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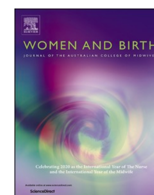

Midwives' experience of personal/professional risk when providing continuity of care to women who decline recommendations: A meta-synthesis of qualitative studies

Priscilla Ford [a], Susan Crowther [b,1,*], Nimisha Waller [c,2]

[a] Self-Employed Midwife on Sabbatical, New Zealand
[b] AUT University, Faculty of Health and Environmental Sciences, Centre for Midwifery and Women's Health Research, New Zealand
[c] Postgraduate Programme Leader (Midwifery), AUT University, Faculty of Health and Environmental Sciences, Centre for Midwifery and Women's Health Research, New Zealand

A R T I C L E I N F O

Keywords:
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Caseloading midwifery

A B S T R A C T

Problem: Women's autonomous choices in pursuit of physiological childbirth are sometimes limited by the midwife's willingness to support those choices, particularly when those choices are contrary to recommendations or outside of guidelines.
Background: Women's reasons for making such choices have received some research attention, however there is a paucity of research examining this phenomenon from the perspective of caseloading midwives' and their perception of personal/professional risk in such situations.
Aim: To synthesise qualitative research which includes the voices of midwives working in a continuity of carer model who perceive any kind of risk to themselves when caring for women who decline current established recommendations.
Methods: Systematic literature search and meta-synthesis were carried out following a pre-determined search strategy. The search was executed in April 2021 and updated in July 2021. Studies were assessed for quality using JBI Critical Appraisal Checklist for Qualitative Research. Data extraction was assisted by JBI QARI Data Extraction Tool for Qualitative Research. GRADE-CERQual was applied to the findings.
Findings: Eight studies qualified for inclusion. Five main themes were synthesised as third order constructs and were incorporated into a line of argument: Women's rights to bodily autonomy and choice in childbearing are violated, and their ability to access safe midwifery care in pursuit of physiological birth is restricted, when midwives practise within a maternity system which is adversarial towards midwives who provide the care which women require. Midwives who provide such care place themselves at risk of damaged reputation, collegial conflict, intimidating disciplinary processes, tensions of 'being torn', and a heavy psychological load. Despite these personal and professional risks, midwives who provide this care do so because it is the ethical and moral thing to do, because they recognise that women need them to, because it can be very rewarding, and because they are able to.
Conclusion: Maternity systems and colleagues can be key risk factors for caseloading midwives who facilitate women's right to decline recommendations. These identified risks can make it unsustainable for midwives to continue providing woman-centred care and contribute to workforce attrition, reducing options/choices for women which paradoxically increases risk to women and babies.

* Corresponding author.
E-mail addresses: priscillaford@xtra.co.nz (P. Ford), susan.crowther@aut.ac.nz (S. Crowther), nimisha.waller@aut.ac.nz (N. Waller).
[1] ORCID ID: 0000-0002-4133-2189
[2] ORCID ID: 0000-0002-7748-0685

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Statement of significance

Problem

Some women decline aspects of recommended care or treatment during childbearing. It is assumed that midwives experience risk to themselves in these situations.

What is already known

Women's reasons for declining recommended care.

What this paper adds

There is a significant gap in understanding about how caseloading midwives perceive risk to themselves, because the question has not specifically been asked. This paper adds a substantial illumination of the nuances involved in providing woman-centred care in a caseloading midwifery model. Midwives who provide such care place themselves at risk. Maternity systems and colleagues can be key risk factors for caseloading midwives who facilitate women's right to decline recommendations.

1. Introduction and background

It is a basic human right to make autonomous informed choices about health care and decline recommended medical treatment, and this right is not negated during childbearing [1,2]. In order to have choices, childbearing women need midwives who are willing to facilitate those choices and who are supportive of women's autonomy. When women make choices in pursuit of a physiological birth, and those choices fall outside of current guidelines, protocols, and consensus statements, these situations can and may present risks for midwives. Practising in a way that meets ethical and legal obligations to women can take a midwife outside of clinical guidelines and has the potential to bring the midwife into conflict with her colleagues and the systems within which she provides care [3]. Rhetoric gives way to systemic pressure with the resulting reality that women must choose from a reduced menu of locally available and permissible options [4,5]. The International Childbirth Initiative [6] asserts that the needs of childbearing women must take precedence over those of midwives and institutions. Yet there can be a tension between woman centred care and midwives' professional obligations and the reality of how societal or practise environment scrutinise care [3,7–12]. How these tensions and subsequent consequences affect caseloading midwives remains to be understood.

Caseloading continuity of carer midwifery has been practised globally throughout history and is currently available in many countries [13]. There is a diversity of models of caseloading care and an array of caseloading definitions. For this article we adapt the 'Midwifery group practice caseload care' classification from the Australian Maternity Care Classification system (MaCCS) [14]. This detailed MaCCS classification reflects the Aotearoa New Zealand model of caseloading midwifery which provides continuity of carer throughout antenatal, intrapartum, and postnatal care in collaboration with medical and allied health care providers. In this model care follows the woman and is provided in primary and secondary services as needed and chosen. Although caseload midwifery as defined in this article is not currently available everywhere and only reported in identified sources from six high income countries this does not infer that such models do not exist and operate in none researched regions. It is evident from the literature published in this domain that there are international variations in public funding, supportive infrastructure, levels of integration with other health services, and the legal scope of practice for midwives. For example, midwives in The Netherlands and Canada have their scope restricted to caring for women experiencing uncomplicated pregnancies, whereas midwives in Australia, Aotearoa New Zealand [NZ], France and United Kingdom [UK] are legally able to continue to provide continuity of care alongside medical colleagues when women have pre-existing medical conditions, and/or when obstetric complications arise [15]. Likewise, there is high variability in availability of access to caseload continuity midwifery even in countries where it exists, for example, in Australia only 8–19 % of women have access to such a model of care [16,17]. From a global perspective the model of care in Aotearoa remains rare.

The midwifery literature suggests that midwives experience risk when caring for women who decline recommendations [3,8], yet how this is experienced specifically by caseloading midwives is largely unknown. The silence in the literature leaves these midwives vulnerable.

