The experiences of midwives when caring for obese women in labour, a qualitative study

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Background: maternal obesity is a significant public health challenge for maternity services, especially those in developed countries. Obesity presents an increased risk of mortality and morbidity during the childbearing continuum.

Caring for the obese woman in labour is challenging for midwives and there is a dearth of qualitative research which examines their experiences.

Objectives: to explore the experiences of midwives caring for obese women in labour.

Design: a qualitative, phenomenological approach was used to enable in-depth exploration of midwives’ experiences.

Setting: one maternity centre in the North of England.

Participants: a purposive sampling approach was used. Eleven midwives who had experience of caring for obese women in labour were interviewed using in depth, digitally recorded semi-structured interviews for data collection.

Methods: interpretative Phenomenological Analysis was performed, and underlying themes emerged from the data resulting in an exhaustive description of midwives’ experiences of caring for obese women in labour.

Findings: the heart sinking phenomena when caring for obese women in labour emerged from the data from these midwives. Midwives were faced with a constant challenge to promote normality during childbearing in a medicalised environment. Mobilisation of the obese woman was a significant factor for midwives who were striving for normality for the woman. A sense of loss of control and helplessness underlying their care provision was apparent. Perceptions of obesity differed, with confusion between embarrassment and empathy emerging. Difficulties of how and when is the best opportunity to address obesity with the women arose. Different provisions of care amongst midwives were discussed.

Key conclusions: the findings suggest that midwives have different levels of understanding of the complexities associated with the condition. There was a sense of frustration at the ‘loss’ of normality for this group of women. Different provisions of care emerged with the need for more explicit guidelines to guide and support midwives. Communication and education were identified as key concepts when addressing the increasing prevalence of obesity.

Implications for practice: it is evident that the maternal obesity phenomenon is growing rapidly and that midwives feel that they are ill equipped to address it. Support must be provided for the practitioners striving for normality for the women.

Continuity of care must be encouraged to enable practitioners to build up a rapport with these vulnerable women through the childbirth continuum. Midwives involvement in developing multidisciplinary guidelines should be encouraged to determine the roles and responsibilities of practitioners.

Antenatal education is key if women are to be made aware of the problems associated with obesity and interdisciplinary learning must be encouraged to ensure support is consistent, appropriate and available to all women.

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Introduction

The normal birth agenda is a key focus for midwives in the UK maternity services. UK government recommendations and policies
emphasise the importance of normal physiological birth for women (for example Royal College of Midwives, 2004; Midwifery 2020 Programme, 2010). At the same time, midwives face significant challenges coping with the evolving needs of women who they encounter in the maternity services.

Maternal obesity for example is increasing nationally in the UK (Arrowsmith et al., 2011) and further evidence indicates that this phenomenon has had an impact on maternity services throughout the developed world (Heslehurst et al., 2010). In England, the Centre for Maternal and Child Enquiries, Royal College of Obstetricians and Gynaecologists (2010) reported that 19% of women of childbearing age have a Body Mass Index (BMI) of 30 kg/m² or more. Furthermore, it has been consistently reported that obesity presents an increased risk of mortality and morbidity for women and their infants during the childbearing continuum. For example, an earlier Triennial Review of Maternal Deaths in women who died were clinically obese (Confidential Enquiry into Maternal and Child Health, 2007). Maternal obesity is now a significant public health challenge for the UK maternity services. Caring for the obese woman in labour is therefore challenging for midwives responsible for managing the care of these women.

Whilst a plethora of literature is available examining many aspects of the condition, such as obese women's experiences of health-care services in general, and the risks associated with obesity during pregnancy, no published studies have been identified which examine midwives' experiences of caring for obese women during labour. One recent Australian study explored midwives' experiences of caring for obese women generally, and reported that they felt that they were struggling with this aspect of care (Schmied et al., 2010). In fact Schmied et al. (2010) suggest that the obesity phenomenon had moved faster than the health service's response to it.

Nyman et al. (2008) examined obese women's experiences of encounters with midwives and doctors during pregnancy and childbirth in Sweden. This study highlighted that despite care givers being well intentioned, some interactions with midwives resulted in negative feelings about their self image.

