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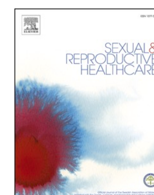

Midwives' action-guiding orientation while attending hospital births – A scoping review

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ABSTRACT

Following the "call for action to research", various aspects of maternity care should be examined so that perinatal care can be improved based on evidence. Clinical midwifery is the most common way of attending births in high-income countries. Midwives are the experts for normal labor and birth and play a central role in caring for women giving birth in a hospital setting. The aim of this scoping review was to explore midwives' action-guiding orientation in their care provision during hospital births in high-income countries. Four databases (CINAHL, PubMed, MEDLINE and PSYNDEX) were searched systematically for studies in English or German on midwives' action-guiding orientation during hospital labor and birth, published between 2000 and February 2022. Only studies from peer-reviewed journals were included. Reporting followed the PRISMA-ScR statement for scoping reviews. From a total of 1572 studies, 26 studies with 4 different research designs were included in the narrative synthesis. The synthesis shows 7 central concepts that emerge in the studies: medicalization of birth versus woman-centered care; midwives' knowledge and experience; midwives' professional identity; midwives' confidence or autonomy in practice; intra-professional and multi-professional relations; continuity of care and relationship with the woman; and working conditions and cultural context. The central concept most reflective of midwives' action-guiding orientation was "medicalization of birth versus woman-centered care." Other elements that affect midwives' action-guiding orientation and represent influencing factors at the micro, meso, and macro levels of obstetric care must be considered if one is to understand the profession and work of midwives.

Introduction

According to the "call for action to research" [1], research interest should focus on all aspects of care that have the potential to contribute to improve outcomes in women's and families' health [2]. Stated by the World Health Organization (WHO), there has been no evident progress in reduction of the already low maternal mortality rates in Europe or Northern America in the past years. Furthermore, the WHO calls for a shift of the focus from sheer mortality rates towards other aspects of care, such as quality of care, equitable access to, and delivery of care as well as regional conditions of care [3].

This development is exemplified by clinical care in childbirth: Since the 1970s, when births in industrialized countries shifted predominantly to clinics, the trend toward medicalization of births prevailed, with the aim of averting dangers to mother and child. As a result, a gradual focus on the risks during childbirth developed, shifting the emphasis away from physiology. In order to counteract these developments, a new movement began at the turn of the millennium. This movement calls for a more humanized care in childbirth [4].

The evidence-based theoretical framework for quality of maternal and newborn care by Renfrew et al. can be seen as a core framework for midwifery profession [5].

The attitudes, preconceptions and practical experiences of midwives are fundamental for their practical work. In this regard, various studies have been conducted [6–9]. However, in the studies, the nomenclature of the terms used to identify perspectives, attitudes and practice knowledge is diverse. The concept of *action-guiding orientation* according to Bohnsack seems suitable to bundle these terms. It is based on the

Abbreviations: OECD, Organization for Economic Cooperation and Development; PICOS, Population, Intervention, Control, Outcome, Setting; PRISMA-ScR, PRISMA Extension for Scoping Reviews; RMC, Respectful Maternity Care; WHO, World Health Organization.

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understanding that *orientation* in action is intertwined with practical knowledge. This orientation, that is guiding action is particularly evident in intuitive practical actions of experts and thus provides clues to the essence of a profession's actions [10]. Thus, the concept of *action-guiding orientation* is relevant for the midwifery profession.

However, so far to our (the authors') knowledge, the concept of midwives' *action-guiding orientation* itself has not been examined in scientific designs.

We set out to summarize literature on midwives' *action-guiding orientation* regarding their care provision, describe the present state of research on this topic, and make recommendations for practice and future research. Such a review of the scope of publications will help to discover and identify aspects that may be universal and of special interest for midwifery in hospitals.

For the intended review, the concept "*action-guiding orientation* of midwives while attending hospital births" was defined as focal point.

Methods

In conducting the scoping review, the 5 stages of Arksey and O'Malley [11] were followed: to identify our research question, search for relevant studies, choose the studies to include, chart the data, summarize the evidence, and report our results. The reporting of our scoping review follows the PRISMA Extension for Scoping Reviews (PRISMA-ScR) reporting statement [12]. No review protocol was published.

