Women’s perceptions of a midwife’s role: An initial investigation

Abstract
The role of the midwife has evolved over the years, influenced by a number of social, political and educational factors (Department of Health and Social Security (DHSS), 1970; Her Majesty’s Stationery Office (HMSO), 1984; Tew, 1986; Donnison, 1988, Department of Health (DH), 1993; Kitzinger, 2005; DH, 2007; National Institute for Health and Clinical Excellence (NICE), 2008). However, little is known about how the contemporary role of the midwife is perceived (Lavender and Chapple, 2002). Some changes were not based on any evidence or health economics (DHSS, 1970; HMSO, 1984). Health costs have predominantly been based on the cost of service provision, rather than costs of unnecessary intervention being considered. The Birthplace study did take into account health economics including intervention costs (Shroeder et al, 2012); therefore, if service changes are made to reflect the benefit of health economics with the new maternity pathway payments (DH, 2012), this may impact on how the role of the midwife is perceived in the future. This qualitative study was conducted to gain understanding of women’s perceptions of the role of the midwife. Four focus groups were conducted (n=9) to identify perceptions of the midwife’s role from women experiencing care from different care providers; women in different periods of their childbearing experience; women who had previous experience of childbearing; and those who had no previous experience of childbearing. Thematic analysis of the transcripts identified four themes: empowerment influence of midwives; influences of media, friends and family; role of monitoring and technology; and influence of doctors. The conclusion was that the model of care and care provider influenced women’s perceptions of the role of the midwife. Women experiencing a consultant-led model of care viewed the role differently to those experiencing amidwifery-led model.

Over time, different patterns of care and a range of lead professionals have influenced care provision in relation to childbirth. The role of the midwife has been influenced by historical factors, research and service changes within the National Health Service (NHS). The medicalisation of childbirth led to a pattern of care that focused on an underpinning principle of ill health rather than focusing on the perspective of normality (Department of Health, 1993; Green et al, 1998), and where the philosophy of a normal birth was only seen in retrospect (Lavender and Walkinshaw, 1998). However, there is now evidence that supports the efficacy and safety of providing care that has a foundation based in a normal model of care (Olsen, 1997; Green et al, 1998; Olsen and Jewell, 2000). Despite this evidence, there is an indication of marked variation in the way maternity care is delivered to women (Foster and Gold, 2002; Hall, 2002). To compound this variation there is a lack of evidence that indicates how women accept these differing models of care (Garcia et al, 1998).

Medicalisation of childbirth has had a considerable influence on the interpretation of normal birth and the role of the midwife. According to Becker and Nachtigall (1992) medicalisation of childbirth can essentially be defined as a process that has resulted in childbirth being regarded as a medical event rather than a social one; an event in which human experiences are redefined as medical problems. Medicalisation is considered the norm when the cultural environment professionals are working in is dominated by intervention, therefore a perception of what normal birth is becomes distorted. Medicalisation of childbirth, combined with modernity (Murphy-Lawless, 1988) and authoritative knowledge (Jordan, 1997), leads to a technocratic model of birth becoming the norm. Birth Choice UK (2011) shows how the caesarean section rates have increased from 12% of births in 1992 to 24.8% in 2010, which has not led to significant improvements to perinatal mortality (The King’s Fund, 2008), suggesting that technocratic birth models may have led to this situation. Little is known about how women currently view the midwife’s role; one of the few studies that exists reports that women are unaware that midwives have the ability to work autonomously, identify risk and deal with obstetric emergencies (Lavender and Chapple, 2002). Sandall et al (2001) found that women reported high levels of satisfaction with care from a midwife working in a case-loading team. The majority knew their carer through pregnancy, labour, birth and the postnatal period. In Walsh’s study (2007) women described how midwives ‘got them through’ labour. This seemed to be achieved by one-to-one support, rather than ‘getting the woman through the process’, which is part of the culture of hospital care.
A further area that warrants investigation is whether women’s role perceptions differ depending on whether they are pregnant or have recently given birth. Focus groups were chosen as a method to provide a baseline of women's perceptions and allow for exploration of the areas identified. Insights into beliefs and attitudes of the underlying behaviour of a specific population can be achieved by using focus groups (Carey, 1994; Asbury, 1995). A purposive sample was chosen to guide the elements discussed from the literature review. This study used a semi-structured interview approach to allow for some flexibility, to protect the participants from disclosing aspects they felt uncomfortable with, but also to allow a change of direction depending on the unfolding discussion within the groups.