There is a paucity of research that has investigated the needs of the obese woman during the intrapartum period (Schmied et al., 2010), therefore the evidence-base is limited which highlights areas that midwives should address during this phase.

Because of the limited evidence in this area of clinical practice, the aim of this study was to examine the experiences of midwives when caring for women with a BMI > 30 kg/m² in labour.

Methodology

Phenomenology is derived from philosophy and is an interpretive approach (Mackey, 2004). Phenomenology contributes to a deeper understanding of lived experiences by exposing taken-for-granted assumptions about ways of knowing (Sokolowski, 2000). A Heideggerian phenomenological stance was adopted in this study because the researcher already had detailed and firsthand knowledge on the subject matter. Mapp (2008) suggests that the researcher interpreted the data collected in terms of their own experiences and knowledge. Data were collected by in-depth interviews and Interpretative Phenomenological Analysis (IPA) was used for data analysis.

IPA was used to analyse the narrative texts and to examine in detail the perceptions and understandings of the midwives (Biggerstaff and Thompson, 2008), rather than make more general claims. The IPA researcher generates codes from the data rather than using pre-existing theory to identify codes that might be applied to the data. This flexible and detailed methodology is useful in a domain where the issues are sensitive and complex (Chapman and Smith, 2002), such as caring for obese women in labour. A research design utilising a phenomenological approach needs to be able to collect descriptions while preserving the spontaneity of subjects' experiences (Jasper, 2006). Furthermore, people who have lived the reality of the subject being investigated provide the only legitimate source of data through which the researcher can access this reality (Baker et al., 1992). The most usual source, therefore, is verbatim transcripts of digitally recorded semi-structured interviews (Reid et al., 2005).

Favourable ethics opinion was achieved from the LREC in 2010 (10/H1011/60). Permission to conduct the study was also gained from the relevant Research Governance departments at the hospital.

Sampling

A purposive sampling approach was used to enable the selection of individuals who have knowledge of the phenomena concerned (Clifford, 1997).

Inclusion and exclusion criteria:

- The inclusion criterion was midwives who had managed the care of an obese woman in labour in the year preceding the data collection period.
- Exclusion criteria included all midwives who had not managed the care of an obese woman in labour in the preceding year.

Access and recruitment

The majority of midwives at the research setting worked in all areas of the maternity unit on a four monthly rotational basis. Consequently they provided intrapartum care for several months each year. Community midwives were included because they also work regularly in the labour ward. Posters were displayed in relevant clinical areas to attract volunteers. Those who expressed interest were provided with a Participant Information Sheet, and those who wanted to take part were given an interview date and time at least one day following initial contact with the researcher (GS).

Data collection

Eleven in-depth, semi-structured interviews were performed and digitally recorded by GS between December 2010 and January 2011. Small sample sizes are used in phenomenology because the aim of the interviews is to generate in-depth data (Biggerstaff and Thompson, 2008). Verbal and written consent was obtained prior to each interview. An interview guide was used to facilitate and guide the questioning process (Smith and Osborn, 2003). This style accommodated the diversity of the participants' discussions, as these varied considerably. Each interview lasted up to an hour and commenced with the question ‘Tell me about your experiences of caring for obese women in labour. Tell me everything that you have found’. Following the initial response to this question, probing questions were used to elicit more detail.

Data analysis

Interviews were transcribed verbatim by GS. All data were anonymised and stored appropriately within research governance regulations.
IPA was used to analyse the narrative texts. IPA differs from thematic analysis as the analysis process involves seeking patterns in the data that are theoretically related to the epistemology of the method; in the case of IPA, patterns related to experiences in order to understand reality for the participants (Braun and Clarke, 2006). Each transcript was read several times with themes related to experiences identified within each text, capturing the essential features of the initial readings (Thomas, 2006). Similar themes would often emerge and subsequently, connections were forged between the themes until an organised and coherent thematic account was produced (Chapman and Smith, 2002). Connections across the transcripts were made, and clusters of themes which best represent the respondents’ experiences were given a name to represent the super-ordinate themes (Smith and Osborn, 2003). Finally the most superior themes were translated into a narrative account, where the themes were outlined, exemplified and illustrated with verbatim extracts from the participants. It was acknowledged that analysis should be developed around substantial verbatim excerpts from the data to illustrate the importance of the participant’s experiences (Reid et al., 2005). It has also been suggested that extensive quotes enable participants to depict their voices and to ‘let the data speak for itself’ (Walsh, 1997, p. 179). Organising the data into broad themes provided the focus for the analysis which enabled representation of commonalities across the midwives’ accounts whilst attempting to accommodate variations between the data set.

