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Normal birth, magical birth: the role of the 36-week birth talk in caseload midwifery practice

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Abstract
Objective: to obtain a detailed description of the 36-week birth talk, and how it is delivered to and perceived by women and their birth partners.
Design and method: two qualitative methods: ethnography and interpretative phenomenological analysis. Non-participant observation of five birth talks and in-depth semi-structured interviews with midwives, women and their birth partners.
Setting: two caseload midwifery practices in an inner city area of England, and women's homes.
Sample: five birth talks, five case-loading midwives, five childbearing women and five birth partners.
Findings: a rich description of the content and conduct of the birth talk emerged from the data. In addition, three master themes were identified: a new philosophy for birth ('don't forget the magic'); the construction of authoritative midwifery knowledge ('they make you believe that you can have what you want'); and achieving a sense of coherence ('making sense of the birth').
Implications for practice, policy, education and research: the majority of data from this study suggest that the effectiveness of a birth talk cannot be separated from the philosophy and continuity associated with caseload midwifery practice. The birth talk is therefore probably not transferable per se into different models of care in order to achieve higher rates of normal birth. Further evaluation of the effectiveness of the birth talk in clinical practice, and further research into alternative birth philosophies in different settings is now required. Caseload midwifery practice has been shown to benefit women and midwives. This study would seem to concur with these previous findings. The sense of coherence concept could prove to be a useful tool to measure outcomes in future midwifery research.
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Keywords Ethnography; Interpretative phenomenological analysis; Birth talk; Antenatal education; Normal birth; Caseload midwifery practice; Authoritative knowledge; Midwifery philosophies; Sense of coherence

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Introduction

Medical intervention in childbirth is now the norm in the UK and most affluent countries (Henley-Einion, 2003). The caesarean section rate in England rose from 4.6% in 1970 (Savage, 2001) to 23% in 2005/2006 (Information Centre, 2007). In 2005–2006, women who had normal births in England (47%) and Scotland (39.4%) were in the minority (BirthChoice UK, 2006). English maternity statistics define a normal birth as one 'without surgical intervention, use of instruments, induction, episiotomy, epidural or general anaesthetic'. Thus, the 'normal delivery' group includes women who have: augmentation of labour; artificial rupture of the membranes if not part of medical induction of labour; Entonox; opioids; electronic fetal monitoring; managed third stage of labour; and antenatal, delivery or postnatal complications (including, for example, postpartum haemorrhage, perineal tear, repair of perineal trauma, and admission to special care baby unit or neonatal intensive care unit) (Information Centre, 2007; Maternity Care Working Party, 2007).

There is increasing concern about the public health impact and short- and long-term effects of rising intervention and caesarean rates in childbirth (National Institutes of Health, 2006; Gray et al., 2007; Villar et al., 2007). There is also a suggestion that events which occur in childbirth can affect women's fears for future births (Ayers and Pickering, 2001; Gottvall and Waldenstrom, 2002; Murphy et al., 2003; Weaver et al., 2007). Finally, there is also evidence that increasing intervention is costly (Petrou and Glazener, 2002), and that caesarean section costs a health service substantially more than other modes of delivery (Henderson et al., 2001) in a range of settings (Tracy and Tracy, 2003).

The need has been identified for further research into the factors that maximise normal births and healthy outcomes for mothers and babies (Department of Health, 2005), and one such factor may be appropriate antenatal preparation for birth. Providing antenatal education is part of the midwife's role (Nursing and Midwifery Council, 2005). In standard National Health Service (NHS) midwifery, antenatal classes are promoted and the use of birth plans is encouraged. However, the effectiveness of such practices is disputed by professionals themselves (McIntosh, 1993; Price, 1998; Spiby, 1999; Nolan, 2001). Women have been found to be dissatisfied with the information they receive during pregnancy and childbirth, particularly when expecting their first baby, and disadvantaged groups have difficulty accessing the information they need (Singh et al., 2002). Nolan (1997, 2003) describes antenatal education as an artificial construct which has historically reflected paternalistic obstetric values. A Cochrane Review found that the effects of antenatal education remain largely unknown (due to poor quality trials), and concluded that further research is required to develop effective ways of helping health professionals support pregnant women and their partners in preparing for birth and parenting, based on parents' needs (Gagnon, 2007).