Participants
The sample was recruited from a hospital trust in the West Midlands that provides three different birth environments: the woman’s home; a midwifery-led unit; and a consultant-led labour ward. Women within the purposive sample were given information leaflets by the community midwives and asked by them if they would like to participate. The community midwives gave contact details of the women who wished to participate, who were then contacted by phone. If they agreed to participate, their name, phone number, parity and lead professional details were recorded; they were placed in the appropriate sample and invited to the group. Three of the focus groups were held at the hospital, one was held at a local health centre.

Data collection
Consent was gained by the hospital trust and from the local research ethics committee for the study to commence. Consent was obtained from participants. A second consent form had to be completed for the use of quotations obtained and used in research reports, as specified by the research ethic’s committee. The focus groups were recorded using audiotape. Ground rules around confidentiality and respecting each other’s voices and opinions were discussed at the beginning of each focus group. Walsh and Baker (2004) discuss how facilitating focus groups can be a specialised task as some participants’ viewpoint and voice can overshadow others. It is therefore important that the group is facilitated fairly, allowing everyone to contribute.
The interviews were transcribed verbatim. The women were able to withdraw from the study at any time and this would not affect the care they were receiving. Data was kept within a locked cabinet on NHS premises. A semi-structured interview plan was used, which had been agreed by the Ethics’ Committee. Field notes were made following the discussions. A reflexive approach was used.

Data analysis
The data recordings were listened to three times by the researchers before transcribing. Computer software was not used, but the data broken down manually, allowing immersion into the data. The transcripts were coded using words that were reoccurring line by line. These were then grouped into themes, repeating the process for each focus group. This experience was extremely valuable, as it gave a sense of knowing the data ‘inside out’. Collective analysis of the completed transcripts was then carried out. Multiple analysts were used (Tracey Cooper, Tina Lavender) to prevent interpreter bias. Rigor was maintained by ensuring a clear audit trail, being reflexive and presenting sufficient participant quotes.

Results
For each focus group, ten women declared an interest to participate and were telephoned the day before the focus group to encourage attendance. On contact, it was clear that some women had changed their mind about attending and others failed to attend unexpectedly. The groups were therefore small in size, varying from two to three participants in each. A small group size (two to four participants) allows in-depth data to be collected, if drawn from a purposive sample (Morgan, 2004). It is especially meaningful if the sample is purposive (Morgan, 2004), as the participants may have ‘common ground’, making it easier to explore certain aspects relating to that particular group of individuals.

Focus groups comprised of four groups: two primigravid women in the antenatal period (20–24 weeks gestation) of pregnancy; two multigravid women in the antenatal period (20–24 weeks gestation) of pregnancy; three women in the postnatal period (6 weeks) who received midwifery-led care and gave birth on the midwife-led unit or at home; and two women in the postnatal period (6 weeks) who received consultant-led care and delivered on central delivery suite (Table 1).

While analysing the data it became apparent that women’s views reflected two clear viewpoints: women experiencing midwifery-led care; and women experiencing consultant-led care. Group 1 perceived the role of the midwife in a different way to the views expressed in Groups 2, 3 and 4. It was surprising how different the two viewpoints were, therefore the researchers checked and rechecked over the data, to ensure accuracy of analysis. The themes identified were: midwife’s influence on women’s empowerment; influence of family, friends and media; technology and monitoring; and the influence of doctors. The over-arching theme was that women experiencing midwifery-led care have a different view of the midwife’s role compared to women experiencing consultant-led care.

The influence of midwives on women’s empowerment
Conceptualisation of empowerment is viewed by the researchers as midwives giving support, reassurance and encouragement which produces self-belief in the women that they ‘can get through’ labour and ‘do it’ themselves.

