and non-linear process" (p. 95) which is unique to the woman and her baby and influenced by her current situation. Downe and McCourt wrote about the importance of a focus on the woman's 'unique normality' rather than the woman's labour and birth fitting into a classification of 'normal'. They posited that "the promotion of the conditions for physiological birth is best achieved by the recognition of flexible definitions of normality, understood in the context of uncertainty, non-linearity, and complexity" (Downe & McCourt cited in Downe & Byrom, 2019, p. 95).

In this research study, rather than referring to supporting 'normal birth', I focus on the process by using the terms 'supporting physiological birth' and 'supporting normality' interchangeably. By these terms, I refer to the process of providing the space to maximise the potential for physiological birth. It is about enabling and facilitating the normal physiological labour and birth process to unfold undisturbed whenever possible, and supporting what is normal for the woman, allowing for the uniqueness of her current situation. A component of this process is seeing and appropriately protecting the 'normality' and physiological within a woman's situation when there is some complexity.

International guidelines recommend a physiological approach to care during labour and birth, such as the WHO (2018) guide: "*Intrapartum Care for a Positive Birth Experience*" and the National Institute for Clinical Excellence (NICE, 2017) guidelines for intrapartum care for healthy women and their babies. However, it is evident that there are barriers to implementing a physiological approach in some hospital facilities.

Professional: New Zealand Context

This research study was conducted in New Zealand. Participants have experience of maternity services and the New Zealand model of care. At the time of data collection, participants were working in the greater Auckland region. Maternity care is publicly funded in New Zealand, and services are categorised by the level of care in terms of risk and complexity that a woman requires: primary, secondary, or tertiary (Ministry of Health, 2020a). Women are able to choose a Lead Maternity Carer (LMC) who will be responsible for their care throughout the antenatal, intrapartum, and postnatal periods, providing continuity of care. Data from the Ministry of Health (2019) show that 93.6% of women in New Zealand in 2017 chose to have an LMC midwife. Women can also choose to have a GP or a private obstetrician as their LMC. These practitioners also provide continuity of care throughout the woman's journey, but with the support of midwifery services in the intrapartum and postnatal periods.

The midwifery model of care in New Zealand is woman-centred, and a partnership relationship with the woman and her whānau sits at its core. A partnership relationship is built on trust, respect, and shared decision-making. This relationship has been described as being akin to a "professional friend" (Miller & Bear cited in Pairman, Tracy, Dahlen, & Dixon, 2019, p. 300).

It is well understood that model of care can influence practise and birth outcomes, and undoubtedly this would be an influencing factor in how midwives and obstetricians experience place in relation to supporting physiological birth. However, the model of maternity care in New Zealand is reasonably consistent, but there are still significant differences in rates of spontaneous vaginal birth by 'place'. The focus of this research is therefore to explore the influence that 'place' itself has on practitioners' experience of supporting physiological birth, whilst acknowledging the influence that model of care may have.

All midwives are autonomous practitioners in New Zealand. Lead maternity carer midwives work in primary healthcare, although they can continue to care for the woman and baby when complications arise with obstetric/paediatric/mental health input in the woman's care. The Referral Guidelines provide a framework to guide midwives in relation to consultation with, and referral to, obstetric and other medical services and transfer of care where necessary (Ministry of Health, 2012).

Midwives may either be self-employed (LMC) providing continuity of care to women throughout their pregnancy, birth, and postnatal period; or be employed by primary (midwife-led); secondary or tertiary (hospital, obstetric-led) maternity facilities. Employed midwives provide midwifery care to women, babies, and their whānau whilst they are in maternity facilities, or as part of a community midwifery team (some teams may also provide continuity of care). Midwives in New Zealand can support women to birth at home, in primary birthing units, or in secondary/tertiary hospital maternity units.

Obstetricians may be employed by DHBs in secondary/tertiary hospital maternity facilities, they may have private obstetric practices working as LMCs, or sometimes work in a combination of both. Obstetricians working in secondary/tertiary hospital maternity settings are involved in women's care when a midwife requests an obstetric consultation. Obstetricians lead the woman's care in collaboration with a midwife/midwifery team if she is transferred from primary (midwife-led) to secondary/tertiary (obstetric-led) care.

Although midwives and obstetricians are likely to have divergent professional philosophies they work alongside each other, and these relationships and the interface between the practitioners could be significant for supporting physiological birth. According to Rooks (1999) at the core of the medical model lies risk; a belief that labour and birth are risky, and normality can only be determined retrospectively. Contrastingly at the centre of midwifery philosophy lies supporting normality; a belief that unnecessary labour and birth interventions should be avoided, but that focusing on normality does not exclude medical interventions if needed (Rooks, 1999). Therefore, it is important for this research to explore the experiences of both midwives and obstetricians, bringing closer into view how their different experiences and interrelations with and within 'place' shape their practise in relation to supporting normality.

Orientation to the Research

Primary birthing unit

Primary birthing units are midwifery-led and may be freestanding or alongside hospital maternity facilities. There are currently 52 primary birthing units within New Zealand, accommodating and providing intrapartum and postnatal care to healthy low-risk women and their babies. Primary birthing units do not offer epidural analgesia or

operative births. Access to secondary/tertiary maternity services requires transfer to a hospital.

Secondary/tertiary hospital maternity unit

Secondary maternity facilities provide specialist midwifery and obstetric services to women with complications of pregnancy and may provide care to women who are low risk if this is what the woman chooses. Tertiary facilities are the specialist maternity providers for women who have high risk needs (although also provide care to low-risk women) and are able to provide high dependency maternal and neonatal care. There are six tertiary maternity facilities throughout New Zealand.

Women's choice of place of birth in New Zealand

The decision regarding place of birth is made by the woman; all women should receive evidence-based information about place of birth when they book with a LMC to facilitate informed choice. Healthy low-risk women can choose to birth at home, in a primary birthing unit, or in a hospital maternity facility. This choice may be constrained by the area in which the woman lives, her knowledge in relation to the choices available to her, and by her choice of LMC.

My Pre-understandings in Relation to 'Place'

"The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (Gadamer, 2013, p. 239). Pre-understandings, also known as prejudices, are the 'already there' understandings and beliefs about the phenomenon that the researcher brings to the study. These inform the research question and are 'present' throughout the research process (van Manen, 1990). These understandings and assumptions cannot be put aside and, in phenomenological studies, are instrumental in the unfolding of new understandings from the research (Gadamer, 2013). They are the starting blocks, and a lens through which to aid questioning of the phenomenon and generation of new understanding. My prejudices were created by, and are bound within, my history, my midwifery journey, and have been heightened by key moments along the way. Prior to the commencement of the research, my prejudices were discussed with my supervisors in a 'pre-understandings interview' to bring these to the forefront to raise awareness and aid efficacious self-reflection and reflexiveness throughout the research process.

I will briefly outline my midwifery journey, including some short examples to show how my curiosity in relation to place has grown. The aim is to provide a background in relation to the lens that I 'see' through in relation to this research study. I have practised as a midwife for over 28 years, working in a range of roles and places. I trained as a midwife in the United Kingdom following two years working as a registered nurse. In New Zealand I have been lucky enough to continue to develop this lens through which I see and understand midwifery care and maternity services and facilities. The foundation of this lens has been created by practising in primary, secondary, and tertiary maternity facilities, both as an employed and self-employed midwife. This experience has provided me with a broad understanding of midwifery and maternity care both in the United Kingdom and in New Zealand from different angles. The experience has generated insight, and an ever-growing curiosity about the influence of 'place' on practise.

Having the privilege of teaching midwifery students further developed the lens that I 'see' through. Quality and safety aspects of midwifery were my next focus in my role coordinating the Maternity Quality and Safety Programme for a large DHB. This position guided me to a different angle of vision, raising my awareness of maternity care from a service perspective. I became more interested in data, considering it to identify opportunities for quality improvement. I became increasingly aware of the barriers to change and progress, and that 'place' was a core variable, sometimes representing a barrier to evidence-based practise. It is here where I really started to 'see' the influence of 'place'. During this time I completed a Master of Health Science degree and began a Doctor of Health Science.

Postgraduate study has expanded my lens; it has been a catalyst for questioning, analysis, and reflection. My passion for research grew which led me to a one-year secondment working as a Midwifery Research Fellow at a DHB and AUT University combined. As mentioned earlier, I was involved in a research study examining what shaped midwives' perspectives and practise of ARM in low-risk labour. This experience further highlighted for me the centrality of 'place' and, in particular, the facility culture that resides within it, in relation to midwives being more, or less, able to support physiological birth.

The next part of my midwifery journey, as a midwife consultant in a tertiary maternity facility, has further grown my angle of vision and strengthened my passion around optimally supporting a physiological approach to labour and birth. When I started this role I read the annual report (maternity). Within the data it was clear that intervention in labour

and birth was relatively routine, and not just for women with pregnancy complications. Many variables could be seen within the data that appeared to influence rates of intervention; 'place' evidently a key influence. I became increasingly concerned that some women may be receiving interventions in labour and birth that could be safely avoided. Unnecessary interventions could create both risk for some mother and babies, and increased acuity and pressure on staff already struggling in an under-resourced service, potentially also equating to risk (as well as increased cost to the DHB). I believe that the current situation with many low-risk women having labour and birth interventions that could be avoided is not sustainable and represents increased risk in our maternity services.

I believe that the very best place for healthy low-risk women to birth is in a primary environment; however, the majority of low-risk women continue to choose to birth in hospital maternity units. I believe that the woman's mind and emotions are pivotal to her labour and birth experience, progress, and outcomes. I feel that this element of wellbeing is often superseded by the woman's physical needs. I have seen the influence of place on women, and how in a primary environment women are often more relaxed and better able to trust in and let their physiology lead. As soon as the woman enters the birthing room, the subtle differences are evident and, I believe, these have more of an effect than we realise. For example, in many hospital maternity facilities the bed is central, with the oxygen and suction behind it, the hospital gown placed in readiness, and the CTG monitor positioned at the side of the bed. This is a sharp contrast to the more homely and non-clinical primary environment. It is my belief that place is significant to the way midwives and obstetricians practise. Reflecting on my experiences, I too have felt differently caring for low-risk women in primary and secondary environments. I have always felt in primary units that the place and space are working *with midwives* to best support the woman.

I recently had a conversation with a midwife colleague, Sarah, who has always passionately supported women to birth physiologically whenever possible, and always kept the woman at the very centre of her care. She changed her workplace and became employed by a large secondary maternity facility. I saw her in the birthing unit and her approach had changed. She was caring for a woman who had recently arrived in the early stages of labour (her cervix was 3cm dilated) and her baby was in a posterior position. She told me that she had just done an ARM so that she could augment the woman's labour with oxytocin, get an epidural cited, and, in her words, "get things moving along". I asked her why she had taken that approach, and she told me that if the woman was staying in the

unit, then she needed to ‘get on and give birth’, and intervention was unavoidable due to the baby’s posterior position.

This was a sharp contrast to the approach that Sarah would have taken prior to her current place of work. I listened to Sarah updating the clinical charge midwife (CCM) about the interventions and her plan of care; ARM was clearly routine and normalised within this hospital facility. A plan was made to reassess the woman in 2 hours and, if she had not made adequate progress, Sarah would consult with an obstetrician. It seemed that Sarah was not expecting the woman to have a normal birth. This expectation was influencing her practise decisions, even though the woman had not had time to establish in labour. Sarah was caught up in the drive to keep things moving on the maternity unit. It seems that she was influenced by the culture of the facility and perhaps doing what was expected.

Earlier in my career I have felt pressure in some maternity facilities to comply with expected practise. Looking back, I have myself sometimes done admission CTGs when I knew that they were not needed, feeling concerned that I would be questioned why I had not conformed with expected practise if there were complications or a poor outcome. On reflection, my actions were to protect myself. In my first job as a midwife, I worked at a hospital facility that had central monitoring; there was a CTG monitor in every room and all CTG recordings could be seen on monitors in the midwives’ station. Most women received continuous monitoring and the senior midwives and obstetricians would consistently keep watch of the screens outside of the rooms. They would make decisions on the CTG trace without fully understanding what was currently happening in the room. This was accepted practise. It was the ‘done thing’. Every woman was put on the monitor on admission, and usually remained on it throughout her labour and birth. If the monitor was taken off, a senior midwife would often come to the door and ask what was happening in the room. Evidence became available suggesting that this practise could lead to increased intervention in labour and birth. It is likely that this system was convenient and efficient for the unit. It meant that the woman’s labour could be ‘watched’ which equated to a perception of increased safety and, I suspect, a convenience when staffing was not adequate. The place drove practise which superseded the evidence. The ‘normal’ and expected practise shaped by ‘place’ influenced the culture within the maternity facility.

Maternity facility culture cannot be ‘seen’ but it is tangible; it is experienced. Each maternity facility that I have worked in has had a different culture, a different ‘feel’, and

evidently different shared beliefs regarding what constitutes ‘the truth’. During my time teaching student midwives, it was clear that the facility in which the students were working impacted their perspectives on practise issues. I noticed significant trends in the perspectives of students when they had been working at certain places, and they would share new ‘truths’ about practise that they had learnt during their placements.

I regularly hear maternity facility culture discussed amongst midwives and it is usually positioned to be something which is out of our control, a pre-destined and influential entity. I recall a recent conversation with a midwife colleague who worked on the midwifery bureau at two different hospital maternity facilities and at a primary birthing unit. She shared that many women in one of the hospital facilities routinely had an intravenous cannula inserted when they were admitted in labour along with an admission CTG, both ‘just in case’. This reflected a culture which highly anticipated risk, complications, and interventions. It was expected practise which she did at this facility but did not do at the others in the same circumstances. Practise did not reflect the woman’s risk; rather, was influenced by ‘place’.

Women are coming to the maternity facility to our care, and they put their faith in us as midwives and obstetricians. They trust us to keep them safe and act in their best interests. When women receive labour and birth interventions that could have been safely avoided, as well as not receiving interventions when they are clinically indicated, then we have not acted in their best interests. We may have allowed competing needs and competing pressures to come before what is right for the woman and baby.
I believe that providing primary care in a secondary maternity unit is a ‘pressure point’ for supporting physiological birth. I do not feel that it is impossible for a secondary maternity environment to be efficacious in supporting low-risk women to give birth if that is the place they choose. However, I feel that it would take additional insight into the enablers and barriers within place to supporting a physiological approach to labour and birth, and a commitment towards this way of working.

The place that the woman walks into when she is in labour is a significant determinant of her birth outcome, and considerable differences are evident when places are experienced. I feel that this is an ‘elephant in the room’—one that needs to be looked at more closely. My midwifery journey, so far, has left me aspiring to better understand how ‘place’ influences how midwives and obstetricians are able to support physiological birth. Anecdotally, the current system is not working optimally for all women and babies.

Developing a better understanding of the elements of place that best support and lay the foundations for physiological birth could help to facilitate practitioner reflection. It could also generate insight into the barriers and enablers within 'place' to supporting a physiological approach to labour and birth.

Summary

It is evident that 'place' influences labour and birth outcomes. This hermeneutic phenomenological research study seeks to unpack the complex interplay between midwives and obstetricians and 'place'. It aims to reveal new insights into how 'place' is experienced and shapes practise in relation to supporting a physiological approach to labour and birth. Exploring and searching for meaning within midwives' and obstetricians' lived experiences of 'place' may be instrumental in uncovering 'place' and bringing the relationship between 'place' and practise closer into view.

Overview of Thesis

This study is presented in nine chapters. The current chapter has introduced the rationale and purpose for the study and provided background information to situate the research.

Chapter Two: The review of the literature. In this chapter, literature was re-viewed with the purpose of understanding what is already 'known' about the relationship between place and supporting physiological birth, identifying what is not so well understood, and to provoke thinking on and around the phenomenon. In keeping with the methodology, this review of the literature reflects a hermeneutic 'style'.

Chapter Three: The methodology. This chapter outlines the methodological underpinnings which have provided the foundations for the study and guided the research throughout. Philosophers, Heidegger and Gadamer, and their philosophical notions, are outlined here.

Chapter Four: The research methods. In this chapter the research methods used throughout the study are described and discussed. These include the ethics process, how participants were selected and recruited, how data were collected, the process used for data analysis, and how rigour and truthfulness have been upheld.

Chapter Five: The first findings chapter: 'Messages from the Space Influencing Normality'. This chapter shows how place 'paints a picture' about its intentionality, and

how it directs the practitioner, both in terms of the physicality of the environment and the way the practitioner feels within 'place'.

Chapter Six: The second findings chapter: 'Attunement Towards Normality'. 'Place' is not neutral, and this chapter shows an attunement or a heightened 'alertness' within 'place'. The focus of this attunement influences the perceived balance between risk and normality. An attunement to risk and pathology within 'place' can make it more difficult for practitioners to 'see' and identify normality. When practitioners can more clearly see the relationship between risk and normality there is greater openness to opportunities for physiological birth.

Chapter Seven: The third findings chapter: 'Place is a Field of Play'. This chapter shows how participants' experience of supporting physiological birth is influenced by the 'play of the game' within 'place' in conjunction with the degree that they need to juggle with key tensions. The game has safety at its core (the woman and baby, the facility, and the 'self') and the key tensions are identified as protection, time, efficiency, and resources.

Chapter Eight: The fourth findings chapter: 'Safeguarding the Art of Being Appropriately Patient'. This chapter shows the 'already there' in 'place' which safeguards an appropriately patient approach towards labour and birth. In this chapter, the nurturing and support of an 'in-between space' between primary and secondary maternity care is highlighted as being an enabler to practitioners supporting physiological birth.

Chapter Nine: The discussion chapter. In this concluding chapter I bring the research findings together and discuss the key insights from the study. Recent pieces of literature are incorporated to further support the significance of the research findings. The chapter offers recommendations for practise, maternity services, education, and future research. The strengths and limitations of the study are also discussed.

Chapter Two: Literature Review

> To read in a hermeneutic way is to be attuned and engaged. One brings a willingness to be surprised, openness to difference and courage to make the leap into the space of thinking. (Smythe & Spence, 2012, p. 17)

Introduction

The key purpose of reviewing literature in a hermeneutic research study is to create a background for the study and to provoke thinking. This literature review is a "call to thinking" (Smythe & Spence, 2012, p. 22) about 'place' in relation to supporting physiological birth. I approached the literature review initially prior to the start of the research with a curiosity as to why 'low-risk primiparae' in New Zealand had significant differences in birth outcomes depending on which hospital maternity facility they gave birth in, and how 'place' could influence practise.

Gadamer (1982) wrote that hermeneutics seeks to generate thinking in a different way; seeing things from a different horizon, thinking afresh, or looking beyond what is evident. This literature review aimed to bring about a deeper understanding in relation to 'place' and physiological birth, and to situate the research study amidst what was already understood. It provides insight into understanding that has been generated by other studies in this field and shows how the exploration of key pieces of literature generated my 'call to thinking'. This 'call to thinking' continued following completion of the research study when I returned to the literature to complete the review with a deeper understanding. This extended process of engagement with the literature is more instrumental in identifying relevance and developing meaning in relation to the phenomenon (Boel & Cecez-Kecmanovic, 2010).

The process of engaging with literature hermeneutically reflects the philosophical underpinnings of a hermeneutic approach and is therefore different from other styles of literature review. Rather than systematically reviewing the body of literature, a hermeneutic re-view of the literature seeks to develop a deeper understanding, uncover insights, and is "a way to be attuned" (Smythe & Spence, 2012, p. 23) rather than following a set of rules. Van Manen (1997) wrote that a hermeneutic literature review is a dialogue with the literature. This approach to engaging with the literature requires attuned questioning, and an attentiveness and openness to what could be revealed (Crowther, Smythe, & Spence, 2014).

Gadamer wrote that "understanding does not aim at having the final word" (Barthold, 2012, p. 6). The understanding generated from the review of the literature reflects a 'fusion of horizons' (Gadamer, 2004): those of the authors and researchers of the studies, my own pre-understandings upon which I was constantly reflexive, and the resulting understandings that emerged and continued to grow. The initial insights developed from the first review of the literature were built on with this research study: How do midwives and obstetricians experience place in relation to supporting physiological birth? Insights were then cultivated further on completion of the research study as I returned to the literature with a changed horizon. This time the search of the literature was more targeted in terms of exploring existing understanding further.

Reviewing the literature

I searched for literature using the following databases: CINAHL, Intermid, Medline (via EBSCO, PubMed, Ovid), ScienceDirect, MIDIRS, Psyc Info, Google Scholar published within the last ten years. Whilst I optimally sought literature from the past six years, I broadened the search timeframe to consider seminal studies which may not have been so recent. Search terms were used such as: place of birth, birth environment and practise, supporting physiological birth, avoiding labour and birth interventions, organisational culture in maternity. The research studies reviewed were predominantly qualitative in nature or used a mixed methods approach (with the exception of the quantitative studies about birthplace and birth outcomes).

I started the search of the literature by uncovering what is understood about the relationship between birthplace and physiological birth, but first I highlight what is meant by birthplace and birth space.

Birthplace/Birth Space

As discussed in Chapter one, place and space are separate, but tightly interwoven entities. These terms are often used interchangeably in the literature. At times, place is used, but the literature is referring to space, which represents a challenge when looking for further insights in relation to birthplace and space. Nørgård and Bengtsen (2016) made a distinction between place and space in relation to a university. They relate the university to the human body, suggesting in their analogy that place is the biological body itself, and that space relates to the subjective experience of how the body is feeling. Withers (2009) writes about place as a location, but also about a 'sense of

place' referring to this as being the 'affective attachment' that people have to a place. Casey (as cited in Withers, 2009) described the relationship between place and space as "space is transformed symbolically into a place, that is, a space with a history" (p. 647). While I have attempted to differentiate between 'place' and 'space' where 'place' is a physical entity and 'space' the experience of being-there, there is often a blurring of the two for 'place' always is experienced by the practitioner as 'space'.

'Place' and Birth Outcomes

Place of birth is well understood both nationally and internationally to be significant in relation to birth outcomes. There is a strong body of evidence which shows that women who are healthy and are considered to be 'low-risk' have better birth outcomes when they commence labour at a primary maternity unit or at home rather than a secondary/tertiary hospital facility, illuminating the centrality of 'place' (Bailey, 2017; Birthplace in England Collaborative Group, 2011; Davis et al., 2011; Grigg et al., 2017; Farry, McAra-Couper, Weldon, & Clemons 2019; Scarf et al., 2018).

Exploring the body of quantitative evidence in relation to birthplace lays the foundations for this review of the literature around birthplace, identifies what is understood to be the 'truth' in relation to birthplace and birth outcomes, and helps to identify what is not 'seen' within the numerical data. Arguably, quantitative research is sometimes seen as holding more credibility, perhaps having a 'higher status' than qualitative evidence. Heidegger however cautioned us about limiting our thinking and understanding in relation to 'being' with a reliance on the scientific method. According to Heidegger, as exposed by Wilberg (2003) the scientific method is unable to uncover the whole truth about 'being'; rather this remains covered when using purely a scientific angle of vision. He notes that Heidegger suggests the importance of a knowing relationship with science, an appreciation of its limitations, and the importance of also understanding the human experience of the phenomena (Wilberg, 2003).

The 'Birthplace in England' study (Brocklehurst et al., 2011) is the most comprehensive comparative data to date on birthplace in relation to birth outcomes. This national prospective cohort study set out to discover whether the incidence of adverse perinatal outcomes for women at low risk of complications differed for births planned at home, or at a freestanding midwifery unit or alongside midwifery unit, compared with an obstetric unit. The cohort consisted of 64, 538 women in England who were classified as having

low-risk pregnancies (immediately prior to labour they had no medical or obstetric risk factors as listed in the NICE intrapartum care guidelines). For this study the exposure was planned place of birth at the start of care in labour and the primary outcome was perinatal mortality and intrapartum morbidity. Mortality and morbidity consisted of the following: Stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, and fractured humerus or clavicle. Secondary outcomes included other adverse perinatal outcomes, adverse maternal outcomes, interventions during labour and birth, and outcomes for women who transferred to an obstetric unit.

Adjustments were made for confounding variables: maternal age, ethnicity, understanding of English, marital status, BMI, Index of Multiple Deprivation score, parity, and gestation. The study found the incidence of adverse perinatal outcomes to be low in all settings, and no statistical difference was found between the birth settings for multiparous women. For nulliparous women there was also no difference in the primary outcomes between midwifery units and obstetric units, but the planned home birth group were found to have more adverse perinatal outcomes (9.3 per 1000 as opposed to 5.3 per 1000).

The researchers found that both nulliparae and multiparae in all non-obstetric unit groups were significantly more likely to have a normal birth (defined as birth without induction of labour, epidural/spinal anaesthesia, episiotomy, general anaesthesia, forceps, ventouse, or caesarean) compared to women in the obstetric unit group. Percentages of women having a normal birth differed significantly across the four groups: 88% in the planned home birth group, 83% for women who birthed in a freestanding midwifery unit, 76% in the alongside midwifery unit group, and 58% in the obstetric unit group. These significant differences in rates of normal birth occurred despite transfer rates to an obstetric unit for nulliparae in non-obstetric unit groups of 36-45%.

The rates of augmentation of labour, analgesia use, instrumental birth, caesarean section, episiotomy, and active management of the third stage, were all reported to be significant higher for women in the obstetric unit group. The data is less reliable in relation to adverse maternal outcomes, as rates of these were low. However, results suggest that rates of third/fourth degree perineal trauma, blood transfusion, and admission to a higher level of care were lower in the planned home and freestanding midwifery unit groups. Women in these primary birthing groups were also more likely to initiate breastfeeding within ‘place’.

Whilst this study was conducted in England (Brocklehurst et al., 2011), there are many similarities between England and New Zealand in terms of birthing places, and the maternity system. In New Zealand, women are predominantly cared for by community-based LMCs, as discussed in Chapter One, which is a different midwifery model to the National Health Service in England. Further, New Zealand is sparsely populated in comparison to England with a number of remote-rural primary maternity units distant from a large obstetric hospital. However, multicentre studies undertaken in New Zealand and Scotland have shown similarities in relation to rural midwifery in both countries such as the challenges rural midwives may encounter with long travel distances during intrapartum transfers (Crowther, Deery, Daellenbach, & Davies et al., 2018; Gilkison, Rankin, Kensington, & Daellenbach et al., 2017). Other research studies from high income countries, irrespective of the possible differences in maternity systems and models of care, also show similar findings to the 'Birthplace in England' study.

A systematic review and meta-analysis by Scarf et al. (2018) explored maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high income countries (Australia, the Netherlands, The United Kingdom, other European countries, Nordic countries, New Zealand, America, and Japan). Scarf et al. included 28 studies and concluded that women with low-risk pregnancies who planned to birth in hospital had significantly lower odds of having a normal vaginal birth than when birth was planned in primary settings, and that place of birth did not significantly impact on infant mortality/morbidity. There are some New Zealand studies that have examined the relationship between place of birth and birth outcomes (Bailey, 2017; Davis et al., 2011; Farry et al., 2019). Although not as large as the 'Birthplace in England' study they directly reflect New Zealand's maternity system and model of care, and also report similar findings to studies conducted internationally.

A retrospective cohort study by Davis et al. (2011) examined the relationship between planned place of birth, mode of birth, intrapartum intervention rates and neonatal outcomes among low-risk women in New Zealand birthing between 2006 and 2007 having midwifery-led care (n=16, 453). The primary outcome of the study was mode of birth, and secondary outcomes included artificial rupture of membranes, augmentation of labour, pharmacological pain relief, episiotomy, perineal trauma, blood loss, APGAR score less than 7, and admission to neonatal intensive care unit. Data was obtained via the Midwifery Maternity Provider Organisation (MMPO) database (data collected for

statistical and claiming purposes); this cohort of women birthed throughout New Zealand either at home, in a primary maternity unit, secondary hospital unit, or a tertiary hospital unit. The majority of the women in this cohort (70.9%) planned to birth in hospital maternity units. The initial cohort of greater than 33,000 women were reduced to 16,453; tight exclusion criteria were used to eliminate women identified as having any 'risk' factors.

Relative risks were adjusted for maternal age, parity, ethnicity, and maternal smoking. The findings reported that women who planned to birth in a secondary or tertiary hospital unit had a significantly increased risk of operative birth and all secondary outcome labour and birth interventions. The findings showed that the risk of an emergency caesarean was 4.62 times higher for women who planned to birth in a tertiary hospital unit than for a woman planning to birth in a primary maternity unit (95% CI 3.66-5.84). Babies of women who planned to birth in hospital units had a higher risk of admission to neonatal intensive care unit (RR 1.40, 95% CI 1.05-1.87; RR 1.78, 95% CI 1.31-2.42) than women who planned to birth in primary settings. However, there were no differences found in APGAR scores of less than seven. No differences were found in estimated blood loss greater than 1000ml.

Bailey (2017) conducted an observational study to compare maternal and perinatal outcomes for low-risk women birthing in freestanding maternity units and in a hospital maternity unit in South Auckland New Zealand, between January 2003 and December 2010. The cohort consisted of 47, 381 women with a singleton pregnancy, cephalic presentation, 37 weeks gestation or above, and who laboured spontaneously. Women were excluded from the study if they did not meet the criteria for birthing at a primary maternity unit. Primary outcomes for this study were instrumental and caesarean delivery, peripartum blood transfusion, level 2-3 neonatal unit admission, and peripartum death. The researchers adjusted for confounding variables of age, ethnicity, and deprivation score. These adjusted confounding variables are limited due to the unavailability of data, which may have influenced the results.

Findings showed that all women who planned to birth at primary maternity units had significantly lower rates of instrumental and caesarean delivery and blood transfusions, and there was no increase in neonatal unit admission (this admission rate was lower for babies of nulliparous women who laboured in primary units). For example, nulliparous

women planning to birth at a primary maternity unit had a 7.2% caesarean section rate as opposed to 12.6% for women birthing at the secondary/tertiary hospital unit (OR 0.5, CI 95%, 0.44-0.59). For multiparous women the caesarean section rate was 0.7% for women planning to birth at a primary maternity unit, and 2.3% at a hospital unit (OR 0.34, CI 95%, 0.26-0.46). Bailey (2017) concluded that primary maternity units had significantly lower rates of labour and birth intervention than secondary/tertiary hospitals even though the model of midwifery care was similar.

Farry et al. (2019) undertook a retrospective cohort study to compare perinatal outcomes for healthy pregnant women (n=4, 207) presenting at primary and tertiary settings in South Auckland, New Zealand. Of this cohort, 26.5% gave birth at one of the three primary maternity units, and 73.5% at the tertiary level obstetric-led hospital unit. The intrapartum and immediate postpartum (within 12 hours of birth) transfer rate was 9.3% in total, significantly smaller than in the 'Birthplace in England' study. Farry et al. adjusted for confounding variables of parity, smoking status, ethnicity, BMI, socio-economic decile, and maternal age. Findings showed that low-risk women who presented at a primary maternity unit in labour were four times less likely to undergo a caesarean section (OR 0.25, CI 0.157-0.339), two times less likely to have a postpartum haemorrhage (aOR 0.536, 95% CI, 0.424-0.676), five times less likely to be acutely admitted following birth (aOR 0.201, 95% CI, 0.102- 0.398), three times less likely to have a baby with an APGAR score below 7 at 5 minutes following birth (OR 0.313, 95% CI 0.124-0.791), and two times less likely to have their baby admitted to NICU.

This body of evidence on birthplace and birth outcomes is consistent, and collectively shows a strong relationship between 'place' and mode of birth, labour and birth interventions, and various perinatal morbidity outcome measures. There are likely to be some differences in maternity services and models of care in the different countries where studies have been undertaken, yet the outcomes indicate the same relationships. The evidence suggests that the increase in labour and birth interventions in these low-risk cohorts, presumably done to reduce risk to the woman and baby, evidently did not appear to equate to a reduction in morbidity (using the documented outcome measures). This further illuminates the importance of better understanding what aspects of birthplace best enable, or represent a barrier, to physiological birth.

The influence of birthplace on birth outcomes is likely to be complex. Whilst the quantitative research studies undeniably highlight the correlation between place and

birth outcomes, the studies are not able to capture how 'place' is experienced. It is reasonable to suggest that birthplace and birth space to some degree shape how midwives and obstetrician's practise, influencing birth outcomes. Greater insight into practitioner's experience of 'place' would complement the existing quantitative studies, and further uncover the phenomenon.

A New Zealand study by Miller and Skinner (2012) suggests that LMC midwives changed their practise according to 'place' when caring for nulliparous women considered low-risk. Participant midwives (n=12) completed a survey and provided information about their most recent labour and birth outcome data and their midwifery care and practises for 10 low-risk nulliparous women who started spontaneous labour at home, and 10 who started spontaneous labour in the hospital (n=228:109 home births and 116 hospital births). These cohorts were matched for risk status, and data about their labour care and birth outcomes were compared. Findings showed that the women who chose to give birth at home were significantly more likely to have a normal birth, and less likely to receive labour and birth interventions. Findings also suggest that women birthing at home were more likely to receive evidence-based care from their midwife; for example, in relation to fetal surveillance, vaginal examination, artificial rupture of membranes, positions for labour and birth, and management of the third stage of labour. This is a relatively small study, but points towards the influence of 'place' in relation to midwifery practise.

An earlier meta-analysis by O'Connell and Downe (2009) also suggests that midwives may change their practise according to the maternity facility to conform to practises common to the workplace. This study examined 14 qualitative research studies conducted in five countries related to midwives' experiences of hospital labour and birth practise. O'Connell and Downe concluded that '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 (p. 604).

According to Tracy and Grigg (in Pairman et al., 2019) the notions of safety, risk, and choice sit at the core of the debate around the optimal birthplace for women with uncomplicated pregnancies. There is a growing understanding that hospital maternity facilities could potentially represent risk to some women (Newnham, McKellar, &

Pincombe, 2017). In 2014 the NICE guidelines recommended that women should be informed that birthing in an obstetric-led unit is associated with an increased risk of intervention compared to birthing in a midwifery-led unit. However, 86% of women in New Zealand in 2018 gave birth in secondary or tertiary hospital maternity units (Ministry of Health, 2020c).

Place and Practise

In my reading of the literature in relation to 'place' and supporting physiological birth, it became evident that there were seven key area's that stood out as being significant to understanding the influence that 'place' may have on practise: 'the design and feel of the birth space', 'ideology and discourse', 'perspectives on birth', 'construction of safety', 'experience of time within place', 'confidence in normality', and 'the meaning of midwifery'. Collectively they began, and continued to, shape a picture of enablers and barriers within 'place' to practitioners supporting a physiological approach to labour and birth, bringing the phenomenon closer into view.

The design and 'feel' of the birthplace

The design and the 'feel' of the birthplace and space are interwoven. My exploration of the literature started with birthplace design and how this influenced practise in relation to supporting physiological birth. This led to an exploration of studies which focussed on the design and aesthetics in relation to the 'feel' of the birthplace, and the 'mood' within it.

Birthplace design

There is a body of literature which suggests that the design and aesthetics of the birthplace influences the care that is more readily facilitated within the space. Many studies focus on the design of the birthplace from the woman's perspective, and how this influences how the women feels, behaves, and her labour and birth choices and outcomes. I focussed my search on studies which identify how design influences practitioners' experience, or how this shapes their practise. There is a gap in the literature here, with very few studies focusing on the relationship between design of the birthplace and practise.

The influence of the birthing environment was researched by Plough et al. (2019) who conducted an exploratory study into the relationship between birthing facility design,

intrapartum care, and birth outcomes. The authors researched the design features, health care provider mix, annual birth volume and the low-risk caesarean section rate for 12 birthing facilities (nine hospital facilities and three free standing birthing units) and conducted interviews with the birthing facility managers. In addition, they conducted a secondary analysis on data from a previous literature review that they had undertaken which included birthing facilities across America.

Plough et al. identified three main design trends that were evidently influencing the provision of intrapartum care and were found to be associated with a lower low-risk caesarean rate. The authors describe these as 'flexibility and adaptability', 'physical and cognitive anchoring', and 'shared knowledge and workload'. In flexibility and adaptability, the researchers refer to designs with an overflow space that could accommodate additional labour and birth beds when the facility is full; this could reduce pressure for practitioners to intervene to increase the flow of women through the facility. Physical and cognitive anchoring refers to designs that can anchor practitioners to specific patterns of care, for example central CTG monitoring systems, and centralised information on the labour board. The shared knowledge and workload theme relates to the design features that provide shared spaces which facilitate team collaboration, and the sharing of workloads amongst the team.

The study by Plough et al. highlighted how the design and layout of the birthplace shapes how it is used by practitioners. It shows how the provision of space and equipment influence what is possible, and more likely to occur, and the possible influence this may have on birth outcomes. It also points towards how the design of the birthplace reflects its intentionality, which continues to shape practise and birth outcomes within 'place'. This study provides a helicopter view of systems and operations within the birthplace rather than the focus being on how the space feels to the practitioners, and how this influences decision-making.

An ethnographic study by Small, Sidebotham, Fenwick, and Gamble (2021) also highlighted how the equipment within the birthplace influences practise. The researchers sought to uncover the impact of the introduction of a central fetal monitoring system on the practises of midwives and obstetricians (n=50) in a large Australian hospital maternity facility. Data were collected using one-to-one interviews, focus groups, and observation of clinicians using the central fetal monitoring system. The researchers found that the presence of the fetal monitoring system directly

influenced the provision of care and birth outcomes, the process of risk assessment and decision-making, and the dynamics within the maternity team.

The monitors visible outside the birthing room were being surveilled by medical and midwifery staff, who would interpret the fetal monitoring and at times make decisions based on this information without fully appreciating the woman's situation. The findings identified that as a result midwives were fearful of the maternity team coming into the room on the basis of this assessment, undermining them, and disturbing the woman. Midwives found themselves entering data into the monitoring system to reassure the team watching outside the room, and this took them away from being with the woman. Midwives also reported that they at times suggested that the woman restrict her movement in order to ensure that the monitoring was not disturbed, and at times hurried the second stage of labour, to prevent disturbance and disruption. The study found that obstetricians felt a sense of responsibility to act when they saw what they considered to be a potential problem, but midwives found the obstetrician's unrequested interruption to be undermining of their midwifery expertise. Midwives also felt that at times the system was a catalyst for unnecessary intervention, particularly in the second stage of labour.

This study by Small et al. (2021) suggests the presence of the central fetal monitoring system in the birthplace changed the mood of the space and resulted in a shift in practitioner's focus away from the woman as being central, and towards the technology. It shows how the presence of this equipment shaped the relationships, behaviour, and practises of the maternity team, which evidently ultimately influenced birth outcomes. This equipment influenced the way that midwives felt about their practise, increased their levels of fear, and the resulting behaviours of the maternity team resulted in midwives feeling less confident. This highlights that the way that midwives feel within the space could be fundamental to their practise.

Hammond, Foureur, and Homer (2014) undertook a video ethnographic study to explore the influence of birth room design on eight participant midwives in hospital and birth centre settings in Australia. The researchers found that the birth space design, both in terms of the architecture, equipment, and the aesthetics of the space had a significant effect on the midwives. Results identified that the look and feel of the room was as important as the equipment in it, and these all influenced how the midwives felt, how they were able to use the space, and ultimately influenced their practise.

These studies highlight the importance of looking both at and beyond the operational functionality of the birthing place/space to better understand practitioner's experience of 'being in' the space. I went on to explore the literature which brought further into view the 'feel' and 'mood' of the birthing space and the influence that this has on how practitioners experience 'place'.

Experiencing the 'feel' of the birthing place/space

Although the birthplace itself has been understood for many years to impact on women's labour and birth outcomes, it is relatively recently that researchers have considered the effects of being in the space on the way that midwives feel emotionally, which could influence their experience of 'place' and how they practise. Whilst acknowledging the significance of the design of the birth space, studies suggest that the birth space is more than just the aesthetics, the layout, and the equipment, but that the environment contributes to the 'feel' or 'mood' of the place. Although difficult to measure, this could be significant in relation to practise within the birthing place.