2. Reflexivity

All authors have extensive experiences working in caseload midwifery practice. PF is currently practising as a caseloading midwife; she became a midwife because she is passionate about supporting women's autonomous right to choose their own pathway through maternity care, and that extends to their right to decline professional recommendations. SC has worked in caseload practice both in the UK and in NZ. She shares the passion about ensuring women maintain autonomy whilst acutely aware of the sustainability for the midwife when tensions arise. NW has worked in secondary/tertiary facilities in the UK and NZ, as well as in caseload midwifery practice in NZ. She is passionate that women maintain autonomy in any setting they choose for their maternity care. The challenge is in ensuring consistency of such support from all involved in women's care. Our positionality has the potential to affect this research project [18] therefore this has been made transparent.

3. Methodology and methods

A review protocol was developed a priori and submitted to Open Science Framework [19].

3.1. Review aim, objectives and question

The aim of this review was to synthesise existing qualitative research which includes the voices of midwives working in a continuity of carer model who perceive any kind of risk to themselves when caring for women who decline recommendations. The three objectives were:

1. Generate practice-based knowledge about an unexplored aspect of caseloading midwifery to support midwives to support women who request care outside of recommendations.
2. Provide insight for allied health professionals into the personal and professional challenges and vulnerabilities experienced by midwives to improve relationships between professions, thereby increasing safety for childbearing women.
3. Inform and recommend a program of research that highlights mechanisms for safe, acceptable, and sustainable caseload midwifery practise in situations where women choose care outside of current established recommendations.

Reading studies involving caseloading midwives in Aotearoa New Zealand across multiple topics revealed brief glimpses of midwives' experiences and perceptions of risk to themselves when women in their care declined recommendations. This review was designed to put a different question to existing published qualitative data in this domain: *How do caseloading midwives experience risk to themselves when women decline recommendations?* In order to ensure formation of robust question the PCC framework was adopted (See Box 1).

Box 1
PCC Framework.

PopulationCaseloading midwives providing continuity of carer.

ConceptPerception or experience of personal or professional risk.

ContextCaring for women who decline recommendations.

3.2. Seven-phase method

The review method was a meta-synthesis using the seven-phase [20] interpretative meta-ethnography (See Box 2). This method was chosen for its ability to synthesise a new interpretation or theory going beyond the findings of the included primary studies [21]. Sandelowski, Docherty [22] outline an approach which enables studies with heterogeneous methodologies to be synthesised, by explicitly recognising these prior to and throughout the stages of analysis.

3.3. Search strategy and inclusion criteria

The initial search was conducted during April 2021 and repeated in July 2021 using the following search terms for published research: midwi* AND "maternal refusal" OR "treatment refusal" OR "declin* recommended care" OR "unconventional birth choice". Adding AND caseloading OR case-loading OR "continuity of care" OR holistic OR "relational continuity" reduced numbers of results considerably, but this eliminated important possible sources of data, so PF returned to the wider search strategy. Databases searched on advice of specialist librarian were CINAHL Complete (EBSCOhost), MEDLINE, MIDIRS, PsychINFO, Scopus, and Web of Science.

Publication dates were limited to 1990–current as this was the time that legislation changes in Aotearoa New Zealand returned autonomy to midwives, allowing them to carry caseloads and provide maternity care on their own authority without medical supervision. This timeframe includes international conversation stimulated in 1993 by *Changing Childbirth* report in UK [23].

3.4. Inclusion criteria

This meta-synthesis considered studies which included midwives providing continuity of care in a caseloading model, which focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research. Mixed methods were included if there was a large qualitative component to the data. Studies could be published or unpublished, but accessible, and available in English. Box 3 provides details of the inclusion criteria.

A maximum of 10 studies were to be included to ensure all relevant data were able to be given sufficient attention without threatening the depth of analysis or the validity of interpretive findings. [22] If more than 10 topically similar studies were located, tighter boundaries would be set for the purposeful sampling to keep the project manageable. The outcomes of the searches are provided in the PRISMA flow chart (See Fig. 1).

No published research was identified which specifically investigated this topic or question. Very few studies have looked at the broader topic of midwives' experiences of caring for women 'outside of guidelines' or making 'unconventional birth choices' for example [9,24–27]; contained within these explorations are occasional voices of midwives feeling at risk when women made 'unconventional' choices. Most of these studies explored this phenomenon from the perspective of midwives who were not caseloading or were providing fragmented care, which is quite a different context.

The search continued for unpublished research such as Masters and PhD theses in Tuwhera, NZ Research, Trove, and ProQuest Dissertations and Theses Global. Tuwhera is specific to AUT, and the search phrase yielded nothing, so PF simplified the search to "lead maternity carer" [LMC] as this is specific to Aotearoa New Zealand; this brought 33 results which was a manageable number of extracts to read, and this yielded one of the included studies. NZ Research register produced 77 articles from the original search terms; interestingly, adding "lead maternity carer" to the search reduced results to 16, and relevant studies were not captured. Trove (Australian register) produced 10 articles from the original search terms; the few that were relevant were duplicates of previously identified sources. ProQuest Dissertation and Theses Global search produced 76 results, but nothing relevant to this inquiry. That completed the structured literature search, and PF continued searching for any further relevant sources using 'berrypicking', an iterative process involving checking reference lists of papers to identify further possible sources not picked up in the database search process (Bates, as cited in [28]).

Box 2
[20]Noblit and Hare's seven phases.

PhaseActivity.

1Getting started (the search).

2Deciding what is relevant to the initial interest; establish inclusion and exclusion criteria.

3Reading studies and extracting data.

4Determining how studies are related (identifying common themes and concepts), or dissonant. Compare and contrast exercise.

5Translating studies (checking first and/or second order concepts and themes against each other).

6Synthesising translations (create new third order constructs and line of argument).

7Expressing the synthesis and writing up the review findings.

Box 3
Inclusion criteria.

Inclusion criteriaDescription/rationale.

Continuity of care midwifeAlso known as caseloading, holistic, relational care.

Post 1990Autonomy legislated in New Zealand midwifery and continuity of care was beginning to be highlighted in the literature internationally.

Available in EnglishInsufficient funding to use translation work for this review.

Published or unpublishedEnsure range of sources and 'voices' included.