The women were asked what they thought the role of the midwife was:

‘She let me take the lead … She made me believe in myself, that I could do it.’ Sarah (Group 1, homebirth)

‘She let me basically get on with it. My previous experience (on labour ward) they were sort of like they were in

Table 1. Focus group pseudonyms

<table>
<thead>
<tr>
<th>Group 1: Louise, Sarah, Liz</th>
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<tr>
<td>Women who were within 6 weeks of having their baby (postnatal)</td>
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<tr>
<td>Receiving midwifery-led care (MLC)</td>
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<tr>
<td>Gave birth in midwifery-led setting</td>
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<th>Group 2: Shona, Carol</th>
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<td>Women in at least their second pregnancy (antenatal/multigravid)</td>
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<td>Incidentally receiving consultant-led care (CLC)</td>
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<th>Group 3: Susan, Tara</th>
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<tr>
<td>Women in their first pregnancy (antenatal/primigravid)</td>
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<tr>
<td>Incidentally receiving consultant-led care (CLC)</td>
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<th>Group 4: Jane, Debbie</th>
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<tr>
<td>Women who were within 6 weeks of having their baby (postnatal)</td>
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<tr>
<td>Receiving consultant-led care (CLC)</td>
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<td>Gave birth in a consultant-led setting</td>
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charge, you just go with what they want you to do. My midwife this time kept saying where do you want it, you can have it anywhere upstairs, downstairs, wherever. She let me be in control. I knew what I had to do and she helped me do it.’ Liz (Group 1, homebirth)

The women in Group 1 made their own decisions and managed without pharmacological pain relief. They enjoyed having a known midwife and they all birthed naturally. They viewed birth as a social, rather than a medical event.

This belief in themselves and their bodies seemed to be fed from the midwives. The empowerment women felt seemed to support them achieving a physiological birth. It is presumed that the midwives had a strong belief in themselves in the physiological birth process for them to feel confident in their own ability. Conversely, there is no evidence within this study, of women who had experienced consultant-led care being influenced by the midwife in this way.

Women expressed how they befriended the midwife and how this ‘connection’ assisted them to have faith in their ‘body and soul’ enabling them to have a positive childbirth experience. This was evident from their body language (for example, emotional, facial expressions) and their narratives:

‘She did so much more than I thought, I did feel really close to mine, I got really emotional the last time I saw her.’ Sarah (Group 1)

‘She was amazing, yes, I couldn’t have done it without her, she helped me so much. It was just the way that she was, she made me know that I could do it.’ Louise (Group 1, waterbirth on midwife-led unit)

This theme was only identified in Group 1.

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The influence of the media, family and friends

The media can be extremely powerful in relation to birth (Betterton, 1996). There are many television programmes, books and magazines containing real life or fictional interpretations of pregnancy, labour and birth; these can influence how women interpret the role of the midwife. Family and friends can equally influence women’s perceptions of the midwife’s role. The primigravida (primip) antenatal group were influenced by family and through the media:

‘I saw a lot of normal births on television; I was expecting to have a normal birth, but the doctor said I would have to see what happens as lots of things can go wrong.’ Susan (Group 3)

This shows how the influence of the media can shape a woman’s expectations of their forthcoming birth experience. It is positive and encouraging that Susan had seen a lot of normal births on television, but disappointing that the doctor was not supportive and appeared to view birth as being complicated and needing to be controlled; this appeared to change her perspective. Family and friends also influenced women’s perceptions of the midwife’s role:

‘My friends and my family have influenced me the most on what to expect.’ Debbie (Group 4)

‘My mum and my sister told me what it was going to be like … you can’t read it can you? It’s just about how it is, I have taken my sister’s advice, I’m going to have an epidural.’ Tara (Group 3)

Friends’ experiences are likely to be more recent and relate to birth choices offered at the current time. Families’ views of birth and the role of the midwife may be influenced by previous experiences and historically how the business of birth was performed at that time. Mothers have anxieties about their daughters becoming a mother themselves and want to advise and protect her within this new experience. Her partner’s mother may also feel the same (Marchant, 2004). Therefore first-time mothers have a lot of support and advice, but it may conflict with that given by the midwife. The multigravida (multip), antenatal (A/N) group of women, also experiencing consultant-led care (CLC), were influenced by their previous experiences:

‘We have done it all before (childbirth) so it is second nature.’ Shona (Group 2)

‘Yes, I agree, I know now what they want me to do because of having the other one, I just do what I’m told.’ Carol (Group 2)

Shona described her experiences as ‘second nature’ suggesting that she does not view them as natural. The consultant-led care women seemed
to have an underlying acceptance of what they were offered:

‘I just do what I am told ... It's not worth planning what I want to do, he [consultant] will tell me what he wants and I will do it, because he knows what's best.’ Shona (Group 2)