A qualitative descriptive study by Davies and Homer (2016) explored the impact of 'place' on the behaviours, emotions, and experiences of a cohort of 12 midwives in Australia and the United Kingdom. The participants worked in a variety of maternity settings; home, a birth centre co-located with a tertiary centre, and hospital settings. They all practised in at least two settings, at least one being primary, and provided continuity of midwifery care in at least one setting. The authors wrote about the birthing environment as having both tangible and non-tangible elements in relation to its effect on those within the space. They refer to tangible elements as being the physical environment such as the layout, design, and equipment in the space and non-tangible elements as being aspects of the workplace culture.

Davis and Homer (2016) found that although the midwives' practise was consistently underpinned by the same individually held philosophies and practise principles, each place had a different 'feel'. Consequently, the midwives felt differently within the space, which influenced their mood and shaped their practise. The participant midwives felt more stressed in the hospital settings than in primary settings and felt that the expectation to be busy could take them away from 'being with' the woman. This 'mood' or culture was more important than the physical environment itself but was in part influenced by it.

Although the midwives went into the different places with the same philosophy about practise and the model of care may have also been the same, the way that 'being in' the place itself *made them feel* influenced how they practised. This suggests that collectively the physical space and the mood within it 'paint a picture' which could shape experience and practise on an emotional level. It is interesting that the expectation of being busy, rather than busyness itself, could take the midwives away from 'being with' the woman, a core and fundamental part of the midwives' role. This could have been influenced by the 'mood' or ambience, or by expectations within 'place'. This brings into question the valuing of midwifery itself within 'place', and how this shapes midwives' experiences, and how they feel about themselves as midwives.

Other authors have theorised about the mechanisms that may be creating this emotional response to 'being in' the birth space. For example, Hammond, Foureur, Homer, and Davis (2013) explored the literature in relation to the birth environment, neurobiology, and midwifery practise and hypothesized that there could be a relationship for midwives between their perceptions of the birth space, experiences within it, and their own release of oxytocin. They proposed that oxytocin release influenced by a calm and supportive environment could subsequently be central to midwives feeling calm and empathetic, influence how they interact with others, and aid their ability to provide emotionally sensitive care to women.

Hammond, Homer, and Foureur (2017) sought to better understand the characteristics of hospital birth rooms that support midwifery practise, influencing the midwives' experience within the space. This is a qualitative descriptive study using critical realism (a theoretical framework that positions the influence of thoughts, feelings, and social phenomena as equal to objects and artefacts). The researchers studied sixteen midwives working in a recently renovated tertiary maternity facility in Australia. Findings showed that midwifery practise was influenced by a combination of the functionality of the environmental design, the friendliness and feel of the space, and what these qualities equated to in relation to freedom to practise midwifery responsively and with an "enhanced sense of coherence" (Hammond et al., 2017, p. 136).

The findings of the study by Hammond et al. (2017) highlight the importance of characteristics such as a warm, calm, and friendly ambience which creates a sense of normality, along with a reduction in feelings of stress and a sense of feeling safe. The research findings also identify the importance of medical equipment not being dominant

in the room and midwives having the flexibility and space to use equipment for supporting physiological birth. The authors concluded that if midwives are supported by the environment this can enhance their wellbeing which will have a ripple effect on the care that they are able to provide.

Hammond et al. (2017) took the exploration of the birth space beyond just its functionality and towards the 'meaning' generated by the space and what this represented for the midwives. It seems that the birthing environment not only influences what it is possible to achieve within the space, but also generates an emotional response in the practitioner. The way that the space is 'felt' is multifaceted, and this comes together as a sense of the space. This 'sense of the space' and emotional response to 'being in' the space could be central to how safe and supported midwives feel to support physiological birth. A space that is experienced and 'felt' to support a physiological approach to care creates both ease and safety in supporting normality.

It is interesting to consider the authors comment about participants experiencing freedom to practise midwifery. This suggests that the midwives felt an alignment with the space and perhaps with what the space represented. The 'mood' of the birth space and how free midwives feel to practise midwifery responsively, although influenced in part by the functionality and aesthetics of the room, is likely to also be influenced by the culture that inhabits the space. This is underpinned by the ideologies and dominant discourses within 'place'.

Evidence is limited in relation to how the birthing place feels to practitioners and *makes them feel*, influencing their practise. The pockets of evidence are thought-provoking, and bring closer into view an aspect of 'place' which could be having a significant effect on both practise and birth outcomes.

Ideology and Discourse

Space is not simply inert, but is always populated with social, political, and ideological meaning (Lefebvre & Enders, 1976). Lefebvre and Enders (1976) write about how ownership of space communicates messages about economic power and productivity. Place and space therefore are not neutral territory but are instead entrenched in discourse and power relations (Davis & Walker, 2010; Hammond et al., 2013). Davis and Walker (2010) argued that "birthplace is as much a material as it is political and

discursive entity" (p. 378) and that place in its totality reflects the dominant ideologies in relation to birth.

There is a body of evidence which suggests that the norms, values, and ideologies that are dominant within the maternity facility are key determinants of midwifery practise. For example, Hastie and Fahy (2011) found that facility culture influences behaviours and practises by shaping, guiding, and restricting discourses that are acceptable within a facility. They concluded that "the local culture and organisational context at the time of the interaction are more important than the specific individuals in predicting how midwives and doctors will interact in a particular maternity setting" (Hastie & Fahy, 2011, p. 77). It is reasonable to assume that the interaction between midwives and obstetricians is likely to have an influence on the degree to which a physiological approach to labour and birth is supported. The underlying ideologies and culture within 'place' are part of the foundations for practise.

An exploratory descriptive research study by Seibold, Licqurish, Rolls, and Hopkins (2010) explored midwives' perceptions of birth space and clinical risk management, and their impact on practise before and after a move to a new birthing facility within a hospital in Victoria, Australia. Focus groups were conducted with three different groups of midwives, 18 midwives in total: those working rostered shifts in the hospital, and both hospital and self-employed case loading midwives.

Seibold et al. (2010) emphasised that although the midwives worked hard to create a safe space for women, the space was ultimately 'owned' by the hospital and inhabited by a biomedical and risk discourse and pressure to conform to this. The researchers found that despite a more optimal birth space design, midwifery practise remained the same as there was no change in ideologies or the hierarchical structure within 'place'. Along with this, additional time pressures due to increased busyness negated the improvements to the birthing space. The researchers identified the notion of 'lending the space' which ultimately the hospital controlled. Although case-loading midwives felt that building trusting relationships with women in their care gave them the best opportunity to mitigate the influences of the technocratic model, they also found this difficult, despite the advantage that the model of care afforded them. The authors concluded that the driving philosophy of place, space, and the practitioners within it were fundamental to creating an optimal birth space, rather than this being simply influenced by the design and aesthetics of the space itself.

It seems that the underlying ideologies and dominant discourse and workplace culture are very much 'present' both in the physical environment and in the 'mood' or 'atmosphere' of the space, shaping practise within it. This could influence how birth is perceived by practitioners.

Perspectives on Birth

Experience of 'place' could influence midwives' and obstetricians' attitudes towards birth, and vice versa; understanding practitioner's attitudes towards birth could bring 'place' in relation to supporting physiological birth closer into sight. Recent studies include both midwives and obstetricians, and show their construction of meaning around birth, and illuminate the lens that they are 'seeing' through.

A survey study of Australian midwives and obstetricians by Coates, Donnolley, and Henry (2021) explored the perspectives of 217 midwives and 58 obstetricians working in eight Sydney hospitals in relation to birth options and labour interventions. The findings showed a significant variation between midwives and obstetricians views regarding birth options and labour and birth interventions, with midwives favouring a more physiological approach to labour and birth, and obstetricians preferring a more risk-based interventionist approach (particularly caesarean section).

Obstetricians were evidently much more concerned about risk in relation to vaginal birth than were midwife participants, and less concerned that having a physiological birth 'matters' for the woman. Obstetricians expressed significantly less confidence in the safety of birth outside of the hospital setting, and in safety in relation to the practise of self-employed midwives than did the midwife participants. Findings suggested that midwives were more concerned about reducing unnecessary caesarean sections than were obstetricians, again reflecting the obstetrician's comfort in a more risk-based approach to care (Coates et al., 2021). This survey study highlights that practitioners' perspectives around risk and safety in relation to birth options influence how they perceive birth options and labour and birth interventions.

This indicates that underlying philosophies and ideologies could significantly influence both practitioners' perspectives in relation to birth and how they experience, and contribute to, 'place'. However, the nature of their practise within the birthing place could also be reflected in how they construct meaning around birth.

Experience of traumatic events

Slade, Balling, Sheen, and Goodfellow et al. (2020) conducted a mixed methods study in the UK to explore work-related post-traumatic stress symptoms in obstetricians and gynaecologists. The researchers used a cross sectional survey (n=1095) and in-depth interviews (n=43) to collect data. Findings showed that two thirds of participants experienced traumatic work-related events which they found personally traumatic, with 18% reporting clinical symptoms of post-traumatic stress disorder and a further 13% reporting subclinical symptoms. Traumatic events were shown to have both immediate and longer-term effects and were associated with high levels of anxiety whilst in the workplace, and some distancing from engaging with women. The resultant anxiety was shown to be associated with more defensive practise, and an interventionist approach.

Experience of birth trauma has also been shown to influence midwifery practise. Minooee, Cummins, Sims, Foureur, and Travaglia (2020) did a scoping review of the literature in relation to birth trauma and midwifery decision-making. The authors included a total of 40 studies spanning from 1990 to 2018. They found that midwives also experienced post-traumatic stress, and this could lead midwives to lose confidence in themselves, lose trust in birth, and become 'hyper-vigilant', guarded, and risk averse. Findings showed that midwives experience of birth trauma can impact on how they estimate clinical risk.

Practitioners' experience of practising within 'place' and the degree of trauma and complexity that they encounter could shape their practise in relation to supporting physiological birth. This understanding led me to explore the body of literature around the construction of safety in relation to labour and birth.

Construction of 'Safety'

Risk, and resulting fear in relation to risk, was strongly represented in relation to supporting physiological birth in 'place' within the body of literature explored. All studies that were reviewed focused on hospital maternity facilities which illuminated a risk-based approach to care. A focus on risk in hospital facilities could be central to practitioners' experience of place, and perspectives in relation to supporting physiological birth. Katz Rothman (1989) wrote that: "I have come to see that it is not that birth is 'managed' the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed" (p. 178).

Healy et al. (2016) conducted a qualitative study in Ireland into midwives' and obstetricians' perception of risk and how this affects care for low-risk women. They interviewed a group of 25 participants with a variety of professional roles, and from different settings and models of care. The researchers found that midwifery was 'assuming a peripheral position in relation to normal birth' as a result of a risk-based culture and technocratic approach to maternity care and an increased prominence and 'higher' position of obstetrics (Healy et al., 2016, p. 370).

The study highlighted that the midwives were detained by risk management processes required within 'place'. This ultimately took them away from being with the woman and from supporting other midwives, placing risk at the centre of the facility culture. Obstetricians in this study acknowledged that many of the woman referred to them did not need obstetric input, but midwives referred to obstetricians in the pursuit of reassurance due to a fear of risk. At the core of this study sits a risk-based approach to care and fear driving practise. Also of importance is that the midwives in this study were evidently practising *within* an obstetric led facility rather than *alongside* obstetricians.

Scamell (2016) undertook an ethnographic research study in the UK exploring how risk management influenced midwives' understanding of birth and their construction of risk. Data collection involved observation in various labour and birth settings, shadowing of midwifery management teams, and ethnographic interviews with participants. Results showed a strong connection between fear and risk and identified that although the participant midwives were committed to supporting physiological birth, this was very easily 'unsettled' by the organisational risk technologies and operations. Underpinning this was a risk-based approach to care, accelerating midwives' sensitivity to risk.

Other researchers have further explored the consequences that a risk-based approach and fear of risk has for practise. Spendlove (2018) explored experiences, tensions, and consequences of contemporary risk work for midwives and obstetricians in an obstetric-led maternity unit in England using an interpretive ethnographic approach. The researcher engaged in 300 hours of participant observation and interviewed 21 midwives and 16 obstetricians about their experiences in relation to risk. The research findings identified the centrality of risk management practises for both midwives and obstetricians, and how this influenced anxiety and fear of uncertainty in relation to labour and birth, resulting from a 'blame culture'. Defensive practise consequently was

used to minimise perceived risk, which could lead to avoidable labour and birth interventions.

Fear of risk and potential blame triggered midwife and obstetrician participants to 'manage' labour and birth to try to minimise risk. Subsequently more women required obstetric-led care resulting in more interventions, and midwives found it difficult to challenge this. This study also highlighted that for midwives increased paperwork related to risk management, along with defensive practises resulting from the risk discourse, equated to less time spent with women. Participants acknowledged that less time with the woman in itself represents risk. Spendlove recognised that the dominant technocratic model resulted in a risk-based approach, influencing professional role boundaries, and disempowering the 'normality paradigm' of midwifery. This focus on risk left midwives feeling less autonomous and concerned that the professional status of midwifery could potentially be lost. It presents an important question as to how midwives can feel safe to support physiological birth whilst working within a technocratic model of care in the hospital space.

A grounded theory study by Page and Mander (2014) further revealed how the 'normality paradigm' could be either unsettled or supported within 'place'. Page and Mander found that support was integral to midwives' experience of intrapartum uncertainty when caring for women in low-risk labour. Nineteen midwives who practised in a range of maternity settings, including hospital, and both alongside and stand-alone primary birthing units in Scotland were purposively recruited and took part in interviews or focus groups. Findings showed that midwives experienced a pressure point when they were faced with 'grey areas' of intrapartum practise where they sometimes questioned and found it difficult to determine the boundaries of normality and whether they needed to take action.

It seems that it is at this 'grey area' point where intrapartum uncertainty could potentially lead to midwives considering the labour not to be within the boundaries of 'normal'. Page and Mander (2014) found that support at this point took the onus away from the individual and built a collective boundary of normality. This may have better enabled patience, especially if the perceptions around normality challenged the 'normality boundaries' of the maternity facility. Boundaries of normality were evidently setting-specific, with midwives working in primary settings being more comfortable with intrapartum uncertainty and having more flexibility regarding time in relation to

labour and birth; ‘place’ largely determining practise at the boundaries of normality, and to a degree constructing where these boundaries lie.

It is interesting to consider fear, and practitioners not feeling safe to let labour ‘be’. This could be fear of a woman’s time in labour in relation to perceived risk, leading to intervention. However, labour and birth intervention could also be a risk, but this risk does not appear to be feared in the same way in hospital maternity facilities. Practising outside of the dominant discourse of the place and this practise not being supported could be at the heart of fear. This could be a significant catalyst to labour and birth interventions that may otherwise be safely avoided.

A mixed methods study by Toohill, Fenwick, Sidebotham, Gamble, and Creedy (2018) further explores the impact of fear in relation to practise. The researchers investigated the prevalence of birth related fear and trauma in a convenience sample of midwives working in a variety of settings in Queensland Australia (n=249). Both quantitative and qualitative data was collected using an online survey. The authors found that the majority of midwives (93.6%) reported being exposed to traumatic birth experiences, and 8.6% of participants had high levels of birth fear (as opposed to low levels). There was a significant relationship between midwives with high levels of birth fear and low levels of confidence and worry in relation to advising a woman about her birth options and caring for women in labour. The authors found that whilst trauma was not associated with practise concerns for this cohort, there was a correlation between fear, confidence, and practise.

The authors reported a relationship between midwives’ fear of birth, and particular practise concerns: feeling professionally disrespected or overruled, feeling unable to protect women from care and interventions that they felt were inappropriate, feeling unsupported in the workplace, and working within a culture of blame (Toohill et al., 2018). These practise concerns are all specific to ‘place’. This was further intensified by understaffing, pressured workloads, and a fear of litigation. These findings highlight again the centrality of fear in relation to practicing outside of the dominant discourse of ‘place’ and not feeling supported in this practise.

These studies together indicate that practitioners are experiencing how ‘safety’ is constructed within the birthplace, which is influencing their perception of risk and subsequently shaping their practise. The research studies suggest that both the message

that the focus on risk communicates to practitioners about birth, and the required risk-based practises, can be significant barriers to safely supporting physiological birth. It is also evident within this literature that how 'safety' in relation to birth is constructed and understood within 'place' influences how time is perceived in relation to risk, and how it is experienced.

Experience of Time within 'Place'

Sitting alongside risk and safety within the literature is time. It was evident when reviewing the literature that time was a pivotal thread in relation to hospital maternity facilities, and the resulting pressure experienced being a barrier to practitioners supporting a physiological approach to labour and birth. Studies identified that both prescribed facility timeframes in relation to labour and birth, and pressure from operational demands, influenced midwifery practise. Associated practises in relation to clock time during labour and birth vary according to the maternity facility (Skogheim & Hanssen, 2015). The notion and perception of time in relation to labour and birth is core to the assessment of labour progress, and therefore to intervention in labour and birth when prescribed timeframes are understood to have not been met (Skogheim & Hanssen, 2015).

A UK participatory action research study identified that organisational time pressures, driven by operational tensions, were key to midwives' interaction with mothers when labour began (Shallow, Deery, & Kirkham, 2018). These time constraints were understood to shape the midwives' practise, but interestingly the researchers concluded that underpinning and driving them was a pressure to conform to the culture of the facility. "The dominant techno-medical environment of UK labour wards provides a breeding ground for behaviours that are sometimes inappropriate and masked by real issues of work overload in a service configuration no longer fit for purpose" (Shallow et al., 2018, p. 69).

This brings into question the needs of the facility being incorporated within decision-making, and whether these needs are creating pressures that influence how midwives provide labour and birth care; whether facilitating 'efficiency' for the facility is influencing what is accepted as 'normal' labour progress. Shallow's study also suggests that the dominant technocratic model fills the birthing place and perhaps 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 and baby and enables a more facility-centric approach to decision-making.

Other studies highlight how there can become a focus on, and surveillance of, women's labour progress within hospital facilities in the name of 'efficiency'. An ethnographic study by Newnham et al. (2017) explored the culture of a large tertiary hospital birthing facility in Australia in relation to women's use of epidural anaesthesia. This study used a theoretical framework consisting of critical medical anthropology, Foucauldian, and feminist theory. Data collection involved participant observation in the birthing facility, discussions with midwives and obstetricians, and interviews with 16 women both antenatally and postnatally. Hospital and policy document analysis contributed to data triangulation. Findings highlighted the centrality of institutional surveillance of women's progress in labour, and this was shown by the journey board (large whiteboard in the midwives' station) which displayed women's information throughout their labour and birth.

This journey board aided surveillance of women labouring in the birthing place, but also served as a management tool to aid 'efficiency'. The authors concluded that the board drove a facility-centric approach to care, aiding surveillance and management of time in relation to labour, enabling the dominant technocratic culture to be increasingly visible. This made conditions for a technocratic culture readily available. This study highlights how operational mechanisms and artefacts can drive pressures within the birthing place representing barriers to supporting a physiological approach to labour and birth against what could be a driving 'tide of efficiency' within 'place'.

A grounded theory study by Hansson, Lundgren, Hensing, and Carlsson (2019) proposed that the drive for 'efficiency' in hospital settings could result in midwives collaborating less with colleagues and 'withdrawing' their practise from sight. The study explored midwives' work in a birthing facility within a Swedish hospital from the perspectives of obstetricians, assistant nurses, and managers working alongside them in the facility (27 participants in total). The authors write that the midwives existed in a strained context, referred to as the 'baby factory', working on an 'assembly-line' principle due to workload pressures.

The research findings identified that midwives worked behind a veil allowing only fragments of reality to be seen by other professionals, resulting in less collaboration and

a perception that midwives 'marched to their own drum'. The authors reported that this left the other professionals feeling excluded, insecure, and frustrated, leading to them using strategies to gain access to the midwifery world. This led to midwifery care being scrutinised, practise being more regulated, and admittance to the birth room being sought. The authors concluded that these tensions resulted from a power struggle between professionals.

This was evidently a strategy by the midwives to avoid the pressure in relation to the busyness which may have been a catalyst to unnecessary labour and birth intervention perhaps in the interests of 'efficiency' for the facility. It also suggests an ideological dissonance between the midwives and their colleagues. However, this led to a lack of trust perhaps fuelled by fear of risk, driving increased surveillance and practise regulation. Whilst the midwives were 'holding space' for normality, this practise may have ultimately resulted in less credibility and trust in the midwives' practise. This approach left supporting normality hidden from sight and possibly misunderstood, leaving the dominant technocratic model with a central presence in the space and unchallenged. The study highlights the importance of confidence and faith in normality, leading to safety and credibility in supporting a physiological approach to labour and birth.

Confidence in Normality

Confidence and faith in supporting a physiological approach to birth was found to be important to supporting normality within the literature. Studies which illuminated this confidence related to primary birthing; midwives birthing in primary birthing units or in the woman's home. In contrast, research in relation to midwives' experience of supporting a physiological approach to birth within hospital settings focused on strategies to support confidence and faith in normality.

Hunter, Smythe, and Spence (2018) explored what enables, safeguards, and sustains midwives to provide labour care in freestanding midwifery-led units. This hermeneutic phenomenological study was undertaken in the Auckland region of New Zealand and involved in-depth interviews with 14 participants who were involved in providing midwifery care/antenatal obstetric consultations in midwifery-led units: eleven midwives and three obstetricians. The authors found that collegial support from midwifery and obstetric colleagues, and a shared confidence in women labouring in

midwifery-led units, both enabled and sustained midwives to feel confident in supporting physiological birth. The congruence of the midwives' philosophy and faith in normal birth was also fundamental to this support and strengthening of confidence. Hunter et al. (2018) demonstrated that the teams held confidence and faith in physiological birth together, both midwives and obstetricians, strengthening this belief system and bringing a feeling of safety in relation to primary birthing. This study brings into question whether perhaps working in hospital facilities impacts on practitioner's confidence and faith in physiological birth. In their findings, Hunter et al. showcase the centrality of trusting relationships and shared philosophies in relation to physiological birth for underpinning a collaborative confidence. At the core of this, midwifery knowledge was evidently trusted and respected by midwives and obstetricians working in these primary maternity settings.

A study by Hunter and Segrott (2014) suggested a greater dissonance in relation to confidence and faith in a physiological approach to birth amongst the hospital maternity team. Hunter and Segrott write about the implementation and evaluation of a clinical pathway for normal labour in Wales, UK. This evidence-based pathway was used only by midwives while providing midwife-led intrapartum care to low-risk women, and the aim of the pathway was to reduce unnecessary interventions and support physiological birth. The pathway legitimised a midwifery philosophy and model of care which anticipated normality and supported the woman's physiology to lead. As a result, the researchers found that midwives felt supported to adopt a more patient approach to labour care and became more confident in challenging a technocratic approach to intrapartum care. Midwives in the study felt protected, supported, and more autonomous. The authors write that the pathway made visible the midwives' authoritative knowledge in caring for low-risk women and redefined the midwifery-led space.

This brings further into view the challenges that midwives can face in relation to supporting physiological birth amidst a technocratic model and culture, and the need for support, visibility, and credibility of a physiological approach to care. The pathway evidently helped midwives to feel safe in supporting physiological birth and validated their decision-making. A focus on and anticipation of normality could not only keep physiology and normality central but may also help practitioners to identify and 'see' normality amidst a risk-based culture in hospital facilities. These studies also raise an

important question about the way in which practitioners work together within 'place' and how this could be central to their experience of supporting physiological birth.

The Meaning of Midwifery

Midwives being able to practise autonomously within 'place' was a key theme in relation to supporting physiological birth which continued to present itself in the literature. The studies examined below were conducted in a range of countries which are likely to have differences in their models of maternity care, yet the core findings which related to midwifery autonomy had many similarities.

Nilsson, Olafsdottir, Lundgren, Berg, and Dellenborg (2019) undertook a mixed methods study drawing on ethnographic methods to better understand the meaning of midwifery practise in a hospital birthing setting. The study was conducted in Sweden prior to the introduction of a midwifery model of care. The results identified that midwives in this hospital facility provided care in a 'field of tension'. This prevented them from acting autonomously and left them in doubt of their knowledge and skills and with an ambivalent relationship between midwifery, medicine, and the institution. Midwives in this study questioned whether they were practicing 'real midwifery' or instead complying with the institutional demands and technocratic model of care. They were concerned that the model of care created a disconnect between the midwife and the woman. Results showed that the technocratic model of care dominated the environment and the atmosphere in the birthing facility, and regulated midwifery practise with its overriding 'presence'.

Although this study (Nilsson et al., 2019) was done in a different country and possibly within different model of care, it identifies that midwives and midwifery care may be compromised when working within an overriding technocratic, obstetric-led model. It seems that sometimes midwives are working *within obstetrics* rather than *alongside obstetricians* influencing the professional dynamics and also practise. Nilsson et al. (2019) identified that the resulting dissonance left midwives feeling powerless, questioning their knowledge and skills, and complying with facility demands. This is suggestive of a power imbalance, and perhaps an undervaluing of midwifery and midwives.

An Australian study by Catling and Rossiter (2020) brings this notion closer to home, reflecting a similar model of care to New Zealand. The authors conducted a national

survey of Australian midwives used a mixed method design to examine the influence of workplace culture on midwives' perspectives of their profession and their capacity to provide woman-centred care. A total of 322 midwives shared their experiences of workplace culture via an online survey and 23 midwives were interviewed. Participants worked in a variety of maternity settings throughout Australia, both primary birthing units and hospital maternity facilities. Findings showed that midwives and midwifery were compromised by staff shortages and the dominant technocratic, overwhelmingly medically focussed, and hierarchical model. This influenced midwives' ability to 'be a midwife', minimised the importance of midwifery care, and led to midwives feeling powerlessness in their workplace.

Kirkham (2009) wrote:

> The privileging of technology over care is evident throughout health care and much of the discourse of modern nursing and midwifery demonstrates how status comes with technical rather than caring work. If time is limited, it is the technical rather than the caring work which must be done. (p. 232)

Kirkham's words resonate with the findings of the studies by Nilsson et al. (2019) and Catling and Rossiter (2020), suggesting that it is the perceived importance associated with providing technical care as opposed to caring work which results in its elevated status: 'doing to' the woman rather than 'being with' or 'not doing' holding greater importance. Considering that a fundamental part of supporting physiological birth is well understood to be 'being with' the woman, this prioritisation and greater credibility associated with 'doing to' the woman is a significant barrier to supporting a physiological approach to care.

These studies indicate that within an obstetric led hospital facility, technocratic care is perhaps more highly valued, and may also be perceived as equating to greater safety. Whilst this may be the case for women who have more complexities, applying it to women where it is not clinically indicated can represent a risk and is a barrier to supporting physiological birth. As this care due to its prevalence is likely to be what is 'visible' in the birthing place, this is likely to further normalise and validate it. Within the studies by Nilsson et al. (2019) and Catling and Rossiter (2020) is also a feeling that midwifery care may not be understood to be as credible as technocratic care in the hospital setting, concerningly disconnecting midwives from women and woman-

centred care. Perhaps this is not simply a result of the technocratic model, but instead a product of a hierarchical maternity model which could leave midwifery undervalued, under-represented, and under-seen.

A discussion paper called 'Watchful attendance' during labour and birth by de Jonge, Dahlen, and Downe (2021) illuminates the lack of visibility of 'being with' the woman during labour and birth, 'taking time', and the dynamic of care that this encompasses which is well understood to be an essential component of supporting normality. Instead, what is often visible in organisations is the monitoring and 'doing to' care that is recorded and accounted for, such as labour and birth interventions, pain relief, examinations, CTG interpretation. The authors propose that 'being with' the woman, all that this represents in terms of presence, support, ongoing holistic assessment of wellbeing and responsive individualised care, should be referred to as 'watchful waiting'. This term incorporates the continuous support, clinical assessment, and responsiveness. Giving this holistic midwifery care a name could help to legitimise it and make it more visible, more easily referred to, documented, measured, and accounted for.

This evidence suggests that the prominence and position of midwifery and midwifery care within 'place' matters in relation to supporting a physiological approach to care. Midwives are the guardians of normal birth. The body of evidence suggests that midwives may be more able to be 'guardians of normality' in places where midwifery philosophy is central.

Closing Thoughts

The literature suggests that 'place/space' and all that it represents for practitioners in relation to supporting physiological birth is multifaceted. It points towards 'layers' of barriers and enablers within 'place' to supporting a physiological approach to labour and birth, from the environment to how practitioners 'feel' and what could shape their perspectives and practises. This literature review incorporated both national and international studies, and despite likely differences in models of midwifery and maternity care, findings point to many similarities in terms of the influence of 'place' in relation to supporting physiological birth. This review suggests that 'place' influences how time, risk, and safety is understood, and what is valued and credible within 'place'.

Whilst this exploration of the body of evidence has generated a better understanding of the phenomenon, there are some gaps in the literature which raise further questions. The quantitative studies provide very good evidence that 'place' influences birth outcomes, but these do not capture what elements of 'place' represent barriers or enablers to midwives and obstetricians supporting a physiological approach to labour and birth. There are pockets of evidence from qualitative and mixed methods studies pointing towards what may be influencing practise within the birthing place, but it is difficult to put together the 'big picture'.

Very few studies focus on the relationship between the birthing environment and practise. The literature on how 'place' makes midwives feel is thought-provoking and could be central to their practise, but evidence is very limited in this area. Furthermore, most of the available studies about birthplace focus on the perspectives and practises of midwives; little is understood about how place influences the practise of obstetricians, or how this influences interdisciplinary relationships and collaborative decision-making. The available literature illuminates the importance of developing a better understanding of how 'being-in' the birthing place and interacting with the place as the here-and-now mooded space influences how midwives and obstetricians' practise in relation to supporting physiological birth. Capturing how they experience birthplace would bring the phenomenon of 'place/space' closer into view.

Chapter Three: Methodology

> To take on phenomenological hermeneutics is to engage in an experience of thinking, that seeks to begin to reveal the phenomenon in question from its hiddenness. (Smythe & Spence, 2020, p. 2)

Introduction

This hermeneutic phenomenological research study seeks to uncover midwives' and obstetricians' experience of 'place' in relation to supporting physiological birth. The study needed a philosophical approach that would facilitate the uncovering and revealing, and the interpretation of meaning. It was 'place' which I sought to bring closer into view in relation to how practitioners are able to support physiological birth. The methodological assumption is that as midwives and obstetricians interact with 'place', an understanding about how this phenomenon shapes their practise develops. My specific interest relates to how they go about (or are constrained from) supporting a physiological approach to labour and birth. The nature of my research question, therefore, led me to hermeneutic phenomenology.

Phenomenology seeks to uncover meanings about everyday human lived experiences (van Manen, 1997). Van Manen (2014) wrote that phenomenology is "in some sense, always descriptive and interpretive, linguistic and hermeneutic" (p. 26). In other words, lived experience is told in the form of stories or 'opinions-about' becoming text, which is then interpreted in the manner of hermeneutics (Gadamer, 1982). Hermeneutics is the interpretation of text (Gadamer, 1982). Hermeneutic phenomenology is about 'questioning' of the data rather than 'answering'; acknowledging that the act of reflecting, pondering, and querying is what leads the researcher to insights (van Manen, 2014).

Hermeneutic phenomenology allows the researcher to uncover meanings within lived experiences which may have been hidden, or not recognised. It may be that we are so close that we cannot see it, or perhaps it is taken for granted. Phenomenon simply means that which appears (van Manen, 1990). This methodology recognises the relationship that the researcher already has with the phenomenon itself. As a researcher and a practising midwife, I brought lived experience of practising within many maternity birthing facilities to the research. There was an ongoing challenge to be open to my own prejudices (Gadamer, 1982) as I interpreted the experiences of others.

Gadamer (2007) contended that

> the practical science directed towards this practical knowledge is neither theoretical science in the style of mathematics nor expert know-how in the sense of a knowledgeable mastery of operational procedures (poiesis), but a unique sort of science. It must arise from practice itself and be related back to practice. (p. 231)

My interest is very practise focused. In my current role as a midwifery leader, I am part of a team seeking to maximise opportunities for physiological birth within a hospital maternity facility. I appreciate that first there needs to be understanding before change can be initiated. My aim is for this hermeneutic phenomenological study to bring forth insights that will help guide practise initiatives.

In this chapter, I outline the hermeneutic phenomenological approach which underpins and guides this research; and introduce the two main philosophers—Heidegger and Gadamer—whose philosophical notions have been drawn on throughout this study. Their philosophies and philosophical notions are interwoven throughout the research, from the research question, through to the findings and discussion. These are ever-present and a fundamental part of methodological congruence. Further information is written about philosophical notions during this thesis as they relate to the text.

First, a Side-Track

Initially, my intent was that my research would have an appreciative inquiry (AI) lens to keep a focus on what works well, or could work well, in relation to supporting normality. Appreciative inquiry is based on a social constructionist orientation to meaning and reality. It is a strength-based methodology which aims to affect change in organisations. It facilitates inquiry, imagination, and innovation seeking to uncover 'what gives life to an organisation' and to strengthen capacity for potential (Cooperrider & Whitney, 2005). Central to AI is the notion that a problem is discussed in terms of the solution rather than the inquiry being problem orientated (Watkins, Mohr, & Kelly, 2011). It is an inquiry into the 'positive core' of an organisation, a process that harvests collective wisdom, builds energy, and shifts analysis from problem to positive (Cooperrider & Whitney, 2005). Negative experiences are also embraced, because they motivate improvement; excluding such experiences completely can reduce participant engagement (Bellinger & Elliott, 2011).

The discovery phase of AI focuses on what has worked well in people's experience. The 'dream' phase data seeks to bring forth a vision for further improvement. I began this research with a belief that using hermeneutics and an AI lens would develop understanding of the participant's experience; whilst at the same time uncover positive elements that could be used instrumentally in facilitating change. As I began interviewing, it quickly became apparent that participants simply wanted to tell me their stories which were not always positive. While there were some stories that were 'appreciative' most were simply the stories of everyday experience. I came to see that it was prudent to stay focused on their lived experience, and not attempt to expect that research process itself would bring forth change. Thus, I put aside the expectation of enacting an AI approach and, instead, became more focused on the phenomenological interpretation of lived experience.

Within this re-focus came the possibility of bringing a specific critical lens. It seemed that many of the stories were about conditions of 'place' that constrained practise. I considered the philosophical lens of Bourdieu (Grenfell, 2010), exploring such concepts as 'habitus' (the taken-for-granted social practises), 'field' (the social site of practise), 'capital' (the power at play in terms of influences such as economics, culture, symbolic, social), and doxa (that which goes without saying). My hesitation is that such concepts bring assumptions that the issue is one of social construction based on power and vested interest. I wanted to focus this study at a more primordial level and first hear the stories of lived experience. That said, I believe that a follow up study drawing on Bourdieu would be valuable. Meanwhile I became committed to a hermeneutic phenomenological approach.

The Philosophers

I will now introduce the two philosophers, Martin Heidegger and Hans-Georg Gadamer, on whose works I have drawn.

Phenomenology and Martin Heidegger

Martin Heidegger [1889-1976] was a German philosopher. He was a student of Edmund Husserl, who is considered to be the founder of phenomenology. Heidegger achieved his doctorate in 1913; then working as Husserl's assistant. Husserl criticised the positivist sciences and proposed a focus on 'the things themselves' and human lived experience of the world (Cohen, 1987). Contrary to Husserl's beliefs that the researcher

could interpret human experience objectively whilst remaining a detached observer, Heidegger (1927/1962) believed that the researcher is already 'in the world', and what the researcher brings in terms of their experience, understandings, and interpretation of the world cannot be simply put aside. Heidegger's main work, '*Being and Time*' was first published in 1927, and translated into English in 1962. In this work, Heidegger sought to explicate an understanding and meaning of 'Be-ing', of humanness.

Heidegger (1927/1962) took the focus of his phenomenology towards lived experience, and the meaning that lies within it in relation to phenomena. He believed that phenomena are often concealed from view, unnoticed, or disguised; in using phenomenology the phenomenon must be allowed to "show itself in itself" (Heidegger, 1996, p. 28). Heidegger suggested that we may only see hints or clues of the phenomena, which take us closer to 'seeing' and understanding it, but it may not reveal itself fully; something of the phenomena remains hidden. Heidegger (1927/1962) cautioned that the phenomenon may also reveal itself as something which does not reflect what it really is.

Reflecting on, and searching for meaning within, midwives' and obstetricians' lived experiences of 'place' will help to peel back the layers covering the phenomenon, seeking what is there but hidden. In relation to this study, the phenomenon may show itself in how midwives/obstetricians feel about 'being in' the birthing place, what they describe themselves being directed towards, how they stay attuned to labour progress. For this research, there is likely to be a complex and multifaceted interplay between the phenomenon of 'place' in relation to supporting physiological birth and midwives/obstetricians as they interact with the birthing place, and with each other. The study aims to capture this complex interplay within participants' stories of their lived experience of 'place'. The diversity of participants and their roles will further help to allow the phenomenon to reveal itself more clearly and 'be seen'. Key notions will now be discussed.

Being-in-the-world

Heidegger essentially searched for the meaning of 'Being' (ontology). Lived experience or encounters whilst 'being in' the world hold clues about, or glimpses of, phenomena. Heidegger (1927/1962) referred to the notion of 'Dasein', which means 'being human', 'being-in-the-world', 'existence' or one's 'place in the world'; and emphasised how

humans are always situated in the world. Dasein refers to *our way of existing* or 'being' rather than *what we are* (Zuckerman, 2015).

Heidegger (1927/1962) wrote about Dasein as being our 'situatedness' in the world. With Dasein, comes all that the person brings with them in terms of their history of 'being', experiences, perspectives, and understandings. These are the horizon, or vantage point, from which we 'see' and understand our world, and they contribute to our understanding of meaning in relation to our world. We are always already in the world existentially and it is only by 'being in' the world that we can find meaning, but Dasein gets lost or becomes hidden or disguised in the everydayness of being (Heidegger, 1927/1962). According to Heidegger, whilst we are 'in' the world, the horizon or vantage point from which we 'see' and understand our world carries our past experiences and understandings, and these contribute to our understanding of meaning in relation to our world.

Heidegger (1927/1962) recognised that we are not in the world alone, and that 'being-with' others is a fundamental part of Dasein. These 'others' that Heidegger referred to are those who set the rules or terms which Dasein must adapt to; what is considered to be important or significant to 'they' shapes how we experience the world in which we are in. This 'being-with' creates comparisons between one's understanding of oneself, and understanding of others in the world. Heidegger believed that one might see and understand oneself in terms of how one perceives the others see them. He also believed that 'being-in-the-world' with others results in Dasein adapting to the world in terms of what 'others' may require in relation to one's role, tasks, expectations, or use of equipment or environment.

Dasein and 'being-with-others' which exists within midwives' and obstetricians' experiences of their world of work supporting physiological birth will be brought to the research study. Midwives and obstetricians work as a team. The interplay between professionals, and between professionals and 'place', is likely to generate meaning in relation to 'place' and supporting physiological birth.

Being Authentic

Heidegger (1927/1962) talked about the notion of authenticity as when we are being ourselves; when we make, and own, our own choices and decisions. While he wrote of the authenticity that comes when we face our own death, something we can only do for

ourselves, the notion of stripping away all pretence is relevant to everyday life (Heidegger, 1927/1962). When we are 'in' the world, sometimes the influence and control of the 'others' results in a person lacking authenticity as a result of being-in-the-world. Midwives' and obstetricians' being authentic or inauthentic is influenced by their experience of 'place' and the 'others' within the birthing place. This shows itself both in relation to pressures that are experienced and the influences that dictate how they are able to practise. Heidegger wrote of how social norms bring about behaviour that reflects what is expected of one, rather than what one would authentically choose for oneself. Thus, there are influences on how one is able to practise, and how practitioners feel about themselves within 'place'.

