

• Women's views about safety in maternity care

A QUALITATIVE STUDY

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Contents

Background	1
Aims and objectives	3
Methods of investigation	4
Research design	4
Sample size and composition	4
The interviews	5
Analytical approach	6
Findings	7
What does safety in maternity care mean to women?	7
The main aspects of safe and unsafe practice as women experience them	11
The management of problems	29
Conclusions	36
Appendix	38
References	40

Background

Patient safety is now a major health policy priority. As a wide range of new medications become available, interventions become more complex, expectations rise and organisations struggle to meet growing demands. The scale of unsafe events is now known to be huge (Leape *et al* 2002). The Chairman of the World Health Organization (WHO) World Alliance for Patient Safety, Sir Liam Donaldson, stated that ‘the risks of health care are far too high compared with other potentially high-risk industries that have much better safety improvement records’ (Donaldson and Philip 2004).

Leaving aside the fact that health care involves inevitable risks, patient safety is often compromised by human error, avoidable injury and adverse events, leading to a culture of blame. But recent debates (for example, Vincent *et al* 1998; Vincent 2003) have stressed that: (i) patient safety must be viewed not as a matter of individual culpability but in relation to ‘deficiencies in system design’ (Donaldson and Philip 2004) or organisational factors; and (ii) it should be conceptualised positively rather than negatively, emphasising ways to promote safety within processes that carry inevitable risks (Affonso and Doran 2002).

Safety issues are implicated at all levels of health care: *systems* (for example, the regulatory guidelines or rules); *organisations* (for example, the culture or work processes, training of staff and communication between sectors); the *immediate environments* of care (for example, condition of equipment, cleanliness); *interactions* and procedures directly involving staff and patients (for example, clinical interventions or communication); and *individuals* – both patients and staff (for example, their knowledge and skills, and capacity for safe practice). However, the concept of patient safety is still ambiguous. Many issues still need to be clarified, such as the relationship between safety and different health care settings, between safety and risk, and between prevention and practical innovations to improve safety. Further research needs to be carried out, particularly focusing on patients’ perspectives, because these have been relatively neglected and what evidence there is suggests that the public and health care professionals have different views about safety (Kuzel *et al* 2004; Vincent and Coulter 2002).

Maternity care is, of course, an area where safety and risk are a crucial concern, and this is emphasised in government policy.

The priority for modern maternity services is to provide a choice of safe, high-quality maternity care for all women and their partners.

(Department of Health 2007)

However, safety in childbirth is a complicated area, and one that is particularly emphasised within the technocratic, bio-medical model of childbirth prevailing in Western societies (Davis-Floyd 2001). The technocratic approach has been argued as ‘constructing birth as a situation of inherent risk requiring expert technical management... which renders women’s subjective experiences of birth as less consequential than issues of safety’ (Zadoroznyj 1999). However, evidence from women and midwives indicates there are other approaches to childbirth that emphasise the importance of the personal relationship and the naturalness of giving birth, and downplay the dominance of technology, science and

professional expertise. How women view the maternity care they receive – and its safety – is therefore likely to vary depending on their views about childbirth, how risky they perceive it to be and the level of control they expect to exert over the event.

Recent survey findings (Redshaw *et al* 2006) show that while most women are happy with their care during labour and delivery, nearly a quarter said they were ‘not treated with respect by one or more members of staff’. (This proportion is higher for women in disadvantaged areas, women from black and minority ethnic groups, and single mothers.) One in six women said that ‘one or more members of staff did not communicate with them effectively’, one in six said their care was ‘rushed’, and one in ten said that cleanliness and hygiene during labour and delivery were not adequate.

A recent survey of support workers in maternity care, while acknowledging their potential to contribute to improving the quality of care, expresses some anxiety about safety issues where unqualified workers are involved (Sandall *et al* 2007). There have also been a number of recent high-profile enquiries into maternal deaths and other adverse outcomes, which have carefully described and analysed the key causes of unsafe practice (Smith and Dixon 2007). The King’s Fund Inquiry into the Safety of Maternity Services in England is examining whether the recommendations of these enquiries have been implemented and what more can be done to tackle ongoing problems.

There is a need to complement existing studies with more detailed research into women’s views about safety. Official enquiries into maternal deaths have their own particular focus. Survey data provide a useful basis for further work, but do not cover safety issues in detail. More research is needed to shed light on women’s views about safety as a whole, how different aspects of safety are connected in the process of receiving health care, how women prioritise these aspects of care, and how cognitive and emotional responses to safe or unsafe situations are linked (for example, how a woman’s observation of something she defined as unsafe practice made her feel). Safety in health care is not just a matter for clinicians and managers; it must also involve patients – not just because they are the ones who suffer when things go wrong, but also because their behaviour is part of the process of unsafe practice and they are therefore part of the solution.

Aims and objectives

The aim of our study was to obtain the views of women with recent birth experiences about the safety of the maternity care they received, to inform the King's Fund inquiry into the safety of maternity services in England.

The key objectives of the study were:

- to provide an opportunity for women to identify their own areas of concern around safety, and possible solutions to these
- to explore in more detail the extent to which women are aware of and have concerns about factors related to safety (such as communication and quality of working relationships between staff).

These are the main questions we posed:

- What does safe and unsafe maternity care mean to women with recent birth experience?
- What is women's understanding of risk in childbirth? How do women link this to their understanding of safety?
- Which of the major known contributory factors to safety did women have concerns about with regard to their recent birth experience?
- What was the nature of any concern, and how do women perceive, describe and interpret it? How do/did they feel about it?
- Do they have any solutions?
- In their account of the birth experience, how (if at all) do they link one concern about safety with another?
- Which aspects of care do they see as most and least important?
- Compared with any previous birth experiences, do they have views about whether the most recent experience of maternity care was safer or less safe?

Methods of investigation

Research design

We used one-to-one in-depth interviews as the most appropriate method of data collection to achieve our objectives. Allowing women to speak in their own words, give as much detail as they wish, and give their own perceptions and interpretations of their experience, yields data that can be subjected to qualitative analysis.

Sample size and composition

A sample of 30 women was judged sufficient to cover a wide range of viewpoints and the types of birth experience and outcome. (The actual number of women interviewed was 31.) Our intention was to obtain a very varied sample rather than one that was entirely representative of women having a baby in England today, but one that excluded the most unusual circumstances or characteristics that would fail to be of general relevance.

In particular, we wanted to ensure that we sampled some women from minority ethnic groups, recent immigrants, young mothers and those from disadvantaged social backgrounds. The Appendix (see page 40) shows that we achieved this goal: the sample ranged from very young mothers (the youngest being 17) to women over 35 (the oldest being 40); and while most were white, we included several black and Asian women, with nearly half of the sample having been born abroad. Household income ranged from less than £15,000 through to five women whose household income was more than £60,000. Some women had higher degrees, some had no qualifications; some were working, many were not (including some asylum seekers who had no right to employment in this country). Most women were living with a husband or partner but several were not. For about a third of the sample this was their first pregnancy but others already had one or more children. Only one woman (3 per cent of the sample) gave birth at home. This reflects the national picture, with 97 per cent of respondents to the national survey of women's experience of maternity care (Redshaw *et al* 2006) giving birth in a hospital or birth centre.

Most of the women and their babies were now in good health, but several had experienced quite complicated births, including emergency caesareans, induced births, and forceps and ventouse deliveries. In this respect our sample differed somewhat from the average maternity population. For example, only nine interviewees (29 per cent of the sample) experienced a non-instrumental vaginal birth, compared with 64.6 per cent of women in the national survey; and 38.7 per cent of our sample gave birth by caesarean section compared with 23 per cent of respondents to the national survey. Of our sample, 16 per cent had babies who were admitted to a neonatal unit, compared with 10 per cent of respondents to the national survey. It is difficult to explain these differences. We did not specify complicated birth experiences in our recruitment process. However, in endeavouring to recruit women from a range of backgrounds, the final sample was perhaps rather skewed towards more vulnerable groups who may have been more likely to experience complications.

We recruited the sample through local voluntary or community groups (see Table 1 below for details). Each woman was offered a thank-you gift of £30. We limited the sample to women who had given birth in the last three months because they would be more likely to recall the rich detail of their experience, and because they were likely to be more interested

in recounting it than if it were in the more distant past (the most recent baby will also be young enough to be less of a distraction).

TABLE 1: DETAILS OF INTERVIEWS CONDUCTED

Location of interviews	Number of interviews	Recruited via
Reading	5	SureStart
Manchester	3	SureStart
Malvern Hills	5	National Childbirth Trust
Cheshire	5	National Childbirth Trust
London	3	YMCA Hostel
London	3	Homeless families charity
London	1	Personal contact
Leicester	4	Refugee Action
Sheffield	1	Refugee Action
Oxford	1	Peers Early Education Partnership
Total	31	

The interviews

We designed a topic guide that we piloted with two women at the start of the fieldwork period. These two interviews were included within the eventual sample, because it was not necessary to make significant changes to the guide as a result of the pilots.

Most interviews took place in people’s homes, although a few women were interviewed in centres run by the recruiting voluntary organisation. We used a short self-completion questionnaire to obtain respondents’ basic characteristics and their circumstances at the start of the interview.

