What is a Good Birth? Using Q Method to Explore the Diversity of Attitudes about Good Birth

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Abstract: Birth literature reveals many perspectives about "good birth," and an investigation into a good birth is necessary because women and children are entitled to the experience that most supports their health as well as their psychological wellbeing and fulfillment. There exists a culture within maternity services of professionals working with apparently conflicting agendas, which may contribute to service user input being excluded. The objective of this study was to understand the viewpoints about "good birth" using a Q methodology approach. Seventeen participants, comprised of mothers, midwives, and obstetricians, completed online Q-sorts. Factor analysis revealed three factors, which were interpreted and named: 1) The quality of the relationship between the mother and her midwife or obstetrician and the importance of a safe outcome, 2) Personal and professional practice balanced with client-centered work and empowerment, and 3) Risk and expectations management as a way of valuing patient experience. Clinical implications for birthing professionals and psychologists are explored in the discussion. Research needs to highlight the variety of understandings of what constitutes a good birth, in order to increase collaborative working in maternity services.

Keywords: Good Birth, Q Method, Maternity Services

Birth is a major event in at least two people's lives, and has a profound effect on the mother and her child. The birth experience may color the family's long-term health and wellbeing and their use of health services (Tyler, 2012). Moreover, high-quality obstetric care for all women is one of the key demands of the International Safe Motherhood Initiative (The

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Inter-Agency Working Group for Safe Motherhood, 1987), and according to Pittrof, Campbell and Filippi (2002), it encompasses not just the medical outcome but satisfaction for women, families, and care providers.

Negative birth experiences are important in a wider context for the health providers internationally, and have been the subject of a vast amount of research. This research includes post-traumatic stress disorder (PTSD) (Ayers, Eagle & Waring, 2006; Creedy, Sochet & Horsfall, 2000; Leeds & Hargreaves, 2008; Ryding, Wijma & Wijma, 1997), depression (Beck, Gable, Sakala & Declercq, 2011; Leeds & Hargreaves, 2008), a decreased ability to bond with the new baby (Bailham & Joseph, 2003) subsequent infertility (Gottval & Waldenström, 2002), and sexual avoidance (Bailham & Joseph, 2003). The purpose of the current research is to discover the diverse perspectives regarding what a "good birth" is, encourage cooperation along shared lines of agreement, and elucidate any competing interests in England's system of birthing.

Epistemological Position

This research has been conducted from a holistic feminist perspective, (Obando, 2003) which maintains that wellbeing and fulfillment are as important in healthcare outcomes as disease prevention. This perspective takes into account personal experiences of women including not only the physical, but also the social, historical, political, cultural, economic, and emotional determinants of health (Hastie, Porch and Brown, 1995). Additionally, the researcher has been mindful of the harmful effects of patriarchal systems on individual actors in them, regardless of gender (Hooks, 2000, p.ix). For this reason, the position of social constructionism was the epistemological stance adopted. Feminism and social constructionism go hand in hand, as feminism encourages the viewing of issues through different lenses, in order to understand them completely, and as all truth is socially constructed, it therefore must be contextually located within the time and systems in which it developed. Understanding that societal perspectives and "truths" are socially constructed allows for deconstruction of oppressive systems.

Service Development

Service guidelines for birth echo the perspective that maternity services should promote fulfillment (Department of Health, 1993; Tyler,

2012). Critical thinking and research into these services also encourage choice facilitation for women (Kitzinger, 2005; Hastie, Porch and Brown, 1995). Toward that end, therefore, the focus of this research is to elucidate stakeholder perspectives regarding what makes a good birth in the hopes that contributing to understanding across groups will facilitate effective cooperation between them.

Previous Research

Differing agendas amongst professionals about what makes a good birth?

International contemporary research carried out into healthcare practitioners' views of birthing has shown that there are significant differences of opinion on a wide variety of issues between midwives and obstetricians (Klein et al., 2009; Reime et al., 2004).

With few exceptions, obstetricians take a medicalized, risk-focused view that many women require assistance, in the form of interventions up to and including surgery, in order to ensure the health of both mother and child (Davis, 2008). In contrast, midwives traditionally identify with the perspective that most women's bodies are naturally equipped to carry and deliver babies, and that they are helping in and supporting a natural process (Davis, 2008; Gould, 2000) in which the woman's psychological wellbeing is a factor. Whilst it is important to recognize that these are generalizations, there is evidence of different perspectives on birth experience, normality, and success. Obstetricians were significantly more likely than midwives to endorse the statement "Childbirth is only normal in retrospect" ($p<0.001$) and significantly less likely to endorse "I believe the most important determinant of a successful birth is the woman's own confidence and determination" ($p<0.01$) (Reime et al., 2004). Dunphy, Dunphy, Cantwell, and Bourke (2010) found that practitioners' attitudes towards being woman-centered may have affected clinical care; obstetricians who were open to being influenced by the wishes of a woman in labor were less likely to deliver a baby with severe asphyxia. If practitioners do have different attitudes towards birth, and these attitudes affect clinical care, then there is the potential for professionals to hold conflicting attitudes about what is "best" for women, or even what defines a "good birth." There is some evidence of this in the discourses within the disciplines of midwifery and obstetrics, which indicates a culture of antagonism (e.g. Simkin, 2006; Feldman, Cymbalist, Vedam, & Kotaska, 2010; Remer, 2008; Walsh, 2010; Goer, 2002) and may ultimately affect collaborative teamwork.