In caseload midwifery practice, it is common practice for an individualised 'birth talk' to take place at around 36 weeks of gestation (Leap, 1996; Sandall et al., 2001; Kemp, 2002; Randle, 2002) between the pregnant woman and her birth supporter/s and the midwives who will be present at the birth. Caseload midwifery practice has been associated with higher than average normal birth rates (Page et al., 2001; Sandall et al., 2001; Henty, 2004). The birth talk is suggested as one midwifery intervention, among others, that may account for this (Sandall et al., 2001).

This study aimed to describe the 36-week birth talk and explore midwives', women's and their birth partners' experience of the birth talk. This study is intended to be the first step of a larger evaluation of the effectiveness of the birth talk in clinical practice.

An initial literature review was conducted on all aspects of antenatal education and preparation for birth. This showed that within formal midwifery literature, the birth talk has not been fully described, and there is no high-quality evidence to support its use. Leap (1996) describes the birth talk as a meeting with an individual women and her birth partner/s at which pictures of births are viewed together, and the processes and roles of participants in a labour are explored. The emphasis is on optimising the potential for physiological birth and on building the woman's confidence in her ability to birth without intervention.

Methods

Research design

Two qualitative research approaches were used: ethnography and interpretative phenomenological analysis (IPA). Donovan (2006) proposes that midwives can understand pregnancy, childbirth and motherhood from a cultural perspective through ethnography; she also suggests that ethnography may include other methods of data analysis. IPA was chosen as the framework for the analysis. This is

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concerned with trying to understand how people make sense of their experiences (Willig, 2001) and is being used increasingly within the sphere of reproductive health (Touroni and Coyle, 2002; Kay and Kingston, 2002; Robson, 2002; Holt and Slade, 2003; Maker and Odgen, 2003). Combining or triangulating ethnographic and IPA approaches can lead to greater understanding of experiences (Maggs-Rapport, 2000).

Sampling and recruitment

IPA studies are based on small purposively selected samples (Smith, 2003). Two well-established caseload midwifery practices were selected, both of which include birth talks as standard practice. Women were sought from a variety of ethnic and cultural groups, parities and living arrangements, thus the sample of five birth talks and 15 participants allowed for diversity of practice and experience, but also allowed for the identification of common themes. Two women were primiparous and three were multiparous. Two women were White British, one was White European, one was from South East Asia and one was from Africa. The five birth partners were of White British, Black Caribbean and South East Asian origin, and included the father of the baby and friends. The five midwives were drawn from two group practices and had between 4 and 18 years of experience.

'Internal coherence' (Smith and Osborn, 2003) occurred as no new themes emerged from the data. Two birth talks were observed and the interview schedules were piloted with midwifery colleagues prior to the collection of data. Access for this study was negotiated with the NHS trust, the midwifery practices and the individual participants. The midwives acted as 'gatekeepers' (Hammersley and Atkinson, 1995) to the women and their birth partners, who in turn displayed trust in their midwives' confidence in the researcher.

Ethical considerations

The study was approved by the Ethics Committee of Kings College London as well as the Ethics Committee and Research and Development Committee of the NHS trust. Written consent was obtained from each participant, and non-native English speakers were offered translation services. All data were anonymised and pseudonyms were used. Prior arrangements were made for debriefing clients and field supervision if necessary.

Data collection

Data collection took place between March and June 2003 and was recorded by audiotaping and field notes. Five birth talks were observed, and in-depth semi-structured interviews, 45–90-min long, were subsequently conducted with midwives, women and their birth partners within 3 weeks of the birth. Semi-structured interviews are the exemplary method of data collection in IPA (Smith and Osborn, 2003). Separate interview schedules were devised for midwives and couples. The woman and her birth partner were interviewed together in order to capture shared meanings and stories (Arksey, 1996). Midwives were interviewed individually, either in the homes or their practice offices.

