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# The grounded theory of Coalescence of Perceptions, Practice and Power: An understanding of governance in midwifery practice

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## Abstract

**Aims:** This study aimed to understand midwifery care during labour, particularly decision-making processes, within Australian health systems.

**Background:** Midwifery, founded on a wellness model of motherhood, is at risk of being medicalized. Whilst medical intervention is lifesaving, it requires judicious use. Governance provides oversight to care. Exploring decision-making contributes to understanding governance of practices.

**Method:** Straussian grounded theory using semi-structured interviews. Eighteen Australian registered midwives were interviewed about their practice when caring for women during labour.

**Results:** Midwives were caught between divergent positions; birth as natural versus birth as risk. Experienced midwives discussed focussing on the woman, yet less experienced were preoccupied with mandatory protocols like early warning tools. Practice was governed by midwives approach within context of labour. The final theory: The Coalescence of Perceptions, Practice and Power, comprising three categories: perceptions and behaviour, shifting practice and power within practice, emerged.

**Conclusions:** Coalescence Theory elucidates how professional decision making by midwives during care provision is subject to power within practice, thereby governed by tensions, competing priorities and organizational mandates.

**Implications for Midwifery Managers:** Midwifery managers are well positioned to negotiate the nuanced space that envelopes birthing processes, namely, expert knowledge, policy mandates and staffing capability and resources, for effective collaborative governance. In this way, managers sustain good governance.

KEYWORDS
early warning tool, governance, intrapartum, midwifery or midwife, midwifery practice, risk aversion

## 1 | INTRODUCTION

The relationship between midwifery and improved perinatal outcomes is well established, leading to calls for increased access to midwifery care (United Nations Population Fund, 2021) (Tracy et al., 2013). The World Health Organization has identified that midwifery practice remains underutilized, and full scope of practice is limited (World Health Organization, 2016). For health systems to strengthen midwifery it is essential to identify how the systems themselves may enhance or impede midwifery practice (Renfrew et al., 2014).

Contemporary midwifery practice intersects at two disparate approaches, confidence in spontaneous birth versus birth as risk (Scamell, 2016) and the dominance of obstetrics and managerialization over midwifery knowledge and autonomy (Zolkefli et al., 2020). The need to control and mitigate risk has resulted in the standardization of care; in opposition to woman-centred, individualization of care (Prosen, 2022). Understandably, the need to control emerges from fear of the unknown (birth) and the risk this poses to women, infants, institutions and professionals.

This paper reports on a study that sought to better understand midwives' care, specifically decision-making processes, when providing care for labouring women. The theory generated from this research posits factors, behaviours and practice germane to governance.

## 2 | BACKGROUND

Governance refers to 'A framework through which health service organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish' (Healthcare Commission, 1998). Governance encompasses the system by which an institution is controlled and operates, and the mechanisms by which it and its people are held to account. Ethics, risk management, compliance and administration are all elements of governance (Governance Institute of Australia, 2022). Governance seeks to combine organizational, managerial and clinical approaches that enhance quality of care via development of processes that facilitate or safeguard good care and enable improvement (Arulkumaran, 2010). Therefore, governance differs from statute-driven regulation. Governance accommodates the breadth of people, tools, stakeholders, and practice. In a midwifery context, clinical governance comprises interwoven components, such as the woman, the midwives, the environment, organizational policies and procedures and the leadership team.

A central concern in governance is risk. The nature of risk, including how it is characterized, defined, perceived and managed is specific to circumstances. These circumstances inform risk tolerance and the establishment and management of processes. However, it is imperative that the public trust in the quality of maternity services.

In Australia, the safety and quality commission stipulate the standards of all aspects of health care provision. In the midwifery context, reports such as Confidential Enquiries into Maternal Deaths in the United Kingdom (UK) (Carle et al., 2013) and standard statements such as the Australian Commission on Safety and Quality in Health Care (ACSQHC) advocate for early warning tools and protocols to mitigate risk and assure good governance (ACSQHC, 2017). Accordingly, current institutional policies encourage or even mandate midwives' use of an EWT in all birthing scenarios.