If professionals think that their perspective is at odds with others in their multi-disciplinary team, difficulties may arise in working together. There is evidence that a woman giving birth desires control over her birth experience (Vandevusse, 1999; Eaton, 2013), kindness, respect (Sinclair, 2007; Green & Baston, 2003), and knowledgeable, gentle staff who give information and work collaboratively with her and her supporters (Lavender, Walkinshaw, & Walton, 1999). Therefore, it would benefit women to have a team around them who understand and respect one another's perspective.

Freedman (2002) demonstrated that some medical professionals may guide or even ignore patient opinions, believing they know best, and that physician-patient interactions may be characterized by asymmetrical power relations that do not allow for the full airing of patient concerns (Marvel, Epstein, Flowers, & Beckman, 1999). Houghton, Bedwell, Forsey, Baker, & Lavender, (2008) explored women's views on choice of birth venue with the views of midwives, GPs, and obstetricians. This study found that many obstetricians and midwives have biases about birth setting, but did not investigate other factors, such as personal qualities of staff, other support, analgesia, or technology. However, there is a paucity of literature integrating both mothers' and healthcare providers' views about what makes a good birth.

Aims

Many studies about mother, midwife, and obstetric opinions have originated in North America or Australia. This research will be conducted in England, where there is a lack of published research available into what is considered to make a good birth. Differences among countries in both birth culture and other sociological factors, such as healthcare provision, class, religion, and the status of women make England a distinct culture, deserving of its own research.

This study will examine the range of opinions in both published literature and popular media about what constitutes a good birth. It will then examine the extent to which people share an understanding about good birth, whilst also investigating how these viewpoints differ, and attempt to understand why people hold these viewpoints.

Method

The Principal Investigator

The Principal Investigator (PI) is a female, white, middle-class, feminist trainee clinical psychologist of North-American origin. She has lived in Britain for five years. She has experience of working in maternity services, and has never been pregnant.

The PI acknowledges that research is a fundamentally subjective process and that her position will have affected the items in the Q-sort as well as the factor interpretation and, therefore, she has performed a Q-sort prior to gathering data. For a visual representation of the researcher's Q-sort, please contact the researcher.

Peer review and ethical approval

This research was peer-reviewed by Staffordshire University. A National Health Service (NHS) local research ethics committee and the participating Hospital Trust's Research and Development department both granted ethical approval.

Design: Outline of Q-methodology

The intent of Q-methodology is to capture the subjective viewpoints of participants regarding a concept in a publicly accessible form (the Q-sort). Q-methodology employs quantitative and qualitative techniques and therefore provides a holistic look at the diversity of perspectives.

Four main steps comprise the process of completing a Q-methodology research project: deciding on the statements (developing the "Q-set"), sampling participants, having participants complete the study by participating in Q-sorts, and finally, data analysis (factor analysis), interpretation, and synthesis for practice (Watts & Stenner, 2012).

Q Methodology

Q-methodology was developed by Stephenson (Watts & Stenner, 2012) as a method to mathematically analyze and make sense of subjective data. A rigorous method, it sets out to discover what viewpoints exist within a given community about a particular area of interest, for example "what constitutes a good birth?".

Developing the Q-Set.

The primary purpose of a Q-set is to represent the diversity of opinions across a particular topic, and to provide good coverage in relation to the research question. There is no correct way to generate a Q-set, but rigor must be demonstrated in its production (Watts & Stenner, p 58, 2012).

Sources for the initial concourse for the Q set included a literature review of academic journals, obstetric and midwifery textbooks, popular media, and conversations in supervision with psychologists working in maternity services. Inductive thematic analysis was utilized, which is "a method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, p 6, 2006). Thematic analysis is compatible with constructionist paradigms within psychology (Braun & Clarke, 2006).

The researcher used thematic analysis as a method of data reduction, which helped to identify similarities and differences in sort terms. This ensured the best possible coverage while attempting to make the Q-set as manageable as possible for sorting.

Therefore, once gathered from the various sources, the initial concourse of 231 potential sort terms was coded inductively using a color-dot system to develop themes. Potential sort terms were eventually grouped into themes of "respect/kindness," "environment," "litigation/hospital policy/efficiency/finance," "staff needs," "education/information," "safety," "control/choice," "physiology," "expectations and satisfaction," "collaboration," "empowerment," "technology and interventions," and "support."

As the researcher was unable to pilot or co-construct the q-statements in the populations intended for study due to limitations of ethical approval, thematic analysis, used throughout the Q-set construction process, was adapted to privilege words and phrases which appeared more frequently in the initial concourse. The researcher tallied the frequency with which these words and phrases appeared in the initial concourse and included the most frequently occurring words and phrases in the final Q set, thereby privileging their place above other, less frequently occurring words. The researcher drew these words and phrases from media and literature developed by mothers, midwives, and obstetricians, to measure the perspectives of these groups, and therefore it was felt that commonly occurring statements in the concourse were important to represent as a part of the Q-set.

The final Q set was reviewed for face and content validity by Academic and Clinical Supervisors, other clinical psychologists and

peers, who were asked to examine the Q set for repetition and overlap in the statements and to comment on breadth and depth of coverage of the topic.

Sampling participants.

In order to obtain diverse views, a strategic sampling approach was applied. Three groups participated in this study: mothers, obstetricians, and midwives. Box 1 shows inclusion and exclusion criteria. Mothers were recruited through hospital wards and community midwives; midwives were recruited through the research midwife at the participating NHS trust; obstetricians were recruited both through training sessions and by word of mouth.

