UK midwives' perspectives on the practice of intrapartum midwifery-led care within the hospital setting: a qualitative study

Rachel Housego

ORIGINAL

Abstract

Background: Increasing intervention rates and decreasing physiological birth rates indicate the continuing medicalisation of childbirth in the United Kingdom (UK). This could reduce access to midwifery-led care, which adopts a 'with woman' approach, and supports physiology. Medical care is associated with a decline in maternal and neonatal morbidity and mortality but can have significant consequences for physical and psychological health. It is therefore imperative to understand the driving forces behind this trend.

Aims: This qualitative research sought to explore the extent to which midwives feel they can practise midwifery-led care and identify midwives' perceived barriers and facilitators to providing midwifery-led care.

Methodology: Three focus groups were conducted with midwives from across the UK. One group was composed of midwives experienced on the obstetric-led unit (n=4); one group included midwives who worked in midwife-led units (n=4); and finally, there was a mixed group of midwives (n=6). Focus groups were conducted via Microsoft Teams, transcribed verbatim and analysed using thematic analysis.

Results: Participants identified a shift in midwifery practice, whereby obstetrics is playing an increasing role in maternity care. They perceived an erosion of midwifery practice, defined by a reduction in physiological practices and the promotion of women's choice. This was attributed to numerous interconnected structural, cultural, and individual factors. These included but were not limited to: midwife mental health and a perceived lack of experience in promoting physiology; a shift in a perception of maternity care; a change in maternity culture; and the changing epidemiology of the birthing population.

Conclusion: This study concludes that the identified barriers and facilitators to midwifery-led care require further exploration to address these issues within practice. As a key theme identified, methods to support midwives' mental health should also be implemented. In addition, addressing staffing to reduce burnout, incorporating midwifery philosophy into training, developing antenatal and preconceptual education for women, and improving access to midwifery-led birthing units, have been identified as key recommendations from this study.

Introduction

Midwifery is an approach to care in which women-centred care is paramount and the physiological, biological, and cultural processes of birth are optimised (International Confederation of Midwives 2005). Despite the numerous benefits attributed to a midwifery-led approach, obstetric intervention is increasingly used on women unlikely to benefit (Dahlen et al 2022). While obstetrics saves lives, as demonstrated by reducing maternal (Donaldson & Rutter 2018) and neonatal (NHS England 2019) mortality and morbidity, medical interventions also

impact long-term psychological and physical health for women and children (Humphrey & Tucker 2009, D'Souza 2013, Patterson et al 2018).

Maternity care

A midwifery model of care places women's values, preferences and beliefs at its centre and supports the physiological process of pregnancy and birth unless emergency medical intervention is required (Brubaker & Dillaway 2009, Renfrew et al 2014).

Intrapartum guidelines (National Institute for Health and Care Excellence (NICE) 2014, World Health Organization (WHO) 2018) promote this approach to birth as it is associated with numerous benefits for women and neonates. These benefits include: reduced risk of haemorrhage (Davis et al 2012); less psychological morbidity (Michels et al 2013); more successful breastfeeding (Moore & Anderson 2007); improvements in bonding (Moore & Anderson 2007); and maternal satisfaction in the birth experience (Leap et al 2010).

In addition, midwifery philosophy aims to provide midwife-led, women-centred, continuity of care (Sandall et al 2016), which improves women's and infants' health outcomes (Begley et al 2011, Birthplace in England Collaborative Group 2011), maternal satisfaction (Sandall et al 2016), and cost control (Tracy et al 2013).

Nonetheless, data show increasing rates of epidurals and caesarean section (CS) and decreasing rates of physiological birth within the UK (Care Quality Commission (CQC) 2022). This suggests a trend towards increasing medicalisation of childbirth, whereby birth is perceived as pathological (Einion 2017). Medical intervention, such as CS, has reduced maternal and infant mortality (NHS England 2019, Knight et al 2021), however, this frequently utilised lifesaving intervention poses significant risks to women and neonates, and has high costs (D'Souza 2013). In fact, a global study (2004–2008) concluded that CS should only be carried out where a clear benefit is anticipated (Souza et al 2010). Despite this, UK CS rates are increasing – from 12 per cent in 2000 to 21 per cent in 2015 (Wise 2018).