## 3 | STUDY DESIGN

This study adopted a hybrid grounded theory methodology as conceived by Strauss and Corbin (1990) and advanced by Adele Clarke's Situational Analysis (2003). Grounded theory, a qualitative methodology, using humanistic methods to discern people's experiences and to understand them was deemed fitting (Denzin & Lincoln, 2018; Glaser & Strauss, 1967).

## 4 | SAMPLE/PARTICIPANTS

A purposive sample of currently employed Australian registered midwives providing intrapartum care were invited to participate. The sample was identified and located via the Australian College of Midwives membership newsletter, LinkedIn, and Facebook online recruitment. A total of 18 midwives consented to participation. These midwives had varying levels of experiences from 1 year post graduation to 40 years as a practising midwife. They worked in a range of maternity contexts and models of care; some midwife led and some not. All participants were allocated a pseudonym for the transcriptions and reporting of findings.

## 5 | DATA COLLECTION

Individual, semi structured interviews were conducted with all 18 participants. The interviews were conducted in a private office by the lead author (BF) a registered midwife undertaking a PhD and the private residences of participants via Zoom videoconferencing. Interviews were 40 to 60 min long and were recorded then transcribed verbatim using N-Vivo. Field notes and memos were made during and after each interview.

## 6 | ETHICAL CONSIDERATIONS

Ethics approval was received from the relevant institutional Human Research Ethics Committee (HREC) prior to the study commencing. Midwives were provided with an information sheet and consent form prior to participation.

## 7 | DATA ANALYSIS

Data analysis was conducted according to the tenets of Straussian grounded theory, namely, methods of coding, constant comparative

analysis, theoretical sampling and memoing (Strauss & Corbin, 1990). Data analysis was expanded via situational analysis (Clarke, 2005), highlighting social action/interaction and mechanisms of power within midwives' professional setting. Data coding was undertaken by two authors (BF and AB). Themes were derived from the data. Theoretical saturation and generation of themes was discussed with all supervisors.

## 8 | RESULTS

From analysis of the findings the theory of Coalescence of Perceptions, Practice and Power, emerged. Three themes were central to this theory 'Perceptions and behaviours', 'Shifting practice' and 'Power within practice' and are discussed in detail below.

### 8.1 | Perceptions and behaviours

Midwifery practice is based on a wellness model with the woman at the centre of care, based on an understanding that pregnancy and birth are a normal, healthy state of being rather than an illness. Whilst experienced midwives discussed a focus on the woman, those less experienced were preoccupied with designated protocols and procedures during labour. Two sub-categories illustrated these disparate positions: Behaviours guided by woman centred care and behaviours guided by protocols.

#### 8.1.1 | Behaviours guided by woman centred care

Experienced midwives spoke of their expert knowledge and their midwifery skills to provide woman centred care and support spontaneous birth. Primarily these participants spoke of implementing midwifery 'knowingness' and skills of looking, feeling, listening to maternal cues, physical, behavioural and verbal to assess the labour. They explained that listening to women is important because women often know when something is wrong, and this can be a significant indicator for the midwife before external signs become apparent. Listening with purpose to how the woman vocalizes, her changes in tone and the types of sounds she makes alerts them to the stages of labour and therefore progress. Participants spoke of supporting the woman to spontaneously labour in response to her body's own physiology during home birth.

> ***Pam***: *Listening is a very good tool, listening to the different sounds she's making, it's watching and listening to those changes. That's about progression in labour as opposed to Early Warning Tool observations.*

They explained that this midwifery approach promoted a woman's self-efficacy, to know she can and will birth her baby, as well as fostering her burgeoning self-belief, and confidence that crystallized into self-empowerment.

The participants regarded the ability to look, listen and feel for the inherent rhythm of natural labour, and to be guided by this, the woman's own body, including how she moved and positioned herself as paramount.

