Intrapartum uncertainty: A feature of normal birth, as experienced by midwives in Scotland

Miranda Page, BA (Hons), RM, MSc, PhD (Clinical Research Fellow)a, Rosemary Mander, MSc, PhD, RGN, SCM (Emeritus Professor of Midwifery)b

a NMAHP Research Unit, Iris Murdoch Building, University of Stirling, Stirling, FK9 4LA, UK
b School of Health, University of Edinburgh, Teviot Place, Edinburgh, EH8 9AG, UK

Abstract

Objective: to explore midwives’ perceptions of intrapartum uncertainty when caring for women in low risk labour.

Design: a grounded theory approach was used to capture the experiences of midwives practising in Scotland. Data were generated through unstructured in-depth one-to-one interviews and focus groups.

Setting: four Health Boards in Scotland.

Participants: 19 midwives, practising in a range of maternity settings, participated in the study. The maternity settings included; obstetric led labour wards, alongside maternity units, stand-alone community maternity units, and community and independent practice. They also had a mixture of clinical experience, ranging from one to 20 years in practice.

Findings: Three categories emerged from the analysis, intrapartum uncertainty, the normality boundary and threshold pressures. Recognising the point at which a labour deviates away from normal constitutes ‘intrapartum uncertainty’. In these situations midwives develop a normality boundary that shape their clinical judgements and decisions. The boundary becomes the limit, edge or border of what they accept as normal in a labour. Therefore if midwives tolerate intrapartum uncertainty they are more likely to construct labours as normal, than midwives with a lower tolerance of uncertainty. This can be mediated by threshold pressures that expand or contract their definitions of normality. So that supportive environments and good relationships with women enable midwives to tolerate uncertainty and thus maintain normality.

Implications for practice: the reemphasise on midwifery practice as a means of supporting normal birth has been promoted as a way of ‘demedicalising’ birth for low risk women. However to maintain normality midwives need to understand the impact uncertainty has on their decision making. Supporting midwives to tolerate uncertainty, either at unit or national level, will expand definitions of normality so that birth can remain natural and dynamic.

Introduction

Concern about the persistently high levels of emergency caesarean sections, from 14% in 1990 to 26% in 2010 (ISD, 2010) continues to rise questions about the increasing medicalisation of childbirth (Lavender et al., 2012). The ineffectiveness of such an approach for women with low risk factors for complications in labour has been voiced (RCM, 2002; Niino, 2011) and fears have been raised that the over use of a medical model in childbirth for this group of women can lead to unnecessary interventions and increased levels of maternal and infant morbidity (Thacker and Stroup, 1999; Newburn, 2003; Waldenstrom et al., 2004).

One reason given for the apparent over use of intrapartum interventions is the rising rate of obstetric litigation, which has created an increasingly risk adverse culture within the NHS (Symon, 2006; Niino, 2011). Paradoxically although risk management seeks the reduction of harm and the promotion of safety, it can have the effect of increasing anxiety amongst health care practitioners, which in turn increases risk aversion and defensive practices that may not be of benefit for all women and infants (Crawford, 2004; Beck, 2009). Attempting to reverse this trend has seen government policies promoting a less interventionist approach to childbirth. For example; Keeping Childbirth Natural and Dynamic (Scottish Government, 2008), aims to maximise the opportunities for women to have as natural a birth experience as
possible. In support of this comes guidelines to stream women into care pathways based on risk factors (Scottish Government, 2008), the assumption being that women following a low risk care pathway will have minimal intervention.

However, research has shown variation in the application of such an approach, with intervention rates varying between hospitals with similar client groups. This suggests that practitioner preference, and cultural and organisational factors within maternity units may play a part in mediating the use of interventions, and in some cases, may buffer some of the more extreme effects of a risk adverse culture (NHS Institute, 2007).