Attunement

Dasein, or 'being in' the world, is always attuned, which 'sets a tone'. Attunements may be felt within a mood or atmosphere; or an emotion, which is a shared phenomenon rather than being a personal feeling (Heidegger 1927/1962). Heidegger (1927/1962) posited that "Existentially, attunement implies a disclosive submission to the world, out of which we can encounter something that matters to us" (p. 177). He wrote that attunements can make it possible to "direct oneself towards something" (Heidegger, 1927/1962, p. 176).

In relation to this research study, midwives and obstetricians are all already 'in' the world within 'place'. They are attuned to a 'mood' in the birthing place which will be directing them towards something, and influencing their practise. This could be, for example, the philosophies within 'place', facility culture, fear, or a particular atmosphere. Attunements cannot be 'seen' as such; they are experienced. It is the story that reveals how attunement led to action (or not). Attunement is also key to understanding each woman's labour. It goes beyond the measures of progress to discern more subtle cues.

Temporality

Heidegger referred to lived or experienced time as 'temporality'. For Heidegger, time sits centrally to our situatedness in-the-world. According to Heidegger (1927/1962), time is the horizon, or vantage point, for understanding our being-in-the-world, and for Being to be meaningful. He wrote about time being understood in relation to Dasein as being purposeful; for the sake of something, or for the potentiality of being of Dasein,

which refers to our practical engagement with phenomena in the present. Heidegger talked about temporality as having three dimensions: future, past, and present; and believed that this represents meaning of temporality better than linear 'clock time' or 'world time'. Time, according to Heidegger, is 'already there', we step into it when we are 'in' the world.

In relation to this study, time could be 'felt' or experienced differently depending on the practitioner's experience of 'place'. Time can feel 'against one', bringing a feeling of needing to hurry, or can feel 'too slow' as one waits for emergency assistance.

Spatiality

Heidegger (1927/1962) referred to the notion of existential spatiality in terms of how we experience the spaces which we are 'in'. This is closely linked to temporality in relation to our 'situation'. Heidegger's philosophy of place and space depicts space as not being neutral; it has 'already there' meanings which give context and meaning to all that is present and available in the space (Catena & Masi, 2017). Malpas (2006), in his writing about Heidegger's notion of existential spatiality, explained that the characteristics, orientation, ordering of things, and the potentiality of ourselves and how we relate to the world around us, are shaped; our existence is spatial. Heidegger referred to a 'nearing' of things, which is not purely in relation to spatial distance; rather, a bringing closer, or a bringing into light in terms of attention, being 'seen', and degree of importance (Malpas, 2006).

According to Heidegger, all human engagement with the world is 'located and orientated'; thus, fostering a particular mode of spatial engagement. We must be orientated in-the-world in order to be capable of action or involvement, and this requires a space to disclose itself in terms of its meaning and purpose, creating a "sense of space… [an] emergence of the world" (Malpas, 2012, p. 120), which incorporates both subjective and objective understandings of it. Heidegger believed that this orientation and sense of space is also influenced by the capacity of the agents themselves in relation to how their relatedness to the world is shaped (Malpas, 2012).

In spite of the centrality of the notion of spatiality in shaping how we relate to the world that we are 'in', spatiality is often 'unseen' or concealed (Malpas, 2006). In relation to this research study, how practitioners 'felt', perceived, practised, and what they were 'directed towards' in the space, all contained meaning in relation to the phenomenon.

The space in which the practitioners were 'in', 'set the scene' in terms of messages which could influence their practise and how things were 'seen' or understood. These notions lie at the heart of my study.

Hermeneutics and Hans-Georg Gadamer

Hans-Georg Gadamer [1900-2002] was a German philosopher of the 20th century, and a student of Martin Heidegger. He wrote '*Truth and Method*' which was first published in 1960. His philosophical hermeneutics is an interpretive method of exploring, interpreting, and 'coming to understand' the meaning of human experiences—expanding on the work of Heidegger (Paul, 2012). According to Gadamer, understanding is interpretation and interpretation understanding, with language being the medium for sharing and understanding human experience (Paul, 2012). Gadamer had a strong emphasis on dialogue and believed that it is within conversations that new understandings are spoken, heard, and understood (Moules, McCaffrey, Field, & Laing, 2015).

Hermeneutics simply means to analyse and interpret text; and is underpinned by an interpretivist theoretical perspective which aims to understand human and social reality (Crotty, 1998). Within this interpretivist approach, researchers seek culturally and historically situated interpretations of the social world (Crotty, 1998). The notion of aletheia, or 'the event of concealment and unconcealment' is at the core of hermeneutics; this happens when something reveals itself or is revealed by the process of interpretation (Moules et al., 2015).

Gadamer's philosophical approach relates well to this research because it focuses on explicating the professional experiential knowledge of the significance that place has in relation to supporting physiological birth. Midwives' and obstetricians' experience of place is very much embedded in the human world. Using this human science, an interpretive approach will uncover that which is often unspoken or taken for granted.

Hermeneutics does not represent a prescribed procedure for understanding; rather, offers a philosophy which exemplifies the conditions needed for understanding to take place (Kinsella, 2006). In *Truth and Method* Gadamer (2013) articulated a philosophical approach that showed the conditions that facilitate new understanding: prejudice, fusion

of horizons, and the hermeneutic circle. I will outline these hermeneutic concepts below.

Historicity and Prejudice

"The very idea of a situation means that we are not standing outside it and hence are unable to have any objective knowledge of it. We are always within the situation" (Gadamer, 1960/1982, pp. 268-269). Gadamer believed that tradition and history are core to our understanding (which exists in language), and the way that we perceive this is in relation to our current understandings (Crotty, 1998). "Our historical consciousness is always filled with a variety of voices in which the echo of the past is heard" (Gadamer, 1975, p. 285). In this research, the participants' experiences are framed within tradition and history which may bring cultural and power influences that shape their horizons. This also applies to me, as the researcher, as my understanding is also situated. Thus, it was important to share my preunderstandings in Chapter One.

Hermeneutics recognises that all understanding is situated; the interpreter is not objective but, instead, is 'sympathetically engaged' with the author of the text (Kinsella, 2006). Van Manen (1990) noted that the researchers' pre-understandings and knowledge about the phenomenon is one of the challenges of phenomenological inquiry, although this is also understood to be one of its strengths. According to Gadamer, the interpreter, along with their interaction with, and understanding of, the world, is central to the interpretation (Thirsk & Clark, 2017). This a priori knowledge brings depth to the exploration; a careful balance is built between what is already believed and what new insights could be uncovered and understood (Thirsk & Clark, 2017).

Gadamer (1960/1982) suggested that "recognition that all understanding inevitably involves some prejudice gives the hermeneutical problem its real thrust" (p. 239). Prejudices are required in order to expose what is to be understood (Gadamer, 1975). Gadamer (1960/1982) emphasised that although the researcher 'brings themselves' to the research (along with their tradition and history), and objectivity is not possible, the researcher must continually acknowledge their pre-understandings and bias (fore-structure) as part of the interpretive process. The situatedness of the researcher is, therefore, critical to the interpretive process and the development of understanding—but, the researcher must be reflective.

Fusion of horizons

The notion of the fusion of horizons situates the researcher within the study. Hermeneutic inquiry aims to develop new understandings with a fusion of horizons of the text and the interpreter, and the horizons of the past and the present (Crotty, 1998). According to Gadamer, the 'miracle of understanding' occurs when the interpreter has captured the author's meaning within the text and included their own comprehension of this meaning. Known as the 'fusion of horizons', this describes how new and old understandings merge under a new horizon (Austgard, 2012). Gadamer (2013), however, cautioned about the importance of remaining open to 'newness' within the text in order to 'see' and understand the phenomenon from the participants' perspective.

Applying this notion to the research study allowed me to use my 'range of vision' to better 'see' and understand the participants' range of vision, and what informed this vision as seen in their lived experience of the phenomenon. This extended the horizons past what was near or obvious, and helped me to look beyond what could be seen with an open attitude to what remained unconcealed.

The hermeneutic circle

The hermeneutic circle is central to hermeneutic understanding and refers to a continuous interplay of interpretation in the search for meaning. It was described by Crotty (1998) as "understanding the whole through grasping its parts and comprehending the meaning of parts through divining the whole" (p. 92). It is an interpretational movement which shifts from looking at the meaning of the entirety of the text, to the parts of the texts, and back to its entirety (Austgard, 2012). In other words, the researcher moves back and forth between interpreting particular parts of the text and interpreting the 'overall'. New details of the parts add to and build the overall interpretation, which in turn can highlight further 'parts' as significant; this circle of interpretation leading to a richer understanding of the phenomenon (Drefyus, 1991).

Engaging with the hermeneutic circle is a search for understanding; a constant process involving the interpreter being aware of their own pre-conceptions alongside being open to the text, developing a new understanding of meaning (Paul, 2012). Gadamer (2013) wrote that the hermeneutic circle has no beginning or end and is ever moving, with movement of understanding shifting from the whole to the parts, and back to the whole; the researcher staying open to the 'newness' of the text in searching for meaning.

The notion of the hermeneutic circle informed my thinking and 'gave me permission' to be dynamic in this thinking and in my relationship with the data—to move from the parts to the whole, ponder, question, be open to surprises, allow understanding and meaning to expand grow and develop. It represented an authority for creativity whilst remaining congruent with the methodology, which generated richness in the research findings.

Heidegger's Connection with the National Socialist Party

It is important to acknowledge Heidegger's controversial connection with the Nationalist Socialist Party (NSP). I had some initial concerns as to whether this may have influenced his philosophies and will outline my exploration of literature about this connection and some perspectives that have been argued about its significance. Heidegger's involvement in the NSP is well documented. When Heidegger became Rector of Freiberg University in 1933, he also joined the Nazi party (Wolin, 1990). Heidegger's support at this time may have represented kudos for the party, as the first Nazi Rector of Freiburg University (Koonz, 2013). According to Wolin (1990), Heidegger's support of the Nazi party was complex, and the party may have been seen at the time as reflecting an anti-modernist view, with which Heidegger resonated. Wolin goes on to state that there was propaganda written by the NSP which made reference to 'Dasein' and 'Being' in a revolutionary way, supportive of protecting these notions, which was misleading.

Gadamer (1994) cautioned that it is important that we situate Heidegger's political connections, believing that the mood in Europe at this time may have been significant. Further, Thomson (2005) wrote that Heidegger believed that a radical change in the university, raising the profile of philosophy, may have resulted from the works of the NSP. When he came to realise the nature of the Nazi party, Heidegger withdrew his support, expressed in an interview, magazine article, and his refusal to eliminate the university library of books by Jewish authors (Schalow & Denker, 2010). However, Heidegger's '*Black Notebooks*', published in 2014, contained notes on his thinking from 1931-1941; some of which is felt to have an anti-Semetic nature (Escudero, 2015). Although Heidegger did not make any kind of public apology for his connection with the Nazi party, there are glimpses to be seen that he refuted this political orientation. Heidegger publicly condemned the racial hatred towards the Jews, and helped some Jewish colleagues and students (Wolin, 1990). Wolin (1990) also wrote that Gadamer

argued that Heidegger's political mistakes were not in any way linked with his philosophy. It is important to acknowledge this connection, undoubtably of concern, but we must also acknowledge that we have only been presented with part of the picture. I made a decision to remain attuned and vigilant, and have not seen or felt any evidence of this political connection in the works of Heidegger that I have read and used in this thesis. His focus on lived experience kept me interested in exploring his writing for it brought me insights that enabled me to ask more thoughtful questions of the data.

Summary

In this methodology chapter, I have discussed the philosophical notions and philosophers that underpin and guide this research study. I have shown how I have used these notions to create the conditions for understanding to take place, and aid the process of interpretation and search for meaning. I have positioned myself as the researcher within the study as a key, reflexive, part of the interpretive process. The next chapter will show how the methodology has informed how the research study was conducted, and the research methods will be outlined.

Chapter Four: Methods

> Phenomenological method is driven by a pathos: being swept up in a spell of wonder about phenomena as they appear, show, present, or give themselves to us. In the encounter with things and events of the world, phenomenology directs its gaze towards the regions where meanings and understandings originate. (van Manen, 2016, p. 24)

Introduction

In this chapter I will describe the methods that were used to conduct this hermeneutic phenomenological research study, in the search for meaning related to midwives' and obstetricians' experience of 'place' in relation to supporting physiological birth. Hermeneutics does not represent a stepped linear process towards understanding; rather, offers a philosophy which exemplifies the conditions needed for understanding to take place (Kinsella, 2006; van Manen, 2007). This chapter will, therefore, build from the methodology discussed in Chapter Three which lays the philosophical foundations, facilitating these conditions for the research.

Gadamer (2001) cautioned that "Applying the method is what the person does who never finds out anything new, who never brings to light an interpretation that has revelatory power" (p. 42). This research study is concerned with lived experiences of supporting normality, about 'being-in' the particular world of a birthing facility. The phenomenon is complex and dynamic; and the methods used in this study reflect and accommodate this human complexity.

Ethical considerations

Approval for this research study was gained from Auckland University of Technology Ethics Committee (AUTEC) (Appendix A) and allowed me to recruit up to 15 participants (midwives and registrars) working in the greater Auckland region. A further application to AUTEC approved an amendment to recruit consultant obstetricians as participants in the study.

The principles of the Treaty of Waitangi have been interpreted in a manner that acknowledges and affirms the ethical understandings of both Māori and Pākehā (meaning other) New Zealanders (Hudson & Russell, 2009), as required for any research undertaken in New Zealand. Although this research study does not focus

specifically on Māori health outcomes, all research can have an impact on Māori. Therefore, at the heart of this research, and throughout the process the guiding ethical principles of partnership, participation, and protection were embodied (Hudson & Russell, 2009).

Partnership

Partnership refers to working with Māori to ensure that the rights of Māori are respected and protected. Consultation with Nga Maia (the Māori midwifery group within the New Zealand College of Midwives) occurred prior to commencing the research study. Participants were able to bring their whānau to the interview if this was their preference. Participants' experiences and perspectives were gifted to the research. The place of interview was chosen by each participant to suit their needs. Using semi-structured interviews to collect the data, I worked in partnership with participants, exploring their practises and perspectives. The research topic was a meaningful one for all participants involved, and the chosen methodology meant that the participants' voices were very much heard. A small gift was offered to all participants as a koha—a token of my appreciation and respect.

Participation

This second ethical principle embodies the involvement of Māori in the research process, particularly if the research involves Māori. I aimed to purposively recruit Māori participants for my study. A Māori midwife was asked to act as an advisor, and had input throughout the study from recruitment. She was able to offer advice in relation to identifying key informants and acted as an intermediary during recruitment. Two Māori midwives elected to participate in my research study. Participation in this research study was completely voluntary. No participants had a line manager relationship with myself, the primary researcher. This study needed 'key informants'; however, it was essential that participating in the study had some benefit for the participants themselves.

Protection

The ethical principle of protection embodies the protection of the cultural rights of Māori in the research process and acknowledges the need for equity. The safety and comfort of all participants was paramount throughout the study. Participants were shown respect and valued for giving time to my study. There was no pressure for participants to answer questions with which they did not feel comfortable during the

interviews. Participants were free to withdraw from the research study at any stage prior to data analysis and were given the contact details of both of my supervisors should they have wished to do so. The crafted stories from the transcripts were returned to participants to enable them to change or withdraw any data.

Although harm to the participants was not anticipated, AUT counselling services were available should participants have experienced any discomfort or disturbance as a result of participating in the research. There was a potential for the interviews to bring up a previous negative experience that the participant had encountered, although this information was not purposively sought. The counselling service was not required.

It was essential to protect participants from being identified, as well as their practices and facilities in which they work. Participants may have discussed suboptimal elements of either their own practises or that of others; thus, confidentiality was guaranteed. It was possible that the data may have revealed negative elements of facility culture within individual maternity facilities; hence, it was important that the facilities themselves were not identified or identifiable within the research data. Pseudonyms were used for participants, practices, and maternity facilities. Participants were also given the opportunity to delete or change any information from their crafted stories if they wished.

Although highly unlikely, there was a potential for participants to talk about and disclose identifiable information about women in their care. All participants were reminded at the beginning of their interview not to disclose any names or identifiable information, and the utmost care was taken to stop any such discussion during the interview. These are health professionals who are well versed in protecting confidentiality, so although this was a possibility that needed to be carefully considered and protective measures implemented, I felt confident that participating in this research would not represent a threat to privacy.

As per AUTEC requirements, all data collected during this research will be kept electronically for six years; electronic data were downloaded to an external storage device and stored securely. Further, all data collected during this research was stored securely on AUT premises in a location separate from participant consent forms.

Recruiting Participants

During the study, I worked in an Auckland maternity service and had some insight into the various 'places' of practise. Through my professional networks I knew a wide number of midwives and obstetricians who worked across these different places. Potential participants were approached by a colleague acting as an intermediary and asked if they were interested in taking part in the research. An intermediary was used to reduce any risk of potential participants feeling coerced to participate. If they were interested in taking part in the study, they were then asked to email myself, as the researcher. A participant information sheet was provided to aid informed consent (Appendix B). The study group was selected ensuring that they represented the recruitment criteria for the study. The recruitment process was successful, with an overwhelming majority of potential participants who were approached agreeing to take part in the research. None of the participants withdrew during the study.

Purposive sampling

Sampling in qualitative research is central to the quality of the study (Cleary, Horsfall, & Hayter, 2014). Participants were purposively selected for this research to ensure that 'key informants' were recruited. According to Patton (1990), "purposive sampling enables the researcher to identify information-rich cases, who can provide detailed insight for study in depth" (p. 169). Purposive sampling is used when the researcher has a-priori theoretical understanding of the topic, knowing that certain 'key informants' have an important perspective which will be of benefit to the study (Robinson, 2014). Participants who practised in a range of maternity facilities in the greater Auckland region (secondary/tertiary hospital maternity facilities and primary birthing units) were sought, and purposive sampling ensured that the following range of participants were recruited:

- LMCs (self-employed community midwives) from a range of demographic areas in the greater Auckland region who provide care to women in both primary birthing units and secondary/tertiary maternity units.
- Core midwives (employed by the hospital) who regularly work in the labour and birth unit.
- CCMs (clinical charge midwives in secondary/tertiary hospital maternity units) who regularly work in the labour and birth unit.
- Registrars/consultant obstetricians who work in secondary/tertiary hospital maternity units.

Participants were recruited in a successive manner in keeping with a hermeneutic phenomenological study. This technique allowed a continuous process of reflecting on each interview, which helped me to remain attuned to further questions and identify any gaps that would further uncover and enrich new insights and understanding. For example, an interview with a registrar identified the importance of involving consultant obstetricians in the research study. This interview showed that the influence of the consultant obstetrician was important in the way that the registrar practised in relation to supporting normality. Without including the perspectives of consultant obstetricians, I felt that a key piece of the 'picture' was missing. Interviews with core midwives, CCMs, self-employed community midwives, and a registrar were building understanding of their individual experiences of 'place' in relation to supporting physiological birth, as well as a growing holistic understanding of the phenomenon. A further application was submitted to AUTEC to include consultant obstetricians as participants; permission was gained and I went on to recruit two consultant obstetricians.

Introducing the Participants

In total, 12 participants who practised in the greater Auckland region were recruited for the study. These were midwives (hospital and community, and CCMs) who worked in a primary birthing facility, a secondary/tertiary hospital facility, or both. The LMC midwives (community) often have access agreements with more than one facility. Registrar and consultant obstetricians worked in hospital (secondary/tertiary) maternity facilities. My intention with the representation of participants was not for the research results to be generalisable, but to generate a rich understanding of 'place' in relation to supporting physiological birth. New understandings were generated from these different angles of vision in relation to the same phenomenon, and highlighted the complex interplay of relationships within 'place' which influence practise. Professionals in maternity do not work in isolation, they are interconnected and interrelated; capturing this was important. Obstetricians bring an important perspective because they work closely with midwives and this relationship is central to practise. Pseudonyms were used in this thesis for all participants.

Participant 1: Francesca is an experienced LMC midwife who mostly births in a hospital maternity facility, occasionally in a primary birthing unit.

Participant 2: Chloe is an experienced midwife who works in a rural location and births mostly in a primary maternity unit but continues to provide care to women in a hospital maternity unit when secondary care is required.

Participant 3: Harriet is a registrar who has practised obstetrics in more than one hospital maternity facility in the greater Auckland region.

Participant 4: Lara is an experienced CCM who regularly coordinates in the labour and birthing unit within a hospital maternity unit.

Participant 5: Holly is an LMC midwife with just over one year of experience who births at a hospital maternity facility and has recently worked in two other hospital units during her midwifery programme.

Participant 6: Emily is an experienced CCM who regularly coordinates in the labour and birthing unit of a hospital maternity facility.

Participant 7: Clara is an experienced LMC midwife who has mostly worked rurally as a homebirth midwife, but also has recently birthed in a hospital maternity facility.

Participant 8: Mia is an experienced midwife (who has also worked as a CCM) who regularly works in labour and birthing unit in a hospital maternity facility.

Participant 9: Isabel is a consultant obstetrician in a hospital maternity facility.

Participant 10: Aroha is a midwife who has recently qualified, working as an LMC midwife. She births in a primary birthing unit and also a hospital maternity facility.

Participant 11: Natalie is a consultant obstetrician who practises privately, birthing in a hospital maternity facility.

Participant 12: Hana is an experienced midwife who works as a core midwife in a hospital maternity facility.

Data Collection

It was important that participants chose a location/medium where they felt safe and relaxed to share their experiences and perspectives openly and honestly. Participants gave consent in writing (Appendix C) once they had been fully informed about the study and had the opportunity to ask questions prior to commencement of the

interviews. Data were collected using semi-structured, conversational individual interviews at a time that suited the participants. The location and method (face to face or Zoom) also reflected the preferences of the participants, with all participants choosing to meet face to face.

According to Morse and Field (1995), semi-structured interviews allow the participants the freedom to describe their experiences whilst ensuring that the researcher obtains the required data. Conducting the research interviews was a careful and considered balance between guiding the participant in relation to the research questions and allowing the conversation the freedom to flow and develop to 'ripen' and nurture possibilities for 'newness'.

Hermeneutic inquiry goes *behind* what is said and asks questions *beyond* what is said (Gadamer, 2013). It strives to uncover a new, or a different understanding (Thirsk & Clark, 2017). Gadamer (2013) referred to the notion of a 'genuine conversation' being one that is emergent and not pre-determined; having its own spirit, the language carrying a truth within it which allows meaning to emerge. However, whilst a good hermeneutic interview needs to be open to the 'newness', the interview needs to be conducted to keep the research question central (Moules, McCaffrey, Field, & Laing, 2015).

Interview questions were open-ended and reflected the hermeneutic phenomenological methodology. They aimed to capture the essence of the participants' experience of the phenomenon. Questions also reflected an appreciative inquiry lens or 'flavour' that with which the research study began. The questions drove the collection of rich stories, aiding interpretation and gaining new insights and understanding about the meaning of 'place' in relation to participants' experiences of supporting normality (see Appendix D for a list of indicative questions). Some questions were instrumental in uncovering the positive in relation to what worked well in practise. This focus provoked constructive dialogue and uncovered meaning within the participants' experiences to aid understanding and insight into the phenomenon about what worked well in practise. As the study progressed and I recognised the need to stay more phenomenological, my questions simply aimed to bring forth stories about trying to support physiological birth in a particular place. In some sense, 'place' disappeared for the participant as it was simply 'where they were'. It was my role as interpreter to 'see' the influence of the place in which they were working.

During some of the interviews, it was more challenging to maintain the appreciative 'flavour'. Some participants were very frustrated about their experiences of 'place', feeling that the maternity facility in which they were practising was not supporting them to support physiological birth. The difficulties experienced in relation to supporting physiological birth were central to dialogue in some interviews. Appreciative questions do not always need to be positive but need to have a focus on solutions if they are inquiring about the negative (Cooperrider & Whitney, 2005). Therefore, I heard what was not working well, prompted participants to expand about the barriers, and guided participants to consider what would work well. At times this led participants to consider what the ideal would consist of, and how their current situation could be improved, but most often they stayed storytelling. The choice to stay focused on the lived experience meant I relaxed my style of questioning and stayed attuned to the stories that were being told.

My aim was the generation of rich data within which the participants' experience of the phenomenon would yield a deeper understanding. During the interviews I remained focussed on the research question, heightened through stories that illuminated participants' experience of the phenomenon. I encouraged participants to 'delve deeper' when needed with additional thoughts, details of the experience, and perspectives. Moules et al. (2015) wrote that good research questions cannot always be answered immediately, and the participant may need time for reflection. When there were silences following a question asked during the interview, I sat comfortably with silence, providing the time for the participant to consider the question and reflect on their perspectives and experiences.

Obtaining 'enough' narratives

According to Smythe (2011),

> One reaches a state of 'knowing' that one more interview will be too many. Already the insights are emerging like a river of thought. To keep pouring in more runs the risk of overflowing the banks which somehow hold the thoughts in a coherent whole. (p. 41)

I set out to interview up to 15 participants, trusting that I would realise the upper limit when I found it. Following initial analysis of interview 12, it became apparent that the study was nearing completion. Fewer new insights were being seen, but existing

insights were being strengthened. To honour the existing participants with time to deeply explore their data I decided to stop the data collection.

Transcribing and returning data to participants

The interviews were digitally audio-recorded and transcribed verbatim, capturing non-verbal as well as verbal forms of communication. I reflected on the interview itself and the data following each interview. I wrote notes to go alongside the transcripts when I felt that non-verbal communication could be salient to meaning and may not have been captured by the recording.

The stories that I had identified as key to answering the research question, and that I planned to work with further, were sent back to participants for review. They were asked to identify any elements that they were not happy with, anything that they felt did not reflect what they intended to communicate, and anything that they would like to add. One participant provided additional information, but no data were changed by any of the participants.

Crafting stories

Data which stood out as being important to understanding participants' experience of 'place' in relation to supporting normality was highlighted and stories were crafted. Crowther, Ironside, Spence, and Smythe (2017) affirmed that stories are crafted from the data in order to explicate meaning and draw the reader to new understandings. Stories were crafted in this research using data which were key to developing understanding into the phenomenon and central to building new conjectures. The process itself was an important means of me dwelling with the data and pondering its meaning.

These stories principally used the participants' words verbatim, as their stories captured and showcased their experiences very well. The stories were therefore not returned again to participants for further validation. In crafting the stories, extraneous detail that did not add to the story, or information that could identify the participant, was removed. Sentences that repeated information were taken out. I now had the key stories for the research findings. The process of interpretation continued, and underlying meaning became more evident as my thinking and questioning process began to incorporate philosophical notions.

The Interpretive Journey

> Hermeneutic thinking is not something done in one's 'mind' in a logical, systematic manner. Heidegger suggests thinking already has a mood…we are already drawn to a particular part of the story; already sensing what matters; already overlooking the taken for granted. (Smythe, 2011, p. 44)

Hermeneutic phenomenology is not about what to do in the research process but about asking 'what is going on' within the data that we want to capture (Koch, 1998). Some philosophers argue that a prescriptive method of thematic analysis should not be applied to aid interpretation in hermeneutic research (e.g., Ho, Chiang, & Leung, 2017). According to Crowther, Smythe, and Spence (2014) a 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. However, it is important that the hermeneutic phenomenological researcher justifies the methodological consciousness that they used.

Although there is not a prescribed method for analysis of data in hermeneutic phenomenological research, there are key principles, as suggested by Moules et al. (2015), which I followed. The data should be transcribed verbatim and printed to assist sustained and tangible engagement with the data. As the data are read, notes—ideas, thoughts, questions—can be made on the transcripts. The researcher immerses themselves in the data; reading and re-reading, writing, and re-writing, reflecting, and noting significant interpretations. These reflections, insights, and interpretations were shared and discussed with my research supervisors throughout the process.

Thinking and interpretation occurred from the beginning of this study, developing the foundations for understanding; foundations that were continually built on throughout the research process. According to Moules et al. (2015) analysis is synonymous with interpretation in hermeneutic research, and runs throughout the research process from the data collection and threads, through all engagement with the data. In hermeneutic research, data analysis is divergent; it remains open to new understandings, uncovering interpretive conjectures about the phenomenon so that it can be seen differently rather than focusing on a single theme (Moules et al., 2015).

The non-linear iterative process in this research study was guided by hermeneutic phenomenological methodology and remained consistent with the underlying philosophy, although a space was consistently held for creative thought. It was in this

space where questioning and reflection were allowed to be creative with the data. This space was held for my thoughts to keep coming back and re-visiting the participants' words and re-consider the meaning that lay within and beneath them, until new understandings were developed.

I came to appreciate the nature of the hermeneutic way:

> To embrace phenomenological hermeneutics is to recognise that the insights one seeks lie 'hidden' in the telling of an experience and the interpretation of another's meaning. It is to take on the quest of uncovering, revealing, and bringing to light. To do that in a hermeneutic manner is to go by the way that takes-one-along. It is to question, to ponder, to dwell, to walk away into the openness that lets the insights come. (Smythe & Spence, 2020, p. 8)

Throughout the data analysis and writing process, I found myself immersed in an unfolding way, never quite sure where it was leading, but always sensing I was gaining new understanding. Interpretive insight and uncovering meaning within the participants' experiences seemed to happen in 'layers'. Once the stories were crafted, the process of writing and re-thinking, and re-writing began; each time the process itself fostered greater insight and uncovered and 'teased out' hidden meaning from the data. Re-writing is not simply polishing the text, but is a process of unearthing the meaning that sits within participants experiences, bringing this more clearly into view (Smythe, 2011). Interpretive conjectures and notions were considered on their own as 'parts', and considered holistically as a 'whole', building an ever-growing picture of the phenomenon.

During this process, philosophical notions, mostly from Heidegger and Gadamer, were explored and incorporated into the thinking process. These notions were a lens through which further meaning could be explicated and they drew out a deeper understanding of what was happening within the participants' experiences; the philosophy brought richness to the developing understanding. Crowther and Thomson (2020) referred to this process of deepening the interpretative analysis and surfacing meaning using the lens of philosophical writings/notions as an 'interpretive leap'. As my writing evolved following this leap, my interpretations revealed new illuminations and further questions for analysis. An example of my initial analysis process is shown in Appendix F, alongside the interpretation as written in the research findings (analysis deepened and gained greater clarity with the process of writing and re-writing).

Engaging in circling

Heidegger (2008) cautioned researchers not to settle for interpretation too soon as this could result in missing hidden meaning within the participant's experience. There is always a danger of first reflecting the researchers' own perspectives. Being immersed in, and 'sitting with', the data was central to the interpretation for this study. The process involved listening and thinking, writing notes, and reflecting on initial thoughts and notions. It facilitated reflection on my initial thoughts and pre-existing understandings, and was a catalyst for further questioning of the data and my thoughts. I was purposely very considered and patient, allowing notions to emerge from the data. Re-reading and further listening often brought additional understanding of the meaning lying within the data. A diary was kept of my early thoughts during this initial period of consideration which I continued to build on.

Crowther, Smythe, and Spence (2015) wrote that the phenomenological researcher becomes attuned to an emergent way of working with the data. Crowther and Thomson (2020) contended that during this time of immersion and reflection, the researcher attunes to what shows itself as being significant within the data in relation to the phenomenon; what surprises or inspires them or stands out. The researcher gets 'a sense of' the participants' lived experience of the phenomenon.

I initially experienced challenges with the lack of a linear process and realised that my search for meaning was being constrained. I felt that although new understandings were generated from the data, there was a barrier. Reflection with my supervisors helped me to realise that my desire to 'do it the right way' was a barrier to creative thought. I then came to fully comprehend and appreciate the centrality of hermeneutic methodology providing the conditions for understanding to take place. The creative space was initiated, strongly supported with the philosophical underpinnings, and these were a 'springboard'.

Once I trusted my understanding of the methodology and 'relaxed into this space', which allowed greater exploration and questioning of the data, my insights in relation to the meaning that lay within and beneath the data emerged. I became more comfortable with the creative tensions that were present throughout the interpretive process (and beyond). I 'allowed the data in', letting my questioning of the data dwell, standing back from it and understanding the essence, then going back to the stories and 'seeing' more.

I became comfortable with a degree of uncertainty and 'sat with it' until new understandings were comprehended, and with an acceptance that a 'completion' of understanding would not be reached. An important influence was putting aside my quest to bring a specific appreciative lens and, instead, letting the primordial experience reveal itself in a phenomenological manner.

I allowed myself to be present in the process, allowed my history and prejudices (whilst remaining continually reflexive) to meet the participants' words. I began to see how my midwifery experience and understanding of what the participants had themselves experienced helped me to work with the data. I could 'sit inside' the story and appreciate what was happening, whilst remaining reflexive and open to meaning that was not initially seen. Without fear of a lack of perfection I followed my thoughts and, as the words flowed, so did my questioning. Analysis of the data constantly led to further questioning which, at times, was driven by my pre-understandings and made me question these, leading to new and deeper understandings.

Moules et al. (2015) suggested that interpretation is enhanced by in-depth, reflexive discussion with the research team, and this was done with my research supervisors. Central to the interpretive process is the hermeneutic circle (as described in Chapter Three) which represents an ongoing process throughout the analysis. Davey (2006) described the interpretive process as encouraging a 'creative tension' between our own horizons and those that are different within the data. The 'fusion of horizons' was, therefore, central to the data analysis. Notes which captured ideas and possible meanings were taken during this interpretive process which helped the generation of interpretive conjectures.

Throughout the process of data analysis, reflexivity was a central tenet; it was foregrounded. I brought to the research my prejudices (pre-understanding) and horizons; my history, opinions that are shaped by my experiences, and my world view. According to Gadamer (2013), it is impossible for the researcher to be completely objective, but they must make explicit what has shaped their understanding. Assisted by my supervisors, I remained open to my prejudices and horizons being challenged or changed, and open to new understandings. Early in the interpretive journey there had been specific challenges at the hospital maternity facility where I work in relation to supporting normality. When I discussed my analysis and thoughts about the data with my supervisors, they recognised that the

experience that I had lived, may have influenced the way that I was 'seeing' the data. This was a real lesson regarding reflexivity, and was instrumental in helping me to understand and really 'feel' the point at which my pre-understandings aided the understanding of the data, and where they may have coloured it.

Identifying the key themes

There came a point when the findings chapters needed to be shaped. This followed a long season of dwelling with the data through interpretive writing of each story. Curiously, at the end of this process, I just knew where I needed to begin, and thus drafted the first findings chapter. The next followed, and so it went on. There was no logical method to this process (Smythe & Spence, 2020); rather, it was my way of telling the reader about the insights that had emerged, akin to telling my own story.

Establishing Trustworthiness and Rigour

"Rigour is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of the work" (Sandelowski, 1993, p. 2). Rigour and credibility are recognised when the research results are understood to be significant, plausible, and accepted within the field to which they relate (Gabrielsen, Lindström, & Nåden, 2013). Acknowledging that rigour is fundamental to all research, Sandelowski (1993) highlighted the important balance between achieving trustworthiness in the research and limiting the interpretive potential of the study. Sandelowski cautioned that focusing too much on rigour enhancing techniques during research can potentially restrict the creativity of qualitative research.

According to Moules et al. (2015) rigour in hermeneutic research does not reflect a strict methodical process but, instead, is a comprehensive attention to developing understanding about the phenomenon. Methodological and philosophical congruence was, therefore, central throughout this research study. 'Reflexive conversations' with my supervisors remained core to the interpretive journey. It was important for me to keep notes of my reflections, thoughts, questions, creative tensions with the text, and interpretive conjectures. These helped to make visible the process towards understanding, demonstrating rigour in the conduct of the research study.
De Witt and Ploeg (2006) described an appraisal outlining five criteria of rigour in phenomenological research studies on which I reflected during this study. These criteria are: balanced integration, openness, concreteness, resonance, and

actualisation. I will briefly outline these expressions of rigour and how they relate to this study.

Balanced integration

Balanced integration refers to the measures taken to ensure the creation of a rich, balanced, and integrated study with a consistency of concepts throughout the methods and findings. I have incorporated this criterion by ensuring methodological congruence throughout the study. I have shown that questioning, thinking, interpretation, understanding, and meaning-making has been rich and considered throughout, joining philosophical notions with participants' experiences. I have integrated a range of different voices into the research study, aiding balance and depth.

Openness

This notion refers to the researcher having a systematic explicit process in relation to the research process and decisions made throughout. In describing the process that I have taken throughout the research and rationale for decisions, I have created an openness for 'seeing inside' the research study. An audit trail of the research process was also kept (Koch, 1996).

Concreteness

Concreteness is the researcher situating the reader within the story so that they can recognise and identify with the situation, making the study meaningful and useful to them. I have provided explanations where needed to aid clarity of understanding and the depth of description will also aid the reader to identify with the situation. I have considered recommendations for practise and study limitations in the discussion chapter.

Resonance

Resonance relates to the reader being touched by the study in a way that they see and understand the phenomenon in an insightful and meaningful way. I have been reassured by colleagues who expressed a sense of resonance when I shared particular aspects of my findings. I also had several participants expressing that they themselves saw and understood the phenomenon in a more meaningful or different way following the interview process due to their exploration of, and reflection on, their experience.

Actualisation

This fifth expression of rigour refers to the potential for future and ongoing interpretation of the phenomenon. This study has uncovered meaning in relation to the phenomenon which could be further questioned and explored. Phenomenological research does not completely uncover and reveal the phenomenon, always leaving room for growth.

Summary

In this chapter I have shown how I have used research methods to uncover and come to better understand midwives' and obstetricians' experience of place in relation to supporting physiological birth, and the meaning in relation to 'place' that lies within these experiences. As a result of using these methods, rich data were produced. I have demonstrated how I worked with this data staying close to the methodological underpinnings and principles to bring forth the research findings. I have outlined how I have endeavoured to maintain rigor and trustworthiness throughout the research process. I now move on to the research findings.

Chapter Five: 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. (Heidegger, 1971, p. 72)

Introduction

In this chapter, the dialectics between the practitioner and the birthing environment are considered in relation to the participants' experience of place/space as supporting physiological birth. The influence of the labour and birth environment, was identified as a core theme within the research data, having both a practical and an emotional influence on participants. Many participants were passionate about supporting physiological birth; however, they felt that interacting with the birthing environment entailed working in a space that is not neutral; a space that has unwritten directions or hidden agendas that influence labouring women, midwives, and obstetricians. Findings suggest that the 'small things' in relation to the physical space may, in fact, represent 'big things' in relation to supporting normality in the labour/birth process. Thus, the messages communicated by the environment regarding normality and pathology are central to how practitioners are able to support physiological birth.

Participants talked about how the environment could influence 'possible experiences'. The messages imparted from the 'place' represent a 'flavour' and create a 'mood' or 'feeling' which brings forth a feeling of the 'space' in which one is working. Many participants indicated that the 'mood' or 'feel' of the space was significant both for practitioners and women; it 'paints a picture' and generates a sense of possibilities. Some midwife participants talked about the emotional effect of the birthing environment, how it made them feel while they were at work and, how it could, ultimately, influence their practise.

I began this research with a desire to focus on what works well, and how that could be even better. I wanted to minimise conversations that became caught up in struggle and despair. I made an effort to include an appreciative focus and draw participants into dreaming about how normal labour and birth could flourish. The data in this chapter

starts with a focus on 'how it could be better' but as was the way of the interviews slides quickly into 'how it is' for that is what participants seemed to need to talk about.

Philosophical Underpinnings to My Analysis

In this chapter I draw upon Heidegger's philosophical notions of 'dwelling' and 'mood' to aid understanding of the data. Heidegger (1971) wrote about dwelling in a place as being at peace and being safeguarded within. Heidegger suggested that to dwell means "to cherish and protect, to preserve and care for, specifically tilling the soil, to cultivate the vine" (p. 349). According to Heidegger, in order for dwelling to occur, a 'mood' of looking after, nurturing, and 'owning' the essence of what the place should be must be created. Heidegger believed that if a house (or 'place') is cold, uncomfortable, and devoid of 'mood', it is merely a place which delivers necessary functions. However, mood cannot be simply built; instead, the conditions must be fostered. That is, "We can only pay attention to and foster that which encourages 'ripening'" (Heidegger, 1954/1993, p. 349). Participants' dwelling in the maternity facility, within the 'mood' or 'feeling' of the place, shaped by the environment, recognised how this influenced their experience of supporting physiological birth.