The interviews focused on safety issues, rather than, for example, the courtesy of staff, the woman’s involvement in decisions or her general feelings about the birth experience. The interviews involved probing and prompting where necessary, and allowed the women time to raise and discuss any matters they saw as relevant to safety in maternity care. The average length of interviews was 45 minutes, but the range was from 20–60 minutes.

The topic guide covered the following:

- the meaning of ‘safety’ (including comparison with ‘quality’ and ‘risk’)
- account of recent birth experience (including management of any clinical complexities, for example, diabetes)
- perceptions of and feelings about safety and non-safety in recent pre-labour, labour

- and delivery, including examples of unsafe practice and views about these
- detailed accounts of any specific aspects of safety relevant to participants' recent experience:
 - communication between staff
 - working relationships between staff (for example, handovers, division of labour)
 - communication between staff and patients (quality and quantity)
 - supervision of staff/students
 - perceived knowledge/skill of staff (for example, in using equipment, carrying out procedures)
 - staff availability/staff shortages/attentiveness to patients
 - physical environment, including equipment (for example, cleanliness, availability, whether in working order)
 - specialist services if necessary (for example, availability, speed of access)
 - anything else women see as important to safety
 - accounts of why problems occurred, whether they could have been prevented, and what women think should or could have been done to solve the problems
 - how the recent birth experience compares on safety with any previous birth(s).

Analytical approach

We recorded all interviews and transcribed them fully. The aim of the analysis was to generate themes and broader categories and to identify relationships between them, or between them and participants' characteristics. The process followed the usual stages for qualitative analysis using a thematic approach: familiarisation with the data through reading transcripts and listening to the recordings; indexing of data using NVivo software; identification and development of broader categories; comparison between participants and exploration of relationships between categories; and refinement of key descriptive findings (plus some explanatory hypotheses where possible).

Findings

What does safety in maternity care mean to women?

THE ELEMENTS OF SAFE CARE

Safety can be defined as the reduction of harm and the management of risk. Within a health context it can encompass a number of interrelated elements at both organisational and individual levels. Coulter and Ellins list the factors that can influence clinical practice, including: the safety culture of the organisation, the work environment, staffing levels, skill-mix, team working, availability and use of protocols, and communication (Coulter and Ellins 2006). In discussing the meaning of safety on a more general level, the women interviewed for this research directly and indirectly alluded to several of these factors, but the consistent theme was the importance they placed on the skills and professionalism of the individuals caring for them.

I think having midwives there... and knowing that they're around and trusting that they're doing what they should be doing basically.

(27-year-old English woman)

Given that childbirth is a very personal experience, it is perhaps not surprising that the quality of care provided by individual staff was seen as central to safe care. But a number of other factors were also mentioned, including cleanliness, being well informed about what to expect, regular monitoring, appropriate equipment, security on the labour ward, shared decision-making and the prevention of accidents.

Well, safety is mainly for me avoiding any accidents... so actually preparing everything so that you can prevent the worst from happening.

(31-year-old German woman)

Several women referred to the importance of early identification of problems and the emergency systems to deal with them, but only one woman referred to the importance of safety protocols in a more general sense.

Well, I suppose that should something go wrong, there's the correct procedures in place and people, that you're being monitored correctly, that there's professionals there to help you should something go wrong.

(38-year-old South African woman)

I think it probably means having enough staff and feeling that you get the attention that you require and that things are done according to what type of protocols are laid out.

(33-year-old English woman)

Interviewees' perceptions of unsafe care included a lack of staff, poor monitoring and inadequate or conflicting information. But some women also referred to being left alone, not knowing who was caring for them, having to rely on maternity care assistants and not receiving the full attention of their midwives.

Walking into somewhere that was disorganised or... where people ignored you. Pressing a button and nobody coming for quite some time, it being open to anyone walking through, again, and not knowing the people at all and just being left, having no one around at all.

(29-year-old English woman)

UNDERSTANDING OF RISK

Some women were undoubtedly more aware of the potential risks of childbirth than others. This tended to depend on previous experiences, stories they had picked up by word of mouth, complications foreseen during their pregnancy and their own propensity to search for information.

I wouldn't call it safe and natural. I've had two different experiences. My first baby was delivered by caesarean, I had quite a bad birth with her.

(24-year-old English woman)

Because I had low iron... and she said if I didn't take my tablet I could bleed to death.

(18-year-old Portuguese woman)

For most women, having their baby in a hospital reduced the risks and made both them and their partners feel secure in the knowledge that there would be staff and facilities on hand to deal with any emergency.

And then talking with my partner and we were like, no, it's not good, and he felt much safer being in the hospital rather than being at home. Because he knew there was plenty of staff and there was, you know, if you had to go in for a caesarean or if the baby, if something went wrong with the baby, then everything's much quicker really and there's more equipment and everything.

(26-year-old French woman)

However, one new mother felt she would have been safer at home and another woman, although not unduly concerned herself, recognised that the local hospital could itself be a risk factor.

I think that one of the other things that made me want a home birth was my views on, well, maybe unfounded, I don't know, but sort of cleanliness in hospitals and aftercare as well because obviously I know that that's, you know, it plays a big part in patient safety.

(27-year-old English woman)

I think it's very much on your mind, well, what's this hospital like and, you know, you definitely hear bad stories about people who've been to that hospital and 'Oh, I'd never have a baby at [hospital]'. I mean, you hear things like that.

(33-year-old English woman)

A relatively high proportion of the women who participated in this research experienced some form of intervention in the birth of their child. Two women drew attention to the fact that these interventions could in themselves lead to greater risks to the mother and child,

while another thought that in some cases doctors and midwives may err on the side of caution and intervene unnecessarily.

I know that at various points things can escalate. I mean, certainly in the NCT [National Childbirth Trust] classes we were always told, you know, that once you start down a certain route, you know, very often things will go from some sort of, I can't remember the word now, but bringing on the labour and it sort of escalates on through and it sort of ends up at caesarean.

(39-year-old English woman)

That's why people have more caesareans because they, you know, somebody panics that the baby's at risk, and they don't really know if the baby's at risk or not half the time.

(33-year-old English woman)

FEELING SAFE AND BEING SAFE

In discussions about how they actually felt during their recent experience of childbirth, safety did not appear to be a major preoccupation of the women we interviewed. Indeed, pain and the fear of pain concerned several women far more. This could be because many women, like most NHS patients, assume a basic level of safe care. One woman pointed out that for her peace of mind she had to have faith in the organisation and individuals responsible for her care.

I think that place is safe, a lot of doctor, midwife, and lots of baby born every day, and my husband was there, and I haven't got any option that safe or not, I feel I have to be safe.

(29-year-old Indian woman)

This feeling of safety was almost invariably based upon women's trust in the health professionals – in most cases midwives – caring for them. Individualised attention from supportive, caring and experienced midwives mattered more than anything else.

And the safety thing, I don't know if that bothers me as much as being, you being an individual to them, because once you become an individual, a person to them, then they're naturally going to make you feel safe, aren't they? They're naturally going to make you feel that they're doing everything within their power to make, to be concerned for you, to consider you in everything that they're doing.

(32-year-old English woman)

Interviewees also referred to the importance of having things explained adequately, the presence of a partner, good communication between staff, being regularly monitored, security measures on the labour ward, and the fact that when things did go wrong, there was an immediate response. When women felt unsafe it was often because they did not know what to expect.

Yes, I was really scared because I didn't know what was going to happen... I felt like I was going to die, I was almost certain that I'd never like actually make it, I just thought it was never ever going to end, so I suppose in a way I didn't feel safe.

(24-year-old English woman)

I was totally unprepared and I think that made me a bit panicky.

(38-year-old South African woman)

A few women referred to things happening around them on the labour ward that may not have directly impacted on their own safety, but nevertheless affected their confidence in the staff caring for them.

There was something unprofessional, and there was somebody else, because you can hear everybody else's problems... that you could hear that this particular person had an injection which was the, the injection was run out of date, you know... the patient saw... and they gave her the wrong nametag as well, another patient... which made me feel unsafe.

(31-year-old German woman)

On the other hand, when things around them seemed to go well, it boosted their confidence.

It's not just giving birth, the problems that people have when they go into hospitals, when they have the problems with their families, legal problems such as, you know, they don't want the father to be in because there are injunctions and that kind of thing... And the way that they dealt with those issues as well was, they really knew what they were doing.

(29-year-old English woman)

Two women – one born in Germany, the other in France – preferred the less medicalised approach to childbirth in England.

And I feel safer when it's like this rather than when it's full-on technological and medical thing run. Because then you think in the back of your mind that something can actually go wrong, but if you go the other way where everything's sort of just natural and that's what life is all about basically, then you're like, well, it's what we're supposed to be doing so it can't be any problem.

(26-year-old French woman)

Women generally felt that their care was safe. Having a positive outcome and a healthy baby would probably have coloured this perception, whatever the difficulties they might have experienced during labour.

Well, I pulled through OK, so yes, I'd say I was safe.

(24-year-old English woman)

In terms of the safety I'd say, you know, the baby's born, you know, healthy, and you're OK, and so in that respect that they know what they're doing.

(34-year-old English woman)

HIGH-QUALITY CARE

Those women who did distinguish between safe and high-quality care felt that safe care was the basic standard they should expect, but that high-quality care meant something over and above this.