Identifying the research question

The guiding questions for the scoping review were: What is the current state of research on the topic of midwives' *orientation* in the care of hospital births? Which aspects of the concept of *action-guiding orientation* have been scientifically studied? What were the results of the studies?

Search for relevant studies

A systematic literature search was performed between June 30 and July 27, 2020 via the following databases: CINAHL, PubMed, MEDLINE and PSYNDEX. PICOS criteria (Population, Intervention, Control, Outcome, Setting) were defined where appropriate, using MeSH, synonyms and free-text terms, aiming at a systematization of the search strategy (see Table 1 and Table 2). A supplemental literature search was conducted in February 2022. An additional hand search was done by checking the reference lists of the studies considered.

Selection of sources for inclusion

We included publications that met the following inclusion criteria (see Table 2):

(a) scientific papers published in peer-reviewed journals; (b) publications of the past 2 decades from the year 2000 onwards, as clinical midwifery practice has distinctly changed since then; (c) articles published in English or German language; (d) publications of studies in industrialized countries where midwifery care is predominantly concordant were considered relevant. The latter criteria included OECD (Organization for Economic Cooperation and Development) countries as their health systems, economies and societal status were assumed to be more comparable than those of low-income or newly industrializing countries. However, due to the lack of comparability of midwifery services and practice, studies from the USA and Canada were excluded.

As it was expected that the concept of *action-guiding orientation* would not be identically named in research studies, all general perspectives on midwives' own practice during hospital birth were included, comprising midwives' attitudes, mindset, philosophy, expectations or practice. That's why a specific focus on single items or a special group of women cared for was not intended. Exclusion criteria were research reports on women's or partners' perspectives on birth, traditional midwives or student midwives, or community birth. Moreover, studies with a focus other than the midwives' orientation (e.g. pathology, socioeconomic status, organizational topics, evaluation of programs, or historical perspective) were excluded (see Table 2).

The database search identified 1540 studies; a further 32 studies were found with citation tracking and search update in 2022, resulting in a total of 1572 studies. After screening of titles, duplicates were removed resulting in 287 studies. All were transferred to the application Covidence [13], with the exclusion of 4 studies that could not be accessed. After screening of abstracts in Covidence, which was done independently by 2 researchers (GA, KL), the full texts of 110 studies were screened.

In the end, a total number of 26 studies were included in the narrative synthesis (see Fig. 1). The characteristics of the included studies are shown in Table 3.

Table 2
PI(C)O(S) and inclusion and exclusion criteria.

	PI(C)O(S)	Inclusion	Exclusion
Population	midwife (midwi*, health personnel, nurse midwi*)	midwives	women's or partners' perspectives on birth, traditional midwives or student midwives
Intervention	birth (labor/labour, childbirth, intrapartum, obstetric)	hospital context	community birth
Outcome	orientation, persuasion, attitude, philosophy, behavior/ behaviour, practice, experience, performance, routine, habit	perspectives on *orientation* of midwifery care or their usual manner of professional behavior during birth	focus on pathological topics, socioeconomic status in relation to birth, special needs of women special topics during labor and birth, general perspectives on clinical labor and birth organizational topics, evaluation of programs
Study design		scientific design study published in / after 2000	historical perspective

Table 1
Search strategy in PubMed Database.

MeSH Terms used	#1: "*nurse midwives*"[MeSH Major Topic] OR "*midwifery*"[MeSH Major Topic]	#2: "*labor, obstetric*"[MeSH Major Topic] OR "*natural childbirth*"[MeSH Major Topic] OR "*birth*"[Title/Abstract]	# 3: "*attitude*"[MeSH Major Topic] OR "*mindfulness*"[MeSH Major Topic] OR "*professional practice*"[MeSH Major Topic] OR "*orientation*"[MeSH Major Topic] OR "*philosophy*"[MeSH Major Topic]	#1 AND #3 AND #2
Number of hits	18,747	323,721	657,390	791
Filter: Abstract available → Final hits from PubMed: 570				