Dreaming of an Ideal Environment for Normality to Flourish

Participants talked about how the birth environment could optimally 'make room' for physiological birth, supporting practitioners to dwell in the place and create the right 'mood' to support normality.

'Painting a picture' of normality

Aroha (LMC midwife), describes the centrality of an optimum birth space to support physiological birth and what this should look and feel like:

> *I think practically speaking, the physical building itself should look less like a hospital and that the birthing unit should be soothing colours. The aesthetic of the room matters. We want women to walk in and think 'oh cool this is where my baby's going to be born' and not 'oh this looks like somewhere where I'd have a caesarean'. It looks like somewhere you would go to visit someone who's just had surgery. So I think aesthetically it doesn't really look like a place that you go to have a baby. It needs to be homely and welcoming, and communicate to the woman that it is a positive, celebratory time for them; they are going to meet their baby*

> *there. I often wonder how much the environment we bring women into at hospital facilities is just another thing on top of another thing that's making them not have a normal birth. When appropriate, obviously if there's an emergency, you need to turn the lights on, but otherwise they should be dimmed. There should be a birthing pool in every room; everybody should have the option to have a water birth if they can. There should be a birthing stool in every room, and one of those fancy birth beds. This really gives women so much empowerment to be able to birth, to feel comfortable, and to use gravity to help them. There's only one CTG in my local hospital birthing unit that has wireless capability so only one woman at a time can go into the shower with a CTG on. So if we want women to birth normally we have to help them to do this.* (Aroha, LMC midwife)

Aroha highlights that the aesthetics of the birth space/place, and the objects and equipment available within it, matter in relation to supporting normality. She suggests that the environmental space, in its totality, represents an influential package which must 'feel right' if practitioners are to optimally support physiological birth. Messages that are received from the birth environment itself are powerful and significant to a woman's labour and birth experience, and birth outcome; they 'paint a picture' and influence how she feels, and what she can expect in the place.

Aroha believes that to support physiological birth an optimal space should be available with aesthetics/objects/equipment that communicate and facilitate normality; a clinical technocratic environment itself can create the foundations for labour and birth interventions. She talks about the availability of equipment and objects in the space as shaping the options that are available to the midwife to support the woman. This placement of objects and equipment can both influence the 'mood' of the place and have an emotional effect but can also have a practical/physical impact in relation to creating 'possible experiences'.

Husserl referred to 'the 'intuitive world' (the world of everyday experience) and 'the intuitive space' (space of the world of everyday life). These have their own intuitive limit-forms, the ideal degrees of intuitiveness which influence "the anticipated nature according to the normal sphere of proximity, built consequently in the possible

experiences" (Costa, 2017 p. 127). For Heidegger, space relates to our relationship with equipment. Heidegger (1954/1993) talked about encountering objects in terms of their platial meaning. Engagement with objects and what these mean to the person is central to their experience in a place. Experience is, therefore, not only grounded *in place* but *by place*, and is a mirror image of the objects themselves, their interconnectedness, and what they represent. In other words, objects within the space and the equipmental ordering influences our interaction with the objects and how we understand their meaning within the space, directing us towards 'possible experiences'. Heidegger referred to this as our "ownmost potentiality to be" (Olivier, 2017, p. 12). The meaning in relation to the same objects and engagement with them might be different depending on the context, so framed by the place itself (Olivier, 2017).

If objects and equipment in the birthing environment are set up and interconnected to encourage interaction that facilitates normality, this will support physiological birth. The birth environment creates opportunities and barriers in relation to what is easily facilitated; the 'intuitive limit-forms' of the space resulting in the 'normal sphere of proximity' and 'possible experiences' that can be anticipated given what the space is influencing. Aroha gives the example of the lack of waterproof telemetry CTG machines which is a barrier to the midwife being able to recommend the use of water if there is a need to monitor the baby.

The birth environment itself 'paints a picture' about 'possible experiences' and the availability and arrangement of objects and equipment influence practitioners' interaction with the environment, shaping practise. Ideally the birthing environment should be set up to anticipate and facilitate normality, the key 'possible experience'. The space can be adapted to accommodate care and treatment if complications arise, rather than the key focus of the space reflecting pathology.

Creating a 'sense of space' and 'sense of purpose'

Francesca (LMC midwife) builds further on the notion of an ideal environment for normality to dwell. She describes how the birth environment itself both reflects and creates the 'mood' influencing practise:

> *There's no way I can offer water except standing in the shower because there are no birth pools available at all. They deliberately don't have any water birth facilities because they consider that women wanting a water*

> *birth should not be at the hospital unit. If I could design a unit it would have birth pools. I would have a lovely midwifery-led normal birth area [within the hospital unit] so that women can choose to have their babies there and know that they've got this insurance policy that they want, to decrease their fear. And I can tell you we'd have lots more normal births. It would have beautiful spaces for women to walk, an environment that's got a relaxed feel about it, where they can chat to other women who are labouring if that's what they want to do. Or they can bring people to support them, two or three not just one.* (Francesca, LMC midwife)

Francesca talks about how the birthing environment can influence practise and experience of place. She gives the example of the hospital facility that has no birth pools, reflecting the facility's expectations of care during labour and birth, and limiting 'possible experiences'. She suggests that this hospital birthing space does not emerge in a way that enables a practitioner to support physiological birth. She highlights the way that the place can operationalise its underlying philosophies which in turn constrains or enables space. Francesca describes what the ultimate birthing environment would be like, but also highlights the importance of it being underpinned by a union of the primary birth place becoming a space imbued with midwifery philosophy.

Francesca feels that, ultimately, hospital maternity facilities should have a midwifery-led unit within them; believing that this would better meet women's needs and improve opportunities to support normality. She suggests that it is not just the physical environment of this midwifery-led unit that would make the difference to birth outcomes, but also the midwifery philosophy dwelling within it, driving expectations and practises; the relaxed laid-back feel, the beautiful spaces for women to walk, the understanding that support during labour improves birth outcomes.

Heidegger believed that there is orientation only where space is disclosed regarding its purpose, creating a 'sense of space' (Malpas, 2012). Francesca feels that the orientation of a separate primary birth space within the hospital should authentically reflect and communicate its midwifery core and truly embody supporting normality. The environment should create the 'right feel' putting midwifery philosophy into structure, the space aligning with the intentionality of the place. She describes creating a sense of space that is relaxed, safe, focused on normality, and woman-centred. Such a space

would have its own 'intuitive limit form' directly shaping 'possible experiences'. The environment, married with and reflecting midwifery philosophy, would then disclose and drive both a 'sense of space' and a 'sense of purpose' of the space. Through and within the birthing environment shines the underpinning philosophies of the place; together, creating a 'sense of space' and 'sense of purpose' of the space influencing experience of supporting normality within it. Clearly disclosing the purpose of the space as being supporting of physiological birth could better orientate practise to reflect such a process, strengthening and symbolising this central thread.

The Space Communicating and Shaping 'Possible Experiences'

Many participants described how the birth environment itself represents and reflects the underlying shared philosophies and culture of the place (maternity facility). They talked about how the birth space communicates strong messages in relation to normality and pathology, influencing understanding of intentionality of place in relation to labour and birth.

Operationalising intentionality

Emily (clinical charge midwife) describes how practise could be influenced by the allocation of space within the maternity facility:

> *Recently we have increased our theatre space availability and elective caesarean lists. I am worried as I'm of the opinion that as soon as you make a space, you'll fill it, it's natural. And now we have 'oh we have a theatre available, there must be a woman who must need a caesarean section', and we go hunting to fill it. Culturally and subtly that will be fulfilled, and it's not supporting normal labour and birth.* (Emily, clinical charge midwife)

Emily describes how the opportunity that is created for birth by the physical environment within the maternity facility can ultimately influence practise. Emily suggests that increasing the capacity of the elective caesarean section list has potentially 'made room' for additional surgery, improved ease of access, and, perhaps, communicated a message about intentionality and expectations of the place. Such messaging could further normalise intervention in labour and birth, perhaps influencing

the ‘mood’ or ‘feel’ of the place and building the message about ‘possible opportunities’ that have been made room for.

Intentionality from a phenomenological perspective is the relational structure between the consciousness of an individual and the world in which they inhabit (Simms, 2017). Simms (2017) wrote that places ‘act on people’ and, by virtue of their physical environment, influence certain actions and behaviours. According to Smith (2013), intentionality is the central part of an experience as it is directing the experience toward something by virtue of its meaning. Heidegger (1993), in relation to the essence of dwelling, wrote that “the bridge swings over the stream with ease and power. It does not just connect banks that are already there. The banks emerge as banks only as the bridge crosses the stream” (p. 354).

Perhaps, here, the additional theatre space represents the bridge over the stream, having a strong purposeful presence in the maternity facility. Pivotal, influential, and building its own banks beyond the ‘already there’, reshaping the space/place. This allocation of space, representing opportunities for surgical intervention, could impact decisions in relation to labour and birth and possibly lead to caesarean section being done more readily. It draws attention to the technocratic model making it increasingly visible. It communicates a message that surgery is a central part of the birthing unit and space has been created to ensure ease of access, directing experience towards the opportunity for intervention.

Intentionality influences the essence of dwelling in the place, along with the ‘mood’ and ‘feel’ of the place, shaping expectations, practises, and possible opportunities. This alludes to the importance and influence of creating opportunity for physiological birth with the birthing environment and equipment within it; ‘building bridges’ that direct intentionality towards normality (e.g., providing pools for labouring women as previously discussed).

A dichotomy between philosophy and the birth environment

Natalie (obstetrician) also talks about the influence of the birthing environment in shaping possible experiences and practise. She discusses the challenges of supporting normality in a hospital birth space:

> *I suppose the hospital is still a hospital and they still have the bed in the middle of the room. It would be nice if there was no bed there, if you*

> *could just hide it away in the wall and only bring it down if you needed it. I suppose it isn't really feasible, but because the bed's there, women get on it. I'm forever encouraging women to be off the bed and suggesting that they go for a walk, use the Swiss ball, go in the pool or in the shower, and try and get them upright and mobile. Sometimes it's a bit hard to get hold of the birthing mats and we haven't got any birthing stools at the moment which I think are great for second stage. It's a real shame because I think when a woman is mobile in labour the stool can help them with a difficult second stage if they're having trouble getting baby around the corner. Probably that would just make the difference between someone having a ventouse and perhaps achieving a normal birth.* (Natalie, obstetrician)

Natalie describes the centrality of the bed in a birth environment and how it influences the care that can be offered in the space, potentially influencing birth outcomes. She describes these hospital birth rooms as contradicting the messages that she is giving to women about supporting normality, suggesting that the birthing environment is instead set up to meet the needs of 'patients' receiving treatment rather than for women who are moving around in labour. As Natalie interacts with the woman in the space, it is made more difficult for her to encourage women to be upright and mobile; the environment is directing the woman towards using the bed. She gives an example of how a birthing stool could potentially make a difference between a woman having a normal birth and a ventouse, but these stools are not available. Birthing mats are not easily accessible; yet the bed is prominent and permanent in the room which encourages and directs women to use it.

According to Olivier (2017), experience is thought to reflect objects or artefacts within the space which are instrumental in creating impressions or influencing beliefs and feelings. Natalie describes the hospital birthing environment at this facility as an obstacle to normality; it is not supporting women or practitioners to do the 'right thing' in relation to physiological birth. Alternatives to the bed are not always available. The lack of equipment is instrumental in creating an impression or 'feeling' about what is expected within the space and shaping practise.

Supporting physiological birth is much more challenging when the practitioner is fighting against a birthing environment that is not working with them. The physical environment can give an impression about what is expected within the space, shape what is possible to achieve, and shape the path of least resistance.

Creating the Right Mood for Normality

Participants described the importance of creating the right 'feel' or 'mood' to nurture normality. Participants all acknowledged the importance of a purposeful birth space for primary birthing which itself 'directs towards' physiological birth. They shared stories about the challenges of doing their best to support physiological birth in birth rooms within hospital facilities and dreamt of more optimal spaces and 'moods' to work within.

Cultivating the space and 'mood' for birth to dwell

Clara (LMC midwife) highlights that the central focus of the maternity facility should be supporting physiological birth:

> *We need to create a facility which has a bigger focus on low level birthing. One where it's seen as abnormal to need to have all these interventions done. Firstly, it must be homely. It can be on site because then more women would use it if they know they can access secondary services just through the doors if needed. There should be the ability for anxious women to come in when they need to so they can do their early labour there when they are too frightened to be home. They can have the baby listened to, but done in such a low level way that they might start thinking that they might as well be home. It's bringing it all back down into the context of normal. The midwife also needs to be able to work a certain number of hours and have a break or have a room she can go to relax and sleep, and be able to get meals.* (Clara, LMC midwife)

Clara describes a relaxed and nurturing environment for both the woman and the midwife that would optimally create opportunities for physiological birth. Participants, such as Clara, believe that a purposeful space that is separate within the hospital maternity facility would better 'set the scene' and 'make room' for normality, providing better opportunities for physiological birth. It would accommodate the woman's physiological and psychological needs, with an aim to reset what is considered to be

‘normal’ and ‘expected’ whilst meeting the woman’s perception of safety. Clara’s story captures how such a space within hospital facilities would instead work *with* the woman to allow her physiology to lead and set its own normal which would drive the woman’s expectations of labour and birth and also midwifery practise.

The space that Clara describes sounds to be midwifery-led, and this ‘placedness’ of midwifery and midwives within the space could be central in cultivating the right mood and ‘essence of place’ for physiological birth. Clara suggests that the ‘feel’ of the place should be homely, and that the midwife also needs to feel relaxed and ‘at home’; to be able to relax, sleep, and eat in the space, and to feel that midwifery, itself, is able to be ‘at home’.

Heidegger (1954/1993), alongside ‘dwelling’, used the term *wohnen* to describe feeling at home in a place; safeguarded and feeling at peace. Many midwives in this study described feeling ‘at home’ in midwifery led primary birthing units, which is the feeling that Clara is describing. This could be a result of the more relaxed and homely environment, or perhaps the midwifery-led nature of the place itself. It could also be the freedom to practise in a way that feels authentic and is aligned with midwifery philosophies, which needs to be safeguarded.

According to Heidegger (1971), a fundamental element of dwelling is both creating and ‘doing’ the cherishing, protecting, cultivating, and preserving within the place. Heidegger suggested that in order to dwell in a place there needs to be some responsibility for ownership of, and ability to shape, the ‘mood’ and the ‘essence’ of place. Perhaps it is important that midwives feel that they have some responsibility for ownership of the ‘essence’ of place and can be instrumental in ‘setting the scene’ and the direction. Perhaps it is important that midwives are themselves able to create the ‘mood’ within the birthing space within which midwifery itself can dwell and flourish, and they are truly doing the cherishing, protecting, cultivating, and preserving.
In order for midwives to truly dwell in a place and create the ‘right mood’ for labour and birth, they need to be involved in doing the cultivating and protecting of the ‘essence’ of the place. The ability for midwives to be central in creating the mood, and have a responsibility for ‘owning’ the ‘essence’ of the place, is important for supporting physiological birth. It seems that normality is best supported when this essence of place authentically reflects the midwifery philosophy.

Respecting the mood in the birth room

Emily (clinical charge midwife) echoes the importance of creating the 'right mood' for birth and describes the impact of the 'mood' and the maternity facility culture inside the birth room:

> *I think the feeling of the culture within the birth room really matters, both the environment and the vibe. We have to understand that every time someone walks in a room the dynamics change which will have an effect, either positive or negative. Sometimes even a word or a 'look' can change the feel, or bring fear into the room. This is really impactful and I think women really do feel it, they read the subliminal cues that say 'unsafe, unsafe', and this can slow down labour and birth. That's why we have to respect the room, and the midwife that's in the room also needs to know that she's completely supported because this support really matters for the care that she is able to give.* (Emily, clinical charge midwife)

Emily describes how she believes the environment and atmosphere within the birth room has an impact on the way the woman feels, on the labour and birth, and also influences how the midwife, herself, feels and practises. She highlights the importance of the energy and the subliminal messages that are being communicated within the birth space, and suggests that these messages are communicated both by the physical environment and the attitude and 'presence' of the people within the space.

Heidegger spoke of 'games' taking place within a mood (*Stimmung*); the space where the game is played in itself creating an 'atmosphere' or a 'feeling'. Providing care for a woman in labour could be considered a 'game' in that there are unique players and an unfolding situation that is outside direct control. For Heidegger, the mood that arises from the game is always spatial and relates to being-in-the-world (Botz-Bornstein, 2017).

Within Emily's words, the 'feeling' or 'mood' within the space is highlighted as being central to supporting physiological birth. This is something that cannot be seen, but from which the message that is communicated is powerful for both woman and midwife. The 'feeling' is associated with support, safety, but ultimately, it is underpinned by the importance of respect for the woman's birth space. Emily suggests

that this ‘mood’ or ‘feel’ also affects how the *midwife feels*. If the midwife feels that the maternity team around her support physiological birth, she will feel safe and empowered to continue this practise.

A space that feels safe—environmentally and emotionally—is central to nurturing physiological birth. The ‘mood’ or ‘feel’ of the space can be created and influenced by subtle cues and is pivotal in communicating safety. It is important that this ‘mood’ or ‘atmosphere’ is respected in the birthing room and not disturbed or disrupted.

A Safe Dwelling Place for Midwifery

Some midwife participants talked about how ‘being there’ in the place itself, within its particular mood, makes them ‘feel’ a certain way, at times influencing their practise.

Feeling relaxed and ‘at home’

Aroha (LMC midwife) talks about the centrality of the physical surroundings and how she feels much more relaxed when she is working in a primary birthing unit than in the hospital maternity facility:

> *My usual workplace (and most ‘normal’) is facility ‘A’ [primary birthing unit]. It’s quiet, small, and has a really relaxed feel. The midwives there, probably because I have a good relationship with them, 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. I think the energy of the local hospital unit [large hospital] is a lot busier; just even the level of noise there. It’s such a different vibe in the hospital birthing unit. I tend to be asking for permission a lot more there, whereas in a primary birthing unit it’s more of a collegial approach. The hospital birthing suite doesn’t look any different from any other place in the hospital, it looks like a surgical ward. The physical environment itself for me is so important. Physiological birth unfolds better when you’re comfortable and when you’re in surroundings that feel good to you. When I’m relaxed, the woman is relaxed, and everything’s going to be fine.* (Aroha, LMC midwife)

Aroha compares the 'mood' of the primary birthing unit with the hospital maternity facility, and how important being there within the 'mood' of the place is in determining how she feels and, sometimes, how she is able to practise. She talks positively about the relaxed 'feel' of the primary unit where she suggests that she feels more confident, relaxed, and supported to practise midwifery autonomously. In contrast, Aroha describes feeling less relaxed, somehow inhibited, in the busier, noisier, and more clinical hospital environment; sometimes feeling that she needs to ask permission to do things in this space. It seems that Aroha feels 'at home' in the primary birthing unit but not in the hospital space. Perhaps Aroha is not as familiar with the hospital space and processes, perhaps the 'mood' or 'feel' of the place influences how she feels, or maybe the position or 'placedness' of midwifery is not as central in this hospital facility.

Malpas (2006) wrote that our understanding of place leads us to an orientated situatedness or 'placedness' where we are orientated to the position that we hold within the place. Heidegger (1977) also wrote about existential dwelling, whereby Dasein or being-in-the-world has gained an authentic understanding of the 'essence' of place and lives accordingly. Similarly, Aroha talks about the importance of practitioners being in surroundings which 'feel good' to them, mentioning the importance of the aesthetics and the 'feel' or 'mood' of the birthing environment itself. She expressed that if she feels relaxed and comfortable in the space, it will help the woman to also feel relaxed—both of which could be instrumental in supporting normality.

The way in which the midwife actually feels in, and as a response to, the place/space is important in supporting normality. The practitioner can be orientated towards the 'essence' of the place by the physical environment, how this environment makes them feel, and how they understand they are positioned professionally within the space. Feeling relaxed and 'at home' is easier when midwifery has a safe place to dwell.

A 'sense of' our own space

Chloe (LMC midwife) also talks about how she feels very differently about dwelling in relation to two different maternity places. She describes how the place itself has an impact on how safe and relaxed she feels working within it:

> *I feel like I have two workplaces. So there's the primary workplace (primary birthing unit) that I share with the LMC group that I'm in, and we all support each other incredibly well and empower women, and physiological birth is what we're all about throughout. We are all unified*

> *in supporting physiological birth, that's why we work here. So I feel like that's my workplace where I'm really happy, comfortable, and safe. Then there's the other workplace which is the hospital. When I go there, I feel completely different, and I also have to work much harder to support normal birth. It feels to me like these two places are very different.* (Chloe, LMC midwife)

Although Chloe is not talking just about the birthing environment, she is articulating a 'sense of place' which clearly differs between the two places and influences how she is able to dwell and feel 'at home' and support physiological birth. She is suggesting that when she is in the primary birthing space with her likeminded midwifery colleagues this makes her feel safe and supported. She talks about then feeling empowered to support physiological birth—a key thread throughout the care that is provided by their team in their midwifery space. Chloe articulates a sense of belonging to the primary midwifery space and responsibility for the running of the place. Chloe indicates that she feels differently when she is in the hospital maternity space, perhaps not feeling as comfortable and well supported, as affiliated with the underlying philosophies, or such a sense of responsibility or belonging.

According to Relph (2009), the deepest sense of place is associated with feeling 'at home', where you are familiar with the place and others are familiar with you, and where you feel responsible for how well the place runs. For Heidegger (1954/1993) it is fundamental that in order to dwell in a place and call it our own, we need to identify with it, feel involved and familiar, and feel a sense of belonging to the place. He believed that this is central to feeling 'at home' (Heidegger 1954/1993). Chloe expresses both a level of belonging to, identity with, and a responsibility for the running of the primary midwifery space that she shares with her colleagues and suggests that it was here where she feels relaxed and 'at home' and is able to truly dwell.

A sense of 'our place', where the practitioner feels safe, supported and 'at home', can be instrumental in them feeling empowered to support normality. A sense of belonging to the place and feeling involved with, and a level of responsibility for, how well the place runs is integral to dwelling.

Summary

The birth environment reflects the intentionality of the place and is influential in relation to supporting physiological birth. It ‘paints a picture’ about ‘possible experiences’ and creates a ‘mood’ or ‘feeling’ in the space, shaping what practitioners are directed towards. As midwives interact with the space, the objects and equipment influence what is possible in relation to practise. The environment also has an emotional effect and ushers a ‘sense of space’. These impressions can influence practise and shape the ‘path of least resistance’. Therefore, both the physicality of the environment itself and the way that the practitioner actually feels in the space are important and can influence their practise. Their ability to ‘dwell’ and feel ‘at home’ in the place, feeling that they are instrumental in creating the ‘essence’ of the place, could be fundamental to how safe practitioners feel to practise authentically. The ‘placedness’ of midwifery and physiological birth, and how central these are to the ‘essence’ of the place, is core to the ‘dwelling’ of normality.

Chapter Six: Attunement Towards Normality

Introduction

Within the stories of this research into midwives' and obstetricians' experience of 'place' in relation to supporting physiological birth, participants described experiencing a particular 'tone' or attitude in the maternity facility in relation to respect for, and connection with, enabling the woman's physiology to lead and be supported. They talked about how the culture in which they were working influenced their experience of place in relation to supporting physiological birth. It predisposed them to an alertness and perception in relation to normality and risk which influenced their ability to work with the woman's physiology. In this chapter, I draw upon Heidegger's philosophical notions of 'attunement', 'relatedness', and 'ready-to-hand' as a lens through which to further examine and better understand the meaning within the data.

Philosophical Underpinnings to My Analysis

Heidegger (1927/1962) wrote that Dasein in its everyday being is fundamentally 'attuned' towards things or situations within the world; a person has a disposition towards certain directions, circumstances, or tones within the world. According to Heidegger, this attunement is responsible for being open and responsive to possibilities (Greaves, 2010). An attunement "makes it possible… to direct oneself toward something" (Heidegger, 1927/1962, p. 176). We are aware of the relevant features of the world in which we are in because we are attuned to them, and this attunement makes things 'matter' to an individual (Heidegger, 1927/1962). For example, a midwife walking into a birthing unit quickly learns how to attune to how busy it is on that day by the level of noise, the pace of activity, the 'mess' in the utility room, all bringing forth a mood of busyness.

Heidegger (1992) likened his notion of 'relatedness' to a cabinet maker's apprentice. Understanding the craft entails appreciating the depth of and differences in the wood that the apprentice is working with and seeing the 'essence' of what the wood 'is'. Heidegger suggested that relatedness to the craft is more than building the cabinets-it is about 'becoming' the craft. For the midwife or doctor, it is not merely understanding nor measuring the progress of labour, it is attuning to the ongoing labouring in a variety of ways that bring a knowing often hard to put into words.

Heidegger talked about modes of experiencing the world and suggests that most human activity is absorbed with experiencing entities around us. These entities are ready-to-hand which, according to Heidegger, is the presence of something that is defined by its functional role; what the objective is behind its presence, what it is used for, or its potential action (McInerney, 1992). In ready-to-handness the midwife is almost un-thinking as she supports the woman in whatever way matters in the moment. An attunement and relatedness towards valuing normality is a key thread throughout this chapter.

Physiological Birth as the Central Thread and Expectation

Many participants talked about the importance of physiological labour and birth being the expectation valued amongst the team. They shared stories of how the place held this focus and helped them to support normality.

A focus towards normal birth

Natalie (obstetrician) talks about a maternity facility where normal birth was the focus; it was expected, and normality was central to the culture:

> *The maternity unit at [now a hospital facility]… was more of a birthing unit. You just had a couple of little 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. If you booked there you expected that there were no epidurals and that you would have baby naturally and only be transferred if there was a problem. There was definitely that feeling that if the woman and her baby were well you weren't expecting a lot of intervention.* (Natalie, obstetrician)

In describing how the focus and purpose of the place influences birth outcomes, Natalie highlights that this birthing place set clear expectations regarding its focus and the care that was likely to be received there. The conditions to support physiological birth are ready-to hand in both the birth space and the culture in the social connectedness. The majority of the space was set up to accommodate and facilitate physiological birth with only small designated areas available for women needing intervention. Normal birth without intervention was the expectation at this place. The culture of the facility had set the scene for women before they arrived; hence, they expected the focus to be towards

physiological birth. There was no immediate access to an epidural or caesarean—that was not ready-to-hand—instead, requiring transfer to another hospital.

In his writing about Heidegger's notion of ready-to hand, Malpas (2006) stated that: "Heidegger thus understands things ready-to hand as being ordered in relation to one another in a way that reflects their ordering within such a teleological or 'referential' totality" (p. 84). Malpas continued:

> And so, not only does the idea of things as ready-to-hand refer to an ordering of things and places and to a system of social interconnectedness, but it also indicates the way in which that social realm and our interconnections with it are organized in space and, conversely, (but significantly, given the derivative character of spatiality for Heidegger), the way in which the spatial also takes on a certain ordering in virtue of the social. (p. 88)

In these quotes, Malpas helps us to see that any space has within it ready-to-hand ways of going about things, of working with others, of knowing what matters. No space is free from a kind of ordering which shapes practise. Natalie's description of a particular birthing unit shows how this plays out.

Natalie suggests that in this unit normal labour and birth were not considered to be a 'problem' or something that needed intervention, unless a problem did occur. It is, therefore, unlikely that women would have received intervention unless it was clinically indicated. 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 pathologised. Everything was ready-to-hand to let the labour unfold in its own way, reflecting the underpinning teleology and influencing practise.
Natalie explained the point at which things changed at this maternity facility:

> *They then moved to the main hospital block and the feeling about the birthing facility kind of changed your perspectives. They had anaesthetists and therefore an epidural service was available, and then shortly after that then the specialists were able to do caesareans. Access to the anaesthetic service and access to the theatre came along quite quickly from moving to the base hospital. It probably saved one or two babies, where there was a cord prolapse or an abruption, but I felt for a*

> *lot of women who didn't need intervention, it started creeping in and became the norm. You could get anaesthetists and have an epidural readily, whereas previously there wasn't the expectation of having it. So women's expectations and their choice of place of birth are very important, and psychologically they affect how you approach the birth.* (Natalie, obstetrician)

Natalie describes how intervention in women's labour and birth later became ready-to-hand and a central part of the culture at this hospital facility. It became the new normal, even though for many women it may have been safely avoided. She saw how this easy access to intervention may have influenced practitioners' perspectives and practises and also women's expectations. The order of things had changed, the team and processes had expanded and the social realm of interconnectedness now involved obstetricians and anaesthetists. As Maplas (2006) wrote in the quote above, the space and the social realm within it 'takes on a certain ordering' which is a product of what the space is intended for, suggesting what matters within the space. Having these practitioners (and the resulting relationships with them), equipment, and care ready-to-hand, consequently made intervention in labour easy, more accepted, more prominent, and perhaps the path of least resistance. The space was set up to accommodate a technocratic approach to labour.

Natalie said that there was a different 'feeling' about the birthing facility when it moved to the main hospital block. The focus and discourse had changed from physiological labour and birth being the expectation and the core business, to a focus on anticipating risk and potential problems. A more technocratic approach to labour and birth was now of a 'higher order'. Women may have perceived that this equated to increased safety. More intervention and managing labour and birth was the result of striving for increased safety.

According to Gadamer (2013), what constitutes the 'truth' or the way we understand and appreciate something can be captured and seen; for example, within a work of art, a performance, or through play. I include a 'good labour and birth' in this list of examples. Whatever we call 'truth' 'becomes' when the observer, spectator, player (or health professional) come to an understanding about the picture that is being painted, the game that is being played, the message that is being communicated. They actively participate in this process of understanding of the truth. Such understanding is always

situated. In relation to Natalie's account, the 'truth' was played out in the labour and birthing field by the players who were engaged in playing this game. The 'truth' behind this game, it seems, was centred on possibilities on-hand able to be brought into the play of care. An anaesthetist standing at the door made an epidural much more accessible than organising transfer to another hospital. The ability to perform a caesarean on site perhaps also made intervention feel safer—any untoward consequences could quickly be addressed.

A shared understanding that physiological labour and birth (when appropriate) equates with safety is central to supporting normality. Conditions for physiological birth need to be the 'ready to hand'; supporting normality is then the 'game', the valued goal and 'truth', the path of least resistance. Paradoxically, the conditions that support normal birth are a lack of centrality of interventionist equipment and anaesthetists or obstetricians.

Collectively 'tacking' towards physiological birth

Clara (LMC midwife) tells a story about 'tacking' towards normal birth:

> *I remember looking after a woman and we were out in the forest in a little cottage setting to have the baby. Then the baby got itself in a difficult position so we wound up having to change direction and go into the hospital. It always made me think, particularly with her, of a yacht tacking in the wind. We hit an obstacle where it's going not quite as it should so we set another course; we'd wait this long and reassess so we tacked in another direction, but kept tacking towards normal birth while we could. So we got to the hospital and there was another obstacle which we talked about. Finally we tacked our way right into theatre and it was fine because there had been sensible discussion around it all as a team, we knew we had explored all avenues regarding physiological labour and birth, and we knew when we got to theatre that's where we needed to be and were extremely grateful for the expertise that was there.* (Clara, LMC midwife)

Clara describes how she was able to work with the woman and the hospital maternity team to keep 'tacking' towards normality while this was possible. The woman's physiological birth was held as the focus of the care, the 'destination', and normality remained the default. Clara talks about her 'craft' as she held *this woman* and *this baby*

at *this time* in *this place* at the centre of her decision-making and continued to support the woman's physiology. As with tacking in sailing, the midwife *works with* the 'powers' to guide the woman to her destination. Just as the sailor would position their yacht for the tack, the midwife aims to optimally 'position' the woman to give her the best chance of moving towards her destination and maximising the strength from the 'powers'. This takes teamwork, strategy, and careful timing, with attunement sitting as a key driver.

When an obstacle to normality was met, Clara and the hospital team navigated in a different direction, all still 'tacking' towards the same destination while appropriate. It is not about considering just the obstacle or risk per se, but also accounting for the reassuring elements in the woman's labour and what it meant for the woman at 'this point'. Not every risk is the same for every woman or even for the same woman at a different time. The risk must be seen within the 'essence' of the situation.

Clara and the hospital team did not intervene at the first obstacle because the baby was not ideally positioned. The woman's care was carefully considered to accommodate where she was at that time, in that space, and for that stage of her labour. The essence of her situation was responded to. Possibilities and risk were continually explored as things changed; a picture was built and adjusted in real time. Clara and the maternity team 'tacked' towards a 'favourable wind' in response to the woman and the baby in each moment. How does one learn how to 'tack'? It is more akin to a craft than a skill. It is an attunement to the interplay of so many things coming together in the moment.
As briefly described in the introduction to this chapter, Heidegger (1992) wrote about the centrality of relatedness in relation to a craft:

> A cabinet maker's apprentice, someone who is learning to build cabinets and the like, will serve as an example. His learning is not mere practice, to gain facility in the use of tools. Nor does he merely gather knowledge about the customary forms of things he is to build. If he is to become a true cabinet maker, he makes himself answer and respond above all to the different kinds of wood and to the shapes slumbering within the wood - to wood as it enters into man's dwelling with all the hidden riches of its essence, In fact the relatedness to wood is what maintains the whole craft. Without that relatedness, the craft will never be anything but empty busywork, any occupation with it will be determined exclusively by

> business concerns. Every handicraft, all human dealings, are constantly in that danger. (p. 379)

Clara and the hospital team knew their 'craft', and they knew how to 'answer and respond' to what was presented to them. They appreciated and understood the depth lying behind what was visible on the surface, and in front of what they could see. They related to the 'essence' of the woman and her labour as it changed in relation to all influencing factors, some of which could be controlled and some that could not. Clara and the hospital team related to this 'essence' through the lens of their craft and they were open to possibilities. It seems that the team's relatedness to the craft and to the woman added a depth of understanding and greater meaning to their decision-making.

Relatedness supports more meaningful and responsive decisions which holistically consider the 'essence' of each situation. This relatedness adds a depth of understanding about the uniqueness of the woman and baby, the labour as it changes, elements of normality and risk, and the appreciation of the full situation in real time.

Pride in physiological birth

Natalie (obstetrician) talks about the importance of the maternity team having a pride in their birth outcomes, and physiological birth being valued:

> *Our team leaders and professors were very much into stats and so they audited everything we did. We had a meeting once a week at [hospital facility]; it was educational, based on an interesting case study, but we also presented all the birth outcome data. We would look at how many normal births there had been, how many assisted births, how many caesarean sections and any concerning outcomes. It was very well attended, and the senior clinicians always came too. It was almost like a competition at that stage to see who had the best outcomes. I was on … team and the specialists who were the leaders of that team took pride in having good outcomes. So if they had high levels of normal births and lower levels of caesarean sections than another team, they felt like they were doing a good job, that was the culture. People were proud of having good outcomes and having low caesarean section rates and good vaginal birth rates.* (Natalie, LMC obstetrician)

According to Gadamer's notion of play, the game itself is presented through the players. If supporting normality is a meaningful 'game' and becomes part of the consciousness

of the players, then players may cultivate a meaningful culture from within themselves. 'Play' would then more readily and authentically reflect a true consciousness of supporting normality.

It seems that there was an 'already there' belief at this place that physiological birth should be highly valued. This belief and goal were bigger than the individuals, and the shared goal connected them together in practise. Gadamer (2013) described the notion of Erlebnis as being experience that is "rounded into the unity of a significant whole" (p. 71). Gadamer went on to say that "its meaning remains fused within the whole movement of life and constantly accompanies it" and that the notion has been referred to as "the very stuff of consciousness" (p. 71). This suggests significance to the experience that is bigger than the individual experiencing it, and that the meaning within the experience is an ever-present driving thread.

Collection and peer review of the birth outcome data heightened visibility of birth outcomes. Natalie describes a culture that has pride in achieving good birth outcomes and high rates of physiological birth as being central to this ethos. According to Heidegger (2001), "Just as one only listens to what makes noise, so one only counts as being what works and leads to practical, useful result" (p. 118). The collection and review of the data 'made noise' that the obstetric team evidently heard because it made sense and was meaningful to them. Evidently, they considered rates of physiological birth to be important and embraced the 'why' behind this phenomenon.

The act of discussing the data also, evidently, 'made noise', creating a level of accountability for practise amongst the teams. Heidegger (2001) went on to write that "Whenever I take notice of something as something, then I myself have 'measured up to' what a thing is" (p. 100). Physiological birth was evidently held up as the focus of the meeting, a shared goal; it was taken notice of. It seems that in the process of peer review, reflection took place on how one's own practise 'measured up' in relation to the comparisons. Such reflection may have been instrumental in shaping perspectives and attitudes, keeping the shared culture of 'normality' strong and operationalising it in everyday practise. It seems that for these teams, having low rates of physiological birth may have reflected badly on the specialists who were leading the team which, in itself, could influence the practise of the team at large.

Physiological birth is supported when it becomes a consciousness and a 'spirit' which is grown and fostered by the maternity team. It becomes meaningful both to the individuals and to the wider team. It is 'taken notice of', and the team are invested in it and reflect on their practise against the shared goal. The collective embracing and 'becoming' of this principle and goal could foster a proactive and cognisant culture of supporting normality driven from within the individual practitioner.

'Normalising the normal' by setting the tone

Chloe draws attention to what gets talked about:

> *Physiological birth needs to be gossiped, and made the 'norm'. You can see how negative gossip affects the mood in maternity units. You can see how, when staff don't agree with things a negative opinion is quickly built, the same can be of a positive opinion, so we should gossip and support the good stuff. Supporting positive talk about physiological birth needs to be driven from ground level in order to have a chance of survival, and advocating for it too. For example, this morning there was a woman who was 3 centimetres dilated, contracting really well, and then one of the staff said 'oh she's having an induction I need to break her waters'. We talked about this and I discussed with her that it would be much better to leave them intact as she was already in labour.* (Chloe, LMC midwife)

According to Heidegger (1927/1962), 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. Chloe talks about drawing attention towards physiological labour and birth to awaken and strengthen attunement with normality. This would help to 'normalise the normal', keeping it visible, buoyant, and affirmative. She suggests the power of discourse and 'mood' within the field, and the importance of the team, themselves, 'owning' and engaging with the discourse.

This fundamental tone must be driven and collectively owned by the clinicians working 'on the floor'; and Chloe suggests that if ideas originate and are nurtured from within the team, they are much more effective in creating change. It needs to matter to the practitioners who are making the decisions. Chloe talks about encouraging an attunement with the woman's physiology and challenging decisions to intervene with

the woman's physiology if re-establishment is not needed; further awakening an attunement with normality.

Chloe picks something up in conversation that brought forth a challenge to her colleague. She was attuned to a situation that could be kept free from immediate intervention. Malabou and Skafish (2011), when writing about the works of Heidegger, noted:

> An attunement is a way, not merely a form or mode but a way-in the sense of a melody that does not merely hover over the so-called proper being at hand of man, but that sets the tone for such being that is, attunes and determines the manner and way of his being. …Attunement is a fundamental manner, the fundamental way in which Dasein is as Dasein. (p. 250)

Chloe, being attuned to supporting normality, influenced her 'being' in the place and determined her manner of being, as well as setting the tone and expectation of being for her colleague. In such a way a 'melody' of normality comes to be what gets heard and responded towards.

Positively communicating physiological labour and birth in the maternity field influences attunement towards normality for the team, setting the tone of what is important and meaningful in the place, and generating expectations about what practitioners should be directing themselves towards. Determining this manner of being optimally lies in the hands of the practitioners working in the field.