I think probably I would expect safe care automatically. You've got to have safe care to be able to give birth in a satisfactory environment, but high-quality care, I feel as though that's extra on top of the safe care.

(39-year-old English woman)

High-quality care, I'm sure that would mean you're getting safe care and the best they can provide you with.

(24-year-old English woman)

The extra factors that were believed to constitute high-quality care included one-to-one care, more birthing pools, feeling respected, a proactive rather than reactive approach, the ability to choose the position in which to give birth, music, and an excellent meal to follow the birth. For one interviewee, this kind of extra attention was more likely to be available to those who could afford private care.

That's the sort of thing that maybe you kind of have to pay for really if you went privately, and being in a nicer environment, a nice room, you know, your own room rather than a ward. That sort of thing I think is all part of, sort of, better quality, a better-quality experience, but doesn't necessarily mean you're safer.

(33-year-old English woman)

A German woman thought that high-quality care was more readily available in Germany than in England.

Like, if I compare with Germany and what I experience in England, it's probably, I felt very safe, but I think in Germany, I think it's more high quality because everything is like, because it's very much a reputation thing... for the hospital.

(31-year-old German woman)

The main aspects of safe and unsafe practice as women experience them

STAFFING LEVELS

Good staffing levels are generally recognised as being an essential part of safe health care and in recent years much concern has been expressed about staff shortages in maternity care (Smith and Dixon 2007). The women interviewed for this study said this was the safety factor that mattered more than anything else. When they felt there were not enough staff available, they certainly tended to feel more anxious, if not exactly unsafe.

Women's experiences varied depending on how busy the hospital was on admission – not all those we interviewed felt that staffing levels were too low. Three young women who all had non-assisted vaginal deliveries at different times in the same London hospital had very different experiences.

Respondent: *No, it was the same midwife throughout.*

Interviewer: *And she didn't have anyone to assist her?*

Respondent: *No, no one.*

(24-year-old English woman)

Well, there were two midwives there and my mum.

(17-year-old English woman)

Well, there was three midwives, one of them was a student.

(18-year-old Portuguese woman)

Certainly there always seemed to have been an abundance of staff when responding to an emergency.

I was a bit disappointed about that I had the elective caesarean, but when... it happened I was already prepared because I said, OK, that's the way it is. And I was... very surprised how nice it was, because it was very, lots of staff... because my husband, he counted, there was 10 people.

(31-year-old German woman)

However, several interviewees felt staffing levels were inadequate.

But there was only one midwife on duty upstairs because they were very overstretched the day that I was at the delivery suite. They usually have 12 or 13 births and they had 28 that day, so it was an unusual day.

(38-year-old South African woman)

A shortage of staff meant that women were also being discharged quickly from one hospital.

But I think they were so... well, I actually heard one of them say, 'We've got to start sort of getting rid of people', kind of thing, because they had so many... well, they had plenty of beds but there just wasn't any staff.

(34-year-old English woman)

One woman was somewhat anxious about giving birth after hearing that the maternity unit at this same hospital had sometimes been closed because it became too busy. Another referred to the closure of the local birthing centre, which had put additional stress on the hospital. This shortage of staff in some hospitals contrasted with the one woman who had opted for a home birth. She had the full attention of two midwives throughout her labour.

Staffing shortages seem to have been most noticeable on the postnatal wards, where care was generally perceived to be less satisfactory. In some cases this dissatisfaction might be attributable to a sense of anti-climax following the birth and the fact that the women were no longer the centre of the midwives' attention. However, there were also a few occasions when safety might have become an issue.

Because the staff was really nice, but totally understaffed. So when they, if you have a caesarean you can't move the first hours, and there was no one who would give the baby to me... but I think what makes you a bit insecure is if you feel like it's understaffed, I think it's an issue. Because... if there's not enough people who look after you, even though if they are well trained and everything, but you still don't have the care you need. For example, there was one woman... she was screaming and

crying and really, she must have been in pain. And it affected all of us because we had to listen to that, she screamed and cried for an hour.

(31-year-old German woman)

CONFIDENCE IN STAFF

It follows from their definitions of safe care that for almost all of the women interviewed, feeling safe was related to confidence in the maternity staff (usually the midwives) looking after them.

If you're confident in the people that are dealing with you, you naturally feel safe.

(32-year-old English woman)

I think trusting in the professionals that they know what they're doing really is the main thing that made me feel safe.

(38-year-old South African woman)

Good communication and a general air of professionalism contributed greatly to this sense of confidence, but the best, and therefore safest, care was provided by those midwives who were also supportive and reassuring.

I just felt confident in them because they had the air that they knew exactly what they were doing, getting everything ready and I was in safe hands.

(35-year-old English woman)

Yes, they made me feel safe, they, you know, they reassured me and, yes, I didn't feel a threat at all.

(33-year-old English woman)

However, not everyone felt such confidence in all the health professionals involved in their care. One woman contrasted the skill of the doctors with that of the midwives and found the latter somewhat lacking.

In the surgery because I could see that they, I don't know, I felt safe in the surgery because I could see that... I think the higher staff really was good, but the nurses and some midwives are not always, the doctors I felt always safe with.

(31-year-old German woman)

One woman continued to feel safe, despite an understandable lack of confidence in her anaesthetist following a series of unsuccessful attempts to administer an effective epidural. Once again, it was the presence of a reassuring and professional midwife that seemed to make the difference.

I mean, obviously, I had got concerns about the anaesthetist... But the fact that the midwife was in there sort of keeping an eye on things as well, I did feel quite safe with her around because she was very calm.

(32-year-old English woman)

Opinions about maternity care assistants and students were more mixed, with some women having better experiences than others.

To me it appeared that the health care assistants just weren't properly trained, that they didn't know what they were doing, that's why you're given all the conflicting information, in my opinion.

(38-year-old South African woman)

They had the assistants who just seemed to be very well trained, they were, you never got the sense that they didn't know what they were doing, they were all very calmly efficient.

(29-year-old English woman)

The parents of newly born twins were quite clear that they did not want students being responsible for any aspect of their birth. Another had little confidence in the student midwife involved in her care.

Well, there was three midwives, one of them was a student... She was really nice, but she didn't actually know what she was doing. She kept asking the other midwife, 'Should I do this now?'. And then I was going to the midwives, 'She doesn't know what she's doing, she's going to kill me, she's going to kill my baby'.

(18-year-old Portuguese woman)

In contrast, there were a few occasions when students played a very positive role. Interestingly, the extent of a student midwife's training could sometimes sway a woman's opinion, irrespective of the evidence of her own experience, while a student's manner could also compensate for lack of training.

When the student... was touching her, told her she was five centimetres dilated, she was now trying to... break the waters for the baby to come out. So she tried and tried and she was in so much pain, that's when the fully qualified midwife came in. So when she tried to see what is going wrong, then she came to realise actually she wasn't five centimetres dilated, she was two centimetres dilated... She says she doesn't mind if a trainee student is used to help the mother to be, but what would have been good is for a nurse to be next to her... And then she said... the nurse... asked the student, 'Have you done any deliveries?'. And she said, 'Yes, I have done 26'. So she says when she heard that she felt confident and she was sure everything was going to be all right.

(27-year-old woman from Ivory Coast via an interpreter)

I thought she was really nice but I think she was either very newly qualified or perhaps not quite... There was a point when I was saying, well, 'She said this about the drugs', and they were like, 'Yes but, you know, [student] is junior and she doesn't know...'. Whereas from my point of view I trusted her more than the other ones because of the way that she treated me.

(33-year-old English woman)

BEING LEFT ALONE

Our interviewees highlighted the importance of regular monitoring during labour, yet several reported being left alone with their partner or a relative for varying periods of time. In most cases this did not cause a problem as they felt secure in the knowledge that, had they needed attention, it would have been forthcoming very quickly. One young woman even asked the midwives to leave her alone from time to time during labour so that she could get some rest.

There was a call bell if I should have needed any assistance. As I previously said, my husband was with me all the time so if there had been a sudden emergency it would have been easy to have got somebody, so there was no problem. It was only for short periods of time.

(39-year-old English woman)

Four women described becoming anxious when they were left alone during labour. One of these felt she had been abandoned for long stretches of time – both before and after a caesarean section. Indeed, several others felt they were more or less abandoned once the baby had been born and they were moved to the postnatal ward. This often appeared to be due to a shortage of staff.

She, first of all when she came in she said she was going to be looking after us, but then she, we didn't see her the rest of the time... We were in the hospital at 11.00pm, the first examination was at 1.30am, no one came back until 5.30am.

(34-year-old English woman)

And then you go on to a sort of, I don't know what they call the particular rooms but you go on to sort of the recovery ward or whatever it is... And the midwife I had in there was very good to start with but then at one point she just disappeared, and my partner had left because it was quite late at night, I told him to go, and she just left me and I didn't have the buzzer or anything else, you know, so I just sort of, I felt a bit panicky about that because I couldn't get to someone and the baby was the other side of the room. So I felt, well, I can't actually get to her any other way, I had to get someone, I was actually calling, just shouting out of the room, and she didn't come back for a very long time, but I mean I assume they were very, very busy.