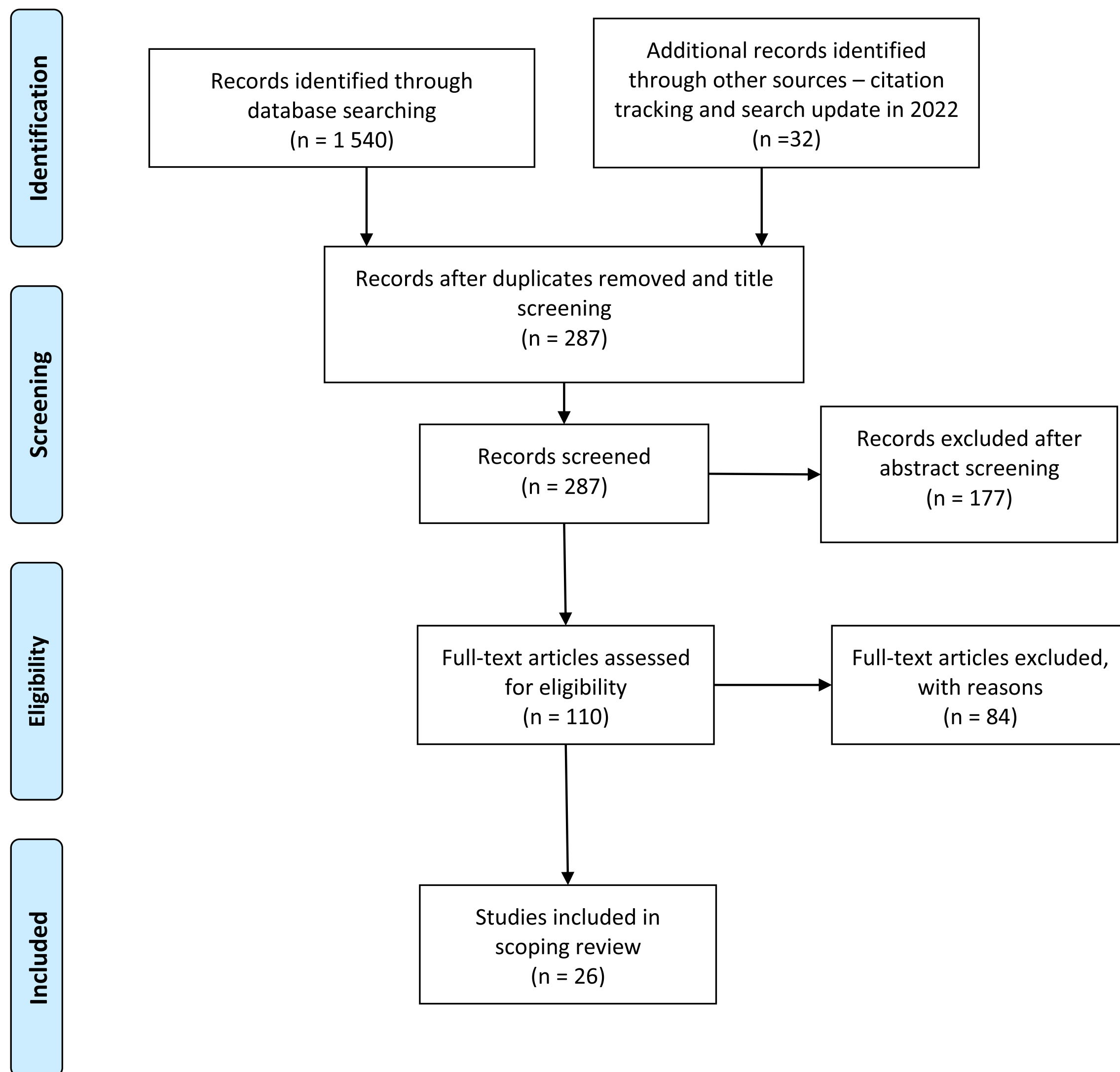

Fig. 1. PRISMA flow diagram of study selection.