Facility Culture Shaping Perception of Risk and Normality

Many participants talked about how the place affected the way in which risk in relation to labour and birth was perceived, anticipated, and managed.

Fear and perception of risk

Clara (LMC midwife) talks about how the main focus of the place (and the place of the practitioner within it) can shape the way that risk is perceived, communicated, anticipated, and accommodated:

> *Those of us who have been privileged enough to work with women committed to the low level non-interventional sort of births know how beautiful birth can be; but an obstetrician who's only called in to deal*

> *with the disasters has only seen this side. I think there is an element of fear there now in women too and whether we like it or not, we feed that fear because we're so afraid that something could be missed and there will be a consequence for us. Fear is the elephant in the room. No woman wants to put her baby or herself at risk, so most women are going to follow the pathway that the professional person frames as being the safest. I think we're now aware that we need to keep ourselves safe and somehow the belief amongst some is that the ultimate safety is to perform a caesarean, and anything short of that may have got a better outcome if a caesarean have been done. If you're always swimming in shark infested water, you forget that there are waters where there are no sharks. It's almost as though a good outcome is considered to have just dodged the sharks. This philosophy around birth is gaining momentum which is really sad to see.* (Clara, LMC midwife)

Clara describes how the discourse in this hospital field is that normality can only exist retrospectively if the 'sharks' have been avoided; the sharks being what is understood to represent risk. Heidegger considers that understanding and discourse exist alongside attunement as key components of Dasein or being-in-the-world, and that attunement and understanding are determined through discourse (Kalary & Schalow, 2011). Being surrounded by a discourse of risk informs expectations. Evidently, in this facility, there is less attunement with normality. The practitioner is more attuned to risk and pathology—the central discourse. The resulting shaped understanding and responsiveness becomes a lens through which the practitioner always sees, influencing their approach to possibilities of risk. Fear of the 'sharks' is dominating the space in this field, influencing the play of the game.

Clara suggests that being in the hospital field can be a barrier to authentic 'relatedness to the craft'. Risk and pathology appear to be fuelling concern, limiting attunement with reassuring features of normality and colouring the way that normality is understood. The 'truth' remains hidden as the true relationship of normality, and risk cannot be authentically seen. There could be an element of defensive practise in this field due to fear of risk, and there appears to be a perception of safety in a technocratic approach to labour and birth which could leave the practitioner and the woman afraid of 'swimming in shark infested water'. There may not be any sharks nearby, but the anticipation of

them shapes play, leading to avoidable interventions. Perhaps it is not just the clinical risks that present as sharks, but the practitioners who are always on 'shark patrol'. These practitioners are watching the field, highly attuned to risk or potential for risk, setting the tone to match this discourse.

An overriding discourse that labour and birth are risky and that managing labour and birth equates to risk reduction is a barrier to supporting physiological birth. A woman's risk simply 'is', but this has the potential to be perceived, framed, and constructed differently depending on discourse, attunement, and understanding. If complications are anticipated, even if risk is not evident, then prophylactic intervention is more likely; in itself, representing a risk. Intervention may equate to armour to protect practitioners themselves.

Relatedness with normality could reduce attunement with risk

Harriet (registrar) talks about the influence of the lens that practitioners see labour and birth through, and the importance of understanding physiological labour and birth:

> *I would love to get house surgeons working with midwives caring for women where labour and birth is normal. If they see physiological labour and birth where interventions are not needed, this would help to change their perspectives. They would see that things can happen normally without us actually doing anything. A lot of the consultants don't agree with water birth. One consultant said that only elephants or hippopotamus should give birth in water. I'm not entirely sold on the idea of a water birth because I've heard these people say don't do it. But I think they're probably coming from the point where they've probably seen complications, but not the women for who it all goes well as we are not involved in those births. So, every time someone's having a water birth I don't feel comfortable. I don't think I've ever actually seen a water birth but I feel uneasy when I hear that it's going on in the unit while I'm on.* (Harriet, registrar)

Harriet draws attention to the context in which her medical colleagues learn about labour and birth. Heidegger (1992), in pondering the manner in which one learns, wrote: "Whether or not a cabinetmaker's apprentice, while he is learning, will come to respond to wood and wooden things depends obviously on the presence of some teacher who can teach the apprentice such matters" (p. 379). Harriet highlights the importance of

being taught by a practitioner who is responsive to the needs of women in primary care and truly understands the 'craft' in this field in order to appreciate it.

Harriet reveals her concern about water birth in keeping with other obstetricians. It is likely that obstetricians will have had little or no experience of such practise, leading to uncertainty and perhaps vulnerability if they feel they need to be involved. The very nature of being-in-water provides a barrier between the woman and the health professionals. If a doctor has never seen a water birth, how can they know that the midwife is still attuned to signs that there may be problems? How can they know that the woman is much more relaxed? How can they appreciate the sacred quality of such a birth (Crowther et al., 2015). Being-there, being-alongside a teacher who 'knows' is the only way to learn for oneself.

Obstetricians' perspectives are underpinned by their immersion in obstetric risk and morbidities, which heightens their attunement with risk. It is likely that they have experienced poor outcomes and, therefore, perhaps see intervention per se as equating to a reduction in morbidity. Safety for the obstetrician may be associated with feeling in control and 'managing' labour. Obstetricians working alongside and learning 'the craft' from midwives, who have a relatedness to women in primary care (including being involved in water births), could help to balance perspectives, reduce fear, and facilitate better attunement with normality.

Appropriately Keeping Women in Primary Care in the Hospital Maternity Space

Both midwife and obstetrician participants acknowledged the importance of women remaining under the care of a midwife (primary care), without obstetric involvement, while they are considered to be low-risk.

Midwives taking responsibility for primary care in the hospital field

Mia, a clinical charge midwife (CCM), expressed her concerns about some women being referred to a registrar when this could be safely avoided:

> *The charge midwives want to protect the woman's right to have a normal vaginal birth and sometimes you're fighting other practitioners, some days it's all day. It takes confidence and experience. If I'm the CCM I can say to the hospital midwife 'I want you to ring me as a first line before calling the registrar'. I take full responsibility for everything that happens, it's about being prepared to take responsibility instead of things*

> *(obstetric consultations, interventions) constantly being done 'just in case'. But not only that, the registrar might be in theatre so then has to ring the charge midwife and say 'can you go and have a look at that room'. This was born out of busyness in the unit. But that doesn't always work for LMCs, so the LMC often rings the registrar as a first line because they may feel that they are entitled to do that. But I know what the priority is in the unit and what the registrar is doing. It's frustrating when a midwife asks me to have a look at a CTG in the second stage and it's really normal, and then they panic and ring the registrar. The registrar may be junior and they come and do an operative delivery and you know that the woman could have had a normal birth. The baby comes out with great APGAR scores and you know is perfectly fine because actually that was a normal second stage trace*. (Mia, clinical charge midwife)

Mia talks about the importance of the strength and responsibility-taking of senior midwives in order to effectively triage risk and reassure obstetricians when obstetric assessment is not necessary. Their credibility helps obstetricians feel confident that they will be called if they are needed and stand back when they are not. Heidegger (1962) wrote that "By way of being attuned, Dasein 'sees' possibilities, in terms of which it is. In the projective disclosure of such possibilities, it is already attuned in every case" (p. 148). When senior midwives are attuned to possibilities of women appropriately and safely remaining in primary care, it could sometimes avoid a woman being referred to the obstetric team too early.

Trust and responsibility are essential in order for team support to work well. Mia highlights that when this process has not been followed, the rationale is practitioner fear or a lack of trust. It could also be influenced by the midwife wanting intervention at that point, knowing that it would be provided by the registrar. Tensions at the LMC/core interface could also influence an LMC's decision not to follow the process of liaising with the CCM in the first instance. There is a hint of this in Mia's words.

Calling the CCM first, where possible, when a consultation is being considered, might provide a second 'layer' of possibilities which are attuned to normality. Interventions can be viewed as efficiency, saving time. However, there are consequences to

'efficiency' interventions. When processes are understood as being meaningful and beneficial to the practitioner themselves, they are more likely to be embraced. Harriet (registrar) also talks about the central role of the midwife (particularly the charge midwife) in taking responsibility for the care of women when they are considered to be low-risk:

> *From our point of view we (obstetric team) will stay out as much as possible and try not to intervene, and that's usually strongly encouraged by the charge midwives wherever possible. If you have a midwife, particularly a charge midwife, who's strongly in favour of just standing back a little bit and waiting and who are confident that you don't have to be involved, you don't have to go into the room, and they take charge from that point of view; I think it makes a difference. They'll sometimes say 'no actually, I think this woman is fine she doesn't need to see you, we will continue with what we're doing', and this helps to reduce intervention. Once we are involved the expectation is for us to do something.* (Harriet, registrar)

According to the Referral Guidelines (Ministry of Health, 2012), the LMC midwife is ultimately responsible for the woman whilst she is in primary care. In some hospital facilities, there is a pressure point when women under the DHB community team are cared for by employed midwives but are also under the care of an obstetric team. In this situation, the obstetric team may feel a responsibility for the care of the woman, even when she is in primary care. Harriet, however, describes a reliance on the midwives to protect normality and appropriately take responsibility for primary care, suggesting that perhaps sometimes obstetricians may be asked to be involved in the woman's care when the woman could safely have more time to labour physiologically.

Harriet highlights a potential space that is, at times, present when an obstetric referral is being considered, but is not immediately required for the wellbeing of the woman or baby. The utilisation of this space has the potential to better support physiological birth, depending on the practitioners who are holding the weight of responsibility for decisions within this space. Sometimes the woman may be referred to an obstetrician when perhaps this space would have been better held by the midwifery team. When midwives, supported by the CCM, hold the weight of responsibility in this space, obstetricians can appropriately stand back. Harriet acknowledges that once the registrar

is invited into the woman's care then intervention is more likely, and she feels she is expected to 'do something'. Harriet feels that the CCMs are central to avoiding unnecessary obstetric involvement.

Once the registrar is involved in a woman's care, there is an understanding that the game has changed and 'allowing time' is no longer as simple. The rules and expectations of the game move towards managing the risk/potential risk. Labour progress that may be interpreted to be 'slow' may then become pathologised. For some women, this could be safely avoided by additional midwifery support in the primary space when possibilities are appropriately seen for physiological birth which is facilitated by patience, confidence, and attunement to a discourse of normality.

Leading the Service with the Needs of the Individual

Within many of the participants' stories, the centrality of the individual woman and the degree of flexibility to accommodate her individual needs was core. Embracing, adapting, and working around the woman's needs, in order to labour and birth physiologically, was evidently important to support physiological birth.

Nurturing the woman in the latent phase: Attuning to the woman's needs

Emily (CCM) describes how accommodating and supporting the woman's needs during the latent phase of labour can provide wrap-around support which can support physiological birth:

> *When we have an acceptance of women popping in and out of the maternity unit in labour because they need a touchstone for reassurance this really makes a difference. If they then want to come that's fine, it's accepted and we tell them that it's all going well and say 'come whenever you need to'. I think if they can believe that they are safe this makes a difference. It's about going with what they need and letting it happen, because labour takes time. The length of time that women labour can sometimes be exhausting for the LMC midwife. And I think that in itself influences physiological birth, because midwives have got nothing left and this affects decisions that they make. So, supporting the LMC midwife, along with the woman, is essential.* (Emily, clinical charge midwife)

Emily describes how patiently nurturing the latent phase of labour by being open to women coming into the maternity facility (and leaving again) when they need reassurance supports the woman, the LMC midwife, and the woman's labour. This approach reflects the 'play of the game' in this hospital field; at its core, play accommodates the woman's physiological and psychological needs. Chloe talks about going with what the woman herself needs and 'letting it happen', appreciating that labour takes time. The woman is not expected to conform to the timeframe or rules of the facility; instead, there is attunement towards normality and the optimal conditions to support this process. Thus, there is an attunement to a psychological/physiological connection during labour, in that the woman needs to feel safe in order that her labour can progress.

'Relatedness to the craft' (in relation to this data) would be a knowing about the uniqueness, yet similarities, with each woman and each labour; the many different ways in which women respond to labour. Yet, some fundamental needs link them all which, ultimately, brings into view more clearly for the midwife the 'truth' in relation to the essence of normal labour and birth and its physiology. Relatedness brings a depth of understanding, a 'coming into presence' of the phenomenon, perhaps associated wisdom and 'knowing'. It seems that the team in this hospital field understood the 'essence' or 'truth' in relation to early labour and accommodated this.

Even though intervention is ready-to hand at this hospital, a patient approach to supporting the woman's physiology to lead is evident. "Existentially, attunement implies a disclosive submission to the world, out of which we can encounter something that matters to us" (Heidegger, 1927/1962, p. 177). Perhaps when practitioners are attuned to a discourse that supporting normality matters, it can limit the influence of the more technocratic shapers.

Optimally, the LMC midwife visits the woman at home during early labour rather than the woman going to hospital for reassurance. However, there are multiple reasons as to why this is not always possible. The woman may be having a long latent phase, and the woman (and midwife) needs support in addition to the home visits. The midwife may be in the hospital, or may be resting following a birth, or the woman may be under the care of the hospital team.

Emily acknowledges that when the facility can lift the time-pressure from LMC midwives and support women in the early stages of labour, then this in itself invests in the LMC's capacity to allow the woman's labour to lead, to establish in its own time without intervening. Perhaps, at times, intervention during the latent phase could be a result of LMC midwives' strategies in coping with the unpredictable and changing demands of the role. Perhaps when demands on the LMC midwife are high, they do not always have the capacity to support a woman to let her physiology lead in the latent phase. This patient woman-centred approach reduces the likelihood of intervention and spreads the responsibility for the woman's care at this pressure point across the wider team, providing a wrap- around support with psychological support at the centre; ultimately, supporting labour to evolve at its own pace.

The open and accommodating 'play' in the field is truly supporting women to feel confident to remain at home until their labour is established, if home visits are not a possibility. In doing so, the hospital midwives are supporting the woman, the LMC, and the service. Patience and insight into the importance of this stage being nurtured is critical, along with a shared understanding at the practitioner interface. Attunement with normal labour physiology, and to a discourse that supporting normality matters, can ultimately represent a catalyst for creating opportunities for physiological birth within a hospital space.

Culture of Supporting Women to Labour Rather than Saving Them

Many participants talked about how a culture of walking alongside the woman throughout labour and birth, rather than aiming to 'treat' labour, was central to supporting normality. It was evident that the balance between practitioners' faith and fear was core for supporting physiological birth.

Understanding, embracing, and protecting normality

Mia (CCM) talks about the importance of truly understanding the 'normal' in relation to labour and birth physiology, and getting 'back to basics' regarding an approach to midwifery care in order to appropriately avoid interventions:

> *It's important that we really understand what normal is, what the woman's body can do. You know how women can get quite distressed during the latent phase and often all they need is emotional support. They don't need an epidural, they don't need an ARM, they just need*

> *emotional support; they need reassurance that they are safe. Or a woman might come in really distressed in strong active labour asking for an epidural and they go and arrange an epidural for her. Well everybody wants an epidural approaching full dilatation! Of course she is distressed, but let's get her through this without the epidural, it's actually too late for an epidural. So instead of maintaining the primary they're giving it away, because they may not recognise what a woman's body can do and the normal process of events, and may not trust in the woman's body. They are frightened to send the woman home in the latent phase, support her emotionally, get the family onside, and because they're frightened to send her home they do an ARM. Midwives can also behave differently because of feeling that they need to practise defensively, which can create different outcomes. I think that's a culture that is medically driven.* (Mia, clinical charge midwife)

As Mia describes, midwives may be looking through a technocratic lens, attuned primarily to risk. This lens may be inhibiting their ability to 'see' the simplicity within the situation that does not require intervention. This simplicity, instead, needs space and time to allow it to unfold; but, most of all, requires an authentic recognition, an ease of vision, and a particular 'state of mind'. Heidegger (2001), in writing of the 'simple' stated: "The simple hardly speaks to us any longer in its simplicity because the traditional scientific way of thinking has ruined our capacity to be astonished about what is supposedly and specifically self-evident" (p. 102). Being attuned to simplicity is more difficult amidst a technocratic culture as the simple is not appreciated in its true form or seen in its true splendour. It is, instead, perhaps lost in the 'noise' of the anticipation of complexity and striving for scientific explanation and control.

Perhaps midwives are too readily travelling into the technocratic space to meet what they understand to be facility expectations or do what the woman appears to want in the moment instead of what would better support physiological birth. Intervention has become readily accepted to 'treat' what is in fact normal and expected during physiological labour. Mia suggests that when midwives truly are related to the craft and understand normality, then supporting physiological labour and birth can more easily become a 'state of mind'. Normality can then be seen in perspective even within a technocratic field.

Midwives being afraid to send women home in the latent phase may be a result of their attunement with risk; the woman is no longer being observed, so perhaps the midwife feels some vulnerability regarding risk and possible morbidity. Mia suggests that midwives may be practising defensively, so could be concerned about potential risk to themselves professionally. Midwives may be concerned about 'pushing women too far' or may not have the courage to stand by what they know to be normal. Women may refuse to go home from hospital, or may not feel comfortable remaining at home.

It could be that some midwives have become so comfortable with managing labour and birth that they are uncomfortable with what may be understood to be 'uncontrolled'. Perhaps they see their role as 'treating' the pain rather than supporting the woman to work with her physiology. This could reflect a shift in perception of labour and birth and midwives' 'placedness' within it.

Malpas (2012) wrote about the works of Heidegger, and noted that "Place, and our relatedness to place, can of course figure in "states of mind" which is to say that we can encounter particular places as we can also have a sense of our own placedness" (p. 63). Relatedness to place and a sense of 'placedness' could be influencing the way midwives feel about their practise and the 'essence' of birth in the maternity facility. It may influence their confidence in midwifery skills if intervention and technology are understood amidst this culture to equate to increased safety and competency. According to McAra Couper et al. (2010), the normalisation and acceptance of technology in relation to labour and birth has resulted in skills and understanding that sit outside of this being marginalised. Midwives' perception of the placedness of midwifery within the maternity facility may be central to their perception of the value and credibility of their midwifery skills within the place, and their confidence to support physiological birth.

Each episode of practise happens in a particular place with its inherent 'state of mind'. For example, in the place of a particular facility, intervention could be the 'path of least resistance' and is ready-to-hand. In that place, having an epidural is normalised, may be done as a first line, and staff are skilled and comfortable with 'managing' labour with an epidural. The woman, herself, may be driving intervention; there could be an expectation from the woman that she can choose to have an epidural when she wants it (McAra Couper et al., 2010). It could influence the way in which midwives see the

'place' of their midwifery skills, and the position that they have in relation to the technocratic model.

When midwives work in a place where there is an overriding attunement with risk, it can make it more difficult for midwives to remain 'related to their craft'. It can influence their understanding of the 'essence' of birth in the maternity facility and unsettle their 'seeing' of simplicity. Understanding and remaining attuned to normality is core to supporting physiological birth, along with a strong belief that it is safe, optimal, and credible. A sense that the place of midwifery is cardinal within the maternity field is central to midwives being 'related to their craft' and normality being a state of mind.

Relating to pain as a normal part of labour

Isabel (obstetrician) talks about perception of pain and how feeling discomfort could be a precursor to practitioners augmenting a woman's labour:

> *I think we have a culture where it's not accepted to see someone in pain and agony, and so it's difficult to watch that for both family members as well as staff. We tend to perhaps, if we are intervening, ensure that there is a reasonably quick progression through the stages, for better or worse.* (Isabel, obstetrician)

Isobel suggests that by being in the hospital field, practitioners are influenced by and engaged with the surrounding equipment which is orientating and influencing practise. Malpas (2006), in relation to Heidegger's notion of 'ready-to-hand', wrote:

> Notice that both dis-tance and orientation are themselves directly related to the equipmental structure associated with the ready-to-hand. Consequently, inasmuch as being-there always finds itself engaged with things, so it always finds itself enmeshed with some equipmental structure, and so, given the configuration of things, places and regions within that structure, being-there always finds itself orientated in a particular way with certain things, places, and regions standing out as salient for it. (p. 91)

This orientation towards, and relationship with, surroundings and ready-to-hand equipment in the space may be influencing the way that practitioners understand and experience a woman having labour pain, and their subsequent response. This

understanding may mean that practitioners are more likely to expedite the labour process, perhaps to minimise the time 'exposed' to the pain, leading to more intervention. By 'being there' in the space, they are directly related to, and interconnected with, what is ready-to-hand. The arrangement of what is ready-to-hand presupposes orientation, and represents a medium for decision-making.

Perspectives may also be associated with a discourse that pain is related to dysfunction and pathology that needs to be 'fixed' rather than being part of a normal physiological process. It perhaps reflects practitioner fear—fear of the physiological process, and possibly feeling disempowered to be able to 'fix' the situation unless we intervene, which shows, again, that intervention during labour and birth is influenced by many variables, not purely what is best for the woman and baby.

Having the means to intervene quickly and easily ready-to-hand in the maternity field orientates and influences 'play'. This orientation being the 'normal' represents a barrier to practitioners being attuned to normality and allowing the woman's physiology to lead. These interventions could be both for the comfort of the woman and the comfort of the practitioner.

Summary

Place/space is seldom 'neutral'. Practitioners are attuned to an overriding 'tone' or 'attitude' which reflects the discourse of the birthing place. Amidst a more technocratic hospital field there is a heightened attunement to risk and pathology, shaping an alertness to 'abnormal' which can influence the degree to which normality is 'seen'. Although a woman's risk 'is', the anticipation of risk and how it is threaded into her care can bring its potentiality to the foreground and may result in surveillance or 'just in case' interventions in pursuit of safety. Risk, then, takes a 'front seat' with the 'default' set closely to align with anticipating risk and pathology.

When practitioners are able to see the relationship between normality and risk, it influences their being-open to opportunities for physiological birth. Fear of a potential risk may lead some midwives to refer prematurely to obstetricians leading to avoidable interventions. In contrast, conditions for physiological birth being 'ready-to-hand' can influence 'attunement to a discourse of normality' and more responsive decision-making acknowledging the uniqueness of each woman, which includes additional support from senior midwives, especially before referring to an obstetrician. Having an

attunement to labour physiology and a ‘relatedness to the midwifery craft’ can aid illumination of the ‘essence’ of each situation.

Chapter Seven: Place is a Field of Play

> Correlatively, the space in which the game's movement takes place is not simply the open space in which one 'plays oneself out' [sich ausspielt] but one that is specially marked out and reserved for the movement of the game. Human play requires a playing field [Spielraum]. Setting off the playing field – just like setting off sacred precincts, as Huizinga rightly points out sets off the sphere of play as a closed world, one without transition and mediation to the world of aims. (Gadamer, 2013, p. 111)

Introduction

In this chapter, I have considered Gadamer's concept of 'play' to examine the notion that labour and birthing facilities are 'fields of play'. Gadamer (2013) described the human ontological condition in terms of play and proposed that what constitutes 'the truth' can be revealed in play itself. Looking through the lens of this notion helped to develop understanding into how 'the game' is played in the maternity labour and birth 'field', and how such play influences how midwives and obstetricians support physiological birth. The midwives and obstetricians are both 'players' participating in the game and 'spectators' watching the game.

Gadamer understood the structure of play to be a back-and-forth motion that is not tied to any goal of which would bring it to completion. He used examples of the play of light or waves, the play of gears in machinery, the interplay of limbs, a play on words. Play also occurs in collaboration with something or someone. There are rules of the game, and play has inherent risks. Gadamer (2013) proposed that human play within the field is always intended. Within the field of play there are restrictions, regulations, and expectations in relation to the behaviour of the players, and also meaningful purpose related to the play which influence how the game is played but do not restrict the free element of play. Gadamer also wrote about the spectators of the game being participants involved in the game alongside the players, rather than just sitting on the sidelines. Each player has an understanding of the game and how they believe it should be played, along with a vested interest underpinning their play (Gadamer, 2013).

Participants described drivers that shape the play within the field of the labour and birthing facility, influencing their experience in relation to supporting physiological

birth. These key threads running through the data are related to the 'play of protection', 'play of time', 'play of efficiency', and the 'play of resources'. These all relate to the ways that the players and teams of players play the game within the field and negotiate their way around the key threads. However, teams of players perhaps have different meanings which reflect the interests of the players and the interests of the field itself.

Central to this chapter is the notion of 'the rush'; participants described a lack of patience and a tension in relation to time and progress during labour which, along with the surrounding 'play', they considered central to their experience of supporting physiological birth. It seems that the 'play of the field' was a key pressure point for this cohort of midwives and obstetricians, influencing how they were able, or at times unable, to support physiological birth

The 'Play of Protection'

Many participants talked about 'the rush' regarding time and progress during labour and birth in the hospital field of play. Participants described how they 'hold space' for the woman to labour and birth physiologically, protecting the woman from pressure in relation to time and progress. At the centre of the play of protection is the notion of which player 'has the ball', the interests that the players and teams bring to the 'play', and the players' perception of what constitutes protection, along with whom they are protecting.

Playing a guardian angel role behind closed doors

Francesca talks about her role in the 'play of protection' which safeguards the woman from pressure within the hospital field that tends to 'rush' labour and birth:

> *I don't like institutional pressure put on the woman. I find this difficult and I'll sometimes dig my toes in; I want to deliberately irritate the institution for putting the institution's needs first when this could have a negative impact on the woman. I didn't feel this pressure in the primary birthing units. They do leave me in the hospital though; I keep the charge midwife informed about what's happening in the room, but it doesn't mean I invite people in quickly if all is going well. I've got to protect the woman from the institution's expectations around time and birth space. I know that intervention could be easy; Intervention is really easy. If you're in a secondary (hospital) unit then you have to be a guardian, a*

> *greater guardian. You have to be like 1000 angels, not just one. If you're at a primary birthing unit you can guard physiological birth with ease, there isn't the same pressure there. It's harder work to do that in hospital units. Midwives who do guard physiological birth in hospital facilities need more kudos and recognition for this. But if you're committed to a midwifery philosophy you can support lots of women with complexities to have normal births.* (Francesca, LMC midwife)

Francesca describes how she protects the woman from 'institutional pressure' in order to 'hold space' for her to labour and birth physiologically in a hospital facility. She suggests this guardian angel role is much more challenging when working in a hospital facility than in a primary unit. Francesca describes the 'play of protection' here as protecting the woman from the ease of intervention in relation to 'the rush' that is central to the culture in the hospital field.

It is clear that 'the rush' is not the 'game' that Francesca is prepared to play. However, as a player who has to be like 1000 angels in order to protect the woman, holding the ball in the hospital space takes hard work, strength, and commitment. She has learnt, from experience, that facility staff may bring with them pressure to intervene. Although she protects the woman in the safety of her room, she uses good communication to keep the charge midwife informed, perhaps as a strategy to keep pressure in relation to time and progress at bay.

There is a real sense of time as a construct within Francesca's words; a concept of time in relation to labour progress changing within the space, 'the time of the space'. The facility's expectations regarding time and progress are 'already there' in the field. These expectations may be influenced by guidelines and policies, shared understanding, and facility needs. This 'already there' reflects the essence of the game at play. Francesca highlights that in a primary unit there is not the same pressure in relation to time and progress.

Intervention is easy and available in this hospital field, influencing play. Heidegger (1927/1962) talked about Dasein, or being-in-the-world, as being an engagement with physical surroundings towards projects that are being undertaken there. He discussed readiness-to-hand as being the presence of something that is defined by its functional role; what the objective is behind its presence, what it is used for, or its potential action

(McInerney, 1991). The potential action of intervention is to accelerate labour progress and it appears that this is readily accepted as 'normal play' in the field, which is likely to affect practitioners' perspectives.

Francesca talked about commitment to a midwifery philosophy of supporting normality as being key to the 'play of protection' and to mitigating some of the pressure in relation to time and progress. The New Zealand College of Midwives (2006) *Consensus Statement for Normal Birth* states that

> Every action the midwife makes, from her first interaction with the woman, needs to support keeping birth normal thereby supporting the normal cascade that occurs when labour and birth happen physiologically. Any and every interaction/decision affects this natural cascade in a positive or negative way. (p. 1)

If the woman and baby are showing no signs of distress, and if there is still progress, albeit at a slower pace, then the midwife will wait and watch. However, pressures in relation to facility needs may, at times, be in direct tension with this approach.

The management of labour due to time restraints seems to be the path of least resistance and central to the game in the hospital field. However, when practise is led by a strong midwifery philosophy of supporting physiological birth, it can be instrumental in protecting women from unnecessary intervention. The 'play of protection' in the hospital space is an interplay between players/teams with inherent tensions around time and progress in labour. Some players are protecting the woman from the 'ready to hand' ease of intervention in the hospital field. For other players, this readiness of intervention may be perceived as 'safety' in relation to the woman and baby, or safety in relation to the facility.

Safety and the tension of responsibility

Holly (LMC midwife) describes the tensions and competing perspectives regarding responsibility and 'protection' which are played out at the practitioner interface:

> *I brought a woman into the hospital recently and the first thing the CCM said to me was 'so where's she at? What's she doing? Have you examined her?' She questioned my decision not to do a vaginal examination, but it was clear that the woman was in established labour and I didn't need proof of that, it's such an arbitrary measure. But I think*

you've got to be quick to thwart those things off. I do sometimes feel the pressure to intervene, but I don't follow; I don't do it just because I'm feeling pressured! I feel like I can hold that space pretty well and just say 'no, actually we're just going to wait a little bit and see what happens'. I guess that's probably why I'm feeling tired and burnt out because that gets exhausting.

It makes me think a lot about my communication and I've learned that if I communicate excessively, they'll leave me alone (registrars and CCMs). If they know exactly what's going on in my room and the progress that's being made, then they've got no reason to be knocking on the door and it keeps them at bay. It makes them feel like they're still in control of everything. As one of the midwives said to me, they were 'sharking' outside of my room, but I was keeping them informed enough that they stayed out. (Holly, LMC midwife)

Holly describes the expectations of play and tensions regarding the timeliness of progress in labour and birth as being central to 'business' in the maternity field; a rush to keep things moving and a need to justify decisions if expectations are not met. She talks about the primary focus and interest of the CCM being the woman's cervical dilatation; the measure of her labour progress is a priority. This suggests an understanding that the cervix dilates at a pre-determined rate which, therefore, is a clear guide as to when progress must be deemed as 'slow'. It is likely that Holly's decision not to do a vaginal examination to assess cervical dilation was to avoid the fixed measuring point; Holly commented, '*she was 3cm dilated and fully effaced at 8am, so as a primigravida, by 2pm we would expect her to be nearing full dilatation*'. By avoiding this fixed measure, Holly is able to talk generally in terms of 'making progress' for she, in her experience of being with labouring women, has more subtle measures of assessment. Those outside the door can only trust that Holly is reading the situation appropriately. They have no 'measure' to reassure them and no information that offers the clinical picture they would expect. Perhaps a woman's progress in labour is one indicator of safety in a field where timeliness is valued.

If Holly was caring for this woman at home, she would carry full responsibility. In a primary birthing unit it is likely that Holly would be known and trusted in a different

way to when she is in a larger hospital facility. In the hospital field facility, staff are also at play, which changes the game. There are tensions at the practitioner interface around responsibilities for the welfare of the woman and baby. Holly talks about carrying the weight of responsibility to protect the woman's space to birth within the hospital field, and that keeping the CCM well informed meant that they did not have a good rationale for entering into the room. She portrays the CCM and registrar as representing the facility pressure regarding time and progress. However, for facility staff, having more insight into the woman's care could represent protection. Perhaps in asking about the woman's labour progress they are seeking reassurance around safety, and the potential need for their involvement in the woman's care. At the core of their enquiry could lay feelings of responsibility.

It is important to consider why the CCM and registrar were 'sharking' outside of the birth room. Perhaps they were thinking ahead of time about the potential for their help to be needed. They may have remembered previous times when it was later revealed that there had been ongoing problems behind the closed door which resulted in poor outcomes.

Holly indicates that she does not feel that the CCM and registrar are supporting her to appropriately support the woman; they are not walking alongside her in the same direction. Perhaps the CCM and registrar also felt a disconnection. 'Sharking' suggests impatience or uneasiness, and an eagerness to have that resolved by being let into the room. If Holly had felt that the facility maternity team were 'with' her then she may have felt less segregated from them. Holly refers to the CCMs and registrars as 'they', suggesting that she sees them as a team, together; possibly separate from her. There is perhaps a lack of connection within the wider maternity team and so possibly a reduced support of each other.

Midwives, like Holly, have learnt to work with this tension at the interface by shutting the door on staff from the facility, while still assuring them that what is happening behind the closed door is safe. Relationships require trust on both sides. The midwife needs to trust her ongoing judgement of 'this is safe', while the facility staff need to trust that the verbal report of the midwife reflects safe care. In doing so, they take on the responsibility for 'not interfering'. The longer the door is shut, the potential for greater tension among facility staff; but, potentially, the greater possibility of a woman having an un-interfered-with labour and birth.

Heidegger talked about the nature of dwelling, or 'being-in' or 'residing', and how this involves a familiarity or connection where one goes about looking after something or taking care. Heidegger believed that our situatedness in the world cannot be separated from what we are already engaged with and that which is closest to us (Malpas, 2006). Perhaps, fundamentally, the nature of dwelling and taking care, for Holly and the facility staff, precedes different perspectives. For Holly, it is likely to be focussed solely on looking after the individual woman in her care. She understands her history, plans for her labour and birth, her feelings, her experience so far, her wider whānau. The CCM and registrar, in contrast, are engaged with, and taking care of, the outcomes for all women who pass through the labour and birthing unit. They would have felt a level of responsibility for how the needs of one woman have to be prioritised alongside those of others. They would also be anticipating potentially needing to take responsibility for the woman's care if Holly needed to hand over to them (e.g., if the woman developed complications or Holly needed support).

Feeling safe sits at the core, driving this play of protection. Perhaps the facility staff wanted reassurance of safety, which they sought through empirical measures as they were not directly involved in the woman's care, and which may have been understood by Holly to be pressure. They may have also been seeking to appease their sense of responsibility. They were likely looking for reassurance of the wellbeing of the woman and baby, and that their involvement was not now nor likely to be needed in the near future. All of the players here, whether directly playing the game or spectators on the other side of closed doors, are involved in the game.

Trust is also central and works two ways. According to Gadamer, 'the being of play' is communicated by the playing out of play itself (Williams, 2018). Here, it appears that distrust is being played out resulting in tension. Holly shows a degree of distrust in the facility staff, seeing them as bringing pressure to intervene when she felt it was not needed and could compromise the woman's care and experience. Lack of trust created a barrier to connecting further with them. The facility staff may have also felt a level of distrust as they were being kept out of the woman's care and needed reassurance about safety due to their feeling a degree of actual and potential responsibility. If Holly felt that she could trust the facility staff to walk with her, she would have been more likely to 'let them in', and not feel that she had to protect the woman from their involvement. This, in turn, would have helped the facility staff to feel reassured about safety and

confident to step back, trusting that their help was not required. Nixon (2017) wrote about Gadamer's notion of mutual understanding:

> To grow in understanding we need spaces for discussion, creative collaboration, and improvisatory talk. We need to be able to feel our way towards understanding, to be allowed to work through half-formed ideas and arguments, to risk being misunderstood or only partially understood. If such spaces of open-mindedness are disallowed—through, for example, a pedantic over-insistence on 'correctness' or an all-too-familiar obsession with outcomes—then education stalls. (p. 31)

These words highlight the importance of creating the opportunity to facilitate mutual understanding through creating space for communication, questioning, consideration, and growth, through facilitating connectedness.

At the centre of the 'play of protection' is, perhaps, what constitutes safety for the players; the safety of the woman and baby, safety of the labour and birth field, and safety of self in relation to both actual and potential responsibility. A disconnect between players can create further division on the field as the players attempt to 'keep the ball' rather than playing the game as a team. The focus on timeliness and related pressure to intervene during labour can be a catalyst to disconnection in order to protect normality. This in turn can lead to further focus on progress in seeking reassurance of safety. Perhaps the focus on timeliness in the hospital field has driven normality into the perceived safety of the room.

The desire to 'hold the ball' to protect the woman

Chloe (LMC midwife) tells a story of when the hospital facility staff stepped in to intervene in a woman's labour when it could have potentially been avoided. Chloe was unable to convince them to allow more time. She was no longer 'holding the ball' and was unable to protect the woman in the way that she thought was best:

> *Recently, at a hospital maternity facility, I looked after a woman being induced, and the syntocinon infusion was stopped overnight. They told me that morning that they would start again at 7am, so I arranged to be there then, but I walked in to find that they were taking her to theatre because they'd started the infusion at 6 and it 'wasn't working'. They said 'the head's high', but she was a multip so it was likely to be. The woman and the baby were both fine. I did an examination in the pre-op*

> *room but there was nothing I could say that would stop them and I feel sad that I wasn't way more pushy because the woman haemorrhaged (post-caesarean) and needed care in the intensive care unit. They didn't give her a chance; they didn't look at the bigger picture and see that this woman had birthed vaginally really well and had never needed to have a caesarean, this baby wasn't any bigger. They were going by institutional rules. It was really sad. They created a problem, and this poor woman took months to recover*. (Chloe, LMC midwife)

Chloe describes a situation where the woman seemingly was not given time for her labour to establish when she was being induced. Even though the woman and the baby were well, a decision was made without Chloe's input that the induction had failed and that a caesarean section was needed. There is a feeling that the facility 'players' were perhaps 'seeing' reasons to indicate that the induction had not been effective; the syntocinon was not working, the head was high. However, equally, they were not 'seeing' the reassuring factors which Chloe, perhaps, would have been able to highlight if she had been involved in the decision-making process.

Although Chloe was involved in the game, she was not able to 'hold the ball' or even be involved in the play regarding the decision-making process around birth. She alludes to feeling a lack of control to influence the play regarding time, as though her voice was not heard and valued, and the play was unfair. It seems that the facility staff were playing 'their way' and by 'their rules'. Ideally a three-way conversation should have occurred between Chloe, the woman, and the obstetrician prior to the decision being made for the caesarean section.

It seems that there is perhaps conflict between the two models of practise, and, to a degree, there is a barrier built up between them. This perhaps reflects the different perceptions around what constitutes safety. For Chloe, safety was likely to be understood as protecting the woman from unnecessary intervention in the absence of immediate risk and giving labour more time. For facility staff, safety perhaps constituted avoiding what they perceived to be potential risk. Maybe they had been involved in situations where this scenario had resulted in a poor outcome and wanted to avoid the risk.

There is likely to be pressure for facility players to comply with facility rules and expectations of the game. There is likely to be fear of the consequences of not following 'the rules' if there were to be a poor outcome. Perhaps there was some defensive practise, with the 'play of protection' extending to practitioners keeping themselves safe. Perhaps the facility rules also reflect the needs of the facility with regard to 'efficiency'. The facility rules are likely to have been set to keep women safe; but, as the hospital provides care to many women with complexities, practise guidelines tend to reflect the needs of women with complexity. Accommodation of increased complexity and risk could perhaps lead to women considered to be lower risk sometimes receiving 'just in case' interventions that could possibly be safely avoided.

It would seem that avoiding the involvement of other players who have a different model of practise could be seen (either consciously or unconsciously) as a strategy to 'hold onto the ball' regarding the decision-making. In holding the ball, the players are influencing the decision with their own interests. The 'play of protection' could extend to practitioners perceiving that they are keeping both themselves and the facility safe.

The 'Play of Time'

Participants shared stories suggesting differences in the perception of time and progress in relation to labour depending on the place; and how time in the space is played, influencing the ability of players to support physiological birth.