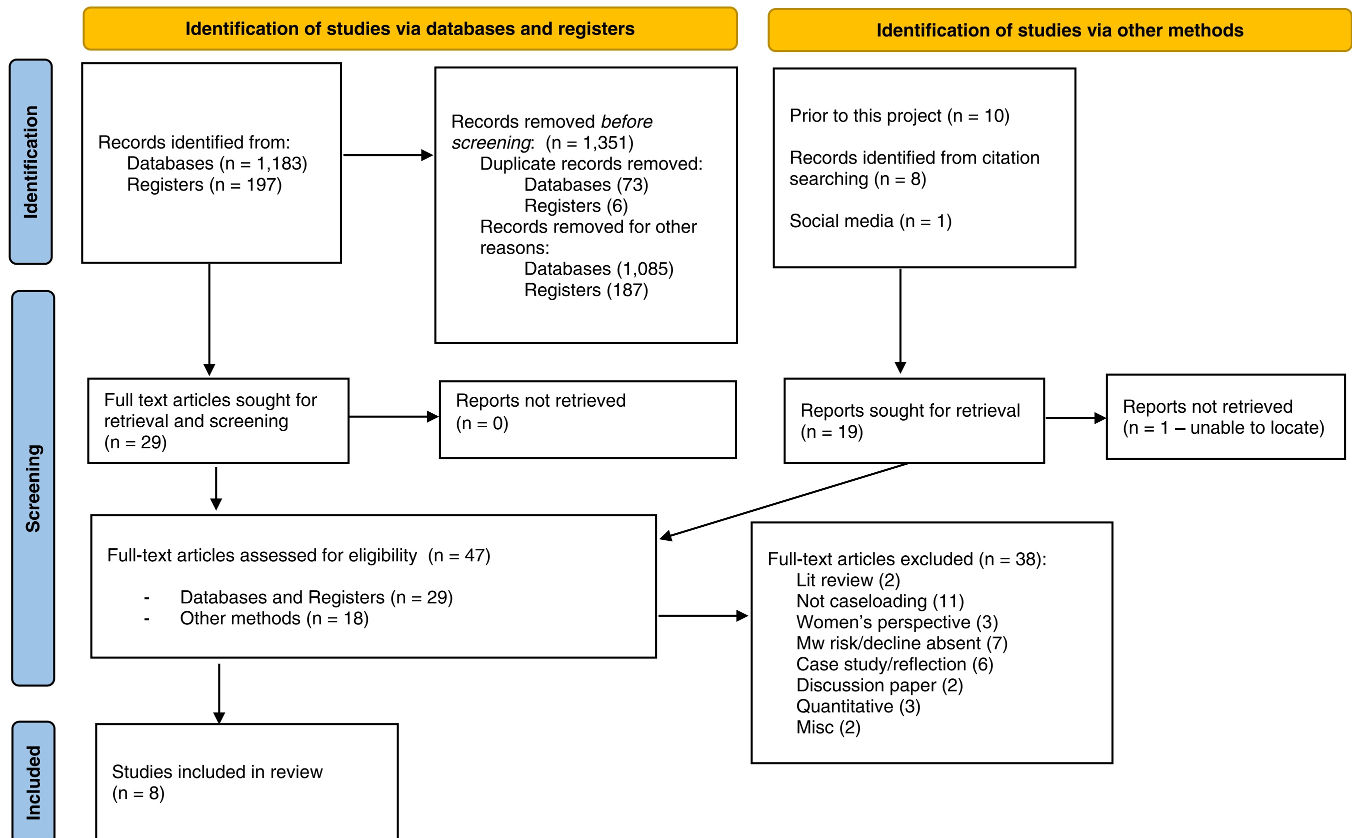

Fig. 1. Prisma diagram of search results.

3.5. Phase 2 – screening and quality appraisal

Identified possible sources were assessed and evaluated for quality and rigour by PF using JBI Critical Appraisal Checklist for Qualitative Research, and checked by another member of the research team (SC and NW) – see appendix 3 for example. Studies were only included if they met seven out of a possible ten quality criteria, with ethical standards being an essential criterion. Throughout the project, the relevant data and emerging findings were discussed as a team until consensus was reached. GRADE-CERQual was applied to the findings, using Lewin et al.'s [29] four stage process that assesses methodological quality, coherence, relevance and adequacy of the findings (See Table 1). PF did the initial application of the CERQual process and SC independently verified the Qualitative Evidence Profile grading (See Supplementary Material).

3.6. Phase 3 – reading studies and extracting data

Eight studies met inclusion criteria [3,8–12,30,31], and extraction of relevant data was commenced using JBI QARI Data Extraction Tool for Qualitative Research. With the review aim and question in the foreground, this involved an iterative process of reading and re-reading studies, gradually extracting data which included background information on each study such as methodology, aim, population, setting, participants and then identified 'first order constructs' – the voices of primary research participants, and any 'second order constructs' – the themes or concepts expressed by original study authors as an interpretation of participants' views [32]. Some of the studies did not yield second order constructs because their research focus was not sufficiently closely related to this specific research question, but did provide relevant first order constructs because this is not an uncommon phenomenon in midwifery practice. The study most closely aligned with this research question, Feeley [8], provided second order constructs, but midwives were included from across a range of working contexts who

Table 1
Background Overview of Included Studies.