(34-year-old English woman)

TEAM WORKING

Research has identified a lack of good team working as contributing to poor obstetric outcomes, but the participants in this research seldom appreciated its importance in terms of safety. Only one interviewee regarded excellent communication between staff as the most important safety factor in her care. This might be because women were not always aware that they were being cared for by teams. Individual midwives may have been responsible for different stages of labour, doctors and anaesthetists may only have appeared infrequently and paediatricians were not generally seen as part of the maternity team at all.

When questioned about the elements of successful team working, there were few examples of poor practice. Staff generally seem to have appreciated the importance of introducing themselves to women and their partners, particularly on shift changeovers, and most

women seemed very happy with the handover of information between the staff responsible for their care.

I felt that when midwives went off shift they obviously handed over very well because other midwives would come on and they would know where I was up to in my care plan and everything, not only during the labour but also afterwards.

(39-year-old English woman)

Only one woman expressed concern about a confusion over her chart.

I landed up having two different charts at one stage, which confused the midwives that were swapping over, and I actually had to ask them about what was happening about my different drug care stuff. Because one was saying, 'Oh no, you're not having this', and the other one saying, 'When did you last have it?' and looking at the wrong chart. And in the end, then one midwife came and sorted it all out.

(38-year-old South African woman)

Tensions were occasionally reported between doctors and midwives, and midwives and maternity care assistants who, it was thought, may have felt put upon. In two cases, disagreements between different members of the maternity team had led to confusion and uncertainty for the women and their partners.

The next day when the midwife come and I say I have too much pain in my stomach, and then go back to the hospital. She phoned... 'When did you discharge her? It's only a few hours, she's supposed to stay...'. That midwife, she was really angry, she said, 'This patient, she is not well... she's supposed to be admitted... because she's got infection'.

(27-year-old Somali woman via an interpreter)

The doctor actually had a disagreement with the midwife in front of us, which left us a bit confused about what exactly was the situation... The midwife was saying... that the baby wasn't in a good position, basically that the baby was side on. When the doctor examined me the first time he had actually moved and he'd moved down, and she said, it, you know, it wasn't possible that he'd moved from that position all the way to being in the pelvis, and she was, they were sort of just disagreeing about it.

(34-year-old English woman)

One interviewee noted that midwives often appeared to act as the woman's advocate, protecting them against the decisions of the doctors.

If you wanted something and the doctor was against it, the midwives would stick up for you.

(29-year-old English woman)

In general, women found the atmosphere in the delivery suite to be calm and controlled. The attitude and demeanour of the health professionals were obviously key to this sense of calm, but women also referred to music, low lights and, in one case, a massage to relieve back pain.

It was very calm, very calm, you know, it was really pleasant and calm. And I think actually the, I remember now, the midwife actually went and got some aromatherapy oils and actually gave me a massage on my back.

(25-year-old Irish woman)

Only one or two interviewees had different experiences.

It was rushed, very rushed. I actually felt quite stressed out, it actually felt like everybody was rushing around.

(38-year-old South African woman)

INFORMATION AND COMMUNICATION

Good communication with mother and birth partner often seemed to go hand in hand with confidence in health care staff – the better the communication with the doctors and midwives, the more our interviewees trusted them. Being talked through the birth process in a way that they could understand was viewed as hugely reassuring. Even when the women themselves were slightly ‘out of it’ on gas and air or other forms of pain relief, it was important to them that their partner was receiving regular updates on progress and was told what to expect.

Interviewer: *Did the staff make you feel confident and safe?*

Respondent: *Yes, very much so... because they were constantly communicating with us, letting us know what was happening and what stage we should be at and why that wasn't happening, and what they were planning on doing next.*

(35-year-old English woman)

There were several examples of poor communication. Some women were very unhappy with the lack of information provided by their midwives during labour, and one woman felt that her partner had not been sufficiently involved.

The fathers really aren't considered, they're not, they're really not addressed, they're really not considered at all.

(33-year-old English woman)

One woman contrasted the lack of information before her caesarean section with the amount of information she was given during the actual operation.

That's another thing that I find really weird, you're kind of, you're left in the dark for such a long time but when, you know, obviously when they're doing the operation then, they talk you through every minute little thing, which is fantastic. But up until that point I hadn't had a clue what was going on half the time.

(34-year-old English woman)

Postnatal information was also sometimes inadequate. One interviewee felt she was not properly informed about the implications of a second-degree tear, while another felt she had not been properly informed about a drain following a caesarean section.

It was only me actually asking sort of how many stitches, and at that point it became very vague, 'Oh, you've got a second-degree tear...'. But no kind of explanation as to what that was. But I knew because, again, I had the internet and the books and I kind of knew that the first degree was the minor, the second degree was kind of, it's the muscles as well, but the third and fourth degree is when you sort of, it's the back passage again. And I was just, just terrified.

(35-year-old English woman)

Then the next day, I guess they took the catheter and stuff out and I'd got like a drain in which was pretty horrible... I was told on the Saturday night, 'Oh no, the drain's got to be below the bed otherwise it won't drain'. Nobody had told me that so, you know, I'd had it kind of just lying on the bed.

(33-year-old English woman)

Two women commented on occasions when they were excluded from discussions about the progress of their labour. Others received contradictory information, though this was usually on the postnatal ward and invariably concerned care of the baby.

He had a little eye infection, all gummy stuff coming out of his eye, so I asked what the best thing to do was. One lady said, 'Oh, just rinse it out with water'. So I said, 'Well, shouldn't it be sterile water or something?'. And she said, 'Oh, nowadays we just use tap water'. So I thought that was weird because I'd read about when you bath them even, when you top and tail them you're supposed to use boiled water. So I got a second opinion. The second opinion lady, which was also one of the health care assistants, said, 'Oh no, no, it has to be sterile water'.

(38-year-old South African woman)

BIRTH PLANS AND SHARED DECISION-MAKING

Many of the women had drawn up birth plans in advance and for some, being able to determine the shape and progress of the birth was another part of feeling safe. A few had toured the labour ward beforehand, which meant they felt familiar with the environment when they went into hospital. This also contributed to a sense of being in control.

I felt that I fully had control of the situation myself with the TENS machine and also breathing exercises which I managed very well. But again, that was very much supported by the midwives. And I felt at [hospital] they were very willing to let you sort of get on with the birth in whichever way you wanted to. I thought that was excellent from my point of view.

(39-year-old English woman)

The fact that I'd just had a tour beforehand and I knew, you know, what I was going to, so it was familiar to a certain extent.

(32-year-old English woman)

Conversely, another woman spoke about the apprehension she felt because she had not had a tour in advance.

Yes, I hadn't had a tour, and even though I was in for the week, I didn't actually have a look at the delivery suite... And that was the one thing that I was actually really apprehensive about, that was going into the unknown through the double doors at the side.

(29-year-old English woman)

However, some women did not feel it was worth formulating a birth plan, believing that things seldom work out the way they are envisaged. Several talked of 'going with the flow'.

I didn't really bother with a birth plan because I thought it's never going to happen as you expect anyway, because I was speaking to a lot of women and they all said, you know, it never goes the way you expect because obviously you always hope for a natural birth.

(31-year-old German woman)

A few women went further and felt that birth plans were essentially pointless because no one looked at them and that women seldom had any real choices.

I mean in my opinion the reason they get you to do a birth plan is to distract you or something, because nobody looks at it... How I felt is that you had choices but you don't in real life, so I think perhaps it would be better to warn people that yes, we're giving you these choices but actually on the day it could very likely go that you don't have these choices, so prepare yourself for every eventuality.

(38-year-old South African woman)

It is certainly true that, in this research sample, very few women were able to follow their birth plan completely. Being under the influence of strong painkillers also reduces the extent to which women feel in control of the situation. One woman felt that her decision not to have an epidural meant she was able to maintain better control of what was happening to her.

So, because I had no pain relief and with no gas and air I was very much, I think I was very much in control and just in a lot, a lot of pain, so I was able to make decisions.

(35-year-old English woman)

Many women recognised the value of shared decision-making. But there were several instances when, as problems escalated, they accepted that it was better to leave the decisions to the health professionals, even though as this comment illustrates, there may have been a lingering question over the extent to which they could have challenged the doctors.

The way it went with the induction is I felt that... it was right for the professionals to make the decisions on my behalf really and sort of inform me. In theory I could have asked not to be induced... But then I felt like it wouldn't have been appropriate because it would compromise the safety of the baby. So the decisions I could make, I think I was able to make. I was asked if I wanted the epidural, I could have said no, but as it was I said yes. They were sort of like giving me information, but I couldn't have really said no, I don't want the caesarean, because it would have put the baby at risk.

I mean, I'm not sure what would have happened if I'd tried to refuse these things at any point.

(34-year-old English woman)

But the safety of their child was so paramount that the women were usually prepared to accept whatever they were told. This was particularly the case for younger women and those who did not speak good English.

I was just thinking about saving my daughter and saving my own life, so whatever they were saying to me to do I was just signing, so that was the most important thing.

(27-year-old woman from Ivory Coast)

The difficulty of maintaining a share in decision-making during childbirth is illustrated by one woman who was very assertive when she first went into labour but, as things changed and became more difficult, she was prepared to hand over complete control to the professionals.

But I wasn't going to go home. And I think when you're in labour, I think you either go very meek or you get very assertive.