Charting data

For charting the central results of the review an inductive process was performed. While reading the relevant studies, emerging concepts were noticed and categorized in an iterative process. This resulted (after the repetition of this process) in seven central concepts, which covered the main contents of the identified studies. During the second turn of the charting process, the results were assigned to the emerging categories, if they were reported in the abstract or full-text as results. The whole process was executed twice by KL, aiming for validity of the analytical steps and discussing cases of unclear inclusion with GA. Subsequently, a narrative synthesis was done to summarize and synthesize the results that due to the different methodical designs of studies were presented in different forms. In the case of qualitative studies, reported results or concepts were summarized and, when adequate, renamed on an abstracted level. Table 3 shows the seven central concepts which arose from the studies.

The personal competences and beliefs of midwives that are element of the seven concepts can be named as individual perspectives, representing a micro-level of *action-guiding orientation*. This micro-level can be understood as surrounded by the *meso*-level-elements of personal contacts during birth care that are directly related to midwifery work. And finally, as a social context of midwifery, elements of the macro-level, such as cultural and workplace conditions can be regarded (see Fig. 2).

Results

Three different levels touching midwives' work in hospital settings.

Micro-level elements

Professional identity

The concept of *being with the woman* was estimated as the concept identifying midwifery practice and distinguishing it from medical practice [14]. For example, the notion of *being a good midwife* was underpinned by the fact that the only way to do so was seen in providing continuous support for the woman in labor [15]. This holds great challenges for midwives, as even within established midwifery systems, there was a slow adaption process with a move away from traditional skills and the midwives eventually lost their professional self-confidence [16]. Midwives also wished for more role models, aiming at developing a more distinct professional identity [17]. Additionally, midwives saw their professional task in promoting physiological birth [18–20].

Midwives' confidence or autonomy in practice

Implementing continuity of care did not only facilitate taking into account women's preferences but increased the midwife's autonomy in her practice by being in a better position to support her well-being [21]. Midwives were more likely to work autonomously when they could rely

Table 3
Characteristics of the included studies and central concepts emerging from the studies.

First Author/ Year/ Country of Origin	Objective	Research Design	Data Collection Method	Sample	Results						
					Medicalization of Birth vs Woman-centered Care	Midwives' Knowledge / Experience	Professional identity	Midwives' Confidence or Autonomy in Practice	Intra-professional and multi-professional Relations	Continuity of Care / Relationship with the Woman	Working Conditions / Cultural Context
Andren, 2021 Sweden	Midwiveś experiences of how the birthing room affects them in their work to promote a normal physiological birth	Qualitative approach	Interview study	15 midwives	X		X			X	X
Aune, 2014, Norway	Experiences of midwives providing continuous supportive presence in the delivery room	Qualitative approach	Interview study	10 midwives	X		X	X	X	X	X
Aune, 2018, Norway	Experiences of midwives promoting normal birth	Qualitative approach	Interview study	9 midwives	X				X	X	X
Berg, 2012, Sweden & Iceland	Evidence-based midwifery model of woman-centered care	Theoretical/ Qualitative approach	Hermeneutic approach & focus group study	30 midwives	X	X				X	X
Blaaka, 2008, Norway	Midwives' experiences of daily work between biomedical and phenomenological system	Qualitative approach	Interview study	7 midwives	X	X				X	
Bradfield, 2019, Australia	Midwives' perceptions of 'being with the woman'	Qualitative approach	Interview study	31 midwives	X		X			X	
Carolan-Olah, 2015, Australia	Midwives' experiences and views on factors that facilitate or impede normal birth	Qualitative approach	Interview study	22 midwives	X	X		X		X	X
Copeland, 2014, Australia	Midwives' perceptions about childbirth and in particular their beliefs about normality and risk	Qualitative approach	Interview study with photo elicitation	12 midwives	X	X		X	X	X	
Deliktas Demirci, 2021, Turkey	Midwives' experiences of promoting normal births	Qualitative approach	Interview study	12 midwives	X			X	X	X	X
First Author/ Year/ Country of Origin	Objective	Research Design	Data Collection Method	Sample	Results Medicalization of Birth vs Woman-centered Care	Midwives' Knowledge / Experience	Professional identity	Midwives' Confidence or Autonomy in Practice	Intra-professional and multi-professional Relations	Continuity of Care / Relationship with the Woman	Working Conditions / Cultural Context
Healy, 2017, Ireland	Midwives' and obstetricians' perception of risk and its affect on care practices for normal birth	Qualitative approach	Interview study	16 midwives 9 other clinicians	X			X	X		X
						X	X	X			X