Data analysis

The tapes were listened to and transcribed immediately, and each transcript was read several times. Initial notes developed into 'emerging themes' and then 'subordinate themes' as the researcher looked for connections between them, constantly checking back to the transcript to make sure the connections 'worked' with the primary material (Smith and Osborn, 2003). A new list of 'clustered themes' was produced, with extracts from the text pasted in. Finally, a table of master themes was constructed (Smith et al., 1999).

Validation of themes

Given the potentially traumatic subject matter of the data and time constraints, the researcher's supervisors (both experienced qualitative researchers) and an independent IPA expert, rather than the participants, checked that the themes were consistent with the data (Harris and Lindsey, 2002).

Reflexivity

Reflexivity means having sensitivity to ways in which the researcher has affected the research process and findings (Murphy et al., 1998). Unlike some other qualitative methods where the researcher's identity or perceptions are 'bracketed' or set to one side, IPA specifically uses the researcher's perspectives to shape the analysis, using their conceptions to help make sense of the participant's experience (Smith and Osborn, 2003). In this study, the researcher considered the practice of the midwives to be akin to herself philosophically and felt comfortable with the interactions observed between midwives and

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Table 1 Birth outcomes—place of birth.

Name	Parity	Place of birth	Reason for transfer
Wendy	0	Hospital	Meconium-stained liquor
Anh	0	Home	n/a
Tapiwa	0	Hospital	Slow progress in first stage
Monika	1	Home	n/a
Claire	1	Home (water birth)	n/a

n/a, not applicable.

women. Listening to the tapes promptly and subsequently transcribing them herself allowed the researcher to appraise her communication style, interview technique and level of participation in birth talks.[1]

Findings

Outlined below is an overview of birth talk content and delivery, followed by discussion of the three key themes that emerged from the data. Firstly, the communication of an underpinning philosophy that birth is both normal and transformational, and that birth is a social and cultural event. Secondly, the communication of authoritative midwifery knowledge grounded in experience and expertise that reinforces the message. Finally, how this particular type of preparation engenders a sense of coherence, enabling women to 'make sense' of their birth experience, providing a strong grounding for future parenthood.

Birth outcomes

This study did not set out to be representative. However, it is worth noting that all five women had spontaneous vaginal births, and laboured for some time at home (see Table 1 for place of birth). At the time, the caesarean section rate in the trust was around 27%. All women were attended by a known midwife. All the women breast fed their babies at birth, and four were still breast feeding 3 weeks later.

What happens at a birth talk?

The birth talk almost always takes place in a woman's home, and takes approximately 45–90 min. There are usually at least three people at a birth talk: a woman; her partner and/or chosen birth partner/s; and one or two midwives. All of the birth talks observed started with a standard antenatal check (blood pressure measurement, urinalysis and abdominal palpation).

Establishing ground rules for calling the midwives

Midwives who hold a caseload are on call much, or all, of the time. Setting ground rules for pager use was felt to protect midwives from being called unnecessarily, increase the likelihood of the known midwife being present at the birth, prevent unnecessary admissions to hospital, and empower the woman and her partner:

> So, in the daytime … it's good to let me know what's happening, even if you don't need me to be here… But at night time … as long as someone is with you… you don't need to call me until they're coming like this, every 2 or 3 min, then call me. OK? But if you're frightened or worried, then call me anytime, OK? (Heather, midwife to Tapiwa)

Demystifying birth

The conversation then generally followed a chronological path through labour, using visual aids freely, trying to make sense of the birth process for women and their birth partners. Sally explains:

> A lot of women may get to 36 weeks of pregnancy without really having much idea of what they're doing when a baby comes. So … one of my main aims for the birth talk is making sense of what's going to happen so that when it does happen they can relate it to something that they've heard or seen. (Sally, midwife)

Discussing the place of birth

At all of the birth talks observed, midwives spoke about home birth as the norm. The method of

[1]All details regarding participants have been anonymised.