(35-year-old English woman)

'I don't care how you get this baby out, I don't care, just do it, it needs to happen'. So, but there wasn't ever any choice, but at that point I didn't actually... I just wanted her out and safe and however they did it, they did it.

(35-year-old English woman)

One woman expressed frustration that her midwives did not always respect her point of view, while another thought that feeling so out of control of the situation might have added to the distress of her child.

There are times when you kind of, you kind of want to say to them look, you know, I'm not stupid, you know, you can just, you know, or I'm not making this decision because I'm ill-informed, I'm not saying what I want in an ill-informed way.

(33-year-old English woman)

Because I'm sure that if you are more prepared and the whole experience is less stressful and you're not, I don't know, I felt totally out of control, but if you had felt a bit more control perhaps you, you know, it wouldn't get to the stage where... the baby's in distress.

(38-year-old South African woman)

VULNERABLE GROUPS

We interviewed five women who were living in hostel accommodation or housing provided with the help of a charity for homeless families. Three of these women were also teenagers. We also interviewed nine black and Asian women, several of whom were asylum seekers. Such women are often identified as vulnerable in terms of maternity care and research has suggested that they are sometimes subject to prejudice from health professionals who judge them in a negative way (Murray and Bacchus 2005). Certainly one of these interviewees

expressed a real lack of confidence in the midwives who cared for her on the labour ward, the delivery suite and on the postnatal ward. She found them to be rude, impatient and 'snappy'. Although this may not have led her to think that her care was actually unsafe, it certainly made her feel more frightened, particularly as her previous birth experience had resulted in a caesarean and she did not feel that she was offered enough support to keep pushing.

I think because she was a bit snappy she, you know, she asked me, 'How old are you?'. Like as if to say, how old are you, you know, 'act your age', 'you don't have to behave like this'. And I was thinking, god, I'm in the middle of a labour, I'm in a lot of pain, you know. 'You're not five'. I think she said. I said, 'Well you know, if I was five I don't think I'd be sitting in this bed trying to push a baby out of me'.

(24-year-old English woman)

Another interviewee also felt that her midwife could have been more supportive. Given the importance that all women placed on the bond they formed with their midwives, this undoubtedly made her feel less safe.

I don't know, I think maybe she didn't like us... You know, during the labour it's like a very hard time, so the patient wants to be encouraged, they want to be given a good explanation and like, you know what I mean, talking to you or something like that, yes. But that, the first one she didn't do that, so that's no good.

(27-year-old Somalian woman via an interpreter)

Cultural factors may affect women's attitude to childbirth pain (Callister *et al* 2003). Certainly, the apparent dismissal of a woman's early labour pains seemed particularly difficult for women from another culture and country to understand.

She said that for her in terms of safety, when a woman rings up saying that she's complaining about any pain, it will be good to meet the lady and to see her, instead of saying to her just wait or trying to assess the situation from a distance. She said in her case she was alone and she didn't really know what was going on. She had her first pain around 5.00am, she rang at 8.00am, they told her to wait. She rang again at 12, she was told to wait again, and she rang again around 3.00pm. It's at that time they said, OK, come, come over to the hospital.

(27-year-old woman from Ivory Coast via an interpreter)

You know, I had a labour pain for last three days and I don't understand why they don't take me to the labour ward. Three days is long time to be bearing this sort of pain. And I think they have got some thing, problem, or they think this is not labour pain, that's why they don't take me up labour ward.

(29-year-old Indian woman)

However, most of the women in this sub-group spoke very positively about the midwives caring for them. One woman, alone in this country, felt greatly reassured by the way the midwives encouraged her to open up about her worries and fears about a particular medical problem that might affect the birth. (The interviewee chose not to elaborate on the nature of this problem.)

They make me feel confident and more open to things that I was keeping inside, these things that I was so scared about. They make me feel like if I can open up and talk to them.

(31-year-old Zimbabwean woman)

Staff at one hospital acknowledged the vulnerability of a teenage interviewee and were reluctant to discharge her too quickly after the birth.

They wanted to keep me in longer because I live by myself here and because I'm only 17; they didn't want to discharge me yet. But I didn't want to stay there, so they said they'd only discharge me if I go to my mum's house.

(17-year-old English woman)

Another young woman trusted absolutely in the midwives caring for her.

Yes, I felt safe because I knew that they would help me, if there was anything they would help me, so I had nothing to worry about.

(17-year-old woman from Sierra Leone)

However, she did feel excluded from discussions about her care at times, which may have been due to clinicians' assumptions about her ability to understand what was happening.

They were a bit talking like secrets, so I couldn't hear them, what they were saying and stuff... Like a secret, talking to each other and... But I couldn't really hear what they were saying and stuff like that because they were speaking like big things like, like not my type of, like talking hospital things, I couldn't really understand what they were saying.

(17-year-old woman from Sierra Leone)

She was also provided with very little information about the pain relief she was given.

They didn't tell me that they were going to give me anything... They just, they said that it will help me more to give birth and stuff, so I just, they said it would release the pains. So I just tried it, I said OK, and we just used it then.

(17-year-old woman from Sierra Leone)

It was generally more difficult for the very young women to articulate exactly what safety meant to them in terms of giving birth.

I don't know, if you went on to like the labour ward and it was dirty and there's like doctors and midwives walking around with like... I don't know really. I've never really seen it to be unsafe or anything, so I wouldn't really know.

(17-year-old English woman)

As with some of the older interviewees, two of the three teenage mothers were more concerned about pain than safety.

Interviewer: *You weren't worried that it might be dangerous?*

Respondent: *No... I didn't look at that part, I was looking at the painful part.*
(17-year-old woman from Sierra Leone)

But one young woman, who was very anaemic throughout her pregnancy, recognised some of the risks associated with childbirth.

I didn't feel scared but, you know, there's always a risk... bleed to death... And that's it really.

(18-year-old Portuguese woman)

Seven of our interviewees were not currently living with a husband or partner (although only four of them were without a partner at the birth). Research suggests that this may also have an impact on maternity care. For example, Rowe *et al* (2007) have shown that the odds of attending late for pregnancy care for women living without a partner can be over twice as high as those living with a partner. Some of the women concerned were also asylum seekers and without the support of other family members. They naturally felt more alone and therefore more frightened, but maternity care staff did seem to have given them reassurance.

And the time I was giving birth, I was so scared, I was like this because I didn't know what to do because I've got no family here, it's only me, so I found it so difficult for me to deal with it by myself. But just because of the nurses of the hospital, I managed to talk to them and then they managed to keep on talking to me about how can they make me feel better.

(31-year-old Zimbabwean woman)

Other women may not have had a partner, but had the support of relatives during the birth.

I did feel safe because I knew that if anything happened, my cousin would go and call them and stuff.

(17-year-old woman from Sierra Leone)

SUPPORT FOR NON-ENGLISH SPEAKERS

We interviewed 11 women whose first language was not English. Seven of these either required someone to interpret on their behalf or had very limited English. However, interpreters were seldom provided by the hospital and women had to rely on partners or friends or simply get by using gestures and limited communication.

I tell them I do not speak very clearly English, but I try... And when I speak they understand me, yes... I speak bad but, bad but they understand me... And when they speak to me I can understand, yes.

(34-year-old Congolese woman)

She say no, there was the friend of her sister, she say the friend was sister of her friend was there to always interpret, to help facilitate.

(27-year-old woman from Ivory Coast via an interpreter)

I was so scared and upset and I couldn't talk English in a foreign country, but they were very kind... We could talk by looking at each other and by gesturing.

(39-year-old Bulgarian woman via an interpreter)

In most cases the absence of an interpreter did not appear to cause the women concerned any distress. But worryingly, one woman who claimed to understand what staff were telling her consented to a caesarean section without actually understanding what was happening until it was explained to her after the surgery. It is also clear from another woman's testimony that the kind of information exchange conducted in these circumstances was extremely basic.

I understand like they said when I have to push the baby, when I have to take the mask, when I have to take the water, drink water, they explain.

(28-year-old Bangladeshi woman via an interpreter)

Only one woman seems to have been provided with an interpreter and only then for part of her labour.

But, you know, because of my language is not that good, I know sometimes I need, if somebody can come, and especially when they did my blood transfusion and they asked me and I said it's Urdu, and they called an Urdu interpreter, and that interpreter explained thoroughly and that I think very best thing for me. And then I understand why they giving me the blood.

(29-year-old Indian woman via an interpreter)

In general, non-English speakers spoke positively about their experience of childbirth. As in most other cases, the fact that they felt safe owed much to the caring attention of the midwifery staff. However, one woman from Somalia clearly felt unhappy about her treatment.

Interviewer: *Did you have any problems with safety when you had your baby?*

Respondent: *Yes, she had. She say first of all when she had, she was on labour, whenever she reached there for the first time, they didn't receive her, just ignoring her, you know.*

(27-year-old Somali woman via an interpreter)

PAIN RELIEF

Although not necessarily linked to safety, pain relief formed a significant part of the discussion with our interviewees. Indeed, many women seemed far more concerned with pain or the fear of pain than with safety per se. Epidurals were widely requested. However, the procedure does not always appear to have been straightforward or satisfactory and this could have led to potential safety risks. Delays in receiving an epidural and an unnecessary second epidural meant that three women could not feel anything when they were trying to push.