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Table 3 (*continued*)

First Author/ Year/ Country of Origin	Objective	Research Design	Data Collection Method	Sample	Results Medicalization of Birth vs Woman-centered Care	Midwives' Knowledge / Experience	Professional identity	Midwives' Confidence or Autonomy in Practice	Intra-professional and multi-professional Relations	Continuity of Care / Relationship with the Woman	Working Conditions / Cultural Context
Hildingsson, 2016, Australia, New Zealand, Sweden	Comparison of sense of empowerment across midwives in different countries	Quantitative approach	Cross-sectional study Questionnaire study	1 037 Australian midwives 1073 New Zealand midwives 475 Swedish midwives							
Hyde, 2004, Ireland	Midwives' perceptions of their role in the labor ward	Qualitative approach	Interview study	12 midwives	X	X			X	X	
Jangsten, 2010, Sweden	Midwives' experiences of management of third stage of labor	Qualitative approach	Focus group discussions	32 midwives	X	X		X	X		
Keating, 2009, Ireland	Midwives' experiences of facilitating normal birth in an obstetric led unit	Qualitative approach	Interview study	10 midwives	X	X			X	X	X
Larsson, 2009, Sweden	Midwives' understanding of their professional role and identity	Qualitative approach	Focus group study	20 midwives	X	X	X	X	X	X	X
Lavender, 2004, United Kingdom	Views of midwives working in maternity services	Qualitative approach	Focus group study	120 midwives 6 other clinicians	X			X	X		X
Martin-Arribas, 2020, Spain	Midwives' experiences on the facilitators and barriers of normal birth in conventional obstetric units.	Qualitative approach	Focus group study	33 midwives	X	X			X	X	X
O'Connell, 2009	Midwives' perceptions of hospital midwifery	Secondary research	Metasynthesis	14 studies	X						X
Peterwerth, 2022, Germany	Deeper understanding of the situations which midwives and obstetricians perceive as risky and of the factors affecting their risk perception	Qualitative approach	Focus group study	18 midwives 6 obstetricians	X			X	X	X	X
Prosen, 2019, Slovenia	Perspectives of healthcare professionals on	Qualitative approach	Interview study	16 midwives 4 obstetricians	X	X					X

(*continued on next page*)

Table 3 (*continued*)

First Author/ Year/ Country of Origin	Objective	Research Design	Data Collection Method	Sample	Results Medicalization of Birth vs Woman-centered Care	Midwives' Knowledge / Experience	Professional identity	Midwives' Confidence or Autonomy in Practice	Intra-professional and multi-professional Relations	Continuity of Care / Relationship with the Woman	Working Conditions / Cultural Context
	medicalization of childbirth										
Reed, 2016, Australia	Midwifery practice during physiological birth	Qualitative approach	Interview study	10 midwives 10 women	X	X			X	X	X
Scamell, 2016, United Kingdom	Constitution of midwives' understandings of childbirth in context with risk management	Qualitative approach	Ethnographic data collection	33 midwives 6 other clinicians 19 service users	X			X			X
Seibold, 2010, Australia	Midwives' perceptions of birth space and clinical risk management	Qualitative approach	Participatory approach & observation & focus group study	18/17 midwives	X				X		X
Styles, 2020, Australia	Midwifery's and obstetrics staff experience with implementation of midwifery continuity of care	Qualitative approach	Longitudinal interview & focus group study	15/17 midwives 6/5 obstetricians	X			X		X	X
Thelin, 2014, Sweden	Midwives' lived experience of caring during childbirth	Qualitative approach	Interview study & written narratives	10 midwives	X	X		X	X	X	
van Kelst, 2013, Belgium	Midwives' views on actual and ideal maternity care	Qualitative approach	Interview study	12 midwives	X				X	X	

X = results as reported in the study, but renamed for the process of charting.