Box 1.

Inclusion and Exclusion Criteria

Inclusion Criteria

- Participants are mothers who have given birth in the past six months,
  trainee or qualified obstetricians, trainee or qualified midwives
- Participants speak English
- Participants are over 18 years of age
- Participants are willing to participate in the study

Exclusion Criteria

- Midwives or obstetricians who have given birth in the previous 6 months
- People who are unable to read or write

The participants in this study comprised five mothers, six midwives, and six obstetricians; therefore, there were 17 participants in total. Figures 1-3 detail demographic characteristics.

Figure 1.

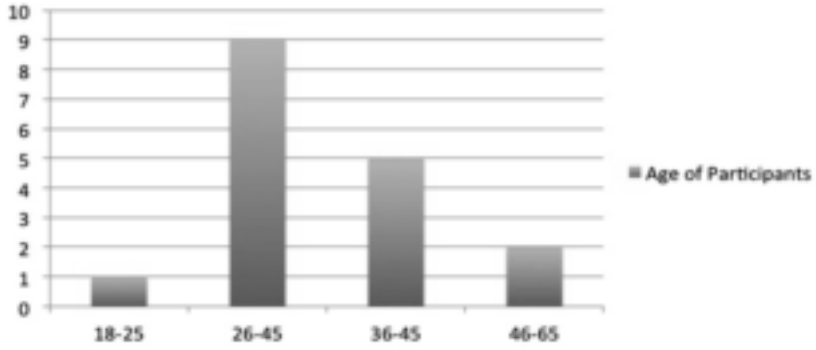


Figure 2.

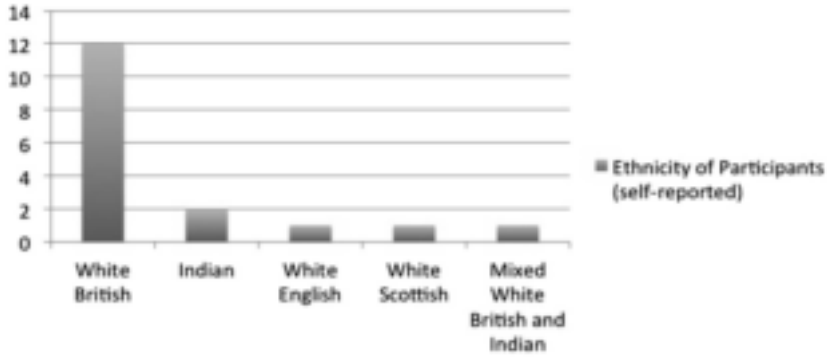
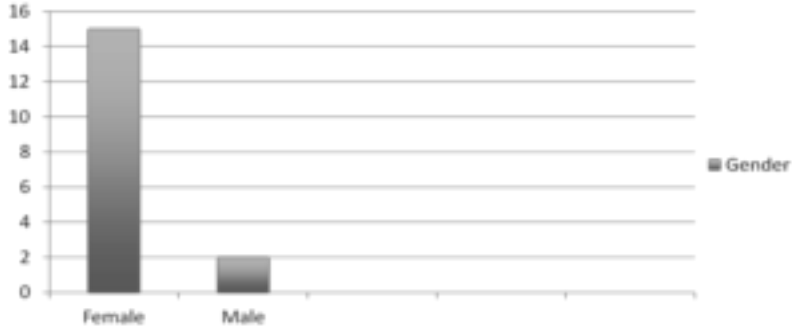


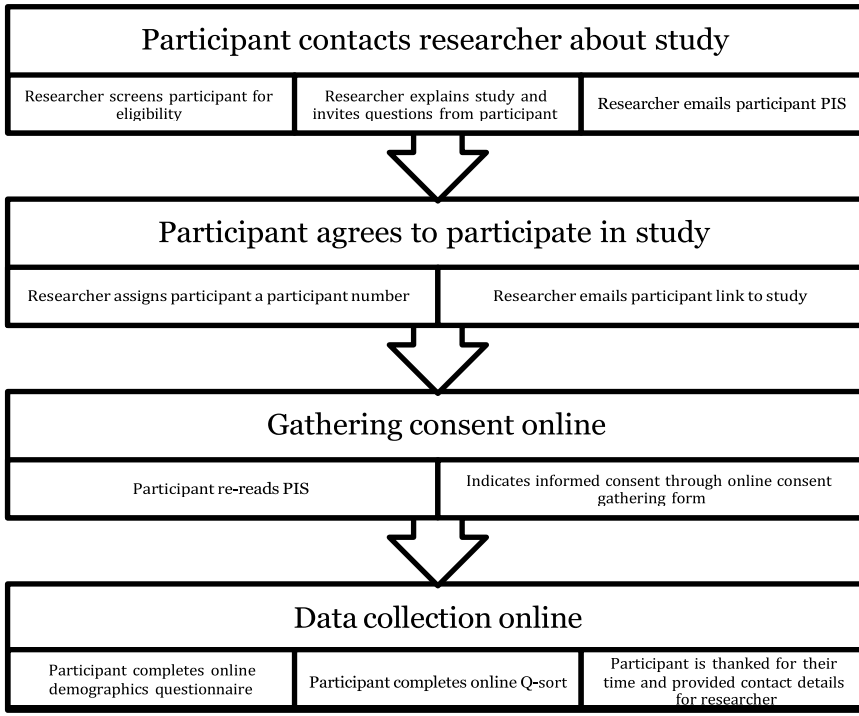
Figure 3.