Analysis should balance the phenomenological description with insightful interpretation, supported firmly by the participants’ accounts of their experiences.

Rigour

Despite this being a small study, efforts were made to ensure credibility of the data. One researcher carrying out all of the interviews ensured consistency throughout data collection, for example, with the use of similar phrases and probes and prompts used across responses to generate in-depth data. The researcher had previously undertaken training in data collection during research methodology study. Data generated were also discussed within the research team to ensure that the interview technique was appropriate. A detailed description of the research process will assist other researchers to replicate the study (Lewis, 2009). Data were recorded to improve referential adequacy (Patton, 2002) and findings were frequently discussed with an academic supervisor to minimise researcher bias.

Transparency and reflexivity

Conducting research within one’s own professional group can produce challenges such as role confusion, and over-identification with participants (Allen, 2004). However, authors who have had prior or existing membership of the group being studied have reported benefits from ‘insider’ knowledge or status (Burns et al., 2010). The researcher is a senior labour ward coordinator and a Supervisor of Midwives. Supervisors of midwives have undertaken additional training to support, teach and supervise other midwives, acting as role models within the profession (Nursing and Midwifery Council (NMC), 2008). The researcher was, therefore, well known and familiar to all the midwives interviewed, and thus has a degree of acceptance as an experienced peer midwife (Simmons, 2007). However, it would be naïve to assume that this would not impact some of the responses of the midwives, particularly the more junior midwives interviewed within the study. To attempt to address this, the researcher spent time reassuring midwives that confidentiality was a high priority, and that the intention was not to scrutinise individual practice, but to capture the broad spectrum of labour ward practice as a whole.

It could also be suggested that because the researcher is familiar with the participants they would be more open and direct in their replies, than to a stranger carrying out the study (Asselin, 2003). Simmons (2007) discusses early rapport building to be an advantage of ‘insider’ research. Participants may be aware of her experiences which would encourage directness and honesty and a sense of empathy with the difficulties that they encounter. Midwives would acknowledge their familiarity with the researcher and look to her for approval for comments they were making, for example ‘you know how it is?’ There were several occasions during the interview process where the boundaries between researcher and clinician became blurred (Burns et al., 2010) as the midwives asked the researcher’s opinion.

Commonality between the researcher and the participants has been acknowledged previously (Dwyer and Buckle, 2009). During the interview process the researcher maintained a reflexive journal as advocated by Koch (1996) in an attempt to address and make sense of the issue of familiarity with the participants. It could be suggested that midwives volunteered to participate in the study to please the researcher solely because of their clinical relationship. This is impossible to determine; however it is evident that all midwives made a valuable contribution to the data set.

Findings

Demographic data

The demographic data of the 11 midwives who participated in the study are outlined in Table 1.

The phenomenon of ‘heart sink’ that emerged during data analysis phase has six interlinked themes. These are explained in detail below.

Normal birth in a medicalised environment

All the midwives interviewed were keen to promote normal birth for obese women, but all had different degrees of awareness of the complications associated with obesity. The labelling of these obese women as ‘high risk’ restricted the care that these midwives’ felt facilitated normality of the birth process, and would ultimately improve the outcome for the woman.

However, some contradictions between midwives became apparent when midwives discussed their provision of care. Midwives frequently referred to the women in their care as ‘high risk’ but discussed at length the advantages of mobility and intermittent electronic fetal heart rate monitoring, and of keeping women ‘low risk’ and mobile in an attempt to achieve the best physiological outcome for them. This suggests that there is a struggle and difficulties faced by the midwives trying to promote normality in childbirth for the high risk, obese woman.