Medicalisation is not intrinsically evil (Zola 1972); globally there has been almost a 50 per cent decline in maternal mortality since 1990 (Donaldson & Rutter 2018) and the UK stillbirth rate has declined by 18 per cent since 2020 (NHS England 2019). The life-saving capabilities of medical care suggest medicine has a place in maternity care; however, not all pregnancies require medical management. Despite this, research suggests increasing numbers of pregnancies are medically managed (Einion 2017, Dahlen et al 2022) and intervention is employed on women unlikely to benefit (Dahlen et al 2022).

To adopt a midwifery model of care is not to exclude medical care but to utilise it when indicated. Sources suggest midwifery-led care has become harder to practise, due to medical domination (Bosch 1998, Hopkins 2000, Hadjigeorgiou & Coxon 2014). In addition, a primary focus on mortality can result in different outcomes than an emphasis on what women consider to be meaningful and valuable (Shaw et al 2016).

A significant impact of medical influence relates to maternal mental health, with birth trauma being more prevalent in women following intervention, especially when they feel coerced (Dahlen et al 2022). Patterson et al (2018) found that 45 per cent of women find childbirth traumatic, and four per cent develop PTSD (post-traumatic stress disorder). These figures are particularly notable when high levels of intervention are thought to be unjustified (McDougall et al 2016).

Aim

This study's aims were to understand the extent to which midwives feel they can practice midwifery-led care and poses the following research question: '*What are the barriers and facilitators to midwives practising midwifery-led care, within the hospital setting, in the intrapartum period?*'

Methodology

A generic qualitative approach was used, generating theory through inductive analysis. Data were collected through the use of focus groups conducted via Microsoft Teams, transcribed verbatim and analysed using thematic analysis. Focus groups were utilised to mitigate time constraints and were homogenous groups (that is, UK midwives) enabling a safe environment to share experience and dilute the power imbalance between researcher and participants (Barbour 2005). As a midwife, the researcher was a member of the homogenous group, and this helped mitigate power imbalance, facilitating discussion. As this study was exploratory, and time restricted, opportunistic sampling was used.

Recruitment

Advertisements were placed in *MIDIRS Midwifery Digest* journal, and on the Royal College of Midwives' (RCM) web and social media pages. These sources provided access to a sizeable proportion of the midwifery population; however, the recruitment method was reliant on midwives accessing the advertisement. As advertising might not target all the population segments (UK midwives), links to the studies were also posted on midwifery research forums and social media pages. Midwives actively applied to participate in this study, potentially inducing sampling bias (Green & Thorogood 2018).

All recruited midwives were experienced in an intrapartum clinical area. Midwives with current or recent experience in the hospital setting were chosen as opposed to those predominately facilitating home births as most births occur within the hospital (Einion 2017). From 2019–2020 only 2.1 per cent of births in England were at home (NHS Digital 2021) and only 14 per cent of births were in a midwifery-led unit (Walsh et al 2018).

Participants were all female, varied in ethnic origin and their experience ranged from two to 30 years; this is commensurate with NMC data on the midwifery population (Nursing and Midwifery Council (NMC) 2022).

Participants consented for their data to be stored for three years and, to ensure data security and maintain confidentiality, the data were anonymised and stored on a secure drive. Participants had the right to withdraw, and for their data to be removed.

Focus groups

The design involved three focus groups: a mixed group, an obstetric-unit group, and a midwife-led unit group. This captured the perspective of midwives working in different clinical settings: literature suggests birth setting influences midwife perception and approaches to midwifery-led care (Simonds et al 2007, Page & Mander 2014). Due to the nature of midwives' working shifts it proved challenging to allocate groups within a feasible timeline. Snowball sampling was used to allocate further participants. Following recruitment, three focus groups were made of equally divided groups of six.

Due to the geographical variation of participants, COVID-19 considerations, and time commitments, focus groups were conducted via Microsoft Teams.