Because there were so many other births and there wasn't any anaesthetists, I couldn't have an epidural... In my mind I was ready to have an epidural so that's what was

going to happen. So if I'd known that there was a chance that wasn't going to happen, I think I would have been better prepared for it and... perhaps he [baby] wouldn't have got into this stress if I hadn't been so stressed out.

(38-year-old South African woman)

And the epidural started wearing off a little bit so it was topped up just before 1 o'clock. The hospital policy... is to push for an hour. I pushed for an hour, and there was lots of encouragement from my husband and from the midwife, although it would seem, looking back on it, that I probably wasn't doing it right and I think that was probably partly due to the epidural, I couldn't feel what I was doing. Because I only managed to push him a certain way and then he got stuck and he wouldn't come any further.

(32-year-old English woman)

But I think the delay in the epidural, in the end I got quite worked up, I believed I couldn't do it, I was in pain and I was managing because I was doing, sort of breathing through it and kind of just concentrating on that one contraction. But if I had maybe had the epidural earlier, when it actually came to pushing I would have been able to feel and that would have gone more smoother. But who knows?

(35-year-old English woman)

In two cases, anaesthetists had quite serious difficulties administering the epidural.

They then tried to do an epidural, the anaesthetist came in and tried to do an epidural, and the first time he hit a blood vessel, the second time it only worked on one side, the third time he hit another blood vessel, then he was called away to do something else, came back, couldn't, did another attempt and couldn't get the needle in... The fifth time he actually managed to get the epidural in and working, so that was, that all took about four hours to get that to take.

(32-year-old English woman)

EQUIPMENT

All of the women interviewed reported that some form of monitoring equipment had been used during the process of childbirth. One woman referred to diagnostic testing equipment not being immediately available and a few cases of malfunction were mentioned.

[Son] had lots of blood sugars taken from a prick in his heel, and I know on some occasions there were discrepancies between the, I think it's some kind of refraction test, it's some kind of way that the blood sample that they take refracts the light, it's the way they measure the blood sugar of the blood sample. And I think there was some question as to, if the machine wasn't quite, I don't know, quite clean from the previous sample or something, that it could be, it could give a false reading and there could be differences between different pieces of equipment. So they sometimes did it twice and tested it on another piece of equipment.

(32-year-old English woman)

Sometimes the machinery wouldn't work... The blood pressure machine, I think once I was dead. I didn't have a blood pressure a few times, and it was like really sky high

like, like ridiculously high, you know, like you would be dead... So they had to do it just the old-fashioned, you know, manual way.

(33-year-old English woman)

I think they used monitoring or sometimes child heartbeat and the one they are using is not properly working, and then they remove that one and bring another one.

(28-year-old Bangladeshi woman)

A week before one woman gave birth it was discovered that her baby was in the breech position. An attempt was made to turn the baby and during this process it is important that the foetal heart rate is monitored. Unfortunately, this does not appear to have been done correctly the first time around.

She did it at the wrong side or something. Because the person who came after, she said, 'Oh, this hasn't been done properly', so, which makes us feel unsafe because you as a patient don't want to say 'you're not doing it properly' because they should know.

(31-year-old German woman)

The presence of equipment was reassuring in most cases, including the amount of equipment brought by midwives to the one home birth featured in this research.

So in terms of equipment, everything was laid out pretty much earlier on actually... They had all the canisters of the gas and air lined up... I'm not quite sure how many we went through of those, it was good to see them all there anyway.

(27-year-old English woman)

ENVIRONMENT

Women clearly associate cleanliness with safety and recent media coverage of the MRSA (methicillin-resistant *Staphylococcus aureus*) superbug has no doubt contributed to their anxieties in this regard.

I was paranoid about MRSA, I must admit I brought in my own spray.

(33-year-old English woman)

However, the only concerns expressed related to poor standards of hygiene on the postnatal wards.

Even where I was sleeping in the room... it was dirty, when I moved to that room I found it dirty, it was dirty, the toilets were dirty, they were unclean. You know, if the person had given birth, obviously you need something, you need clean surfaces because that place is used by people who have just given birth, I don't know of other places which is unsafe.

(27-year-old Zimbabwean woman)

I felt that maybe the beds weren't changed as frequently as possibly I would have liked. Because I'd had a ventouse delivery obviously I'd had stitches and I was

bleeding, so we had the maternity mats on the bed and that kind of thing. But I actually had to ask to have my sheets changed.

(39-year-old English woman)

Elsewhere, women were generally happy and even impressed with the standard of cleanliness.

It was incredibly clean and hygienic... I was in the bed and the cleaner came around, she moved all the furniture out, she dusted all the surfaces with a damp cloth, all the, you know, around the top of the curtain and even where they've got these televisions that come out on arms, she dusted all there as well and it was immaculate, it really was good.

(29-year-old English woman)

SYSTEMS AND PROTOCOLS

Although some of the factors already mentioned may fall within the scope of hospital safety protocols, women seldom made any reference to particular hospital policies. An interviewee with high blood pressure knew that the safety guidelines in her local hospital meant she couldn't be induced over the weekend.

They didn't induce me on the Sunday because I was classed as high risk and if you're high risk they want to make sure they've got someone who can be with you all the time, and they didn't have anybody.

(29-year-old English woman)

One woman who had chosen to have a water birth was largely reassured that the midwife went away to check the correct procedure before allowing her into the pool.

She said that she needed to go off and check the actual procedures and protocols regarding water as a pain relief option because obviously... it... can sometimes actually slow down labour. It didn't panic me because I thought, well, at least she's going to check, rather than just dumping me in there.

(39-year-old English woman)

But another woman felt slightly frustrated that her student midwife was sticking so closely to the hospital protocol and another felt that rigid guidelines did not allow for a more tailored approach to maternity care.

Because I'd got this student midwife, she was following the hospital policy to an absolute, to the letter... which meant I had to be laid down on the bed and monitored constantly, which I hated... I could have done with her being a bit more flexible.

(29-year-old English woman)

That's one thing actually altogether I didn't like in the pregnancy and the delivery thing, that everything is a lot after what is written in the book and what they are telling you and not really towards the special needs of the person.

(31-year-old German woman)

In one case, hospital guidelines clearly had to be adapted according to the levels of activity on the delivery suite, but this new mother actually appreciated the extra flexibility it gave her.

The hospital policy in [city] is to push for an hour... I actually ended up pushing for an hour and 40 minutes because they were very busy on the unit and the doctor didn't come, which I didn't mind about at all.

(32-year-old English woman)

The only woman to refer to the importance of protocols in her definition of safe care was also disturbed by a change of protocol at her local hospital that meant her labour did not proceed as quickly as she would have liked.

And it's interesting actually because they had recently changed their protocols... The midwife ended up having to show me the new protocols. It wasn't worrying as such... I was desperate to get a move on with it all, because I did find it hard leaving my son. I think that I thought that I should have another prostegen gel and they said no.

(33-year-old English woman)

COMPARISONS WITH PREVIOUS BIRTH EXPERIENCES

Thirteen of the women interviewed had given birth before, in some cases in other countries. Three interviewees compared their most recent experience unfavourably to previous births.

But the whole experience, yes, I think it was more, it was a lot more scary. I was really scared, you know, I was saying 'give me a caesarean' in the end, I was really screaming for a caesarean because I felt, 'Oh god, that's the easiest way, please help me, I don't think I can do it'. It's just, I don't know, the pushing and that's quite scary.

(24-year-old English woman)

Respondent: *Yes, the first time I felt really well, I felt safe, I felt well looked after, I wasn't sort of anxious about what was going to happen because there always seemed to be someone sort of checking on you, telling you what was happening.*

Interviewer: *Did you not feel safe this time around then?*

Respondent: *I was definitely starting to feel anxious after four hours of no one coming in.*
(34-year-old English woman)

One woman, who had previously given birth in Somalia, felt that she was discharged too early and indeed was subsequently proved right when a community midwife diagnosed an infection.

Because back home when we stay at the hospital 12 hours, until the babies get... until the baby get good, everything it is OK, check the baby and then after 12 hours back home. Now after three hours we say go back home.

(27-year-old Somalian woman)

But in most other cases where comparisons were made, the most recent birth was considered to be a much more positive experience. In one particular case, the differences

registered in almost every category from staffing levels, to team working, cleanliness and shared decision-making. In another, the obstetrician had managed a potential surgical complication much more successfully than in a previous birth.

When I started bleeding and I thought, oh no, and she said to me, 'Has this happened before?'. And I said, 'Yes, it has happened before and it was really bad'. She said, 'Oh, don't worry about it, we'll sort it out'. And I thought, 'Oh god, I hope you do'. And she did.

(32-year-old English woman)

The management of problems

Only nine interviewees (29 per cent) experienced a non-instrumental vaginal birth and a relatively large percentage of the women interviewed had developed problems that required some form of intervention. These complications included pre-eclampsia, a drop in the baby's heart rate, a breech baby and twin-to-twin transfusion in a pair of monochromic twins. The interventions varied from induction, ventouse and forceps delivery to caesarean section. Several women had episiotomies or tore. In a few of these cases women identified potential safety risks associated with the way in which the situations were managed.