The need to use electronic fetal heart monitoring (cardiotocography known as CTG in practice) to auscultate the fetal heart appeared to be the major obstacle in facilitating the normal birth process:

Well initially I wouldn’t try with a Pinards because that causes more embarrassment trying to press on to a big tummy...The CTG, well you have to explain to them that ‘because there is quite a bit of you’ it is not always easy to position it accurately. Midwife 5
Several midwives expressed concern that using the CTG precipitated the ‘cascade of intervention’ described by Inch (1985):

Quite often you decide to do an admission CTG and because that’s not very good, with loss of contact, then you end up with them being kept on and kept on (continuous monitoring) until, like all women they don’t mobilise, so the contractions go off and labour slows down. Midwife 9

One labour ward midwife admitted:

If they need continuous monitoring I wouldn’t even bother with the abdominal transducer, I would just put a fetal scalp electrode on… Midwife 7

The dilemma faced by these midwives was clearly apparent. There was an uncertainty amongst these midwives as to whether continuous electronic fetal heart rate monitoring was required; however all agreed that this impacts a woman’s mobility in labour.

Mobilisation

Mobilisation of the women during labour was a key theme in the data, and its importance to these midwives was reiterated throughout. Mobilisation has significant implications in terms of normalisation of childbirth and the majority of the midwives admitted that they only perceived maternal size to be a problem when mobility was affected. The midwives considered mobilisation to be key in achieving a normal birth for the woman, but they had difficulty rationalising whether it was appropriate to encourage mobilisation in a group of high risk women where close monitoring of mother and fetus is advocated. The contradiction and confusion for care provision was clearly evident.

Several midwives expressed a feeling of ‘dread’ when obese women requested an epidural for analgesia because this would have limitations for their mobility:

I dread it because I can’t position her, I can’t lift her legs, I can’t bend her legs, and I can’t examine her. Midwife 1

All the midwives interviewed agreed that mobilisation was the key to obese women achieving a normal birth, and that the birthing pool may facilitate this. However, they all acknowledged that obese women were not given the option of using the pool because of associated risks:

No one is going to want to put her in the pool. Who is going to let them go in the pool? Midwife 10

Despite being able to state all the advantages that a pool childbirth may have, Participant 10 could not rationalise the use of the pool for a woman that she knew to be high risk.

Feelings of helplessness

Feeling helpless was clearly evident in these data. Discussion around the difficulties of normal practice emerged during the interviews:

Well, from admission the first problem is the palpation. I am thinking ‘is it a head’ and I have to be honest it could be a head, it could be a bottom, it could be anything. Until I have done a VE (vaginal examination) I can’t be 100% sure. Midwife 10

Midwife 7 verbalised frustration when having to involve the obstetricians for routine tasks which were more difficult on women with a raised BMI:

If she has a fat layer and it’s a difficult cannulation I have to get an anaesthetist or doctor to do it so it takes stuff out of my role and it annoys me because I want to do it for her myself.

Once again, the sense of helplessness emerged.

Role blurring and confusion between midwives and obstetricians were apparent throughout the interviews. Although these midwives were aware of the need for medical support, there was a strong sense that they felt that the care of women with a raised BMI was ‘over medicalised’, which in turn led to the ‘cascade of intervention’, and the possibility of a less than optimum outcome related to the mode of birth.

Perceptions of obesity

These midwives had different perspectives and perceptions of obesity.

Midwife 5 described a ‘blame culture’ surrounding these women:

I mean we will say ‘My God she’s a big girl’ and people will say ‘you’d think she would do something about it.

There was a suggestion from several midwives that obese women lost their identity and were known as a ‘condition’, rather than an individual:

Sometimes you come on a shift and they are doing handover, they don’t give a name to the woman, they just say she is a raised BMI… Midwife 4

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Table 1

Table to illustrate baseline demographic data of the participants.