Procedure

The PI conducted a screening procedure and provided each participant with a number. Next, participants were linked to the online Q-sort using POETQ software (Jeffares, Dickinson & Hughes, 2012). Upon arriving at the Q-sort webpage, the participants read an information sheet, completed an online consent process, and provided demographic data (Figure 5). They then completed the online Q-sorts (Figure 6). Importantly, participants were provided with the contact information of the PI in case they became distressed while completing, or following the data collection.

Figure 4.



Statistical Analysis

From Q-sorts to factor arrays.

The seventeen sorts gathered using the POETQ online software were intercorrelated and subject to a by-sort centroid factor analysis (Table 1) using PQMethod software (Schmolck, 2002).

Table 1
Factor matrix with loadings for Q-sorts

Qsort	Factor 1	Factor 2	Factor 3
1	0.7992*	-0.0880	0.1003
2	0.7589*	-0.3365*	-0.0056
3	0.7412*	0.1139	-0.0056
4	0.8006*	-0.0368	0.0565
5	0.8378*	0.0827	0.0730
6	0.8180*	0.0346	0.0217
7	0.7950*	-0.0898	0.0864
8	0.7302*	0.1783	-0.1618
9	0.7757*	0.2182^	0.1095
10	0.6911*	-0.1962	0.0757
11	0.8525*	0.0303	-0.0423
12	0.8062*	-0.0553	-0.4549*
13	0.8130*	0.1825	-0.3090*
14	0.7325*	-0.2027^	0.1060
15	0.7370*	-0.2547^	-0.0640
16	0.7820*	0.2632*	0.1207
17	0.7559*	0.1342	0.1877

*=significant at $p<0.01$

Four factors were extracted, which together explained 67% of the study variance, although Factor 3 explained no significant study variance and was consequently dropped from the analysis. Therefore, Factor 4 will hereafter be referred to as Factor 3.

All of the sorts loaded significantly at the $p<0.01$ level onto Factor 1. Seven further sorts loaded onto Factors 2 and 3 (see Table 1). Due to the emergence of a dominant factor, which explained the most study variance across sorts (61%), the decision was made not to rotate the factors, but instead to accept an unrotated, three factor solution. Factor loadings of ±0.26 or above were significant at the $p<0.01$ level, and factor loadings of ±0.198 or above were significant at the $p<0.05$ level, in accordance with Z-scores suggested by Brown (1980, p222-223), (S. Brown, personal communication, April 12 2013). Factor arrays are

displayed in Table 2, which show where each statement fell on the statistical factor array produced by PQmethod (Schmolck, 2002).

Table 2
Factor arrays for statements mentioned in results section, in order of mention

Factor and statement names	1	2	3
Factor One			
75. A good birth should have good communication between health professionals, the mother, and supporters	+6	0	-3
52. To make a good birth, the medical professionals or birth helpers listen to the mother	+5	-5	-2
91. During a good birth, the medical professionals or birth helpers work cooperatively with the mother	+4	-2	0
79. During a good birth, decision making is inclusive	+3	0	-3
93. For a good birth, the medical professionals or birth helpers should be working together	+3	0	0
78. During a good birth, the mother feels treated with respect	+5	-3	-3
71. Trustworthy medical professionals or birth helpers make a good birth	+4	0	-6
69. To make a good birth, the medical professionals or birth helpers should be knowledgeable.	+5	0	-1
42. A good birth is one that means optimal safety for the baby	+4	+1	-3
43. A good birth protects both mental and physical safety for the mother	+6	-4	-4
84. A good birth means optimal safety for the baby and mother	+5	0	-2
15. During a good birth, the mother feels safe	+6	-6	-6
2. To make a good birth, women should be flexible with their expectations	+6	-4	-6
32. A good birth means no interventions- medical professionals do not interfere with the mother's process at all	-5	+2	+5
33. A good birth means no surgical interventions	-5	+3	+6
16. A good birth is unmedicated (drug-free)	-6	+6	-6
22. During a good birth, the mother uses only gas and air/entonox/laughing gas (no other drug-based pain therapy)	-5	+4	+6
34. A good birth means avoidance of unnecessary interventions	+4	0	-5
18. A good birth incorporates all the latest technology	-5	+5	+1
27. An episiotomy makes a good birth	-5	+4	+3

65. To make a good birth, the medical professionals or birth helpers should be female.	-6	+3	+5
64. To make a good birth, the medical professionals or birth helpers attending should have children of their own	-6	+3	+6
96. A good birth is profitable – it should make money for those assisting the birth (the hospital, the medical professionals, the birth helpers)	-6	+4	+5
Factor Two			
44. A good birth has a low litigious (legal) risk to the medical professionals or birth helpers	0	+5	+1
94. A good birth means that hospital policy and national guidance is adhered to	-1	+4	+1
47. During a good birth, the medical professionals or birth helpers are able to provide continuous support.	+1	-4	0
30. A good birth starts when both the mother and baby are ready.	-1	-4	+4
6. A good birth is centered on the client's needs and wishes	0	-6	+2
1. After a good birth, women feel their expectations of the birth were met	+1	-6	-2
68. During a good birth, the medical professionals or birth helpers are gentle.	+1	-5	-1
14. Before a good birth, the mother feels she can do it.	+2	-6	-3
74. During a good birth, the medical professionals or birth helpers maintain a sense of humor all the time	-1	+4	+1
Factor 3			
8. During a good birth, the mother is able to go with the flow	+1	-2	-6
54. To have a good birth, obstetric help should be quickly and easily available	+3	-2	-5
3. After a good birth, the mother feels that the medical professionals or birth helpers have done a good job	+4	-5	+6

Q-sorts loading onto a factor together in the same direction indicate that they share a similar sorting pattern, which is indicative of a specific shared viewpoint. In some cases, Q sorts may load onto a factor together, but actually be representative of two different viewpoints, which indicates the presence of a "bipolar factor." In this case, sorts generated by participants may have similar sorting patterns but appear as though they were mirror images to each other and there may be a continuum of views within a factor. An example of the bipolar factor occurs in Factor 2.