> ***Julie***: *We were quietly listening, and we picked up that her breathing was getting a whole lot heavier and yes, she was fully dilated and just letting us know this through her vocalisations, but you must be with someone and uninterrupted for that time.*

#### 8.1.2 | Behaviours guided by protocols

Some midwives specifically discussed the benefit of mandated protocols, such as Early Warning Tools (EWT), in directing how they provided care for women in labour. These participants discussed the assistance the tools and accompanying escalation provided in prompting assessments, timely communication and advising on actions. This was especially helpful and appreciated when midwives were less experienced or became overwhelmed. However, protocols were found to be time consuming due to compliance with frequency of routine observations and associated documentation. This served to reduce 'being with woman' and *Jane* shared how she became focused on doing 'obs' [observations] because she did not have sufficient time to sit with women.

> ***Jane***: *There's not that ability to sit with the woman and palp for ten minutes because that ten minutes is literally when you've got another set of Obs due again and your back at the start.*

However, junior midwives highlighted the confidence that completing the EWTs provides as it justifies their course of action and sharing of responsibility. Jane also shared:

> ***Jane***: *It gives you confidence and validation in communicating to medical staff. It's got more guts behind it, especially when you're junior and escalating. You're covering your bum and they're aware that if something happens later, you will say I told you so!*

Several participants discussed the role of EWTs as a form of validation that provided objective data upon which to base escalation of care, rather than subjective assessments related to the midwife 'knowing' the woman, and the woman 'knowing' her body.

> ***Rosemary***: *The EWT is useful when you are not feeling heard because doctors will listen to the EWT.*
>
> ***Andrea***: *The EWT protocol dictates that I must tell doctors about it, and they must review. It's a great help.*

However, introduction of computerized early warning systems to reduce errors was seen as both a benefit and a limitation. Rosemary found flaws within the computerized tool and suggested it was not foolproof, triggering unnecessary observation.

> *With the electronic system, if you do not do the entire EWT, it will not tell you what the score is. It will just tell you that you have not put enough data in, so it does not work unless you are putting it all in at the exact same time even if it's not due.*

## 8.2 | Shifting practice

The second theme, Shifting Practice, describes the juxtapositions of 'birth as normal' and 'birth as risky'. These juxtapositions were significant in midwives' behaviours when prioritizing care for the woman. Some midwives spoke about how they managed to create synergies, for example, Parvin explained 'working around'

> ***Parvin***: *Midwives tailor their care to the woman individually to a degree. We're still told we've got to do these observations in the mandated timeframe, but there are ways around it, like choosing when to take the obs and who to escalate to.*

Others accepted their utility, for example,

> ***Brooke***: *We are mitigating for the youngest midwife so it's the same for each birth, every time, for each midwife. That's being consistent and the consistency is about safety.*

However, for other midwives their practice was challenged when these elements competed, rather than synchronized. Somewhat surprisingly, the perceptions of midwives' use of EWTs were consistent in their voiced concern about losing the individuality of each midwife-woman relationship, although there were differences in how seriously they perceived the impact; this was associated with their willingness to comply with institutional mandates. Adherence to policy could result in care focused on technological and procedural components. The sub-themes that make up the theme of Shifting Practice are Compliance and Defiance, that emerged through the midwives' discussions around the choice between their professional survival (compliance) and their midwifery philosophy (defiance).

### 8.2.1 | Compliance

Midwives discussed an imperative to comply. Reasons included being 'blamed' when things went wrong because protocols had not been followed and this had consequences. Care and decision making that were considered outside of, or contrary to, policies were subject to documentation in risk management systems. Hospital cultures were organized to reduce adverse outcomes therefore recorded incidents were carefully reviewed. Most participants voiced an understanding of the significant impact that not following protocols could have on individual midwife's autonomy. *Pam* shared non-compliance could 'destroy you':

> ***Pam***: *The power and the system puts midwives in a position where you have got to choose between yourself and the woman because if this goes badly, you'll be absolutely destroyed.*

*Brooke* flagged the importance of knowing 'the boundary line' to remain compliant.