<table>
<thead>
<tr>
<th>Midwife</th>
<th>Age range</th>
<th>Clinical band/seniority</th>
<th>Length of experience as a midwife</th>
<th>Area worked in past six months</th>
<th>Highest academic qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>41–50</td>
<td>6</td>
<td>4 yrs</td>
<td>Central Delivery Suite (CDS)</td>
<td>Midwifery degree</td>
</tr>
<tr>
<td>2</td>
<td>41–50</td>
<td>6</td>
<td>7 yrs</td>
<td>Community</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>3</td>
<td>51–60</td>
<td>7</td>
<td>22 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>4</td>
<td>21–30</td>
<td>7</td>
<td>7 yrs</td>
<td>Community</td>
<td>Diploma in Midwifery</td>
</tr>
<tr>
<td>5</td>
<td>51–60</td>
<td>7</td>
<td>35 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>6</td>
<td>41–50</td>
<td>6</td>
<td>14 yrs</td>
<td>Postnatal</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>7</td>
<td>41–50</td>
<td>6</td>
<td>27 yrs</td>
<td>Community</td>
<td>Diploma in Midwifery</td>
</tr>
<tr>
<td>8</td>
<td>21–30</td>
<td>5</td>
<td>2 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>9</td>
<td>31–40</td>
<td>6</td>
<td>16 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>10</td>
<td>51–60</td>
<td>6</td>
<td>14 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
<tr>
<td>11</td>
<td>21–30</td>
<td>6</td>
<td>4 yrs</td>
<td>CDS</td>
<td>Midwifery Degree</td>
</tr>
</tbody>
</table>

*Midwives who do not hold an academic qualification as they qualified as a midwife before midwifery professional awards were combined with academic awards such as Diploma or degree in Midwifery.*
All the midwives felt that women were aware of their size and felt embarrassment addressing a woman’s size and were unsure on how to do so:

They are very aware of their size so I try in a verbal and non verbal way to make them feel like we deal with it every day and that nothing is different. Midwife 2

Several of the midwives viewed obesity as being self inflicted; however, this was not a view held by all. Some midwives discussed their thoughts that obesity was a product of the society that we live in and that the profession would have to adapt, rather than expecting the women themselves to change. Once again this embraces the concept of normalisation of the abnormal. It could be suggested that as a society it is easier to make acceptable the unacceptable, rather than tackle the issue:

We have made it very acceptable and almost encouraged people to be overweight in the way they feed themselves. They can go into shops and buy trendy clothes whereas twenty years ago they would have been forced to address it. Midwife 10

Some midwives found that women try to compensate for their size, even going as far as apologising for the difficulties they create. Midwife 3 admitted:

They ‘lift their tummy up’ whilst you are doing an examination, they are over helpful really, some of them. I think they probably look at the size of me and the size of them and the over helpfulness kicks in really.

Midwives had different opinions about how women perceived their own weight issues. Some assumed that obese women were embarrassed by their size; others felt that the women did not see their size as an issue at all:

They don’t realise the risks that they are putting themselves at and they don’t see it as their risk because it’s our fault if it doesn’t go right and somebody is to blame and it’s never them. Midwife 5

Several midwives honestly admitted that it was their own embarrassment that prevented them tackling the issue of size and its limitations to care with the women. In an attempt to protect a woman’s feelings, these midwives were not keeping women fully informed of the associated risks of labour, thus making change unlikely. Withholding information ultimately takes away the responsibility of the women for their own health.

Knowledge and how to address it

The real dilemma for these midwives was how to address obesity with the women without causing offence. Although no one felt able to address it in labour directly, midwives did have different strategies that they adopted. Phrases such as ‘well there is enough of mum here,’ Midwife 10, or ‘sometimes it is difficult when there is a bit of extra padding,’ Midwife 5, were used.

Midwives meeting women for the first time in labour felt it inappropriate to cause embarrassment to women at their most vulnerable time, when discussion about their obesity would be of little benefit. All agreed that they should be more direct, but did not know how.

Provision of care

All midwives were aware of the need for specialist, bariatric equipment (specialised equipment to support health professionals caring for obese pregnant women) but were concerned that an over emphasis on this would result in embarrassment for the women. Midwife 7 discussed the bariatric chair that is available on Central Delivery Suite:

We have got that big chair which is awful. I think it’s absolutely disgusting. It’s like two armchairs put together and put in the room for her to sit on. And I think ‘poor woman’, it’s just plonked in the middle of the room and everyone is looking at it thinking that is her chair.

Midwives preferred the bariatric mattresses to be installed on the bed before the woman arrived, rather than have the woman witness the staff changing the mattresses around:

Ideally it would be nice to have mattresses across the board so we are not following them round and making a big song and dance about it. Midwife 5

Some expressed the opinion that equipment should be ‘one size fits all’ in order to spare embarrassment for the obese woman whilst acknowledging that this appears to make obesity more acceptable as it avoids having to address it directly.

