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An ethnographic study of the philosophy, culture and practices within an urban freestanding midwifery unit.

Summary

Service users and providers deserve to engage with healthcare systems that are functional, evidence-based and engender positive experiences. Current and recurrent maternity scandals urge us to explore the key characteristics of well-performing services as well as those which fail. Theory generation is important for the progress of maternity care, safety improvement, and enhancing organisational culture. This ethnographic study explored the key characteristics of a well-functioning FMU and also embedded a systematic review of evidence on MUs in high-income settings, to create logic models.

Background and rationale

Research evidence suggests that midwifery units (MUs) are associated with optimal clinical outcomes, experiences and cost-effectiveness.[1,2,3,4]. On the basis of this, NICE guideline G190,[5] provided clear recommendations about the birthplace information to be provided to healthy women and birthing people eligible for midwife-led care birth settings. The NICE Quality Standards[6] also recommend commissioners and providers to ensure that the four birth settings (home, AMU, FMU and OU) are made available to service users.

However, to date there is a knowledge gap regarding key elements in midwifery practice, environment, and organisation of care, which may potentially affect the care outcomes in MUs as well as staff job satisfaction and wellbeing. This ethnographic study aimed at contributing to knowledge and theory-generation in the field of midwifery-led birth settings and particularly midwifery units.

Aim

The aim of this study was to shed light on philosophy, organisational culture and practices within a FMU model of care, by highlighting the key landmarks, which describe well-functioning FMUs.

Funding

The study was funded by a National Institute for Health Research Doctoral Clinical Academic Training Fellowship awarded in 2009.

Theoretical underpinning

This study was a post-critical feminist ethnography. By embracing a constructivist epistemology (co-produced creation of knowledge), I engaged with the current discourses around FMUs and aimed to contribute to the co-produced construction of knowledge (see figure 1).[7] Post-critical means aiming to critically analyse power dynamics including my own position and influence as an insider researcher. As a feminist my aim in engaging with this project was, not only to study the reality as it was, but also to challenge the status quo by promoting women's preferences and a maternity care based on a bio-psycho-social model of care.

Figure 1- The theoretical underpinning

Methodology

Workplace culture is of paramount importance when trying to understand the context of midwifery practice and ethnography is a well-suited method to study it. Ethnography aims to gain an insider's or 'emic' perspective, to make sense of 'why people do what they do' and how a group functions within its context.[8] Understanding the worldview and the tacit 'unwritten rules of the group' is crucial for comprehending why 'midwives do what they do', therefore opening the possibility of theory generation. This enables the development of a theoretical framework on the way MUs function and midwifery skills are enacted.

In this study, I embraced the argument, originally raised by African American scholars, and later proposed by feminist and critical theorists, which stresses that the distinction between insider and outsider is situational. Before starting the fieldwork, I undertook an exercise in positionality by reflecting on my background, beliefs and different power dynamics in the field depending on the participants I engaged with. I also reflected on my positionality at every step of my data collection and analysis. Reflexivity is "the process of a continual internal dialogue and critical self-evaluation of a researcher's positionality, as well as active acknowledgment and explicit recognition that this position may affect the research process and outcome".[9(p220)]

I kept a reflexive diary of my emotional responses to the field experiences and interactions to help with unconscious bias and to later reflect on my assumptions. This was also used for reflection with my PhD supervisors thus helping me to manage bias. Discussions with participants and 'key informants' from the FMU helped interpretation and ensured member validation.

Ethics approval was applied for in August 2010 and obtained from the Southeast MREC In December 2010. A favorable opinion from the Local NHS R&D was also given in February 2011 after applying for and obtaining Service Support Costs from the CLRN.

Methods

The setting was an urban purpose built FMU, opened in 2008,[10,11] with a target number of 500 births/year with optimal clinical outcomes and high rates positive service user experiences.[3] Additionally, the FMU served a multi-ethnic population, shedding light on how to offer inclusive care based on a bio-psycho-social model of care.

The project adhered to research governance at all times. Safe storage for the consent forms was provided by the university. Files with anonymised data were secured in a password protected laptop in and password protected encrypted folders.