Players in the field, 'holding the ball', and the 'play of time'

Harriet (registrar) talks about the impact of the practitioners who are in the space, their own perspectives in relation to time and labour progress, and what determines who is 'holding the ball' and driving the play of time:

> *It's very dependent on the perspectives of the people who are working, along with a difference in perspectives between midwives and the obstetric team. You might have one consultant saying it's fine to be more patient and wait, and an hour later when there's a new consultant even though there may still be no CTG concerns or signs of obstruction they might say 'We have waited long enough it's time that we got on with it and did a caesarean'. It's very dependent on the consultant involved particularly. It depends on what their level of patience is like and their threshold to intervene. I was recently working with one of the consultants*

> *who's very much in favour of giving labour and birth time. The woman had been 9 centimetres dilated for quite a while and my next assessment would have meant a caesarean section if she wasn't fully dilated. The consultant, however, said, 'Just give her time there are no other signs of obstruction. I know we should expect her to be fully dilated at this point but we can give her time as the CTG is normal and there's nothing else to be concerned about'. And so that's what we did, we just gave her more time. I think here [hospital facility Z] there's a strong wish to intervene less where possible among the midwifery staff, and in contrast the medical team tend to feel like we should be 'doing something'.* (Harriet, registrar)

Harriet describes the centrality of the perspectives of the practitioners who are in the space for the play of time, particularly consultant obstetricians, in relation to patience with labour progress. She talks about competing philosophies which influence the interpretation of labour progress within the hospital field. Harriet highlights the leadership by the consultant who confidently reassured her that it was safe to wait for labour progress, even though to do so was playing a little outside of the normal expectations of the place. It seems that the consultant felt safe to watch and wait for longer, reassured by the absence of other indications of risk, suggesting that in this instance, this player did not see time to be a risk.

Gadamer (2004) talked about the players in his notion of the 'game' and how they all bring something to the game itself and collectively create or shape reality. Gadamer referred to the 'interplay of move and countermove' where players create the game and, within the game itself, create a space where changing horizons overlap. Although there are rules of the game, Gadamer (2013) wrote that the player is still able to play with possibilities and has the freedom to make a decision to work outside of the rules of play, but this is not without risk: "One enjoys a freedom of decision which at the same time is endangered and irrevocably limited" (p. 110).

The consultant obstetrician stepped outside of the rules of the game and, as no additional risk was evident, considered that there was no pressure to intervene immediately and expedite the birth. Maybe the consultant's position in relation to authority facilitated the play of time. Perhaps it took the consultant's involvement in the

game to allow Harriet (who reports to the consultant) to be open to shifting horizons and feel that she could deviate slightly from the facility's expectations.

The interpretation of time in relation to labour and birth by obstetricians is perhaps individually constructed by their perspective on what they consider to be 'normal' and 'acceptable' progress, along with their level of patience and confidence in physiological birth. When the obstetrician feels safe and confident to not hurry labour and birth, possibly stepping outside of operational timeframes, they can be effective in supporting birth and perhaps fostering a culture of 'appropriately allowing time'. Harriet suggests that the lack of a shared philosophy and cohesiveness within the hospital field can equate to differences and pressure points regarding how time is played; thereby highlighting the centrality of the three-way conversation in ensuring that the woman's and the midwives' voices are central to the game and could influence horizons.

Harriet talks about time and progress in relation to the assessment of risk and the threshold of practitioner's patience to wait and threshold for intervening. She suggests that sometimes a consultant may say '*we've waited long enough it's time that we got on with it and do a caesarean*' (Harriet) even though there may be no other clinical concerns. She does not suggest that this is related to the operational demands of the maternity unit; rather it is more about what the obstetrician considers to be 'long enough'. It seems that the play of time is multifaceted and influenced by more than simply clinical risk. Perhaps the notion of 'time' in labour is considered by some to be a risk in itself. It is also feasible that the 'play of time' is influenced by the way 'things are done' at the facility, potentially shaping practitioners' perspectives.

Harriet talks about the midwifery team at facility Z preferring to intervene less, whilst the medical team tend to feel like they should be 'doing something'. This consultant obstetrician had the confidence to 'do nothing' and allow more time for the woman to labour; perhaps avoiding intervention that may otherwise have been done by the registrar. For the registrar, perhaps the play of time is ultimately driven by the consultant who may be more confident to step outside of the accepted facility parameters. Perhaps, at times, registrars need this support to feel confident that 'doing nothing' can in fact be 'doing something' in relation to supporting normality.

The facility expectations for 'acceptable' progress during labour and birth are central to the play of time, as are the players' confidence to step outside of these parameters where

appropriate. If players consider time in labour in itself to be a risk, they are less likely to feel safe with the 'play of time' and, instead, stand close to the prescribed linear time frames which exist in the facility. The understanding that time in labour in itself is a risk perhaps influences players to believe that they should be 'doing something' in order to accelerate progress and 'reduce risk'. What is considered to be 'truth' could be influenced by the practitioner's philosophy, experience, the level of play with time, and degree of uncertainty that they feel comfortable with in the field.

Perception of Time in the Field Influencing What Constitutes 'Normal'

Clara (LMC midwife) talks about how she tries to preserve what is 'normal' in relation to labour progress whilst in the hospital field and enable the 'play of time' to work with the woman's physiology:

> *For me in hospital what is 'normal' still remains 'normal', it's just the attitude there (hospital maternity facility) to it that isn't normal. So if I had a woman who was having a sleep during labour, a resting phase, I wouldn't see that as a signal to intervene unless it went on and on. I wouldn't discuss this with the CCM or registrar, because what am I going to say? I'm not going to go out and say 'this labour and birth is really normal and she's going through a resting phase' because I think that would then invite interventions into the room. They would want to start syntocinon and interventions aren't needed to hurry a resting phase when all is well. If you've got a woman where all her recordings are fine, baby's fine, and there's no sign of any compromise anywhere, you've got time. And so you just use that time.* (Clara, LMC midwife)

Clara clearly understood how the woman's resting phase was likely to have been interpreted by facility staff and believed that they would consider it to represent a risk, requiring intervention. Clara believes that intervention in this situation would have been unnecessary, and that this phase was completely normal for *this woman*, at *this time*. She believed that she had time, but not if this information was shared with the CCM or registrar.

Perhaps the focus in the hospital field has become pathology: anticipating it, identifying it, and treating it. This may have led to some pathologising of what is normal, creating tensions and fear, and influencing perspectives in relation to time. Maybe the

assumptions of linear cervical dilatation and contractions increasing in frequency and intensity are engrained as ‘this is what should happen’. However, evidence suggests that normal labour progress is not always linear, and the diagnosis of dystocia may not distinguish between a healthy myometrium which is resting, dystocia associated with maternal stress, and dystocia associated with pathology (Karaçam, Walsh & Bugg, 2014). Clara, however, indicates that she had assessed, and would continue to assess, the woman’s situation for risk or compromise, and was reassured that, in this case, at this time, it was safe to be patient.

The midwife here is driving the play of time and ‘holds the ball’, but she has not involved other players due to fear that she would be expected to artificially rupture the woman’s membranes and consult with an obstetrician if labour progress continued to be ‘slow’ by facility expectations. However, in ‘holding the ball’ inside the room, Clara is not sharing this normality with the other players.

Gadamer used the concept of mimesis in relation to truth to describe how art presents the truth and suggested that this is when “something is represented in such a way that it is actually present in sensuous abundance” (Williams, 2018, p. 325). Gadamer went on to say that truth is represented and communicated to ‘the audience’ through their interaction with the phenomenon itself and interplay with it; the back and forth between players integral to play being instrumental in presenting their truth (Williams, 2018). Furthermore, Gadamer (2013) proposed that “a festival exists only in being celebrated… the festival is celebrated because it is there” (p. 122).

These insights would suggest that by sharing information about the woman’s resting phase with the facility team, and how it may relate to normal labour physiology, could influence what is considered to be a ‘truth’ in relation to time and progress. These conversations could be instrumental in making the resting phase ‘abundant’ in the hospital field as a normal part of labour in the absence of other signs of risk. Players’ perception of what constitutes truth may be challenged but, if this normality was continually ‘played’, a new collective truth could be nurtured.

There is perhaps tension when providing care to low-risk women in a hospital space, central to which is time. Time appears to be the way in which players understand progress in labour in relation to pathology and risk, influencing their play of time. This culture may at times lead to pathologising of the ‘normal’, creating tensions and fear in

relation to time and risk. Keeping the play of time within the room, in order to protect normality and 'keep the ball', could potentially be a catalyst to 'losing the ball' in relation to the shared understanding of time, labour progress, and risk.

A culture of busyness driving 'the rush'

Clara (LMC midwife) talks about a culture of intervening readily in labour and birth, more often in larger hospital facilities, in order to 'hurry things along' due to practitioner fear and the busyness of the place:

> *There becomes a culture in the hospital establishment and the culture then starts to effect the behaviours of incoming professionals. It's usually based on the fear factor again which impacts on the desire to hurry things along. I think that the place affects you when there is a culture there that's settled for quick intervention. I think sometimes the bigger the facility the more it becomes a numbers game. And so it creates a tension around the labour. You might think we can wait a little longer, and at that smaller facility I think you're probably more proactive with this.* (Clara, LMC midwife)

Clara indicates that the tension that is created around labour ultimately relates to how the culture of the labour and birthing field understands the relationship between time and risk. She suggests that in a smaller maternity facility, perhaps time is not at such a premium and not a central focus. At a smaller facility, practitioners may be more proactive with being patient when they feel it is appropriate to wait a little longer, suggesting that they may feel more able and empowered to facilitate waiting, and that consideration of capacity is not such a priority.

According to Gadamer (2013) games have their own spirit, and the nature of the game is determined by the rules of play that determine how the field is filled:

> The playing field on which the game is played is, as it were, set by the nature of the game itself and is defined far more by the structure that determines the movement of the game from within than by what it comes up against, i.e. the boundaries of the open space, limiting movement from without. (p. 111)

In other words, there is an understanding about the game which is ‘already there’ in the field. An understanding that things will be done in a certain way, creating expectations that influences practise and determines the ‘movements of the game’.

Clara describes how practitioner fear, along with the capacity and acuity of the facility, can drive and replicate a culture which normalises intervening readily in labour, almost as though to reduce the ‘time exposed to the risk’. Clara talks about it being more of an issue at bigger hospital facilities, possibly the fear and desire to rush things along creating a tension around the labour. Maybe in bigger maternity facilities the tension around time and ‘efficiency’ increases when dealing with competing pressures to meet the needs of many women. A larger, busier hospital facility may also disempower the midwife, possibly then making intervention more likely.

Clara talks about place influencing a desire to hurry things along when the facility has ‘settled’ for quick intervention which suggests perhaps an understanding that a ‘quick intervention’ is not optimal, but reluctantly accepted as it could be meeting the needs of the facility. Clara paints a picture of a culture of intervening more quickly shaping the perspectives and practise of practitioners; thereby feasibly constraining the play of time to support physiology, and play supports the underlying ‘game’ which is happening on the field.

Clara refers to the ‘fear factor’ as being central to a culture of settling for a quick intervention. It is important to consider, therefore, what may be causing the fear. It could be the fear of not coping with the ongoing workload if labour is not ‘managed’, not meeting the expectations of the place in relation to perceived ‘efficiency’, or perhaps fearing a poor outcome if labour is prolonged. It may be that with larger numbers there is statistically more likelihood of poor outcomes. Heidegger (1927/1962) wrote how experiences from the past precede Dasein and create an interpretive lens through which the present is seen, providing a fore-concept for interpretation. The ‘already has been’ leaps ahead to inform understanding, becoming ‘present’ in Dasein. Players may have had experiences of poor outcomes which have remained ‘there’ and resulted in decision-making to intervene more readily in labour and birth in an attempt to avoid the situation happening again.

The play of time is shaped by the spirit of the game in the labour and birthing field. This spirit or culture is already there in the field and influences how the game is played. It

constructs an understanding that things will be done in a certain way. It would seem that in the bigger hospital facilities the shared understanding about the game is informed by the history of the game that has been played and the large volumes of women being cared for. The 'fear factor' may be a result of having cared for more women with complexities bringing risk and pathology to the forefront of the spirit of the game; thus, creating tension around time in labour, and central to driving 'the rush'.

The 'Play of Efficiency'

Within many of the participants' stories, there was a key thread of the experience of a pressure in relation to the notion of, and need for, 'efficiency' in the hospital labour and birthing field. This was highlighted as a barrier to being able to be appropriately woman-centred and effectively support physiological birth.

The mood of 'the rush'

Aroha (LMC midwife) describes the mood of 'the rush' in which this pressure in relation to 'efficiency' transcends, and how this is central to the facility culture and the play of the field:

> *I think the energy of facility W (hospital maternity facility) is a lot busier that the primary unit where I also work, even just the level of noise there, and there are people rushing through corridors. The rush of the place makes you feel like you'd better hurry up. I often feel pressured to hurry things along there. It seems so stressful I don't know how they do it. So I empathise but then it's not the woman's problem. She's labouring and she should be allowed to labour in peace without having to be forced to augment her labour to speed things up. Sometimes it's just the words they say; 'is your woman progressing? What's happening in your room? Is she up, is she mobilising?' Pressure, pressure, pressure. Sometimes you'll have the charge midwife or the obstetric team come round and say 'hi, just in case we need to meet you later, at least we're meeting you now and not in an emergency'. But then often with that brief introduction, there'll be a scan of what's happening in the room and then 'okay if she hasn't had a baby in half an hour I'll come back', without me prompting this. Sometimes I feel like 'failure to progress' is decided when we probably could fix this fairly easy, but the woman's not given that chance or that time. They'll just say 'she's not progressed, it's been*

> *half an hour (or whatever the time frame is they want) and so we need syntocinon now'. I just think that that's the only way they can try and hurry things up because they've got 10 other people waiting, it's the nature of the beast really isn't it? Intervention to speed things up for the benefit of the unit/staff is just the normal*. (Aroha, LMC midwife)

Aroha describes the mood of 'the rush' in the hospital facility and how the busyness and rush of the field may directly correlate with a pressure to rush women's labour and birth. She describes a lack of calm and peace in this place which creates a particular energy that may be a catalyst to not being appropriately patient. She sets a scene of being caught up amidst this pressure to rush when in the hospital field; the pressure, or mood, being all around and dominating and defining the purpose of the space. Perhaps this 'rush' has become a key part of the culture, irrespective of the busyness of the facility, rather than purely the busyness itself always being a catalyst.

For Heidegger (1927/1962), mood or 'Stimmung' is always spatial. It is present in the background, a phenomenon which is felt but is unseen. The mood discloses our being-in-the-world or Dasein (Heidegger, 1927/1962). According to Heidegger, as humans we are always attuned to mood in relation to Dasein, and games or play take place within a mood; this atmosphere is created by the place in which the game is played. The mood can frame or colour the world around us and determine our way of being. According to Heidegger,

> Stimmung is a way, not merely a form or a mode, but a way – in the sense of a melody that does not merely hover over the so-called proper being at hand of man, but that sets the tone for such being, i.e. attunes (stimmt) and determines (be-stimmt) the manner and way of his being. (pp. 29-30)

Heidegger also talked about the notion of Care, which he describes as being a holistic pre-supposed background to Dasein which reflects the purpose and intention of phenomena and being-in-the-world, and what is already in place to support this purpose. The notion of Care primarily orientates towards future possibilities in relation to serving a particular purpose in the world; moving towards something in order to achieve something, or for the sake of something (Heidegger, 1927/1962). The mood of 'the rush' in relation to this text is perhaps communicating meaning to those players in the space in relation to understanding the purpose of 'being in the game' in that space. This

mood seemingly communicates about the possibilities within the field and the game itself, the underlying rationale, and what purpose they serve and aims they hope to achieve. Aroha suggests that the message about the game is that it is about timeliness, and that the facility is ready, able, and willing to accelerate labour with ease. Timeliness is valued, normalised, and the means to do so is ready-to-hand.

Holdsworth (2020) wrote about anticipation of time pressure and busyness in time-space, and how it can influence experiences of temporality and modes of being. Holdsworth suggested that busyness is internal as well as external; busy habits may form which can influence an individual's response to 'temporal pressure points'. It is feasible that working in a busy facility could create a mood of busyness that prevails even in the absence of busyness, which could then create a pressure to rush. There is also always the possibility that at any minute in the hospital field new admissions could arrive; such knowledge creating additional anticipation for players. Perhaps busyness is always 'present' as it is always anticipated.

Aroha suggests that 'adequate' progress is a central concern for the game once the woman is in the hospital field. It seems that the time frames for 'acceptable' progress, diagnosis of labour dystocia and the need for augmentation, are influenced by this mood of the game. Aroha talks about pressure as being both a result of the workload and of the mood of 'the rush'. Perhaps 'the rush' is normalised and central to facility culture, and the maternity team may be attuned to it. Within Aroha's words is a feeling that time in the hospital field is at a premium. It feels that the primary aim of the game is ensuring that progress is made in the facility as a whole, at a pace that is considered to be efficient collectively for the facility.

The field of the hospital labour and birthing facility can emanate a mood of busyness and 'timeliness'. Busyness is always 'present' and busy habits prevail, even if it is not actually busy, as busyness is always anticipated. This mood, in part, defines and colours the purpose of the space and the play within it, and reflects the nature of the game. It communicates a message that time and efficiency is central to play, and progress in labour is regulated within the field. The purpose of play is always moving towards progress, and progress is, perhaps, considered collectively as a field-of-play rather than the focus being on the individual.

Watching and judging the 'play of efficiency'

Hana (core midwife) talks about how spectators watching and judging the play in relation to time and progress in labour in the hospital field can create a pressure for efficiency. She indicates conflicting perspectives, and suggests a 'work around' to play out players' perspectives in relation to what constitutes 'efficiency':

> *The barrier to taking an evidence-based approach and tailoring care to meet the individual needs of the woman (in relation to time and progress in labour) is judgement from your colleagues, particularly your obstetric colleagues. There is much more defensive risk-based practise there as opposed to listening to the woman's needs. You know that everybody else is watching (regarding time and progress in labour) particularly during the second stage of labour. As a result women are never fully dilated. If there's no progress the clock has been ticking, even when the woman is low risk and everything is going well. I don't like the clocks.* (Hana, core midwife, hospital facility)

Hana describes the notion of time in the facility space as being watched, monitored, judged, limited; core currency in the hospital labour and birth field. She feels judged by colleagues in relation to the timeliness of a woman's labour. This judgment, it seems, is reflecting a collective culture around time in relation to labour progress in the field. Within these words is a suggestion that such pressure, driven perhaps by practitioner fear and perception of risk, could lead to intervention that sometimes could be safely avoided. Risk is to the woman and baby, and perhaps risk is also to the practitioner.

According to Gadamer, the spectators of the game are active participants in the game alongside the players, rather than just merely observing the play. They must take the game seriously and may be drawn into it. "A game, even when played before spectators, is not presented for anyone; if others participate in the play by spectating, their involvement is accidental to the emergence of play" (Williams, 2018, p. 325). Therefore, other players in the labour and birth field, who are involved in the play by observing or watching, can in fact change the play of the game. Furthermore Gadamer (2013) believed that in order to participate in the game through spectating, the spectator must be 'present' in the game—the game is of significance and concern to them. Those watching and judging, therefore, have a vested interest in the play and a perspective which they want to exercise and enact.

Hana indicates that there are conflicting perspectives around what 'efficiency' means for the players, the field itself, and the woman's labour and birth. She does not like 'the clocks' and the way that these do not consider risk in relation to individual clinical needs: the clocks also equate to the facility's time restrictions even when women are low-risk. Hana talks about not noting when a woman is fully dilated; a strategy to allow the woman more time to birth without the pressure to progress in a 'timely way'. Women are never fully dilated as this, in itself, is a trigger for the clocks to be activated. It is a strategy from her perspective to support physiological birth, having to 'work around' the game itself in order to 'hold the ball' and influence play.

The notion of 'efficiency' in the game appears to be associated with fear of risk in relation to time in labour against the risk of accelerating labour progress. If there are spectators observing within the field who care for more women with higher risk, it could influence their perspectives around 'efficiency'. Perhaps the notion of 'efficiency' in the hospital maternity field does not purely relate to meeting facility needs in terms of capacity, but it is also perceived by some players as a means of risk reduction and increasing safety.

Heidegger (1927/1962) wrote about judging in relation to Dasein; "We can bring the first structural moment of judging to light and pay heed to our intuition that judging is a form of knowing, if we conceptualize knowing as "understanding" (p. 385). Heidegger argued that understanding is not purely a matter of knowledge but is underpinned by knowing how to 'get around' in the world in which we inhabit. Hana talks about the watching and judging being related to defensive risk-based practise. Perhaps the obstetric team's understanding of labour taking time is constructed by experiences where this delay represented increased risk. Perhaps they feel an increased responsibility for the safety of the woman and baby during a woman's second stage. They could feel that they may themselves be judged for 'allowing' more time and not intervening, particularly if there was a poor outcome.

The notion and play of 'efficiency' in the hospital field may not purely relate to meeting facility needs in terms of time and capacity; perhaps it is also perceived by some as reducing risk. There could be fear associated with not meeting expectations around time frames, particularly during the second stage of labour, as these limits could equate to efficiency and safety for some practitioners. However, efficiency and safety for others could be appropriately avoiding intervention and allowing time.

Fear of not playing to the expectations of the team regarding time and efficiency

Harriet (registrar) talked about the pressure she felt before obstetric handover and how this could influence her decision-making regarding time, progress, and labour intervention. Here there may be different perspectives at play, but the play of efficiency is kept central:

> *Handovers in the morning can be stressful and your decisions can be challenged. When it comes to two hours before the handover you start to question your every decision, and it can influence your decision-making in the lead up in order to reflect what you know will be expected of you at the handover. They'll sometimes question your management of a woman's labour and birth, 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 it often is.* (Harriet, registrar)

Harriet describes how the morning obstetric handover meeting is a catalyst driving and shaping decision-making, one that can ultimately influence the care given to women. The core of the catalyst is the fear of not conforming to obstetric expectations of how things are to be done in the facility. The meeting embodies a technocratic approach and reinforces this philosophy, keeping it strong and visible. Harriet alludes to a strongly held belief among the obstetric team in 'managing' labour and birth and not creating 'delays' in the process, along with the obstetric team having a responsibility for 'managing' women's labour progress.

Harriet also alludes to not fully agreeing with this perspective but feels fearful about not complying with her colleagues' expectations of her. Heidegger's (1927/1962) notion of comportment is the way in which a person self-relates to the phenomenon that they are faced with, the 'taking of an attitude'. Gadamer believed that when we are at play we allow our comportment to be directed by the rules of the game, and the 'truth' of the game itself is presented through the play. Players fulfil their assigned tasks and the play itself takes priority over the player, shaping their play movement (Tate, 2012). Central to these notions is the 'already there' of play into which the registrar is coming into in relation to place. How the obstetric team perceive their role within the game and their collective philosophy towards labour and birth are core to play.

Harriet's words suggest that the fear of causing a delay according to these obstetric expectations could lead her to intervene (where possibly she may not have done otherwise) in the lead up to the meeting because she is anticipating judgment. It seems that there is no flexibility with the rules of the game regarding time, progress, and intervention to accelerate labour and birth. Perhaps the registrars' capacity in relation to the 'play of time and efficiency' is ultimately led by the consultant obstetrician to who they are reporting.

Gadamer believed that spectators of the game are also participating in the play, and when play is intended for an audience, then play transforms into 'structure' (Tate, 2012). Gadamer also believed that when this occurs, the play is no longer representing the movements of the players; instead, purely embodies the game itself, and the game's needs are seen. The spectators, for who the play is intended, and the player are then equally involved in the play; the spectators have been given 'methodological privilege' (Tate, 2012). In influencing and structuring the play for the obstetric team, Harriet perhaps opens the gate to equal representation in the play itself from these spectators.

Harriet talks about colleagues sometimes questioning why she has waited and, in doing so, 'caused a delay'. The focus on delay suggests that 'efficiency' is highly valued by the obstetric team; 'you have now delayed things for a good hour or two' suggests that the 'delay' is a bad thing, rather than it sometimes being seen as normal during labour, and an opportunity for the woman to have time to birth. In 'delaying progress' the delay may have been perceived as a risk to the woman and baby, or may have been perceived as a delay for the obstetric team and the operational running of the facility. The focus on time, progress, and efficiency perhaps indicates a perception amongst the obstetric team that labour progress is always linear—in spite of a body of evidence to suggest that it is not.

Efficiency, it would seem, is core to the game in the hospital field, and this notion is shaped by expectations which are continually reinforced as a central thread. Judgment from spectators who are equally engaged as players regulates these expectations. Perhaps the 'play of efficiency' is in fact understood to be the 'play of protection'; perhaps protection of the woman and baby, the facility as a whole, and the practitioners themselves are understood to be connected to the notion of efficiency.

The 'Play of Resources'

Within many of the participants' stories it was evident that a lack of resources in hospital facilities could itself influence how play was perceived within the space, and how the movements of play were able to be carried out.

Not enough players in the hospital field

Lara (CCM) describes the tensions created by strained facility staff resources, influencing perspectives around 'time' and 'play':

> *Having the time to provide good care is essential if we are to support physiological birth. The staffing issue and the stress directly impacts on our ability to give women a good chance, to give them the time that they need for their labour and birth. So having more staff would really help but at the moment we can't fill the roster gaps. There are many occasions where it's been so busy and I, as the CCM, haven't been able to spend enough time supporting staff to support women. When a woman has been pushing for a while some new energy in the room, a few suggestions, or just some support can make a difference to the outcome. Sometimes though I've had to just send the doctor in when progress was slow and in hindsight I knew that I should have gone in and spent time assessing the situation and helping, but due to lack of staff and the busyness of the unit I just wasn't able to.*
>
> *There are also times, it's terrible to say, when I've done, or asked for a vaginal examination to be done, just in the hope that the woman has progressed so that we could call in her LMC, there was no other indication for it. I know that this doesn't support physiological birth, it isn't good care and it really bothers me, but you have to look at the overall picture across the unit. Sometimes we are just that desperately short of staff. Just last week on more than one occasion we were challenged by the registrars that the woman wasn't actively managed well enough in her labour. I also often feel pressured (regarding time and progress in relation to labour and birth) particularly when handing over to the next CCM.* (Lara, clinical charge midwife)

Lara acknowledges that the CCM role is instrumental in supporting midwives to support physiological birth; it aids play and supports the game if the game is appropriately supporting physiological birth. She talks about a wrap-around support for midwives in the form of an additional layer of midwifery expertise. She gives examples of it being important when midwives need support in order to support the woman, to provide new energy in the room and additional suggestions, or to spend time assessing the woman who is making slow progress prior to considering whether or not an obstetrician is needed—essentially supporting a game of creating opportunities for normality.

In relation to Gadamer's notion of play, the capacity of the play here reflects available resources or players. Lara highlights how a lack of time, due to poor staffing and busyness resulting in high acuity in the hospital labour and birthing field, is creating pressure. This pressure can, at times, represent a catalyst for intervention that may otherwise have been avoided. Lara describes time as being directly related to staff resource and is at a premium. It seems that the notion of time in relation to labour and birth is determined by the resource capacity of the facility and creates a tension between the care and support that Lara ideally would like to give and that which she is able to provide. Players have to play the game in a way that perhaps feels inauthentic to its true nature, but their strategies of play are to survive in the game. It seems the movement of the game is adjusted here in order to just maintain play rather than to 'hold the ball'.

Lara describes the 'helicopter view' over the facility being core to overall safety within the field and suggests that this is the primary view taken in the hospital field. The individual is a part of this view, but the facility as a collective and the operational considerations appear to be key drivers for decision-making and thus opportunities for play. The drivers appear to be influential in determining opportunities for physiological birth. Intervention may at times be an instrument to aid the safe running of the maternity facility overall within the constraints of the staffing resources available.

However, whilst acknowledging that busyness and lack of staff is central in Lara's account, it is perhaps more than just 'busyness' that Lara is suggesting may be driving interventions. Perhaps the busyness has influenced the facility culture itself, normalising the management of labour and birth. Perhaps busyness is always anticipated in the labour and birth field due to its acute nature and finite resources available. Lara highlights the pressure that she feels to keep women's labours progressing in the facility and be able to justify this to her colleagues if progress is not 'adequate'. Efficiency has

perhaps become the culture, the core business of the facility, the overriding expectation. The 'time of the space' being influenced by busyness and acuity along with the anticipation of busyness, driving the play.

Optimally, a key component of 'the game' would be safely and appropriately supporting normality whenever possible, particularly for the midwifery team, giving labour and birth 'time'. However, when resources are compromised, they may instead be reluctantly played just to keep labour and birth progress moving in the field, even if it means that physiological birth is not optimally supported. Intervention may be used as an instrument to aid the safe running of the maternity facility overall within the constraints of the staffing resources available. 'Play' is then led by this changed objective of the game; allocating resources to cope with capacity.

Space and time as limited resources to be regulated driving play

Francesca (LMC midwife) talks about the pressure on beds influencing perspectives of time in relation to labour and birth, how time itself is allocated and play influenced, in a busy hospital facility:

> *The facility, because it's so busy, doesn't respect time for physiological birth at all. There's a lack of staff as well as lack of beds, and the high rate of interventions and acuity means that the facility needs come first. That is very evident when you're in there. Recently a woman birthed, and the charge midwife kept asking if we would be out of the room soon because another woman was being induced and needed the bed. That bed space is hugely valuable, a main priority. There's an unspoken 'thank goodness she's had a normal birth' so that the bed can be vacated; a sense of the staff (the charge midwife particularly) being grateful and supportive, but that's because the physiological birth suits the needs of the institution. Sometimes the membranes are left intact when women are being induced, but I think this is less about the benefits this has for the woman and baby and more about reflecting the needs of the facility; it stalls the induction if there are not enough beds or staff. Letting a woman's physiology lead in this case happens when it's convenient and beneficial to the facility. There needs to be more midwives and more beds to ease the pressure of needing that bed for the next woman. We need 6-8*

> *hour post birth beds so that the woman could stay there and be monitored if needed.* (Francesca, LMC midwife)

The focus on physiological birth appears to be lost amidst the play of resources. Francesca indicates that physiological birth appears to be appreciated when it equates to less time in the birth space, which represents efficiency and convenience for the facility. This play of resources is driven by the acuity of the field, and acuity itself is in part created by the high rates of intervention. Normality is convenient for the facility if it means that space is available more quickly; otherwise, it is perhaps not a priority of the game.

Play in relation to supporting normality is tightly regulated in response to available resources. There is pressure to keep women moving through the facility at a pace that is convenient for the facility to keep freeing up bed space and cope with capacity. Within Francesca's words is a suggestion of a facility regulation of time and play in relation to labour and birth progress to ensure that beds and staff are available to meet the needs of the women continuing to access the service. Francesca feels that more beds and midwives, and a post birth unit, would help to ease and lift this pressure from the birth bed, potentially freeing up resources 'available' for birth.

Francesca describes how the pressure created by the busyness and acuity can impact on the 'allocation' of time as a resource. It seems that the resource of time is considered and allocated according to facility capacity and needs, influencing practise. The objective of the game, at times, puts pressure on practitioners to organise the timing of woman's care around facility needs rather than purely in response to clinical need.

Gadamer (1986) talked about the experience of time, and how both boredom and bustle equate to 'empty time'. Here, time is experienced as something to be 'spent'. The busyness of the place is perhaps shaping the perception of time as a commodity to be allocated due to a lack of resources. In seeing time as something to be spent, to some degree the individual is lost and supporting physiological birth is no longer a priority or a convenience. These data suggest that the game here is managing the flow through the facility without compromising safety; either the safety of the women and babies or safety of the facility itself. It seems that the mode of birth and the woman's experience is a secondary consideration.

Time is allocated as a resource according to facility capacity and facility needs driving the play of the game. Flow through the facility is central to play, and resources are allocated and regulated, including time and space, to ensure that the game is played efficiently. This 'assembly line' can be sped up or slowed down to suit the needs of the facility by regulating resources and, subsequently, as a response changing play. Supporting physiological birth is convenient to the game when it is efficient for the facility and the associated utilisation of available resources is low. However, it is not a priority.

Standing back, there exists a vicious cycle. If the allocation of resources was appropriate (including place of birth) and intervention only performed when it was in the best interests of the woman and baby then the overall rate of intervention and, therefore, acuity and use of space would be lower. There would be more time and space available, and consequently less ongoing pressure to intervene. These findings paint a picture of a wheel in which we have found ourselves trapped, with intervention being a catalyst for more intervention.

Summary

The birthing place is a field of play, and the 'play of the game' was a key thread in the emergent findings. The participants' experience of supporting physiological birth was directly linked to key tensions that they had to negotiate when 'playing the game'. The game has safety at its core: the safety of the woman and baby, the facility, and 'self.' With safety comes responsibility, along with fear of risk (to the woman and baby, the facility, and to 'self'). Key tensions negotiated by participants were related to protection, time, efficiency, and resources. Sometimes juggling these key tensions created pressure points which constrained their ability to support normality and became catalysts for intervention.

Time in relation to progress in labour was seen as a central tension in hospital facilities. It seems that efficiency is highly valued, and that time is related to perception of risk in relation to labour and birth. 'The rush' regarding time and progress, created a 'mood of busyness'. This 'mood' is prevalent to the culture and may be present irrespective of the busyness of the facility. Fear underpins the pursuit of safety whilst juggling the tensions, a further barrier to supporting normality. A vicious cycle emerges, with intervention in relation to 'efficiency' creating busyness and being a catalyst for further

intervention. Such a vicious cycle may be the result of a risk-based approach, in a busy hospital facility, with strained resources. ‘The play of normality’ was identified as potentially ‘playing out’ a new collective ‘truth’, influencing the mood of the labouring unit towards letting the physiological process unfold.

Chapter Eight: Safeguarding the 'Art of Being Appropriately Patient'

Introduction

In this chapter, the notion of safeguarding the 'art of being appropriately patient' is considered alongside the research question. For some women, intervention in labour and birth is a necessity for reducing risk and can be lifesaving. Alternatively, intervention may increase risk for the woman and baby and can cause harm when it is not clinically indicated, negatively impacting the woman's experience (Miller et al., 2016; WHO, 2018). It is the intervention that occurs before it is clinically needed that is a concern in relation to supporting physiological birth. Participants talked about how being 'on the cusp' of needing secondary care could sometimes be a particular pressure point in relation to being patient.

There is a strong appreciative thread of practitioners protecting normality by appropriately giving labour time and reducing unnecessary interventions. Participants highlighted that even in situations where complications arise during labour and birth there is often still some normality within the situation that can be appropriately and safely protected. Within their stories, participants also explore some of the factors that may be driving interventions, and how this cascade may, in part, be practitioner or facility influenced.

Midwifery and medicine are both considered to be an art and a science. Participants described and gave examples of the 'art of being appropriately patient' in the birthing place, and these discussions offered insight into how this 'art' influences their experience of supporting physiological birth, and what safeguards this art in the birthing place. I have used the philosophical notions of 'phronesis' (practical wisdom) and 'solicitude' (safeguarding) to facilitate understanding of the meaning within the data.

Philosophical Underpinnings to My Analysis

Gadamer's notions of art (techne) phronesis (practical wisdom) and episteme (knowledge) all relate to practise. For Gadamer, phronesis is not simply the excellence of techne, the art of practise, but a 'mastery of navigating' and 'mode of self-knowledge' in relation to practise. Gadamer went on to say that the person who holds practical wisdom is said to 'deliberate well'; their deliberation or practise concerns a

knowledgeable orientation towards the 'right way' to be in the world, and they are in pursuit of the best of themselves and the best for others (Landes, 2015).

Being-in-the-world always involves care for something that matters to us as a fundamental part of our existence (Heidegger, 1927/1962). Heidegger's (1927/1962) notion of solicitude is a safeguarding or mode of caring of others who are in need, and a process whereby Dasein continually reorientates itself when engaging with others. According to Heidegger (1971), the act of safeguarding is to free something 'into its own essence'.

Confidence in the Art of Standing Back and 'Holding Off'

Some midwife participants talked about working alongside obstetricians who supported them well to support physiological birth. They described situations where the obstetricians had 'appropriately held off' intervening when it was not clinically needed.

Reducing the pressure to 'do something'

Mia (CCM) talks about sometimes needing a second opinion and support from an obstetric colleague without any expectation that they should 'do something':

> *When I was in LMC practise there was an amazing obstetrician and he was really good at walking away and I loved it, he brought a real calmness. It gave me confidence in myself, as well as in the woman. It gave me real confidence because he was really good at just not intervening if there was no need to intervene. Just because he was called, it didn't mean to say he had to do something. He'd come down and have a look at the CTG and he'd say 'fine carry on I'll just go and get a cup of coffee' which was great, and you just needed that. Whereas now there seems to be an expectation that if you ring the registrar they have to 'do something' resulting in intervention, and that's a big problem.*

> *I felt safe even if the obstetrician said 'right I'm going home everything is fine', that made me feel safe. Sometimes I'd be a little bit doubtful about something; I'd be pretty sure it was okay but I would like somebody else to say that. But you didn't want somebody to come in and either do a lactate or step in and do an operative delivery if that's not what was needed. He was really good at walking away. He had experience, and a*

> *real respect for women. He would encourage the woman too, and reassure her when things were normal and that there was no need for him to intervene at that point, so he had a really high vaginal birth rate.* (Mia, clinical charge midwife)

Mia suggests that this obstetrician understood the art of appropriately 'holding off' and had the confidence to empower both the woman and the midwife to continue supporting normality when safe and appropriate. She indicates that he just did what was in the best interest of the woman and baby, and there were no other expectations or pressure. Mia describes the obstetrician as calmly and patiently walking alongside and bringing in an extra layer of security and reassurance, enabling her to feel safe to patiently continue. It seems that they were working as a team, and the primary/secondary interface appears to be more of a continuum of care in response to the woman's needs rather than it being clearly delineated.

Heidegger describes his notion of solicitude, or safeguarding, as 'leaping'. It manifests itself by either 'leaping-in' or 'leaping-ahead' and occurs on a continuum (Heidegger, 1927/1962). 'Leaping-in' is taking over the care and can be dominating of the other. Contrastingly, 'leaping-ahead' involves moving ahead to allow the other to be free to see possibilities and remain in control. Mia suggests that the obstetrician's 'leaping-ahead' allowed her to remain free to see possibilities. The 'essence' of care remained primary in nature and midwifery-led, supported to be so by the obstetrician's safeguarding. His experienced and respected opinion validated Mia's decision-making and gave her confidence that no further actions were needed at that point. Perhaps the obstetrician had a similar philosophy towards birth and trust in the midwifery team. Perhaps he understood that his role was not simply about 'fixing the problem' with interventions, but that a 'less is more' approach was sometimes more effective.

Mia goes on to suggest that this situation may have been 'on the cusp' of potentially requiring secondary care. Being 'on the cusp' could be a pressure point in relation to intervention and yet this space can be an opportunity to appropriately and safely support normality. She indicates that there are some situations where a formal obstetric consultation may not be warranted (the obstetrician may then come with the expectation that they need to do something) but where a second opinion or 'fresh eyes' is needed. In this case, the second opinion kept the woman in midwifery-led care and the obstetrician

supported the midwife in the decision. Perhaps it brought the midwife a feeling that the responsibility for the decision was shared.

It needs to be considered whether this is still an obstetric consultation, even though Mia appears to see it to be less formal. When Mia asked for the obstetrician's opinion, she wanted someone to validate her clinical assessment but not to step in and intervene unnecessarily. Mia has asked the obstetrician for his opinion, which is consulting; but perhaps it did not feel to Mia like a 'formal' consultation where the decision-making is handed to the obstetrician. For the obstetrician, however, it is likely to have been understood to be a consultation. The difference may be that in this case the obstetrician was confident in the art of appropriately standing back. As a result of knowing and trusting in this approach, Mia felt confident to ask for a second opinion when she needed reassurance that obstetric involvement was *not required*; rather than care being rigidly defined by its primary or secondary nature, this suggests more of a fluid continuum with the team standing together to best meet the woman's needs.