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calling the midwife is the same regardless of whether or not the woman has decided on her place of birth, and does not therefore exclude those women who only make that decision when in labour. Gail explained her approach to discussing place of birth with women:

> Some women might be very clear (about where they want to give birth) but others might … surprise you and say …'I'd quite like a home birth' … or they might say 'I'd just like to wait and see what happens'…. I feel … a duty to be clear what the evidence is about home births … and some women will then say … 'I still think I prefer to give birth in hospital' and you say 'well absolutely fine, but on the other hand I can come and visit you when you are in labour and you can still make up your mind then'. (Gail, midwife)

Talking about pain

Midwives expressed their desire to be honest about pain, but also to be positive and to assure women that they would probably be able to cope with it. Women appreciated the midwives' attitudes to pain:

> With Charlie's birth, no one had told me I can deal with the pain. … What I needed was someone to say 'come on Claire, you can do this, breathe through it'… (This time) Lizzie was brilliant… making me believe I could do it. (Claire, woman)

Talking about the birth and after the birth

Describing the birth itself was often illustrated with the use of photographs, drawings or acting. Practical preparation for the birth was mentioned briefly, and a printed sheet with information was provided. The assumption was made that women would breast feed. Midwives also explored couple's preferences for neonatal vitamin K and mentioned the baby's newborn check:

> I ask the parents if …they've read anything about vitamin K… I ask them to tell me what they know and I elaborate on what they know. I go through the pros and cons and talk about the research that was done and what it showed, and just ask them what they feel about it really. (Maxine, midwife)

Master themes emerging from the data

A new philosophy for birth: 'don't forget the magic'

The philosophy of the midwives in the practices was clearly the foundation for the birth talk and the delivery of midwifery care. This philosophy believes that birth is both normal and transformational, and that birth is a social and cultural event.

Birth is normal. Physiological birth was understood as normal birth by midwives. The birth talk was seen as a crucial opportunity to reinforce this message. Women's and birth partners' experiences demonstrated that the message had indeed been conveyed:

> I think actually having the conversation together, all of us together… going through various scenarios… … kind of normalised birth… made it into just a normal process… it's not an illness. (Claire and David, woman and partner)

Midwives were observed taking every opportunity to speak about women's bodies positively and affirm women in their capacity to birth a baby. The philosophy of normality was further reinforced by making the birth seem real and achievable. Maxine explained:

> It makes it more real, within their own circle of reality. It is a bit unbelievable birth, you know ...so making it as real as possible, taking it away from the hospital environment where things are very removed and not so real, and bringing it back into the home of the woman and her partner possibly where they are going to have their baby. (Maxine, midwife)

Birth is transformational. In contrast to the concept of birth as normal, midwives also demonstrated a philosophy of birth as a life-changing process. Sally explains her understanding of transformative birth:

> It's about going beyond the physical stuff and talking about the beauty of birth and the magic of birth and how incredible it is, and how fantastic it is, and about how lucky they are that they're about to do that.. let's celebrate it! What I would like to say … is 'don't forget the magic'. (Sally, midwife)

Several midwives spoke of empowering the woman. Anh, Claire and David illustrate the outworking of this philosophy of empowerment and transformative birth:

> (Now) I am very pleased … when I (was in) pain I feel it's very terrible and I want everything to

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pass quickly. But Sally said 'I'm not bring(ing) the baby to you... you must do everything for the baby and you (will) feel very happy when you saw baby here....' And when I saw baby you know I feel very confident and I feel I am very happy... (and) actually I like Sally's ways. (Anh, woman)

Giving birth to her was ... just such a lovely experience... Lizzie... was able to make me feel that I could actually cope with it... It was still bloody painful, but it was positive.... we couldn't believe we were at home. (Claire, woman)

...How could you top that?! (David, partner)

Birth is a social and cultural event. The birth talk was observed to provide a ritual to mark the imminence of the birth. Birth was put back into the context of the woman and her family or support network. Where the woman did not have a rich social network, the midwife was instrumental in forming this, building networks between individual clients and through antenatal groups. There was a special place for the role of the woman's partner and/or birth partner, and children were welcomed at births and birth talks.