Year & author	Title of source/article, Aim, Summary findings/Themes	Methodology/Method	Population Sample
2019 Feeley[8] [PhD Thesis which resulted in peer reviewed published paper by Feeley[8], Thomson & Downe, 2019]	*'Practising outside of the box, whilst within the system': A feminist narrative inquiry of NHS midwives supporting and facilitating women's alternative physiological birthing choices.* **UK Based** Question: What are the processes, experiences, and sociocultural-political influences upon NHS midwives who self-define as facilitative of women's alternative birthing choices? Aim: to generate practice-based and heuristic knowledge for the benefit of other midwives to deliver 'full-scope' midwifery to meet the needs of women making alternative physiological birthing choices.	Qual feminist pragmatist narrative inquiry. Self-written narrative or interview. Thematic analysis (Braun & Clarke)	N = 45 (Caseloading 18) UK NHS employed midwives Mix of care models, including caseloading and clear who these are.
2019 Hollander et al.[9]	*Addressing a need. Holistic midwifery in the Netherlands: A qualitative analysis* (journal article included in book: *Birthing outside the system*) **Netherlands based** Aim: to provide other maternity care professionals with insight and to improve professional relationships between all care providers in the field. Core theme: Addressing a need. Holistic midwives explained that many of their clients had no other choice than to home birth in a high risk pregnancy because they felt let down by the regular system of maternity care. Holistic midwives appear to deliver an important service. They provide continuity of care and succeed in establishing a relationship with their clients built on trust and mutual respect, truly putting their clients' needs first. Some women feel let down by the regular system, and holistic midwives may be the last resort before those women choose to deliver unattended by any medical professional. Maternity care providers should consider working with holistic midwives in the interest of good patient care.	Exploratory qual design with constructivist approach, grounded theory method. Semi-structured individual interviews, then feedback focus group to confirm.	N = 24 'holistic' midwives in Netherlands
2021 Hunter et al.[3]	*The experiences of privately practising midwives in Australia who have been reported to the Australian Health Practitioner Regulation Agency: A qualitative study* **Australia based** Aim: to explore the experiences of PPMs in Australia who have been reported to the AHPRA. Over-arching theme: Caught between women and the system. Themes: The suppression of midwifery, A flawed system, Lack of support, Devastation on so many levels, Making changes in the aftermath, and Walking a tight rope forever.	Qual interpretive methodology, feminist thematic analysis method. Semi-structured, individual, in-depth interviews.	N = 8 independent Australian midwives
2019 Madeley et al.[26]	*An interpretative phenomenological study of midwives supporting home birth for women with complex needs* **UK based** Aim: to explore the experiences of midwives who specifically facilitate home birth for women with complex needs. Themes: The radical midwife, The conflicted midwife Conclusions: It is no longer acceptable to assume that home birth for women with complex needs is exceptional. This must be the catalyst to move towards a constructive discourse with midwives, women and the wider team to address and expand the evidence base and pathways to support those who are already facilitating this care and those who will inevitably continue to provide care 'outside of current guidelines'.	Qual interpretive methodology. Phenomenological analysis method. Semi-structured individual interviews.	N = 6 UK community midwives
2009 Patterson[10] [PhD Thesis]	*A time of travelling hopefully: a mixed methods study of decision making by women and midwives about maternity transfers in rural Aotearoa, New Zealand* **NZ based** Aim: to explore how women and midwives arrive at the decision to either stay, or transfer from a primary/rural maternity facility to a secondary or tertiary facility in labour or post birth. Themes: Helping women decide about birthplace; Deciding about transfer in labour; Reflecting on the transfer decision; Considering issues for rural areas and their impact on decision making. Findings: Midwives make cautious and timely decisions about transfer in labour and birth. Further, a rural birthing service contributes to the health and well being of the	Mixed methods – national survey of rural maternity units, plus individual and small group interviews of women & midwives. Thematic analysis.	N = 15 Rural community caseloading self-employed midwives (in NZ these midwives are LMCs or Lead Maternity Carers)

(*continued on next page*)

Table 1 (*continued*)

Year & author	Title of source/article, Aim, Summary findings/Themes	Methodology/Method	Population Sample
	community and ought to be appropriately resourced to provide the optimal environment for safe decisions about transfer.		
2005 Skinner[11] [PhD Thesis]	*Risk and the midwife: A descriptive and interpretive examination of the referral for obstetric consultation practices and attitudes of New Zealand midwives* **NZ based** Question: How do midwives express and manage risk in their practice? It examines this question by identifying and investigating the referral for obstetric consultation as the place where risk is most clearly identified, not only risk to the mother and her baby, but also risk to the midwife herself. Findings: Midwives managed complex and challenging tasks in a birth environment that was by its very nature uncertain and risky. Birth is set in a context of complex power relations in which the techno rational approach still holds the authoritative position. Issues of evidence based care and informed consent are the most current constructions that they have needed to incorporate. most fundamental difficulty was that of accountability. … perceiving that the consequences would be dire. They were fearful and anxious. This then challenged their ability to build trusting relationships both with the woman and with obstetricians. The next area of difficulty was that of authoritative knowledge and the dominance of the techno-rational paradigm. It was seen that accountability would be assessed from the medical or techno rational perspective. Medicine was regarded as authoritative, not in the sense of being right but of having the power to claim that they were right.	Critical realism Mixed methods: survey (quant) and focus groups (qual), feminist lens	N = 27 Caseloading midwives in 6 focus groups
2010 Symon et al.[27]	*Examining Autonomy's Boundaries: A Follow-up Review of Perinatal Mortality Cases in UK Independent Midwifery* **UK based** Review of independent midwives' management, responding to concerns that care management may have been a factor. 14/15 women were 'at risk' at start of labour; twins, breech, VBAC, maternal illness. 12/15 booked homebirths. Conclusions: Planned home birth in the presence of significant risk factors would take many practitioners beyond their comfort zones, and detailed discussions about possible or likely outcomes are essential. Professional responsibilities are not abnegated simply because a practitioner wishes to promote a pregnant woman's choice making. The independent midwives in this study saw themselves as enablers and facilitators in this respect, but still were guided by their professional duties. A great deal of rhetoric abounds about ''patient'' choice in contemporary health care. If the reality is to match the rhetoric, then we must accept that planned home birth in high-risk situations, although rare, is a logical consequence of full autonomy for the pregnant woman.	Qual Descriptive Thematic analysis of case notes; semi-structured interviews with midwives	N = 15 Independent midwives
2011 Young[12] [PhD Thesis]	*The experience of burnout in case loading midwives: An interpretive phenomenological study* **NZ Based** Question: What is the experience of case loading midwives who burnout? Conclusions: Individual powerlessness because of the erosion of self lies at the heart of burnout. Participants' stories were uniformly of a crippling loss of self-rule and self-sufficiency. They spoke of the loss of joy, of passion, of self, of family, of friends… Without the tools to recognise the potential for burnout amongst midwives engaging in the high demands of continuity of carer, midwifery opens the door to invite it in.	Qual interpretive phenomenology (hermeneutics) Narrative interpretation of interview transcripts.	N = 12 + 4 partners LMC midwives (see above)

self-identified as facilitative of alternative birth choices. Midwives providing continuity of care were easily identified so that raw data as first order constructs were easily extracted; second order constructs were only included in this study's data if they were attributable to midwives working in a caseloading model. This closely detailed process of working with sources and manually extracting data enabled the synthesis of studies using heterogeneous methodologies [22].

3.7. Phase 4 – determining how studies are related or dissonant

This involved grouping studies together to examine how they were related to each other and how they were different, comparing and contrasting the studies within and between groups. Studies were grouped according to:

1. geography, e.g., studies based in NZ in comparison to other regions in the world,
2. published studies compared to unpublished theses,
3. studies involving midwives who self-define as willingly facilitative of 'alternative' or 'against guideline' care contrasted with studies of midwives who find themselves in that situation, and
4. studies examining the phenomenon of an actual negative outcome (Hunter [3] – reported to a legal body; Symon [31] – neonatal death; Young [12] – midwife burnout), versus those where midwives expressed awareness of this possibility.