Interestingly, an alternative line of thought was offered:

We need to provide care for any woman regardless of size so it’s us that need re-educating. We need a different way of thinking. Midwife 7

I think we will just learn to deal with these bariatric ladies the same as we have had to learn to deal with diabetes. Midwife 2

It is evident that subconsciously, despite the lack of explicit guidelines, midwives were trying to adapt their care for the high risk women. They promoted normality in childbirth within the boundaries of a high risk environment, but tried to make concessions within their provision of care.

The phenomenon

The frustration and exasperation felt by these midwives can be likened to the ‘heart sinking’ feeling described by O’Dowd (1988, p. 528), a General Practitioner. He discussed the concept of ‘heart sink’ patients as those who exasperated, defeated and overwhelmed professionals by their behaviour. He described them as a source of stress as they aroused negative feelings leaving professionals feeling unprofessional and frustrated.

The ‘heart sink’ phenomenon has been widely highlighted in research related to General Practice in the medical literature, but this is a new concept for midwifery studies. This concept has been adapted to this study because it describes the feelings and sensations that all midwives interviewed were familiar with. The sensation of frustration and exasperation that has previously been discussed by O’Dowd (1988) clearly emerged during the analysis process. See Fig. 1 for an overview of the heart sink phenomenon.

Discussion

These findings have provided a unique insight into the perceptions and experiences of midwives who care for obese women in labour. The phenomenon emerging from the interviews was feelings exacerbated by the continuing struggle by these midwives to implement and maintain normality during childbirth, whilst simultaneously providing care to a high-risk group of obese women. This constant struggle manifested itself as a feeling of
‘heart sink’ in these midwives. The heart sink phenomenon is discussed within the context of wider literature.

**Normal birth in a medicalised environment**

Those interviewed were unanimous that one of the major barriers to achieving normality during birth was difficulties experienced in monitoring fetal well-being and consequential requirement for continuous electronic fetal heart rate monitoring. Joint guidance published by Centre for Maternal and Child Enquiries and Royal College of Obstetricians and Gynaecologists (2010) guides midwives with their choice of care for the obese woman. Whilst it states that ‘in the absence of other obstetric or medical indications, obesity alone is not an indication for induction of labour and a normal birth should be encouraged’ (Centre for Maternal and Child Enquiries, Royal College of Obstetricians and Gynaecologists, 2010, p. 11), it provides little information on how to achieve this. The guideline acknowledges that ‘fetal heart rate monitoring can be a challenge’ (p. 11) and it advocates close surveillance of the fetal heart during labour, using invasive methods (fetal scalp electrode) or ultrasound assessment if necessary. It implies the use of continuous electronic fetal monitoring, which impacts upon a woman’s mobility, and may trigger the cascade of intervention (Wickham, 2005). These midwives were conscious of this, but were unsure how to overcome it.

Perhaps a different approach to the care of the obese woman should be considered and ‘optimal birth’ rather than normal birth advocated. The concept of optimal birth aims to achieve the best possible birth for the woman given her circumstances at that time (Kennedy et al., 2010). Furthermore, studies have shown that women consider a vaginal childbirth (including instrumental intervention) to be a ‘normal birth’ (Turner et al., 2008). The aim of the study was to explore midwives experiences of caring for obese women in labour, and interestingly all the midwives except one talked about the difficulties and obstacles to achieving a normal childbirth and the sense of hopelessness and frustration if this did not happen. Only one midwife interviewed in this study discussed the concept of achieving the best outcome on the day and providing a positive birth experience for the women regardless of mode of childbirth. This illustrates how the philosophy of fostering normal birth that is inherent in UK midwifery practice today has the potential to affect midwives’ experiences in their practice.

Striving for a birth with no intervention in a medicalised environment was certainly a challenge for these midwives.
However, it could be argued that attempting to normalise what is clearly an abnormal situation rather than address it directly is escalating a problem that is already spiralling beyond control (Heslehurst et al., 2007).