DIAGNOSING LABOUR

O'Driscoll *et al* (1973) described diagnosis of labour as one of the most important but problematic aspects of intrapartum care. Some women in our study spoke about the lack of precision in diagnosing labour, which often caused anxiety – for instance, when they felt they should be admitted but were told to wait, or on some occasions were sent home. One woman had been backwards and forwards to her local hospital three times and on the final occasion had stood her ground.

That's when I had the comment about 'childbirth does hurt, you know'. So I just said, 'Well, I know that... But I'm in agony and I can't cope with this any more'. And she examined me again and I was about three centimetres and she said, she was definitely going to send me home, but I just at that point was not going to have any of it... if I hadn't pushed I would have been sent home, and I would have been in a very different situation because half an hour after I saw the midwife my waters broke... I would imagine I would have either, I would have been in the car, that would mean a whole different...

(35-year-old English woman)

Research conducted with midwives in a maternity unit in the north of England demonstrated that they have to balance pressure from women seeking admission with their own clinical judgement and the situation on the labour ward (Cheyne *et al* 2006). Some interviewees felt that they were discouraged from going to hospital when they were in an advanced stage of labour because the staff could not cope.

About 3 o'clock, rang in when they were about three minutes apart. I was a little bit surprised to be told at that stage to stay at home, but subsequently discovered that they were very busy on the ward at the time.

(32-year-old English woman)

Even when a woman had been admitted, there seem to have been a few problems determining what stage of labour she had reached.

But she told me that no, I couldn't be in labour, I should just go and have a hot bath and I would feel better, which I tried but didn't feel better at all, it got worse, they came on quicker and longer. Fortunately my partner was still with me... So he eventually got hold of her again and she came back and checked to see if I was in labour, and I was already five centimetres dilated so she decided yes, I was in full-blown labour.

(38-year-old South African woman)

In one case, midwives appeared to disagree about the progress of labour and only just returned to the woman in time for the delivery of her baby.

When she [midwife] go, the baby's coming very fast and... the baby's coming down the bed on my leg.

(27-year-old Somali woman via an interpreter)

INDUCED BIRTHS

Nine women were induced. (NB: in addition there were two non-English speakers who may also have been induced, but this was not completely clear in their interviews.) This was usually simply because the baby was overdue, but in one case it had been planned beforehand because of complications in a previous pregnancy resulting in the birth of a child with a disability.

It's difficult to know exactly what caused this problem but one factor could be the fact that he was late and the placenta was a bit worn out. So neither me nor the doctor wanted me to go late this time... So the idea was I would have a planned induction at 38½ weeks.

(33-year-old English woman)

However, reflecting on this experience, which ultimately resulted in an emergency caesarean when the induction failed, the woman felt that it would never have worked because at a week and a half before she was due, her daughter was just not ready to be born. Thinking retrospectively, another interviewee now felt unsure about having been induced.

And I think I'd probably ask not to be induced at 12 days... Just from speaking to other mums from the postnatal groups, that everybody who has had an induction seems to have had a more difficult time of it than people that have gone into labour naturally. Because I've just done research on the internet subsequently and there doesn't seem to be a definite time that a baby's gestation is, I mean sometimes it's 42 [weeks], it can go to 44, I mean, some women, they're even four weeks overdue and then go into birth naturally and everything's fine and as long as your placenta is not calcifying, it sounds like it's perfectly OK to wait.

(38-year-old South African woman)

The only woman who had chosen to have her baby at home also felt that being induced was more likely to increase the safety risks.

I know with certain interventions like being induced, then I know that it can speed the process up, so it puts a greater strain on the baby and the heart rate, and I know that's often what leads to other things and having to deliver the baby quite quickly. And also it would be more intense as well so... You're more likely to have more drugs and stuff like that. So that was kind of my view on having different interventions that, you know, it could make it a little bit more risky in some parts.

(27-year-old English woman)

CAESAREAN SECTIONS

Twelve women gave birth by caesarean section, two of these electively. Half of the ten emergency caesarean sections were carried out when induction failed to progress labour sufficiently. Some doubts were expressed about the timing and appropriateness of the decision to deliver in this way. One woman felt she could have been spared a lot of anxiety and pain if she had been booked in for an elective section while another suspected the staff wanted her to deliver before the end of a shift.

They did mention something about the shift, you won't have this baby by the end of our shift, and then a C section was being mentioned. And I did think to myself, 'Oh, is that because you want this baby out before the next shift?'. But then I thought, no, it's all stupid... But I don't know, they do seem to give C sections more willy-nilly now, I think.

(33-year-old English woman)

One of the two women who had had elective caesarean sections felt it would be safer because her baby was in the breech position.

I knew from other friends that if your baby is wrong side, it's safer to do it, so I didn't even think about anything else.

(31-year-old German woman)

She also compared the normal delivery unit at her local hospital rather unfavourably with theatre.

When I looked at where you have normal birth, it wasn't really high standard but OK-ish, and the midwives were really nice, but then I had a caesarean, I thought it was really clean.

(31-year-old German woman)

The other woman who had an elective caesarean, who delivered twins, was determined to choose this option. This echoes research carried out by York *et al* (2005), which suggests that women who have had an emergency caesarean for a previous birth are concerned about safety. Control over childbirth is very important to them.

My birth plan from the very beginning was, if I would have had a singleton I would have fought to have a section because of the experience that I had last time... I was so scared about what was going to happen that I just thought, I need to have a very controlled environment.

(32-year-old English woman)

A caesarean section, like any surgical procedure, carries risks. In two cases women appear to have been inadequately anaesthetised, one of them subsequently being given a general anaesthetic, the other feeling quite traumatised for three or four weeks after the birth.

I didn't expect to feel that much, and I was worried that I didn't have enough anaesthetic, so I suppose in that case I didn't feel as safe as I should have done.

(35-year-old English woman)

Two women haemorrhaged after their operations and another felt that her emergency caesarean section may have been unnecessary and due to the obstetrician being rather over-cautious when the mother felt she knew her own baby better.

But the doctor decided he wanted to do a caesarean because of her heart traces, they were concerned she might have the cord around her neck or something like that... There was nothing wrong with her at all. She was just a big baby and... I did keep saying to them, 'She doesn't move around any more than this... She hasn't all the way through my pregnancy'.

(32-year-old English woman)

But another interviewee, whose baby was also born by caesarean section, did not believe it was ever possible to achieve total safety and that doctors often chose to err on the side of caution.

I don't think you can be a hundred per cent safe... Things can go wrong for you or your child... Basically... the doctors are making... their decisions on, you know, based on their experience and their best guess at what's going on. But they don't know exactly what's going on and that's why people have more caesareans because they, you know, somebody panics that the baby's at risk, and they don't really know if the baby's at risk or not half the time.

(33-year-old English woman)

One woman who had an emergency caesarean felt that if she had not been more assertive, serious risks may have developed.

The thing that really worried me was, had I not pressed the buzzer, you know, because they were saying if my waters broke it would have been really serious. So I was, what concerns me enormously is that I had to actually ask for someone to come, ask for someone to do an examination, and I think that's what really surprised me, you just have to be really assertive about making sure that you're sort of looked at.

(34-year-old English woman)

EPISIOTOMIES

At least five women needed episiotomies (in another case, it was not clear whether the woman tore or was cut) and another three tore (one of these in addition to being cut). Two women reported waiting several hours for a doctor to stitch them. For one woman her episiotomy led to yet further complications. She had been given a choice between a cut and a tear when it was decided that she required a ventouse delivery. She chose a cut, but also suffered a fourth-degree tear. When she went into theatre to be stitched she was given a spinal block.

Came out of that and then I landed up with... a hole in the spine where the spinal fluid leaks out, so I had like a migraine headache [and] I had to feed lying down, because you have to stay prone because then it'll, in theory, heal up.

(38-year-old South African woman)

Two interviewees wondered if their tears could have been prevented by better advice on when to push.

I know that there is an issue with pushing, for example, too soon, and that when the baby's head is crowned you're supposed to stop pushing. And I don't remember being given an instruction, well, 'don't push now'. But then I thought, well, probably perhaps for water births it's different. So it has crossed my mind that I didn't have that instruction, don't push, so whether or not that would have had any impact on whether or not I tore, I don't know.

(39-year-old English woman)

A woman who had suffered synthesis pubic dysfunction during pregnancy was somewhat disturbed by the fact that she had been put in stirrups when being stitched following a bad tear.

And one thing, and I didn't say anything by then, but they put me in the stirrups... and with my problem with my pelvis I'm not supposed to do that. But I was too tired to say anything by then, but they shouldn't really have done that.

(26-year-old French woman)

MEDICATION

One woman was concerned that she had been given medication unnecessarily. Although the nature of the medication did not make this a particularly serious risk, the implications of an error of this kind are obvious.

I think the only time that I did get a bit worried was when I was given a tablet for something. And again, because I trusted them, I just took it, and it was for iron deficiency... and I didn't have an iron deficiency. My level was, it was on the cusp, but it was OK apparently. Because I questioned it the next time they came around with the medication, I said, 'Well, don't I need this tablet?'

(29-year-old English woman)

POSTNATAL CARE

Although there were quite a few complaints about the quality of care on the postnatal wards, women seldom had serious concerns about the safety of the care they received. However, one woman had a worrying experience following a caesarean section.