I was offered that I could catch the baby and cut the cord ...I really liked that, the fact that I was, you know, given that chance to do that. (Julie, partner)

The construction of authoritative midwifery knowledge: 'they make you believe that you can have what you want'

Women and birth partners displayed high levels of confidence in midwives and trusted the knowledge and information given to them by their midwives as 'authoritative'. A number of factors contributed to this.

Connectedness. Midwives used a variety of strategies to connect and engage with women and birth partners. Photographs were shown at five of the six birth talks observed:

I think the photos are really powerful... the fact that we all looked at them together... it was a bonding kind of thing, for a couple to do it together, cos it's like you're all going to share it together... Also it's like going through a mini birth because they tell you the story; ... It's a journey... and we're going on it (too) and it's going to be fine. (Wendy and Julie, woman and partner)

Commercial and hand-drawn pictures were also shown at birth talks. Midwives acted out birth processes, positions, noises and behaviours. Birth stories were told at birth talks and, reportedly, at ante-/postnatal groups by midwives and other women.

Continuity and trust. Midwives' knowledge appeared to be accepted as authoritative because of the relationship of trust between the midwife, the woman and her partner:

I remember being quite surprised and shocked when (Anh and Xuan) said we'd like to have our baby at home... I know that at the booking I had talked to them about it... but I think (the decision) was about trusting me as their carer, as their professional who was going to be looking after them. (Sally, midwife)

Lizzie and Heather managed the birth brilliantly ... When they were explaining why they had to do things, I did believe them and trust them you know, and I believed their reasons for doing them. (Wendy, woman)

Choice: reality not rhetoric. The midwives in the study all expressed a deep commitment to enabling women to make informed choices about childbirth. Choices are discussed from the outset of midwifery care, but the birth talk was seen as a time to pull information together and make sense of it. Midwives acknowledged that making choices can be difficult:

Just supposing you had someone who had decided (in labour) to stay at home to have her baby when she'd always said she never wanted to do that...If (she's) coping well with her labour, even though she had said she wanted to be in hospital for the actual birth, it's not always right to assume she wants to go straight off to the hospital and it's not always right to assume that she doesn't. (Gail, midwife)

Peer support: the bedrock for authoritative knowledge. Midwives from both practices spoke of the importance of proactive team-building and peer support to enable them to swim against the prevailing obstetric-led culture of birth and to present midwifery knowledge as having authority. This support was mainly from within the practice itself; in order for this to be achieved, midwives considered it essential for the practice to choose its own members and to be self-managing, with all members having equal status. Weekly practice meetings were prioritised. Maxine illustrates:

The team is all democratic.....We choose the midwives that we think would be suitable ...Obviously, there are some clashes in the team but the majority of the time we all support and respect each other well. And having that is so important. ... If I'm off and (my pager) goes through to Jenny or Caroline or whoever, she is

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going to give more or less the same kind of advice and have more or less the same attitude as me and that makes a big difference. (Maxine, midwife)

Achieving a sense of coherence: making sense of the birth

The women in the study were interviewed within 3 weeks of their babies' births. All of them and their birth partners described their births positively and demonstrated what Antonovsky (1987) describes as a 'sense of coherence'. This concept relates to how people understand, manage and attribute meaning to life events. This sense of coherence was evident in several ways: couples demonstrated understanding of birth as natural and manageable; the ability to embrace the birth experience and move on; and the enrichment of relationships.