**Mobilisation**

Mobilisation was seen to have significant implications for the normalisation of childbirth (Lawrence et al., 2009). The midwives described the ‘heart sinking’ phenomena they experienced when observing an obese woman walk down the corridor to a delivery room. They acknowledged that it affected all aspects of the care they offered if a woman’s ability to move around freely during labour was limited. This concept is supported by Kennedy et al. (2010) who discussed the idea of keeping labouring women out of the bed to maximise the likelihood of normal childbirth. Despite all the midwives advocating the need for mobilisation, all felt restricted by the risks they knew to be associated with the high risk condition. All midwives acknowledged that given a choice they would support women to remain as mobile as possible throughout labour, but that they felt that this choice was not available to them. Research suggests that women who are upright and mobile have better birth experiences than those who are not (Newburn, 2009).

**Feelings of helplessness**

Lindsey (2006) suggests that the high risk pregnancy can be disempowering for both women and midwives and that a woman should be assessed on an individual basis, rather than classed as a care package. This recommendation is made in other studies (Heslehurst et al., 2007; Jevitt, 2009) implying that midwives require increased skills in providing individualised care. However, in practice safety versus choice is a real dilemma faced by midwives. The concept of risk management is high on the agenda for maternity services (Mackenzie and Van Teijlingen, 2010) and it would be naive to assume that a woman experiencing a high risk pregnancy will be given the same care options as a woman with a straightforward, low risk pregnancy. The challenge for midwives is to plan individualised care, incorporating the needs and wishes of the woman, whilst ensuring safety as a priority.

The lack of appropriate equipment was identified by these midwives as a barrier to providing effective care. Merrill and Grassley (2008) identified that women were aware that equipment such as blood pressure cuffs, theatre gowns and beds did not fit so perhaps this would present an opportunity for midwives to discuss obesity more openly. However, several midwives advocated that a ‘one size fits all’ approach should be adopted to prevent embarrassment for the women. This concept would enable midwives to avoid addressing obesity directly, preventing their own embarrassment, which some midwives acknowledged as part of their practice.

**Perceptions of obesity**

It was evident that participants in this study believed that BMI status was misleading, and that other factors such as woman’s mobility and midwives’ own clinical judgement were more important indicators of obesity. They discussed the concept that caring for a woman with a BMI of 30 kg/m² is commonplace, that woman are becoming larger, and perhaps classifications of obesity should be altered to reflect this, thus normalising obesity (Johnson et al., 2008). Several midwives acknowledged that obesity is becoming a normal situation in our society, and that as health professionals we must learn to adapt to it.

Midwives acknowledged that they felt uncomfortable addressing a woman’s size and were unsure how to do so (Heslehurst et al., 2007). Indeed, the literature supports the evidence that the midwives felt ill equipped and that they lacked the skills and knowledge to communicate with the women about their weight (Brown and Thompson, 2007).

These ramifications of changing perceptions of obesity have implications for all of society. Schmied et al. (2010) argue that by raising the threshold for those considered to be obese in order to reduce the need for specialized services may mean that women who would benefit from specialist dietary and lifestyle advice would be missed.

It was clear that these midwives had become gatekeepers of information in an attempt to protect the women at their most vulnerable time. Gate-keeping is the process of ‘allowing or denying another person access to something’ (Lee, 2005, p. 36). Denying women access to information about the severity of the condition removes their choice to take remedial action resulting in a vicious circle of cause and effect.

Smith and Lavender (2011) advocate that women are more receptive to lifestyle advice during pregnancy because they perceive their weight to be more problematic than when they are not pregnant. Midwives acknowledged that the antenatal period provides opportunity to discuss diet and lifestyle, but are unsure how to do so. However, whether this is because there is little available in terms of referral pathways was unclear in these findings.

Postnatal education was also felt to be acceptable, with midwives feeling that women would be more receptive to advice postnatally (Cahill et al., 2010). The key to this success appeared to be the focussed training of the midwives to ensure that they are adequately prepared to deliver appropriate advice to the women.

**Provision of care**

A suggestion that emerged from the data was the concept that choice was compromised to ensure safety (Symon, 2006). Midwives verbalised the need for more explicit guidance to help them plan and implement care for the obese woman but they recognised that this would limit birth choices.