Results

Factor interpretations

Descriptions of factor interpretations are presented below. Comments that support factor interpretations provided by participants are noted in italics.

Factor 1: **The quality of the relationship and the importance of a safe outcome**. Factor 1 explained 61% of the study variance. Every participant loaded onto this factor, which indicates the presence of a dominant narrative about a good birth.

Communication was an important aspect of this factor. Both communication amongst healthcare professionals and between healthcare professionals and mothers were deemed to be important to a good birth. A mother stated "Nobody knows a woman's body as well as she does herself. She can say if she thinks there is a problem or if something does not 'feel right.'" All parties agreed that it was important for mothers to feel listened to, and that their involvement in decisions was a sign of respect to them.

All participants also valued knowledge and trustworthiness, which were seen to be linked, as mothers could trust professionals who were knowledgeable, and an obstetrician indicated that, "knowledge is central to exercising judgment."

Safety was also linked to knowledge, and safety for both the mother and baby was seen as very important for the process. An obstetrician contributed, "It is essential for (trust) to happen if we want to ensure a safe environment for both mother and child." Both mental and physical safety were mentioned, and valued by all groups. A trainee obstetrician commented, "The outcome of the birthing process and the pregnancy is to produce a new life/child. I would say that a healthy child at the end of the process is the best outcome yet not forgetting about the health of the mother."

Helping women to have flexible expectations about her birth was linked to mental safety. Professionals were concerned that women might be upset or feel let down by unrealistic expectations: "[women should be flexible with their expectations] so a change in plan is not upsetting."

Interventions, technology, and medication were seen as being unimportant contributors to good births, but also as necessary at times, "Surgical interventions are sometimes the only way to ensure safety of mum and child and should be available if the need arises." Participants made clear that the use of these interventions must be judicious, and

based on a good risk assessment: "Technology needs to be validated and useful rather than used just for its own sake." A mother's wishes are also important: "A birth can be good with drug treatment or natural methods. It is dependent on the mother's preferences." An inclusive viewpoint was evident, as participants felt that excluding births from being good just because they involved a caesarean section or other intervention was unfair: "Women can still have good birth experiences after a caesarean birth; it is not fair to say their birth is not 'good.'"

The demographic characteristics of birth helpers were seen to be unimportant, with participants making clear that neither gender nor parenthood conferred extra safety, care, or empathy.

Profit was seen by all participants as something that should be unrelated to a good birth, and that professionals should focus instead on the mother's needs and wishes, although allocating resources appropriately in the health service was increasingly becoming important: "Profit should not come into it, although we do have to [make good use of money] now in the health service… profit [is not a] good word, better 'good use of resources'."

Factor 2: Personal and professional practice balanced with client-centered work and empowerment. Factor 2 explained 3% of the study variance and five participants loaded significantly onto this factor at the $p>0.05$ level (see Table 1) indicating that there is a small influence on the main discourse for some participants.

Three of these participants loaded negatively onto this factor, and two loaded positively, making this a bipolar factor (refer to "From Q-sorts to factor arrays," above, for further explanation), which encapsulates two viewpoints on a continuum. One end of this continuum is centered on prioritizing hospital management and personal practice, while the other end prioritizes client-centered working. Three of these participants were trainee or qualified obstetricians, one male and two female, one was a female midwife, and one was a mother. In order to preserve confidentiality, quotes will not be attributed to participant groups.

Hospital Management, Guidance, and Policy. The five sorts loading onto this factor highlight particular viewpoints regarding hospital management and policy side of professional practice, in the making of a good birth. "A good birth has a low litigious risk" (44) and "a good birth means that hospital policy and national guidance is adhered to" (94) were key statements. A participant who loaded positively onto this factor wrote about informed consent as a way to avoid litigation as

well as an important part of medicine: "This [informed consent] is a tenet of modern Western medicine and avoids the legal charge of assault and battery."

Personal practice. The statement "medical professionals and birth helpers maintain a sense of humor all the time" (74) was highly ranked on the factor array. Maintaining a sense of humor is a well-documented way for practitioners to maintain mental distance from their work (Smith & Kleinman, 1989). Practitioners loaded both negatively and positively onto Factor 2, and therefore there is evidence that practitioners value this statement in very different ways.

Client-centered working and empowerment. Additionally, the rankings of statements showed that obstetricians and midwives being able to provide continuous support, birth starting when mother and baby were both ready[1], the birth being centered on the mother's needs and wishes, the mother feeling her expectations had been met after the birth, midwives and obstetricians are gentle, and the mother feeling she can do it were important contributors to this factor. The existence of polarized loadings, combined with qualitative statements from participants, indicate that those who loaded negatively on this factor may have a slightly more client-centered and client-empowerment influence on their idea of what a good birth is, while remaining mindful of other factors such as safety, "If professionals/helpers are not gentle a patient may feel scared or unsafe and this will detract from the birthing experience." "A mother must feel accepted and her wishes must be of paramount importance together with the safety of the baby and herself."