Birth is natural and manageable. Women and birth partners were observed to demonstrate an understanding of birth as natural (or physiological) and manageable. Monika reflects:

> (I thought) women have the strength to do this ... I take it as a challenge and yes it's going to be difficult, but I can do this ... we're made to do this. And so I wasn't really afraid at all. (Monika, woman)

Embracing the birth and moving on. When interviewed, all women and partners had already attributed a strong sense of meaning to the birth, and appeared to have been enriched, or even healed, rather than traumatised by the experience. There was also evidence of couples expressing hope about the future. Claire shared how this, her second birth, had finally enabled her to come to terms with her traumatic first birth:

> (I found Charlie's birth) very difficult to deal with and I didn't bond with him hardly at all... Whereas (this) birth ... I bonded with her a lot quicker ... it had a real effect on her, and on us... don't think I ever came to terms with (my first) birth, not until after I'd had (this baby). (Claire, woman)

Enriching relationships. Couples demonstrated that the birth experience had enriched their relationship. Xuan was happy that he was able to share the birth with his wife, something that is not encouraged in his own culture:

> I was happy, you know, because I influenced her, and I could share everything with her on that important day. (Xuan, partner)

Discussion

Limitations

IPA is limited to articulate participants; it does not attempt to explain people's experiences, only to describe them (O'Connor and Hallam, 2000; Willig, 2001). Qualitative work in general does not lead to specifically statistically generalisable findings, although the themes generated may be theoretically generalisable.

Midwifery philosophies

The midwifery philosophy demonstrated in this study echoes Aikins-Murphy's (2004) philosophy for midwifery which believes in women and their potential for normality, and with Kennedy's (2000) description of exemplary midwifery practice which supports normality whilst respecting the uniqueness of the woman. The biomedical model of birth has been criticised for being feto-centric (Rothman, 2001), seeing women's bodies as defective and abnormal, and suppressing women's knowledge of their bodies, even by women themselves (Jordan, 1996; Cahill, 2001; Davis Floyd and Mather, 2002). Feminist and sociological writers (Annandale and Clark, 1996; Jordan, 1996) suggest that patriarchal institutions and models for birth can take away any notion of achievement for the woman. Being in control of the childbirth experience has been shown to be important to women (Green et al., 1990; Simkin, 1991; Gibbins and Thomson, 2001).

The concept of normality in childbirth may originate from a pathological and technocratic perspective which is inappropriate for midwifery (Davis-Floyd and Sargent, 1996; Fielder et al., 2004). Downe and McCourt (2004) suggest that normal and abnormal are unhelpful concepts for midwifery; rather, normality can be viewed as a continuum, with every woman being capable of her own unique normality. The philosophy of birth as a transformational or life-changing process is supported by Fleming (1998), who speaks of the 'miracle of birth' which occurs when midwives are concerned with the making of a mother, not just the making of babies. Giving value to the woman's experience is associated with a social model of childbirth (Walsh and Newburn, 2002). Birth everywhere is socially marked and shaped (Jordan, 1993; Sookhoo, 2003). The social model of childbirth portrayed in this study is described by Davis-Floyd and Mather (2002) as holistic. This philosophy is common to caseload midwifery care

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and has been shown to be appreciated and valued by women (Walsh, 1999; Page et al., 2001; Sandall et al., 2001).

Authoritative midwifery knowledge

Authoritative knowledge is defined as the knowledge within a community which is considered legitimate and which counts (Jordan, 1996). Within UK midwifery culture, biomedical knowledge is largely considered to be authoritative, and women can be steered towards making choices which favour medicalised childbirth (Levy, 1999; Walsh and Newburn, 2002; Stapleton et al., 2002a). Fleming (1998) suggests that midwives continue to perpetuate their own position of subordination in relation to the medical profession. Behaviours such as lack of mutual support, pressure to conform, policing of colleagues, bullying and horizontal violence have all been described amongst midwives (Leap, 1997; Kirkham, 1999; Gould, 2002; Stapleton et al., 2002b; Fielder et al., 2004; Kitzinger, 2004). Fielder et al. (2004) describe midwifery culture as non-connected and polarised, with midwives' thinking and doing seen as mutually exclusive.