> ***Brooke***: *My registration is on the line and the hospital policies are telling me what to do. It is a line in the sand, and for the sake of your registration, you must come to the line.*

Adherence to policy was viewed as self-preservation. Consequences for non-compliance included being blamed for adverse outcomes and being seen as a rogue whose practice was untrustworthy. Further to this were concerns regarding loss of employment and litigation. This was shared by *Pam*:

> ***Pam***: *The CEO mandated that if we don't escalate, our job is on the line, so that put fear in people.*

Conditions of employment left midwives with a choice to comply for professional protection versus using their midwifery knowledge in defiance. In this way midwifery autonomy was constrained and compliance with policy enforced.

### 8.2.2 | Defiance

Defiance manifested in the attempt to provide care consistent with midwives' stated ideals. The outcome of defiance was visible in midwives entering private practice and homebirth, to draw on tools that better fitted with their model of care. Midwives spoke of using their 'soft' midwifery skills. They felt drawing on their midwifery radar or intuition was enhanced when they were not interrupted by mandated, regimented assessment taking and documentation. *Anastasia* discussed the importance of recording to demonstrate her safe practice, whilst *Millicent* highlighted the 'alarms' were different in the home birth context.

> ***Anastasia***: *We cannot go away from observation charts, and as a home birth midwife, I use an old Partogram. I write on my Partogram the labour progress so that if I'm audited, I can show that I'm safe.*

***Millicent***: *At home it's an alert, not an alarmed scenario. You don't have a boss on the alert for you, because at home it's not an alarm situation.*

Midwives who wanted to maintain woman focused care within hospital settings sought to make conscious decisions about reporting. These participants spoke of being selective to whom they would escalate and where possible would seek out likeminded and respectful professionals for consultation. Defiance was more probable when the midwives could liaise or seek out the assistance of likeminded colleagues.

## 8.3 | Power within practice

Midwives were mixed in their considerations of the value of tools and accompanying processes that directed their practice. The final theme of Power within Practice describes the contestations governing midwifery practice that seek to minimize risk and strive for consistency, to improve quality of care. Sub-themes of accountability and autonomy exercised the elements of power within the context of practice. How these played out in relation to perceptions, behaviours, shifting practice and resources resulted in the operation of governance.

### 8.3.1 | Accountability of care provision

For the majority of participants 'accountability' was achieved through completion of record keeping and escalation. Objective evidence assisted in demonstrating completion of their work, that is, their practice was transparent. Accountability also includes reducing the misuse of resources. Requesting a Met call without consideration of appropriate staffing can inadvertently reduce safety. Removing specialist resources from more appropriate areas whilst failing to respond with the correct team places both the women and other patients at risk. EWT escalation routinely results in a MET call and although midwives felt a sense of relief, it was important that the appropriate team responded. In some instances, the wrong team responded.

***Scarlet***: *We've tried to find our clogs in the EWT and it's that there is not a specific call for the obstetricians. The MET Call brings the whole hospital but no obstetrician. Obstetricians don't automatically get called.*

Participants were concerned that prioritizing the 'safety option', detailed adherence to form filling contributed to the medicalization of birth. This altered the role of midwives to technicians, namely, recording scheduled physiological observations, and escalating deviations to supposed more knowledgeable staff, subsequently diminishing development of midwifery expertise.

***Jane***: *You've got to do things by the book, ticking boxes to make sure that you cover your bum because if something goes wrong it's your fault. It's stopping you from thinking, seeing the bigger picture.*

Though these mandated tools and processes enhanced safety and accountability by helping senior midwives to provide supervision for junior staff and those who were overwhelmed or fatigued. Camille shared that having a *helicopter view* created a *safety net* in the birth suite.

***Camille***: *We have staff in birth suites that you can't see. EWTs helped that, more for the junior midwives but we take that helicopter view with the senior midwives too because fatigue can take over.*

Close adherence to accountability conflicted with independent opinions. When discussing this the midwives expressed frustration, and emotional exhaustion because their passion caring for women was eroded. This led to emotional exhaustion and leaving the profession as expressed by Millicent.