A total of 82 participants (see table 1) were recruited and provided written consent. All FMU staff was offered participation and provided written consent (30 participants). The recruitment of service user participants (18 women, 15 partners and 4 other birth supporters) was purposive with the aim to reflect the diversity of women using the FMU, in terms of ethnicity, age, parity and social class. Also, a purposive sample of linked professionals and stakeholders form the referral OU was obtained (15 participants). A Participant Information Sheet was provided to all participants and 24hrs interval between providing information and signing the consent form was ensured.

Table 1- The research participants

Participants	Subcategories	Number
Barkantine staff	Midwives	23
	Maternity care assistant	6
	Admin	1
Hospital	Midwives	2
	Obstetricians	1
Students	Student mw	3
	Mw placement	2
Stake holders	Managers	2
	Consultants	2

	Steering group	2
	Commissioners	1
Service users	Women	18
	Fathers	15
	Other birth supporters	4
		Total participants = 82

Several service users engaged with my research project as PPI members at different times. Two service users remained engaged for the whole duration of the project.

I conducted participant observation, an ethnographic method of data collection, and immersed myself in the various activities of the MU in all shifts at different times and days of the week over a period of twelve months for a total of 30 shifts of 12 hours. This included team meetings, antenatal appointments, unit tours, active birth workshops, breastfeeding support groups and other activities. I was also 'on call' for the women who had agreed for me to be present at their birth. As an 'insider' participant observer I was able to blend well with the everyday activities of the group because I shared the 'group language' and culture. At first not having a clinical role resulted in some awkwardness but this improved with time and by getting into my researcher role of decoding insiders' knowledge and understanding.

While on the field, I collected brief jotted notes, which I wrote more extensively within the following 24 hours, to ensure that the memory was still clear for all events, dynamics and dialogues. I generated a 'thick description', which aimed to give a sense of environment, events and emotions and perceptions of those involved (observer included).[12] Four points guided my observation and field notes: physical setting and persons involved in the scene, events, timing, observer's feelings and impressions. The observation followed three steps: descriptive, focused and selective.[12] At the beginning of the process, I recorded almost everything. Later I focused on certain important aspects of the setting. Eventually I selected only very specific and relevant issues.[12] My feelings and impressions were captured in the reflexive diary, which I kept separated from my observational field notes.

A dynamic process interconnected my participant observation and the semi-structured interviews: the observation guided the development of the questions for the interviews and the findings of the interviews, on the other hand, have guided the observation.[12] This approach also offered the opportunity of checking for consistency between what participants said in the interviews and were doing in practice. For instance, by observing the practice of one midwife I could confirm whether what the person said at the interview was

consistent with what she/he did, observing any differences and exploring these in the analysis. Similarly, for service users I could check consistency between antenatal and postnatal interviews and observation notes. I had a thematic guide and started the interview by asking general questions on participant's background and experiences (see table 2). I also followed up with some focused questions, including a description of what they considered a good day and a bad day, to elicit a range of feelings and reflections about their work, perceptions and values.

Table 2- Topics explored during the interviews with FMU staff and service users

Topics guide for staff interviews:

- Midwives' background
- Motivation for working at the FMU
- First impressions when started working there
- Challenges
- The team
- If and how practice changed
- What keeps birth normal
- A 'good day' and a 'bad day' at the birth centre
- Current issues

Topics guide for service users:
Antenatally:

- what are your hopes and expectations for the birth?
- what is important to you regarding the care?
- why have you decided to give birth at the FMU?

Postnatally:

- what were your experiences; die they met your expectations?
- what was the most important aspect of care for you?
- if you had a transfer, how was the experience?
- If anything did not meet your expectations or you felt uncomfortable with, what was it?

I interviewed women antenatally and postnatally, which enabled me to observe and explore their experiences at different stages of their maternity journey. Some additional women and birth supporters were only interviewed postnatally. Interviews were carried out both at the FMU and/or at the woman's home.

For both staff and service users the length of the interviews varied, but they never exceeded one hour. Confidentiality and anonymity were ensured at every stage of the research. The interviews were tape-recorded and later transcribed 'verbatim' professionally. Every transcript was checked against the audio recording to correct any mistake in transcription.

This also enabled me to reflect on the interviews and start generating some analytical memos.