Perhaps the concept of choice and its appropriateness to the care midwives are able to provide should be examined. These midwives identified that choice for these high risk women is limited and so the profession should question whether we are giving women unrealistic expectations about the type of care they can expect to receive. Heslehurst et al. (2007) discussed the reduced choice that obese women have in their care plans and in terms of mode of childbirth because of the fear by health-care professionals of causing stress and upset to women whose pregnancies are already classed as high risk. It is evident that safety versus sensitivity is a further dilemma that the obese woman creates for the midwives providing care (Symon, 2006).

It is clear from the discussions that care for the obese woman in labour must be multifaceted. Midwives are faced with a conundrum of challenges to ensure that the balance of care incorporates both safety and choice. Support of the woman is paramount and a compromise should be reached between the multidisciplinary team to ensure the woman achieves a positive birth experience. Education and communication (Heslehurst et al., 2010) have been shown to be key elements in achieving this.

**Strengths of the study**

The literature search suggests that this is the first study of midwives’ experiences of caring for obese women in labour that...
has been undertaken. The phenomenological approach enabled the researcher to work with the midwives in flexible collaboration (Mapp, 2008), to identify and interpret the relevant meanings that were used to make sense of the things that happened to them. A rigorous approach was adopted to ensure transparency through data collection and analysis (McNeill and Nolan, 2011).

The interviews were transcribed by the researcher demonstrating trustworthiness of the findings (Halcomb and Davidson, 2006) and ensured an in-depth understanding of the emerging data during the interview process.

Verbatim quotations were used to illustrate and authenticate the midwives experiences (Polit and Hungler, 1998).

**Limitations**

It must be acknowledged that this was a small study which examined the experiences of 11 midwives and so the findings are not generalised to other populations (Jasper, 2006). Furthermore, researchers using IPA are aware that interviews are not a neutral means of data collection (Rapley, 2001), and it could be suggested that recruitment for the study was not an entirely neutral process because the midwives were aware of the researcher. Had the study been performed in a different trust than the one that the researcher worked in, then arguably the findings may have been very different.

The study was limited to the experience of the midwives but a larger study incorporating the views of other health-care professionals such as obstetricians and anaesthetists may be of value in the future.

**Recommendations for practice and research**

It was evident that for these midwives, their main experiences of caring for obese women in labour were focussed on fostering a normal physiological birth, but they also recognised that providing care was challenging. It was clear that they felt they required more support in this aspect of their role. Continuous midwifery support for women in labour has been shown to lead to positive outcomes (Hatem et al., 2008). Ultimately the relationship between the women and the clinical care providers was crucial.

Continuity of care throughout pregnancy to the postnatal care would enable midwives to build a rapport with these vulnerable women. Having a more comfortable relationship and knowing the woman and how she may respond may provide opportunity for midwives to address the subject of obesity without concern of causing embarrassment or offence.

Midwives should be also involved in developing multidisciplinary clinical guidelines to define roles and responsibilities for practitioners. It is important to develop networks and pathways for clinical care, whilst recognising clinical leadership, multidisciplinary working and defining roles and responsibilities (Department of Health, 2007). A national, strategic, long term approach was identified by Heslehurst et al. (2010) as necessary to address maternal obesity effectively.

Given the recent recommendations on the management of women with obesity in pregnancy (Centre for Maternal and Child Enquiries, Royal College of Obstetricians and Gynaecologists, 2010), effective communication should be paramount in clinical practice. Obese women should be informed of the difficulties associated with their care in a clear and sensitive manner to enable them to be involved in the decision making processes so that the appropriate management can be planned.

The importance of antenatal education should not be underestimated. Informing women of the facts and inherent difficulties associated with obesity and discussing their choices for the intrapartum period will enable appropriate management plans to be implemented. Furthermore, it may be prudent to place more emphasis on a positive birth experience, advocating an optimal birth rather than a normal, vaginal childbirth.

Services need to be developed and training provided for midwives and student midwives to enable them to address the issue of maternal obesity in a sensitive but professional manner. Interdisciplinary learning should be facilitated to ensure a clear understanding of each other’s roles to ensure that support is consistent, appropriate and most importantly, available to all obese women.

**References**