Central to these data is the presence of, and connection with, experienced obstetricians at the hospital facility who are confident in the art of insightful deliberation. Trusting relationships between midwives and obstetricians are core to working the 'art of being appropriately patient' together. 'Alongside support' from an experienced midwifery colleague could also safeguard this art and be instrumental at the 'cusp' of referral to secondary services—a potential pressure point for intervention. The interface between primary and secondary care although is, in part, defined, is also, in part, constructed due to the apparent differences in how it is managed. How the interface is understood in a facility could be central to safeguarding the art of appropriately holding off.

Not 'leaping-in' when it can be safely avoided

Holly (LMC midwife) describes a situation where she worked with an obstetrician and together safely and appropriately 'stood back':

> *Just recently I had an experience with a primip having a bradycardia at 8cm, involuntarily pushing as the baby rotated to OA. The consultant entered the room and stood in the background and watched. After some time he assessed the woman vaginally 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'. The fetal heart was dropping but he remained calm and reassuring and so we carried on. Shortly after the woman*

> *birthed her baby herself in good condition. I believe if this was a registrar the woman would have been assessed vaginally immediately, and the tone would not have been as relaxed or calm; she would likely have ended up with a ventouse delivery. I think if a primip is being taken to theatre for an emergency caesarean section at full dilatation a consultant should be assessing her to ensure that an instrumental delivery isn't possible.* (Holly, LMC midwife)

Holly indicated that this obstetrician brought a further layer of support and security into the room at a time when potentially intervention may have been needed. It appears that the woman was again 'on the cusp' between a physiological birth or ventouse delivery. This is a very good example of how a midwife and obstetrician can work collegially to support the woman and together facilitate the best outcome. Holly describes feeling reassured that the obstetrician appeared to be calm, which supported her to continue to support normality while safe and appropriate. He could see that the baby was rotating to an anterior position and was likely to birth normally, so held off. As the woman may have potentially needed intervention, he stayed in the room in case but did not actively 'leap-in' and intervene.

Gadamer's notion of phronesis, or practical wisdom, relates to Holly's words. Landes (2015) wrote that "Phronesis is a mode of being by which the person is never merely producing according to steps, but rather is in the world and in their practises circumspectively" (p. 265). According to Gadamer, the physician's 'art of healing' requires insight into the subtle nuances of the 'too much' and the 'too little'. Referring to the 'art of healing' Gadamer (1996) wrote:

> The expert practice of this art inserts itself entirely within the process of nature in so far as it seeks to restore this process when it is disturbed, and to do so in such a way that the art can allow itself to disappear once the natural equilibrium of health has returned. (p. 34)

The consultant obstetrician likely brought insight to the situation from years of practise, allowing him to not practise according to 'the steps', but feel confident that it was safe to stand back and watch. He situated his art within the physiological process focusing on the optimal way to restore equilibrium in the best interests of the woman and baby. He then stood back but stayed present. This highlights a different perspective in relation to the interface with the midwife when the obstetrician is consulted. It could be argued

that anecdotally obstetricians tend to step in when consulted with, as the expectation at that point. However, this obstetrician held off and remained in the background.

It can be incredibly stressful to listen, even for a short period, to a temporary drop in the fetal heart rate or abnormal CTG, and watch and wait. Perhaps it would have been less stressful for the obstetrician to step in and intervene, but the consultant's experience with birth may have brought a respect for physiology and an expert understanding of when it is safe to stand back. Possibly this facility was not busy and the obstetrician did not feel pressured for time (whilst this should not influence practise, it is realistic to assume that at times it could). This consultant showed a commitment to supporting physiological birth, and this approach suggests an appreciation that it is the best outcome for the woman and baby whenever it can be safely achieved. It also suggests that perhaps normality is the 'norm' at the place, and that he perceived his role as central to supporting rather than primarily about 'leaping-in' with intervention.

Holly indicated that a registrar may have been more likely to have intervened straight away and possibly birthed the baby by ventouse. Perhaps a registrar would feel that because they are answerable to the consultant they need to show responsiveness to the consultation and step in to 'resolve the risk'. Perhaps registrars do not have the same depth of experience in relation to physiological birth so are more likely to feel that they need to 'do something'. There could also be a degree of defensive practise, creating a reluctance to 'hold off'. Holly talked about the need for presence of the consultant obstetrician when a primiparous woman is taken to theatre for a caesarean at full dilatation; the consultant could support the registrar in exploring the feasibility of an instrumental birth.

A workplace culture of physiological birth being considered the best outcome and shared goal, whenever possible, is important for supporting normality. Bringing practical wisdom and insight into the subtle balance between the 'too much' and the 'too little' to a situation where a woman is 'on the cusp' of requiring intervention could potentially safeguard her from intervention and allow more time.

Protecting the Normality Within the Situation

Participants highlighted that acknowledging and identifying the normality within situations where some intervention may be needed could, potentially, safely reduce

intervention. They talked about how they used this notion to protect and support physiological birth.

Intervening 'just enough'

Isabel (obstetrician) talked about a colleague who supported as much normality as possible with a considered approach to using forceps, doing the minimum amount of intervention required:

> *I can remember an obstetrician who would take the forceps blades off as the head was crowning and the woman would then continue to push the baby out, and I think that is really lovely. It's lovely from the perspective of reducing the risk of trauma, but also lovely for women to feel that they've had that control, they have done the rest themselves.* (Isabel, obstetrician)

Isabel highlights how the obstetrician facilitated the normal within a situation, no longer considered to be low-risk, by using intervention judiciously and doing 'just enough' whilst keeping the woman and baby safe. By withdrawing the intervention when the risk was averted, the obstetrician allowed physiology to continue to lead. Isabel suggests that this practise kept the woman at the centre of the decision-making; it minimised the potential for harm and maximised the opportunity for a positive experience and outcome for the woman.

Isabel's story highlights that secondary care may not need to be completely threaded throughout the care just because the woman requires some form of intervention. This approach suggests that both the woman's experience and physiological birth is valued, sitting at the centre of the care given. Here, once the risk was overcome, the care effectively shifted back to support normality and the woman had as normal an experience as possible. The shift out of requiring intervention and back to normality suggests that primary care is considered the default. Once the risk has been resolved, normality can be resumed whenever it is safe to do so.

In contrast, continuing with an intervention beyond what is clinically needed could be a reflection of the normalisation of interventions and 'doing to' in some hospital facilities. In hospital maternity facilities, often once a woman is in secondary care she will remain there until at least after the birth and will receive the 'full' scope of the intervention(s)

irrespective of whether it is clinically required. She may receive a myriad of 'just in case' treatments/interventions.

The data suggest the benefits regarding supporting normality of an approach to care that embodies 'first doing no harm'. 'Too much' in relation to intervention is considered as potentially causing harm, and important in the vital balance of 'too much too soon' and 'too little too late' (Miller et al., 2016). Safeguarding has a central focus with the aim of intervention being to re-establish the equilibrium and stop when it is safe, thus supporting the normality that lies within the situation.

Safeguarding with certainty

Harriet (registrar) describes how the use of lactates during labour aids decision-making and can facilitate time and patience during labour and birth:

> *I think that when doing lactates is the norm in a unit and is encouraged it makes a difference because it makes us more confident in our decision-making. We then know that we've got time and we can watch and wait for at least the next hour or two, confident that the baby is still getting enough oxygen. We do lots of lactates here (facility Z) and this practise is really well supported; the charge midwife has sometimes already got the kit outside the door. When I worked at facility X we didn't do as many lactates. I have to admit, and I feel a bit bad about saying this, but if I went back now I feel that if the consultant said 'don't do the lactate and just go straight for a caesarean section', I think I would do that. It's very hard to challenge that.* (Harriet, registrar)

Harriet suggests that encouraging and normalising the use of lactates in a maternity facility may be key to supporting this practise. Harriet talks of this practise being well supported by the maternity team at facility Z, and that the charge midwife sometimes has the kit ready and placed outside the room when taking lactates could be appropriate. Harriet indicates that a reassuring result enables her to feel more confident with not intervening; confident that the baby is well-oxygenated and supporting her to appropriately 'hold off' for a period of time. Perhaps, without this additional indicator of fetal wellbeing, Harriet would, at times, be more likely to intervene, concerned that the baby may be at risk if she did not step in.

Harriet suggests that the support of this practise by the maternity team may aid the balance between 'too little too late' and 'too much too soon' with regard to intervention, safely supporting normality when appropriate (Miller et al., 2016). She expresses a desire to be able to be more patient, and the additional evidence helps her to feel confident to safely hold off.

Although Harriet indicates that she supports the use of lactates and can see the value in doing them, she talks of not feeling as able to do them if the practise is not supported by the consultant on call. It is the norm in facility Z and an expectation by the team at large that lactates are appropriately considered. Embracing and valuing this practise in all units could, perhaps, support the practise; and in doing that, support normality. Having the equipment to do lactates readily available in the birthing space can help to support a more considered, patient approach, providing additional evidence of 'safety'. The consultant obstetricians are, however, central to encouraging this practise. The level of cooperation for supporting normality from the senior team is core to how well it can be achieved at the maternity facility, influencing safeguarding of the 'art of being appropriately patient'.

Avoiding Practitioner Driven 'Cascade of Intervention'

Participants talked about ways in which they avoided driving the 'cascade of intervention' themselves, many acknowledging that it requires a conscious effort.

Stopping at the therapeutic effect

Hana (core midwife, hospital facility) talks about the induction of labour process in a hospital facility and how she takes an individualised approach:

> *I feel like with a lot of our inductions we try and keep things as low risk as possible whilst recognising that there are some risk factors. We give an hour or two for the woman to get into labour after an ARM (artificial rupture of membranes) before starting syntocinon. However, I like to judge it by change and progress rather than just time. For example, if the woman has gone from not contracting to contracting two contractions in 10 minutes during those 2 hours, there are signs that she's getting into labour herself. I recognise that we've broken the water and it's an intervention and she's being induced for whatever reason, but actually her body is responding. It's really unfair to place a 1-2 hour time limit on*

> *women at any stage of labour, so I try to hold off and give the woman more of a chance to labour before starting syntocinon.* (Hana, core midwife hospital facility)

Hana describes how she uses a considered approach towards induction; only intervening when the woman's physiology has had a chance and ensuring that each step of the induction process is clinically needed. She seeks to support and boost the woman's physiology rather than taking the lead with the intervention. This approach enables the woman's physiology to lead rather than the time constraints decided by the facility. Her approach to care is individualised to *this woman*, and whilst she safely considers the woman's risk, the full impact of the 'secondary care package' is not applied to the woman simply because she is in a hospital facility and having her labour induced. The woman receives only the intervention that she needs and is supported to labour and birth as physiologically as possible.

This is an approach to risk that considers the risk itself in the context of the current situation; in contrast to labelling the woman as being 'high-risk' because she has fallen into a particular category. Clearly Hana felt able to work within her own boundaries of time and felt confident at this facility to treat only the woman's individual risk. She indicates that 'this' care was individualised to meet the needs of 'this' woman and baby at 'this time' to induce labour rather than enacting a routine package of care. This woman was no longer considered to be 'low-risk' as she required an induction of labour, so some obstetric oversight was required. Hana, however, was still able to decide whether or not the intervention needed to continue, or if it had produced enough of a therapeutic effect. Treatment continued only until a therapeutic effect was reached. Dasein continually reorientated itself when engaging with 'taking care' and evolved in response to the changing clinical picture.

The culture of the maternity facility may be safeguarding the 'art of being appropriately patient' by being accommodating of preserving normality and supporting individualised rather than routine care. Care needs to be based on the changing clinical picture with a more fluid movement in and out of low-risk/complex care depending on the risk that is presenting 'now'.

Holding the ability to stand strong with support

Clara (rural LMC midwife) reflects on influences that could drive intervention:

> *I've come close to intervening in labour and birth when it wasn't really needed. In part it depends on how tired you are because you do lose your ability to stand strong. If you've been there for hours and you're being pressured to persuade the woman you are caring for to do something that you have a sense is not quite right, it's really easy to capitulate. You start then thinking okay, turn up the syntocinon which will move things along, or they'll have the caesarean or forceps/ventouse and I can get to bed. That's not where you want to be but that's sometimes where the conditions of your work places you if you don't have the right support.* (Clara, rural LMC midwife)

Clara is suggesting that intervention is easy in the hospital facility. It is available, accessible, done with ease, accepted as the 'normal', and, perhaps, understood to be equated with efficiency. It is almost as though 'managing' labour is the normal. It seems that it requires the midwife to have energy, drive, tenacity, and strength in order to stand strong and counteract the pressure to support a woman through a long labour. Clara is suggesting that pressure to intervene could be coming from the core team and, possibly, she may see herself as needing to stay to continue to 'protect' the woman and support normality.

Clara describes a vulnerability when practitioners are fatigued. She indicates that support for the midwife when she is too tired to stand strong and 'hold back the pressure' may be instrumental in avoiding interventions. Thus, the working conditions within the facility regarding support for the midwife and the current model of care are key factors to practitioners' ability to support normality.

Conditions of work may lead to practitioners having to compromise their values regarding supporting normality. It could be, albeit reluctantly, that their tiredness may inform their decision to move to intervention to augment the labour. At times, practitioner fatigue seems to be tolerated in the midwifery continuity of care model; yet it is unacceptable. If the midwife is too tired to continue to provide care to the woman, ideally care can be handed over to the back-up midwife, otherwise to the hospital team. A reluctance to hand over may be due to financial implications, reflect a very busy hospital maternity facility, or a reluctance to leave the woman.

Clinical and emotional support for the LMC midwife in the labour and birthing space from LMC and hospital midwifery colleagues could be instrumental in supporting physiological birth, safeguarding the 'art of being appropriately patient'. Working amidst a service and a model that is under strain and without adequate support could leave practitioners reluctantly intervening to augment a woman's labour in order to safeguard themselves (and ultimately the woman).

A Culture of 'Doing With' Women

Participants talked about how the culture, expectations, and focus of care in maternity facilities can drive practise decisions and influence practitioners' ability to be 'appropriately patient'.

Holly (LMC midwife) talks about the contrast between two hospital maternity facilities in relation to supporting physiological birth, suggesting that one of the facilities 'medicalises the normal' with a culture of managing labour and 'doing to' women:

> *The hospital facilities all operate quite differently and it has an impact on practise and on birth outcomes. I think facility X is probably the extreme regarding intervention; it makes facility Y look like a primary birthing unit with their approach to labour and birth. I think the culture of facility X is 'doing to'; it's all about what needs to be 'done' to women. And that's not good when it comes to women in primary care. It does not have a culture of understanding what normal birth is about, what it needs, or how to support it. Many woman are medicalised just because they are in that unit. This care may have been different elsewhere, so it is dependent on place rather than clinical need. Labour is something to 'manage', with epidurals and syntocinon infusion being the normal package of care. Birth pools are empty and there is little encouragement to use them. Much of the unit's focus is on standardised care with their policies and guidelines that don't take into consideration the individual, or the woman and her family's perception of risk.*
>
> *Facility Y has very strong midwifery leadership so feels more of a midwifery led unit, and I think not having the registrars and dealing directly with the consultants makes a really positive difference there too*

> *regarding supporting normal birth; the consultants have a huge wealth of knowledge.* (Holly, LMC midwife)

Holly highlights the differences between two hospital maternity facilities that appear to impact on practitioners' approach to labour and birth, and suggests that women may receive different care and opportunities depending where they birth. She indicates that at the core of this difference in approach lies the degree of understanding regarding what is optimal practise, the commitment to supporting normality, and the 'presence' of midwifery. Holly suggests that the culture of 'doing to' women is central in hospital facility X and is core to expectations and care. She talks about birth pools being available at the facility but with little encouragement to use them. She perceives women receive interventions that may not always be clinically indicated.

Holly describes what she calls a technochratic approach to labour and birth at facility X, a 'doing to' women and a culture of 'medicalising' and 'managing' labour. Heidegger had concerns around the overuse of technology and reminds us of the need to be cautious. He suggested that it is important that we adopt a way of being with, or comportment towards technology, that does not allow it to dominate (Malpas, 2006). Heidegger was concerned about the 'essence' of technology and our lack of understanding of this danger. His fear was that entities become 'products', and the presence of technology creates a 'technological ordering'; "technology appropriates everything to a single ordered totality" (Malpas, 2006, p. 282).

Holly suggests that managing (intervening in) labour and birth in facility X has been normalised and is at the heart of the culture there, driving the 'technological ordering' in the place. This approach may not be clinically appropriate for all low-risk women but is routine in the facility. At this facility it seems to be expected that women need (or possibly request) this level of 'management' of their labour and birth; that 'doing to' and 'managing' labour and birth is normal practise. Risk reduction may be at the essence of the technocratic model, or perhaps perceived efficiency, but it appears that its essence at this place has, to use Heidegger's words, become a 'single ordered totality'; it appears to have magnified beyond its essence. The ripple effects from the increased management of labour can be seen in practise; for example, the lack of use of the pools. If women are receiving more augmentation with syntocinon this may then exclude the use of water, and the ripples continue.

Holly talks about how one of the hospital facilities has strong midwifery leadership making it feel more like a midwifery-led unit. This strong midwifery 'presence' may be influencing the facility culture by making support of normality more central and visible. The leadership could be keeping the midwifery voice strong within the team. Further, the facility does not have registrars present, so midwives consult directly with consultant obstetricians when needed. Holly indicates that the consultants' wealth of knowledge, alongside good interprofessional relationships, equates to better support of physiological birth. These proposed benefits perhaps indicate that consultants may intervene less during labour and birth than their colleagues in-training.

The 'art of appropriately being patient' is best safeguarded by facilities where physiological birth is the focus, the midwifery voice and 'presence' is strong and central. Amid such a culture, the danger of the technocratic imperative is understood and therefore used judiciously. Direct support from consultant obstetricians brings their wealth of knowledge straight to the midwife and the clinical space where it is likely each knows and respects the expertise of the other.

Facility expectations constraining individualised care

Aroha (LMC midwife) talks about some of the expectations and constraints when practising in the hospital space:

> *There are lots of rules and restrictions at hospital facility Z unlike at primary birthing unit A. For example, 'it is past the four hours, so now you've got to do this' (intervention) or 'you need a CTG, you must lie down'. It's such a different vibe there (facility Z). I find that I tend to be asking for permission a lot; 'can I do this' 'am I allowed to…' where I feel like in a primary birthing unit it's more of a collegial conversation. So I feel like there you have to do certain things in certain ways. I feel like you're told 'you have to do this', there's not much leeway.* (Aroha, LMC midwife)

Aroha describes having to fall into line with the hospital facility's expectations when caring for a woman in the facility. She talks of feeling that she is in their hospital space and on their terms, perhaps feeling disempowered. She feels pressured to practise in a way which complies with the facility's time constraints and expectations, influencing her decision-making. Aroha may not agree with a woman needing to have a CTG, or needing to have a 'routine' intervention performed after a prescribed timeframe, but

these are expected to be done to meet the expectations of the place. Therefore, some women will receive interventions that may not be clinically indicated.

Horizon means a range of vision from a certain vantage point; “we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons” (Gadamer, 2014, p. 313). Gadamer (2014) wrote that an open horizon means having the ability to see beyond what is close at hand, developing deeper understanding of what constitutes the whole. A horizon suggests only temporary limits and can expand, which happens through fusion with other horizons (Gadamer, 2014). Aroha suggests that there is perhaps a narrow horizon at this hospital facility, shaping practise from this vantage point.

Aroha talks about asking for permission regarding practise. She appears to feel that she must comply with practise that the facility ‘allows’, which reflects the shared horizon in the place. In contrast, in a primary unit, Aroha considers her conversations with core staff are more collegial, perhaps indicating that their philosophies are more closely aligned, horizons may be more open, or a result of the primary unit being midwifery-led.

It seems there is expectation that some interventions are applied to all women, irrespective of clinical need. It is likely that the rules and restrictions at the hospital facility have been implemented for all women to guide a degree of uniformity of what is deemed to be ‘safe’ practise. Hospital facilities have to meet the needs of all women, but it appears that they are predominantly set up to meet the needs of women with increased complexities. However, some of this care may also be being applied to low-risk women. An intervention, for example an admission CTG, may decrease risk when it is clinically indicated, but the same intervention may represent increased risk if it is not indicated. A horizon or range of vision existing in the place that is narrow, and from a vantage point where the focus is risk and complexity is likely to be a barrier to practitioners being appropriately patient.

Trust, Respect, and Unity

Participants talked about the importance of a well-connected maternity team who trust and respect each other. They recognised that this sits at the heart of safeguarding the ‘art of being appropriately patient’.

Emily (CCM) described a breech birth where the midwives were supported to support physiological birth:

> *This breech birth was a perfect example of midwives taking responsibility and it was awesome because we knew what was normal and what wasn't, and we were very clear about that. The woman went on and had a normal vaginal breech birth. I was in the room supporting the LMC who was caring for the woman. The CCM was supporting us outside as well; she sat with the obstetricians and the anaesthetist (who had forceps at the ready to come in and rescue). We were completely undisturbed; there were no taps on the door, so there was no interruption to what was going on in the room. The CCM was basically saying 'you need to trust the midwives that are in there because they're really confident, they're really experienced and they know what they're doing. They'll let us know if there's a problem'. I think the obstetricians were being respectful, and I understand their fear and concern, but they didn't bring it into the room; this could have undermined the confidence of the people that were there.* (Emily, clinical charge midwife)

Emily describes how when there is professional trust and respect between midwives and obstetricians it can help to support physiological birth and the team is better able to work together to do whatever is in the best interests of the woman and baby. She feels that here the midwives and obstetricians worked together as one team and had faith in each other, which was pivotal in nurturing and sustaining the 'art of patience' in this situation. Flores and Solomon (1998) believed that trust must be 'continuously authenticated', entails responsibility, and presupposes trustworthiness. They go on to say that trust and trustworthiness tend to be reciprocal.

The CCM helped the obstetricians to feel safe to stay out of the room by inspiring confidence in the midwives to provide safe care and appropriately seek assistance from them if needed. The midwifery presence and voice seemed to be strong at this place, which may have influenced the level of patience. Murray and McCrone's (2015) review of the literature on trust found that underneath trust lies three qualities: interpersonal and technical competence, moral competence, and vigilance. Reassuring the obstetricians that the midwifery team embodied these qualities would have made the decision to trust easier.

Heidegger's notion of 'solicitude' as caring and safeguarding relates to Emily's experience. Heidegger (1927/1962) wrote about 'leaping-in' and 'leaping-ahead' (as described on page 75). Rather than 'leaping-in' and taking over the care of this woman, the obstetricians 'leapt-ahead', patiently supporting the midwives to continue to lead the care of the woman while all was going well. At the same time, recognising problems could arise, they stayed in the facility in case they were needed. Their presence would have helped the midwives to feel safe to continue in the knowledge that they were present outside the room should things change. The obstetricians were ready and prepared to 'leap-in' if they were needed; their practical wisdom or 'phronesis' supported their insightful deliberating about the best way to care for the woman, enabling the experienced midwifery team to feel safe to continue to use their practical wisdom inside the room.

Gadamer believed that at the very heart of phronesis or practical wisdom is an intention to achieve the best for 'the other' along with giving the best 'of themselves' (Landes, 2015). The obstetric team's actions allowed a more patient approach to care, despite 'standing back' possibly not being easy for them to do. However, their aim was doing the best for the woman. The midwives stood in support of each other and shared responsibility rather than the LMC feeling that she was standing alone, which would be a vulnerable place.

A strong midwifery 'presence' in the place is therefore instrumental in supporting patience, alongside a unified team approach and collegial trust. Orange (2011) wrote about the 'hermeneutics of trust' which works to find understanding where differences exist by working from what the parties have in common. It is important for the whole team to have a shared goal of supporting physiological birth and to recognise their different strengths in relation to each situation, supporting the strengths of the other. Unity, trust, and respect assisted these experienced practitioners to use their practical wisdom to optimally walk the continuum of solicitude (care or safeguarding), fostering the 'art of patience'.

A team approach to patience

Francesca (LMC midwife) talks about a situation when the 'right combination of' the maternity team worked together as one to facilitate an appropriately patient approach to care:

> *The woman really wanted a normal birth and progressed quickly from 3 centimetres to an anterior lip, the baby was direct OP and deflexed. The charge midwife and myself had a discussion; the CTG was fabulous, we'd had 2 hours of an anterior lip, by which time we need a registrar to review (and thank goodness it was a certain obstetrician on call because this obstetrician we knew would be happy to try for a bit longer as everything was fine). So we tried a bit longer and I was supported. It was acknowledged that the woman was really keen to have a normal birth. It was a team approach to supporting physiological birth; with the right combination in the team you can appropriately sit with it and be patient when all is well. That's why a lot of midwives (and I do it myself all the time) when coming in say 'who's the CCM? Who's the consultant'? Because that's going to influence how much I need to protect the woman, or not.* (Francesca, LMC midwife)

Francesca describes a situation where a woman was making slow progress at the end of the first stage of labour, and she really appreciated the support of the maternity team in order that she could support the woman to have more time to birth. She expresses how having the 'right team' working together makes a significant difference to being able to support physiological birth. This idea alludes to the notion of 'it taking a village' and the importance of shared ideologies and philosophies, collegial support, and standing together with a collective goal to support normality with the woman's needs being central. It is important that supporting physiological birth is shared and understood as being everyone's responsibility, creating a 'snowball effect', rather than it being reliant on just the midwife caring for the woman. Francesca suggests that this support and endorsement of her decisions from the charge midwife and obstetrician (the 'right' ones) enabled her to be able to be patient rather than intervening in the labour.

Francesca indicates that there may have been a pressure point 'on the cusp' of needing secondary care when she involved the registrar if the 'right' obstetrician had not been on call. The consultant on call is pivotal in safeguarding the 'art of being appropriately patient' as, ultimately, they are the one making the decision (or the registrar may be influenced by their expectations) regarding time and intervention when progress is slow. Francesca also talks about the 'right' CCM, who worked and stood *with* Francesca, providing an extra layer of support for a patient approach.

When supporting physiological birth is understood at the facility to be everyone's responsibility, it can influence how well practitioners are able to do this successfully. It 'takes a village', and it is important that the 'villagers' are all invested in the goal of supporting each other to support normality. This shared and connected approach could be instrumental in safeguarding patience in relation to labour and birth.

Safeguarding with Senior Obstetric Support 'Walking Alongside'

Participants talked about the importance of being able to easily access 'alongside support' from a consultant obstetrician at all times, and discussed the practise implications of both having and not having this support consistently available to them.

'Present' senior obstetric support on site

From the perspective of a registrar, Harriet (registrar) talks about the benefits of having a consultant obstetrician on site 24/7:

> *The consultant on call always comes in when I ask them to, but before calling I always think twice, especially on a night shift because they do 24 hour calls and they often have clinic in the morning and so I'm a bit scared. It's just this guilt in the back of your mind, you feel awful because you don't want to wake them. You shouldn't feel that way because it's their job, but it's always there. Sometimes the charge midwives will make the call to the consultant and I'm always happy for them to do it! It's a lot better when the consultant says 'okay I'm sleeping downstairs call me for anything' then you know they are fine with being called and its easier for them to pop back down if everything's fine. It would be interesting to know what facility W do because their consultants are rostered on at night so they're expected to be there working, and they don't have to work the next morning. I imagine they do things differently because of that.*

> *When I was a house surgeon at facility X the registrar called the consultant on call to discuss a CTG. The registrar had done a lactate which was normal and she felt safe to continue. But at this maternity facility the consultants did not often come in at night, and he just said to do a caesarean because the labour 'would probably go on all night'. So it was a decision made by the consultant (remotely) to do a caesarean*

> *when possibly this woman could have progressed given more time. Or if this had happened during daylight hours and the consultant was already onsite, then maybe they would have tried harder to help the woman to birth normally.* (Harriet, registrar)

Harriet describes how the on call arrangements for consultant obstetricians within the hospital facility can be a precursor to decision-making and a variable in the influence of place on opportunities for physiological birth. Harriet acknowledges that the on-call arrangements in maternity facilities impact on obstetric decisions and women's care, and that operational factors and competing interests are inherent tensions within decisions that are made.

Whilst acknowledging that the consultant on call always responds to Harriet's request for help, she describes some reluctance to call for fear of disturbing them, particularly at night, as in this hospital facility the consultants are not onsite overnight and are expected to work the following day. Clearly, it takes strength to call which could represent a potential barrier to asking for help. In contrast, Harriet describes the ease of calling the consultant when they are staying on site and can attend more easily and conveniently; they have made it understood that they are 'available', they are 'present'. She feels that having a consultant obstetrician on site 24/7 could better support physiological birth.

Harriet talks about a situation where the consultant obstetrician provided advice about doing a caesarean section whilst not onsite overnight, and how this may have been different if the consultant was present and able to assess the woman. There is a feeling within these words that perhaps the caesarean may have been safely avoided at that time given the normal lactate, and that the consultant may have been more patient if they had been onsite. Perhaps the consultant was concerned that they would be called again disturbing what may have been much needed sleep.

Having consultant obstetricians onsite 24/7 can reduce barriers to their assistance being requested and help them to feel safe and supported, providing an ever-present safety net. Having consultants onsite may also reduce the need for them to 'leap-in' due to not being 'present' enough to feel confident to 'leap-ahead'.

The connected consultant

Isabel describes the impact of the availability of consultant obstetricians on site at the hospital facility 24/7:

> *Our consultants are onsite 24/7 and are approachable and very keen to be involved. They have already agreed to be onsite so they recognise that they're going to be up. I think the registrars call a bit more often than they would if consultants weren't onsite. I think having a senior eye looking at a situation has an impact on the woman's care. When I was a registrar and not having the consultant onsite 24/7 I did a number of things I wouldn't do now. I'd be much happier to do a caesarean rather than try an instrumental delivery if the head was high. Now, in this situation, our registrars have a consultant standing behind them who has assessed and decided with them whether the woman is suitable for vaginal delivery or not.* (Isabel, obstetrician)

Isabel feels that having 24/7 access to consultant obstetricians who are onsite can support the maternity team to better support physiological birth, providing 'alongside support' and an additional 'layer' of secondary assessment. Isabel describes the consultant on call as being readily available but is saying more than just that they are in the hospital building. She is saying here they are very much 'present' and involved with what is happening on the birthing unit, being connected and a part of the team at this hospital facility. This obstetric presence and closer connection, rather than making intervention more likely, may help practitioners to support birth and empower them not to intervene where it is not needed.

Consultant availability enables registrars and midwives to call them more easily and without hesitation; consultants expect to be called and consider it integral to their role. The importance of them actually being there and being involved rather than just being available on the phone is key. The data suggest they bring a confidence to stand back and not intervene where appropriate; a safety net.

Isabel indicates that having this 'present' senior support easily available at all times directly effects decision-making and outcomes of care. Isabel believes that this can ensure that the many variables are carefully considered prior to a decision being made for a caesarean section. For Gadamer, 'phronesis' is more than practise excellence, but a 'mastery of navigating' and 'mode of self-knowledge' (Landes, 2015). Perhaps this

equates to a greater understanding of the art of standing back and being appropriately patient; the art of being present, but not always needing to intervene. The art of deliberating the continuum of 'leaping-in' and 'leaping-ahead'.

Isabel suggests that the registrars are in a learning situation at the hospital facility and need the ongoing support of the consultant on call. This appears to be in contrast to other hospital facilities where the registrar is often the senior obstetrician present and making most of the decisions, with the consultant on call available only when needed. This situation could be fundamental to decision-making which may at times be influenced by fear and lack of support. For a registrar, technology and 'doing to' may be more familiar, and better align with their philosophy and comfort. Isabel talks about the present consultant as giving registrars more confidence to appropriately facilitate vaginal birth, rather than at times doing a caesarean section when it could be avoided, possibly due to fear.

The consistent availability and true 'presence' of consultant obstetricians in the birthing facility can help to provide additional support for physiological birth and provides extra support for registrars and midwives, making it easier for them to access support at the point that they need it. Being 'present' in the space is more than just being physically there but being connected with the team and walking alongside them providing care, supporting them to be patient when it is safe and appropriate.

Summary

The 'art of being appropriately patient' is fundamental to supporting physiological birth. Practitioners bring qualities for this art, but there are many things that are 'already there' in the place that are instrumental in safeguarding patience and enabling these qualities to play out in practise. This research identified a pressure point 'at the cusp' of referral to secondary services, suggesting that how the interface between primary and secondary care, and midwives and obstetricians, is managed could be pivotal regarding patience. Greater fluidity at this interface allows for a better responsiveness to 'this' situation. Relationships between midwives and obstetricians based on partnership that is respectful and supportive are more likely to be open to a spirit of patience. The art of patience can be strengthened by a 'first do no harm' approach to care that aims to re-establish the equilibrium, with a focus on not exceeding the level of intervention needed. A strong midwifery 'presence' is at the heart of safeguarding patience,

alongside trusting relationships within a unified team. The maternity facility is a team setting; being patient is a team sport. Having senior support with ‘practical wisdom’ consistently ‘present’ and connected with the team is integral to nurturing the art of patience. Patience enables “the growth that ripens into fruit of its own accord” (Heidegger, 1993, p. 349). In other words, being patient enables labour to progress in its own way, hopefully towards successful birth.

Chapter Nine: Discussion and Recommendations

Introduction

In this closing chapter, the study findings which explored how midwives and obstetricians experience place in relation to supporting a physiological approach to labour and birth will be drawn together. The findings will be discussed in relation to ways of supporting physiological birth, along with philosophical notions and current literature. I conclude the chapter with recommendations for practise, education, research, and maternity services.

Whilst hermeneutic phenomenology acknowledges that there is no absolute truth, the findings of hermeneutic research are instrumental in pointing towards what is happening; to allow the phenomenon to come closer into view and be more deeply understood. The findings of this research unpack the meaning of midwives' and obstetricians' experience of place in relation to supporting normality and uncover perspectives to "understand in a different way" (Gadamer, 1975, p. 264). Findings suggest what could represent barriers and enablers to supporting physiological birth within 'place'. Insights have been teased out that may point to how midwives and obstetricians can practise embracing a spirit of phronesis.

Overview of Findings

Midwives and obstetricians do experience 'place' in relation to supporting physiological birth. Whilst practising in the birthing space they join in the 'play of the game' and influence play for the purpose of safely supporting women to birth in the facility. Place has its own tensions that practitioners are juggling whilst 'playing the game'. They seek to protect the woman from 'unnecessary' intervention, to hide from clock time, and to prioritise physiological birth over efficiency.

While experiencing 'place', practitioners recognise the influence 'being there' has on their practise; they can also influence how things happen within the place. Place is not solely driving their practise, yet it is a core 'shaper'. Practitioners experience 'place' emotionally which brings forth a mood to which they attune. They are mindful of what is ready-to-hand in the environment, should intervention be required. They constantly reappraise how safe they feel to be appropriately patient in waiting for labour to

progress. Within the place, practitioners experience ‘fear of risk’ versus ‘hope of safe normality’. Their position along this continuum shapes their practise.

How the practitioner experiences ‘place’ while juggling key tensions influences their perception of risk to the woman and baby, the facility, and/or ‘self’. Juggling key tensions in the birthing place can lead to ‘the rush’, a catalyst to interventions, some of which could have perhaps been safely and appropriately avoided. The findings identify an opportunity, a space, which can mitigate ‘the rush’ and aid the practitioner to more clearly ‘see’ normality and risk against the woman’s uniqueness.

It was apparent that some practitioners experienced a dissonance between a risk-based approach and their own philosophies. This dissonance resulted in the practitioner feeling a pressure to conform to the dominant discourse of being proactive in initiating early intervention. It was evident that this pressure swayed how practitioners felt in the place, how they perceived risk, and, ultimately, how they practised. Consequently, sometimes this led to ‘supporting normality’ being kept behind closed doors in the birthing room. Although this strategy may reduce the pressure to intervene, my findings show that working behind closed doors could be a barrier to showcasing the way normal birth can be successfully supported. My findings reveal that keeping supporting normality central and visible in the birthing place and amongst the team helps to strengthen, legitimise, and normalise the ‘play’ to appropriately avoid intervention.

Participants talked of a degree of surveillance which was felt as a pressure in relation to time and progress in labour. This surveillance was identified as being associated with the perceived safety of the facility and the ‘self’ rather than purely the protection of the individual woman and baby. Paradoxically, the fear of risk driving intervention brings its own risks to the woman and baby associated with the intervention itself. Interventions create risk to the facility in terms of higher acuity to manage the intervention, thus putting additional strain on the existing resources. Midwives then have less time to ‘be with’ the woman, and senior midwives less time to support the midwifery team, which is a risk and significant barrier to supporting normality. A vicious cycle with ‘fear of risk’ at the core drives ‘the rush’ in hospital facilities.

In places where midwives and obstetricians understood that appropriately ‘standing back’ and not intervening (doing nothing) could represent ‘doing something’ in relation to supporting physiological birth, then this safeguarded supporting normality. It was

apparent that in places where this was not the case obstetricians sometimes felt an expectation to 'do something' in terms of intervention when asked to review a woman in labour. Obstetricians may presume the midwife has exhausted all avenues to support normality; thus intervention is now required, and this is their role. However, 'fear of risk' amidst a heightened attunement to risk and pathology may lead midwives to involve an obstetrician before all measures have been considered. Findings highlighted that involving a senior midwife for support in this 'in-between space' may be the most appropriate option prior to involving an obstetrician.

The narrow ridge

This research shows that there is a space in-between supporting physiological birth, and labour and birth intervention; I referred to this in my findings as 'on the cusp' between primary and secondary care. This space sits central to the research findings and represents an important opportunity for appropriately supporting normality. In this space the possibilities of 'awaiting' for labour to progress of its own accord **OR** stepping in to intervene remain open; the practitioner is open to both. In this space, the practitioner is holistically assessing the woman and thinking ahead. They are seeing a situation that could represent normality and lead safely to physiological birth; however, there may be risk that is not yet fully disclosed. For example, the woman may not be progressing as quickly as expected, while all other aspects remain reassuring.

Buber (2002) referred to such an 'in-between space' as the "narrow ridge… a rocky ridge between the gulfs" (p. 218). He suggested that on the narrow ridge sureness may not have been reached, but that which is undisclosed is brought closer. This notion relates to the findings of my study, which identify an in-between space between what we understand to be primary and secondary care (the cusp of supporting physiological birth versus instigating intervention) where there may be some uncertainty.

According to Buber (2002), walking the 'narrow ridge' can be uncomfortable as the practitioner is faced with conflicting tensions and perspectives. It is, however, a space to consider various possibilities and collaborate. Opposing views can be pondered. Greater fluidity at this interface between what we understand to be primary and secondary care allows for better opportunity to consider the dynamics between risk and normality. It allows for practitioners to see more clearly the 'essence' of the situation in relation to *this woman* at *this point* in her labour with *these* reassuring factors of safe normality, and *this* risk. This space is not completely black or white, primary or secondary; instead,

is experienced as a pale shade of grey until the woman's situation further unfolds. Once it does unfold, given time, the 'grey' may become a darker shade if further risk reveals itself, or the 'white' may return if there is hope of safe normality. The woman's care is tailored to meet her evolving and changing needs giving the insights this in-between space brings. The 'narrow ridge' is shown below in Figure 2.