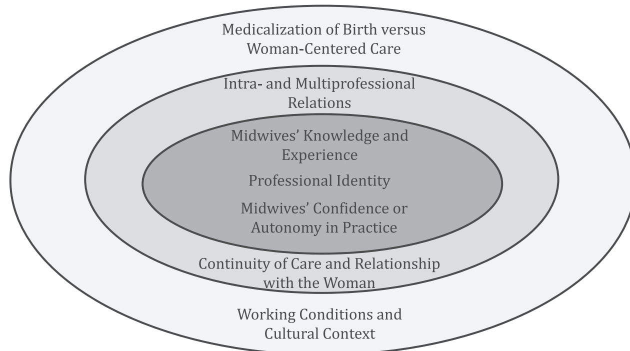

Fig. 2. Elements of midwives' orientation in clinical practice.

on their knowledge and skills [20,22], or reflected their thoughts and feelings about childbirth [19].

Midwives experienced positive effects on their own confidence, when also their confidence in the woman's strength was present [23]. On the contrary, negative effects on midwives' confidence in normal labor and birth were likely when clinical risk management concepts and obstetric practices promised safety [24], resulting in a feeling of disempowerment [25]. This also was the case, if the system of maternity care provision negatively impacted on midwives' autonomy in practice [26]. A sense of empowerment in midwives seemed to be connected with sense of a greater autonomy and recognition by medical professions or managers, when working in a health system that supported midwives' autonomy in practice [27].

Midwives' knowledge and experience

There was a holistic picture of knowledge and experience in daily practice, indicating that for example in some areas of hospital practice the midwives' knowledge was based on recent evidence leading to a more humanized childbirth [16]. On the other hand, their viewpoint on labor and birth seemed to be not always fully evidence-based [28]. Midwives' education and skills were seen as adequate to perform their role, while access to staff education and training were rated as rather insufficient [27]. From midwives' perception of their own expertise a sense of power over the care situation emerged [19,29,30] and their professional midwifery skills seemed to have increased by progress in medical technology [16]. In contrast, embodied and grounded knowledge helped in implementing a woman-centered midwifery-model of care [20,31] or might over the course of several years result as a consequence of practice experiences [23].

Meso-level elements

Intra-professional and multi-professional relations

An important element in multi-professional relationships seems to be the fact that obstetricians are the ones having the final say in any decision on maternity practice [20,25,26,32,33]. However, working as part of a team midwives could rely on was cited as a key point in successfully or unsuccessfully managing risky situations during childbirth, resulting in negotiations about best care [19,30]. Midwives from Sweden experienced their professional recognition and appreciation mostly as very good, but midwives from Australia and New Zealand regarded themselves appreciated only to a certain extent [27]. Swedish midwives made positive experiences in an improved communication with obstetricians, however, they were not consulting each other as they have done decades ago [16]. When caring for physiologic births, younger midwives seemed to be referring more to clinical guidelines and obstetricians' decisions [16], but also made positive experiences in support from, and training by, their colleagues [33]. At the same time younger midwives sometimes felt helpless on changing the philosophy towards more woman centered care [25].

Continuity of care and relationship with the woman

Based on experienced discrepancies between ideal and actual care, midwives strongly wished for more continuity in care [25,34], which is regarded an essential part of *being with the woman* [16,35]. A positive aspect of building a mutual relationship with the woman is the opportunity to increase confidence in the woman as well as accompanying or directing parents in their journey to parenthood [14,19,23,25,36,37]. In the context of a trusting relationship, it is necessary for midwives to manage disturbances for the woman and to reflect the women's inner wisdom in midwifery practice [18,19,38]. Limitations in satisfying the woman's desires seemed to arise from technological interventions or unsupportive environment in the labor ward during the birth process [25,29]. In addition, the responsibility for the woman in care became clear when the woman's autonomy was threatened in risky situations [30].