Data analysis

Focus group discussions were transcribed manually verbatim. Keywords or meaningful phrases were highlighted and codes were then generated and categorised to organise the data. Codes were placed under themes and a thematic map was generated, allowing interconnected and key themes to be identified.

Ethical approval

This research received full ethical approval from King's Ethical Approval Committee

Results and discussion

Due to unforeseen circumstances four participants did not attend; therefore, there were two groups of four and one group of six (Table 1).

Table 1. Focus group allocation

Focus group (FG)	Participants (P)
1. Mixed group	1, 2, 3, 4, 5, 6
2. Obstetric-led unit group	7, 8, 9, 10
3. Midwife-led unit group	11, 12, 13, 14

Numerous interconnected themes impacting midwives' ability to practise midwifery-led care were identified. The themes detailed are in the order by which they were weighted.

The midwife

• Mental health

Midwife mental health was perceived by participants to be a significant barrier to midwife-led care; an interesting finding considering limited reference to this was noted during literature review. Four out of 14 participants (28.5%) referred to being signed off work with mental health conditions. Although this does not account for participants who did not disclose this information, most participants reported experiences of burnout, stress, and fear.

Participants stated that mental health was affected by workplace pressures, such as staffing. This is conceptualised in the RCM (2021) survey which found midwives were planning to leave the profession due to staffing and the poor quality of care they were providing. Participants referred to admitting 'defeat' after strenuous shifts that were exacerbated by staffing shortages. This is evidenced in the estimated shortfall of 3500 midwives in 2018 (RCM 2018) and the latest Ockenden report (Independent Maternity Review 2022).

Participants stated that poor mental health resulted in them coercing women. For instance, participants perceived caring for a woman with an epidural as 'easier' as it allowed them to take a break during a stressful shift. This results in midwives encouraging intervention as a means of respite and diminishes the notion of women as agentic; a contradiction of the role of the midwife as 'with woman'.

Interestingly, participants who predominately worked in midwife-led units did not disclose experiences of burnout or poor mental health. This resonates with the literature which states that midwives experience emotional difficulty when they cannot practise according to their beliefs (Hunter 2004).

• Experience and confidence

Participants identified experience and confidence as being key to the ability to provide midwifery-led care and suggested that negative experiences of facilitating birth in the workplace influence the care they provide to women. Many midwives reportedly do not have the experience, and therefore confidence, to work within a midwifery model. Consequently, they operate within a medical model to provide perceived

security. This was not reflected directly in the literature; however, studies suggest midwives require determination and confidence to facilitate midwifery-led care (Carolan-Olah et al 2015).

Participants who worked in midwife-led birth centres felt more comfortable practising within a midwifery model, as opposed to those whose experience was largely on the obstetric unit. This suggests exposure to midwifery-led care is necessary to build confidence in midwifery practice. Page & Mander (2014) found experience to be key in developing midwives' ability to tolerate uncertainty in labour. Additionally, participants with largely midwifery-led experience felt more confident to promote physiology and women's choice. This is reiterated by Darling et al (2021), who found that midwives who work outside the obstetric unit are more autonomous and able to promote physiology.

Two participants suggested birth setting, rather than midwife experience, influenced midwives' perception and treatment of birth. When working in a midwife-led birth centre, they expect birth to 'go well', whereas they experienced a change in mentality in an obstetric-led unit, perceiving birth as pathological. Similarly, Page & Mander (2014) found midwives reported a more medical model in hospital compared with a homebirth.

Culture

• Culture of fear

The perception of birth as pathological is reflected in the results: participants reported a growing number of women fearful of birth, expecting medical intervention.

Participants discussed how media portrayal of the Ockenden report (Independent Maternity Review 2022) could have a significant effect on women's perception. Media reports such as these can lead women to doubt maternity care provision (Dahlen et al 2022) and participants felt more women would opt for medicalised birth out of perceived safety. Maternal decision to opt for medicalised birth is a result of women accepting this risk-averse culture (Einion 2015). This is reiterated by Wendland (2007) who states women choose CS because it mitigates the unpredictability and danger of birth. Participants corroborated this, stating birth is perceived as pathological and something to be feared, causing women to choose medical birth. In addition, participants perceived midwives as fearful of birth, exacerbated by lack of experience and blame culture.