Risk and uncertainty

There is evidence to suggest that health care professionals' attitudes to risk may account for some of the differences seen in patient care management (Pearson et al., 1995). Decision making and risk appear to be linked (Page, 2010) in as much as decisions are more than mere interpretations of clinical signs and symptoms (Cheyne et al., 2006), but incorporate the behavioural responses of the professional to the degree of risk perceived (Raynor and Marshall, 2005). Furthermore it has been well documented that clinicians are poor at estimating risk (Gigerenzer, 2002) and that the occurrences of rare events are often over inflated (SPCERH, 2001), leading to inappropriate management choices (Mead and Kornbrot, 2004). However in a recent study of referral rates and midwives attitude to risk (Styles et al., 2011) they concluded that midwives' risk propensity could not explain the variation in decision to refer to medical staff. What can then explain why some midwives intervene quicker than others given the same clinical picture?

Studies have shown that behind risk lies uncertainty (Beck, 2009) and it is the practitioners ability to cope with uncertainty that determines how risk is perceived (Gerrity et al., 1995; Lankshear et al., 2005). Uncertainty, unlike risk, is a situation, future event or prediction where there is a lack of empirical evidence (Page, 2010), thereby making it either undesirable or impossible to allot a number to the possible alternative outcomes (Gigerenzer, 2002).

To understand the results of Styles et al.'s study, it is necessary to go behind risk and examine how midwives work with the uncertainty and ambiguity that is present in labours that start spontaneously. By so doing we will gain a better understanding of how midwives determine normality in labour and how this is translated into reframing a labour as normal or abnormal.

The study

Aim

To explore midwives' perceptions of intrapartum uncertainty when caring for women in low risk labour. Of interest is the uncertainty present in these labours and how midwives understand and tolerate these uncertainties when making decisions about the risk status of the labour, in other words the uncertainty around definitions of normality. By concentrating on labours that start as low risk it enables a clearer distinction to be made between midwifery and medical decision making, as midwives are the lead professional when caring for women at low risk of developing complications during labour.

Design

Techniques from grounded theory (Strauss and Corbin, 1998) were used to gain an understanding of midwives' perceptions of intrapartum uncertainty during labours that start as low risk. This understanding is gained through the 'reasons and accounts social actors give for their actions' (Blaikie, 2000, p. 74), and is constructed through their explanation of the phenomenon within a social context (Blaikie, 2000).

Participants

Nineteen midwives participated in the study and were recruited using purposeful and theoretical approaches. Purposeful sampling was undertaken to generate preliminary themes and to suggest a sampling frame (Table 1) that would guide further recruitment. Theoretical sampling explored these themes in greater depth and allowed for contrasting and expansion of the core category (Strauss and Corbin, 1998).

Four Scottish Health Boards were identified that meet the sample frame criteria. Support for the study was initiated through contact with the Heads of Midwifery and Consultant Midwives. Posters and information packages were given to each maternity unit or community practice. Midwives who were interested in taking part contacted the researcher via email. Recruitment to the study was complete once the mix of participants captured; the range of service models, clinical experience and length of service suggested by the findings from the purposive sample data, which is consistent with a grounded theory approach (Strauss and Corbin, 1998). Recruitment continued until no new themes emerged from the data.

Ethical considerations

Information given to midwives clearly stated that participation in the study was voluntary. Likewise, participants had a number of opportunities to ask questions and/or withdraw from the study. In addition, verbal and written reassurances were given that participation would not be discussed with midwifery managers.

It was outlined at the beginning of each session that participants should not discuss cases in a manner that would allow others to identify the client or the situation.

Confidentiality was guaranteed in the storage and reporting of the data, with both participants and practice settings given pseudonyms. Written consent was obtained from each midwife to participate in the study and to allow the interview or focus group to be audio recorded. Ethical approval to conduct the study was granted from the relevant universities involved. Advice was sought from the NHS ethics committee, however, they found there were no ethical issues that needed to be addressed. Management permission to conduct the study was obtained from the units involved.

Data collection

The study adopted a pragmatic approach to data collection, whereby focus groups or interviews were conducted depending on the availability of the participants. The number of interviews and focus groups are outlined in Table 2. All interviews (n=10) and focus groups (n=2) were conducted in person, face to face, by the first author. Each session was audio recorded and lasted approximately one hour. The interviews and focus groups were conducted in a range of settings, in midwives' homes, a meeting room in a hotel, and in maternity units.