Macro-level elements

Medicalization of birth versus woman-centered care

The concept of woman-centered practice is described as a complex and diverse phenomenon with key-elements of communication, advocacy and flexibility amongst others [14,37].

A more or less risk-oriented context is identified as a major barrier in promoting and performing natural births and woman-centered care, this also includes the birthing room [16–18,20,22,24,26,29,32–34,36]. Reasons for medicalization of birth were seen as a complex process entailing measures of risk management, which in the view of midwives did not need to be carried out routinely in normal labor and childbirth [19,28].

While often being described as antipodes or balancing act [30,31,35], medicalization of birth and woman-centered care were also both found to be more or less equally guiding concepts for midwives in promoting normal labor [39]. Regarding the third stage of labor, midwives made an effort in risk assessment to synthesize the woman's birthing experience and her and the newborn's wellbeing [22], whilst trying to comply with the institutional standards [38]. Though experiencing medical care as the dominating mode of care in the hospital context, midwives still see woman-centered care as the ideal they wanted to follow in their daily work [20,25,34], making a special effort to promote physiologic birth in hospital [40]. Overall, the guiding concepts in midwifery seemed to be strongly influenced by existing organizational risk management and its technologies [24]. This sometimes even resulted in a process of relinquishing the idea of physiology in childbirth [19]. However, if there was a possibility to integrate women's preferences in their decisions, midwives were focusing on informed choice [34] or implementing continuity of care [21].

Working conditions and cultural context

An important influence on midwives' viewpoint of physiologic birth appear to be working conditions, which can be a barrier when inadequate, and an enabler when regarded adequate in terms of staffing, facilities and support [20,30,31,36]. However, if the general perspective prevails that birth is a risky business, it may influence midwives' perspectives of labor and birth in a risk-oriented way [24]. Cultural perspectives, as expressed by society, have a big influence on midwives' work: midwives wish for more visibility of their daily efforts in providing midwifery care and more societal recognition of women's strengths [16,25,26,34]. Midwives' own sense of empowerment seems to be more or less moderately touched by the culture of the health system and its conception of childbirth [25,27].

The implementation of the concept of continuity of care goes along with big organizational changes. However, these changes mostly had positive effects on midwifery work, such as a team approach among midwives, or the utilization of external supervision and mentorship [21]. In contrast, feeling supervised by obstetricians might bring some midwives to change their midwifery practice [38]. And, regarding the

actual working environment, midwives tended to regard it as a woman's space, rather than just a physical space or a place to give birth [32]. Focusing on the women, a lack of knowledge of physiologic birth seems to constitute a barrier to normal birth [16,36].

Discussion

In this review, a holistic picture of midwives' *action-guiding orientation* in clinical settings could be reconstructed.

Macro-level elements appeared in most studies as possibly conditioning midwives' *action-guiding orientation*. However, close links between levels suggest a great complexity of the concept of *action-guiding orientation*. With the exception of one quantitative study [27], all the studies' results highlight at least one aspect of "*medicalization of birth* versus *woman-centered care*". Not all of the studies focused on a possible diametrical relationship between those concepts, but there seems to be an understanding that there are those two dominating cultures in labor wards worldwide. Several study results describing midwives' desire for a more physiologic focus on birth report that the continued exposure to a model of biomedicalization in clinical settings is a daily struggle [17,31,35]. With this in mind, a closer look at the studies, in which midwives reported the integration of biomedical aspects in their daily work, might be helpful. There already are some suggestions to regard the models of holistic care and biomedicalization not as antagonists, but as the ends of a continuum [41]. Midwives from the neighbor countries Norway and Sweden reported different ways of freedom in professional acting. A possible reason for those findings might be the different organization of childbirth care in the two countries [22,35].

The degree of midwives' autonomy or empowerment that was explored in a cross-country study differed also according to country: Swedish and New Zealand's autonomously acting midwives had more sense of empowerment compared to the midwives working in the more medically oriented Australian health care system [27]. This might imply that the subjective sense of professional autonomy influences the midwives' *action-guiding orientation* in a positive way.