Shona trusts the doctor to make decisions for her; she does not appear to object to the doctor asserting power and control over her decisions. She accepts that the doctor has the authoritative knowledge. The women who were experiencing birth for the first time sought out some information related to their experience, but they were compliant in accepting the package of care that they were offered, a factor that resonates with earlier studies (Stapleton et al, 2002). One of the women in the antenatal primigravid focus group did research her choice, but unfortunately was not supported or encouraged by the doctor to aim for a normal birth, but informed that something was likely to go wrong in her pregnancy or during labour; this caused unnecessary anxiety. Louise (Group 1) had used magazines and Sarah (Group 1) used television to research their choices. Liz in the same group used books, midwives and friends to research her birth choices:

‘In a magazine it said that if you have a homebirth you are less likely to have pain relief and will be more relaxed ... My partner thought I was mad, but it was my choice, my decision.’ Louise (Group 1)

‘My midwife has told me so much, but I also found out about pregnancy and birth from my friends who lent me some fabulous books that I found useful.’ Liz (Group 1)

Women experiencing midwifery-led care appeared to research the information they needed to make an informed choice from various sources.

Technology and monitoring: How women perceive what the midwife does
The women receiving midwifery-led care felt that the main role of the midwife was about empowering women to ‘get through’ the normal physiological birth process. Technology and monitoring were both significant features within the data obtained from women receiving consultant-led care. Monitoring the pregnancy, labour and birth were perceived as the midwife’s main role:

‘She obviously does the routine blood tests, checks my water, the heartbeat and where the baby is ... She does very close monitoring, I’m very impressed.’ Tara (Group 3)

‘They monitor, they tell me what’s in my water, what my blood is like and what my blood pressure is and refer to the doctor.’ Carol (Group 2)

The women receiving consultant-led care seemed to view the role of the midwife as performing tasks and using technology. Women appear to get to know about their pregnancy through technological interventions, for example, through ultrasound scans and fetal heart monitors. The women do not seem to view themselves holistically as a whole person, but are disembodied, viewing themselves as different parts needing regulation (Martin, 2001). They view the midwife as knowing her pregnancy through tasks relating to technology and measurement of their body parts. Women receiving consultant-led care defined the midwife as being useful in translating what had been said to them by the doctor and felt that providing a translation of obstetric language was a major part of the midwife’s role:

‘The midwife seems to put it into better words, so it’s not so scary.’ Debbie (Group 4)

‘When I went to see the doctor I didn’t really understand what he was on about, so I waited until I saw the midwife and she explained to me what he had written in my notes, the words they use I just don’t understand it. The midwife made it really easy for me to understand.’ Susan (Group 3)

The women did not question the doctor or ask for a different explanation, they accepted that they needed a translator. Women believed that the doctor had the authoritative knowledge, and therefore did not question the information provided. Women experiencing consultant-led care valued technology, suggesting that technology is progressive:
She had no risk factors so was booked to birth her baby at home. Her experience of visiting her friend in a consultant-led birth setting, including her view of the actions of the midwife caring for her, influenced her decision-making about her birth setting. Sarah had decided she did not want the clinical intervention she witnessed, therefore her perception of the care the midwife was giving also influenced her clinical choices.

Shona and Carol both appeared to be happy to be categorised by the midwife as requiring consultant-led care and be in a consultant-led birth setting. They were both happy to accept monitoring and intervention by the midwives and doctors without question, as they felt that ‘they would do the right thing’ for them. Carol requested to change her lead consultant to one she previously received care from, this was not influenced by midwives, but was her own choice.

How women perceive the role of the doctor, in contrast to the role of the midwife

With the exception of the midwifery-led care postnatal group, when asked about what women think a doctor does, all of the women felt that the doctor was the decision-maker and the midwives carried out their instructions:

‘I think the midwives need the doctor to make the decisions. The midwife is constantly waiting for the doctor to decide on the results she has.’ Susan (Group 3)

‘The midwives do the monitoring on a regular basis, but it is definitely the consultant that is the one who makes the decisions.’ Shona (Group 2)