The interviewing method was unstructured and started with one or two questions, thus ensuring that any data and subsequent theory were truly grounded in the thoughts and feelings of the midwives. Data produced in this manner are denser than from semi-structured interviews, leading to better quality analysis
For an in-depth account of the data collection and analysis process please see Page (2010).

The opening question varied throughout the research as dictated by the iterative nature of the research process, and began with:

I’m interested in exploring uncertainty in childbirth, when you are looking after normal labouring women what makes you feel uncertain?

Trustworthiness

The manner in which the data are collected and analysed is the hallmark of grounded theory. Rigorous coding brings validity and trustworthiness to the data and its interpretation (Strauss and Corbin, 1998). The conceptualisation and abstraction of the data is less likely to contain researcher bias when the interviews are unstructured and the interviewer remains passive (Glaser, 2001). The iterative process of constant comparison between codes enables research bias to be highlighted. As does the use of memo writing that is used in grounded theory as a method of extracting explanations from the data (Glaser, 2001). Issues to do with the validity and trustworthiness of the data were also explored during regular discussions with the research team, where the biases of the researcher were challenged and theories explored and developed.

Data analysis

The interviews and focus groups were transcribed by the first author allowing ample time for immersion in the data. The microanalytic process of conceptualising or abstracting from the data started with repeated listening to and reading of the transcripts. During this first stage of analysis themes, recurring ideas, similarities and differences emerged. Using constant comparison technique (Strauss and Corbin, 1998) incidents or events that shared common characteristics were cross-linked and key statements, sentences or phrases identified and coded. These codes also signposted potential areas for exploration in subsequent interviews.

Categorisation of these codes followed next. Here, open codes were grouped around higher order concepts (Strauss and Corbin, 1998). This stage moved away from word by word and line by line coding and towards synthesis and explanation of larger segments of data (Charmaz, 2006). The final level of analysis, termed “axial” by Strauss (1987) and Strauss and Corbin (1998) linked the categories together in terms of their properties and dimensions. Here the deconstruction or the fracturing of the data (Charmaz, 2006) seen in the previous stages was reversed and data reconstructed. Although in Strauss’ and Corbin’s early work (1998) the two stages, categorisation and axial coding, are described as separate entities, in later work (Corbin and Strauss, 2008) they are merged. In practice Corbin and Strauss (2008, p. 198) now view the distinction between the second and third stage as ‘artificial’ and for explanatory purposes only.

Findings

The analysis yielded seven substantive codes:

- Intrapartum Uncertainty
- Responding to Uncertainty
- Expertise
- Practice Philosophy
- Practice Setting
- Support
- The Midwife/Woman Relationship

Further analysis of these codes produced additional connections and links which resulted in three overarching codes.

1. ‘Intrapartum Uncertainty’ represented the uncertain situation or the unpredictable element of labour and childbirth and remained as a freestanding code.
2. The core category, ‘The Normality Boundary’ was formulated from ‘responding to uncertainty’, ‘expertise’ and ‘practice philosophy’.
3. The mediating factors that acted on the core category became the ‘Threshold Pressures’ which consisted of ‘the practice setting’, ‘support’ and the ‘midwife/woman relationship’.

### Intrapartum uncertainty

In reporting the findings each participant has been given a pseudonym, and an acronym which indicates the type of maternity units they have worked in (see Tables 1 and 2 for an explanation of each acronym):

...here are the grey areas, when there’s meconium and they’re 8cms, and do you keep them and hope that it’s fine, in the back of your head and in your heart you probably know that they’re postdates and the meconium is completely normal and maybe just monitoring them here and having the birth here would be the thing to do. (Chris SACMU)

The ‘grey areas’ of intrapartum practice highlights the quintessential uncertainty that midwives faced when caring for labouring women. It peppered their conversations and formed the core of their stories. For most midwives the process of childbirth was anything but black and white. The murky areas where decisions, actions and outcomes did not follow a clear distinct line highlighted the inherent ambiguity of childbirth. ‘What is happening here?’ ‘Is this normal?’ ‘How do I tell?’ Childbirth unfolded along a timeline that was not always predictable, which makes defining normality at these times difficult. Midwives talked about this divide as ‘the fine line’. Knowing where the line was and deciding on which side a woman’s labour lay were the kind of judgements that midwives needed to make in order to manoeuvre, not only themselves but the women, through the ‘grey areas’ of intrapartum care. ‘The grey area’ was the territory of intrapartum uncertainty ‘the fine line’ the tipping point that determined how and when a midwife would take action:

In uncertainty, cases when it’s not black and white there’s that grey area ‘am I doing just the right thing for this patient?’ (Cheryl CM)

There was an almost desperate need to ‘get it right’ to ‘make the right call’, to correctly gauge the point of deviation and ensure the right level of action was taken. For Cheryl ‘getting it right’ was central to her sense of being a ‘good midwife’. Judging where the ‘fine line’ ran put pressure on midwives to predict the unpredictable. Their sense of failure when they perceived themselves ‘getting it wrong’ was very palpable during the interviews.

When working in ‘Intrapartum Uncertainty’ midwives talked about the difficulty of identifying or applying concepts of normality to an individual woman, in that, normality for one woman might be abnormal for another. ‘There’s an absolutely vast scope of normality’ (Abby MCS). Gauging the subtleties and nuances of a woman’s labour proved extremely tricky when midwives were working in the ‘grey areas’. ‘It’s kind of like everything, a whole gamut of what makes normal people respond in different ways’ (Hanna OLU). If a woman reacted or behaved differently than expected, deciding what this meant required the midwife to put aside generalised concepts of normality:

A doctor comes along and says ‘right OK this is deviating from the normal’… but my question… in my heart I would say ‘why can’t it be normal for this woman’ if everything’s alright with her and the baby? (Abby MCS)

### The Normality Boundary

The Normality Boundary represented the underlying principles that shaped a midwife’s clinical judgements and decisions when they cared for low risk women in labour. Key to these judgements and decisions was her construction of normality, which when applied to an individual labour translated into a boundary. The boundary became the limit, edge or border of what she would accept as normal in a labour. Where this boundary was set was unique to each midwife, as it was determined by her own personal set of values, beliefs and tolerance of uncertainty (Fig. 1).

### Responding to uncertainty

Working with unpredictability produced a range of emotional responses from midwives. They talked about ‘a finger of fear’ of how it made them ‘cautious’ in their approach as well as ‘zealous’ in their care. ‘Anxiety’ or ‘being anxious’ was often cited as an underlying emotion linked to the fear of making a mistake of ‘missing something’, because ‘the right thing to do’ might not be obvious or there might be a number of alternatives to choose from.

However, midwives also spoke about the ‘excitement’ and ‘anticipation’ of the unpredictable. They talked about the uniqueness of each labour and how this brought with it a sense of ‘curiosity’. Because you did not know ‘what was round the corner’ it meant ‘it was never boring’. And it remained interesting because you were ‘kept on your toes’. To be able to work with this degree of uncertainty, and to function with underlying levels of stress, anxiety and for some midwives fear, played a significant
Expertise and practice philosophy

Expertise and practice philosophy were enmeshed in concepts of normality and uncertainty. For some midwives where they practised was determined by their practice philosophy:

During my training and ‘growing up in midwifery’ I was reading Ina May Gaskin (Spiritual Midwifery) and Caroline Flynn (Sensitive Midwifery) and all of these and thinking what I was seeing in my training wasn't what I associated with midwifery and what I saw here was more associated with what I thought midwifery was all about. (Chris SACMU)

Whereas for others, practising in a particular way or setting formed, or reinforced their practice philosophy. It would be too simplistic to say that the midwives in the study had either a medical or midwifery model of care. Most felt that they were practising within a midwifery model when caring for low risk women, however their recognition and tolerance of uncertainty varied considerably.

Midwives who predominately worked in the larger obstetric units found the concept of uncertainty difficult to understand. ‘Doing things the way I always do them’ reduced uncertainty to almost zero. However to achieve this they had to stay within their comfort zone which led to rigidity in practice:

I’m quite happy to be in a room with a totally normal woman just intermittent monitoring (Sophie OLU)

However for Sophie, there was a boundary to her concept of normality, ‘I don’t do standings (deliveries)’. To remain unruffled and in control of the labour room Sophie needed to dictate the childbirth position. Of note is Sophie’s use of the word ‘totally normal’, Sophie cannot allow any ambiguity or doubt to be present.