The confidence midwives feel when caring for a woman in labor is supported by a woman's openness to let the midwife know what she needs [23]. This is a situation that might be realized more easily in a model of woman-centered and continuous care. The concept of *being with the woman* helps the midwives to refine their professional profile [14]. However, this concept is strongly dependent on the amount of time midwives have for the women and easier to be implemented when continuity of care, or one-to-one care, can be realized. Results of this scoping review suggest that the concept of *being with the woman* makes most of the difference in midwives' and obstetricians' care when attending births. This also is according to recent findings [42]. Furthermore, also the notion of the *good midwife* seems to be interconnected with the ability to build a professional partnership-like relationship with the woman: The *good midwife* is accessible and shows physical presence is ready to engage in a close relationship with the woman, and helps with her knowledge and skilled support [7,43,44].

The confidence and autonomy experienced by midwives appears to be fragmented and strongly influenced by various conditions. For example, negative effects in midwives' confidence were reported when external circumstances were regarded as adverse or suppressive [24,26]. To the contrary, other studies revealed a rather positive picture of midwives' *action-guiding orientation* in their clinical work regarding women's wishes and needs during labor and birth. Possibly, a continuous model of midwifery care that is realized (at least in pregnancy) in Sweden accounts for this [23].

At the micro-level, midwives' knowledge and experience were found to influence their *action-guiding orientation* in care provision during labor and birth in positive and negative ways. Regarding effective midwifery training all over the world, the WHO recommendations for respectful maternity care (RMC) take into account predisposing factors. This means that midwifery students are already familiarized with RMC during their training, and that they acquire such practical skills in their teaching units [45]. In industrialized countries, midwives' seem to be concerned about carrying out original midwifery care measures [46]. In this vein, the implementation of the WHO recommendations for RMC might also help implementing more specifically original midwifery care in their countries.

Thus, midwives' *action-guiding orientation* in providing midwifery care during hospital births can be seen as a complex interaction of internal and external factors and conditions: internal factors comprise midwives' inner knowledge and expertise, as well as their confidence and autonomy. External factors pertain to the health care setting, the special features of care provision, and the philosophy of the obstetric system.

Implications

Midwives may benefit from the scoping review's results that entail implications for clinical midwifery practice. Even though external factors at a macro-level cannot be influenced by a single midwife, the parameters at the macro-level may possibly be influenced by a bottom-up perspective. This means that midwives as a group should rely on their knowledge, self-confidence and experience and thereby influence hospital obstetric care in the desired direction. This might lead to alliances with other professional groups in obstetric care, which could help change obstetric routines step by step, synthesizing clinical experience with scientific evidence. Moreover, a strong professional identity might help midwives to gain more confidence in their daily work; midwifery education should focus on this fact and foster its development. As this review reveals, intra-professional and multi-professional relationships can enhance midwives' daily work when being perceived as supportive.

Strengths and limitations

This scoping review shows the complexity of midwifery work in high-income countries and helps in gaining a deeper understanding of fundamental *action-guiding orientation* midwives show in attending clinical births. Yet, the findings of this scoping review cannot be generalized due to narrative synthesis from different research designs. Additionally, as the results from the studies were already rather versatile, midwives' *action-guiding orientation* might have been even more difficult to identify when integrating even more different countries and their midwifery practice. Another limitation of this review is the fact that it focused solely on midwives' *action-guiding orientation* in their care provision in hospital. Therefore, the description of their *orientation* does not include their possibly different orientation in out-of-hospital care during pregnancy, birth and the postpartum period.

Conclusions

Future research should concentrate on a still more detailed examination of external and internal factors influencing the *action-guiding orientation* of midwives. In addition, the hospital management and the leadership of the obstetric departments need to reflect on their philosophy and its effects on midwives' *action-guiding orientation* in childbirth care provision. On the part of the midwives, educational programs need to offer the opportunity to reflect on evidence regarding internal and external factors that affect midwives' self-confidence, autonomy, and woman-oriented care.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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