• Risk-averse culture

Participants perceived a risk-averse culture which stems from a culture of fear, exacerbated by individual midwife experience and mental health. Participants reported these factors result in them working within an obstetric paradigm. Einion (2017) reiterates this: risk management permeates every aspect of society, and the unpredictability of childbirth leads women to have increased medical surveillance and intervention.

Participants perceived that acting in a risk-averse way mitigated poor outcomes, fear, and litigation. These findings are congruent within literature which states fear of litigation leads to defensive actions (Kirkham 2001, Essex et al 2013, Page & Mander 2014). Interestingly, the risk-averse culture was noted to be more significant in participants working in obstetric-led settings, perhaps attributable to their increased fear, and lack of experience in midwifery-led care. This is supported by Keating & Fleming (2009) who suggest midwives with significant hospital-based experience lose confidence in physiological birth practice.

Power

• Hierarchy

Obstetric power and hierarchy were identified as a barrier to midwife-led care. Participants reported that obstetricians had ultimate decision-making power, rather than women. This negates the notion of informed choice, as stipulated in NICE guidelines (2017), and undermines the role of the midwife in working in partnership with women (Renfrew et al 2014).

This obstetric dominance was thought by participants to be more prevalent in obstetric-led units. Birth centre participants perceived women as agentic, facilitating the midwifery philosophy of 'with woman'. In contrast, participants remarked on the power shift when women presented to the obstetric-led unit: here, women were perceived as passive, with the midwife and obstetrician in control. This is corroborated by Keating & Fleming (2009), who noted the hierarchical structure within maternity.

• Lack of education

A recurring theme within the data set pertained to a lack of preconception and antenatal education among women.

The *Women's health strategy for England* report (Department of Health & Social Care (DHSC) 2022) demonstrates the lack of information and awareness women have regarding their health: 74 per cent of surveyed women utilised family and friends as their main source of information. This is significant considering that the experience of friends and family has been suggested to instil fear regarding birth.

Study participants reported that women do not have the information required to make informed decisions. This results in polarised care, whereby women who require medical intervention feel they must conform to an entirely obstetric pathway, without utilising aspects of midwifery philosophy (for example, dimmed lights to stimulate oxytocin (Wickham 2016)). Participants suggested these women have less decision-making authority regarding birth and are swayed by obstetric opinion.

• Language — coercive and disempowering

Participants highlighted that language could be coercive and restrict women's choice. This contradicts midwifery-led care in which women's choice is paramount (Brubaker & Dillaway 2009) and is concerning considering psychological morbidity is associated with coercion (Dahlen et al 2022). It was identified that individual experience could influence the way information was posed to women. This was influenced by mental health, fear, obstetric power, and previous traumatic experience.

With regard to language, 'high risk' and 'low risk' labels were perceived negatively by participants who associated these connotations with polarised care; classifying a woman places them on a pathway for the duration of their pregnancy. Overall, it is evident that language can disempower women through illusion of choice and erosion of confidence.

Women's health

Changes in the population and women's health were identified as a key barrier to midwifery-led care. Participants discussed the increasingly unhealthy population and disclosed how women are now increasingly high risk due to raised body mass index (BMI) and advanced maternal age. This corresponds with McDougall's (2016) argument that increased intervention can be attributed to epidemiological transition; indirect causes of maternal mortality and morbidity have become more apparent. Glick et al (2021) also referred to maternal age as a risk factor for complications in pregnancy and stillbirth.

On the other hand, participants discussed how the number of women classified as 'high risk' and requiring obstetric-led care was unsubstantiated. This perhaps pertains to the risk-averse culture and labelling of women as 'high risk' at booking; women are placed on an obstetric pathway to mitigate adverse outcomes.

Literature suggests that women are increasingly high risk and more obstetric-led care is necessary. Conversely, women's health was the least prominent theme within the data set, although its significance cannot be disputed. It is therefore necessary to explore the care provision of women and assess the levels of input required and then carried out.