Growing expertise in a specific area of practice and repeated exposure to emergency procedures were mechanisms that midwives said helped them feel more confident to deal with uncertainty. ‘We manage our cases very well because we have so many practice drills and that is what gives you confidence’, (Vivienne OLU). Nevertheless, although it prepared for the unexpected emergency, it also seemed to make midwives more cautious and more risk averse. Normality became narrowly defined with only a small degree of ambiguity tolerated before the labour was labelled abnormal. Conversely, other midwives found that experiencing positive outcomes, when caring for low risk women, reinforced their acceptance of uncertainty. This was voiced more often by midwives who worked in stand-alone units or who practised independently.

The effects of the more rigid regimes of obstetric led labour wards, could be buffered by confidence and midwives often cited examples of how they stood up to medical staff and other senior midwives:

I remember one woman I hadn't examined for a long time she didn't want to be examined there wasn't any indication... the co-ordinator said 'you should pop her on the cctg' (cardiotocography) and I said 'why there's no indication for that' and she said 'I'm sure there's a policy that says we should be doing them 4 hourly' and I said 'you find me the policy and come and knock on the door and I'll pop her on the cctg' and I never got a knock on the door of course because there is no policy that says that... (Naomi I)

But their success was often conditional on the level of respect they felt they held in the unit. Where midwives were less known their expertise was challenged:

I've occasionally been treated as if I've got hay hanging out of my ears. (Laura, CM)

In units that had a high proportion of low risk women, midwives felt certain and confident about their own practice. However, they still talked about the event containing innate uncertainty:

Somebody challenged me once that I was working too much in the low risk unit, too much normal and I needed to see more interventions etc. and I challenged them back saying well it’s much more challenging looking after someone where you can’t predict what’s going to happen, you're making decisions for yourself. (Charlotte I)

Not being ‘fazed by the uncertainty’ seemed very different from trying to reduce uncertainty. Remaining positive about and not afraid of uncertainty was helped by trust in the woman’s body. Belief in her ability to birth naturally allowed normality to be given its widest parameters:

We interfere too much, if we leave alone most of the time women will do it ...of course we're here to keep an eye on things in case, but most of the time everything goes OK (Naomi I)

Trusting in the process allowed midwives to ‘go with the flow’ they did not feel they had to orchestrate the labour, they were very much in the background waiting to see if they were needed, ‘it’s very much down to the mothers, what they want to do really just wait until they tell you what’s happening’. (Lesley SACMU). For midwives who trusted the process they felt that often it was professionals, either midwives or medical staff that cause problems, usually by intervening too early before a ‘true problem’ developed. They felt a ‘normal birth’ was achieved by allowing time for the woman’s body to work with the process. Interfering unnecessarily, ‘tampering with nature’, disturbed the complex balance that women needed in order to give birth naturally:

The pool is like a big cocoon—the woman gives birth, brings the baby up herself, sits back on the step relaxes watches the baby and puts the baby to the breast and it’s all just lovely and it just works (Chris SACMU)

Threshold pressures

Three other areas that impacted on how midwives tolerated uncertainty were the ethos of the practice setting, the level of support midwives perceived they had, and their relationship with the woman. These could either reinforce narrow constructs of normality or help to broaden them.

Practice setting

The Practice setting played a significant part in how midwives managed uncertainty. In hospital settings that had a dominant medical model midwives found they had less room to manoeuvre:

There is a difference. Because I’ve worked in hospital and community, home births and hospital births and there’s a huge
difference. At home you're relaxed, you're confident in leaving that woman for much longer. (Lynn, MCS)

However there was often a limit to what they could do:

I think working within a hospital environment I think within those guidelines you know that 'Oh boy you're got some case to answer and some forms to fill out if you let some things go too far'. (Vivienne OLU)

‘Letting things go too far’ set the parameters of normality for that particular unit. Midwives were required to work within this boundary or risk being sanctioned. However, as seen by Lynn, these boundaries were setting specific. The home setting allowed midwives to expand the scope of normality. Whereas managing time in the hospital contained intrapartum uncertainty, at home or in stand-alone midwifery units time remained flexible and developed the midwives’ ability to tolerate the uncertainty this created.