***Millicent***: *I was spending a lot of time being cranky and that was just the system, it wasn't good for my soul. When I left it was frustration at working in a system that wasn't looking out for women.*

### 8.3.2 | Autonomy

The limited ability for midwives to practice to their full scope and provide care as an autonomous professional was evident in the data. Within institutional care, expert knowledge was not facilitated; that is, midwives were not encouraged to explore each woman's separate and often diverse experience. The one size fits all approach diminished the midwives' perceptions of autonomy and also reduced the women's autonomy in woman-centred care.

***Parvin***: *We are dictated to that we must take observations at specific times, that this labour must fit within these timeframes. It's ridiculous, it takes away your autonomy, your ability to make judgments for yourself.*

Not only does Parvin's statement suggest control over how the labour progresses as determined by organizational authority, rather than by physiological indicators, but it also undermines the skill and ability of the midwife and destroys the concept of birthing being a normal phenomenon. The concept of 'normal' was also challenged in the context of autonomous practice. This was recognized by Katha, who identified EWTs can inadvertently impact directly on the woman's well-being and impede critical thinking commensurate with taking independent action akin to autonomous practice:

***Katha***: *What we are doing, at single measurements like blood pressure … … it's not high enough for a MET call, but it's significantly high for her, we don't look at the bigger picture, so what is missed is the woman herself because of that.*

Such individual circumstances can manifest in several ways, such as, parameters being 'outside the normal', though still normal for the woman in labour. This was flagged by Rosemary:

> **Rosemary**: *It doesn't take into consideration the normal rigors of labour, even for a low-risk woman and you could easily get an alert, just because their vital signs may go outside of the pre-determined parameters of normal.*

In relation to individualized care, the participants acknowledged that a mechanism exists within EWTs for altering parameters. However, the participants, disclosed that only doctors were permitted to do so and that, generally, they did not exercise this option. The reluctance to alter EWTs to individual women was seen as a by-product of fear, and potentially reduced autonomous practice.

> ***Soraya***: *Doctors are hesitant to change the parameters. They don't want to change the parameters to suit the woman. I think it's fear …. something going wrong and being blamed.*
>
> ***Katha***: *It is only a consultant, or a senior registrar in consultation with the consultant who can change it but there is reluctance to making them individual to the woman.*

### 8.3.3 | Tensions across accountability and autonomy

These comments by Soraya and Katha demonstrate further complexity to the dual operation of accountability and autonomy. Staff capability and resources also impact power within practice. Organizational responsibility demands sufficient supply of functional resources. Consumption of time and resources to meet service demand was noted as a factor that could justify hastening birth. The finite resources required to meet service demand heightened awareness of associated risks such as staffing and bed vacancy. Participants identified that another limitation of EWTs was its sole focus on physiology and not resources. Midwives identified heavy workloads, but the EWT did not trigger an increase in resources to accommodate this. Emily identified limited utility of the tool in resource planning.

> ***Misako***: *It's all about the mighty dollar, a woman is allowed to occupy this bed for a certain amount of time because more women are coming, and you don't have the bed capacity or staff to look after long labours.*
>
> ***Emily***: *A major limitation would be that it doesn't trigger for staffing. It's just purely physiological, so, if you're getting behind in your workload, people aren't thinking I need to escalate that too.*

## 9 | DISCUSSION

Good midwifery practice delivered in appropriately resourced and supported units is reliant on managers to negotiate the elements of governance, recognizing the many ways information is collected and how it informs care of the labouring woman. This encompasses respecting experience, professional knowledge and the appropriate autonomy that should accompany the level of expertise of the midwife, alongside the diligent collection of physiological parameters of the labouring woman as directed by protocols.

In this study, all participants agreed that mandated assessments are paramount to safe birth. It is the how, when and the why of conducting these assessments, with their critical evaluation, that matters. Herein lies an opportunity for managers to create enabling environments that harness midwifery knowledge. By facilitating equitable collaboration that foregrounds midwifery, shared governance may be achieved. The findings of this study call for balanced approaches to support spontaneous birth whilst remaining alert to risks. The challenge for managers is harnessing the beneficial elements of EWTs whilst addressing deficits to redesign processes that provide flexibility in practice whilst maintaining safety.