Included studies were done in four countries: NZ, Netherlands, Australia and the UK. This was perhaps unsurprising due to the ongoing focus on establishing caseloading practice in these countries; conversely, it was unexpected when no Canadian studies were identified despite some regions within Canada focusing on caseloading practice. Once the studies were separated into the various groups and categories it quickly became apparent that the three NZ studies [10–12] were all the unpublished theses, and all involved midwives who found themselves in situations of being required to facilitate care outside recommendations rather than self-defining as willingly facilitative. The remaining five studies [3,8,9,30,31] were all outside NZ, published in peer-reviewed journals, and examined experiences of midwives who willingly provided such care. (Note that Feeley's [8] study was originally a PhD thesis which then resulted in a published study, being Feeley et al., 2020; the thesis has been used as the primary source for this meta-ethnography because of its more comprehensive data and clear identification of each midwife's working context).

3.8. Phase 5 – translating studies into one another

This was an iterative process of translating themes and concepts, both reciprocal and refutational, from one study into the next to create concepts or metaphors representing multiple studies [21]. Refutational translation involved exploring differences and contradictions in order to explain these, creating a narrative or 'storyline' so that "findings are placed into context" (Finfgeld-Connett, as cited in [21], p. 10). This phase was creative, involving many sticky Post-it notes containing phrases, quotes and concepts, stuck to several huge sheets of paper. Initially messy, the Post-it notes were moved around into groups which morphed and blended, separated and changed many times until, eventually, they settled into a semblance of order and newly synthesised themes started to emerge.

3.9. Phase 6 – synthesising translations

Emergent themes and interpretations were identified through an iterative process involving frequent regressions into previous phases and the primary data to confirm, compare, explore refutational themes and contexts, eventually arriving at new third order constructs, being five key themes, refutational findings, and a line of argument which are now expressed and detailed in phase 7. Table 2 presents the five key themes against the studies from which they emerged through this process.

3.10. Phase 7 – expressing the synthesis (review findings)

The voices of 125 caseloading midwives working in Australia, Netherlands, UK and NZ provided data for this meta-ethnography. These voices were gleaned from eight included studies of heterogeneous research designs, none of which asked specifically about midwives' perceptions of risk to themselves. [3,8–12,30,31] Perceptions of risks to midwives, and what those risks might be, seem to be consistent and interconnected amongst the included studies; however, experience of anxiety around those risks was not universal.

4. Findings

Five themes were identified as third order constructs: Damaged Reputation, Collegial Conflict, Intimidating Disciplinary Processes, Tensions of 'Being Torn', and Heavy Psychological Load. This section describes these five key themes in detail with supporting data from included studies highlighting the concepts within each of the themes. Refutational findings are also detailed, and all these interconnected themes are then woven into a new line of argument.

4.1. Theme: damaged reputation

This theme contained rich data and was contributed to by seven of the eight included studies. Interestingly, this was not generally expressed as risk of a damaged reputation in the event of a poor outcome, but rather as being regarded by colleagues and allied health professionals as an unsafe or even dangerous midwife simply for providing woman-centred care and facilitating choices which went against recommendations. In fact, when data was extracted which specifically considered the possibility of a poor outcome, none of it mentioned the concept of damaged reputation; this was unexpected. This finding suggests that caseloading midwives value their reputations with their colleagues and experience distress when providing ethical woman-centred care causes their colleagues to regard them negatively (See Table 3).

4.2. Theme: collegial conflict

Participants in seven of the eight primary studies provided rich data identifying that caring for women whose choices were outside guidelines brought them into conflict with other midwives and medical colleagues. Transferring in from a planned homebirth for a woman with complexities brought confrontations with colleagues [3]. A midwife in Skinner's paper [11] discusses a prolonged second stage in a primary birth setting which, if they had ended up transferring (declined several times by the woman), would have provoked collegial conflict. Collegial conflict on arrival when transferring in has the potential to increase risk for the woman and/or baby. This effect on caseloading midwives' relationships with colleagues was regarded by Hollander [9] to be a "considerable cost" (p. 14). Skinner [11] agrees, asserting that providing such care comes "at the expense of her professional relationships" (p. 21). Such language suggests that harmonious, supportive relationships with colleagues are a valuable asset which the caseloading midwife is poorer for losing (See Table 4).

4.3. Theme: intimidating disciplinary processes

This theme encompassed everything from internal investigations of appropriate midwifery care within a maternity facility or Trust, through to judicial processes generally described as 'medico-legal' which could result in censure, competence review, formal practice supervision, or even loss of registration. It was not that midwives thought they should not be accountable for their practice, rather a general sense of fear that the processes involved would not be fair or appropriate. Only Young's [12] study did not contribute data to this theme; unsurprising as her research examined the phenomenon of burnout, whereas the other seven studies all examined questions relating to referral or risk. Midwives in Feeley's [8] study were anxious about the impact of "a poor outcome" on themselves, specifically fears of "losing their PIN" and "fears of being scapegoated" (p. 185). Likewise, the studies by Hollander [9], Skinner [11], and Symon [27] all identified fear of judicial processes in the event of a poor outcome, rather than the poor outcome itself. Only one midwife, Tara, quoted in Madeley's [26] study, stands in contrast: *"Emotionally, if a baby or a mum is lost, you have to live with that"* after identifying being *"struck off"* as *"the worst-case scenario"* (p. 629). The possibility of being blamed for a poor outcome is experienced as a

greater risk by midwives than the poor outcome itself. Midwives understand that a poor outcome is always a possibility in every situation. To be unfairly blamed for this in the context of supporting a woman's right to decline recommendations is where their risk lies, and it weighs heavily on their minds. (See Table 5).

4.4. Theme: tensions of 'being torn'

In occupying the space between non-compliant women and the maternity system, midwives often become mediators on a battlefield as worldviews collide, and six primary studies contributed rich data to this theme. Midwives are caught in tension between accountability to the woman, and "the way medicine has the power to define what appropriate midwifery practice should be." [11] As Feeley [8] summarises, "…organisational cultures that stigmatise midwives who work within an authentically woman-centred philosophy can catalyse severe adverse consequences for those midwives." (p. 227). (See Table 6).