In summary, this factor encapsulates the balance between personal and professional practice, where legal and regulatory systems retain much of the power and can constrain clinical maneuverability, client-centered working and empowerment. This could indicate that some health professionals may prioritize individual women over larger systems, while some feel more bound by systemic pressures.

Factor 3: Risk and expectations management as a way of valuing patient experience. Factor 3 explained 3% of the study variance and two participants loaded significantly onto this factor at the $p<0.01$ level indicating that this factor has a small influence on the main discourse for some participants.

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[1] The author had intended this statement to mean that the birth happened as part of a natural process involving expectant management rather than induction.

Both of these participants loaded negatively on to this factor, and both of these participants were female trainee obstetricians. Participants who loaded onto this factor indicated that mothers should be able to go with the flow in order to have a good birth. A participant stated, "It [going with the flow] allows for a more relaxing and fruitful experience."

It was also seen as important that obstetric help was quickly and easily available. These two aspects together were understood to indicate that these participants felt there was a risk that something might go wrong in the birth process, and that women should feel able to relinquish control to the birth professionals so that they could help her without her becoming upset.

The participants also felt, however, that it was important that women evaluate them as having done a good job. Professionals theorized that it may be reassuring for mothers to feel they have entrusted the wellbeing of their baby to competent and caring professionals rather than feeling they have abdicated responsibility by devolving control, "It is a very personal experience for the mother, often an anxious time as well, and the lady's trust in her team and the fact she felt they did their job properly helps reassure her."

Discussion

Q-methodology was used to explore the views of obstetricians, midwives, and mothers about what makes a good birth. Three factors, one dominant and two supplementary, were discovered as a result of centroid factor analysis, and abductive reasoning. The researcher then interpreted the factors in line with accepted Q-methodology practice (Watts & Stenner, 2012).

Due to strategic sampling and the qualitative nature of Q-methodology, factors cannot be viewed as an exhaustive understanding of what a "good birth" is or is not in England. A discussion of these results and their implications for practice and service provision will, however, contribute to a further understanding of the aspects that make up a good birth, enhancing comprehension of why participants may hold certain viewpoints.

Relationships

The results indicated a fairly cohesive dominant viewpoint about what characterized a desirable relationship for women, midwives, and obstetricians in making a good birth. Factor 1 was partly characterized by the quality of the relationship between obstetricians and midwives as

well as between professionals and the mother. Communication, respect, trust, and cooperation, including involvement in decisions, were important. It was felt that midwives and obstetricians should be knowledgeable, as part of each being trustworthy, which included using clinical judgment appropriately.

This finding is in line with existing literature about relationships in birth. Indeed, both a systematic review of 18 studies on caregiver-patient relationships (Hodnett, 2002) and a specific study on high-risk obstetrics (Lerman et al., 2007) indicated that the relationship had a major influence on, or was key to, satisfaction.

This study also found meaningful service user involvement in decision-making to be paramount to a good birth, in line with Hodnett's finding (2002). Professional guidelines regarding how obstetricians and midwives should interact with clients are clear, and supportive of this finding. For example, the Nursing and Midwifery Council's (2008) Standards of Performance and Conduct for Nurses and Midwives specify both that midwives must listen to those in their care and respond to their concerns, as well as supporting their rights to be fully involved in decisions about their care. The NICE guidance produced by the National Collaborating Centre for Women's and Children's Health (2008) also state that the "views, beliefs and values of the woman... in relation to her care and that of her baby should be sought and respected at all times," and that communication is essential, supported as necessary by evidence-based literature. VandeVusse (1999) also found that effective joint decision making contributed to feelings of confidence and comfort.

Having any relationship with birthing staff has been shown to improve a woman's birth experience (Howarth, Swain & Treharne, 2012), and additionally, that relationships between professionals are also very important – a lack of either of these variables has been shown to detract from the birth experience and contribute to anxiety and a sense of vulnerability. However, these findings add to the existing research by showing that a good relationship between staff and women is very important for women to feel that they have had a good birth. Despite concerns raised in the introduction of this paper, it seems that obstetricians and midwives also value relationships between team members. The qualitative results show that mothers who completed this study value a respectful approach between obstetricians and midwives; an approach that allowed clashing models or viewpoints to take over would be "disconcerting and frightening." The implication of this is clear: It is essential that obstetricians and midwives strive to keep the woman

at the center of their care in order to promote both psychological and physiological wellbeing.

In summary, relationships between the mother and the care team, as well as within the care team, form an essential part of having a good birth.

Expectations

The relationship of expectations to satisfaction in childbirth is well documented (Hodnett, 2002). Women who participated in this study raised concerns about the difficulties they experienced adjusting their expectations to the reality of their birth experience.

Flexibility in women's expectations were an important aspect of a good birth, and contributed to Factor 1. The researcher interpreted this finding as participants wanting to protect the mental safety of women who may have planned a different birth from the actual outcome.