Limitations

This study has a small sample size (n=14). Nonetheless, the nature of this exploratory study was never to generalise to the entire population of UK midwives; it successfully identifies indicative areas for further study and provides a detailed, nuanced account of perceived barriers and facilitators to midwifery-led care. Furthermore, the corroboration of study results with existing literature increases validity and reinforces findings.

Conclusion and recommendations

It is apparent that there are numerous interconnected themes impacting midwives' ability to practise midwifery-led care. These require addressing as unnecessary intervention impacts the psychological and physical wellbeing of women and neonates. In addition, women have a fundamental right to birth how they choose (Birthrights 2021), yet this right is diminished by the individual midwife, maternity culture, power, and health.

Based on findings, the following recommendations are made:

- Increase psychological support for midwives
- Improve access to and availability of midwifery-led birth centres; ensure women are encouraged to birth in the appropriate clinical setting
- Increase maternity staffing levels by training and employing more midwives
- Incorporate midwifery-led care philosophy into mandatory training for the MDT
- Ensure all midwives work regularly in midwifery-led settings, where feasible, to facilitate learning and confidence
- Preconception and antenatal education for women regarding their bodies and birth should be facilitated from early years education in school
- Women should be appropriately risk-assessed throughout pregnancy to ensure care is appropriate at birth.

Due to the exploratory nature of this research and limited existing literature, further research is necessitated.

Author

Rachel Housego, Lecturer and Deputy Course Lead for (BSc) Hons Midwifery at University of Suffolk, UK. Email: r.housego@uos.ac.uk. Twitter: rachel_housego

References

Barbour R (2005). Making sense of focus groups. *Medical Education* 39(7):742-50.

Begley C, Devane D, Clarke M, McCann C, Hughes P, Reilly M, Maguire R, Higgins S, Finan A, Gormally S, Doyle M (2011). Comparison of midwife-led and consultant-led care of healthy women at low risk of childbirth complications in the Republic of Ireland: a randomised trial. *BMC Pregnancy and Childbirth* 11:85. https://doi.org/10.1186/1471-2393-11-85 [Accessed 9 December 2022].

Birthplace in England Collaborative Group (2011). Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 343:d7400. https://doi.org/10.1136/bmj.d7400 [Accessed 9 December 2022].

Bosch X (1998). Spanish doctors criticised for high tech births. *BMJ* 317:1406.

Brubaker S, Dillaway H (2009). Medicalization, natural childbirth and birthing experiences. *Sociology Compass* 3(1):31-48.

Care Quality Commission (CQC) (2022). Maternity survey 2021. https://www.cqc.org.uk/publications/surveys/maternity-survey-2021 [Accessed 5 January 2022].

Carolan-Olah M, Kruger G, Garvey-Graham Masters A (2015). Midwives' experiences of the factors that facilitate normal birth among low risk women at a public hospital in Australia. *Midwifery* 31(1):112-21.

Dahlen H, Drandic D, Shah N, Cadee F, Malata A (2022). Supporting midwifery is the answer to the wicked problems in maternity care. *The Lancet Global Health* 10(7):e951-2. https://doi.org/10.1016/s2214-109x(22)00183-8 [Accessed 9 December 2022].

Darling F, McCourt C, Cartwright M (2021). Facilitators and barriers to the implementation of a physiological approach during labour and birth: A systematic review and thematic synthesis. *Midwifery* 92(102861).

Davis D, Baddock S, Pairman S, Hunter M, Benn C, Anderson J, Dixon L, Herbison P (2012). Risk of severe postpartum hemorrhage in low-risk childbearing women in New Zealand: exploring the effect of place of birth and comparing third stage management of labor. *Birth* 39(2):98-105.

Department of Health & Social Care (2022). *Women's health strategy for England*. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#information-and-awareness [Accessed 22 August 2022].

Donaldson L, Rutter P (2018). *Donaldsons' essential public health*. 4th ed. Boca Raton, FL: CRC Press.