4.5. Theme: heavy psychological load

All eight primary studies supported this theme. This was the only risk theme which was not necessarily directly related to colleagues within the maternity system; this theme also encompassed the broadest-ranging aspects. It is possible that caseloading midwives feel an increased burden of responsibility when the woman does not achieve the birth desired because the midwife has been caring for the woman throughout the pregnancy, has participated in the woman's decision-making process, and will be caring for the woman in the aftermath for up to 6 weeks and then potentially further episodes of childbearing. Caseloading midwives may be unable to go off call due to being unable to ask another midwife to take clinical responsibility for a 'risky' birth; this can cause resentment in their own families, create work-life imbalances and threaten sustainability in caseloading practice. General anxiety rises as risks mount, especially if the midwife considers the baby to be at risk. A cluster of such cases can easily overwhelm a midwife's ability to cope, and her sustainability in caseloading practice is threatened (See Table 7).

4.6. Refutational findings

While the findings of this study tend to be negative (the research topic and question being specifically focused on perception of risk), a potentially contrasting, or refutational finding was highlighted. Several studies identified that some midwives felt very positively about providing care to women making choices outside recommended care, finding such care rewarding: *"It is something that I love so, so much"* and when this midwife's partner asks why she keeps "doing this to herself" she responds, *"it's because of how much I love what I do"* [3] (p. e28). A midwife in Madeley et al. [30] expresses similar sentiments: *"I think women are quite rightly getting more empowered,… doing more research for themselves,… not just taking what we are saying as verbatim, that's it, that's that and I LOVE that."* (Tara, p. 630).

Madeley et al. [30] study also outlined how midwives providing homebirth services "felt only a little anxiety around facilitating care for women with complex needs… they appreciated the opportunity to provide such care" and demonstrated a "lack of fear and anxiety around facilitating women's choices and providing high-risk intrapartum care at home…". The participants explained "that the ease with which they provided care to women was grounded in their extensive clinical experience, thus allowing for instinctual decision making." (p. 627). However, the same study also reports data consistent with four of the five key themes in this meta-synthesis. The midwives in Madeley et al.'s [30] study clearly perceived risks to themselves, even if this caused them "only a little anxiety". Hunter et al. [3] concur with this positive finding, with some midwives taking the position that, while they perceived various risks to themselves, they remained steadfast in their position of honouring women's choice and providing a service to enable women to truly have choice in childbearing: *"I don't care anymore to be honest. I know I'm going to get reported… I book a woman because she's a woman and she wants the care I can provide."* This midwife identified that the support went both ways: *"They know how passionate I am so they support me to keep fighting."* (M3, in [3] p. e28). Other midwives in the same study, however, found the risks hugely distressing and this was a cause of attrition. Skinner [11] also found "…some willingness to provide care that went outside the guidelines, that is, not making a referral when it was recommended, if the woman did not want to." (p. 224) and that midwifery commitment was dependent on a perception of women's commitment:

> …as long as she's really committed that's what she wants and as long as everything is okay with the baby you know, all those checks are done and everything like that, I'm quite happy as well but if she's not prepared to sort of stand there and take that risk, well then I'm not either. (p. 205).

A midwife in Skinner's [11] study articulated the strength needed to support women's out-of-guideline choices, and questioned the evidence base on which obstetric guidelines rest:

> Sometimes it means you have to stand up to people. You know I get growled at a bit by obstetricians for not doing guidelines. But I don't care because I've given the women the options, told them the research base information which the obstetrician's guidelines aren't adhering to anyway. So I don't really give a stuff. (p. 225).

Midwife Jess, quoted in Feeley [8], challenges the notion that women's out-of-guideline choices resulted in increased risk, asserting that her continuity working context is *"safe and actually improves outcomes"* and *"we have excellent stats and outcomes that are better than the local and national averages."* Jess clearly finds providing out-of-guidelines care to be personally rewarding, saying, *"without having me as her advocate, she wouldn't have known that she could have made a plan… She probably wouldn't have had a positive, natural birth."* (p. 174). A midwife in Hollander [9] articulated,

> And then, for me, it became an activist kind of thing, like: this is very important, that we take a stand for this (…), that women are entitled

Table 2
Overview of themes represented by included studies.

Theme → Study↓	Damaged reputation	Collegial Conflict	Intimidating Disciplinary Processes	Tensions of 'being torn'	Heavy Psychological Load
Feeley	x	x	x	x	x
Hollander et al	x	x	x	x	x
Hunter et al		x	x	x	x
Madeley et al	x	x	x	x	x
Patterson	x	x	x		x
Skinner	x	x	x	x	x
Symon et al	x		x		x
Young	x	x		x	x

Table 3
Concepts within Damaged Reputation.

Concept within theme	Contributing studies	Example of supporting data
Woman's decision reflects midwife's leading	Feeley [8], Young [12], Madeley [26], Hollander [9]	"…they were often accused of creating the demand they were facilitating…" Hollander [9] (p.16) *"I often feel like I am labelled as a 'troublemaker' midwife when I walk on labour ward. That people think I am brainwashing my women to decline induction or decline prophylactic antibiotics* etc. *when in reality I am just supporting them to make their own informed decisions."* Feeley [8] (p.174) *"That can be difficult for us professionally, there's this idea… that we are always encouraging women to do something out of the guideline, or something strange, and, that we're… mavericks in our practice."* (Dawn, in Madeley [26] p. 628)
Negative critique by colleagues	Hollander [9], Patterson [10], Feeley [8], Young [12], Patterson [10], Skinner [11], Madeley [26]	Rose "…found herself 'questioning' her actions, concerned about how she was perceived by the labour ward midwives." Feeley [8] (p. 178) "Unwarranted negative comments, particularly by medical staff, have the potential to damage the midwife's reputation. …some judgements were made on incomplete information." Patterson [10] (p. 218)
Midwifery failure	Young [12], Feeley [8]	*"…and them saying that you didn't do all that you could, you didn't talk her out of it, I hate that, you get that a lot, 'why can't you talk her out of it?'"* (Edna, in Feeley [8] p. 177) "The practice reality is that repeated failure by a midwife to influence her clients to comply with guidelines and protocols may ultimately reflect on the midwife. Non-compliance was seen as midwifery failure not upholding client choice." Young [12] (p. 17)

to their bodily integrity at all times, and can refuse care, but in the meantime should not be denied care. (p. 13)

It is apparent that despite potential risks to the midwife in these situations some practitioners acknowledge this as essential to their midwifery role in providing choice and agency to women. These midwives report professional and personal satisfaction when they remain with women through challenging situations which confront established approaches despite the potential risk to themselves.