Perhaps since practitioners are aware of the possible consequences of birth, they feel more able to provide "realistic" expectations, and as caring practitioners, they feel it is part of their duty to balance "unrealistic" expectations. Some authors have suggested that expectations should be managed in antenatal care, such as during childbirth classes (Remer, 2008; Wildner, 2004). However, such "management" of women's expectations could be considered a tool to ensure that women do not "expect" births that might be deemed more expensive or risky for the organization providing their care (Anderson, 2004; Feldman et al., 2010).

To facilitate good birth, more research into how personal experience and service constraints influence the expectations of obstetricians and midwives for women's childbirth is needed.

Outcome and risk management

Both Factors 1 and 3 emphasized the importance of the birth's outcome. Factor 1 highlighted that the outcome of a healthy mother and a healthy baby is paramount to a good birth experience by all participants. Mental and physical safeties were inextricably interlinked. However, obstetricians uniquely held a viewpoint relating to a supplementary narrative in Factor 3 indicating that, for some participants, risk management was tied into an easy availability of obstetricians. In Britain, obstetricians are primarily involved with "high-risk" birth experiences due to maternity pathways (Tyler, 2012). They

may therefore more closely associate risk avoidance with good birth experience.

Anthropologists (Jordan, 1997, p. 56; Davis-Floyd, 1992) have suggested that physicians′ power, through their experiences and their training, transfers to them an "authoritative knowledge" (otherwise known as "the facts") where their viewpoint is viewed as not socially constructed or relative, but as natural, legitimate, and in the best interest of all parties. This engenders a tendency to actively manage risks according to guidelines and statistics; it may, however, ignore positive risk-taking, or occlude choices for women who may have different priorities about what makes a good birth.

Interestingly, both obstetricians who loaded onto this factor were still trainees. Hypothetically, they may have completed only the part of the sociological process that confers this knowledge upon them, and are not yet as experienced as qualified obstetricians. Therefore, they are more concerned about this type of risk management. Alternatively, it could be that as trainees, they are finding their place in the birthing system, and are therefore more focused on there being a role for obstetricians. A lack of confidence in their role or their practice could contribute to a lack of confidence in a less medicalized birthing process, leading to an occlusion of choices for women to choose the best birth for them.

Personal and professional practice and the wider systemic implications

Sorts loaded both positively and negatively onto Factor 2, indicating a bipolar construct with personal and professional practice at one end, and client-centered working and empowerment at the other end. All groups were represented on this supplementary factor, indicating an important viewpoint in the discourse on "good birth." Despite the bipolarity of this factor, it is inaccurate to classify those sorts that loaded positively as disagreeing with client-centered working, and important to remember that obstetricians and midwives are affected by births in a variety of ways.

It must be recognized that systems such as an organization′s finances, clinical targets, and potential litigation may each affect professionals in personal ways, including burnout (Bria, Bāban, & Dumitrascu, 2012), and that poor institutional acknowledgment of the needs of staff can lead to compassion fatigue (Menezes, Hodgson, Sahhar, & Metcalfe, 2013). Obstetricians′ and midwives′ professions affect them personally, since their professions form a part of their

identity (Pratt, Rockmann, & Kaufmann, 2006) as well as their livelihood. Therefore, it should not be surprising to find that some obstetricians and midwives adhere to the perspective that lower risk of litigation or adherence to guidelines makes a good birth more than aspects of client-centered working. Research has documented the effects of maternity care staff working in a "fear environment" as a result of medico-legal spectres (Surtees, 2010), and targets and stretched can compete with client-centered practice such as one-to-one care (Francis, 2013).

In order to facilitate good birth, these risks must be managed more appropriately by the systems responsible for them. Women will not have reliable, universal access to the safe, client-centered care that allows for the positive relationships described in this study unless this is made financially and practically possible by wider systems.

Choice and Control

In previous research (Eaton, 2013; VandeVusse, 1999), women feeling in control of the birth experience had been investigated widely as this variable was believed to impact satisfaction. However, no factor arrays in this study showed rankings toward either end of the distribution for related statements: the woman feeling in control of herself (4); the woman feeling in control of her environment (5); the woman being able to let go of being in control of her body (9) or, the woman being in control of the labor process (10). This could indicate that participants felt other aspects of the birth experience were more important for a good birth, and therefore challenge the existing literature. One factor showed a movement towards women relinquishing control and physical safety: "the woman can go with the flow" was a highly ranked statement for participants in Factor 3, although these were sorts contributed by obstetricians.

There are a variety of hypotheses regarding this finding. One is that many of these studies examined the feeling or experience of control in a less-nuanced way, where it either was or was not related to satisfaction, and did not rank it amongst other potentially important variables, including satisfaction itself, in the making of what a "good birth" was. Therefore, it is perhaps seen to be important, but not as important as other aspects of the birth.

Another possible hypothesis is that control itself is a more nuanced variable and that the statements provided were not as meaningful for women as aspects that could contribute to a feeling of control. Women having a relationship with birthing professionals where they feel

listened to and are understood could contribute to a feeling or experience of control. Findings in previous research (Eaton, 2013) regarding control indicated that an experience of control was important for women's satisfaction. However, control was measured in a variety of ways, and definitions included control of panic, personal control, perceived control, control of self, control of staff, and control of contractions. In addition, early field studies of the Labour Agentry Scale, which was used for some satisfaction and control studies, found a significant positive relationship between experienced control and perceived human support (Hodnett & Abel, 1986). Therefore, this finding could reflect the dynamic and multifaceted nature of experiencing control.