Maternity unit managers' responsibility is impacted by financial constraints, rationalization, rapid advancement of technology, growing risk aversion and heightened expectations. Senior management culture significantly influences governance practices that impact organizational attitudes, values and behaviours of the team (Capitulo & Olender, 2019). EWT data are seen as more credible evidence compared to midwifery knowledge because it is presented in terms of medical contextualization (Downey et al., 2017). Managers can address this discord by facilitating equitable collaboration through acknowledging the skills and experiences of midwifery and incorporating these into decision-making. The synergies of knowledge from key stakeholders, regarding birth risk, promotes collaboration based on equality, fostering a more balanced approach.

Good governance is based on a framework of adaptive collaborative processes. Managing workplace relationships and building teams is important. Recognition of leaders at all levels requires an adaptive collaborative process that draws on established relationships together with creating new relationships. For governance to be strengthened, harnessing midwifery and obstetric expertise for mutual collaboration inspires inclusion of midwifery voices. This involves greater diversity in the sharing of knowledge amongst colleagues, including junior staff (DeChant, 2022). To do this, managers need to adopt transparent, inclusive strategies that provide a safe space for all voices to be heard. By providing a safe space for traditionally 'quieter voices', bottom-up contribution to governance, and the resultant policies become both native and oriented to the clinical setting. Subsequently, shared governance inspires staff buy-in, cultivates a no blame learning environment and dynamic partnerships between management, and staff who feel recognized and valued (Manley & Jackson, 2020).

Supporting all midwives to practice to their full scope of practice includes capturing and maintaining a safety net that supports the less

experienced but gives flexibility to those senior and more experienced people. The take home message for managers is to embed EWTs without this limiting scope of practice, critical thinking and avoiding the rigidity of a one size fits all system.

Midwives may be entrenched and fearful of taking ownership of their rightful power to make meaningful contribution to clinical governance. Transformative management must not only understand different perspectives but give credence to other perspectives for inclusion in the co-designing of governance policies. The onus is also on midwives, who must speak up, contribute their voices, knowledge and perspectives to clinical governance.

## 10 | LIMITATIONS

The findings reported herein were collected from Australian midwives working in various roles and models of care across several hospitals. It is accepted that not all maternity contexts, positions in organizational hierarchy, and models of care are represented in this study. Whilst our discussion pertains to governance and consideration to EWTs we did not examine outcomes of safety, rate of intervention or perinatal outcomes; therefore, we are not proposing outcomes from use of EWTs.

## 11 | CONCLUSION

This research is illuminative of governance practices and subsequently, presents considerations for managers. This includes the need to design policies that harmonize interprofessional expertise, emphasize midwifery practice and autonomy and promote individualization of care.

## 12 | IMPLICATION FOR NURSE/MIDWIFE MANAGERS

Managers are well positioned to orchestrate spaces that can be contentious when decision-making calls for different sources of information that do not readily align to suggest a clear, single pathway for best clinical practice. Rather, in complex situations, recommendations derived from expert knowledge, policy mandates, staffing capability and resources require further collaboration of key stakeholders. This paper highlights to midwifery managers that good governance is sustained through a nuanced appreciation and understanding of how multiple factors inform good practice. The findings reported here, ideally, encourage midwifery managers to work with stakeholders to draw on their expert experience, recognize competing elements during the birthing process, facilitate the collection of information from diverse sources, and have confidence in the deliberations of the team necessary to make the decisions for optimal outcomes for the birthing woman.

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## CONFLICT OF INTEREST

No conflict of interest for the authors to declare.

## ETHICS STATEMENT

Ethics approval was received from the relevant institutional Human Research Ethics Committee (HREC) prior to the study commencing. Midwives were provided with an information sheet and consent form prior to participation.

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