4.7. Line of argument

The outcome of the synthesis resulted in five themes and refutational findings and culminates as this line of argument:

> Women's rights to bodily autonomy and choice in childbearing are violated, and their ability to access safe midwifery care in pursuit of physiological birth is restricted, when midwives practise within a maternity system which is adversarial towards midwives who provide the care which women require. Midwives who provide such care place themselves at risk of damaged reputation, collegial conflict, intimidating disciplinary processes, tensions of 'being torn', and a heavy psychological load. Despite these personal and professional risks, midwives who provide this care do so because it is the ethical and moral thing to do, because they recognise that women need them to; because it can be very rewarding; and because they are able to.

Table 4
Concepts within Collegial Conflict.

Concept within theme	Contributing studies	Example of supporting data
Horizontal violence	Hollander [9], Hunter [3]	*"I have been told off by an obstetrician and I have been ignored many times. There are obstetricians who still ignore me. I always find that very intimidating and I let myself be intimidated."* (Midwife 11, Hollander [9] p. 11) *"If this is the way it's going to be, that every time you take on a woman with complexities some [swear word] is going to put in a complaint…"* (M5, Hunter [3] p. e28)
Confrontations	Young [12], Feeley [8], Patterson [10]	"Participants recounted incidents of conflict focusing on their practice not the woman's right of choice when interfacing with secondary services…" Hunter [3] (p. 17) *"…always given the stick that we are not going along with hospital policies"* (Laura, Feeley [8] p. 178) *"It would have been very easy for an obstetrician to say well you should have had this one in hospital because of this that and the other thing. But it was not what she wanted…"* Patterson [10] (p. 167)
Unsupportive relationships	Madeley [26], Hollander [9], Skinner [11]	"They felt the pressure of constantly being judged by regular care providers, whose hostility, distrust and animosity weighed heavily on their minds." Hollander [9] (p. 16) "…ranging from… subtle undermining behaviour to outright hostility" Madeley [26] (p. 628)

5. Discussion

The findings of this meta-synthesis are applicable to all midwives, midwifery leaders and educators. Midwifery workforce shortages and attrition are a global concern [33]. The study by Hollander [9] identified that there were no more than 30 'holistic' midwives (around 1 % of all Dutch community midwives) in The Netherlands who offered caseloading 'alternative' care to women with known risk factors, 24 of whom were study participants. Hollander [9] note that, at follow-up 18 months to 3 years after interview, 9 of the 24 holistic midwives in their study had ceased practising in this way, with the most frequent reasons being, "pressure exerted by regular care providers" and "the threat of legal action being taken against them" (p. 17). None had quit over a bad outcome. The authors point out that, "The type of care they deliver is actually that which both Dutch professional organizations encourage their respective members to provide." (p. 19) and yet these midwives are "stigmatized or even vilified by regular maternity care providers, and they are made to fear legal repercussions in case of a bad outcome, which makes working the way they do emotionally difficult." (p. 10). Hunter [3] examined the experiences of eight privately practising Australian midwives (PPMs) who had been reported to the Australian Health Practitioner Regulation Agency by another health professional when they supported women choosing care outside recommended guidelines. They state there were only 241 PPMs attending homebirths in 2015 across Australia, that this number had halved since 2009 and

Table 5
Concepts within Intimidating Disciplinary Processes.

Concept within theme	Contributing studies	Example of supporting data
Get 'struck off'	Feeley [8], Hunter [3], Madeley [26]	*"I could get struck off is the worst-case scenario, professionally…"* (Tara, in Madeley[26] p. 629)
Medico-legal consequences	Feeley [8], Hollander [9], Hunter [3], Skinner [11], Symon [27]	"…being scapegoated in the event of a poor outcome." Feeley [8] (p. 185) "…made to fear legal repercussions in case of a bad outcome… many participants reported fear of legal repercussions." Hollander [9] (p. 10 & 11) "The findings show that all the reports made to AHPRA about the [midwives] interviewed occurred when the midwives supported women who were choosing care that was considered outside recommended guidelines." Hunter [3](p. e25) *"And some of them say 'oh no I'm fine'. I'm happy with that. I mean I guess I quite actively encourage them [to have a referral] purely from a medico legal point of view. That if something untoward happens and I hadn't done that or suggested that she do that, then you know I'd be very vulnerable. So it's a self-protection thing."* Skinner [11] (p. 225) *"I never get burnt out by the women. I get burnt out by the bullshit."* (M2, Hunter [3] p. e28)

Table 6
Concepts within Tensions of 'Being Torn'.

Concept within theme	Contributing studies	Example ofsupporting data
Systemic opposition	Young [12], Feeley [8], Hollander [9], Madeley [26]	"…an environment where, contrary to the premise of women's choice and control of care, there is pressure to manipulate clients to conform…" Young [12] (p. 18) "The misalignment between the midwives' notions of 'normalcy' and their colleagues left the midwives vulnerable to consequences of stigmatisation." Feeley [8] (p. 211)
Caught in the middle	Skinner [11], Feeley [8], Hunter [3], Madeley [26]	"…the midwife can find herself… either supporting the woman at the expense of her professional relationships or not supporting the woman at the expense of her professional integrity." Skinner [11] (p.21) "The midwives interviewed for this study felt caught between women and the system and this was distressing and felt like an untenable situation for them." Hunter [3] (p. e29)

had reduced by 20 % in one year, suggesting "that the impact of reporting may have had a significant effect on PPMs decision to remain in practice. Certainly, that is what was evident when interviewing these midwives." (p. 29). These are examples of midwives' perception of risk to themselves causing them to withdraw from providing woman-centred care and thus eroding the menu of options available to women. The concern expressed by PPMs in the study was that women had said they

Table 7
Concepts within Heavy Psychological Load.

Concept within theme	Contributing studies	Example of supporting data
Facilitating the plan – being responsible, having to stay on call for weeks…	Feeley [8], Hollander [9]	*"You feel so responsible when it doesn't go right… you shoulder that and you blame yourself"* (Edna, in Feeley [8] p. 177) "…the burden of responsibility when clients appear to make decisions that pose increased risk to the baby" Hollander [9] (p. 12) "Most participants are almost always available for their clients" Hollander [9] (p. 10)
The strain it puts on everything – anxiety, disrupted sleep, mental health issues	Feeley [8], Hollander [9]	*"…my mental health suffers because of it, my family life suffers because of it, …I lose sleep at night because of these women (.) I do (.) we all suffer with anxiety, I'd say 50 % of the midwives that (.) practice in the same way as I do (.) suffer because of the effort and the strain it puts on everything…"* Edna, in Feeley [8] p. 177
Burden of poor outcome	Symon [27], Madeley [26], Feeley [8], Hollander [9]	*"Very scared for however long it took for the investigation… over a year… beating myself up that someone would say I killed the baby."* Symon [27] (p. 285) *"If a baby or a mum is lost, you have to live with that"* (Tara, in Madeley [26] p. 629)

would freebirth if they could not find a midwife to attend them at home; this is supported by a survey conducted by Sassine [5] and other research [3,21,27,29]. Midwifery attrition may contribute to increasing risk for women and babies.