Psychological Implications

The psychological implications of this research are threefold. First, the existence of a common dominant narrative about a good birth is extremely encouraging. Mothers who had a variety of birth experiences all contributed similarly to a viewpoint that emphasized relationships and safety, and both midwives and obstetricians agreed. Therefore, the results indicate that, for these participants, stakeholders in birth broadly agree on goals and a "road map" for creating good birth, which would contribute to more cohesive team working. Ensuring that these viewpoints are understood in service development may help achieve fulfillment and wellbeing as healthcare outcomes for women.

Second, for obstetricians, midwives, and others involved indirectly in the birthing process, such as hospital managers, understanding better where women's priorities lie should aid in resource allocation, both in practice and policy development. Additionally, understanding the viewpoint that elucidated the pressure on staff to choose between prioritizing either client-centered working or professional preservation may help in developing support for staff to achieve both these objectives, which could reduce burnout.

Finally, for regional and national services, the implications are clear. Implementing policy and systemic changes will not only improve outcomes for mothers and babies, but for staff as well.

Specific suggestions for service policy

- Case management models for midwives and obstetricians allow one practitioner to follow each patient through her care and develop a trusting relationship. These models also allow women choice in who they co-create these relationships with as their

pregnancy develops. For financial and feasibility reasons, many services tend towards a team management perspective instead, where women may find themselves at crucial moments with an unfamiliar or unfriendly practitioner. These findings would support one primary practitioner for each woman.

- Resources should be allocated to allow for practitioners to spend more time with each woman both in prenatal care and during the birthing experience – essentially, hospitals should prioritize staffing adequate practitioners on the floor to provide quality one to one care. Currently in NHS hospitals, a practitioner can often be caring for three women at one time. This stretches the practitioners' physical and mental availability, which will impede the ability to literally and figuratively "be there" for the patient.
- Resources should be allocated to practitioners to prevent and recognize burnout and compassion fatigue. Otherwise capable and kind practitioners can cause serious harm when they are working under the influence of these common but infrequently recognized conditions. Counseling should not just be available, but encouraged, following adverse events such as perinatal and postnatal loss or trauma. Finally, policies which support (and make financially viable) a phased return to work for affected practitioners would contribute to making sure that only practitioners who are ready and able to support women during birth are on the floor.
- Clinicians should be trained in different ways to include women in decision-making, so that women are as well informed as possible, and are able to make their own choices regarding their care. A model for this is provided in Freeman & Griew, (2007).
- Clinicians should be trained in accepting and supporting women in the decisions they make regarding their care.

Roles for clinical psychology in creating good birth resulting from this research

Roles for clinical psychologists as a result of these findings could include consultation, service evaluation, or further research to facilitate understanding between policymakers, service-user representatives, and staff. Psychologists could also work with obstetricians or midwives to assist in the setup of peer support groups or individual supervision. This may help staff manage the competing pressures of client-centered working and the emotional and personal impacts of their work, such as those mentioned in Menezes et al. (2013). Finally, since research shows

that a positive birth experience following a traumatic one may have a "redemptive" effect (Thomson & Downe, 2010), psychologists working with pregnant women may be able to work with a woman's team (in addition to any therapeutic work they are conducting themselves) to contribute formulation, advocacy and psychological ideas in order to positively influence any successive birth experience.

Strengths and limitations

One strength of this study is the integration of obstetricians' and midwives' views, along with those of service users. Future research could concentrate on service users who belonged to other demographic categories, such as women who were not White, British, or who did not speak English, or women unable to read or write due to physical or intellectual disability. Understanding the perspectives of these women would develop the research base considerably, as these are women who experience disempowerment in a variety of contexts, and may engage with or experience maternity services very differently from the participants in this study.

Future research might include history-taking from participants in order to briefly describe women's experience giving birth, such as their risk level, mode of delivery, outcomes, prenatal care, and general perception of their birth experience. Additionally, since the participants were drawn from a hospital population only, it may reduce the generalizability of these findings. Future studies should include mothers drawn from other populations, such as women who choose to birth without assistance (freebirthing), or to use private midwives not employed by the NHS.

As Q-methodology is a subjective and quali-qualitative approach to research, it cannot be claimed that findings are generalizable (Watts & Stenner). However, since the concourse was sampled using a range of British resources, the intent is that findings will resonate within similar settings.

Key findings

- There is a common narrative about what makes a good birth that spans both professional and personal boundaries, which makes clear that what is most important is the quality in the patient-professional relationship as well as mental and physical safety for the woman and her child.

- Women's expectations about birth were seen as important, and in some cases, as something professionals had a role in managing.
- Across factors, interventions, place of birth, and analgesia were seen as relatively unimportant to a good birth.
- Client-centered working and personal and professional practice appeared difficult for some staff to balance in making a good birth, as they appeared on a supplementary bipolar factor, which could indicate staff working within a system which does not support both.
- Obstetricians who loaded on one supplementary factor considered the ready availability of obstetrics as well as a woman's ability to relinquish control as necessary parts of risk management, to be part of a good birth.

Conclusion

This study employed Q-methodology to understand the viewpoints of obstetricians, midwives, and mothers about what a good birth is.

The findings from this study indicate the presence of a dominant discourse about what a good birth is, which included the quality of the relationships as well as safety, but also the presence of two supplementary discourses that may influence individual participants' viewpoints to varying degrees.

Further research is recommended to understand supplementary viewpoints and subtopics of this research, such as communication, control, and risk management, more fully. This research will be important due to the impact of the birth experience for women and their families on their ideas about, and future engagement with healthcare, as well as their mental health.

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