Support

Another mechanism that enabled midwives to tolerate uncertainty was the level of support available to her. Midwives talked about selecting midwives whom they trusted and who shared similar ways of practising:

There's certain people you feel comfortable saying oh yeah you're uncertain. But there's certain people, maybe because they're busy maybe it's their mannerisms and I think oh my goodness they're going to think I'm stupid if I run this past them. (Cheryl CM)

Once found support was used in a variety of ways. Trying to understand 'what was going on' and deciding whether it was 'normal' was an important role for the supporter. This aspect of support allowed midwives to explore their normality boundary by 'bouncing ideas' around. They acted as 'sounding boards' for midwives to rehearse arguments and justifications before confronting senior members of staff. It was also seen as a way of sharing responsibility for decision making:

... I come out of the room and then knebol my colleague in the coffee room saying you know 'such and such has happened what would you do, would you carry on pushing or would you call someone in' (Frances, OLU)

Collective discussions on aspects of care or perceptions of how a labour was progressing took the onus way from the individual to 'get it right'. Group discussions acted as an arbiter for what uncertainty was the level of support available to her. Midwives talked about selecting midwives whom they trusted and who shared similar ways of practising:

The midwife/women relationship

The final aspect of care that helped midwives understand what was normal in labour was the relationship formed between the midwife and the labouring woman. By not maintaining distance and embracing intimacy, 'It's almost like being there with a sister or a friend', midwives felt that they became more in tune with the woman and her labour. With this bond came confidence that any deviation they detected was real and not merely a deviation away from some concept of average, for example average length of labour. ‘By being there 100% you know whether it's really a deviation away from her normal’. The women's wishes and feelings about her labour were also taken into account when making decisions about what was ‘normal’. As already mentioned by trusting the process midwives worked with women to jointly achieve normal birth. However the degree of effort midwives ‘put in’ was determined by the woman's own thoughts and feelings about the labour:

If I have a woman who has very determined views I would be more likely to argue for her....but if she's not I become a bit more submissive to the doctors.... (Naomi I)

Discussion

Managed or medicalised labours give the practitioner greater control over the birth process (O'Driscoll and Meagher, 1980; Walsh, 2006). With control comes a higher degree of certainty. Conversely, uncertainty increases as more unpredictability is introduced into the system (Downe and McCourt, 2004). It would follow therefore that labours that are not managed are inherently more uncertain (Katz-Rothman, 1983). In this study midwives discussed what uncertainty meant for them and how it affected their practice. The central construct of uncertainty was identifying normality. The ‘midwifery rules’ (NMC, 2004) make the assumption that identification of deviance ‘from the norm’ is unproblematic and that it constitutes a specific uncontested event. However this study found that definitions of normality were constantly questioned and reconstructed by midwives and because of this identifying deviation became subjective. This may not be surprising given the lack of evidence of what constitutes normal labour (Williams et al., 1998; Gould, 2000). This is exacerbated by what has been termed, the medically managed labour, which comes with a set of norms that may not apply to labours that occur spontaneously and follow a physiological course (Downe and McCourt, 2004).

The use of evidence based practice (EDP) in producing guidelines and care pathways (Scottish Government, 2008) have helped to support midwives in definitions of normality and given them voice to support less interventionist approaches, as was noted by some of the midwives in the study. However there is concern that the evidence may be compromised as research has not always been based on spontaneously physiological labours (Downe and McCourt, 2004). For example, definitions of normal progress have been based on the Friedman curve (Friedman, 1978) which was formulated from observations of hospital labours and therefore failed to make comparisons with women labouring spontaneously at home or in non-medical settings (Gould, 2000). It has also been argued (Walsh, 2006) that hospitals have a vested interest in reducing or confining the length of labour so that women can be processed through the system more efficiently. This has led to a definition of normalcy that may not fit with an individual woman’s physiological progress through labour. Downe (2004, p. 13) makes the case that holding to an ‘absolutism’ position on what constitutes normality is misleading and the findings from this study would substantiate her position that normality is relative depending on individual belief systems and tolerance of uncertainty.