The women see the midwife giving the results to the doctor; therefore, she perceives it as the doctor’s role to inform her if the pregnancy, labour or birth is progressing normally, not the midwife. The women view the doctor as the powerful decision-maker and the midwife as a handmaiden. The way in which midwives conduct their role leads to women interpreting what they see. The women view the doctor as having the authoritative knowledge (Jordan, 1997), which she has perceived by viewing interactions between midwives and doctors. She interprets this as midwives and doctors supporting the technocratic birth culture, rather than supporting the philosophy of normal birth. One of the most interesting aspects of the
Research

The data collected was from the women receiving consultant-led care regarding their choice of health professional:

‘Well I had to have a consultant because of my problems. I am under Mr D, he’s had all of mine.’ Shona (Group 2)

This comment is extremely interesting as the doctor could be mistaken for the woman’s partner. This may be related to the culture within the institutional environment or perhaps related to the trust she has placed in the doctor. She appears to situate herself as owned by Mr D. This also correlates with Carol’s response:

‘I’ve never had a problem with Mr B, I’ve had three children with him, so if there is not a problem why fix it ... He’s never caused any complications. He takes good care and he allows his midwives to take quite a bit of care. He allows them to do all of the monitoring, he will fix me if need be.’ Carol (Group 2)

Carol’s comments correspond with Shona’s in relation to her identifying her children as Mr B’s, placing trust in Mr B to take care of her through this experience. Carol views herself as disembodied; she views Mr B as her body fixer. Carol perceives the midwife as being under the control of Mr B. She perceives the technology used for monitoring by the midwife as the main focus of her role through what she has witnessed. The women experiencing midwifery-led postnatal care were asked what they thought the doctor did, which was in contrast to what has been found above:

‘I haven’t seen a doctor at all through my pregnancy; I have never felt I have needed to.’ Louise (Group 1)

‘The doctor said my baby was breech, I didn’t worry, I just asked my midwife to check, she felt it as being head down and she explained what she was feeling where. She was right it was head down.’ Sarah (Group 1)

The midwifery-led women appear to question the doctor’s decisions, the need to see a doctor and ownership of their bodies. There appears to be a distinction between how the women experiencing consultant-led care and those receiving midwifery-led care perceive the role of the midwife and childbirth.

Discussion

The aims of the focus group were met in that the findings provided useful insight into the perceptions of women regarding the midwives’ role. The empowerment belief of women created by midwives provides a really interesting aspect, which only presented within the views of women experiencing midwifery-led care. Robertson (1994) argues that the all-consuming and overwhelming nature of birth, including the weathering of pain, is an empowering process for women and a process that should not be withheld unless it is detrimental to her or her baby’s wellbeing. This study found that midwives influenced women’s empowerment of the normal physiological birth process in a midwifery-led model and birth setting. Therefore, this influence is key to engaging women with the normal birth process. The distinction between this occurring within a midwifery-led model compared to the women experiencing a consultant-led model has not been found within any other study. The findings suggest that it is the midwife that has given them the belief in the normal physiological process of birth and empowered them to ‘get through’ this process. The midwife helped them believe in an embodied process of mind, body and soul. The underlying framework of the midwifery model is the understanding and the value of connection; the understanding of relatedness of the body and mind (Foster et al, 2004). This connection and understanding was apparent in the findings. Anderson (2006) argues that trust can give feelings of safety and relaxation. She discusses the theory of the relationship between trust and oxytocin levels in the body; if trust is there oxytocin levels will increase, which in turn will progress labour, reduce blood pressure, increase blood circulation and increase healing of wounds. Therefore, the underlying principle of empowerment may be ‘trust’.

Empowerment may also contribute to significant health benefits for mothers and babies. The midwives who created the belief in empowerment to these women worked within a midwifery-led model, where autonomous practice would exist. Kitzinger (2005) discusses how wherever autonomous midwifery exists perinatal mortality rates are at their lowest. These factors may only be able to flourish in a midwifery-led setting, due to the lack of influence from the authoritative knowledge

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from doctors and the technocratic medicalised birth culture, even though it would be beneficial for this to be accessed by all women.