Supporting women's lawful right to decline recommendations in childbearing is the legal and ethical responsibility of every midwife. If meeting that responsibility creates a level of professional and personal risk for a midwife such that she finds the work unsustainable, then something is amiss within the systems of maternity care in which midwives work. Support for women's agency in childbearing needs to become more than rhetoric. All professionals within the maternity care system need to work in ways which support midwives who are caring for 'decliners' so that midwifery autonomy can function in the moral and ethical way it is supposed to. Midwives should not be "reduced to defensive and all-consuming self-preservatory coping mechanisms and behaviours" by their colleagues and the system around maternity care [34], p. 14. Feeley [8] found that having supportive colleagues with similar philosophies was protective of midwives who were enabling women's alternative physiological birth choices, and that "Facilitating factors included positive organisational cultures characterised by strong leadership where midwives were trusted, and women's autonomy was supported." (p. iv). It would appear that the very professions and systems set up to safeguard women and babies through the maternity episode are acting as barriers or saboteurs of safety for the midwives who facilitate women's right to bodily autonomy and provide women with genuine choice. This can make ethical midwifery practice unsustainable and may contribute to workforce attrition. There is global evidence that some women who cannot find a midwife are willing to facilitate their agency and choose to freebirth [3,25,31,35,36]. Moreover, the lack of support from colleagues and systems around midwives who facilitate choices outside and beyond recommendations and guidelines leads to suboptimal communication. It can be construed that in such scenarios, rather than safeguarding women's choices and outcomes, women are put at additional risk [34]. This has implications for

maternity care systems internationally.

None of the five themes which emerged from the meta-synthesis were surprising, although not everything was as had been expected. PF had anticipated finding more emphasis on the effects on midwives' families and the personal toll of providing care to 'decliners'; this may be missing simply because the question had not been asked. It was also anticipated that midwives would be concerned about their public reputation in the event of a poor outcome rather than their reputation amongst their colleagues as being a non-compliant practitioner, and again, it may be that we haven't yet asked the right question. It is possible that LMCs in Aotearoa New Zealand, as publicly-funded but self-employed health professionals, might have more concern about their public reputation as their income depends substantially on this. Reputational concerns can be a significant motivation to 'comply' when midwives are providing care for the majority of women who seek 'mainstream' maternity care from what is perceived as a 'safe' midwife who adheres to normative guidelines and recommendations. It is concerning that no studies have specifically asked this question of caseloading midwives, and it creates a limitation on the 'completeness' of the findings of this study, as contributing data was 'gleaned' from studies asking different questions. The questions posed to the participants of the included studies did not get to the heart of this phenomenon of concern because that is not what the researchers in the eight studies included in the meta-synthesis were investigating.

6. Strengths and limitations

A strength of this study is that all the authors have a background of providing midwifery care to women who decline recommendations so are familiar with the general topic and the reality of providing such care; two of the authors [SC and NW] have experience of practising in this way internationally.

A limitation is that no studies specifically examining the phenomenon of concern were identified; rather, the findings are generated from 'gleanings' found in related studies. It is likely that there are many other studies where midwives have briefly expressed their perception of risk to themselves in any of the multitude situations where a woman might decline recommended care – it was not possible to conduct such an exhaustive search for this study. Moreover, only studies available in English were included and it remains unknown if other non-English sources would have added further to the synthesis. Moreover, this exclusion of non-English articles may have limited the review to high income countries/regions resulting in limitations regarding recommendations for scaling up of midwifery continuity of care across all global regions. A strength of the study is the application of a recognised systematic seven-phase process using verified standardised tools for critical appraisal of articles, robust inclusion/exclusion and data extraction processes. The strength of this synthesis is how cohesive the data was across the eight included studies supporting the five newly synthesised themes; in addition, a strong congruence was established giving strength to the findings. Furthermore, the five themes were quality verified by two authors applying the CERQual process adding confidence, relevance and trustworthiness of the final synthesis and subsequent line of argument.

7. Recommendations for further research

While this meta-ethnography has gone some way towards answering the research question, it raises many more unanswered questions. For example, is there a difference in caseloading midwives' perception of risk to themselves depending on whether they personally are aligned or in agreement with the woman's decision to decline recommended care? We do not know whether the same impacts would be felt by midwives working in more fragmentary services. Damaged reputation – is this a greater risk for caseloading midwives than for midwives providing fragmented care, due to their lengthy relationship with the woman which 'should', according to colleagues and others, provide ample opportunity to 'educate' the woman towards compliance? In facilities where midwives caring for 'decliners' experience supportive collegial relationships, what is it about the culture and leadership which has brought this about? Does 'risk negotiation' and experience/perception happen differently if the midwife and woman are ethnically matched? How do midwives experience the burden of grief following a poor outcome when women decline recommendations, and how is this different to the burden of blame? It was beyond the scope of this review to consider what measures caseloading midwives took to protect and sustain themselves from various risks, and how effective these were. The question of sustainability of caseloading midwifery and safety for women and infants in regards the phenomenon of concern in this review needs further urgent investigation.

8. Conclusion

This meta-synthesis has confirmed that the phenomenon of caseloading midwives' personal and professional risk when women decline recommended care has not been specifically examined in existing research. This reveals a significant gap in our appreciation and understanding about potential vulnerability in caseloading midwifery that may not be sustainable. In this meta-synthesis we have highlighted some evidence of this phenomenon from a variety of related midwifery studies from four global regions. Four of the five risk themes relate specifically to midwives' interactions with other health professionals within their respective maternity systems. The other risk theme, heavy psychological load, has aspects which are contributed to and exacerbated by interactions with colleagues, including midwives and allied health professionals. Midwives' interactions with colleagues creates potential for the provision of ethical care to become impossible to sustain, perhaps increasing risk to the women and babies they care for.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2022.06.014.

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