D'Souza R (2013). Caesarean section on maternal request for non-medical reasons: Putting the UK National Institute of Health and Clinical Excellence guidelines in perspective. *Best Practice & Research Clinical Obstetrics & Gynaecology* 27(2):165-77.

Einion A (2015). Resistance and submission: a critique of representations of birth. In: Burton N *ed. Natal signs: cultural representations of pregnancy, birth and motherhood*. Bradford, Ontario: Demeter Press:172-93.

Einion A (2017). The medicalisation of childbirth. In: Squire C *ed. The social context of birth*. 3rd ed. London: Routledge:169-80.

Essex H, Green J, Baston H, Pickett K (2013). Which women are at an increased risk of a caesarean section or an instrumental vaginal birth in the UK: an exploration within the Millennium Cohort Study. *BJOG: An International Journal of Obstetrics and Gynaecology* 120(6):732-43.

Glick I, Kadish E, Rottenstreich M (2021). Management of pregnancy in women of advanced maternal age: improving outcomes for mother and baby. *International Journal of Women's Health* 13:751-9. https://doi.org/10.2147/IJWH.S283216 [Accessed 9 December 2022].

Green J, Thorogood N (2018). *Qualitative methods for health research*. 4th ed. London: Sage Publications Ltd.

Hadjigeorgiou E, Coxon K (2014). In Cyprus, 'midwifery is dying…'. A qualitative exploration of midwives' perceptions of their role as advocates for normal childbirth. *Midwifery* 30(9):983-90.

Hopkins K (2000). Are Brazilian women really choosing to deliver by cesarean? *Social Science & Medicine* 51(5):725-40.

Humphrey T, Tucker J (2009). Rising rates of obstetric interventions: exploring the determinants of induction of labour. *Journal of Public Health* 31(1):88-94. https://doi.org/10.1093/pubmed/fdn112 [Accessed 13 December 2022].

Hunter B (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery* 20(3):261-72.

Independent Maternity Review (2022). *Ockenden report – Final. Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. HC 1219. https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf [Accessed 14 December 2022].

International Confederation of Midwives (2005). *International definition of the midwife [Last updated 2017]*. The Hague, The Netherlands: International Confederation of Midwives. https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf [Accessed 14 December 2022].

Keating A, Fleming V (2009). Midwives' experiences of facilitating normal birth in an obstetric-led unit: a feminist perspective. *Midwifery* 25(5):518-27.

Kirkham M (2001). The culture of midwifery in the National Health Service in England. *Journal Of Advanced Nursing* 30(3):732-9.

Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ eds, on behalf of MBRRACE-UK (2021). *Saving lives, improving mothers' care. Core report: lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. Oxford: National Perinatal Epidemiology Unit, University of Oxford. Retrieved from https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_CORE_Report_2021_-_FINAL.pdf [Accessed 14 December 2022].

Leap N, Sandall J, Buckland S, Huber U (2010). Journey to confidence: women's experiences of pain in labour and relational continuity of care. *Journal of Midwifery & Women's Health* 55(3):234-42.

McDougall L, Campbell O, Graham W (2016). Maternal Health. An executive summary for *The Lancet's Series. Lancet* September 2016. mathealth2016-exec-summ.pdf (thelancet.com) [Accessed 15 December 2022].

Michels A, Kruske S, Thompson R (2013). Women's postnatal psychological functioning: the role of satisfaction with intrapartum care and the birth experience. *Journal of Reproductive and Infant Psychology* 31(2):172-82.

Moore E, Anderson G (2007). Randomized controlled trial of very early mother-infant skin-to-skin contact and breastfeeding status. *Journal of Midwifery & Women's Health* 52(2):116-25.

National Institute for Health and Care Excellence (2014). *Intrapartum care for healthy women and babies. Clinical guideline [CG190]*. London: NICE. https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-forhealthy-women-and-babies-pdf-35109866447557 [Accessed 14 December 2022].

NHS Digital (2021). *Number of reported births and home deliveries in England*. https://digital.nhs.uk/supplementary-information/2021/number-of-reported-births-and-home-deliveries-in-england [Accessed 14 December 2022].