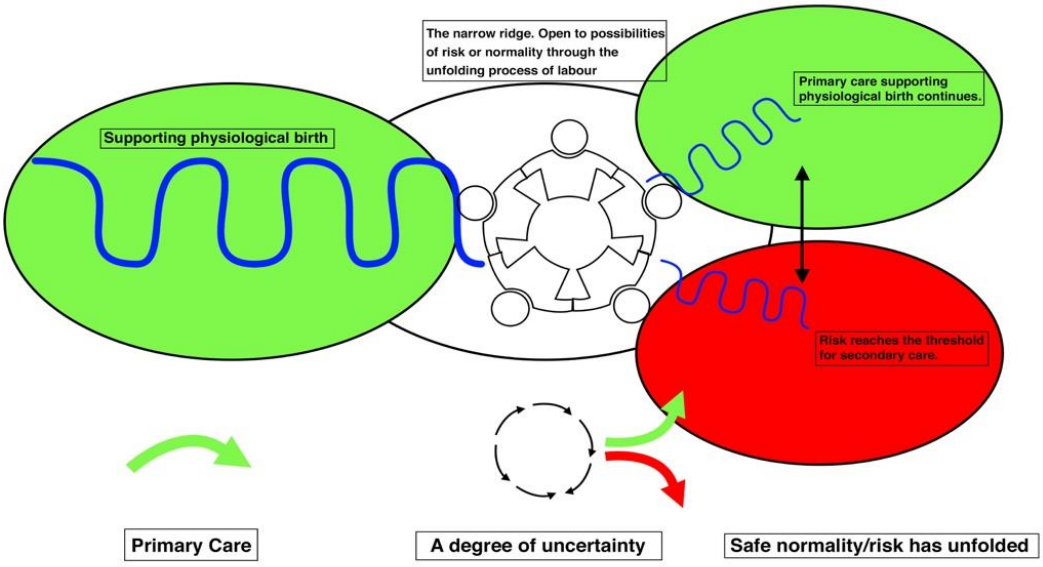

Figure 2. Providing woman-centred care on the 'narrow ridge'

The 'narrow ridge' can be seen here, representing a holding of space in-between primary care and a greater understanding of risk and normality when there is a degree of uncertainty. The blue lines represent the woman's labour and birth journey and are not straight as labour progress may not be linear. The importance of additional support in this in-between space is shown by the image of the connected group. Deliberation of the dynamics between risk and normality in this space is shown by the circle of arrows, leading to an unfolding of either safe normality (continuing in primary care, shown in green) or increasing risk (a move to secondary care, shown in red).

According to Gadamer (2004), "To acquire a horizon means that one learns to look beyond what is close at hand—not in order to look away from it but to see it better, within a larger whole and in true proportion" (p. 304). This notion captures the in-between space, whereby the situation is given space to allow it to unfold and

possibilities to be explored with openness in relation to normality and risk for *this* woman and baby.

The narrow ridge is experienced as being wider in some birthing facilities, allowing for more patience and fluidity at the interface, and experienced as being narrower in others. Places where the ridge 'feels' wider hold more enablers which safeguard physiological birth, mitigating the potential tensions, and allowing practitioners to safely stand in this in-between space and clearly 'see the essence' of the situation. Some practitioners can safely and appropriately hold this space and enable the woman's labour to further unfold, carefully watching for signs of normality and risk, resulting in a more patient approach to care. For others, being 'appropriately patient' in this space is more difficult. The level of a practitioner's comfort and perception of risk and safety in this space is in part influenced by 'place'.

Smythe (2010) wrote that "safety is not a thing; it is an interpretive act. To interpret is to question, to listen, to watch, to be attuned to the uniqueness of each situation" (p. 1481). Midwives and obstetricians who are skilled with phronesis (practical wisdom) and experienced in physiological birth have learnt to safely hold this space. On the narrow ridge, these skilled practitioners with 'practical wisdom' wrap an additional layer of support around this in-between space.

Gadamer referred to phronesis as "the responsible taking up of uncertainty itself" (Landes, 2015, p. 269), and goes on to say that "Phronesis ensures that the making occurs in the right context, with the right aim, for the right reasons, so as to effect the right change in the situation" (Landes, 2015, p. 270). Practitioners with practical wisdom in this in-between space are more comfortable dwelling with uncertainty and the non-linear, whilst withstanding the facility pressures within place. They are able to wait, remaining open to safe normality and risk, and 'see' the unfolding situation for what it is in relation to the woman's uniqueness. They peel back the layers of influence which place has and see *only* what is in the best interests of the woman and baby.

'Fear of risk', especially in a labour/birth facility where there is a heightened attunement to risk and pathology, is a barrier to waiting in hope for an unfolding safe normality. Patience in relation to labour and birth is a 'team sport'. Respectful collaboration is central. This team approach to patience broadens the in-between space and allows greater fluidity in-between primary and secondary care. Midwives experience this

respectful collaboration when midwifery is valued in the place and the midwifery voice is 'visible'. Obstetricians show respectful collaboration through supporting physiological birth and judicious intervening.

How do midwives and obstetricians experience place in relation to supporting physiological birth? They experience 'place' as a ridge that they need to navigate with care. In a primary birthing unit the ridge is likely to be wider, allowing them to feel more sure-footed with a strong commitment to supporting physiological birth. Nevertheless, within a hospital facility, there are ways of 'broadening the ridge', holding additional space for hope which offers the woman greater opportunity to achieve a physiological labour and birth.

A 'sense of place'

Midwives and obstetricians experienced a 'sense of place' which reflects the intentionality and core business of the place. They experienced an understanding of their professional place within the birthing facility; but how practise plays out is about more than professional persona. Astute practitioners came to understand what really 'mattered' within the place. On a practical level, the message was driven in terms of what the environment and policies made possible. Overlaying that was the 'mood' to which they were attuned and the ways that the space made practitioners feel. The practitioner feels what is expected within the space, what is considered to be safe, and what is readily available to facilitate its focus. They also bring a mood of care for the woman and, for many, a deep trust in the process of physiological birth. 'Wanting' to support physiological birth within safe parameters is a key influence on how 'place' becomes a 'space' of safe possibilities of waiting, trusting, and bearing witness to the body's unfolding of labour and birth.

Linking My Findings to Other Research Studies

The 'feel' of 'place'

My findings highlight that environment is more than simply aesthetics and equipment; the practitioner interacts with the birthing space which shapes what they are directed towards. Practitioners experienced greater hope for safe normality when working in primary birthing units than in hospital facilities, even when caring for healthy low-risk women in hospital. The core business of the primary birthing place is set up for the 'play of normality' to be the focus. The hospital environment is set up to meet the needs

of women requiring a more technocratic approach to labour and birth. Setola et al. (2019) echoed 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.

Fear of risk and hope for normality

Every birthing place has a 'mood' or 'feel', and this mood to which practitioners are attuned influences their relationship between fear of risk and hope of safe normality. Heidegger (1927/1962) suggested that understandings occur within moods, or attunements, so these can communicate an influential message about the intentionality of place. Arguably, maternity organisations are usually attuned to moods of fear and anxiety (Crowther, Cooper, Meechan, & Ashanasy, 2019).

> When the organisational mood of maternity care is attuned to fear, routinised risk-avoidance strategies become morally and practically essential, and childbirth becomes an industrial process in which cost efficiency and risk management are prioritised regardless of unique individual needs and wishes. (Crowther et al., 2019, p. 116)

The findings of my study point towards a relationship between an attunement to risk and pathology and an increased likelihood of labour and birth interventions; decision-making is influenced by competing needs and pressures in relation to perceived safety; the needs of the facility, or the 'self'.

Balanced and shared approaches to labour and birth

My findings highlight the significance of the balance between fear of risk and hope of safe normality when midwives and obstetricians support physiological birth. This was also confirmed by Darling, McCourt, and Cartwright's (2021) systematic review in relation to supporting a physiological approach to labour and birth care in obstetric settings. The findings identified two overarching themes: perceptions of birth as inherently physiological and perceptions of birth as inherently risky. The authors found that experience in primary birth settings enhanced midwives' autonomy in implementing a physiological approach which, in turn, influenced other midwives and obstetricians in the obstetric unit. Support and role modelling of a physiological approach from senior midwives was found to be a key enabler, along with close collaboration between midwives and obstetricians. Collaboration was found to equate to more autonomous midwifery decision-making and a discourse of normality.

Midwives as keepers of 'normal'

Both the findings of my study and the review by Darling et al. (2021) show the importance of midwives leading a 'play of normality' within the birthing place. Keeping supporting physiological birth practise as central, visible, modelled, and upheld in the birthing facility is essential for the perception of the 'play of normality' as being safe. Midwives are the 'keepers of normal'; yet, this role can become lost when practising amidst a technocratic model of care. Staying connected to primary birthing and having senior midwives and senior obstetricians confident in physiological birth who can provide alongside support is a key enabler for supporting the practitioner to feel safe to be patient. This notion was affirmed by Coddington, Catling, and Homer (2020) who observed that experience with home birth enhanced hospital-based midwives' understanding of physiological birth, and the range of 'normal' transformed their attitudes towards and confidence in undisturbed birth. The experience resulted in midwives taking this practise change to their work in the hospital setting.

Valuing midwives

Leading the 'play of normality' requires midwives to feel able to stand confidently as midwives in the space and feel that they are supported. The findings of my research identified that midwives need to feel that midwifery is valued, respected, 'visible', and 'present' in the place to feel confident to practise authentically. The significance of the 'placedness' of midwifery was highlighted in a study by Hansson et al. (2021) which explored the hospital workplace of the midwife in relation to their wellbeing and practise, and the feasibility of working as a midwife. The study highlighted, as did my study, the importance of midwives feeling recognised for their responsibility for normal births, leading to a strong sense of autonomy, professional identity, professional courage, and a sense of their work being meaningful; Hansson et al. referred to this as 'visualising midwifery'.

Making normal labour and birth visible

The study by Hansson et al. (2021) also illuminated that sufficient organisational resources were essential for midwives to be 'with woman' and that busyness places a strain on midwifery care. Hansson et al.'s study echoed my findings in relation to the importance of midwifery and the 'play of normality' being 'visible' and central within the 'place', and how keeping supporting normality behind closed doors can lead to this becoming invisible amidst a dominant technocratic discourse. My findings show that

normality needs to be visible, as identifying normality within the 'place' is central to supporting physiological birth.

Recognising the uniqueness of each woman

It was evident in my findings that, alongside normality being 'visible', holding the woman's uniqueness at the centre was key to practitioner's being able to easily 'see the normal'. When midwives and obstetricians were experienced in physiological birth and understood normal labour physiology, it brought a feeling of safety to that which is non-linear and to 'sitting with uncertainty'. This finding is echoed by Weckend, Bayes, and Davison (2020) who highlighted that 'place' can influence how labour plateaus are understood in relation to normality and pathology, and the likelihood that the plateau will result in labour intervention. An extensive study on labour progress by Oladapo et al. (2018) identified that cervical dilatation is not uniform for all women. The pattern of dilatation is not always linear; the progression of spontaneous labour is more akin to a stepped process, having periods of accelerated activity, along with periods of slower activity and progress.

The impact of 'time' pressure

My study shows that when practitioners let physiology take the lead and *worked with* the woman's body, intervention, if needed, was used judiciously. However, the 'time of the place' was identified in my study as representing a central tension in hospital birthing facilities in relation to labour progress, and a catalyst to a practitioner driven cascade of intervention. This tension in the hospital birthing space was also identified as a barrier to supporting a physiological approach to birth by Miller (2020). Miller referred to the pressure to 'hurry' labour progress as a "relentless-moving-forward-momentum" (p. 195) which reflects the birthing facility culture. Miller's study highlights that the very conditions that facilitate safe care for women with complexities in the hospital space (poisedness for action and emergency care, surveillance, and control) represent a barrier to *working with* a woman's physiology during physiological labour and allowing it to unfold.

Recommendations for Practise

Midwives need to lead a 'play of normality' in the birthing place. Midwives need to talk about practises in relation to supporting physiological birth in shared spaces in the birthing place, share experiences, and celebrate their expertise in normal birth. They

need to make the ‘non-linear’ and their practical wisdom visible to, and heard by, the wider maternity team. Senior midwives who are experienced in and passionate about physiological birth are key to leading this ‘play of normality’. It is important that they advocate for, inspire, and empower and support their colleagues in a physiological approach. They are pivotal to challenging inappropriate decisions while guiding and supporting the practitioner to a different approach. There is a need to involve practitioners who might not be comfortable with an ‘appropriately patient’ approach towards labour and birth; conversations are necessary regarding wisdom in appropriately ‘not doing’ interventions.

Wrapping an extra layer of ‘alongside’ midwifery support around physiological birth is core to nurturing an appropriately patient approach. Midwives should consult with the CCM or a senior midwife before involving an obstetrician in the woman’s care, unless in an emergency situation. Working together and standing alongside each other as midwives to best support the woman is essential in supporting normality.

Patience is a team sport. Trusting, respectful, supportive relationships amongst midwives and obstetricians are essential for sharing an appropriately attuned approach to labour and birth. It needs to start with a professional respect and understanding of each other. Fostering a sense of ‘team’ and shared goals within ‘place’ aids team connection. The maternity team should be ‘present’, connected, and available for each other to facilitate a sense of safety and effective communication. This would help to avoid barriers to practitioners asking for support. ‘Presence’ and connection would likely help to ‘broaden the ridge’ in the ‘in-between space’ and facilitate a greater openness to possibilities and a more patient approach in between midwife-led (primary) and obstetric-led (secondary) care.

To further cultivate openness, there needs to be greater fluidity between what we understand to be primary and secondary care for the team to best meet each woman’s individual needs. It may be that the midwife needs ‘fresh eyes’ from the registrar, reassurance perhaps that continuing to be patient is appropriate. It may be that the midwife is concerned about the woman’s progress and believes that involving the designated senior midwife in the woman’s care for further consideration is the best initial approach. The registrar may have been involved in the woman’s care; yet, the woman’s situation may normalise. Thus, the woman is suitable to return to primary midwife-led care. Greater fluidity would be nurtured by trusting team relationships and

could be led by the senior midwifery and obstetric clinical team. At the same time, the team would need to recognise the danger of blurred boundaries resulting in no one person carrying responsibility and ensure there was always clarity in who was in-charge.

The midwifery voice needs to be strong within 'place', and core to this is professional respect. Obstetricians respecting midwives as equal colleagues and partners in maternity care (and vice versa), creates space for all to practise authentically in open dialogue and trust. This is partly determined by having obstetricians who are experienced with having faith in physiological birth but is also driven by the intentionality of place and how authority is situated. Obstetric colleagues working alongside midwives in the primary space might strengthen mutual professional respect and trust (discussed in recommendations for education). Obstetricians supporting an appropriately patient approach to labour care would strengthen midwives' trust and respect in them. Midwives should be central to discussions at key decision-making points during labour, prior to where there is a possibility of intervention. Three-way conversations between the woman, the midwife, and the obstetrician, when obstetricians are involved, should be consistently facilitated and normalised throughout the woman's maternity journey.

Practitioner reflection is recommended prior to making any decision to intervene in a woman's labour. It is important for all practitioners to consider at this point: Is the intervention in the best interests of the woman and baby? Is there a safe alternative to doing the intervention? Are there are any other competing needs or pressures within 'place' that are driving the intervention?

Recommendations for Maternity Services

Supporting physiological birth needs to be 'ready to hand' with an environment which supports optimal oxytocin release for women and generates a relaxed, homely, and unhurried mood for practitioners. The environment should be set up to facilitate 'normality' and adjusted for women with more complex needs when required, rather than be set up to accommodate a technocratic approach to care. The default setting within 'place' needs to reflect and 'paint a picture' of an intentionality of appropriately supporting a physiological approach to labour and birth; it should have an ambience of 'normal'.

For example, the bed should not be the central focus of the birth room and optimally should not look like a hospital bed. Equipment for facilitating normality such as balls, birth stools and birth couches etc should be readily available, and technocratic equipment could be accessible but less visible. There should be birth pools available in every room and easy access to waterproof telemetry CTG machines. There should be shared spaces for women to come together, and appropriate spaces for women to mobilise.

A pathway or 'care bundle' for a physiological approach to labour and birth is recommended to keep normality visible, legitimised, and aid attunement to a discourse of 'normality'. This should be shared with both women and their whānau during the antenatal period, and practitioners prior to working at the facility.

Women who are healthy and considered to be low-risk should be encouraged to birth in a primary setting. For women birthing in a hospital setting, there should be careful cohorting to ensure that every woman can labour and birth in the most appropriate space to best meet her needs. Providing a separate midwifery-led birthing space for healthy low-risk women who have chosen to birth in the hospital setting is recommended. This space should anticipate normality, and the optimal conditions for physiological birth should be ready to hand in relation to the birthing environment, equipment, facility culture, mood, and driving underlying philosophy.

Maternity services should take steps to mitigate some of the pressure created by busyness in the birthing unit. This could be done by considering strategies to facilitate the optimal use of space and staff which best enables an appropriate use of resources. An escalation plan to manage high levels of acuity could reduce pressure to intervene and could be achieved by optimising the use of existing space and staff in the hospital facility and elevating appropriate provision of early labour midwifery care in the woman's home. Diverting admission of all low-risk women to local primary birthing facilities is a further escalation strategy for consideration. This should be clearly communicated to women when they initially book for care at the hospital facility. Additionally, LMC access agreements need to automatically include access to primary birthing facilities within the region.

Hospital birthing facilities should have the capacity to increase their birthing space and midwifery staff to accommodate more labouring women when required. This space and

staff would need to be allocated from another maternity area. Investing space and midwives in relieving pressure and facilitating an appropriately patient approach could have ripple effects in reducing overall acuity within the maternity facility. 'Being with' the woman and allowing labour to unfold in the woman's time, rather than that of the facility, is likely to increase rates of physiological birth; and in doing so reduce the acuity in the birthing facility, theatre, and postnatal areas. This would require adequate staffing levels which are central to supporting physiological birth, and an initial 'leap of faith' in the direction of supporting normality.

Consultant obstetricians who are experienced in supporting physiological birth should be onsite 24 hours a day, seven days week, to support the wider maternity team. They should be 'present' in the birthing facility and 'connected' to the wider maternity team; this support must be alongside and needs to be 'felt'. They need to be approachable, accessible, and trusted by the team. They should be present if a caesarean section is being considered, and present for all trial of operative vaginal births.

It is recommended that maternity services conduct a cost analysis in relation to labour and birth scenarios and outcomes. This information should be shared with the wider maternity team, maternity leadership, and senior hospital leadership teams, and should be considered in relation to decision-making about the 'intentionality' of the maternity service—what practises and related outcomes are going to be facilitated and 'made room for' within the place.

Data in relation to birth outcomes should be analysed, visible in the birthing place, and discussed by the wider maternity team. This information should be displayed in the birthing unit, discussed in meetings, and individual practitioner data considered during peer and manager reviews. Transparency is required in relation to trends in birth outcomes. Concerns about low rates of physiological labour and birth must be taken seriously and explored in relation to the clinical appropriateness of the interventions. Successes should be celebrated. Supporting physiological birth needs to be the maternity team's shared business, and it needs to matter within 'place'.

Regular review of LMC access holders and their access agreements in relation to their birth outcome data is recommended. The philosophy of the birthing facility/facilities should be well understood and embraced by practitioners who choose to work within

the ‘place’. If it is not reflected in their practise, it is important that there is the opportunity to reflect on this with the practitioner.

It is recommended that birthing facilities have a driving philosophy that reflects the intentionality in relation to supporting an appropriately patient approach to physiological birth. This philosophy should be visible, shared widely, and sit centrally to all decision-making. It would help to keep a focus on supporting normality and could validate and legitimise this ‘play’.

The presence and ‘placedness’ of a strong midwifery voice is essential in the clinical space, and important in leadership. The position of midwifery leadership in hospital maternity facilities should be equal to obstetric leadership and be equally present in decision-making.

Recommendations for Education

Midwifery entry to registration education

Normal labour and birth physiology should be an ever-present thread and focus throughout midwifery entry to registration education. The centrality of the woman’s unique normality should sit alongside, and students should learn how these can both be instrumental in helping them to ‘see’ normality amidst a risk-based facility culture. Preparing student midwives for the tensions that they may experience in relation to time and labour progress in some hospital facilities would raise awareness of competing pressures within ‘place’ and aid critical thinking in relation to these pressures. It is recommended that the study of place/space in relation to the mood to which practitioners are attuned, its influence on how practitioners feel emotionally, and on practise is incorporated into the programme. This could raise awareness of how place can shape practise, and aid students to consider how they can work to mitigate this when needed.

Students should be encouraged as midwives to always seek alongside support from senior midwives; and, in return, to wrap support around their colleagues. It is recommended that the notions of shared patience and the importance of ‘team’ are embedded into the programme. It is also essential that all student midwives gain experience in supporting women to birth in primary settings. Room should be made for birthing experience in primary settings during the midwifery first year of practise programme for all new graduate midwives. Additional time needs to be created if a

student was unable to gain enough experience in primary settings during their midwifery training.

Midwifery post registration education

Post registration papers related to supporting physiological birth in combination with professional leadership could strengthen the growth of strong, passionate midwifery leaders in this field.

Clinical education

Multi-disciplinary education for midwives and obstetricians in relation to supporting normality is recommended to aid professional trust, respect, and collegiality. It could also support a shared understanding in relation to what constitutes 'normal'. It would offer an opportunity for the team to further develop their navigation of an appropriately patient approach in the 'in-between space'.

Medical student, senior house officer, and registrar education

The physiology of labour and birth, and what constitutes 'normal', should be taught by midwives/midwifery lecturers; midwives are the experts in this field. This would support a good foundation of 'normal' on which to build obstetric education in complexity and help foster interdisciplinary professional respect and trust.

Senior house officers and registrars would benefit from placements working alongside community midwives. They should be involved in the care of women with low-risk pregnancies with an opportunity to assess the woman at home in early labour, and experience labour and birth care in primary birthing facilities and home birth with woman/whānau consent. When working in hospital facilities, they could be encouraged to work alongside midwives who are providing primary care; they should be involved caring for women without epidurals, involved in water births, and see the play of normality.

Recommendations for Future Research

My findings suggest key differences between hospital facilities in relation to practitioners' experience of supporting physiological birth, even facilities within the same DHB. It would be interesting to explore this further by conducting a comparative analysis study using care mapping of labour and birth care of low risk primipara accessing the birthing facilities.

A multi-centre national or international study exploring how midwives and obstetricians experience 'place' in relation to supporting physiological birth would build on the findings of this research study.

Whilst there is some evidence regarding the benefits to midwives in relation to working in primary birthing settings, these studies have not involved obstetricians. A phenomenological research study exploring registrars' experience of working alongside midwives in primary birthing facilities would uncover how this birthing experience influences their perspectives in relation to 'normality'.

An ethnographic study conducted in a hospital maternity facility that has high rates of physiological birth would highlight what was working well and the reasons behind the success.

Finally, an action research study focusing on practise in the 'in-between space' in relation to labour and birth care would aid exploration into what facilitates greater openness to possibilities, fluidity, and patience in this space.

Strengths and Limitations of this Study

The strengths of this research lie in the understanding that was generated from incorporating practitioners working in a range of different roles within maternity services. Participants included LMC midwives working in both rural and urban locations, and primary and secondary settings; CCMs and hospital-based midwives working in four different hospital maternity facilities. The research included perspectives from obstetricians; registrar, LMC private obstetrician, and hospital-based consultant obstetricians. Hearing how participants experienced their different roles within maternity facilities and subsequent angles of vision helped to bring to light the phenomena that were at play within 'place', influencing how practitioners were able to support normality. All midwife and obstetrician participants were practicing in the greater Auckland region. As it is possible that there are regional differences in maternity facilities, this is a limitation of the study. Recruiting participants nationally may have uncovered more diversity of experiences of 'place' and generated deeper understandings.

This research began with the intentions of bringing an AI lens; however, participants seemed to need to tell their stories, whether positive or of times of struggle. The

strength of beginning with a commitment to an appreciative approach was that it kept me attuned to what was working well. Nevertheless, I came to see that to honour the stories the participants were giving me, I needed to stay grounded in hermeneutic phenomenology.

While I contemplated bringing a more critical lens to highlight issues of power and control, it seemed important to stay focused on the experience itself. It may have undermined the spirit of the inquiry to bring too much focus to 'power'. As my findings reveal, an important strategy to grow the rates of physiological birth is to build relationships of respect and trust between midwives and obstetricians. A strength of hermeneutic phenomenology is that it brings attention to the human-to-human relationships.

Using hermeneutic phenomenology brought to the foreground the practitioner's interrelations with and within place, and integral to this my findings highlighted the centrality of the discourses to which practitioners are attuned. Using a discourse analysis would have further illuminated this understanding and would likely have resulted in more focus on how place influences practitioners' perceptions in relation to risk and normality, and how this understanding shapes their practise. This may however have been at the expense of uncovering more broadly the barriers and enablers to supporting a physiological approach to birth, and the essence of place, which using hermeneutic phenomenology has captured.

The focus of the data became the hospital maternity setting. Although several midwives also worked in primary settings, they experienced supporting physiological birth more easily in these places and had more to share about the hospital space. This may have been in relation to frustrations about some of the barriers to supporting normality in the hospital space and may have potentially limited the insights that could have been seen in relation to birthing in the primary space.

This is a hermeneutic phenomenological research study. The purpose of the study is not to claim the 'absolute truth' and to generalise the findings. Instead, the aim of the research is to point to what may be happening within maternity facilities regarding barriers and enablers to supporting a physiological approach, facilitating a greater understanding of how practitioners experience 'place' in relation to supporting normality. Although the study was conducted in New Zealand, the findings may be of

interest and relevance to practitioners working in maternity facilities outside of New Zealand.

Closing Thoughts

As I end the thesis with my closing thoughts, I return to the research question: How do midwives and obstetricians experience place in relation to supporting physiological birth? My research has shown that midwives and obstetricians *do experience* 'place', and 'place' shapes their practise. Midwives and obstetricians are 'in-place' and the layers of influence stand behind them, in front of them, and wrap around them. Practitioners experience the influence of place in relation to supporting normality in what is easier to achieve in the environment, the discourse to which they are attuned, and the mood within 'place'; this influence is seen, interacted with, and 'felt'. In supporting a physiological approach to labour and birth, practitioners are maximising the potential for physiological labour and birth to occur, and 'place' has a combination of enablers and barriers within it. The significance and balance of these represents how 'ready-to-hand' supporting normality is likely to be within 'place'.

It was evident in my research findings that providing woman-centred care may at times be compromised by 'place'. Peeling back the layers, 'place' ultimately shapes practitioners' ability to focus on the woman: accommodating her 'normal' and the best interests of the woman and baby, the woman 'being-in' her own time, and midwives 'being with' the woman. Competing tensions and pressures, along with the dominant discourse within 'place', can steer practitioners' focus away from 'seeing' the woman's uniqueness and blur the perceived relationship between risk and normality. This can make being appropriately patient more challenging.

Patience is a team sport; and connection, collaboration, and shared philosophy are critical. Central to connection is respect, trust, and faith, and an alongside and equal professional position within the hospital facility between midwives and obstetricians. I spoke about the 'narrow ridge' in the research findings in-between primary and secondary maternity care. Convening and nurturing this space exemplifies a key opportunity to better supporting a physiological approach to labour and birth. This in-between space represents an additional opportunity for normality to be supported and recognised. To nurture this space, physiological birth ultimately needs to 'matter' within 'place' and this 'mattering' needs to be shared. The 'play of normality' needs to be led,

modelled, and fostered by midwives, embodied by the wider maternity team, and supported with the environment.

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Appendices

Appendix A: AUTEC Approval

Auckland University of Technology

D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

27 February 2019

Liz Smythe
Faculty of Health and Environmental Sciences

Dear Liz

Re Ethics Application: **19/17 Midwives' and obstetricians' experience of place in relation to supporting physiological birth: a hermeneutic study with an appreciative inquiry lens**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 26 February 2022.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: christine_mellor_nz@yahoo.co.nz; Marion Hunter

Appendix B: Participant Information Sheet

Date Information Sheet Produced:

05/01/2019

Project Title

Midwives' and obstetricians' experience of place in relation to supporting physiological birth: a hermeneutic study with an appreciative inquiry lens

An Invitation

We (researcher and midwife Christine Mellor and supervisor's Dr Liz Smythe and Dr Marion Hunter) are based at AUT University. We would like to invite midwives and obstetricians practicing in the greater Auckland region to take part in interviews which will explore their experiences of birth place/space in relation to supporting physiological birth. We would also like to explore their perspectives on what elements of birth place/space currently work well, and what they consider the ideal would be. Your decision to take part in this study is voluntary. You may withdraw from the study at any time without having to give a reason up until your interview is complete. Whether you choose to take part or not will neither advantage nor disadvantage you.

What is the purpose of this research?

A research study examining the culture of birth place/space in relation to facilitating physiological birth could identify cultural elements of place and space that enhance practitioner's experiences, professional relationships, and evidence-based practices. Ultimately the study aims to develop understanding about what elements of place are optimal in enabling midwives and obstetricians to facilitate physiological birth and develop meaningful insights that could be effective in reducing unnecessary interventions in labour and birth.

This research study could result in publications and presentations, and the study is part of the researcher's Doctor of Health Science degree.

How was I identified and why am I being invited to participate in this research?

Participants for this study are being purposively selected to ensure that 'key informants' are recruited who have an important perspective which will be of benefit to the study. Participants will be selected who work across a range of maternity facilities in the greater Auckland region (secondary/tertiary maternity facilities and primary birthing units). The inclusion criteria are:

- Lead Maternity Carer midwives (self-employed community midwives) from a range of demographic areas in the greater Auckland region who provide care to women in both primary birthing units and secondary/tertiary maternity units
- Core (employed by the hospital) midwives who regularly work in the labour and birth unit and have had experience working in more than one facility as a qualified midwife.
- Clinical Charge Midwives (secondary/tertiary maternity units) who regularly work in the labour and birth unit and have had experience working in more than one facility as a qualified midwife.
- Registrar and consultant obstetricians who work in maternity

The researcher currently works in maternity in the Auckland region and has a good understanding of which potential participants have detailed insight into the phenomenon, and who would be likely to feel comfortable to share this insight openly and honestly. Potential participants will be approached by a colleague acting as an intermediary and invited to participate in the study to reduce the chance of them feeling coerced.

How do I agree to participate in this research?

Participants need to complete a consent form, and this will be provided by the researcher and signed prior to commencement of the interview. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you decide to take part in this study this will involve you taking part in an interview. This will be held at a location of your choice or be done via Skype if you prefer, and at a date and time which is convenient for you. The interview should take approximately one hour of your time. Before the interview begins you will be given the opportunity to ask questions, and also be asked to sign a Consent Form. You will be asked to talk about your experiences of place/space in relation to supporting physiological birth. You will also be asked to talk about what elements of place/space you consider work well in relation to supporting physiological birth, and what you consider the ideal would be.

The interview will be digitally audio-recorded and then transcribed by a transcriber who has signed a Confidentiality Agreement.

What are the discomforts and risks?

We do not anticipate any risks to you from this study. However, occasionally such interviews in which you share your thoughts and experiences can make a person feel uncomfortable. Should counselling be required this will be available through AUT University.

How will these discomforts and risks be alleviated?

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The results of this study may inspire reflection and will be instrumental in identifying elements of maternity facility culture that could help practitioners to support physiological birth, and elements that could represent barriers to this. Results will be transferable between facilities, and potentially influence positive change in both practice and ultimately in women's experiences and birth outcomes. This research study is a component of a Doctor of Health Science degree for the researcher.

How will my privacy be protected?

The identity of the participants, their practices, and all information given will remain completely confidential. Pseudonyms will be used for any presentations/publications. Your identity, contact details and transcripts will be stored is a secured location and only Christine, Liz and Marion will have access to these.

What are the costs of participating in this research?

The only cost to the participant is their time. The interview is expected to take approximately one hour.

What opportunity do I have to consider this invitation?

Please notify the researcher by email, phone call or text within two weeks if you would like to participate in the study. You can contact the researcher also if you have any questions. At the time of the interview you will have the opportunity to ask further questions.

Will I receive feedback on the results of this research?

All participants will receive a summary of the results of the research on completion of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Liz Smythe: *liz.smythe@aut.ac.nz*, 099219999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Christine Mellor: christine_mellor_nz@yahoo.co.nz, ph. 021557502

Project Supervisor Contact Details:

Dr Liz Smythe: liz.smythe@aut.ac.nz, ph. 021351005

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix C: Consent Form

For use when interviews are involved.

Project title: Midwives' and obstetricians' experience of place in relation to supporting physiological birth: a hermeneutic study with an appreciative inquiry lens

Project Supervisor: Dr Liz Smythe and Dr Marion Hunter

Researcher: Christine Mellor

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 5/01/2019
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

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Date:

***Approved by the Auckland University of Technology Ethics Committee on** type the date on which the final approval was granted **AUTEC Reference number** type the AUTEC reference number*

Note: The Participant should retain a copy of this for

Appendix D: List of Indicative Questions

As time went on I became more focused on simply eliciting relevant stories

- Tell me about the main strengths of your current workplace in relation to supporting physiological birth
- Tell me about a time where being in the birthing place has influenced your decisions in relation to keeping birth normal. What would have improved this situation?
- Tell me a story about a time and place when a woman has had intervention in her labour but you have appropriately continued to keep things as normal as possible. What about the place/space aided this? Have you experienced barriers to this in other places?
- Tell me about a time when you left your workplace feeling particularly proud about the care that you had given
- Tell me a story about a particularly special birth that you have experienced that left you feeling inspired by your maternity team. What made the difference, and how could this be replicated?
- Tell me a story about a positive change in practice/outcomes that occurred at a place where you have worked; what do you think facilitated this?
- Tell me about an experience in practice (labour and birth) that you have done differently in two different maternity facilities and how these were different
- Tell me about how you have 'got around' a sense of place influencing your practice
- Tell me a story about a time when you've been challenged about your decision-making regarding labour and birth
- Have you got a story about handing over the care of a woman and feeling concerned about how you managed her care? What were the barriers to best practice?
- Tell me a story about a time when you have appropriately held the midwifery space before referring to an obstetrician where you have seen different practices in other maternity facilities? What about the place/space made the difference for you? What do you think could be the barriers to achieving this in other maternity facilities?
- Have you got a story about how a woman has taken charge of decisions in relation to labour and birth that taught you something?
- Tell me about a time and place where you felt less affected by the tensions in relation to providing primary care in the hospital space
- How could we better support physiological birth?
- How can we reduce tensions in the hospital space when providing primary care?

- If you could manage the maternity facility, what changes would you make to positively influence the culture of place in relation to supporting physiological birth?

Appendix E: Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title:

Midwives' and obstetricians' experience of place in relation to supporting physiological birth: a hermeneutic study with an appreciative inquiry lens

Project Supervisor: ***Dr Liz Smythe and Dr Marion Hunter***

Researcher: ***Christine Mellor***

√ I understand that all the material I will be asked to transcribe is confidential.

√ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

√ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....Shoba Nayar.....

Transcriber's Contact Details (if appropriate):

snayar19@gmail.com.....

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Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Transcriber should retain a copy of this form

Appendix F: An Example of the Process of My Interpretation

The data:

> *I remember looking after a woman and we were out in the forestry in a little cottage setting to have the baby. Then the baby got itself in a difficult position so we wound up having to change direction and go into the hospital. It always made me think, particularly with her, of a yacht tacking in the wind. We hit an obstacle where it's going not quite as it should so we set another course; we'd wait this long and reassess so we tacked in another direction, but kept tacking towards normal birth while we could. So we got to the hospital and there was another obstacle which we talked about. Finally, we tacked our way right into theatre and it was fine because there had been sensible discussion around it all as a team, we knew we had explored all avenues regarding physiological labour and birth, and we knew when we got to theatre that's where we needed to be and were extremely grateful for the expertise that was there.* (Clara, LMC midwife)

Here are some notes on my thoughts in relation to this piece of data:
Description: Clara describes here how she was able to work with the woman and the hospital maternity team to keep 'tacking' towards the best outcome for the woman and baby, without applying a risk-based approach at the first obstacle.

Beginning interpretation: Clara is describing how she was able to hold the woman and baby at the centre of her decision-making and continue to support physiological birth, exploring all avenues until there were no more. When she transferred the woman to the hospital facility, she worked collegially with the hospital team towards the same goal. This story suggests that there was a commitment by the whole team not to intervene too quickly, but to continue to aim for physiological birth while it remained safe. Clara said that there had been 'sensible discussions' with the team, suggesting that the woman had been supported towards the very best care for her at each point and the best outcome.

Interpretation building: This story captures an approach by Clara and the maternity team to continue to safely identify and accommodate the normal that was evident within the woman's situation. They did not simply consider, at the first obstacle, that there were some risks factors, and continue from that point to medically manage the woman's

labour. Instead, they managed *that risk* and continued to support the normal elements within the situation. This is not about normalising the abnormal; instead, appropriately and safely *seeing* the normal that sits within a woman's experience.

Bringing in philosophy: Heidegger (1992) wrote about the centrality of relatedness in relation to a craft, and this notion was considered alongside Clara's story (as shown below).

Reflections and questions in relation to the overall picture: This story suggests the significance of the team which appeared to bring strength in relation to supporting normality. How much of the cascade of intervention is a physiological response and how much is practitioner driven? (There were times when Clara could have intervened in the woman's labour but she held off; was this just her underlying philosophy or was it influenced by place?). What could it have been about this team that enabled an appropriately patient approach to be facilitated?

The story did not need to be crafted but was used in its original state, I just added a title. Here is my interpretation of the story as it is written in the findings:

Collectively 'tacking' towards physiological birth

Clara describes how she was able to work with the woman and the hospital maternity team to keep 'tacking' towards normality while possible. The woman's physiological birth was held as the focus of the care, the 'destination', and normality remained the default. Clara talks about her 'craft' as she held *this woman* and *this baby* at *this time* in *this place* at the centre of her decision-making and continued to support the woman's physiology. As with tacking in sailing, the midwife *works with* the 'powers' to guide the woman to her destination. Just as the sailor would position their yacht for the tack, the midwife aims to optimally 'position' the woman to give her the best chance of moving towards her destination and maximising the strength from the 'powers'. It takes teamwork, strategy, and careful timing, with attunement sitting as a key driver.

When an obstacle to normality was met, Clara and the hospital team navigated in a different direction, all still 'tacking' towards the same destination while appropriate. It is not just about considering the obstacle or risk per se, but also accounting for the reassuring elements in the woman's labour and what it meant for the woman at 'this

point'. Not every risk is the same for every woman or even for the same woman at a different time. The risk must be seen within the 'essence' of the situation.

Clara and the hospital team did not intervene at the first obstacle because the baby was not ideally positioned. The woman's care was carefully considered to accommodate where she was at that time, in that space, and for that stage of her labour. The essence of her situation was responded to. Possibilities and risk were continually explored as things changed; a picture was built and adjusted in real time. Clara and the maternity team 'tacked' towards a 'favourable wind' in response to the woman and the baby in each moment. How does one learn how to 'tack'? It is more akin to a craft than a skill. It is an attunement to the interplay of so many things coming together in the moment.

As briefly described in the introduction to this chapter, Heidegger (1992) wrote about the centrality of relatedness in relation to a craft:

> A cabinet maker's apprentice, someone who is learning to build cabinets and the like, will serve as an example. His learning is not mere practice, to gain facility in the use of tools. Nor does he merely gather knowledge about the customary forms of things he is to build. If he is to become a true cabinet maker, he makes himself answer and respond above all to the different kinds of wood and to the shapes slumbering within the wood - to wood as it enters into man's dwelling with all the hidden riches of its essence, In fact the relatedness to wood is what maintains the whole craft. Without that relatedness, the craft will never be anything but empty busywork, any occupation with it will be determined exclusively by business concerns. Every handicraft, all human dealings, are constantly in that danger. (p. 379)

Clara and the hospital team knew their 'craft', and they knew how to 'answer and respond' to what was presented to them. They appreciated and understood the depth lying behind what was visible on the surface, and in front of what they could see. They related to the 'essence' of the woman and her labour as it changed in relation to all influencing factors, some of which could be controlled and some that could not. Clara and the hospital team related to this 'essence' through the lens of their craft and they were open to possibilities. It seems that the team's relatedness to the craft and to the woman added a depth of understanding and greater meaning to their decision-making.

Relatedness supports more meaningful and responsive decisions which holistically consider the ‘essence’ of each situation. This relatedness adds a depth of understanding about the uniqueness of the woman and baby, the labour as it changes, elements of normality and risk, and the appreciation of the full situation in real time.