In contrast, midwives in this study displayed connected thinking and connected relationships with each other and with clients, facilitating 'authentic midwifery encounters' (Siddiqui, 1999), in which both the midwife and the client are enriched. Connectedness involves acknowledging women's and midwives' intuitive knowledge (Davis-Floyd and Sargent, 1996) and engaging in explorative and attentive communication styles. This fosters trust in the authority of midwives' knowledge, enabling women to make real informed choices, and results in greater satisfaction for women and midwives. Women having choices is central to current UK maternity policy (Department of Health, 2004, 2007). This mirrors findings from other studies of caseload midwifery practice (Walsh, 1999; Page et al., 2001; Sandall et al., 2001; Stevens and McCourt, 2002). Continuity and consistency of midwifery care and the establishment of trusting relationships between midwives and women have been shown to facilitate women's choices and enhance their experiences (Green et al., 1990; Fraser, 1999; Sandall et al., 2001; Kirkham, 2004; McCourt, 2006a).

Sense of coherence

A 'sense of coherence' (Antonovsky, 1987) has been used elsewhere in midwifery-related literature as a tool to measure participants' coping mechanisms and subsequent well-being (Hallgren et al., 1995; Abrahamsson and Ejlertsson, 2002; Borrmann et al., 2002; Soet et al., 2003; Sjostrum et al., 2004). The sense of coherence displayed by participants so soon after their babies' births (and indeed the birth outcomes) appears remarkable in the present technological culture of birth in the UK. Yearley (1997) suggests that the final phase of motherhood as a rite of passage is the 'return from childbirth', but an easy transition to parenthood is unusual (Oakley, 1980; McCourt, 2006b). Some couples never manage to 'work it all out' (Rogan et al., 1997). Women's psychological and emotional well-being after childbirth are associated with having information which allows a sense of choice and personal control over the childbearing process (Green et al., 1990); even when interventions have been used, women may still describe their births as 'normal' if they have been offered choice and control (Viisainen, 2001). Borrmann et al. (2002) found that women achieved a high sense of coherence after birth when their birth attendants had displayed connectedness and competence, and when they had birthed their babies at home.

Conclusion

This study has provided a detailed description of the conduct and content of the 36-week birth talk. The birth talk is a practical meeting that consolidates previous antenatal encounters, explains what happens at a birth, and defines the roles of each participant. At a deeper level, it makes the birth seem real and fosters an understanding of birth as a manageable process that is both normal and transformational; it cements the relationship of trust between a midwife and her clients, and facilitates informed choice. It also plays a part recreating the culture of birth as a social and cultural event. The majority of data from this study suggest that birth talks cannot be separated from the rest of a woman's care; they are the continuation of an ongoing dialogue between midwife and woman throughout the pregnancy. In part, the birth talk is a 'rehearsal' for one particular birth; an opportunity for relationships between particular midwives and families to be deepened. This can only happen when continuity of care is likely to be achieved. Birth talks, as described in this study, have the potential to steer women towards a non-medicalised model of birth that they may not desire; however, the midwives in this study are keen to offer real informed choice, in a UK context where standard midwifery practice often steers

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women towards the cultural norm of medicalised birth.

It is always problematic unpacking complex packages of care. The birth talk is integral to other components of caseload practice such as the underlying philosophy of the midwives, relational continuity over time, early labour assessment at home, and choice of place of birth at this point in time for women with straightforward pregnancies. It is unclear whether the birth talk would have a similar impact as a stand-alone intervention in different care settings. Further evaluation of the effectiveness of the birth talk in clinical practice is now required to examine whether it might be an effective intervention which promotes normal birth, and if so, under what circumstances? Further research into midwifery and alternative birth philosophies in different birth settings would also add to the findings of this small-scale study. Caseload midwifery care in this study allowed midwives to construct and communicate authoritative midwifery knowledge. However, pro-active peer support and shared philosophy and values were essential in facilitating this, together with teams being self-managed and able to recruit their own midwives. Midwives need to examine the knowledge they consider to be authoritative and critically appraise whether they offer truly informed choice or compliance. They must take every opportunity to validate women's knowledge and build their self-belief, in the hope that women may say of them (as Claire said of her midwives):

> They make you believe you can have what you want... At each of my appointments, I always left them feeling that it was possible that it was going to be a good experience.

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