So I had a catheter and that got really... because I remember feeling really that my bladder was really uncomfortable and I just, you know, I just said to my partner who was with me at the time, I just said 'Can you look at the catheter because I'm starting to feel really weird', and he said it was absolutely full to the brim, that it was so full it was starting to come back in... So they did come and empty it and she said that's the fullest catheter I've ever seen. But I think that's, I don't know if that's, I mean it

certainly was uncomfortable, I don't know if it's dangerous for the urine to be going back upwards again...

(34-year-old English woman)

BABIES

Five of the babies born to the women interviewed suffered health problems immediately after birth, all of them spending some time in special care. Two were born prematurely, one had low blood sugar and another had water in her lungs. The fifth baby suffered an adverse reaction to a second dose of pethidine administered too close to his birth.

They assured me that there was enough time between when I was going to have it to probably when baby was going to be born, for it to be out of my system and not affect the baby... But they'd given me another shot of pethidine... and... when he came out he was purple and he'd reacted to the pethidine. So they had to give him an injection, they gave him his vitamin K injection and something to counteract the pethidine, and rushed him off to the special care baby unit for monitoring.

(29-year-old English woman)

IMPACT OF PROBLEMS ON VIEWS ABOUT SAFETY

Despite the number and range of problems encountered, most women seemed reluctant to suggest that their care was actually unsafe. Problems were seldom thought to be preventable, and once identified, women were generally very impressed with the way health professionals responded.

Yes, things did happen very quickly when it was decided that I was going to have to have a ventouse delivery. Things happened very, very quickly and the doctor was called and it was all sorted in the quickest possible time.

(39-year-old English woman)

And that's the point then where they decided that it was really, they had to do the caesarean straight away. So at that point then I thought it was really fast, they came in and that was that, and it was literally within, you know, five minutes you're down in the theatre.

(34-year-old English woman)

The fact that problems were generally resolved, resulting in a healthy baby, contributed significantly to the women's continued faith in the safety of their childbirth experience.

So when I was actually on the ward in labour, I felt like, well, this isn't how it's supposed to be. But then... it all turned out OK in the end really... You see, I don't think that we were unsafe at any stage, you know.

(38-year-old South African woman)

Those interviewees who did question certain aspects of their labour and delivery often did so in retrospect, once they had had time to reflect (a process partly encouraged by the interviews themselves). One woman acknowledged that it was difficult for her to judge whether the correct decision had been made.

Possibly there were some wrong decisions taken, possibly I should have had a caesarean earlier, but it's very difficult to know.

(33-year-old English woman)

It is perhaps a testament to maternity care staff that, even when things went wrong, women still did not feel that they or their babies were unsafe.

I think more I was worried with the haemorrhage as well, I didn't know how bad it was until my husband told me because I was sort of fairly much out of it after the caesarean. But I didn't not feel safe, I felt like I was looked after properly... because they were constantly communicating with us, letting us know what was happening and what stage we should be at and why that wasn't happening, and what they were planning on doing next.

(35-year-old English woman)

SOLUTIONS TO PROBLEMS AND SUGGESTIONS FOR IMPROVEMENT

As their belief in the safety of their care was so rarely dented, it was not easy to elicit suggestions for making childbirth any safer. The one area where there was most agreement was the need to improve staffing levels.

I think, I just don't think there's enough midwives in the units. I mean my experience this time was vastly improved to last time but there's still not enough beds in [hospital] for people and I don't think it's acceptable that women go in to have their baby and then get shipped off to [hospital] or somewhere like that.

(32-year-old English woman)

One woman who had previously given birth in Germany expressed concern that she was not as a matter of routine checked for *B-streptococci*. This bacterium has risk implications during childbirth and if she had not specifically requested the test from her general practitioner her baby might have been infected.

I think you have it in your body but it doesn't matter, but if you give birth it's dangerous because the baby can be infected... I asked in the hospital, I wanted to be checked, and they said, well, they don't do that, I have to ask my GP. OK, the GP did it straight away and I did have B-Strep, which means if you have a natural birth they have to give you antibiotics during birth.

(31-year-old German woman)

But most of the women we interviewed felt they had received good and safe care and volunteered no suggestions for improving safety.

But yes, I felt really looked after so... if you have to go through it then the NHS is not a bad place to do it.

(35-year-old English woman)

Conclusions

A wide variety of findings emerged from this study, with no simple messages on safety in childbirth. The main conclusions drawn were as follows.

- Women often expressed contradictory feelings, which could be quite extreme. One young mother described feeling fearful for her life and that of her child because of the inexperience of a student midwife. Yet she concluded by saying, *'It was amazing though. I want to have another baby just to go through the labour again.'*
- All of the women interviewed felt that the bond they formed with the midwives who were with them throughout the birth was fundamental to the whole experience. The reassurance provided by skilled professionals who kept them well informed and involved them in decisions about their care mattered more than anything else. When this worked well, as it did in most cases, even quite serious complications could be faced with confidence. In the minority of cases where the woman and her midwife failed to form this bond, the woman was far more likely to feel unsafe. It follows that when asked to consider the most important elements of a safe birth, all women talked about having enough experienced staff available.
- As might be predicted, older, better-educated women tended to be more assertive and to expect a greater share in decision-making. However, this was not always the case. The young woman referred to above described herself as being 'quite rude' during her labour and many women who had started by wanting to make the decisions were quite happy to hand over control when problems developed.
- The women interviewed often referred to childbirth being a natural process and the desirability therefore of having a natural birth. However, at the same time many accepted that childbirth carries inherent risks. All but one of the women interviewed chose a hospital over a home birth, feeling safer in the knowledge that facilities would be more readily available if intervention were required.
- In a small, qualitative study such as this it is difficult to tease out many differences in the care experienced by different groups of women. There were indications that cultural differences could alter women's perceptions of safety. For example, women from Germany and France preferred the less-medicalised approach taken in this country, regarding it as safer because it is more natural. Although non-English speakers from Asia and Africa generally reported positive experiences, there were some indications that the all-important relationship with maternity staff was compromised.
- Three of the women in this study were under 20 and one was in the 20–24 age group. All four were from socially disadvantaged communities. While it did not appear that any of them received less safe care, there was evidence of some negative attitudes from maternity staff. Communication between the midwife and the mother (and birth partner) was also likely to be more limited.
- Wider, more systemic safety issues were also mentioned throughout the course of the interviews, from the reputation of certain hospitals to levels of cleanliness and adherence to safety protocols on monitoring, and security on the wards. Some of these factors were more obviously linked to problems encountered by the women than others – for example, inadequate monitoring. But without knowledge of individual hospital guidelines it is difficult to know whether some problems – for example, perceived delays in diagnosing labour, decisions to induce, and the poor administration of pain relief measures – are systemic or specific to individual hospitals. Indeed, in a few

instances, women found that strict adherence to hospital policies led to an inflexible and untailored approach to individual care.

- Finally, the nature of childbirth means that awareness of the various safety factors often listed as significant in influencing outcomes can be affected during labour itself by pain or pain relief and ultimately by the delivery of a healthy baby. So it is perhaps not surprising that, despite the range of complications and interventions experienced by our interviewees, certain safety concerns may have come to light only in retrospect. Even when concerns were raised, an ultimately happy outcome still made women reluctant to describe their overall care as unsafe.

Appendix

CHARACTERISTICS OF THE WOMEN INTERVIEWED

Age (at 30.06.07)	No:	Household income	No:
Under 20 years	3	Up to £15,000	11
20–24 yrs	1	£15,001–30,000	6
25–29 yrs	10	£30,001–45,000	5
30–34 yrs	11	£45,001–60,000	2
35 and over	6	£60,001 & over	5
		Not stated	2
Ethnic group	No:	Country of birth	No:
Asian	2	UK/Ireland	16
Black	7	Other Europe	5
White	21	Africa	8
Mixed	1	Asia	2
Whether living with husband or partner	No:	Highest educational qualification	No:
Yes	24	None	1
No	7	CSE/GCSE/O level or equivalent	5
		A level or equivalent	4
		Vocational qualification or Diploma	9
		Degree or higher	12
Employment status (woman)	No:	Employment status (partner)	No:
Employed	2	Employed	20
Unemployed	3	Unemployed	2
On maternity leave	15	On paternity leave	–
Caring for family	5	Caring for family	–
In full-time education	1	In full-time education	1
No right to employment	5	No right to employment	1

CHARACTERISTICS OF THE BIRTH/BABY

Whether this was first pregnancy	No:	When baby born	No:
First pregnancy	12	January	1
First pregnancy to produce live birth	6	April	5
		May	9
1 or 2 previous babies	12	June	10
		July	6
3 or more previous babies	1		
Characteristics of birth (1)	No:	Characteristics of birth (2)	No:
Hospital birth	30	No intervention	9
Home birth	1	Episiotomy	5
Baby in intensive care	5	Caesarean section	12
		Induced	9
Mother in intensive care	–	Forceps	2
Twins	1	Ventouse	3
IVF	1	Premature	2
Baby's health now	No:	Woman's health since baby's birth	No:
Excellent	19	Excellent	8
Very good	7	Very good	8
Good	5	Good	11
Fair	–	Fair	2
Poor	–	Poor	2

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