Determining normality and working with uncertainty were dilemmas faced by midwives in Green’s (2006) study. They too debated the concept of normality, however unlike this study, Green (2006) found that the dominance of the medical model in defining normality left midwives with little say in how they practised. Where midwives were able to exercise more autonomy (Sookhoo and Biott, 2002) the parameters of what could be accepted as normal increased. Evidence based clinical guidelines were therefore only as good as the willingness of both professions to acknowledge them and management to enforce them. Furthermore this study demonstrated that midwives struggled to use
guidelines when individual woman did not match what should be the ‘norm’ for that group of women.

Experience plays a role in midwives’ ability to tolerate uncertainty. However these findings show that expertise could lead to entrenched ideas and rigid practice, ‘the decision making of tradition’ (Porter et al., 2007, p. 532). Likewise although midwives acknowledged the woman’s wishes and expectations for their labour, how far they were prepared to push the boundaries of what was considered ‘normal’ was depended on how vocal the woman was. This is similar to findings by Porter et al. (2007) where embracing joint decision making between midwives and clients was rarely seen.

Emotional responses to uncertainty have been addressed in studies exploring doctor’s reactions to uncertainty (Gerrity et al., 1995; Timmermans and Angell, 2001; Farnan et al., 2008). While the medical literature cites examples of practitioners experiencing anxiety, stress and frustration when coping with uncertainty, positive responses are rare. However, uncertainty as a positive attribute is found in organisational management research. Clampitt and Williams (2005) found uncertainty viewed positively and in some cases an asset that reduced boredom. This is mirrored in this study where, paradoxically, high risk labours were considered boring because everything was predictable and prescribed. The uniqueness of normal labour was for some, part of its charm and brought excitement and curiosity. In the behavioural literature uncertainty has been cited as a factor that stimulates learning (Dayan and Yu, 2002). Individual differences in tolerance levels may therefore be due to how individuals respond to uncertain stimuli, as either positive or negative (Sorrentino and Roney, 2000).

As units provide supportive environments midwives gain confidence in their practice, but this confidence is often restricted to practices that reflect the prevailing unit model (Hyde and Roche-Reid, 2004; Lavender and Chapple, 2004; Pollard, 2005). An individual practice philosophy that is incongruent with the dominant unit philosophy presents problems for midwives (Hunter, 2004). Midwives with a medically oriented model of care, when working in low risk areas, found similar difficulties in adapting their practice, as midwives working in high risk areas, with a predominately midwifery oriented approach to care (Hunter, 2004). Without support, this adaptation becomes difficult. Over time and with support, the findings suggest that midwives can move away from an interventionist approach and towards more woman focused care (Sookhoo and Biott, 2002). However as the findings have shown, if the ability to support normal birth is not present in units that are more medically focused, then midwives will adapt their approach to mirror that of the prevailing culture (Porter et al., 2007).

Limitations

It is acknowledged that the sample size in this study is small. However it was guided by a robust sampling frame that sought to capture a range of experiences from midwives practising in diverse practice settings and with differing levels of expertise. In addition the depth of the interviews more than compensated for the small number of participants, who were selected specifically for their knowledge of and expertise in coping with uncertain situations. However it is recognised that the study did not capture the full range of practice settings and midwives practising in some of the more remote geographic locations in the UK might have divergent views and experiences of uncertainty that are not represented in this study. Equally their views do not necessarily represent the views of all midwives practising in the UK, as qualitative research is not intended to be generalisable.

Conclusion

Labour and childbirth is a dynamic and complex system that contains much unpredictability. Active management of labour is one mechanism that puts predictability into the system. However, managing such a complex system can lead to higher levels of intervention and a medicalization of childbirth that is not beneficial for all mothers and babies. Supporting a tolerance of uncertainty and allowing a flexibility in definitions of normality may go some way in ‘maximises the opportunities for women to have as natural a birth experience as possible’ (Scottish Government, 2008).

Conflict of interest statement

There are no conflicts of interests.

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