Guidelines and operational procedures can be key documents for an ethnographer. I conducted a rapid analysis of the language used within key documents including clinical guidelines, information provided to service users and operational procedures, and these demonstrated at times a contradicting philosophy of care compared to the MU ethos.

As for previous studies in the borough, a large proportion of the research participants did not have English as their first language. Most of the participants felt confident in carrying out the interview in English. However, in case a participant needed translator arrangements were made. Four interviews were conducted with the help of a bilingual English/ Bengali interpreter.

I created a framework to help keeping track of the data collection and remind me of the tasks to be completed. As shown in Table 3, this framework helped having an overview of the progress of data collection activities and to plan the fieldwork.

Table 3- data collection and tasks framework

Pseudonym	Res Id Number	Consent	Int	Obs An App	Obs Abw	Obs Other	Obs Birth	Transcript	Atlas. Ti
1.		✓	✓	x	x	x	✓	✓	
2.		✓ ✓	✓ ✓	x	✓	x	x	✓	✓
3.		✓ ✓	✓ ✓	✓	X	X	X	✓	✓
4.		✓ ✓	✓ ✓	✓	X	X	X	✓	
5.		✓	✓	✓	X	X	X		

Data collection and analysis were conducted in waves, with breaks in between the field immersion for analysis. This demonstrated particularly helpful in allowing me to gain regular distance from the field to analyse data, write memos to then return to the field with a more focused approach and observe specific aspects of practice and dynamics.

Table 4- Waves of data collection and analysis NEW

Two waves of fieldwork:

- February 2011 to August 2011
- November 2011 to June 2012

Maternity leave from June 2012 to January 2013

Thematic analysis alongside data collection plus 2 waves of analysis:

- September-October 2013
- January-April 2015

Figure 2- The step-by-step research process for the ethnographic study

The thematic analysis followed 6 steps described by Braun & Clarke:

1-Familiarising with data; 2-Generating initial codes; 3-Searching for themes/categories; 4-Reviewing themes/categories (mind-mapping); 5-Defining and naming themes/categories; 6-Producing the report.[13] I made extensive use of 'mind-mapping' concepts and categories in order to make sense of the relationships between codes, categories and themes.[14,15]

Tentative coding and writing analytical memos started simultaneously with data collection.[15] Once I started coding, I had to pay attention at not creating too many codes as this would cause difficulties. I had to often stop and return to mind-mapping activities to clarify which codes were most relevant, referring to my research questions and the focus of the study.[15]

Eventually from the creation of several mind-mapping clouds and the progress in the coding of interviews and field notes, a preliminary descriptive set of categories and subcategories emerged.[15] At this point of the analysis I did not feel confident to move to a more abstract level but I started getting a feel of the core categories and subcategories emerging.[15]

Authenticity and the co-production of interpretation were of paramount importance for the trustworthiness of my research. During the process of analysis and data collection I had several sessions to feedback the preliminary analysis with participants and especially two 'key informants' were of significant help in this process.

Discussion

Against a backdrop of maternity unit scandals, which has emphasised the disastrous impact of poor organisational culture and high tolerance for low clinical standards my PhD work highlighted the importance of creating virtuous cycles, understanding more about what happens when there is ownership, team spirit, accountability, and partnership with service users. In the next paper I will describe the findings related to midwives.

Limitations:

Being an insider researcher, I did not have the advantage of a 'fresh eye' approach to the field, which has been described as advantageous when conducing ethnography. To compensate to this limitation, during the fieldwork, I engaged in conversations and formally interviewed service users and students who were having their first experience of the FMU. Their fresh experience of the FMU was very important for my data collection. On the other hand, I was able to access the 'backstage' dynamics.[8]

Conclusion

Learning more about 'hands-on' ethnography was scary and exciting at the same time. When conducting a PhD project, the impostor-syndrome is strong, and the sense of isolation can be troubling. When clinical-academic midwives, we might be dealing not only with the research process but also challenging situations in the clinical setting and bullying. Some of us will inevitably have a baby in the middle of this process (as it happened to me), adding layers of complexity and increasing the sense of anxiety about completing our PhD. Finding your 'tribe' and getting peer support is crucial. If I have to identify the one thing that I have obtained with my PhD, I would say 'finding my voice'.

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