The influence of the midwife's role in the media appeared to be strong. The women who experienced midwifery-led care were also influenced by friends. Women who experienced consultant-led care were influenced by their family or previous childbirth experiences; if it was their first baby they were also influenced by the stories and imagery seen in the media. Existing research on the influence of women's perceptions of childbirth includes Betterton (1996), Martin (2001), Kitzinger (2005) and Kingdon (2009). Clement (1997) and Garrod (2012) discuss how the power of television particularly shapes the view of contemporary British women concerning the risks, pain and inconveniences associated with childbirth. Women experiencing consultant-led care observed the midwife within a consultant-led environment and viewed their role to be central around their close relationship with technology and monitoring. Houghton et al (2008) found that women viewed using technology as an important part of their role. This study also builds on this knowledge. Sinclair (1999) identified that technology did not undermine the midwife's position, but instead appeared to focus and strengthen it. Following this study, further work needs to be done to investigate further. This was in contrast to the midwife's influence on women's empowerment, which was found within the perceptions of the women observing midwives in a midwifery-led environment.

The women's views of the doctor's role in relation to the role of the midwife revealed differences in the perceptions of women experiencing care led by different health-care professionals. The women experiencing consultant-led care perceived that the doctor is the decision-maker within the relationship with her and the midwife. She views herself as unrelated at times to her body, disembodied. She sees the midwife as a handmaiden to the doctor, who uses technology to test her body and then reports the results to the doctor who makes the decisions about what interventions are needed to ensure her body functions in a timely manner. The rise of faith within science and technology has led women, midwives and doctors to trusting the machines rather than the woman's reported experience of their own observations (Beech and Phipps, 2004). This has led to widespread routine application of obstetrical technology at hospital births. The route to this problem lies in the hierarchical position of the doctor over the midwife, which is based on control of obstetrical technology and the dominance of the obstetric model over the midwifery model, which remains the basis of authoritative knowledge (Fiedler, 1997).

Midwives may be unaware of how they project their role, unaware that their own actions and interactions with colleagues are observed and interpreted by those they are caring for. Lavender and Chapple (2002) discussed that their study suggested there were two types of midwives, but were unable to delve any deeper; this study adds further evidence to this assertion. Hunter's (2005) findings where midwives working in community-based teams were identified as working in a 'with women' model practised in an individualised holistic view of women and met their individual needs, which is similar to the women experiencing midwifery-led care perceptions of the role of the midwife. The participants of the study working within the hospital worked with an institutional approach to birth, these midwives are described as 'with institution' midwives. This way of practising corresponds with the women's views of the midwife's role if they experienced consultant-led care and birth setting. When McFarlane and Downe (1999) assessed midwives training needs they too found two completely different concepts of midwifery depending on if they worked in the community or hospital, which correlates with Hunter's (2005) study. It also resonates with women's view of the midwife's role in this study, depending on the model and birth setting they experienced. It may be of benefit to compare both women and midwives perceptions of the role of the midwife.
The most original finding of this study was the empowerment belief instilled by the midwife about the normal birth process, which inspired women to believe in their bodies to ‘give birth’ when women experienced midwifery-led care and birth setting.

Doctors were perceived as having authoritative knowledge by women experiencing consultant-led care and birth setting.

Interpretations of childbirth and what the role of the midwife entails in the media influenced all women in the study.

There is an assertion that there may be two different types of knowledge on five key findings was found.

The numbers in the focus groups were small, although this did allow for deeper investigation and of certain aspects discovered. Holding the focus groups in children’s centres, may have assisted in a higher attendance, as many women meet here for different groups set up for antenatal women and parents with babies. Other aspects from a larger group may have given different perspectives and may have provided more varied data. The participants were recruited from one hospital trust, therefore the findings may not be consistent with other areas of the country.

Future research investigating midwives’ perceptions of their role is necessary. The women experiencing consultant-led care provide compelling aspects, which need to be explored further to ascertain an in-depth view of how they perceive the role of the midwife. There has been an increasing body of evidence created of women experiencing midwifery-led care (Flint et al, 1989; Page, 1999; Sandall et al, 2001; Walsh, 2007). Views from women experiencing consultant-led care are not frequently investigated in comparison.

Acknowledgment: Gratitude is given to Soo Downe and Carol Kingdon’s help and guidance, who were also involved at different stages of this study.


Strengths and limitations of the study

The strengths of the study were that further knowledge on five key findings was found. This included original knowledge about an empowerment belief instilled by women by midwives working in a midwifery-led model of care about the normal birth process. They also inspired women to believe in their bodies to ‘give birth’ when women experienced midwifery-led care and gave birth in a midwifery-led setting.

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BJM