NHS England (2019). *Saving Babies' Lives Version Two: a care bundle for reducing perinatal mortality*. London: NHS England. https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf [Accessed 14 December 2022].

Nursing and Midwifery Council (2022). *The NMC register. 1 April 2021- 31 March 2022*. London: NMC. https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/nmc-register-march-2022.pdf [Accessed 14 December 2022].

Page M, Mander R (2014). Intrapartum uncertainty: A feature of normal birth, as experienced by midwives in Scotland. *Midwifery* 30(1):28-35.

Patterson J, Hollins Martin C, Karatzias T (2018). PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction. *Journal of Reproductive and Infant Psychology* 37(1):56-83.

Renfrew M, McFadden A, Bastos M, Campbell J, Channon A, Cheung N, Delage Silva D, Downe S, Powell Kennedy H, Malata A, McCormick F, Wick L, Declercq E (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet* 384(9948):1129-45. https://doi.org/10.1016/S0140-6736(14)60789-3 [Accessed 14 December 2022].

Royal College of Midwives (RCM) (2018). *State of maternity services report 2018 – England*. London: Royal College of Midwives. https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf [Accessed 14 December 2022].

Royal College of Midwives (2021). *RCM warns of midwife exodus as maternity staffing crisis grows*. https://www.rcm.org.uk/media-releases/2021/september/rcm-warns-of-midwife-exodus-as-maternity-staffing-crisis-grows/ [Accessed 5 January 2023].

Sandall J, Soltani H, Gates S, Shennan A, Devane D (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. [Accessed 14 December 2022].

Shaw D, Guise J, Shah N, Gemzell-Danielsson K, Joseph K, Levy B, Wong F, Woodd S, Main E (2016). Drivers of maternity care in high-income countries: can health systems support woman-centred care? *The Lancet* 388(10057):2282-95.

Simonds W, Katz Rothman B, Norman B (2007). *Laboring on: birthing in transition in the Unites States*. New York: Routledge.

Souza J, Gülmezoglu A, Lumbiganon P, Laopaiboon M, Carroli G, Fawole B, Ruyan P & the WHO Global Survey on Maternal and Perinatal Health Research Group (2010). Caesarean section without medical indications is associated with an increased risk of adverse short-term maternal outcomes: the 2004-2008 WHO Global Survey on Maternal and Perinatal Health. *BMC Medicine* 8(71). https://doi.org/10.1186/1741-7015-8-71 [Accessed 15 December 2022].

Tracy S, Hartz D, Tracy M, Allen J, Forti A, Hall B, White J, Lainchbury A, Stapleton H, Beckmann M, Bisits A, Homer C, Foureur M, Welsh A, Kildea S (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet* 382(9906):1723-32. https://doi.org/10.1016/S0140-6736(13)61406-3 [Accessed 15 December 2022].

Walsh D, Spiby H, Grigg C, Dodwell M, McCourt C, Culley L, Bishop S, Wilkinson J, Coleby D, Pacanowski L, Thornton J, Byers S (2018). Mapping midwifery and obstetric units in England. *Midwifery* 56:9-16.

Wendland C (2007). The vanishing mother: cesarean section and "evidence-based obstetrics". *Medical Anthropology Quarterly* 21(2):218-33.

Wickham S (2016). *Let there be mood lighting...* https://www.sarawickham.com/articles-2/let-there-be-mood-lighting [Accessed 15 December 2022].

Wise J (2018). Alarming global rise in caesarean births, figures show. *BMJ* 363:k4319.

World Health Organization (2018). *WHO recommendations: intrapartum care for a positive childbirth experience*. Geneva: WHO. https://www.who.int/publications/i/item/9789241550215 [Accessed 15 December 2022].

Zola I (1972). Medicine as an institution of social control. *The Sociological Review* 20(4):487-504. https://doi.org/10.1111/j.1467-954X.1972.tb00220.x [Accessed 15 December 2022].

Housego R. MIDIRS Midwifery Digest, vol 33, no 1, March 2023, pp 17-23.

For more information on this topic see MIC database search packs: MS9 Medicalisation of childbirth; M28 Midwife-led care.